Analysis of the political economy of health, particularly reproductive, maternal, newborn and child health, in four countries of south and east Asia
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### Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>DFID</td>
<td>United Kingdom Department for International Development</td>
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<tr>
<td>NCDs</td>
<td>Non-communicable diseases</td>
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<td>NGOs</td>
<td>Non-government organisations</td>
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<tr>
<td>RMNCH</td>
<td>Reproductive, maternal, newborn and child health</td>
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<td>UHC</td>
<td>Universal health coverage</td>
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1. Why political economy analysis is important for development effectiveness

“What causes governments to give priority to the issue of safe motherhood, 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 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, however, has been left as an unopened black box”. (1)

Social and economic development processes involve much more than technocratic approaches: ‘political economy’1 factors usually determine the fate of reforms (2-13). More specifically, knowledge on 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 essential to understanding the process of socio-economic development. Knowing 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 as aid programs become progressively smaller. The impact of political economy factors is particularly important to understand in post conflict or “fragile” situations, as in Nepal and Bangladesh, respectively. That is because conflict affects health and particularly reproductive, maternal, newborn and child health (RMNCH) outcomes both directly by disrupting basic services, and indirectly by preventing economic growth. On the other hand, governments that effectively and visibly deliver essential social services have stronger political legitimacy (15-19).

Understanding the political economy of 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). It is also important because proven, affordable, interventions that dramatically improve RMNCH outcomes were successfully implemented at scale in some low income Asian countries decades ago (21). Yet if the scientific evidence base for, and cost-effectiveness and affordability of improving RMNCH have been so clear, for so long, why have so many countries failed to invest accordingly? Why, despite apparent political commitment and rhetoric, do several countries in Asia have the lowest absolute and relative levels of government expenditure on health, especially on RMNCH? How can RMNCH be prioritised and resourced in countries which are rapidly decentralising political and economic decision-making to sub-national, even community 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. For example, 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 against very powerful vested interests – the Philippines was able to increase taxes on tobacco, thereby generating additional finances to fund its efforts to effect Universal Health Coverage (UHC)

1 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”. Also see Annex 1.

2 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.
for the poor, at the same time 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 31.5% on fuel, energy and other subsidies primarily benefiting the middle class and elite (22). Fortunately, as fuel prices have fallen in the last 18 months (itself partly related to political economy factors), the burden of these subsidies on the government budget has declined and a new government is phasing them out. Another real world application of political economy analysis is the study of how Nepal 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…. [with campaigning] based primarily on feudal ties, patronage and appeals to historical grievances, rather than advancing a programmatic agenda….” (23). Yet Bangladesh now has growing life expectancy, a low total fertility rate, and among 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 the study of political economy issues to RMNCH.

2. Summary of the methodology used in four recent country studies

The background to this political economy analysis is clear. UNICEF and the Australian Department of Foreign Affairs and Trade wished to better understand the factors that drive priority setting, planning, and resource allocation for RMNCH and the health sector in four countries of Asia – Bangladesh, Indonesia, Philippines and Nepal - where these two organisations have been supporting the development of an “Investment Case” for RMNCH (Figure 1).

Figure 1: Pilot sites for development of an investment case for RMNCH in the four focus countries
Numerous analytical tools and approaches are available to examine the political economy of health and RMNCH in developing countries, as reflected in priorities selected, planning and budgeting by Governments. These include a “how to note” on political economy analysis by the United Kingdom 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 approaches 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. It was determined that no 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 widely especially in Asia (29). Nonetheless, this analysis drew particularly on the framework described in DFID’s “How to” note and “problem driven governance”, which were most applicable to social sectors.

For these analyses, two consultants and UNICEF personnel 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 seven weeks in July-September.

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3 Bangladesh 34 interviews; Indonesia 37 interviews; Philippines 28 interviews; Nepal 76 interviews.
3. Political economy influences on RMNCH and health in the four countries studied

3.1 Issues common to the four countries

The four countries studied face some similar circumstances and challenges. All are low or lower middle income countries; all have had volatile political and economic histories since independence; all are dealing with unfinished issues in RMNCH, communicable disease 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 UHC. Importantly, from a sub-national perspective, all have some form of decentralised/devolved/deconcentrated health system, with 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 and 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 with high levels of patronage and scant attention to subnational levels, but with both major parties taking on pragmatic relationships with non-government organisations (NGOs). Indonesia is on a trajectory towards liberal democracy and is adapting its approach to decentralisation. Democracy and decentralisation are combining to increase the political economy of health as a public sector responsibility, but while national and local politicians are promising “free” healthcare to attract votes, there is limited evidence of financial commitment to sustainably improving health outcomes, especially at sub-national level.

All four countries face the challenge of inadequate financing for health, especially public expenditure on health by Government. In all four, UHC involves “unfunded mandates” and raises serious questions about their capacity to underwrite or sustain “free” health care, even for the poor. Figure 2 shows that while total health expenditure has been increasing in the four countries, it remains below the averages for other low income and lower middle income countries globally or the average for South Asia. Government expenditure on health (an indicator of the true priority attached to health as distinct from political rhetoric) is low; for example in Indonesia it is just $38 per person per year. Private, out of pocket, expenditure is correspondingly high in each country and is the dominant form of health financing, creating barriers to access and a source of impoverishment for the poor. In each country there are missed opportunities for pooling of risks and health finances.

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4 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 (PPP) terms.
Moreover, although not unique among south and east Asian nations, the relative national allocation of
government funding to health in three of these four nations (Philippines, Indonesia and Bangladesh) is much
lower than some of those in the same regions performing better in RMNCH (e.g. Thailand, Malaysia, China, Sri
Lanka) (Table 1), although there are clearly other health system and political economy factors at play in these
nations’ good performance. Total health expenditure as a proportion of gross domestic product per capita in
Philippines, Indonesia and Bangladesh is 1%, well below the WHO-recommended figure of 5% (a target far
exceeded in most developed nations) and the average of 3% in least developed countries. In Nepal, it has risen
from 1% in 2003 to 3% in 2013.

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 on paying private providers, is
the dominant form of health expenditure, all four countries ignore the private sector when planning and
prioritising investments. This may relate to the difficulty for governments and development partners to
actually engage formally with an often highly fragmented and unregulated private sector. Three countries –
Bangladesh is the exception – are actively pursuing decentralisation of planning, prioritisation and resource
allocation to sub-national units. There are many potential 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, in
decentralised systems poorer provinces and districts often have less financial and managerial resources to
respond to local health needs. Decentralised planning may reduce national coordination of programs to
confront communicable diseases. Financing of resources allocated sub-nationally can also be problematic.
Allocative efficiency based on local evidence-based planning is often stymied by rigidities in top-down budget
line items that prevent resource reallocation at sub-national level.

All four countries face challenges with respect to their **health workforce**. All struggle to train adequate
numbers of appropriately qualified staff, place and retain them in rural and remote areas, and ensure service
quality (and in many cases staff attendance). Many promotions and placements are 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.
There are stark **contrasts in approach to the decentralisation** of power, planning and resourcing between the four nations studied. Although still evolving, Indonesia clearly has the most extensive decentralisation, partly reflecting attempts to resist historical pressures for provinces to break away. The Philippines also has a long history of moves to empower local governments following political instability after what many Filipinos consider as a period of dictatorship. Bangladesh has the least decentralisation, possibly reflecting its small size, dense population and homogenous society, and possibly because active NGOs provide many of the services that would normally be provided by government agencies or the private sector. Nepal’s situation is evolving after recent violent political upheaval, with democratisation and tentative moves towards increasing decision-making power and budgeting at sub-national level.

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 a growing role of the private sector, including private “philanthropy” sponsored by banks and corporations, especially in urban and peri-urban areas. The Philippines is using accreditation processes under PhilHealth to formalise and regularise private sector engagement.
4. Key recommendations based on this analysis

Several practical lessons and insights emerged from these analyses:

- **“Success” occurs in a wide range of political or economic systems.** The four nations studied here differ widely in their political and economic circumstances, and in their RMNCH progress. 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 social 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:** Using Indonesia’s high maternal mortality as a case in point, one commentator reports that four factors can increase the priority given to an issue at national-level: “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). The Millennium Development Goals and Countdown to 2015 are two initiatives that have raised the political profile of RMNCH in the four nations studied.

- **Proactively tracking “what works” in terms of priority setting and resource allocation is important in complex and fast moving environments.** Confirming the above perspective, interviews with senior decision makers during this analysis suggested that an intervention in the health sector is likely to receive priority and budget allocations if it combines five key elements simultaneously: it 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, at sub-national levels, evidence needed to be presented after elections because those elections were more often based on personalities and promises; the winning candidate then needed evidence to determine what options to implement.

- **High-level plans and budget allocations are 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 while financing was now increasing rapidly, the systems they had for procurement and financial management were still tailored to a period of austerity and small scale. Several officials suggested a need for training on outsourcing, procurement and consultancy management, rather than on planning itself. Delays in procurement often led to otherwise good and rational plans being abandoned and scarce resources being spent urgently on low priorities just to expend the funds.

- **The unplanned and unexpected can be completely overwhelming.** Development partners must be realistic about how effective and durable are government planning processes, 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. This completely – and appropriately – overturned its country assistance strategy, priorities, planning and budgets, and also reflected the government suspension of many development activities in other parts of the nation. Major political or other events have impacted development programs in all four nations assessed in the last two years.
• **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, for 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. Partners including UNICEF have already been influential in making the benefits package for newborn care more focused on primary and preventive health care and more evidence based, affordable and cost-effective for society and individual households. A similar situation is evolving in Indonesia, and ensuring universal access to a core package of basic services in Nepal also offers an unprecedented opportunity for ensuring equitable progress in RMNCH.

• **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. However, they are rarely used by public health advocates. This is a lost opportunity for engaging in more evidence-based policy dialogue, including within government.

• **Well informed media coverage, including radio and social media, is often a key factor in shaping public opinion.** As noted above, political priority often depends on elevation of the problem in the public discourse. But journalists may not have the technical expertise / time to analyse evidence, 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. Development partners could build on the current UNICEF Philippines initiative of supporting the training of Mayors on the importance of using evidence to determine health priorities in local budgets. Workshops for politicians, media, and other stakeholders on approaches to using evidence to determine what to prioritise in RMNCH have proven useful, including in the four nations studied.
Annex one: 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)

According to the World Bank, political economy 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. Political economy 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 … social trends, and how all of these factors effect or impede change. (26)