The political economy of crisis-affected settings: what does it mean for investments in health systems?

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Policy-making in health systems is shaped by wider social, political and economic processes.[1] A range of actors – individuals and organisations – influence those processes and in doing so determine how policies are introduced and implemented. Crisis-affected settings experience dramatic changes in the policy-making context which may create a 'window of opportunity' for policy reform.[2] Political economy research approaches provide insights in this regard by examining the interplay of actors and interests, and their effects on socioeconomic policies and outcomes.[3] This brief reviews key elements in the response to crises from a political economy perspective, evidence on the opportunities and challenges presented by crises, and lessons in how to best utilise those opportunities to promote investment in health systems.

Key messages

- **The political economy of health system reforms is crucial in all contexts but in crisis-affected settings can be particularly volatile and hard to manage**
- **The government/development partner asymmetry can be particularly pronounced, leading to a variety of problems including poorly contextualised, embedded and implemented policies**
- **On the positive side, crises can trigger 'focusing moments', bringing attention and resources to the health sector, when structural changes can be made more easily in these relatively fluid contexts**
- **To take advantage of these windows, partners need to be prepared to engage rapidly and responsively with local policy entrepreneurs**
- **There is a responsibility to ensure good follow-up and support for implementation as risks in this respect are high; linking with civil society groups to provide monitoring and feedback can be one effective strategy to support this and to ensure inclusion and accountability.**

Political economy of crisis responses

Policy-making processes in health involve a wide range of actors and interests.[1,4] At the national and sub-national levels there are governmental organisations, politicians from across political spectra, businesses, media, professional associations and other civil society organisations which all play a role. Multilateral international actors and transnational business are also important and in the Global South there is likely the additional presence of development agencies and international non-governmental organisations. In crisis-affected settings, particularly those that experience protracted crises, there is often an asymmetry in power between under-resourced internal actors (across all sectors) and well-resourced international actors.[5]
One typology for crisis-affected settings, focused on the nature of the political settlement, is shown in figure 1. [6]

The resources, capacity and mandate of the government is an important driver of the political economy, as is the degree of territorial control. Another factor to be considered is the length and intensity of the conflict or crisis, as well as cross-border dynamics. These have different implications for supportive investments, as illustrated in figure 2.[7]

The form of policies reflects the varying influence of different actors. For example, civil servants may have discretion to introduce or amend policies,[8] and actors can try to use the media to elevate specific issues onto the government's agenda.[9] Individuals and organisations may work together in 'advocacy coalitions' that promote specific agendas and policies,[10] although the success of those coalitions tends to be determined by their leadership, cohesion and political influence.[11]

This briefing paper series has been developed by the ReBUILD Research Programme Consortium to inform a number of key issues around health systems in crisis-affected settings, and draws both on ReBUILD's own work and wider sources. The issues were identified in a research agenda-setting study carried out by the Health Systems in Fragile and Conflict Affected States Thematic Working Group of Health Systems Global.

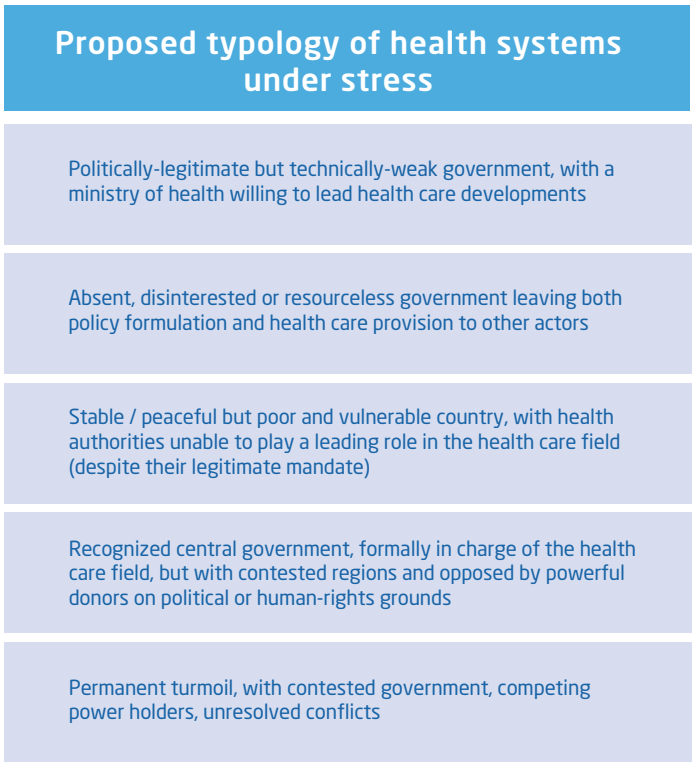

Figure 1. A proposed typology of health systems under stress. From Pavignani & Colombo, 2016[6] (http://bit.ly/2rHYSET)

Crises create pressure for extraordinary immediate policy responses and longer-term reforms aimed at preventing future crises.[12] Examples include decentralisation reforms in Kosovo,[13] and health workforce reforms in Sierra Leone.[14] In these settings crises function as 'focusing events' for specific issues and can lead to a 'window of opportunity' for policy change in conditions where there is a recognised problem, a known policy solution and a conducive political environment.[15] Influential individuals, often senior politicians in post-crisis settings,[16] can function as policy entrepreneurs to push through reforms in this context.

Opportunities for health system reform

Crises can offer an opportunity to challenge the existing political economy of health systems in order to introduce reforms that will lead to more equitable health systems. Health systems are often a lower political priority than other social and economic concerns and ministries of health have lower status than many other government departments.[17,18] Crises in the health system can act as a focusing event that raises the status of health systems issues amongst the public, media, and government.[19]

Realisation of the 'window of opportunity' for health system reform requires strong systems and institutions, however these are often lacking in crisis-affected settings.[14] International organisations therefore have an opportunity to provide impetus for health reforms. The aftermath of the 2014-16 Ebola epidemic in Sierra Leone was marked by significant international interest in rebuilding a more equitable heath system.[20] That included renewed interest in improving coordination and implementation of health workforce policies.[21]

Lessons from crisis-affected settings

Shaping the agenda

Domestic organisations can play an important role in driving policy change **(see accompanying briefs on research capacity and inclusive health systems)**. Government departments, universities, public health bodies and civil society can commission, conduct and/or disseminate research in order to guide health systems policy.[22] However such a role requires support for health systems research capacity building in crisis-affected settings.

International actors are often influential in policy processes. For example international actors were important in raising awareness of the inequitable effects of user fees for healthcare in Liberia and Burundi, generating pressure for fee removal policies.[16] The engagement of international actors with domestic policy processes should extend beyond funded projects, as many health policy activities take place out of the development project context. In more extreme cases, such as Kosovo,[13] international actors may take control of responsibility for health policy altogether. Such arrangements raise concerns for accountability to the wider population,[5] although participation can be encouraged through regular consultations like those used in Kosovo.

Governance

Coordination amongst actors is vital for introducing and implementing policy reforms.[17] The period during and immediately following crises are typically characterised by chaotic environments in which a broad array of organisations are interacting with the health system, many with their own policies and operating procedures.[21] Policy change is typically incremental and fragmented during this period but more substantial reform agendas can take root if there is an alignment of domestic and international political interest.

The case of Sierra Leone suggests an important role for policy entrepreneurs to accelerate reforms in crisis-affected settings. There was little progress with workforce policies in the post-crisis period between 2002 and 2009, before a series of important reforms were

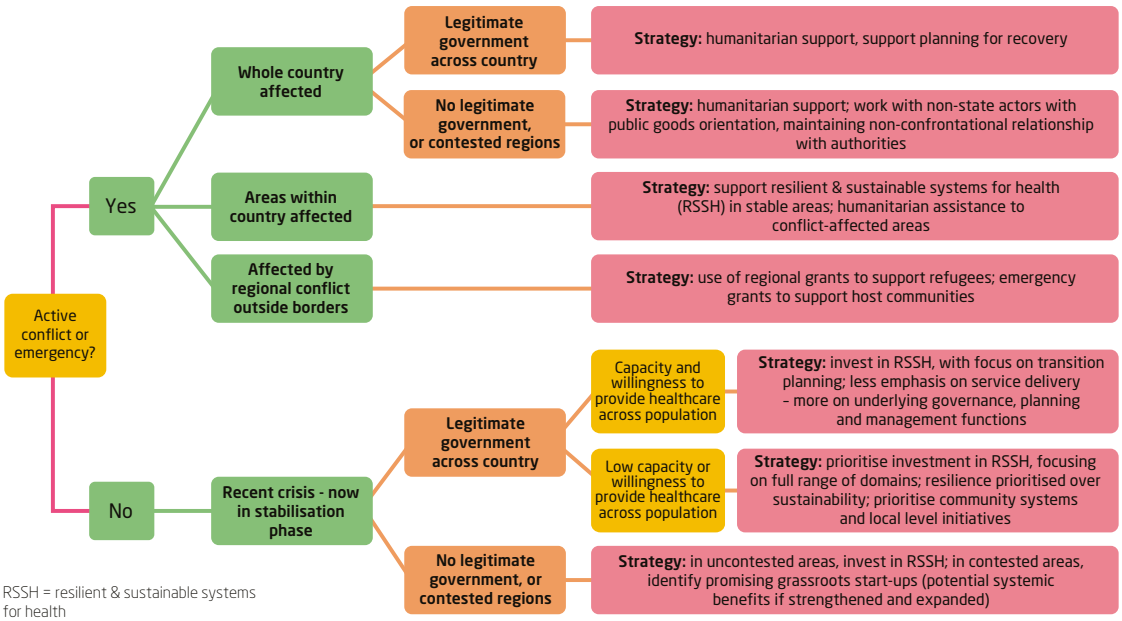

Figure 2. Possible categorisation of crisis affected settings and implications for resilient and sustainable systems for health (RSSH). Adapted from Witter & Pavignani, 2016 [7] (http://bit.ly/2sczLfU)

introduced following direct intervention by the President.[14] Similar senior political interventions were reportedly important in other crisis-affected settings,[16] although there is a risk that reforms subsequently become narrowly associated with particular politicians.

Inclusivity

There is a risk that the framing of crises and responses is used to undermine equity in health systems, for example through the geographic or social exclusion of particular groups **(see accompanying brief on inclusive health systems).** The direct involvement of senior politicians in health system reforms may create clientalist pressures to ensure some social groups benefit more than others. Too much emphasis may be placed on the reconstruction of health facilities rather than less 'visible' (but often more equitable) public health interventions, as has been documented in Nigeria.[23]

The participation of marginalised groups in policy processes can strengthen policy design and ensure their health needs are reflected. However the ability of such groups to participate in policy processes depends on organisation and leadership, which may be limited in crisis-affected settings where civil society is relatively weak.[24]

Implementation

In several examples the introduction of a policy reform agenda has not been matched by implementation as expected on the ground. Several governments in post-crisis settings have introduced policies to remove user fees, only to find that informal systems of fees emerge.[16] One reason for this is that policies are introduced before there is adequate financing and infrastructure in place to implement them.[25] Perceptions amongst health workers are also important in the persistence of user fees, as workers in many crisis-affected contexts consider free healthcare to encourage over-use and to be unsustainable.[26] Decentralised planning processes offer one mechanism to improve the likelihood of implementation by tailoring policies to suit local context.[27]

Lack of planning is exacerbated in settings where there is domestic pressure to demonstrate political leadership. In some post-crisis settings free healthcare announcements have been made by leading politicians and linked to election cycles.[26] Testimony from Burundi suggested that the Ministry of Health was unaware the President was planning to remove user fees until after he had announced the policy.[28] International pressure to demonstrate commitment to reform has similar effects. In Sierra Leone, pressure to produce new policies in line with international recommendations meant that little attention was devoted to the actual implementation of policies.[14] However, the use of civil society monitors provided stronger accountability, at least during the first years of the reform.[29] These examples highlight the trade-off between capitalising on the political 'window of opportunity' and ensuring adequate systems are in place for policy implementation.

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