Why political economy analysis is important for development effectiveness

“What causes governments to give priority to [a particular issue] …, given that national political systems are burdened with thousands of issues to sort through each year? In marked contrast to our extensive knowledge about the medical interventions necessary to prevent [for example] maternal death, we know little about the political interventions necessary to increase the likelihood that national leaders pay meaningful attention to the issue…. What ‘political will’ means … has been left as an unopened black box.” (1)

Ian Anderson, David Hipgrave

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1 Ian Anderson is a consultant hired for this work by UNICEF New York, where David Hipgrave is a Senior Health Specialist
Social and economic development processes involve much more than technocratic approaches: political economy factors usually determine the fate of reforms. This finding is clear from the international literature (2-13). More specifically, how and why governments make and implement decisions; prioritise the allocation of scarce financial and human resources; resolve trade-offs; regulate the private sector; achieve accountability, and interact with civil society and development partners is an essential key to understanding the process of international development. Understanding how governments use or don’t use evidence to shape policies and prioritise the use of their own scarce resources is increasingly important. That is particularly true as more and more countries achieve middle income status, albeit with large burdens of poverty (14) and aid programs become progressively smaller. The impact of political economy factors is particularly important to understand in post conflict situations (or “fragile” situations) as in the case of Nepal. That is because conflict directly affects health and RMNCH outcomes through the disruption of basic services, and indirectly through disrupted economic growth. On the other hand, governments that effectively and visibly deliver essential health and other services can strengthen their political legitimacy (15-19).

Understanding the political economy of reproductive, maternal, newborn and child health (RMNCH) is a particularly important issue. That is partly because there remains a large but preventable RMNCH burden globally, including in Asia and the Pacific, where 2.5 million children aged under five died in 2013, 41% of the global burden (20). Understanding

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2 There is no single, agreed definition of the term “political economy”. The OECD concisely says that: “Political economy analysis is concerned with the interaction of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time”. Further definitions are in Annex 1. Other examples of the application of political economy are available in the separate report “Political Economy Analysis: Quotable Quotes”.

3 The World Bank classifies countries as “middle income” if they had a GNI per capita of more than $1045 but less than $12,746 in 2013. Within the middle income category, those countries with a GNI per capita of less than $4125 are classified as lower middle income, while those above are classified as upper middle income.
the political economy of RMNCH is also important because proven, affordable, interventions that dramatically improve RMNCH outcomes have been successfully implemented at scale in some low income Asian countries decades ago (21). Yet if the scientific evidence base, cost-effectiveness and affordability for improving RMNCH have been so clear, for so long, why have so many countries failed to invest accordingly? Why, despite the political commitments and rhetoric, do several countries in Asia have the lowest absolute and relative levels of government expenditure on health, especially RMNCH? How can RMNCH be prioritised and resourced in countries which are rapidly decentralising political and economic decision making to sub-national, even village level? Political economy analysis can provide insights into these issues for the benefit of governments and their development partners.

Understanding political economy issues has direct, significant, real world implications. After decades of resistance, and against most predictions, strong political leadership and shrewdly generated coalitions were able to legalise modern and safe family planning in the Philippines. Similarly against all expectations – and again very powerful vested interests – the Philippines was able to increase taxes on tobacco, thereby generating additional finances to fund the expansion of Universal Health Coverage (UHC) for the poor, while reducing the leading cause of non-communicable diseases (NCDs). Analysing budgets also provides a revealing “real world” insight into the true priorities of governments, given the political environment in which they operate. For example, government expenditure on health in Indonesia was just 6.2% of total government expenditure in 2011, compared to the 18% expenditure on fuel and energy subsidies that primarily benefit the middle class and elite (22). Another example of the real world application of political economy analysis is that Nepal has achieved remarkable and sustained reductions in maternal and child mortality despite low income, and a civil war. Similarly, Bangladesh ranks low on global measures of human development, budget transparency, and corruption control. Its political situation has been described as “inter-elite contestation for access to patronage resources, with voters deployed as pawns during elections and ignored in between….. Campaigning is based primarily on feudal ties and patronage, and
appeals to historical grievances, rather than advancing a programmatic agenda for addressing current and future challenges.” (23). Yet Bangladesh “now has the longest life expectancy, the lowest total fertility rate, and the lowest infant and under-5 mortality rates in south Asia, despite spending less on health care than several neighbouring countries” (24). These examples demonstrate the great relevance of political economy issues.

**Summary of the methodology used in four recent country studies**

The background to the political economy study is clear. UNICEF and the Australian Department of Foreign Affairs and Trade wished to better understand the political economy factors that drive priority setting, planning, and resource allocations for RMNCH and the health sector in four countries of Asia – Bangladesh, Indonesia, Philippines and Nepal - where these two organisations have been supporting an “Investment Case” for RMNCH.

Numerous analytical tools and approaches are available to examine the political economy of health and RMNCH in developing countries, as they are reflected in priority setting, planning and budgeting by Governments. These include a “how to note” on political economy analysis by the UK Department for International Development (DFID) (25) and the World Bank (26); the approach by the Overseas Development Institute (27); and the World Bank’s “problem driven governance” framework presented by Fritz et al. (28). There are also conceptual approaches that can be applied to political economy analysis, including the “Theory of Change”; “Drivers of Change” and “Most Significant Change”. All have something to offer, but because there is great variety between and within the four countries studied, the analyses did not adhere to one in particular. Indeed, it would be remarkable if one analytical approach could be applied coherently and comprehensively to all four, especially given the focus of the work on sub-national level, which has not been analysed very widely, especially in Asia (29). Nonetheless, this analysis of the political economy of health and RMNCH in four countries did draw on the methodological framework employed by DFID’s “How to” note, and Fritz’s “problem driven governance”; which had the most applicability to the social sectors. For these analyses, two consultants reviewed over 230 published and grey literature reports, and interviewed 175 key informants from government, development partners, academia and civil society in the four countries between May and September 2014. The field work involved one or two week visits to each of the four countries over 7 weeks in July-September.

**Comparisons and contrasts of the key political economy findings**

### Issues common to the four countries

In some ways, the four countries face similar circumstances and challenges. All four are low or lower middle income countries; all four have had volatile political and economic histories since independence; all four need to address an unfinished agenda of RMNCH, communicable diseases and under-nutrition at the same time as they address a growing technical and financial burden of NCDs. All four state they are committed to scaling up Universal Health Coverage (UHC). Importantly, from the point of view of sub-national efforts undertaken by UNICEF, all four countries have some form of decentralised / devolved / deconcentrated health system, although that varies: Nepal and Bangladesh being more centralised, and Indonesia and Philippines more decentralised.

In all four countries there are leadership and governance issues, but with differing implications for RMNCH and the health sector. Political leadership and coalition building in the Philippines, resulting in both modern family planning and increased taxes on tobacco / alcohol to fund UHC clearly benefit RMNCH and the health sector more broadly. Political leadership in Nepal remains log-jammed between conservative and Maoist forces, although both are committed to RMNCH. In Bangladesh political leadership tends to alternate between Government elites focussed on political patronage, with scant national attention to subnational levels. Indonesia is continuing its movement towards democracy and decentralisation. Partly as a result, politicians are offering “free” health care as a vote-catcher. The problem is that, if elected, the increased demand from “free” health care can overwhelm under-resourced public health services. An unqualified and unfunded mandate of “free” health care is also likely to be financially unsustainable, especially for poorer provinces and districts.

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4 Ian Anderson and Dr Midori Sato, who was hired in addition to support the analyses in Nepal and Bangladesh
5 Bangladesh 34 interviews; Indonesia 37 interviews; Philippines 28 interviews; Nepal 76 interviews.
All four countries face the challenge of inadequate financing for health: especially public expenditure on health by Government. In all four countries UHC raises serious questions about the capacity of their health systems to underwrite or sustain “free” health care. Chart 1 below shows that while total health expenditure has been increasing in the four countries, it is still below the averages for other low income, and lower middle income, countries globally or the average for South Asia countries. Government expenditure on health (an indicator of the true priority attached to health as distinct from political rhetoric) is low; in Indonesia just $38 per person per year. Private, out of pocket, expenditure is correspondingly high in all countries and the dominant form of health financing. This form of financing is a barrier to access and / or a source of impoverishment for the poor, and a missed opportunity for pooling of risks and finances.

All four countries face challenges of planning, prioritisation and resource allocation, especially in terms of decentralisation. Despite the fact that private expenditure on health, including to private providers, is the dominant form of health expenditure, all four countries have a “blind spot” when it comes to taking into account the role of the private sector when planning and prioritising investments. Interviews suggest this may have to do with the difficulty for government – and development partners – in actually engaging formally with what is often a highly fragmented and unregulated private sector. All three counties – Bangladesh is the exception – are actively pursuing decentralisation of planning, prioritisation and resource allocation to sub-national units. There are many potential political economy benefits to the health sector and RMNCH in decentralisation. Local communities have the potential to identify their own priorities and allocate resources accordingly. Monitoring and accountability can – in principle – be more direct and robust. On the other hand, decentralisation raises challenges too. Poorer provinces and districts may well have less financial – and managerial – resources to respond to local health needs. Decentralised planning raises new challenges about national coordination of priorities and programs to confront communicable diseases. Evidence based planning (EBP) can identify where, why and how to reallocate resources to their most productive use (“allocative efficiency”) but rigidities in top down budget line items then prevent resource reallocations.

Chart 1. Health expenditure per capita

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<th>Year</th>
<th>Philippines</th>
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<th>Indonesia</th>
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Source: World Development Indicators (2014)

Taking into account the lower cost of goods and services in Indonesia raises this to an estimated 50 “international dollars” per person per year in notional purchasing power parity terms.
All four countries face challenges of planning, prioritisation and resource allocation, especially in terms of decentralisation. Despite the fact that private expenditure on health, including to private providers, is the dominant form of health expenditure, all four countries fail to acknowledge the role of the private sector when planning and prioritising investments. Interviews suggest this may have to do with the difficulty for government – and development partners - in actually engaging formally with what is often a highly fragmented and unregulated private sector. Moreover, three countries – Bangladesh is the exception – are actively pursuing decentralisation of planning, prioritisation and resource allocation to sub-national units. There are many potential political economy benefits to the health sector and RMNCH in decentralisation. Local communities have the potential to identify their own priorities and allocate resources accordingly. Monitoring and accountability can – in principle – be more direct and robust. On the other hand, decentralisation raises challenges too. Poorer provinces and districts may well have less financial – and managerial – resources to respond to local health needs. Decentralised planning raises new challenges about national coordination of priorities and programs to confront communicable diseases, and on health financing. Evidence based planning can identify where, why and how to reallocate resources most productively (“allocative efficiency”) but rigidities in top down budget line items often prevent local resource reallocation.

All four countries face political economy challenges with respect to the health workforce. All struggle to train adequate numbers of appropriately qualified staff, place them in rural and remote areas, and ensure service quality (and in many cases staff attendance). There are many examples of promotions and placements being made on the basis of patronage rather than merit. There are limited institutional or individual incentives – all part of the political economy environment – for improving access to and the quality and safety of care, and equal treatment for poor patients.

All four countries face significant political economy challenges in terms of scaling up UHC, particularly in the face of growing demands to treat NCDs. Expanding UHC will require significant extra financial resources from Government to cover the poor and near-poor. It also involves formidable policy, regulatory and management challenges, especially if it relies on private sector providers, who remain largely unregulated.

Important differences between the countries

There are stark contrasts in approach to the decentralisation of power, planning and resourcing between the four nations studied. Indonesia clearly has the most extensive and intensive form of decentralisation, partly reflecting historical pressures for provinces to break away. Bangladesh has the least decentralisation (possibly reflecting the small but densely populated and homogenous society, and possibly because active NGOs are a de facto form of decentralised decision making and action). The Philippines and Nepal sit in between.

There are also differences in terms of non-state actors. Bangladesh has a long history of active and competent NGOs, including BRAC. Nepal has a strong history of community participation. Indonesia has less engagement of NGOs but is seeing a growing role of the private sector – whether qualified or not – especially in urban and peri-urban areas. The Philippines is using accreditation processes under PhilHealth to formalise and regularise engagement with the private sector.
Practical application of political economy analysis

Several practical lessons and insights emerged from these analyses. These are summarised below.

• “Success” occurs in a wide range of political or economic systems. A recent World Bank study of successful health reforms noted a wide variety of political and economic systems and levels of development in nine countries studied. What mattered was the overall strength and stability of the economic, institutional and societal environment; policy factors (including public and private financing), and implementation factors including the sequencing of reforms (30).

• A problem is not a problem until it is on the political agenda. Indonesia’s “…maternal mortality problem was, by itself, insufficient to catalyse action. The generation of political will required the development of reliable indicators to mark the seriousness of the problem, the persistent and proactive cultivation of national-level policy-makers, the creation of workable policy solutions and the organization of attention-generating focusing events. In this way a longstanding but hidden crisis came to receive meaningful priority…. Four factors that heighten the likelihood that an issue will rise to national-level attention: the existence of clear indicators showing that a problem exists; the presence of effective political entrepreneurs to push the cause; the organization of attention-generating focusing events that promote widespread concern for the issue; and the availability of politically palatable policy alternatives that enable national leaders to understand that the problem is surmountable” (1).

• Proactively tracking “what works” in terms of priority setting and resource allocation is important in complex and fast moving environments, such as Indonesia. Interviews with senior decision makers during the field visits suggested that a proposal in the health sector is likely to get priority and budget allocations if it combines five key elements simultaneously: the intervention addresses a serious issue that affects a large population; there is low technical / political risk in scale up; there is low financial cost or human resource / management burden on the health system; there are quick and identifiable results, and there is media support.

• “Understand the language of finance” and apply it to the health system as a whole. One of the most senior people interviewed – a Vice Minister of Health – said that the key to elevating health issues within the political system was to “understand the language of finance.” Ministries of Finance are persuaded by data on costs and affordability, but these are rarely systematically captured or critically analysed, including by development partners supporting demonstration projects or pilots.

• Evidence matters, but “what evidence”, “whose evidence”, “when is it presented” and “how is it presented” matters more. Interviews in the Philippines confirmed that evidence for decision making needed to be presented at the national level at critical times before decisions were made in the political and budgeting cycle. However evidence needed to be presented after elections at local levels because those elections were usually based around personalities and the winning candidate then needed evidence on what options to implement.

• Upstream EBP becomes irrelevant if downstream implementation and procurement are weak or ill-suited to increased resources. Several interviewees, especially in decentralised settings, said the biggest challenge they now faced was no longer shortage of funds. Rather, the ‘binding constraint’ for them was that financing was now increasing rapidly, yet the systems they had for procurement and financial management were still tailored to a period of austerity and small scale purchases. Several officials suggested training in consultancy management for outsourcing and procurement management, rather than on planning itself. Delays in procurement often led to otherwise good and rational plans being abandoned and scarce resources spent urgently on low priorities just to expense the funds.

• The unplanned and unexpected can be completely overwhelming. Development partners must be realistic about how effective and durable planning processes are, and retain flexibility. UNICEF dramatically scaled up expenditure from $6 million to $36 million in the Philippines within two years of Super Typhoon Haiyan / Yolanda. That completely – and appropriately – overturned the then current country assistance strategy, priorities, planning and budgets.
Scaling up UHC is a major strategic opportunity for development partners, but will require changes in traditional ways of engaging with countries. PhilHealth in the Philippines now directly covers health insurance for around 85 million people (85% of the population). How it sets premiums, benefit packages, for what services, to whom, and on what basis it pays service providers has major implications for RMNCH and the health sector, especially the poor and near poor. Agencies like PhilHealth are arguably now more directly important to health outcomes than traditional health authorities. UNICEF Manila has already been influential in making the benefits package for newborn care more focused on primary and preventive health care, thereby making the program more evidence based, affordable and cost-effective for society and individual households.

The National Health Accounts of a country are a strategic but often under-utilised evidence base for policy dialogue. Done well, they provide a clear and easily accessible overview of the whole health system, including the sources and uses of public and private financing related to health. But interviews confirmed that they are rarely used by public health advocates. This is a lost opportunity for engaging in more evidence based policy dialogue.

Well informed media coverage, including radio and social media, is often a key factor in shaping public opinion. But journalists may not have the technical expertise/time to analyse plans and budgets. UNICEF’s Child Friendly Budgeting approach gives a useful perspective on what to look for in a national and sub-national budget. UNICEF and other development partners could analyse budgets and provide briefing notes/points to look for in a budget. UNICEF and development partners could build on the current Philippines initiative of training Mayors about the importance of including health priorities in the local budgets by holding workshops for politicians, media, and NGOs on key things to look for in a budget that affects women and children’s health.
Annex: Definitions of political economy

There is no single, agreed definition of the term “political economy.” The OECD concisely says that: “Political economy analysis is concerned with the interaction of political and economic processes in a society: the distribution of power and wealth between different groups and individuals, and the processes that create, sustain and transform these relationships over time.” (25) Bueuran says “In its modern form, political economy studies refer to the study of the relations between political and economic processes which involve several factors such as incentives, relationships, and the distribution of power between various interest groups in society, all of whom have an impact on development outcomes” (31).

DFID has a more expansive description, which highlights how political economy analysis can improve development effectiveness: Political economy analysis is a powerful tool for improving the effectiveness of aid. Bridging the traditional concerns of politics and economics, it focuses on how power and resources are distributed and contested in different contexts, and the implications for development outcomes. It gets beneath the formal structures to reveal the underlying interests, incentives and institutions that enable or frustrate change. Such insights are important if we are to advance challenging agendas around governance, economic growth and service delivery, which experience has shown do not lend themselves to technical solutions alone…. It can also contribute to better results by identifying where the main opportunities and barriers for policy reform exist and how donors can use their programming and influencing tools to promote positive change. This understanding is particularly relevant in fragile and conflict-affected environments where the challenge of building peaceful states and societies is fundamentally political. (25)

The World Bank (26) says: What is political economy? Political economy (PE) is the study of both politics and economics, and specifically the interactions between them. It focuses on power and resources, how they are distributed and contested in different country and sector contexts, and the resulting implications for development outcomes. PE analysis involves more than a review of institutional and governance arrangements: it also considers the underlying interests, incentives, rents/rent distribution, historical legacies, prior experiences with reforms, social trends, and how all of these factors effect or impede change.
References
