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Original Article

A rapid assessment of the political economy of health at district level, with a focus on maternal, newborn and child health, in Bangladesh, Indonesia, Nepal and the Philippines

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Abstract

Low- and middle-income countries (LMICs) face many challenges and competing demands in the health sector, including maternal and newborn mortality. The allocation of financial and human resources for maximum health impact is important for social and economic development. Governments must prioritize carefully and allocate scarce resources to maximum effect, but also in ways that are politically acceptable, financially and institutionally feasible, and sustainable. Political economy analysis (PEA)—that gets what, when and why—can help explain that prioritization process. We used PEA to investigate how four Asian LMICs (Bangladesh, Indonesia, Nepal and the Philippines) allocate and utilize resources for maternal, newborn and child health (MNCH). Using mixed research methods including a literature review, field interviews at national and sub-national level, and policy, process and budget analysis in each country, we examined three political economy issues: (1) do these countries demonstrably prioritize MNCH at policy level; (2) if so, is this reflected in the allocation of financial and other resources and (3) if resources are allocated to MNCH, do they achieve the intended outputs and outcomes through actual programme implementation? We also considered the influence of transnational developments. We found that all four countries demonstrate political commitment to health, including MNCH. However, the health sector receives comparatively low public financing, governments often do not follow through on plans or pronouncements, and capacity for related action varies widely. Poor governance and decentralization, lack of data for monitoring and evaluation of progress, and weak public sector human resource capacity were frequent problems; engagement of the private or non-government sectors is an important consideration. Opportunities exist to greatly improve equity and MNCH outcomes in these nations, using a mix of evidence, improved governance, social engagement and the media to influence decisions, increase resource allocation to and improve accountability in the health sector.

Keywords: Political economy, maternal health, child health, health financing, priority-setting, South Asia, East Asia, Bangladesh, Indonesia, Nepal, Philippines

Introduction

Low- and middle-income countries (LMICs) face many challenges in the health sector, particularly population growth, persisting communicable and increasing non-communicable diseases (NCDs), under- and over-nutrition, injuries and mental illness. Many are also vulnerable to health emergencies including pandemics, and these problems all affect the poorest social groups most. Accordingly,

Key Messages

- Governments in the four countries studied provide a policy environment that favours the health sector, but do not match this with appropriate public funding.
- The politics of health sector decision-making and resource allocation can be more complicated in the context of decentralization.
- Weaknesses in access to and use of data and information, human resource capacity and sub-national democratization limit effective political advocacy for the health sector.
- Political economy analysis is an important contribution to determining the reasons for decisions made and resource allocations in the health sector.

LMIC governments must prioritize the allocation of public financial and human resources for the health sector in the most efficient, effective and equitable ways.

Most LMICs have also indicated the intent to achieve universal health coverage (UHC) in line with the Sustainable Development Goal (SDG) target 3.8, but their total health expenditure (THE), and especially *government* expenditure on health (GHE) often remains very low in absolute and relative terms. WHO estimates that 2014 THE from all sources was only $37 per capita in low-income countries (LICs) and GHE as low as $2.50 per capita (https://data.worldbank.org). Millions of people either lack access to essential health care or are impoverished by unexpected or catastrophic expenditure. At the same time, many formerly LICs and now middle-income countries (MICs) have reduced access to concessional external financing. Governments in LMICs spend nearly $20 of domestic resources for every dollar they receive in external development assistance for health (Institute of Health Metrics and Evaluation, 2015). Moreover, many LMICs are devolving decision-making, administration and financing to sub-national levels, creating significant new political, bureaucratic and financial challenges.

These health, financing and administrative challenges imply a need for prioritization. Although scientific evidence may influence experts' priorities for health expenditure, decisions on government spending are often influenced by political factors, and analysis and understanding of these factors can help to explain and influence these decisions. Political economy analysis (PEA), although not well defined, acknowledges that many stakeholders can be explicitly or implicitly involved in economic processes that influence resource allocation, including politicians, bureaucrats, experts (academics, economists) and professional associations, industry, lobbyists, the media, development partners, civil society and the public (United Kingdom Department for International Development, 2009). Understanding these processes, and these stakeholders' incentives and relationships, and how much each relies on 'evidence', can help to explain implicit and explicit preferences.

The political economy of maternal, newborn and child health (MNCH) in South and East Asia is important, given the large burden of disease affecting children and women despite rapid economic development. In 2015, there were almost 2 100 000 deaths among children aged under 5 years, and approximately 71 000 maternal deaths, in these two regions (UNICEF, 2015; World Health Organization, 2015b), a majority of them easily preventable (UNICEF, 2014; World Health Organization, 2015b). Moreover, child under-nutrition is highest, globally, in South Asia (UNICEF, 2013), and inequitable MNCH outcomes prevail within many countries in these regions (Acuin *et al.*, 2011; Hipgrave and Hort, 2014).

This situation exists despite the clear scientific evidence for and the cost-effectiveness and affordability of established MNCH interventions. Despite rapid and sustained economic growth for most countries in South and East Asia, many have low absolute and relative levels of GHE, especially for MNCH (Tangcharoensathien *et al.*, 2011; Hipgrave and Hort, 2014). Indeed, out-of-pocket expenditure on health (OOPE) forms a higher proportion of THE in Asia than in any other global region (Dieleman *et al.*, 2016). PEA can provide insights into the drivers of this inconsistency, and moreover, into how health and MNCH can be prioritized and resourced, even in decentralizing countries with weak capacity for decision-making and resource allocation at the sub-national level.

We present a PEA of district-level health and MNCH financing and performance in four countries in South and East Asia—Bangladesh, Indonesia, Nepal and the Philippines. The study was undertaken in the context of technical assistance on evidence-based MNCH programme prioritization and resource allocation in these countries. All four are relatively new democracies, with attendant problems in responsive and accountable decision-making, and have experienced significant political upheaval in recent decades, negatively affecting security and economic development. Each has also committed to establishing UHC, necessitating important decisions on public resource allocation, but has a burgeoning, mostly unregulated private health sector concentrated in the cities (Meliala *et al.*, 2013), rapidly increasing THE due to private expenditure, and neglected rural communities. This background provided an excellent opportunity to assess how decisions are made on health and MNCH resource allocation, especially for achieving equity.

Method

We applied a mixed-method approach to this analysis and included sub-national levels, where similar research is scant. Several tools and approaches were used to develop a common process that was followed in each country. These included 'how to' notes on PEA prepared by the UK DFID (United Kingdom Department for International Development, 2009) and the World Bank (2011a), an approach developed by the Overseas Development Institute (Harris, 2013) and the World Bank's 'problem-driven governance' framework (Fritz *et al.*, 2009). The work also drew on conceptual approaches that can be applied to PEA, including 'theory of change', 'drivers of change' and 'most significant change'. All were relevant, but none could individually be coherently and comprehensively applied in all four countries because of the significant differences in their political structures, histories, cultures and pattern of economic development. Nonetheless, the analyses drew particularly on the frameworks described by DFID (United Kingdom Department for International Development, 2009) and the World Bank (Fritz *et al.*, 2009),

which applied best to the social sectors. In view of the focus of our research, we particularly used the Bank's problem-driven governance framework, with a focus on the following questions (detailed in Supplementary Web-Annex 1):

1. How are priorities set to improve the health status of women and children?
2. How do those priorities get translated into plans, budgets and allocations at the national and sub-national level?
3. What are the risks and drivers that promote/hinder local level planning, budgeting and resource allocation for MNCH?
4. How can prioritizing of MNCH and local-level planning, budgeting and resource allocation gain even higher-level traction?
5. What could be done differently . . . to support the government to move forward?

We first searched peer-reviewed and grey literature and open-access databases to identify the main political economy characteristics of each country's health and development sectors. We searched combinations of the terms 'political economy', 'priority-setting', 'resource allocation'; 'health', 'maternal health' and 'child health' and 'developing countries' and each country name in the PubMed database available at http://www.ncbi.nlm.nih.gov/pubmed and at www.google.com—with no year restrictions—during May and June 2014. We also checked the references of key reports for possible additional sources. In total, after the exclusion of double hits, over 230 published and grey literature reports were identified and reviewed. We used global databases on government general and health expenditure (http://data.worldbank.org and http://apps.who.int/nha/database) to assess financial inputs. We also used summaries and databases (http://data.unicef.org) to assess health progress, and others on broader health system issues (http://www.who.int/gho/en/) to examine public sector inputs (e.g. human resources). We prepared inception reports for each country, summarizing key health, MNCH, financing, political and economic characteristics, and outlining the proposed methodology and approach, including ethical issues, standardized interview guidelines and questionnaires. Recommended programmes of field interviews were prepared with input from government counterparts and the four UNICEF country offices (see example in Supplementary Web-Annex 1).

Fieldwork involved 1 week in Bangladesh and 2 weeks in each of the other countries during July to September 2014. One author (I.A.) led the process in each country, supported by author M.S. in Bangladesh and Nepal and author D.B.H. in Nepal, and UNICEF local staff. In total, 175 informants were interviewed at national and sub-national levels, selected purposively from among government, development partners, UNICEF staff, academia and local committees active in MNCH (Table 1; lists are included in the reports of each country process easily found online by googling 'UNICEF political economy' and the country name).

Government interviewees included leaders/experts in health and other social sectors, finance and planning. No invited interviewee refused to participate, but scheduling issues resulted in some limitations. Each interview lasted ~60 min; most were conducted individually in private at the respondent's workplace or another location; occasionally up to three members of one group were interviewed together. Recorders were not used to limit privacy concerns; responses were recorded by hand or notebook computer. Two focused group discussions were held with health facility teams and village development committees in Nepal (26 people), and one group of development partners in Bangladesh, local government partners in Papua province (Indonesia) and a range of academics in the Philippines (each of these was 5–10 people). Each interview and discussion followed a standardized process, including the topics covered (Supplementary Web-Annex 1), the findings of the literature/data review and their implications for priorities and activities in MNCH, health and other sectors. Facilitators attempted to triangulate information, perspectives and data from different sources, guaranteeing anonymity to reduce the likelihood of desensitized responses, especially among government personnel. All interviewee responses were anonymized, and ethical approval of the analysis and fieldwork was provided by the Ministry of Health counterparts in each country.

In addition, more data on social sector spending, disbursements and sub-sectoral allocations were gathered in each country, along with local analyses on related policy directions.

All information (from the desk reviews, interviews, discussions and locally gathered data) were analysed, coded and collated by hand around four broad themes developed *pre hoc* and used in preparing this report: (1 and 2) Evidence for health/MNCH's standing as first, a political and second, a financial priority; (3) the administrative and public governance of health and MNCH; and (4) the influence of the regional and global context. Findings from the documentation reviews and fieldwork are reported together.

Results

Evidence for health's standing as a political priority in the four countries

Based on the documented evolution of related policies and other government activities, all four nations prioritize health and MNCH, albeit to varying degrees.

In Bangladesh, the right to health care was enshrined in the 1972 Constitution; key MNCH-related policies have been enacted [including the Population Policy (1976) and Drug Policy (1982)] and sector-wide approaches to health implemented, involving

Table 1. Distribution and classification of interviewed personnel by country

Country	Classification						Total
	Sub-national government officials	National government officials	Other national officials	UNICEF staff	Academia	Donors/other partners	
Bangladesh		12		6		18	36
Indonesia	8	4	1	11		13	37
Nepal	45[a]	8	1	11		9	74
Philippines	8	3	1	4	7	5	28
Total	61	27	3	32	7	45	175

[a]Twenty-six participants in focused-group discussions in two districts, and district officials.

development partners. A sub-national health system at the Upazilla (district) level was established but is relatively powerless to set priority or allocate funds. Remarkable successes in reducing fertility (El Arifeen *et al.*, 2014) and maternal and child mortality (UNICEF and WHO, 2014) have benefited from infrastructure and systems (funded by the government) and community-level service delivery partnerships with non-government organizations (NGOs; El Arifeen *et al.*, 2013); these have bipartisan political support, as described here: 'A high-level political commitment to health dates back to independence. This commitment has endured despite major political changes, including transition from military to civilian rule, and has been facilitated by institutional continuity of civil servants and partnerships between government and the non-governmental sector …' (Balabanova *et al.*, 2013). Bangladesh's family planning programme has been one of the most successful, particularly, in comparison to other LICs. The important role of NGOs in service provision might suggest they have filled a gap due to low health financing by the Bangladesh government. Indeed, a senior government planner recalled that 'Bangladesh welcomed NGOs after liberation because they helped establish independence'. However, several others and a more recent conference presentation (Yousuf, 2016) confirmed that NGO coverage and successes have depended on the country's combination of public sector support for and NGO implementation of key programmes (Ahmed *et al.*, 2013; Chowdhury *et al.*, 2013).

Nepal's recent political history has resulted in the rise of groups traditionally excluded from power and access to economic opportunities. Despite the extreme political upheaval and with consistent donor funding of serial Health Sector Support Programmes [foreign aid represents about 20% of the national budget (Ministry of Finance, 2015) and of THE (Adhikari, 2015)], priority has been given to health, particularly reducing access barriers, ensuring coverage of high-impact interventions and service quality. Indeed, improvement in health outcomes has been a central element of the post-conflict, nation-building agenda, with politicians on all sides understanding the electoral benefits (Tsai, 2009), many health-affirming acts and policies, and the 2007 Constitution declaring health as a basic right (World Health Organization, 2015a). Access to basic MNCH care has mostly been provided by a large group of community health workers, notionally volunteers but partly supported by governments and local communities (Khatri *et al.*, 2017). Interestingly, despite the new empowerment of the Left, the formal private health sector has also grown rapidly in Nepal, suggesting pragmatism and a desire to circumvent former patronage networks that dominated health sector appointments and funding. According to one public sector interviewee, 'almost 50% of patients use private providers and doubt the quality of public services …', although another at district level cautioned that private providers are 'only interested in profits' and on risks associated with the weak capacity of districts to engage such providers.

Successive Philippines governments, particularly the 2010–16 Aquino administration, have also demonstrated willingness to improve and underwrite health and MNCH, with explicit political commitment to the social sectors reflected in the national budget. Decentralization was prioritized, including as a defence against concerns about a return to Marcos-style authoritarianism (Turner, 2006). Aquino's 'Social Contract with the Filipino people' prominently pledged change: '…from treating health as just another area for political patronage to recognizing the advancement and protection of public health …' (Institute for Autonomy and Governance, 2016). The Aquino Health Agenda emphasized UHC, upgrading government hospitals to improve access to and quality of care and increasing the focus on public health (Department of Health, 2010). National guidance on health planning was upgraded, with substantive attempts to monitor progress; a scorecard system systematically monitors progress on 37 important outcome, output and process indicators at sub-national level, overseen by local government. Moreover, the commitment of the administration to social budgeting for three major legislative programmes overcame significant political hurdles. The first was a large, successful cash transfer programme targeting the poor, with MNCH-related conditionalities. Second, despite decades of opposition from tobacco industry alliances in Congress, was the successful passage of increased 'sin taxes' on tobacco and alcohol, with a significant proportion of the revenue directly channelled to UHC, especially for the poorest (Kaiser and Iglesias, 2016). Third, the passage of the 2012 *Responsible Parenthood and Reproductive Health Act* demonstrated the government's commitment to population health and welfare by legalizing modern contraception, despite decades of political and church opposition (Manaloto, 2014).

Indonesia's record on prioritization of health is mixed, and again cannot be considered in isolation of political developments. Under former President Soeharto (1967–98), a highly centralized, paternalistic approach to health led to the introduction of basic community- and village-level services with a strong MNCH focus (Aspinall, 2014). With decentralization, national capacity and authority to ensure implementation of these priority programmes declined, and progress was slow in some areas such as maternal mortality reduction (Shiffman, 2003). Moreover, public expenditure on health has traditionally been very low in Indonesia, and the private health sector, including dual practice, is thriving, especially in urban areas (Hort *et al.*, 2011; Rokx *et al.*, 2012; Meliala *et al.*, 2013). However, as observed elsewhere, democratization has increased perceptions of health as a public sector responsibility, and the engagement of civil society and lobbyists acting on behalf of unions and social movements in related policy-making (Aspinall, 2014). In this context, sub-national authorities increasingly acknowledge the political benefit of prioritizing health, with promises of 'free' or subsidized care and new health services common before local elections. But there is limited evidence of local authorities prioritizing public health or MNCH. Interviewees suggested some interest to make good on such election promises, but limited financial or human resources impede the capacity to follow through. Another problem with Indonesia's decentralization model was the ceding of responsibility for health, especially the district hospitals, to local government, limiting national authorities' ability to influence priorities and ensure standards and progress.

Commitment to UHC is a major indicator of the four governments' commitment to health, with the Philippines and Indonesia most advanced in this regard. In the Philippines, health insurance institutions are arguably now as important as government in determining health access and outcomes, including for the poorest sectors of society. In 2015, the government stated a determination to scale-up insurance coverage beyond the 51% of the population covered in 2010, and PhilHealth, the national insurer, is redesigning the benefit package and providers' eligibility to participate (The Office of the President of the Philippines, 2015). Indonesia's approach to establishing UHC involves the integration of the government-financed health insurance programme for the poor and near-poor, *Jamkesmas*, with all other social insurance programmes, under a single-payer umbrella. *Jamkesmas* has been managed and financed by the Ministry of Health since 2005, insuring over 76 million Indonesians; the new programme will cover the entire population of 240 million (The Economist, 2012). Bangladesh and Nepal's related commitments are much less developed, with Bangladesh aspiring to

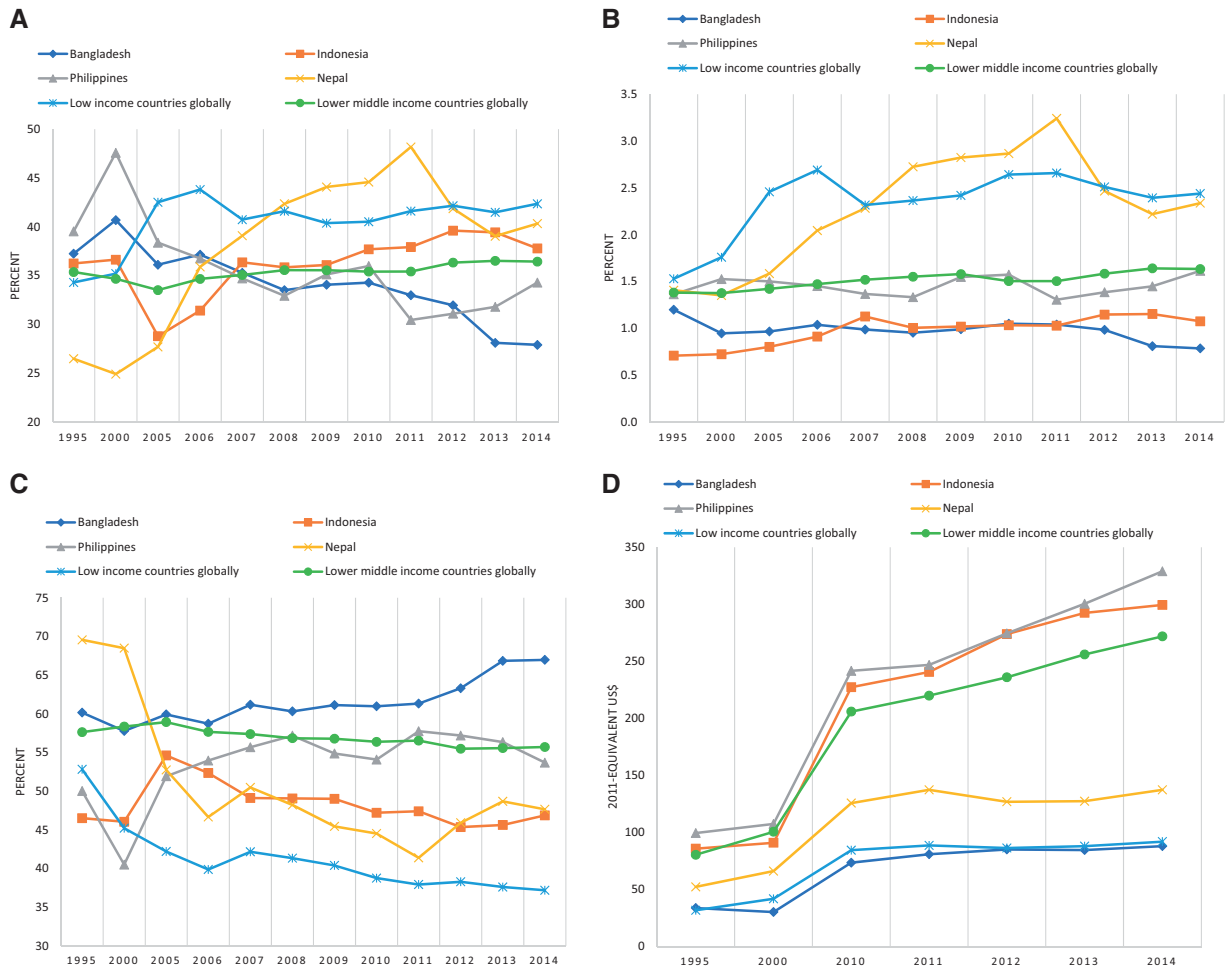

Figure 1. (A) Government expenditure on health (GHE) as a proportion of THE (1995–2014). (B) GHE as a proportion of gross domestic product per capita (1995–2014). (C) Out-of-pocket expenditure on health as a proportion of THE (1995–2014). (D) THE per capita (1995–2014) in constant 2011 international dollars. *Source:* World Development Indicators 2015 (www.data.worldbank.org)

UHC by 2032 (Ministry of Health & Family Welfare Health Economics Unit, 2012; Ahmed *et al.*, 2015), and Nepal only recently committing to health insurance for all (Thapa and Maru, 2017).

Evidence for health and MNCH's standing as a priority for public financing

Absolute and relative expenditure on health is a more reliable expression of priority than political statements and declarations. In this regard, the four nations studied are representative of the Asia-Pacific region, where the contribution of GHE to THE is mostly lower than the average for lower-MICs, and even for LICs globally (Figure 1A). Similarly, 2014 GHE as a proportion of gross domestic product per capita (GDP) [ranging from just 0.8% of GDP in Bangladesh to 2.3% (including external aid) in Nepal], is far lower than the recommended 5% (Chatham House, 2014) (Figure 1B). GHE remains well below the $86 recently recommended (Chatham House, 2014) even for LICs, in all four countries. Consequently, OOPE on health remains high, and well above the global average for LICs (Figure 1C). Although THE is increasing in these four countries (Figure 1D), this is largely due to OOPE.

By way of example, according to domestic sources in 2014/15 Bangladesh allocated only 4.4% of its total government budget to the health sector, down from 7% in 2008/09 and much less than education and technology (13.1%); public administration (15.3%) and other sectors (Bangladesh Ministry of Finance, 2015). Interviewees, and both government documents and independent analysis conceded that health budgeting there is haphazard, based on historical norms rather than burden of disease, equity or population, and is largely conducted in Dhaka (World Bank, 2010; Ahmed *et al.*, 2015). A 2012 analysis by the Health Economics Unit of the Ministry of Health and Family Welfare concluded that: 'Bangladesh hitherto has not adopted a deliberate health care financing strategy. Health financing interventions and programs are either driven by supply-side pressures (salaries for nurses and physicians; medicines and facility consumables), while pilot activities are often initiated in response to emergencies or following international trends. A comprehensive health care financing strategy is critical to meet the challenges confronting the health sector now and in the future' (p. 12) (Ministry of Health & Family Welfare Health Economics Unit, 2012). This concern was reiterated by several donors in Dhaka.

Another factor identified as influencing GHE may be the political economy of the most visible areas of public spending on health vs recurrent costs. Under the former Aquino administration in the Philippines, health attracted a particularly rapid and sustained

increase in budgetary resources, albeit off a low base. However, rapid and large increases in the budget of the Department (Ministry) of Health in recent years (Supplementary Web-Annex 2) have mostly gone to maintenance and other operating expenses, including insurance premiums for the poor. In contrast, the allocation to salaries has remained relatively flat, suggesting reliance of providers on other sources of income, and probably influencing the large-scale out-migration of Philippines-trained health personnel. Similarly, politically expedient non-health government expenditure, such as energy subsidies, consumes a large proportion of some LMIC budgets (Coady *et al.*, 2015), including until recently in Indonesia.

Interestingly, none of those interviewed could explain why their country's government accords such low priority to health financing. Several speculated that while health has political priority, it has the low absorptive capacity, particularly at sub-national level, as mentioned by national government personnel in Bangladesh and Nepal. One government interviewee in Indonesia reported that some district leaders are using the health budget to purchase government bonds. This would be consistent with World Bank Indonesia findings that 'the low level of public spending is … not … the main problem. The capacity to spend and the efficiency of spending, especially at the local level, are arguably even more serious problems. Fragmentation, allocative and technical inefficiencies, low productivity and poor quality result in low utilization rates…' (Chaudhuri, 2009, p. 37). One non-government informant in Bangladesh felt that low public funding for health results from the programme's success, partly due to donor- or self-funded civil society actors who provide a large proportion of community health services. On the other hand, several acknowledged substantive central government efforts at financing particular local health services but without acknowledging declining public-sector health resources overall.

At the time of our assessment, only in Nepal (with its high rate of on-budget foreign-sourced aid funding) was the GHE proportion of THE increasing, albeit from a low 27% in 2005 to around 40% in 2013 (Figure 1A). Indeed, the budget for essential healthcare in Nepal has increased faster than that of the national health ministry (HEART, 2013). However, one interviewee noted that mechanistic resource allocation in Nepal tends to follow earlier spending decisions and is heavily influenced by donor priorities and specific ('vertical') disease control programmes. This was confirmed by both central and district government health personnel, who noted lack of local contextualization and even double funding of some programmes during inefficient planning processes.

A complicating factor in the four countries assessed is that remittances from expatriate workers are an increasing proportion of GDP (25% in Nepal) and household disposable income. This burgeoning private liquidity may influence the political economy of public expenditure on health, as purchasing from private providers, whether regulated or not, becomes more feasible for the population. However, it is unlikely to benefit the very poorest households, whose unskilled residents are less likely to work abroad, vulnerable to exploitation by private providers and most reliant on underfunded public services.

In addition to the low volume and proportion of GHE, complex and poorly regulated public financial management was noted as a major problem in each country (Supplementary Web-Annex 3). Unspent budgets, multiple funding sources and budget lines, delays in fund release, weak accountability and political influences on local fund disbursement affect each step of sub-national health financing to varying degrees in the countries assessed. As noted by a senior UNICEF staff member in one country: 'As you move from the plan to the budget it becomes political' with competition for central funds by other sectors. In Bangladesh, both national and international interviewees noted weak local control over centrally allocated public sector health resources, and in the Philippines, one source mentioned limited evaluation or analysis of the influence of GHE on health outcomes or effective service coverage. These difficulties are not limited to the health sector.

Resource allocation, programme implementation and MNCH outputs and outcomes

Resources may be appropriately allocated to reflect national priorities, but political economy issues influencing implementation may determine whether programme objectives are achieved. Three aspects of public sector governance were consistently mentioned as important influences on the political economy of health and MNCH in the four nations assessed: (1) health priority-setting, planning and budget management; (2) the closely related collection and use of data/evidence and (3) human resources for health (both public and private).

Health sector planning and fund allocation in each of the four countries have, at least until recently in Indonesia and the Philippines, been highly centralized and mechanistic, based on historic inputs and norms rather than outputs, outcomes or changing needs. The processes have lacked transparency, were not informed by impact or performance evaluation and were stymied by political economy influences: rigid budget lines to maintain budget control, vested interests, dominance of national over local priorities, institutional and bureaucratic inertia, and key decision-makers' retention of power and patronage.

Indeed, decentralization of political and financial power, or the absence of it, remains a major political economy influence in all the nations assessed. One study referred to the risk of corrupt local procurement practices; expectations of change after decentralization that proved implausible due to weak supply-side capacity or leadership; misalignment of financing and accountability; or unrealistic expectations in the areas of participation, accountability and transparency (The Asia Foundation, 2012). Another noted the breakdown in public goods, such as disease surveillance and control, or referral networks, when power is devolved to the detriment of national standards or authority (Pisani, 2013). Local or non-health authorities may decide to ignore national health priorities, such as the continued blocking of modern contraception by the Supreme Court in the Philippines (The Manila Times, 2017). Moreover, decentralization may not be 'clean', such that well-connected sub-national leaders may seek discretionary national funds, dampening their incentive to raise and manage funds locally and contributing to inequitable outcomes across districts (World Bank, 2011b).

Among the four nations assessed, Bangladesh provides the best example of these problems (Box 1), but the failure to promote efficiency and quality of implementation noted was not unique to that country. Corrupt procurement practices with attendant implications for waste and programme quality, lax regulation and stewardship of health personnel and weak monitoring were all described by interviewees in each country. A senior finance official in Bangladesh acknowledged 'that local level planning makes sense but the concern is the lack of capacity. The traditional way of thinking is not helpful to local analysis and planning.' Another noted: 'We don't do enough monitoring and accountability, even whether medical staff are present or absent, let alone performing well… local planners also have no authority to incentivize and punish'. A district-level interviewee there called for central planners to pay more attention to local priorities. Senior officials in the Philippines and Indonesia mentioned that

the biggest challenge they now faced was no longer shortage of funding but rather that the systems for procurement, financial oversight, personnel management and program monitoring are still tailored to a period of small-scale purchases, limited programmes and austerity. In Nepal, district staff were unhappy that national priorities and budget ceilings did not match the local situation. On the other hand, despite evolving decentralization, some did not feel they had the authority to make decisions and re-allocate resources, whereas others felt that the capacity for decision-making at the district level was weak.

However, and in contrast with Bangladesh, there are signs of improvement in health sector governance with decentralization in the Philippines (Box 2). There was also, at the time of surveying, a bottom-up process for district-level planning in Nepal with, theoretically, 14 separate steps and the involvement of District Development, Village Development and Health Facility Management Committees. But interviewees generally perceived that these do not influence national priorities or budgets. Indeed, despite the important role of sub-national and community actors in securing Nepal's impressive MNCH achievements, they have limited influence on national or local policy. This has also been observed in other sectors (Jones, 2010). A Local Self-Government Act notionally devolved health planning to the nation's 75 districts in 1999, but in 2012 key parts of health budgeting remained highly centralized, such that the local units were little more than 'simple aggregations of centrally sanctioned budgets' (The Asia Foundation, 2012) with 166 fixed-line items and limited possibility of reallocation, similar to Bangladesh. However, evidence-based, district-level planning and local government empowerment in Nepal is gradually being strengthened with donor support (Matheson, 2014).

In contrast, heavily decentralized Indonesia, acknowledging the sub-national politicization of and weak capacity for priority-setting, planning and fund allocation, is recentralizing to some degree. It is also allocating village-level block grants to encourage community-level prioritization. There are also signs that elected officials are acknowledging community pressure (Aspinall, 2014), a major political economy influence in maturing democracies, and also the efforts of donors (e.g. www.kinerja.or.id) and the media to improve evidence-based, local-level priority setting and planning.

Second, and highly related, this analysis also identified that *the availability and influence of information/data* is an important factor influencing programme implementation and hence a critical influence on the political economy of MNCH and health. In principle, evidence-based planning should help counter the influence of political patronage, lobbyists and rent-seekers. This is important, as poor women and children are usually voiceless in the political process. In Bangladesh, field data on the effectiveness of oral rehydration solution and zinc in the management of childhood diarrheal disease, and evidence on the feasibility of community family planning was important in policy decisions on these interventions. On the other hand, in each country data for planning is often incomplete, old, based on false denominators [e.g. in Bangladesh, an estimated 10 million children under five do not officially exist (Villeneuve, 2015), and in Indonesia only 42% of births in 2007 were registered (Universitas Gajah Mada Centre for Population and Policy Studies, 2011)] or is simply unavailable (e.g. indicators related to subsequent NCD risk among children and reproductive-age women; and virtually anything to do with the private health sector). Some interviewees lamented the lack of availability of and interest in data on health sector performance, efficiency and effectiveness; others speculated that this is because its release might threaten those who are responsible. One comment from a UNICEF staff member at country-level noted district allocations unrelated to needs, population or other circumstances, and that key donors are also concerned about vertical planning with little concern for available data.

Apart from what evidence is important, officials also drew attention to the *timing* of evidence during the annual financial or political cycles, the medium and style of its presentation (including whether it is tailored to the audience and uses the right 'language') and which agency or individual presents it (with a preference for unbiased, known academics or credible institutions). Civil society coalitions with evidence overcame opposition to several public health initiatives related to formula milk promotion and sin-taxes in the Philippines. Policy entrepreneurs have been effective in the use of evidence but require certain qualities and skills to overcome political inertia. Interviews and research in Indonesia (Shiffman, 2003) suggested that health-related proposals are more likely to be funded if they meet five criteria simultaneously: (1) the data indicate that they address serious issues affecting a large population; (2) there is low technical/political risk in scale-up; (3) they incur low cost or personnel/management burden; (4) they yield quick and identifiable results; and (5) they secure media support. Obviously, meeting these criteria is beyond the capacity of most sub-national health authorities, and has affected the political economy of MNCH at this level.

Third, *deployment and retention of effective human resources* is a perennial hurdle for MNCH and the health sector more broadly (Ranson *et al.*, 2010). Each of the four countries studied has major challenges in this regard. Low individual wages and poor conditions due to under-investment by governments have contributed to a chronic shortfall in public sector health personnel, whereas paradoxically salaries overall often absorb a large share of GHE, squeezing out operational expenditure. Low incentives limit productivity; public institutions are often rich in structure but poor in function. Dual practice by public sector personnel is common in these countries, and poor supervision and regulation of both public and private sectors affect the standard of and access to essential health services (Hipgrave and Hort, 2013). The literature reviewed and interviews in all four countries confirmed that promotion or deployment to desirable locations is frequently subject to political or bureaucratic patronage. Professional associations, often politically connected, are very influential, especially benefiting well-connected health staff (Harris *et al.*, 2013). However, the lack of public sector personnel may have underwritten the success of alternatives such as Nepal's community health workers, and the NGOs providing primary care services in Bangladesh.

Even less is known about the activities of private health providers, who are largely unregulated. Although the field interviews and the literature review confirmed the major role of private providers in clinical care, and it is assumed that the private sector will be engaged in UHC, interviewees could not explain why private services were not systematically considered when prioritizing, planning and allocating public health resources. One official in Bangladesh noted: 'We don't know what is happening in the districts. BRAC claim 127, 000 health workers, which is double the government …. Systems are vertical and there is a lack of coordination…'. 'The private sector is like a science fiction movie where two races cannot see each other but keep bumping into each other', said another in Indonesia. Some speculated that as the private sector is amorphous and not well organized, it is difficult to collect key data on or interact with them. Others noted that the government tends to focus on the public sector for historical reasons, with little incentive to change and very limited capacity to regulate the private sector. Decisions on health services are, accordingly, being made despite lacking fundamental information. Finally, some claimed

Box 1. The political economy of centralized financing in Bangladesh's health sector

Highly centralized Bangladesh's health financing comprises at least 32 operational plans covering various diseases and vertical programmes, each developed in isolation. Such fragmentation limits the prioritization of scarce public resources to the highest or more important local needs. Interviewed officials noted little flexibility to reallocate resources; increases exceeding 10% must be approved by cabinet, a resource-intensive and slow process. They also confirmed limited cost consciousness or requirement for operational efficiency or value for money, even within the Ministry of Finance. Although the Ministry of Local Government, with World Bank support, has successfully implemented sub-national planning, interviewees noted weak capacity building and staff turnover at sub-national level, and that successive national governments have been preoccupied with establishing political power, limiting willingness to relinquish control of resources to sub-national levels. Some perceived there is reluctance to devolve power and decision-making in the health sector, given the opportunities for political patronage in staffing appointments, and for corrupt kickbacks in the procurement of supplies and capital investments. Similar conclusions were reached in a recent review of planning, budgeting and financial management in the Bangladesh health sector (The Office of the President of the Philippines, 2015). Moreover, the 'winner takes all' approach to government and the see-sawing power of the major parties has resulted in large programmes being started or stopped by incumbents, impacting services (El Arifeen et al., 2013). Another perspective is that unlike many other countries in Asia, Bangladesh does not have major ethnic or geographic separatist movements, a political economy factor driving decentralization of government elsewhere. It could also be argued that strong NGO and community-based approaches in Bangladesh comprise de facto decentralization.

Box 2. Improving health sector governance with decentralization in the Philippines

In 2005, an Asian Development and World Bank report found disconnects between national and regional/provincial planning, weak budget formulation and execution, limited community participation, poor financial controls and weak enforcement due to elite capture; lack of transparency; an excessively politicized system of rewards and allocations, and uneven institutional strength among national executive, congressional, and provincial and other sub-national actors (World Bank, 2011b). The government has responded accordingly; a 2013 review of health sector planning concluded: 'The government has well developed planning and investment processes at the national and subnational levels. Provincial and city investment plans for health translate national health goals into specific concrete actions at the local level. They become the basis for mobilizing and allotting resources from the national government and development partners … [at local level]. An investment planning tool for local health development … has been developed … [along with a] prioritisation process for allocating resources, based on issues such as health impact, equity, political commitments, and correcting variation in health performance levels' (Jones, 2010, p. 5). During 2014, the Philippines Department of Budget and Management introduced 'performance-informed budgets', declaring that this 'represents the continuing shift away from the dominance of patronage politics and clientelistic relationships towards a more responsive, transparent and accountable public expenditure management system' (Matheson, 2014, p. 2). The Philippines has also introduced a 'grassroots participatory budgeting process' (bottom-up-budgeting) to improve the representation of poorer communities' needs in planning and resource allocation.

there are simply insufficient resources to regulate the private sector (itself a political economy issue), and that private providers were influential behind the scenes. The almost total *neglect of the private sector*, despite its major role in health service provision, underscores the limited consideration being given to the structure and financing of health service provision in these four nations. Nonetheless, the literature suggests financial mechanisms of provider regulation may be feasible (Kozhimannil *et al.*, 2009; Hipgrave and Hort, 2014; Montagu and Goodman, 2016), possibly influencing the quality and range of, and also access to healthcare for the poor.

Influence of the regional and global context on the political economy of health and MNCH

Several major contextual developments with influence on the political economy of health and MNCH were common to the four countries studied.

Current *epidemiologic and demographic transitions* should have major implications for the political economy of the health sector and MNCH, but their apparent influence remains limited. The political economy of MNCH has been protected by high profile global initiatives like the Millennium Development Goal (MDG) and SDG and Countdown to 2015 (UNICEF and WHO, 2014), but certain areas (maternal and newborn mortality, child undernutrition, management of childhood tuberculosis and pneumonia) remain major concerns. Moreover, the political economy of health more generally is heavily threatened by the impending huge impact of NCDs and population ageing on the cost of healthcare and nature of services required in these four and most nations. Despite aspirations for UHC and social health insurance, apart from the Philippines' sin-taxes, it was not evident from this analysis that the financial burden and sources of public funding and personnel required in the context of these changes have been seriously considered.

Finally, although this report has focused on direct influences on the political economy of MNCH in the health sector, we recognize the influence of other sectors and determinants of MNCH outcomes. For example, the prioritization of girls' education; public policy on key industries with health influences (tobacco, agriculture and food production), and on advertising and the media; transport and road networks, etc. all have indirect effects on resource allocation for MNCH. We also recognize the importance of deeply

Box 3. Key observations and recommendations based on this analysis

1. Success occurs in a wide range of circumstances. All four countries have made progress, yet differ widely in their political and economic circumstances. What matters is the strength of the institutional, economic and social environment; policy factors (including on public and private financing), and implementation factors, including the sequencing of reforms.

2. A problem is not a problem until it is on the political agenda. The Countdown initiative raised the political profile of MNCH during the MDG era, but prevailing inequities indicate the need for its continued elevation. Proactively documenting and visualizing 'what works' in terms of priority-setting, resource allocation and health outcomes is important.

3. Understand the language of finance and apply it to the entire health system. Ministries of Finance are persuaded by data on costs and affordability, but these are not systematically captured or critically analysed in many countries. Accountability for results is weakly associated with resource allocation. This may itself be a political economy issue, with authorities preferring lax oversight to detailed scrutiny of public resources.

4. National Health Accounts are under-utilized for policy dialogue. Done well, they provide a clear and easily accessible overview of national health financing, both public and private. However, their quality varies, and they are infrequently used by health advocates, a missed opportunity for engaging in more evidence-based discussion with government.

5. Evidence matters, but what evidence, when it is presented, by whom and how, matters more. Evidence for national decision-making must be presented at critical times during the political and budgeting cycle. At sub-national levels, evidence may be more effectively presented after elections, which are often based on personalities and promises. After winning power, the incumbent needs evidence to prioritize programmes.

6. High-level plans and budget allocations are irrelevant if implementation/procurement is weak or ill-suited to increased resources. As economies improve, procurement, recruitment and financial systems developed in periods of austerity can become constraints, along with weak capacity on outsourcing, negotiation and management. Delays may lead to rational plans being abandoned and resources being expended inappropriately.

7. Health reforms are very likely to involve the private sector, which may provide a majority of services but a minority of health information, frequently bypasses official procurement systems and may ignore practice standards and fee structures. New means of private sector regulation and engagement are imperative for UHC, equity and ensuring quality of care. UHC will require better governance, stewardship and regulation of both the public and private health sectors, especially for community-based chronic disease care.

8. The unplanned and unexpected can be completely overwhelming. Major events have impacted development programmes in all four nations assessed. Development partners must retain flexibility in relation to government planning and prioritization. Unexpected local events (political, natural) may result in suspension of activities in other parts of the nation.

9. The focus on UHC is a strategic opportunity for health. Insurers may influence health services more than the government. How they set premiums, services covered and on what basis they pay service providers has major implications for the health sector and MNCH, especially for the poor. Ensuring universal access to a core package of basic services in such countries offers an unprecedented opportunity for improved equity in MNCH.

10. Well informed media coverage, including social media, is a key factor in shaping public opinion, but journalists may not have the expertise/time to analyse evidence, plans and budgets. Ensuring politicians, media and other stakeholders are adequately skilled on the use of evidence to determine what to prioritize in MNCH may be useful.

ingrained cultural and religious values, including attitudes to child marriage. These and other indirect influences on public policy, priority-setting and public resource allocation may be more important than the best evidence on MNCH and health inequity, however powerfully and no matter by whom it is presented.

Discussion

We conducted a non-systematic but comprehensive review of the political economy of health and MNCH in four important countries of south and east Asia, identifying many important and complex influences difficult to summarize in one paper. We conclude that the apparent political commitment to these issues manifests in a variety of ways, ranging from local or national health authorities influenced by larger national political and economic issues (Nepal; Indonesia); retention of centralized financial control but *de facto* decentralization, allowing NGOs to provide many public health services, with considerable success (Bangladesh), to pro-active, forward-looking processes, albeit sometimes stymied by local officials (Philippines). However, apart from the Philippines, governments are generally not allocating funds where they claim to allocate priority, leaving private individuals to pay for an increasing proportion of services, and yielding inequity and the risk of impoverishment. Poor governance, weak information systems and weak human resource capacity (in both health services and administration)—and the failure to prioritize improving these issues—are themselves political economy issues at all levels. This is not specific to the four nations assessed. These weaknesses have major implications as chronic disease burdens put more pressure on health budgets, both public and private, potentially squeezing out MNCH services, especially in poorer areas or countries (GBD 2016 Causes of Death Collaborators, 2017).

The stated public commitment to UHC in all four countries is encouraging and highly relevant to the post-2015 global health environment. Indeed, recent changes to Indonesia's decentralization law and budget priorities, re-empowerment of province governments, commitment to UHC through a social health insurance platform, and cancelling burdensome fuel subsidies augur well for the public health sector. However, UHC faces major funding and structural challenges. To make UHC financially sustainable, each country will need to identify ways to generate, pool, prioritize and efficiently spend additional financial resources. This, despite a large proportion

of the workforce being employed informally, limiting income tax as a source of public revenue. There is a risk that countries will rely on consumption taxes that, being regressive, will have larger impacts on the poor than the rich. Improving the allocation and flow of, and accountability for resources at each level is another major political economy challenge little influenced by the health sector, particularly in poorer settings and where corruption prevails. Financing UHC remains one of the most vexing problems for the health sector in LMICs worldwide (Somanathan, 2015; Kutzin *et al.*, 2016).

Equally vexing is the locus of political and hence financial authority. Among these four countries this ranged from firm retention in the national capital (in the case of Dhaka) to virtually absolute devolution to district leaders (Indonesia), with the risk (at both extremes) of leadership mainly focusing on controlling funds and/or retaining power, rather than low profile issues like maternal mortality or child under-nutrition. In the Philippines, the national insurance agency appears to have a major influence on health resource allocation and distribution, which situation might become more common as countries adopt social health insurance schemes. Although all four countries are democracies, many interviewees commented that non-health-sector influences have a larger influence on resource allocation and health equity. Local stakeholders and especially development partners alike should take a broad view when considering how best to influence health outcomes in these and similar nations. Except in Nepal, development partners have limited influence on establishing the more evidence-based and fairer allocation of scarce health resources in the countries assessed. Moreover, development partners, particularly bilateral partners, bring their own political economy incentives, reflected in the countries, diseases and local agencies that they choose to fund, the lack of funding for initiatives on NCD management and prevention being a case in point. Nonetheless, in most LMICs inequity prevails, affecting groups or pockets of the population. Development partners, even non-health partners focusing on social or economic development or other outcomes have an opportunity to influence domestic resource allocation and prioritization of MNCH.

There are, of course, limitations to this work. We did not keep a record of the online search results obtained using different combinations of search terms. However, our combination of *pre hoc* and in-country (unpublished) documentation searches enable confidence that the literature identified for each country was comprehensive, at least that written in English. In-country interviews were limited to 2 weeks per country, but the total number of 175 interviewed was reasonable. Field interviews were held in provinces and districts in three countries, but not in Bangladesh. We only examined official documents that were in English. Despite efforts, it was very difficult to identify and interview representatives of the for-profit private sector. Timing and other constraints meant that we mainly focused on MNCH service coverage; we could not assess the quality of care. Finally, this can only be described as a rapid, mostly qualitative analysis and literature review; however, it should encourage consideration of non-health influences on health outcomes in these diverse but populous nations in a dynamic, economically emerging region.

Several recommendations emanate from this analysis; in lieu of lengthy presentation as text, these are summarized in Box 3. UNICEF is using these findings more broadly in the design of its social sector programmes, including on immunization in nine countries in Africa. These recommendations, and indeed this kind of analysis applies to virtually any such programme. They differ from much of what is published on health systems strengthening, which focuses on individual building blocks or disease control programmes and lacks adequate focus on the broader context. Work such as the WHO Health in All Policies approach (World Health Organization, 2014) and new calls for multisectoral approaches to healthcare (not a new concept) suggest this increasingly being recognized.

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Supplementary data

Supplementary data are available at *Health Policy and Planning* online.

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