



# Understanding the Correlation Between Regime Repressiveness and Health Expenditure: A Quantitative Cross-National Analysis Using Data from 24 Countries

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## Abstract

This study investigates the correlation between the repressive nature of a regime and its impact on social spending over time, especially healthcare spending. Freedom House scores are used to measure regime repressiveness, which is a measure of the overall rights and freedoms experienced by a country's citizens.<sup>1</sup> This study systematically categorizes countries into nonrepressive, semirepressive or repressive regimes. Three independent variables were used in this study to measure health expenditure: total health expenditure as a percentage of the GDP (CHE), public health expenditure as a percentage of the total health expenditure (PHE) and out-of-pocket health expenditure as a percentage of the current health expenditure (OHE). Both dependent and independent variables were measured at 2000 and 2015 in order to evaluate changes over time. The findings suggest that the relationship between regime repressiveness and health expenditure is not as linear as previous studies report. In all three variables, the semirepressive regimes are the most mobile and dynamic group of countries in terms of social spending, leading to the conclusion that the relationship between regime repressiveness and health expenditure is not necessarily linear. More research needs to be devoted to exploring the complex nature of semirepressive regimes.

**Key Words** Health, Expenditure, Repressiveness

## INTRODUCTION

In recent years, an increasing number of studies have been devoted to discovering a link between regime type and social spending. Since the “Third Wave of Democratization” following the conclusion of the Cold War in the 1980s, many governments transitioned from authoritarian regimes to democratic regimes.<sup>2</sup> Consequently, an increased interest in studying the effects of this dynamic transformation of power ensued. Economists and political scientists were quick to try to quantify the implications of such a change on society. However, nearly 40 years have passed since this wave of newly formed democracies and the pace of democratization has been slowing down significantly.<sup>2</sup>

Much of the current literature regarding this material reports that the relationship between regime type and social spending is negatively and linearly correlated. As the repressiveness of a regime increases, the total health expenditure (CHE) tends to decrease. Moreover, public health expenditure (PHE), tends to decrease with increasing regime repressiveness while out-of-pocket health expenditure (OHE) tends to increase with increasing repressiveness. Semirepressive regimes have generally not been discussed in

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this literature. In this study, these relationships are tested by running a quantitative cross-national analysis on a set of 24 countries. The results are presented in graphical form, and a discussion and conclusion then follows the data in order to explain the implications of the findings.

## RELATED LITERATURE

The literature related to determining a link between regime type and social spending is essentially divided into two arguments. Kaufman and Segura's (2001) seminal work provides a theoretical framework that explains the relationships between globalization, political pressures and social expenditures. The authors present two opposing hypotheses that attempt to explain the relationship between globalization and social spending: the efficiency hypothesis and the compensation hypothesis.<sup>3</sup>

Beginning with the efficiency hypothesis, Kaufman and Segura explain how high levels of social spending can theoretically reduce competitiveness in global markets. For example, a country with high levels of domestic expenditure on social programs, such as health or education, typically have higher rates of income taxes in order to compensate for the extensive government expenditures. Consequently, the burden of taxes causes the cost of labor to increase, which directly increases the price of production. As a result of increased production costs, domestically produced items are devalued on the international market. Consumers can purchase the same item from a different exporter for much cheaper. In turn, exportation from a country with high social expenditure would be devalued while importation of cheaper, foreign products would be highly favored. According to this hypothesis, the domestic business sector would be inclined to pressure governments into reducing social expenditures in order to become more competitive in international markets.<sup>3</sup>

Furthermore, exposure to international markets reduces the bargaining power of the workers. For example, corporations have a greater ability to exit the domestic economy than the workers. If increased labor costs caused by payroll taxes negatively affect industry leaders, businesses can easily close, relocate their plants, and hire cheaper labor elsewhere. The voices of workers in globally interconnected domestic economies do not carry much weight.

The efficiency hypothesis suggests that as economies integrate and enter competitive global markets, governments are incentivized to pull back on social spending. As governments pull back on social spending, the bargaining power of businesses increases beyond the domestic confines of the state. This action strips the bargaining power from the working class and diminishes the political pushback felt by government leaders.

In contrast to the efficiency hypothesis, the compensation hypothesis proposes that international integration is a destabilizing event that pressures governments into increasing social expenditures. According to this hypothesis, “the welfare state is a mechanism for offsetting the social costs of international integration and the development of human capital.”<sup>3</sup> As a country liberalizes its trade policies and opens up their economy to outside market influences, it is inevitably exposed to greater demands in international markets, which can lead to “social dislocations, uncertainty, and unequal distributive effects.”<sup>3</sup>

Noted economist Simon Kuznets reinforces the disruptive effects of economic expansion brought upon by globalization. His theory of the inverted U-curve proposes that during the initial stages of economic development a country will experience increased levels of domestic inequality. Kuznets's hypothesis rests on the idea that economic expansion brings about new opportunities for investment; opportunities only the wealthy can take advantage of. As a result, these select members of society accumulate more wealth while the majority of citizens remain financially immobile. It is not until advanced stages of development are reached that the inequalities brought on by the process of growth and development begin to equilibrate. The early processes of economic liberalization are highly destabilizing and have great potential for opposition.<sup>4</sup>

As a result, a degree of pressure is placed on political and business leaders to keep much of the population at ease. Edward Muller and Mitchell Seligson (2014) find “that when income inequality is high, the probability of domestic political violence increases substantially.”<sup>5</sup> In this circumstance, the bargaining power is in the hands of the people. The political ramifications are much more extensive because the power is no longer consolidated within the government or in large corporations but vested in the people.

The degree to which people can operate this bargaining power against the state and large businesses is largely dependent on the freedom of the people, a measure of regime repressiveness. Muller and Seligson (2014) explain that “differences in regime structure are relevant to the explanation of cross-national variation in mass political violence.”<sup>5</sup> They present three categories of regimes into which countries can fall: repressive, semirepressive or nonrepressive. The degree of repression felt by the people can largely influence their ability to act on their bargaining power. Muller and Seligson point out three variables closely linked to regime type, which generally shape the actions of political resistance: “(1) the extent to which dissident groups are able to develop strong organizations, (2) their belief in the likelihood of success of collective action, and (3) the range of political opportunities available to them for achieving their goals.”<sup>5</sup>

In repressive regimes, people do not have the ability to easily organize. Organizations such as labor unions or lobbyist groups do not exist because the people are under oppressive control. This authoritarianism has been ingrained in the political tradition of the country and the people are not optimistic about their likelihood of successful collective action. The opportunities to engage in political activities in such regimes are severely limited, if not nonexistent. Even if political engagement opportunities are available, they have a high chance of being corrupted and making little impact.<sup>5</sup> Albeit their repressiveness, authoritarian regimes tend to be stable. The rate of political unrest is relatively low because the consequences of political disobedience are quite severe, which in turn dissuades resistance.<sup>5</sup>

On the contrary, citizens in nonrepressive regimes can easily form organizations because governmental control is not as strict. Organizations, such as labor unions and lobbyist groups, have the ability to protect the people against abuses of government and big business.<sup>5</sup> Citizens are, therefore, optimistic about their chances of successful collective action. One could assume that nonrepressive regimes would be riddled with violent political upheavals due to the ease of successful collective action. This is not the case. Nonrepressive regimes provide peaceful, legal avenues for political engagement. Similarly to repressive regimes, nonrepressive regimes tend to be relatively stable because people have a voice and are able to see an impact as a result of that voice. As a result, the level of violent political resistance is relatively low, which yields a stable society.<sup>5</sup>

Semirepressive regimes present a peculiar case. In these regimes, citizens are not as restricted as those in repressive regimes which means they are able to form relatively strong organizations. Because of this ability, organizers have a high perception of success. Their ability to engage peacefully and fairly in the political process is often limited by corrupt government executives who rig elections, bribe voters, and use other illegal means to maintain power. In semirepressive regimes, the people are only permitted to engage in a type of “pseudo-participation”, which is described as “an elaborate charade of the participatory process.”<sup>5</sup> This means that the people are allowed to vote in elections, organize political groups and engage in civic discourse without severe consequences, but the effects of this engagement are not visible because the participation is not genuine. While government leaders have given some “perceptive freedom” to the people by setting up “a facade of participatory institutions,” the executive control is still in the hands of an authoritarian government.<sup>5</sup>

Consequently, semirepressive regimes tend to be the most unstable. Since citizens are made to believe that their voice matters, they expect results. When governmental policies or leaders do not change to reflect the sentiments of the people, a sense of frustration ensues. This frustration, ergo, manifests itself in the form of violent political resistance because the people realize that peaceful, legal means of adopting change are not effective.<sup>5</sup>

Tying back into the compensation hypothesis, this highlights how the destabilizing effects of globalization can influence social spending in different regimes. For example, the adoption of liberal economics and insertion into competitive markets, a largely democratic transition, may incentivize governments to invest in their people and consequently “enhance the skill level and productivity of the labor force.”<sup>3</sup> Investment in the people through means of social spending is a mutually beneficial activity for both the majority of people and business leaders. Competent, educated and healthy workers are generally happier and more motivated to work, a concept that harkens back to Adam Smith and his “Wealth of Nations.”<sup>6</sup> In essence, governments would be incentivized to expand their commitments to social spending to help ease sociopolitical tensions while businesses would benefit economically.

The literature on this topic generally aligns with the principles of the compensation hypothesis. Democracy encourages social expenditure because politicians in democratic regimes must pay close attention to the pressures of the electorate and interest groups.<sup>7</sup> More specifically, health issues in democracies will hypothetically receive more attention because their disregard could result in removal

of office.<sup>8</sup> If a large number of people are expected to benefit from a particular service, such as health or education, a compensatory government can be expected to increase their attentiveness in that area.

Furthermore, Simon Wigley and Arzu Akkoyunlu-Wigley (2011) find that “young democracies are not as good as more established democracies at targeting social services.”<sup>9</sup> As democratic institutions have time to legitimize, leaders must answer to the people who begin to form “voluntary associations”<sup>9</sup> that regulate and influence social expenditures. The relationship between regime type and social spending is not only linear, but it is also time sensitive. The amount of time democratic institutions have been in place has an effect on governmental expenditure in the health sector.

All in all, the current literature is strong enough to warrant an investigation into the effects of democratic principles on social spending, specifically healthcare spending. The linear relationship between regime repressiveness and healthcare spending will be investigated. Also, the effect of time on this relationship will also be of interest during this study.

## METHODOLOGY

### **Country Sample Selection**

In order to analyze the effects of regime repressiveness on healthcare expenditure over time, a two-part quantitative cross-national analysis was conducted on a set of 24 countries at two distinct years: 2000 and 2015. These years were selected based on the availability of data from the World Bank Open Data database.<sup>10</sup> The sample set was systematically selected in order to eliminate sample selection bias and control for variables not specific to this study. In this study, the total population within a country during the year 2000 was used as the main control variable so that the domestic population volume would not skew the results. The population range used here was one million to ten million people.<sup>10</sup> Countries that did not fit this parameter were removed from the study. Additionally, geographic bias was minimized by applying proportionate country representation from all parts of the world. To do this, five diverse categories of geographic regions were created: southern Africa, central Europe, central America, southern America, and Asia. The countries that satisfied the population control were sorted into their corresponding region. Once a population and geographic control had been implemented, the five categories of countries were stratified according to regime repressiveness. Using the Freedom House scores for the year 2000, each country was designated a number 1-7, either whole number or half number, i.e., 5 or 2.5, which indicated the country’s overall level of freedom.<sup>11</sup> The overall freedom score for a country reflects the average of the political rights score and the civil liberties score given to countries by Freedom House, a globally known institution for bipartisan reporting on worldwide freedom.<sup>12</sup> According to these scores, countries were split into three regime types: nonrepressive, semirepressive and repressive. Countries with a score of 1 to 2.5 are nonrepressive regimes, 3.0 to 4.5 are semirepressive and 5.0 to 7.0 are repressive. Every country in each geographic region was sorted according to the repressiveness of their regime.

At the specified population range, there were some gaps in the data. The number of countries per regime type in certain geographic regions far outweighed those of other regime types in other regions. The number of semirepressive regimes in southern Africa far outnumbered the semirepressive regimes in Asia. To correct this imbalance, two countries were randomly selected for each regime type where the data allowed. For instance, no repressive regimes existed in central or southern America during 2000. Therefore, three repressive countries in both southern Africa and central Europe were analyzed to maintain a sufficient amount of data. Due to the population control, there were no semirepressive regimes in Asia. Consequently, three semirepressive regimes in southern Africa are analyzed to maintain a sufficient amount of data. Overall, eight countries per regime type are included in the sample set. Table 1 displays the 24 sample countries sorted by geographic region and stratified by regime repressiveness.

### **Dependent Variable Selection**

Once the sample set was established, a quantitative analysis was conducted at two points in time (2000 and 2015) wherein three variables that reflect expenditure on health were graphed against Freedom House scores. The Freedom House scores were chosen as the independent variable in this study in order to graphically analyze the effects regime repressiveness has on the various dependent variables chosen.

The three dependent variables are as follows: current health expenditure as a percentage of the gross

domestic product, or GDP (CHE),<sup>13</sup> public health expenditure as a percentage of the current health expenditure (PHE)<sup>14</sup> and out-of-pocket health expenditure as a percentage of the current health expenditure (OHE).<sup>15</sup> The CHE variable is used to reflect a country's overall level of investment in the healthcare sector. The PHE and OHE variables are used to specify the source of that healthcare spending domestically and how the source of spending changes with regime repressiveness. The PHE variable, as defined by the World Bank, is the “share of current health expenditures funded from domestic public sources for health.”<sup>14</sup> The OHE variable, as defined by the World Bank, is “spending on health directly out-of-pocket by households.”<sup>15</sup>

Regime Type	Geographic Regions				
	Southern Africa	Central Europe	Central America	Southern America	Asia
Nonrepressive	Botswana	Croatia	Panama	Uruguay	Mongolia
		Slovakia	El Salvador	Bolivia	
Semirepressive	Central African Republic (CAR)	Armenia	Nicaragua	Paraguay	
	Gabon	Georgia	Honduras		
	Lesotho				
Repressive	Liberia	Oman			Laos
	The Gambia	Turkmenistan			Singapore
	Republic of the Congo (ROC)	United Arab Emirates (UAE)			

**Table 1:** Sample selection of 24 countries sorted by geographic region and stratified by regime repressiveness in 2000.<sup>11</sup>

### Data Display and Interpretation

In order to visualize the relationship of the three independent variables and the Freedom House scores, six separate graphs were created to diagram the association between freedom scores for each country and a particular independent variable at both the year 2000 and 2015. A polynomial regression line was then inserted over the data in order to describe the overall effect of regime repressiveness on the independent variable. In order to easily evaluate the changes in a particular independent variable over time, the values of that variable within each regime type were averaged and placed in Table 2.

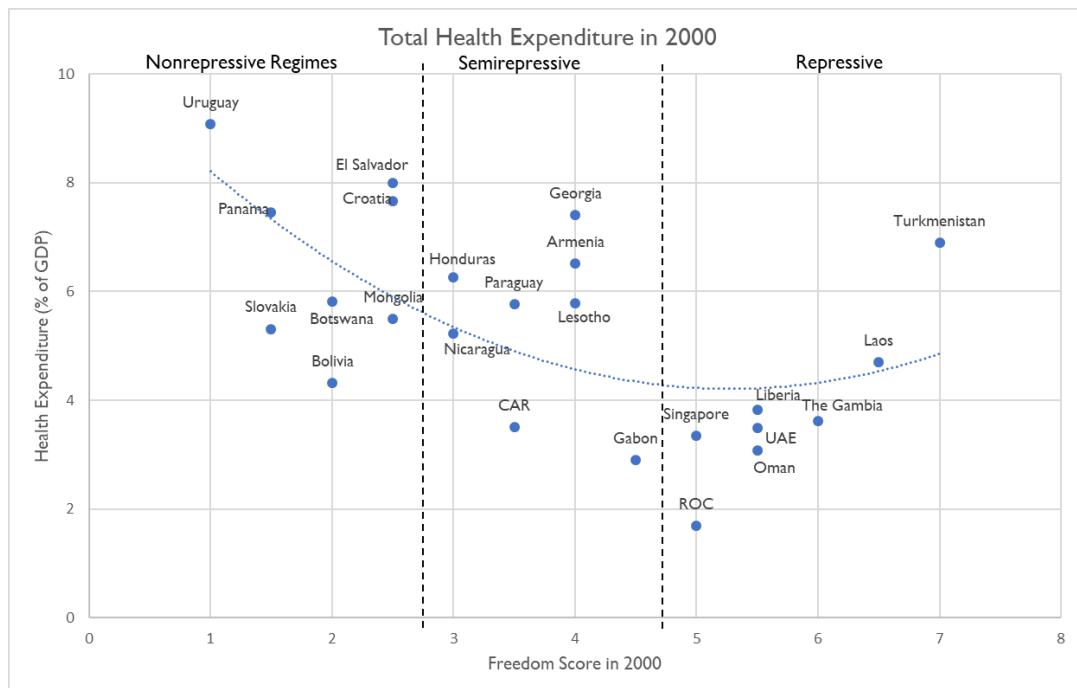
## RESULTS

The results of the cross-national quantitative analysis are visualized in Figures 1-6. The nonrepressive regimes appear to the far left of the graph ( $x = \leq 2.5$ ), the repressive regimes appear to the far right ( $x = \geq 5.0$ ) and the semirepressive regimes appear in the middle ( $x = 3.0-4.5$ ). In order to evaluate trends across time, the health expenditure variables (CHE, PHE, and OHE) were averaged for each regime type at the two distinct time periods (2000 & 2015). The results of this are displayed in Table 2.

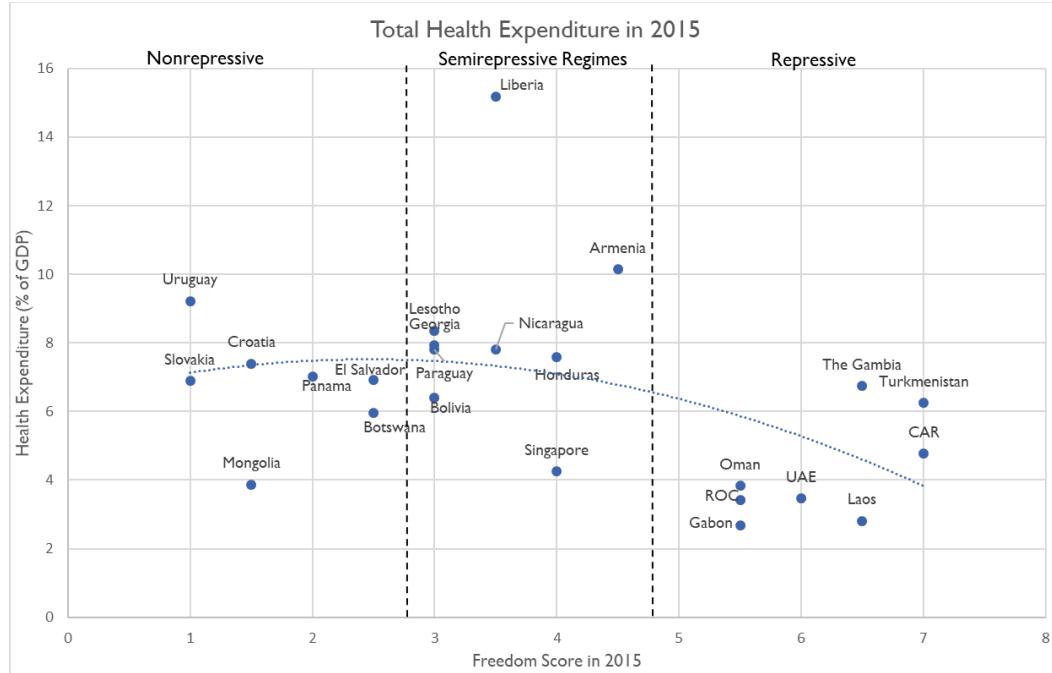
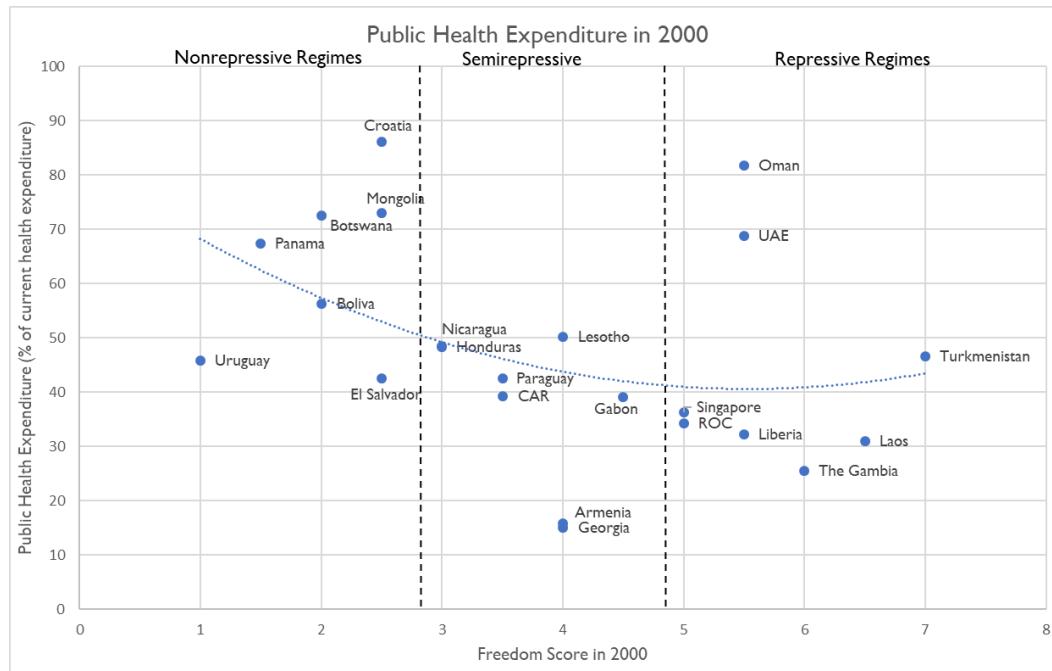
Figures 1 and 2 depict the relationship between regime type and CHE in 2000 and 2015, respectively. In 2000 (Fig. 1), the nonrepressive regimes collectively spent the highest percentage of their GDP on healthcare while the repressive regimes spent the least. In 2015 (Fig. 2), the semirepressive regimes emerged as spending the largest percentage of their GDP on healthcare followed by nonrepressive regimes.

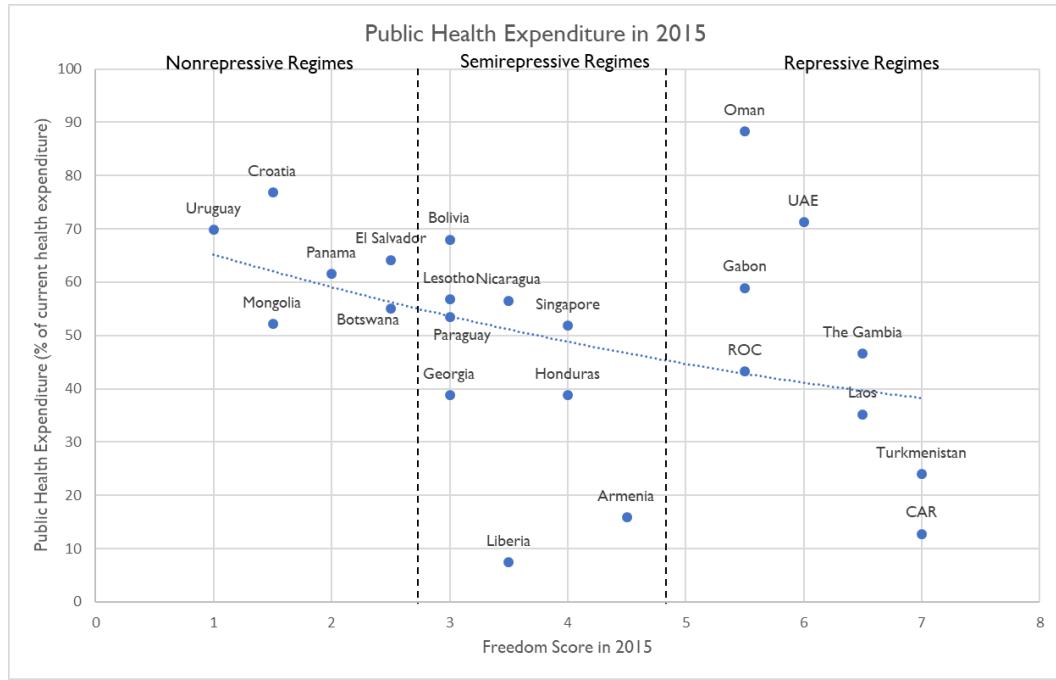
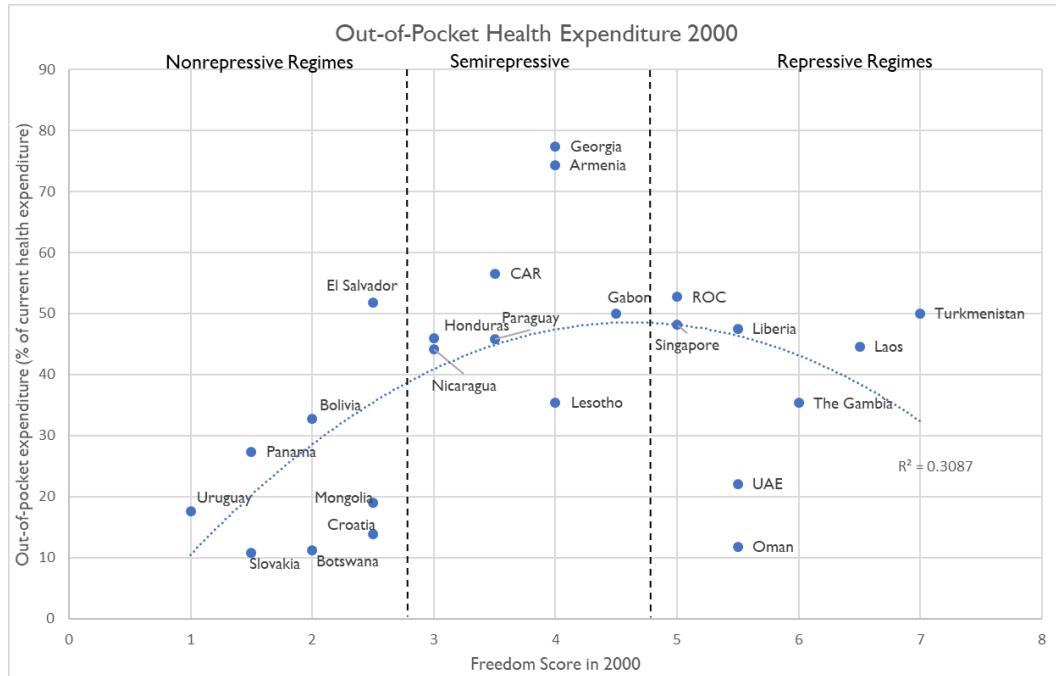
Figures 3 and 4 depict the relationship between regime type and PHE in 2000 and 2015, respectively. In 2000 (Fig. 3), public entities in nonrepressive regimes spent the most on healthcare while public entities in semirepressive regimes spent the least. In 2015 (Fig. 4), the trend remains unchanged. Although the absolute values changed within regime type from 2000 to 2015, their position relative to one another was unaffected by time.

While Figures 3 and 4 depict the relationship between regime type and public health expenditure, Figures 5 and 6 depict complementary data. Figures 5 and 6 display the relationship between regime type and OHE in 2000 and 2015, respectively. Given the inverse nature of the PHE and OHE variables, the expenditure data for the OHE reflects the PHE. In 2000 (Fig. 5), citizens in semirepressive regimes collectively spent the most on healthcare while citizens in nonrepressive regimes spent the least. Again, in 2015 (Fig. 6), citizens in semirepressive regimes spent the most on healthcare out-of-pocket while citizens in nonrepressive regimes spent the least.



**Figure 1:** Total health expenditure in 2000 as a percentage of the GDP.<sup>11,13</sup>

**Figure 2:** Total health expenditure in 2015 as a percentage of the GDP.<sup>13,16</sup>**Figure 3:** Public health expenditure in 2000 as a percentage of the current health expenditure.<sup>11,14</sup>

Figure 4: Public health expenditure in 2015 as a percentage of the current health expenditure.<sup>14,16</sup>Figure 5: Out-of-pocket health expenditure in 2000 as a percentage of the current health expenditure.<sup>11,15</sup>

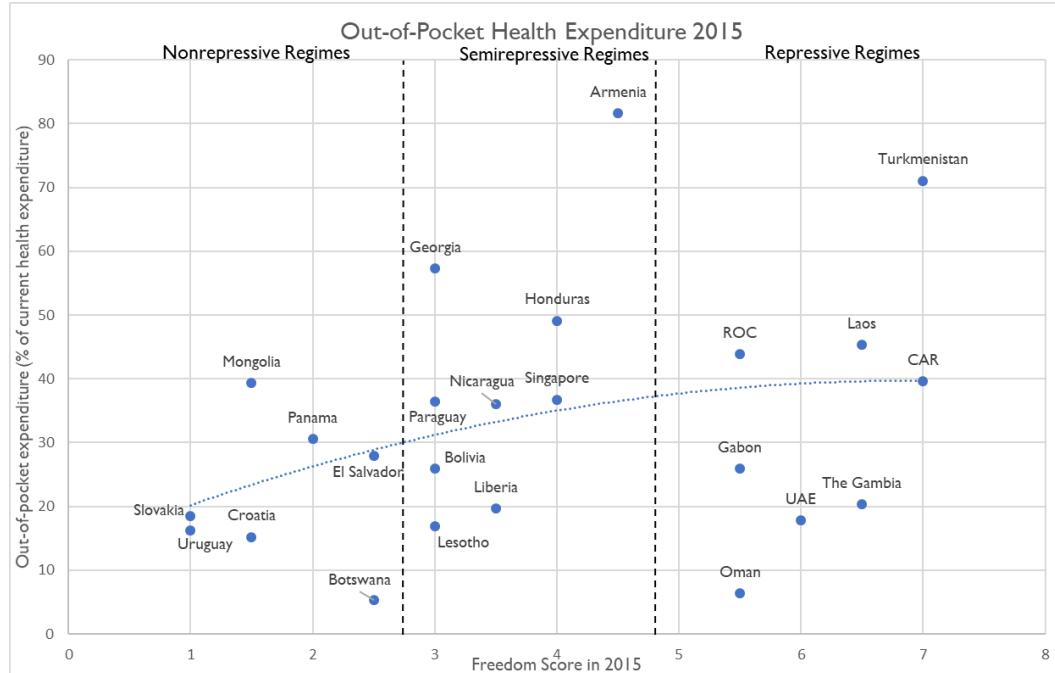


Figure 6: Out-of-pocket health expenditure in 2015 as a percentage of the current health expenditure.<sup>15,16</sup>

Health Expenditure Variable	Year	Regime Type		
		Nonrepressive	Semirepressive	Repressive
Total Health Expenditure as a Percentage of the GDP (CHE)	2000	6.64%	5.42%	3.83%
	2015	5.91%	8.39%	4.25%
Public Health Expenditure as a Percentage of the CHE (PHE)	2000	63.39%	37.34%	44.55%
	2015	63.28%	43.08%	47.52%
Out-of-pocket Health Expenditure as a Percentage of the CHE (OHE)	2000	23.05%	53.69%	39.01%
	2015	21.83%	39.96%	33.78%

**Table 2:** Average percentages of three health expenditure variables according to year and regime type.

## DISCUSSION

The results of this study are not conclusive, but they do provide an interesting insight into the effect regime type has on social spending over time. In this section, each of the three independent variables will be broken down individually and evaluated against the compensation and efficiency hypotheses. The results will be compared to the current literature and used to reaffirm past views, qualify past views or provide new, potentially alternative explanations for the correlation between regime type and healthcare expenditure measures.

I begin with the correlation between regime type and total health expenditure as a percentage of the GDP (Fig. 1 & 2). Upon initial evaluation of the graph from 2000 (Fig. 1), the trendline appears to behave as expected according to the literature, which purports that regime repressiveness and healthcare expenditure are negatively correlated.<sup>7,8,9</sup> Moreover, the trendline appears to have a slight upward curve as it enters into the repressive regimes. However, the expenditure averages generally decrease at an equal increment from nonrepressive to repressive regimes as expected.

Moving to the 2015 graph of the same variable, the results become more interesting. Initially, it is apparent that the curve of the trendline switched from a slightly depressed line to slightly lifted line. This means that some vertical movement must have been made by a particular regime type during the course of 15 years. In order to determine the source of this movement, the difference of the averages between the two time frames was calculated. Between 2000 and 2015, the CHE variable dropped only an average of 0.73% in nonrepressive regimes and gained only an average of 0.42% in the repressive regimes. It was in the semirepressive regimes where the bulk of the difference can be attributed to. Between 2000 and 2015, the CHE variable gained an average of 2.97% in the semirepressive regime category, increasing its average over the nonrepressive and repressive regimes by 2.48% and 4.14%, respectively.

It cannot go unmentioned that Liberia appears to be an outlier in these results. With an expenditure amount of 15.2% of their GDP, it towers 5.1% over the closest semirepressive country, Armenia. That being said, the semirepressive regime average for 2015 was recalculated excluding Liberia and was still found to be 7.53%, a gain of 2.11% from 2000. Regardless of the inclusion or exclusion of Liberia, it can be concluded that the semirepressive regimes as a whole were the most mobile category in terms of expenditure on healthcare.

I continue with the correlation between regime type and public health expenditure as a percentage of the total health expenditure (Fig. 3&4). Upon evaluation of the 2000 graph (Fig. 3), the depression of the trend line curve is more pronounced than the curve in Fig. 1. When out-of-pocket expenditure is removed, and public contributions to health care are evaluated, the results do not fit the literature exactly. According to the literature, one would expect the repressive regimes to have the lowest average PHE, while the nonrepressive regimes would have the highest PHE.<sup>7,8,9</sup> Instead of a strictly linear relationship a slight U-curve is observable where the semirepressive regimes have the lowest average PHE.

When the 2015 graph of the same variable (Fig. 4) is evaluated, the trend looks quite different. In fact, it appears to be linear. As with the previous variable, this means that some vertical movement must have been made by a particular regime type during the course of 15 years. Between 2000 and 2015, the PHE variable dropped only an average of 0.11% in nonrepressive regimes and gained only an average of 2.97% in the repressive regimes. It was in the semirepressive regimes, with an average rise of 5.74%, where the majority of the movement occurred over time.

This implies that the relationship between regime type and public health expenditure is not as black and white as the literature reports. Authoritarian and democratic governments represent the extremes of regime repressiveness. Semirepressive regimes take into account those governments in the middle.

Not every government is strictly authoritarian or democratic and cannot be treated as such.

I finish with the relationship between regime type and out-of-pocket expenditure as a percentage of the total health expenditure (Fig. 5&6). Contrary to the depressed trend line of the PHE variable in 2000 (Fig. 3), the trend line of the OHE variable in 2000 appears in the form of a lifted arch. Given the results of the previous variable, one would expect the OHE variable to mirror the PHE variable. This is because if a government invests a large amount of money into the healthcare sector, the people would not be expected to pay a large amount out-of-pocket and vice-versa. The literature still predicates that the relationship between regime type and the OHE variable should be linear.<sup>7,8,9</sup> The nonrepressive regimes should have the lowest average values and the repressive regimes the highest. Again, this is not the case. The semirepressive regimes have the highest average OHE in 2000 by a far margin. The repressive regimes trail behind them by a difference of 14.68% and the nonrepressive regimes even further by a margin of 30.64%.

Instead of an inverted U-curve trendline like in 2000, the trendline in 2015 (Fig. 6) appears to have flattened out, tapering off only slightly in the repressive regime category. As with the other two variables, this means that some vertical movement must have been made by a particular regime type during the course of 15 years. Between 2000 and 2015, the OHE variable dropped only an average of 1.22% and 5.23% in nonrepressive regimes and repressive regimes, respectively. For the third time, it was the semirepressive regimes, with an average drop of 13.73%, where the majority of the movement occurred over time.

Again, this proves that the relationship between regime type and healthcare spending is not entirely black and white. The current literature fails to account for the dynamic nature of semirepressive regimes. Additionally, current literature overestimates the mobility of democratic and authoritarian governments in terms of their healthcare spending.

## CONCLUSION

The first conclusion that can be drawn is that the relationship between social expenditures in the health sector and regime type is not as linear as the literature makes it out to be. In almost all cases, the literature analyzes this correlation using only the two extremes: authoritarian governments versus democratic governments. Using those two extremes, it is easy to understand how previous researchers came to the conclusion that they did. While there is truth to the statement “democratic regimes typically spend more on healthcare,” it does not describe the entire story. Past studies have failed to highlight the dynamic nature of the semirepressive regimes. In all three variables tested, for example, it was always the semirepressive regimes that were the most charismatic.

A second conclusion is that leaders in semirepressive regimes are heavily influenced and bound by the compensation hypothesis. When a country is met with a destabilizing event, political leaders as well as business leaders are incentivized to increase social spending in order to maintain stability. Leaders in semirepressive regimes are particularly incentivized to abide by this force because these types of regimes tend to be the most unstable and most prone to violent political upheavals.

This would explain why the CHE and the PHE of the semirepressive regimes increased the most over the 15 year period and why the OHE decreased the most. Citizens in semirepressive regimes were not happy with the amount of money they had to pay out-of-pocket for health services. This amount was much more than those in both repressive and nonrepressive regimes. As a result, many people probably could not afford such high out-of-pocket costs, which acted as a destabilizing event. Consequently, the people might have organized and began demanding that the government intervene to make healthcare more affordable. Government leaders were pressured by the people who now had some perceived freedoms. These leaders poured money into the healthcare sector to appease the people and retain their power.

Additionally, research concludes that the instillation of democratic institutions can only do so much in terms of encouraging governments to increase their social spending budgets. In all three variables, the nonrepressive regimes on average changed the least from 2000 to 2015. This results from the fact that political violence is typically low in democratic regimes, which puts less pressure on democratic leaders to conform. Alternatively, this observation could be simply due to the fact that the people are happy with the balance between public and out-of-pocket expenditure on healthcare. Either way, the stagnant results testify to how slowly change transpires in democratic institutions.

Overall, the most important takeaway from this study is that countries in the transition state between autocracy and democracy cannot be ignored. The results presented here demonstrate the dynamic nature of semirepressive regimes. When people are given just a little bit of freedom that they did not have before, the results show that change is possible. In nonrepressive and repressive regimes where society is stable, change is not as easily viable. Moving forward, future studies must acknowledge that governments cannot be simply split into two extremes: democratic or authoritarian. Rather, more research needs to be conducted in order to better understand the complex and forceful nature of semirepressive regimes.

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