Do health systems contribute to reduced fragility and state-building during and after crises?

Brief prepared by **Sophie Witter** and **Benjamin Hunter**

June 2017

The process of 'state-building' after periods of crisis has attracted significant recent attention in humanitarian and development sectors. Health systems are an important outcome of state-building, but are also argued by some to be a driver of the state-building process itself. Access to health services is valued across ideologies and offers a way of encouraging reconciliation and preventing future crises,[1] a logic sometimes referred to as 'health as a bridge to peace'.[2] This brief discusses the associations between health systems and state-building and the empirical evidence in this area.

Key messages

- **The concept of state-building itself is highly contested, with a rich vein of scepticism about the wisdom or feasibility of this as an external project. State-building is more likely to be an unintended positive spin-off of targeted health systems investments than the result of deliberate external engineering.**
- **There are plausible linkages, but empirical evidence is limited, not least because of measurement issues.**
- **There is consensus that health systems have the potential to be an important part of developing the legitimacy of a state through demonstrating capacity to deliver services, accountability to population needs and contributing to social cohesion, for example by provision of healthcare entitlements to all groups (focused on needs).**
- **The post-crisis moment offers risks and opportunities. Risks include capture of resources by privileged elites or increased opportunities for patronage and nepotism; opportunities include a new settlement in which governing actors revive the social contract through equitable financing, distribution of resources (such as infrastructure and staff) and services.**

Key definitions

This brief uses a definition of the 'state' as a set of institutions for governing people within a defined geographical area.[3] Interpretations of the concept range from a focus on formal government institutions,[4] to broader understandings that include individuals and organisations which function on behalf of government and which operate in the private and well as public sectors.[5]

'State-building' refers to 'purposeful action to develop the capacity, institutions and legitimacy of the state in relation to an effective political process for negotiating the mutual demands between state and societal groups'.[6] It is distinct from the civil society-dominated approach of 'peace-building' that emphasises societal relationships,[7,8] and in fact one of the criticisms of 'state-building' approaches is that they prioritise the interests of a narrow set of national elites.[9] Some commentators have distinguished between tangible and intangible elements of state-building,[7] or between constitutive and output domains.[10] There is also contestation as to whether state-building only includes strategies driven by external actors,[11] or whether internally driven processes are included too.[12]

Key concepts used when describing state-building include the 'social contract' and 'legitimacy' of the state.[11] The social contract represents a division of responsibilities between the state and society, in which political institutions are given control over certain societal functions in return for protection from threats to well-being. The related concept of legitimacy refers to the extent to which people then accept the state's 'right to rule' over those societal functions. These concepts are shaped by contextual factors such as popular expectations about the role of the state.[8, 13]

All the briefing papers in this series can be accessed at http://bit.ly/2rUPRH9

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.

www.rebuildconsortium.com

Possible links between health systems and state-building

Health systems researchers have proposed multiple factors that link health systems to state-building within and beyond the health sector, although measurement is a challenge for all models and state-building appears to be a spin-off of health systems strengthening rather than a planned outcome in itself. One model highlights the importance of state capacity to fulfil its health promotion role, of mechanisms for accountability that enable the state to meet its social contract responsibilities, and of encouraging social cohesion through the health system.[14] Effective health system governance and information systems provide a basis for improved service provision, while equitable financing arrangements can protect users from healthcare costs and promote social cohesion.[15]

Other models have placed additional emphasis on using health systems to provide security and stability to communities, and on how equity and responsiveness can enhance state legitimacy.[11,12,16] An appropriately trained, managed and incentivised health workforce can provide services in ways that encourages positive perceptions of the public health system and its legitimacy (see figure 1).[12] Those perceptions may extend beyond the health sector if legitimacy is enhanced across all areas of government.

The post-crisis period is particularly important for state-building. Protracted crises can lead to deterioration in health service provision, decreased protection from health-related costs, and the undermining of state legitimacy.[14] The loss of legitimacy is exacerbated in settings where, in the absence of an effective state-run health system, actors outside the purview of the state become important providers of services.[17] The post-crisis period must therefore be used to urgently restore and expand health system functions and to promote the legitimacy of the state as the lead for health system governance.

Set against that, important concerns have been raised regarding attempts to use health systems to promote state-building.[18] There is a risk that state-building which prioritises the interests of national elites will lead to the politicisation of the health system and the potential social exclusion of non-elite groups. Further, close association between attempts to enhance state legitimacy and allocation of funding for health risks diversion of funds towards high-profile infrastructure and campaigns to the detriment of less visible but still important services.

Empirical evidence

Health system governance

Efforts to promote good governance in the health system after crises can enhance state legitimacy. In Timor-Leste, training for mid-level civil servants facilitated the transfer of health services management from international organisations to the Ministry of Health, thereby enabling the state to take responsibility for health services.[12] However, it is important to also include other levels of health management, such as districts.[19] In Cambodia, donor preference for supporting the national Ministry of Health, large non-governmental organisations and local service provision meant province-level management was neglected and ultimately obstructed effective system functioning.[20]

Quality and visibility of health services

Effective provision of health services during crises can promote state-building, while inadequate provision undermines the process. In Nigeria and Mozambique, privately contracted health services that were more accessible and of better perceived quality were associated with better perceptions of the state by the public, and failures in health service provision by private contractors were blamed on the state.[11,12] Evidence therefore indicates that state-building can be supported by effective public and private provision, however there is also evidence that extensive private contracting for health service management and provision during crises can undermine legitimacy of the state, as reported in Afghanistan.[22]

Reconstruction initiatives that follow conflicts and that have tangible manifestations – or rather, are 'visible'[20] – to the public can demonstrate the capacity and willingness of the state to fulfil the social contract. Governments in Liberia and in Afghanistan 'visibly' restored and expanded primary healthcare throughout the country by focusing on provision of a 'basic package' of health services.[23] In Mozambique, health system reconstruction efforts were initially focused on underserved areas in parts of the country controlled by differing factions and helped to relieve social tensions in those areas.[21,24] However the risk that health system strengthening initiatives become politically driven is real, and an inappropriate focus on high-status infrastructure has been reported in Nigeria.[11]

Human resources for health

Inclusive health workforce policies can expand equitable access to health services while promoting state legitimacy. The post-conflict reintegration of health workers from opposing factions in Angola, Ethiopia, Mozambique and Sierra Leone ensured greater geographical coverage of health services,[12] and re-training of health workers during the latter stages of conflict in Mozambique reportedly prevented attrition by preparing workers for the post-crisis period.[21] There is

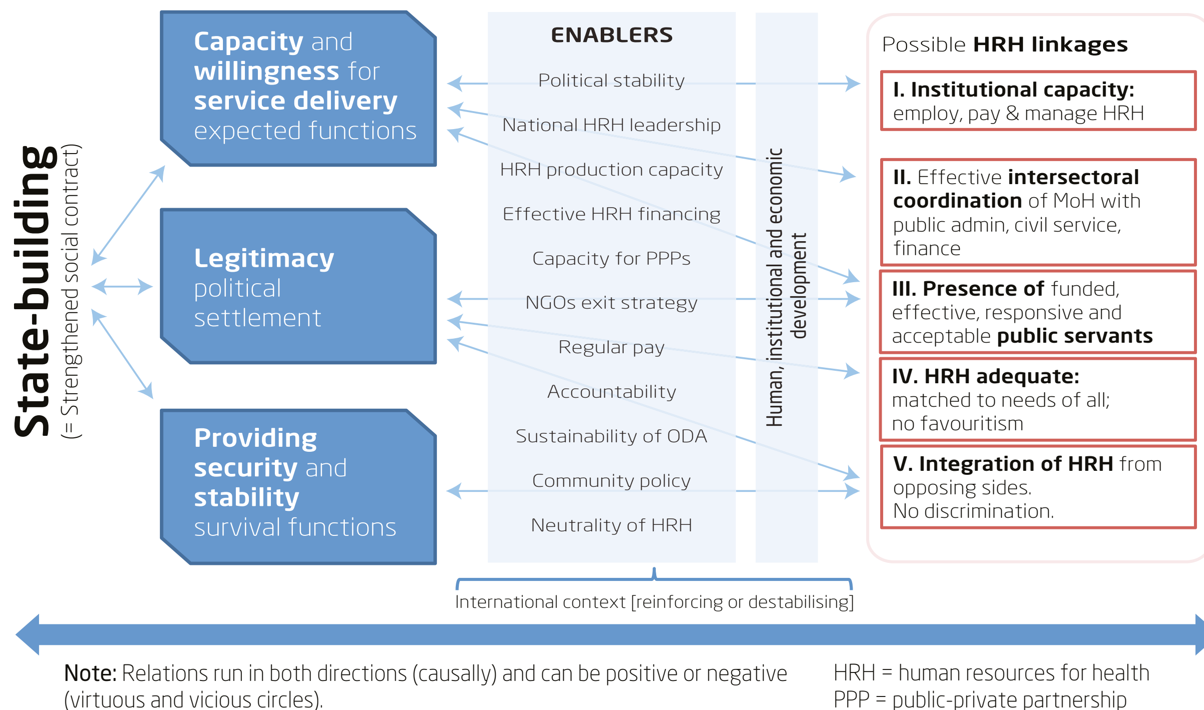

Figure 1. A conceptual framework for state-building and human resources for health. (from Witter et al. 2015 http://bit.ly/2qLLYYv)[12]

a risk that recruitment for government positions is dominated by nepotism among particular social groups, as reported in Afghanistan,[25] and so it is important to place emphasis on meritocratic hiring practices for health system employees, as done in Burundi.[26] Those efforts bring together disparate groups in order to protect health, thereby enhancing social cohesion and the perceived legitimacy of the state.

Appropriate training and incentives for health workers are important as perceived inadequate compensation for work has resulted in the emergence of user fees in many settings.[12] Where health worker wages were a low priority for post-crisis strengthening in Nigeria and Sierra Leone, workers demanded payments from users for certain services.[11] That undermined the state's role in protecting users from healthcare costs.

State-building beyond the health sector

Empirical research in this area points to the importance of health service provision for increasing the visibility and reputation of government, thereby improving its legitimacy in general. Decentralised health management in Sierra Leone appeared to raise the profile of local government and improve community perceptions of the state.[11] Survey data from five post-conflict countries suggest that perceptions of how well health services are run determines user satisfaction with government more broadly,[27] while data from 38 countries indicate that responsive and fair health service provision and protection from healthcare costs is associated with trust in government.[28]

Policy lessons that diffuse from health to other sectors provide a basis for further state-building. For example, research has suggested that the health sector in Timor-Leste acted as a model of good governance for other sectors.[29] However the improvements in health system governance in Timor-Leste relied on support for government capacity building at the central, district and local levels of management, and so its reproducibility in other sectors would rely on similar support.

References

1. World Bank, 2011. World Development Report 2011: Conflict, Security, and Development. Washington DC: World Bank Group http://bit.ly/2pFh1VV
2. World Health Organization, 2002. Report on the Second World Health Organization Consultation on Health as a Bridge for Peace. Versoix: World Health Organization http://bit.ly/2pPZx5j
3. Kurian, G.T., 2010. The State. In G. T. Kurian, ed. The Encyclopedia of Political Science. Washington D. C.: CQ Press
4. Fukuyama, F., 2004. The Imperative of State-Building. Journal of Democracy, 15(2), pp.17–31 http://bit.ly/2qLYMOQ
5. Clarke, J., 2004. Dissolving the Public Realm? The Logics and Limits of Neo-liberalism. Journal of Social Policy, 33(1) http://bit.ly/2qmvo0o
6. OECD, 2008. Service Delivery in Fragile Situations: Key Concepts, Findings and Lessons. Paris: OECD http://bit.ly/2rls2ZK
7. Haider, H., 2011. Statebuilding and Peacebuilding in Situations of Conflict and Fragility. Birmingham: Goverance and Social Development Research Centre http://bit.ly/2qLBoRs
8. Sondorp, E., Coolen, A., 2012. The Evolution of Health Service Delivery in the Liberian Health Sector between 2003 and 2010. London: LSHTM http://bit.ly/2qmvghc
9. Marquette, H. & Beswick, D., 2011. State Building, Security and Development: state building as a new development paradigm? Third World Quarterly, 32(10) http://bit.ly/2pRq3dT
10. Fritzl, V., Menocal, A. R., 2007. Understanding State-Building from a Political Economy Perspective: An Analytical and Conceptual Paper on Processes, Embedded Tensions and Lessons for International Engagement. London: Overseas Development Institute. http://bit.ly/2qmevmA
11. Eldon, J., Waddington, C. & Hadi, Y., 2008. Health Systems Reconstruction and State-building. London: HLSP Institute http://bit.ly/2qqiOeN
12. Witter, S. et al., 2015. State-building and human resources for health in fragile and conflict-affected states: exploring the linkages. Human Resources for Health, 13(1) http://bit.ly/2qLLYYv
13. Mcloughlin, C., 2015. When Does Service Delivery Improve the Legitimacy of a Fragile or Conflict-Affected State? Governance, 28(3) http://bit.ly/2qmrIAO
14. Kruk, M.E. et al., 2010. Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda. Social Science & Medicine, 70(1) http://bit.ly/2rmDJi4
15. Freedman, L.P. et al., 2005. Transforming health systems to improve the lives of women and children. The Lancet, 365(9463) http://bit.ly/2qsuMVc
16. Rubenstein, L., 2009. Post-Conflict Health Reconstruction: New Foundations for US Policy. Washington DC: US Institute for Peace http://bit.ly/2qNXldp
17. Batley, R. & Mcloughlin, C., 2010. Engagement with Non-State Service Providers in Fragile States: Reconciling State-Building and Service Delivery. Development Policy Review, 28(2) http://bit.ly/2qmtFZc
18. Philips, M. & Derderian, K., 2015. Health in the service of state-building in fragile and conflict affected contexts: an additional challenge in the medical-humanitarian environment. Conflict and Health, 9(1) http://bit.ly/2pT9rm1
19. Bertone, M. and Witter, S., 2015. An exploration of the political economy dynamics shaping health worker incentives in three districts in Sierra Leone. Social Science and Medicine, 141 http://bit.ly/1E7P2dC
20. Waldman, R., 2007. Health Programming for Rebuilding States: A Briefing Paper. Arlington: USAID http://bit.ly/2rldA2W
21. Pavignani, E. and Colombo, A., 2001. Providing health services in countries disrupted by civil wars: a comparative analysis of Mozambique and Angola: 1975–2000. Geneva: WHO http://bit.ly/2pGJl4Q
22. Palmer, N., Strong, L., Wali, A., Sondorp, E., 2006. Contracting out health services in fragile states. BMJ (Clinical Research ed), 332 (7543) http://bit.ly/2raMmjm

Nursing staff from surrounding clinics came to support their colleagues at Holme Eden Clinic, Zimbabwe. Photo: World Bank

23. Newbrander, W., Waldman, R. & Shepherd-Banigan, M., 2011. Rebuilding and strengthening health systems and providing basic health services in fragile states. Disasters, 35(4) http://bit.ly/2rlcsfV
24. Vaux T. and Visman, E., 2005. Service Delivery In Countries Emerging From Conflict. London: UK DFID http://bit.ly/2qobfHl
25. Fujita, N. et al., 2011. A Comprehensive Framework for Human Resources for Health System Development in Fragile and Post-Conflict States. PLoS Medicine, 8(12) http://bit.ly/2qouMYi
26. Christensen, C. & Edward, A., 2015. Peace-building and reconciliation dividends of integrated health services delivery in post-conflict Burundi: qualitative assessments of providers and community members. Medicine, Conflict and Survival, 31(1) http://bit.ly/2rmUKbT
27. Mallett, R. at al., 2015. Surveying livelihoods, service delivery and governance: baseline evidence from the Democratic Republic of Congo, Nepal, Pakistan, Sri Lanka and Uganda. London: ODI http://bit.ly/2qNwIQn
28. Rockers, P. C. at al., 2012. Perceptions of the Health System and Public Trust in Government in Low-and Middle-Income Countries: Evidence from the World Health Surveys. Journal of Health Politics, Policy and Law, 37(3) http://bit.ly/2pRc20v
29. Rohland, K., Cliffe, S., 2002. The East Timor Reconstruction Program: Successes, Problems and Tradeoffs. Washington DC: World Bank Group http://bit.ly/2rkKrVJ

The ReBUILD Consortium is an international research partnership working on health systems strengthening in settings affected by conflict or crisis.

For more on ReBUILD's research and outputs, visit the website at **www.rebuildconsortium.com** and follow us at **@ReBUILDRPC.**

For further information, contact:
Sophie Witter – switter@qmu.ac.uk or
Nick Hooton – nick.hooton@lstmed.ac.uk

ReBUILD Consortium
Liverpool School of Tropical Medicine
Pembroke Place
Liverpool, L3 5QA
T: +44(0)151 705 3100
E: **rebuildconsortium@lstmed.ac.uk**

This is an output of a project funded by UK aid from the UK government. However the views expressed do not necessarily reflect the UK government's official policies.