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**The Dynamics of
Policy Change:
Lessons from
Health Financing
Reform in South
Africa and Zambia**

September 2000

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Partnerships
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Reform

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- > *better informed and more participatory policy processes in health sector reform;*
- > *more equitable and sustainable health financing systems;*
- > *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- > *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

This report provides an analysis of the process of health care financing reform in South Africa and Zambia during the 1990s. It is based on detailed investigations of experiences from the time of political transition in each country (1991 in Zambia and 1994 in South Africa) until 1999. The health care financing policies examined include the development and application of resource allocation formulae and a range of resource mobilisation reforms. In some respects these reforms promoted equity and system sustainability. For example, in both countries public sector budgets were reallocated in ways that promoted equity (and, in Zambia, allocative efficiency). The negative impacts included reversals over time in the South African geographical equity gains and reduced health care utilisation levels in Zambia. Important gaps in policy action were also identified in both countries. The critical factor underlying these experiences was found to be the processes of decision making surrounding the policy changes, which were bound by context and yet strongly shaped by key political and technical actors. The particular interests and concerns of these actors, and their corresponding responses to the design details of the reforms, explain the positions they took on the reforms of focus. In addition, their relative power largely explains their ability to block or mobilise support for policy change, although this was sometimes mediated by the particular strategies of policy development and implementation employed in decision making. Reflection on the varying factors explaining the pattern and impacts of policy change in the two countries generated 10 principles that could be used in any country to strengthen processes of decision making surrounding health care financing issues.

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Acronyms

ANC	African National Congress
CBOH	Central Board of Health
CMAZ	Church Medical Association of Zambia
COI	Committee of Inquiry
COSATU	Congress of South African Trade Unions
DG	Director General
DHFE	Directorate of Health Financing and Economics
DHS	District Health System
DOH	Department of Health
DOF	Department of Finance
FAMS	Financial and Administrative Management System
GEAR	Growth, Employment, and Redistribution Strategy
GNP	gross national product
HCFC	Health Care Finance Committee
HCFWG	Health Care Financing Working Group
HIV/AIDS	Human Immunodeficiency Syndrome/Acquired Immune Deficiency Syndrome
HRIT	Health Reform Implementation Team
LCMS	Living Conditions Monitoring Survey
M&E	monitoring and evaluation
MMD	Movement for Multiparty Democracy
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
NGO	nongovernmental organisation
NHI	national health insurance
NHPS	National Health Policies and Strategies
NHS	national health system
PHC	primary health care
PHR	Partnerships for Health Reform Project (USAID)
RAMS	Representative Association of Medical Schemes
RDP	Reconstruction and Development Programme
SAZA	South Africa/Zambia

SHI	social health insurance
SIDA	Swedish International Development Agency
TA	technical assistant
TOR	Terms of Reference
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
ZCCM	Zambia Consolidated Copper Mines

Foreword

Part of the mission of the Partnerships for Health Reform Project (PHR) is to advance “knowledge and methodologies to develop, implement, and monitor health reforms and their impact.” This goal is addressed not only through PHR’s technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The program comprises Major Applied Research studies and Small Applied Research grants.

The Major Applied Research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

- > Analysis of the process of health financing reform
- > The impact of alternative provider payment systems
- > Expanded coverage of priority services through the private sector
- > Equity of health sector revenue generation and allocation patterns
- > Impact of health sector reform on public sector health worker motivation
- > Decentralization: local level priority setting and allocation.

Each Major Applied Research area yields working papers and technical papers. Working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country-case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work, such as multicountry studies and reports presenting methodological developments or policy-relevant conclusions. These more polished pieces will be published as technical papers.

All reports will be disseminated by the PHR Resource Center and via the PHR website.

Sara Bennett, Ph.D.

Director, Applied Research Program
Partnerships for Health Reform

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Executive Summary

Overview of Report

This report provides an analysis of the process of health care financing reform in South Africa and Zambia during the 1990s. It is based on the more detailed investigation of these experiences presented in Lake *et al.* 2000 (for Zambia) and in Gilson *et al.* 1999 (for South Africa). The report complements the country reports by synthesising the two countries' experiences and applying a common framework to consider the similarities and differences in their experiences. Such a synthesis requires a stance that is distanced from the minutiae of experience even while the details are being considered. It seeks to generate valid conclusions concerning why, when, and how policy change was brought about in the two countries as a basis for deriving lessons for other countries about how to strengthen the process of developing and implementing health care financing change.

The report is presented in five chapters. Chapter 1 provides the rationale for the overall study and presents the conceptual framework and details of the methods employed in each country study. Chapter 2 briefly describes the nature and background of financing reform in each country, and Chapter 3 provides a more detailed overview of the roots, nature, and impacts of health care financing change. Chapter 4 then identifies the factors that shaped these experiences, and, from these experiences, Chapter 5 derives 10 principles for strengthening the implementation of financing policy change in any country.

Reforms Assessed

The analysis focused primarily on the 1990s, from the time of political transition in each country (1991 in Zambia and 1994 in South Africa) up to 1999. The health care financing policies examined included the development and application of resource allocation formulae affecting allocations between geographic areas and levels of care, and a range of resource mobilisation reforms, which included the following:

- > Reintroduction of fees at all levels of the system in Zambia
- > Initiation of prepayment schemes in Zambia
- > Removal of fees for care provided to pregnant and lactating women and children under six and all primary care in South Africa
- > Development of social health insurance (SHI) proposals in South Africa that were not implemented by 1999.

Reform Impacts

Assessing the impact of these reforms is difficult, mainly because of parallel changes within the health system, such as decentralisation to districts in Zambia. However, it is clear that the financing reforms had a mixed range of impacts on health system equity and sustainability, which were their primary objectives.

Positive impacts included the reallocation of public sector budgets towards relatively under-resourced areas in both countries; reallocation of public budgets and expenditures towards primary care and away from tertiary levels in Zambia; promotion of improved financial access to primary care with consequent utilisation increases in South Africa; and mobilisation of resources for, and capacity development at, the district level in Zambia.

On the other hand, there were also negative impacts such as reversals over time in the South African geographical equity gains, reduced health care utilisation levels in Zambia, and indications of instability within the South African public health system. In addition, two important pre-existing financing problems were simply not addressed during the period of focus: the resource maldistribution between public and private health care sectors relative to the populations they serve in South Africa and the declining level of public funding available to the public health system in Zambia. Both of these are substantial problems and are not solely the responsibility of the health sector. Although the implementation of a stronger regulatory framework for the private insurance sector in South Africa might be seen as a first step towards tackling its wider problem, few other relevant actions had been implemented. At the same time, by 1999 the Zambian government had not finalised the comprehensive financing policy document intended to provide it with an overall approach to tackling its general sectoral resource constraints. These gaps in policy action reflect weaknesses in health care financing policy change over the period of focus.

Explaining Impacts

Understanding these experiences of policy change – the reforms that were implemented and those that were not, the uneven pattern of implementation, including some policy reversals, and the varying nature of their equity and sustainability impacts – is the central focus of this analysis.

Contextual Factors and Influential Actors

The experiences of health care financing reform were clearly rooted in the processes of decision making surrounding the policy changes, which were bound by context and yet strongly shaped by key actors. These actors included those who ultimately made key decisions, those who provided information, those who supplied resources, those who worked behind the scenes to influence decision makers, and even those who never had a chance to make their voice heard in the decision making.

In each country the nature of political transition gave health reform important political status because it was seen as a leading element within the new government's overall policy programmes. Yet, at the same time, other contextual factors undermined both the implementation of health care financing reforms and their potential for positive impacts. Thus, the massive transformation in South African governance structures that accompanied political transition made it difficult to develop and implement coherent policy change, while the deepening economic crisis in Zambia exacerbated the negative impacts of fee increases on utilisation levels. Contextual features also shaped the influence of different actors in decision making. The political profile of health reforms added weight to the formal role of Ministers of Health in decision making, ensuring that they had a clear and significant influence over the pattern of financing policy change in both countries. The different characters and behaviours of individual ministers heightened their influence. The second key actors in both countries (although working more behind the scenes in Zambia than in South Africa) were the central economic ministries that guided macroeconomic policy and decision making on public spending. In contrast, those civil servants seeking to support policy change, as well as analysts based outside government, had relatively little influence over the decision making. They were influential primarily when they had the support of the minister at the time, or when they participated in relatively routine processes (such as the budget process within which resource allocation decisions are made). In Zambia, however, representatives of donor agencies consistently influenced decision making because

of they controlled resources, and initially they were often seen as an ally of the reformers within government. Other actors who were sometimes important in South Africa policy debates included the trade union movement and groups within the private health sector, particularly the private insurance industry.

Strategies of Policy Development and Implementation

Each actor's influence over the pattern of policy change and its impacts was also mediated by the particular strategies of policy development and implementation employed in decision making. The first national Minister of Health sought to direct health policy change in South Africa by inviting nongovernment analysts to advise her on health financing issues, but then she effectively ignored them. The analysts, nonetheless, continued to work with government technicians in developing relatively detailed SHI proposals that sought to gain support by accommodating the concerns of both the private insurance industry and the national Department of Finance. Yet they ultimately failed to secure adequate political backing to implement the proposals. This missed opportunity for policy change represents the failure of any actor to tackle a critical equity problem for the country, the inequitable availability of resources between the public and private sectors. Similarly, although a team of government technicians and nongovernment analysts in Zambia had developed a comprehensive financing policy as a mechanism to improve the coherence of financing policy change, it had not been approved by 1999. A lack of ministerial interest in the document, as well as opposition from hospital-based staff to some of the proposals, blocked its acceptance. Thus, in both countries technical advisers failed to gain support from their ministers at critical times of policy development and were instead kept at a distance from decision making by those ministers.

Two actors who had even less influence over policy change in either country, although they had a direct influence over policy impacts, were health workers and the general population. In South Africa, fees were removed without adequate preparation, and implementation therefore impacted negatively on staff morale, contributing to some of the public health system's sustainability problems. In contrast, strong communication efforts at the start of the reform programme in Zambia promoted understanding of the reforms amongst health workers, facilitating the implementation process and its positive impacts on sustainability. Despite this, poor communication regarding resource mobilisation policy changes led to their variable implementation across the country and promoted negative impacts. Failure to exempt the poor from fees, for example, helps to explain the utilisation reductions that followed the reintroduction of fees.

Policy Design

Such impacts were clearly a function of aspects of policy design. Unclear equity goals provided a weak foundation for policy change in South Africa. This permitted the SHI proposals to give greater emphasis over time to revenue generation for public hospitals and less to the initial focus on promoting greater cross-subsidisation within the health system. Yet this shift did not draw adequate support for the proposals even while it alienated those actors that saw SHI primarily as a mechanism for strengthening the poorest groups' access to health care. At the same time, both countries gave limited thought as to how they would ensure the linkages between individual financing changes that would promote equity and sustainability gains. For example, in Zambia, the level of the premium in the hospital prepayment scheme was less than the ordinary user fee price. As a result, the prepayment scheme encouraged health care users to bypass less costly primary care facilities in favour of hospitals and to take out insurance coverage only when ill rather than before illness, which defeats a scheme's risk-sharing mechanism. In addition, neither country managed to support resource reallocation by ensuring the parallel redistribution of human and other resources. Finally, experiences of supporting financing policy implementation through parallel institutional reform were mixed. Although Zambia's programme of decentralisation to districts did support the implementation of

financing policies, in South Africa there was little action to strengthen public hospital management even though it was a necessary step in improving revenue generation and use.

Ten Principles to Guide Strengthened Decision Making

A review of the differences and the similarities in the two countries' experiences of financing policy change, the pattern of change, and the varying impacts, ten principles are identified for possible use in other countries. The application of these principles is intended to strengthen processes of decision-making in ways that enable change in health care financing policies to support improved delivery of health care¹. They are:

1. Make financing policy change an integral part of health system development:
 - > Because it has a wide-ranging influence over the patterns of health care provision and use, as well affecting popular support for such change, and must itself be complemented by parallel institutional changes.
2. Pay attention to the “art” of politics (rather than just the “science” of technical analysis):
 - > In order to promote change effectively, and to ensure that policy debate does not become the preserve of the few with the relevant knowledge.
3. Use a balanced mix of open and closed policy processes:
 - > Combining combine broad, public debate about the goals and strategies of policy with more “closed” approaches to identifying which policy options to pursue on the basis of publicly debated goals and to develop detailed design proposals in relation to selected option.
4. Develop wide-ranging strategies of information gathering:
 - > As both formal and informal data (such as the views and opinions of the public and key actors), are important in identifying policy options and in managing the process of change.
5. Apply strategies and tactics:
 - > Because actors strongly influence the pattern of policy change, and so their interests and concerns must be actively considered in identifying strategies that build support for change, whilst offsetting opposition.
6. Balance strong political leadership with effective technical capacity:
 - > To ensure that sound analysis supports appropriate leadership in bringing about sustained policy change, despite change over in leaders.

¹ The country reports provide more detailed conclusions about the design of specific financing reforms as well as country-specific conclusions concerning policy development processes.

7. Establish clear roles for all technicians and analysts:
 - > To enable best use of the limited pool of health economists available within countries.
8. Take account of implementation needs in policy development:
 - > Rather seen implementation as an activity that somehow automatically follows policy development, and does not require both deliberate planning and policy management skills.
9. Enable further policy change through the approach to implementation:
 - > By prioritising policy actions, sequencing the implementation of complex changes, planning for implementation, communicating effectively with implementors and the population about the changes, clarifying the roles and responsibilities of those responsible for implementation and developing capacity through the process of implementation.
10. Put monitoring and evaluation at the centre of implementation:
 - > To consider both what progress has been achieved and what factors explain the pattern of policy change.

Together the application of these ten principles will allow health reformers to take account of the fact that,

“Successfully pursuing long-term reforms in democratising environments involves not just knowing in which direction to move, but paying attention to how to get there” (Brinkerhoff 1996: 1395).

1. Approach and Methods

This chapter outlines the rationale for this study and the overall framework applied within it and gives details of the methods used in collecting and analysing data.

1.1 Project Rationale and Objectives

Facing a scarcity of resources and inefficiency in resource use, public health systems across sub-Saharan Africa have been introducing health care reform with a focus on changes in financing mechanisms since the late 1970s. These reforms include resource mobilisation measures (such as the introduction or increase of user fees) and resource allocation mechanisms, both of which require major changes within public health systems.

Despite the importance of these reforms, few evaluations of experiences with these reforms were available by the mid-1990s. Most reported experience concerned cost recovery mechanisms and that experience had largely been disappointing (Creese and Kutzin 1995; Gilson 1997a; Nolan and Turbat 1995). Cost recovery policies were often found to contribute little to their commonly stated goals of resource mobilisation and improved efficiency of resource use. At the same time, they clearly had the potential to adversely impact other policy objectives, such as equity and longer term health system sustainability. In some cases, the experience of implementing cost recovery mechanisms led to policy reversal (Collins *et al.* 1996).

Even less was known about the factors that enabled policies to achieve their goals or that blocked goal achievement. Broader public sector reform experience suggested that the patterns of policy formulation and implementation were likely to be important influences (e.g., Grindle and Thomas 1991; Haggard and Webb 1993; Nelson 1990; Toye 1992). Delays and reverses in reform implementation had, for example, been shown to result from obstacles such as conflict over policy goals between different interest groups, a lack of relevant information, and limits on the institutional capacity available to design and implement reforms. The key implication of these analyses is that understanding how such factors influence the pattern, pace, and impact of reforms is important in strengthening reform efforts. Such understanding can, in particular, support early action to tackle potential obstacles, and this is critical both in turning reform ideas into changes on the ground and in bringing about positive impacts through these changes. Yet much health policy,

“has been simply concerned with the technical features of policy content, rather than with the processes of putting policy into effect. As a result policy changes have often been implemented ineffectively and expected policy outcomes have not been achieved” (Walt and Gilson 1994: 366).

This two-country study, therefore, sought to undertake an in-depth analysis of the factors in the policy process facilitating or constraining the potential to achieve change of selected health care financing reforms in each country. In particular, it sought to deepen international understanding of the factors facilitating and constraining these reforms' contribution to the broad performance goals of equity and health system sustainability. The study was undertaken in South Africa and Zambia, two sub-Saharan African countries that initiated wide-ranging programmes of health reform in the 1990s following substantive political change. In Zambia, the political change involved the return to

multiparty politics, and in South Africa, it was the removal of the apartheid regime through democratic elections.

Within each country, the specific objectives of the study were to:

- > Document the evolution of selected health care financing reforms in relation to design, steps in policy formulation, and initial implementation, as well as the linkages between individual reforms and between financing reforms and parallel institutional change;
- > Analyse retrospectively the critical factors facilitating and constraining the development and initial implementation of selected reforms; and
- > Critically appraise the selected reforms' potential, or, where possible, actual contribution to the broad performance goals of equity and health system sustainability.

1.2 Conceptual Framework

The framework developed to guide the investigation within each country study is summarised in Figure 1.1. For conceptual clarification the framework posits a linear process of policy change moving from agenda setting around a reform of focus, to reform design, and then through implementation to the achievement of immediate and longer term changes. The framework's primary focus, however, is on the detailed investigation of what factors influence this process at each step and ultimately shape the nature and extent of change achieved by the reform.

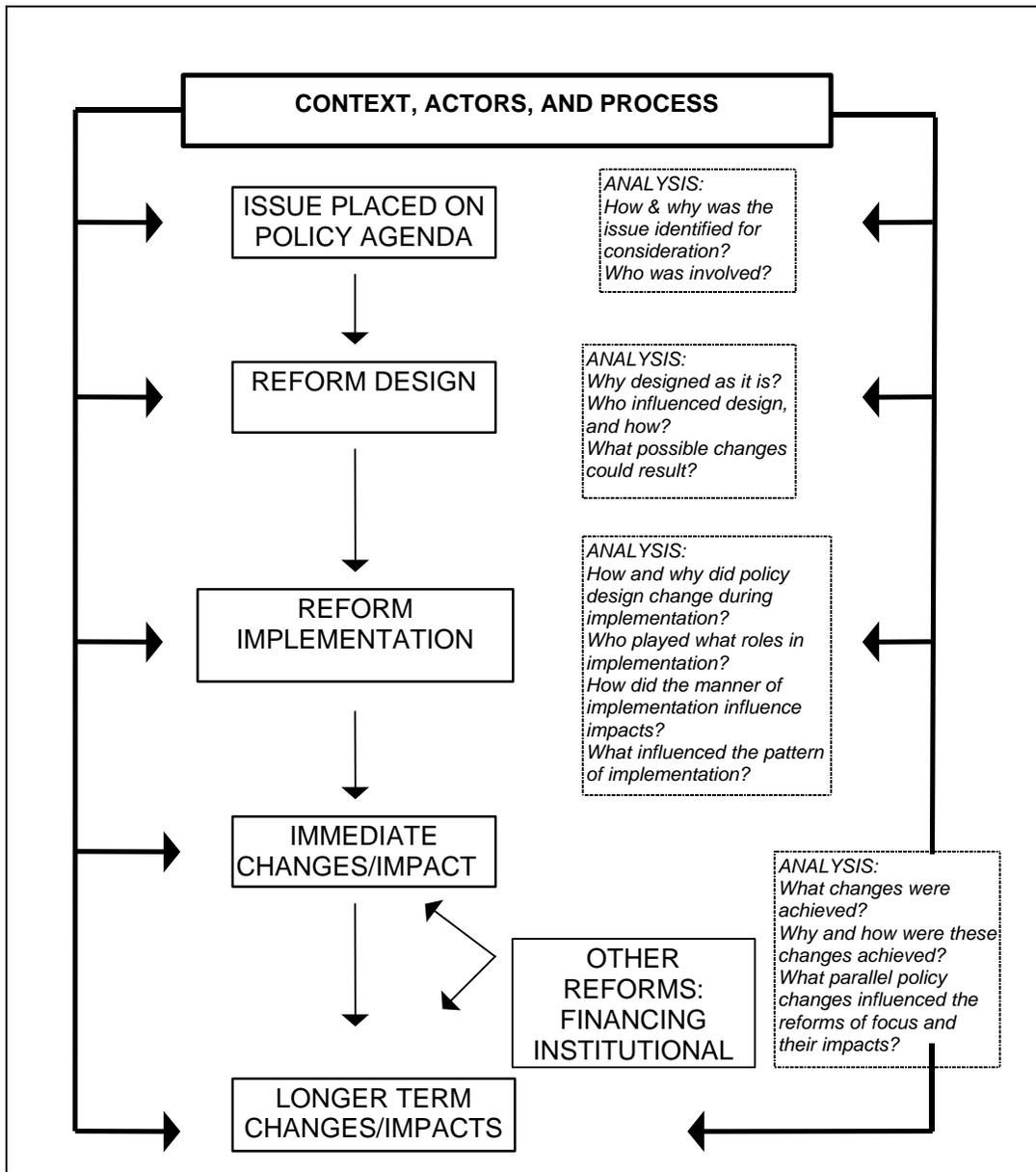
In investigating these factors, the framework points to the need to consider who or what causes an issue to be placed on the policy agenda and why specific reforms are designed in particular ways. Acknowledging that the nature of the reform is likely to change in unexpected ways through the process of implementation, it also allows such changes to themselves become a focus of enquiry. The policy process is never as linear as the diagram suggests. For example, new policy changes are quite often initiated by problems experienced in the implementation of past changes.

Drawing on the policy analysis approach of Walt and Gilson (1994), the framework suggests that the factors influencing each of the steps in the reform process can be categorised into four broad groups:

1. Factors of *context*: for example, the features of the economic, political, health, health system, national, and external environment (Collins *et al.* 1999; Gilson and Mills 1996), or the situational, structural, cultural, and exogenous factors (Leichter 1979) that influence the nature of policymaking and policy change within a country;
2. Factors concerning *actors*: who they are as well as their interests, values, and roles in relation to developing and implementing the reforms of focus.
3. Factors of *process*: the way in which the policies of focus are identified, formulated, and implemented, including issues of consultation, timing, and phasing.
4. Factors of *content*: the nature and design of the specific reform of focus; the interaction between the financing reforms of focus and the interaction between these reforms and parallel institutional changes.

The conceptual framework in Figure 1.1 illustrates how analysis of the influence of these four factors (context, actors, process, and content) can help explain the pattern and pace of policy change and its impacts. The arrows from the box (“Context, Actors, and Process”) at the top of the figure indicate that these three factors influence each stage of policy formulation, implementation, and impact. In addition, the content (i.e., design) of the specific reforms, as well as of parallel reforms and institutions (box at lower right of figure), influences the immediate and longer term impacts of policy. The analytic questions at each of these stages (identified in italics in the boxes on the right-hand side of the figure) represent questions about how the context, actors, and processes have affected the design, implementation, and impacts of the reforms. They allow for assessment both of what influences the actual impacts of any reform and, in cases where it is too soon to judge such impacts, what influences the potential impacts of a reform.

Figure 1.1: The SAZA Study's Conceptual Framework



The framework thus provides a guide to answering two broad research questions:

1. What impacts result from policy change?
 - > For implemented reforms:
 - ⌢ What are the immediate and longer term consequences of the reform?
 - ⌢ Do they achieve their objectives?
 - ⌢ What impacts do they have on equity and sustainability?
 - > For reforms that are yet to be implemented (or are in an early stage of implementation):
 - ⌢ What are the potential consequences of the reform given its design?
 - ⌢ Is it likely to achieve its objectives?
 - ⌢ What are its likely impacts on equity and sustainability?
2. How does the policy process influence impacts?
 - > How do the four factors of context, actors, process, and content:
 - ⌢ Determine the particular nature of the design of each reform and of the package of reforms being taken forward within a country?
 - ⌢ Influence the practice of implementation and the design of the reform?
 - ⌢ Explain how implementation practice differs from policy design?
 - ⌢ Explain the actual/potential immediate and longer term consequences of the reform?
 - ⌢ Explain how other financing and parallel institutional reforms influence the reform and its consequences?

1.3 Research Strategy and Methods

Table 1.1 provides details of the key activities in each main phase of the research in each country.

Table 1.1: Summary of Research Strategy

Phase	Key foci	Data collection/analysis methods
1	delineation of key elements of reform context description of chronology of key events in reform evolution identification of key actors involved in reforms detailed description of the design of the reforms of focus	Data collection: capture of researchers' own knowledge review of key policy documents and evaluation reports key informant interviews with informed and accessible policymakers and policy analysts Data analysis through: development of 'timelines' for each reform of focus initial 'policy characteristics' analysis
2	detailed analysis of the factors facilitating and constraining the reforms of focus assessment of the potential or, where relevant, actual impact of reforms	Data collection: key informant interviews with policymakers and managers central to general reforms or to specific reforms review of parliamentary debates and other documentary material from parliament media analysis collection of secondary data for impact analysis Data analysis: further use of selected policy analysis techniques, e.g., stakeholder analysis, policy mapping techniques impact analysis through use of secondary data
3	draft and finalise country reports	Data collection and analysis: the process of writing a draft report entailed further analysis and then elicited further information through the review process—information that was in turn fed back into report finalisation

An overview of key issues concerning the reforms of focus was undertaken in Phase 1, providing a foundation for the detailed analysis undertaken in Phase 2. The information collected in this phase also allowed the analytical questions guiding the analysis to be revised and fine-tuned. Phase 2 then involved more detailed analysis of the key areas of focus, using a wider range of data analysis techniques and approaches and leading to a draft country report. Finally, in Phase 3 the draft report was developed, reviewed, revised, and finalised.

Table 1.2 provides an overview of the data collection methods used in each country study. As the table above indicates, the study combined the use of qualitative and quantitative methods of evaluation. Qualitative approaches were largely used in assessing the factors facilitating and constraining the reforms of focus, and qualitative and quantitative methods were combined in analysing the actual and potential impact of these reforms. Impact was judged both in terms of equity, involving consideration of the distribution of the benefits and burdens of health care, and in terms of system sustainability, including consideration of financial sustainability (resource mobilisation and improvements in allocative and technical efficiency), the political acceptability of reforms, and the consequences for the organisational capacity of the system (Hilderbrand and Grindle 1994).

In the analysis, the country research teams were inevitably required to interpret the information they had collected and to make a variety of judgements concerning the actual and potential impact of the reforms of focus as well as the factors that influenced their evolution and impact. Such interpretation cannot be avoided in a study of this kind and a variety of strategies were adopted to bring rigour and promote validity in the interpretative judgements that were made. These strategies included the following:

- > Involve both “insiders” (researchers with detailed knowledge of the policy processes) and “outsiders” (researchers with previously less involvement in the policy processes) in the research team
- > Develop guidelines based on the study’s conceptual framework for review of all forms of documentation (including media analysis) and for in-depth interviews, and then revise them as appropriate following their initial application
- > Perform two steps of triangulation in data analysis: first, independent processes of triangulating information from different data sets (i.e., documents, interviews, and media reports), and second, triangulation across these different data sources (i.e., drawing information from documents together with interview data and media reports)
- > Conduct a careful and deliberate review process for the final draft report, allowing analyses to be tested against the judgments and views of country-based key informants as well as international reviewers with broader experience.

1.4 Remaining Methodological Concerns

Despite the careful research process, four specific issues influenced the interpretative analysis undertaken within each country study and, therefore, the analysis presented in this comparative report

1. *The focus of the study*

The focus on financing reforms gave each country study a particular and, possibly, a partial perspective on the overall process of health policy change. In South Africa, for example, these reforms involved a different range of actors than other health reforms that occurred in parallel. Although decentralisation has formed the cornerstone of the Zambian reform package, it was not reviewed in this study in detail. In both countries, therefore, while the studies provide an insight into the broader process of health sector transformation, they do not give a full view of that process.

2. *Researchers as past participants in policy processes*

Recognising the role some research team members have had in past policy processes in the two countries, specific efforts were made to limit their potential influence over analysis and interpretation through a rigorous process of validation and triangulation. However, the potential remains for their personal experiences to have coloured their judgements. Such experiences include not only direct involvement in past policy processes but also the continuing involvement of all team members in policy action. Clearly no analysis of this kind is entirely free of bias.

3. *Interviewee balance*

Although efforts were made to ensure that those interviewed represented a balance of different perspectives, a higher proportion of analysts from outside government were interviewed in South Africa, and, in Zambia, a higher proportion of central government officials, past and present, were

interviewed than were nongovernment observers and analysts. These imbalances may have influenced the analysis presented in the two reports.

4. Interviewee access

The interviewee balance itself reflects some problems in accessing pre-identified government and political interviewees. Most importantly, it proved impossible to arrange interviews with some senior politicians and civil servants in each country, and the views of lower level health care managers and providers also are poorly represented.

Table 1.2: Data Collection Methods Used in Each Country Study

Data source	South Africa (SA)	Zambia (ZA)	Use
1. Researcher knowledge	Knowledge captured from two research team members through interview and personal notes	Knowledge captured from one research team member through interview and personal notes	General, subject to validation through other data collected
2. Document review	In each country, documents used included: contributions to, and reports of, policy debates pre-1994 (SA)/ pre-1991 (ZA); academic analyses of reforms pre- and post-1994(SA)/ 1991(ZA) ; official post-1994(SA)/ 1991(ZA) policy documents and policy input papers; consultancy and evaluation reports on the reforms of focus.		Understanding the context of reform Development of timelines for reforms of focus Identification of design details of reforms of focus Some use in policy characteristics and stakeholder analyses
3. In-depth interviews	28 in-depth interviews with politicians, government officials (health and nonhealth), and nongovernment policy analysts	20 in-depth interviews with politicians, government officials (health and nonhealth, current and former), long-term external technical advisors, nongovernment policy analysts, and representatives of donor agencies Also email questionnaires received from four people previously involved in financing policy processes development	Understanding the context of reform Development of timelines for reforms of focus Identification of design details of reforms of focus Policy characteristics analysis, stakeholder analysis, and other policy analysis techniques
4. Media analysis	Review of health coverage in 12 South African newspapers over the period 1995-99 Also review of The South African Medical Journal.	Review of health coverage in two Zambian newspapers	Understanding the context of reform Some use in policy characteristics and stakeholder analyses

5. Parliamentary data	Review of official parliamentary debates on annual Minister of Health budget speeches Review of national Portfolio Committee on Health reports	not used	Understanding the context of reform Some use in policy characteristics and stakeholder analyses
6. Published evaluations	Various, as outlined in Gilson <i>et al.</i> 1999	Various as outlined in Lake <i>et al.</i> 2000	Assessing impact of the two free care policies and of resource reallocation policies
7. Secondary data	Government budget and expenditure data	Government budget and expenditure data Health facility utilisation data	For additional evaluation of the impact of resource reallocation policies
8. Report review process	Inputs received from 11 internal and external reviewers	Inputs received from three internal and external reviewers, and a policymaker group to which initial analyses were presented	Input into all aspects of report

2. Overview of Country Experiences

This chapter introduces the health financing reforms assessed in this study and provides a basic description of the country contexts in which they were discussed and implemented. It provides a background to the analysis presented in subsequent chapters.

2.1 Period and Reforms of Focus in Each Country

In Zambia the study assessed financing reform experiences between 1990 and 1999, the period immediately preceding the multiparty elections of late 1991 up to, and including, the period in which the study was undertaken (1997-1999). In South Africa the main period of focus was 1994-1999, the term of the country's first democratic government, with some investigation of policy debates in the pre-1994 era (from around 1988). In both countries, however, the latter months of these periods were less closely investigated because the initial analyses of country experiences were being consolidated at that time.

Table 2.1 outlines the health care financing reforms that were the focus of evaluation in each country as well as the parallel, institutional reforms that were being implemented.

Table 2.1: Reforms of Focus

Type of reform	Specific Reforms	
	Zambia (1991-1999)	South Africa (1994-1999)
Resource Mobilisation	Formal introduction/expansion of user fees throughout the public health system	Removal of user fees for publicly-provided care for pregnant and nursing women and children under six (Free Care 1), and removal of user fees for primary care (Free Care 2)
	Development of exemption policy	Restructuring of public hospital fees
	Introduction of prepayment scheme	Development of proposals for social health insurance
Resource Allocation	Development and implementation of interdistrict resource reallocation formulae	Development and implementation of inter-provincial resource reallocation formulae by the national Departments of Health (1994-1996) and Finance (1996+)
	Budgetary decentralisation to district and hospital boards, and budget reform to re-allocate resources between levels of care	Budget reform throughout government through implementation of a Medium Term Expenditure Framework
Parallel, Institutional Reforms	Creation of the Central Board of Health (CBOH) as an executive, implementation arm of the Ministry of Health, which retained core policy responsibilities	Creation of provinces within a semi-federal state, which have significant legislative and implementation authority
	Increased autonomy to public referral hospitals and the establishment of hospital boards	Proposals to strengthen public hospital management
	Strengthening of the district health system with formal autonomous boards	Development of district health system

Note: reforms in italics represent those given limited attention in this analysis.

2.2 The South African Experience

The period of South African experience examined within this study was a time of massive societal change, following the first democratic elections in 1994. The new government, led by the African National Congress (ANC), immediately made strong moves towards reorienting health and broader social service provision towards the needs of the population and away from those of historically powerful interest groups, such as the urban wealthy.

The task it faced was enormous, given the legacy of vast disparities – in wealth, health status, and health care provision – inherited from the apartheid era. South Africa is one of the most inequitable societies in the world. The government-sponsored Poverty and Inequality Report (May 1998) classified just over 50 percent of the population as “poor” and 27 percent as “ultra-poor,” and found that the poorest 40 percent of the population enjoyed only 11 percent of total income. In 1995, the average household income of whites (who constitute approximately 11 percent of the population of 40.6 million) was 4.5 times that of the black population; urban households had double the average income of rural households; and average household income varied by nearly three times across provinces. These inequities occurred in the context of an upper middle-income country with a per capita gross national product (GNP) in 1995 of US\$3,160 (World Bank 1997).

This situation of income inequality and poverty produces health status patterns in some population groups that are characteristic of low-income countries, with important causes of mortality being preventable disease as well as accidents and violence (Bourne 1994). Inequities also result in striking differentials in health status between different races and income categories. For example, the South Africa Demographic and Health Survey (1998) found an infant mortality rate for the 10 years preceding the survey of 11.4 per 1,000 live births for whites and 53.6 for nonurban Africans (Medical Research Council *et al.* 1999). Using household survey data² from the first half of this decade, Gilson and McIntyre (2000) show how, even within population groups, infant mortality experience consistently declines across household income levels (from wealthiest to poorest).

Yet health care services are concentrated in urban areas and focus on curative, hospital-based, specialised care. In 1992-1993, acute care hospitals in general spent over 76 percent of the total recurrent public health expenditure, with academic and tertiary hospitals accounting for 44 percent (McIntyre *et al.* 1995). Only 11 percent of funds were spent on primary care delivered outside the hospital setting. In addition, and in line with general policies to promote privatisation and service the interests of the elite, South Africa’s private health sector had been allowed to grow to substantial proportions by the mid-1990s. In 1992-1993, nearly 61 percent of health care financial resources were derived from private funding sources, and the majority of health personnel worked in the private sector. However, only 23 percent of South Africans enjoyed some degree of access to private sector health care on a regular basis (McIntyre *et al.* 1995). These structural features within the health system gave rise to striking inequities in health care provision. For example, in 1992-1993 public sector expenditure per head of the population was more than three times greater in the richest one-fifth of magisterial districts, grouped by average per capita income, than in the poorest (McIntyre *et al.* 1995). Many of those living in the richest districts also enjoyed private sector care while simultaneously capturing significant public sector subsidies.

In addressing this legacy, the first task of the new government was to tackle the fragmented, apartheid bureaucracy. Government was restructured into a quasi-federal arrangement with a central

² The 1993/94 Living Standards and Development Survey and the 1995 October Household Survey (Hirschowitz and Orkin 1995).

government and nine semiautonomous provincial governments, each with their own legislatures. Other changes included amalgamating 11 separate apartheid administrations, creating new organisational structures, placing staff into new posts, and instituting affirmative action measures. Within the health sector, a new, streamlined national Department of Health (DOH) was reconfigured and entirely new departments were set up in each of the nine new provinces. In accordance with the constitution and the evolution of intergovernmental relations in general, certain powers were devolved to the provincial DOHs. In fact much of the operational decision making in health care delivery was decentralised to the provincial level, with the national DOH retaining only the responsibility for national policymaking and the development of norms and standards by which to ensure equitable and affordable health care provision across the provinces. The newly powerful provincial departments are now responsible for ensuring that comprehensive health care services are provided throughout the country.

The second task of the new health policy makers and managers was the development of a national health policy statement and the strategic planning and legislative processes necessary to translate its principles into practice. This statement was published in 1997 as the White Paper for the Transformation of the Health System in South Africa (Republic of South Africa 1997). It put forward a comprehensive vision and strategic plan for the public health system, touching on all its aspects, although largely failing to deal with the private sector. Envisaging a single, unifying health system that coordinated the efforts of the public, for-profit private, and nongovernmental sectors in the interests of promoting equity, it emphasised the role of the district health system as the key vehicle through which health care would be delivered in accordance with the primary health care approach.

Table 2.2: Health Policy Reforms in South Africa, 1994-1999

Reform	Brief Description
<i>Programmatic changes</i>	
Immunisation	A national polio campaign was conducted in 1995, and Hepatitis B vaccine was included in the range of vaccines provided by the public sector in the same year. A national immunisation campaign was launched in 1996 and repeated in 1997, focussing on polio and measles.
Nutrition	In 1994, a school-feeding programme was identified as a Presidential Lead Project and implemented nationwide. The DOH also launched an Integrated Nutrition Strategy.
Reproductive health care	The constitution stipulates the right to access to reproductive health care. Consequently, reproductive health services have been expanded and the termination of pregnancy was legalised in 1996.
HIV/AIDS	A national AIDS review in 1996 found that, despite increasing budgetary allocations for the control of HIV/AIDS, successes were limited. A new programme entitled "Beyond Awareness," focussing on behavioural change, was launched in 1998.
Tuberculosis	A national tuberculosis review was conducted in 1996, following which the Direct Observed Treatment Short Course was implemented, together with a new monitoring system.
<i>Legislation</i>	
Affordable, accessible, and safe drugs	A national drug policy was launched in 1996 that addressed, among other things, the restructuring of the procurement and distribution system and the reduction of drug costs. An Essential Drugs List was also published. A further set of reforms – the legalisation of parallel importing to allow the procurement of cheaper drugs, and generic substitution – were stalled in their progress through parliament by opposition from the private sector.
Termination of pregnancy	The termination of pregnancy was legalised in 1996.

Statutory councils	The acts governing the statutory councils that fall under the DOH were amended.
Tobacco control	New legislation around the advertisement of cigarettes was introduced in 1995. Further limitations on the tobacco industry were introduced into parliament in 1998/9.
<i>Other initiatives</i>	
Facilities audit	An audit of all hospital facilities conducted in 1996 found that a third of the value of all hospitals would need to be replaced at the cost of R8 billion over the next 8 to 10 years.
Clinic-building programme	This was another Presidential Lead Project. Between October 1995 and mid-1998, 400 clinics were built and 152 extended. Approximately 4750 new primary health care posts were created in the first 1000 days (but not necessarily filled).
Health information systems	Efforts to establish a National Health Information System were slow in being implemented. Provinces are now establishing their own systems fairly independently.
Community service for medical graduates	From July 1998, compulsory community service was introduced for all newly qualified doctors.
Reforms in other sectors that have a health impact	A range of other projects under the Reconstruction and Development Programme (RDP) addressed health status in disadvantaged communities, most important of which were the provision of safe water and the electrification of houses in poor communities.

Source: Adapted from Ntsaluba 1998

By 1999, however, the government had not passed the National Health Bill which, building on the White Paper, was intended to define the powers and functions of national, provincial, and district health authorities. Nonetheless, the new health officials had sought to undertake a radical overhaul of the inequitable and inefficient health system through a very wide programme of health policy change. Table 2.2 summarises the diverse set of actions implemented in parallel to financing policy change between 1994 and 1999. Within this diverse programme, financing policies, such as the speedy moves made to implement the two free care policies and to promote equity by reallocating public health budgets between geographical areas, had a part but were not a dominant component of the reform programme.

2.3 The Zambian Experience

Zambia, like South Africa, experienced substantive political change at the beginning of the period examined in this study. Multiparty elections in 1991 brought about a change in government after a period of 19 years of one-party rule. The new government of the Movement for Multiparty Democracy (MMD) came to power with massive popular support and in an atmosphere of high expectations. It was as if the change in government would automatically transform people's lives overnight. As Zambia was seen as a successful example of transition to multiparty democracy, the donor community was also sympathetic towards the new government and provided support in terms of finance and technical assistance to aid the reform programme. The new government first announced and then rapidly implemented macroeconomic reforms, followed by reforms in key sectors such as agriculture, health, and education and in the civil service.

The new government also inherited massive economic problems from its predecessors, and these provided a continual constraint on reform across all sectors. A key problem for the economy has always been its high dependence on copper, which makes it particularly vulnerable to international economic conditions. In addition, strong state intervention in the economy after independence brought with it a range of inefficiencies. The government preceding the MMD initiated policy change to tackle these problems in 1985 with a World Bank-supported program of macroeconomic

and structural reforms. This was succeeded in the late 1980s by the New Economic Recovery Program, which sought to promote growth through diversification, reduced dependence on imports, and stabilization through the control of inflation. On coming to power, the MMD pursued a similar line of economic policy involving liberalisation of the monetary and exchange rate policy.

Nonetheless, the Zambian economy did not improve and some of the policies introduced did not work as planned – the agricultural sector investment programme, for example, was described as a “*complete, utter and costly failure*” (*Profit* magazine, January 1995). As a result, growth rates remained very low, inflation rates were high, and poverty increased. Zambia joined the ranks of those officially designated as “low-income countries” in 1991, and it has since become one of the poorest countries in the world. The 1998 World Bank estimate of per capita GNP was US\$330, down from \$370 in 1995. The distribution of income in the country is also highly skewed, with an estimated Gini coefficient of 0.5 (Seshemani *et al.* 1999). An estimated 58 percent of the national population was said to be extremely poor in 1991 (World Bank 1994), and this had increased to 66 percent by 1996 (Central Statistics Office 1997). Given also the burden of the HIV/AIDS epidemic, it is not surprising that infant mortality rates have increased in the last decade or more, and that life expectancy at birth has decreased. After reaching a peak of around 54 years in the mid-1980s, life expectancy declined to 45.5 years by 1992 (Government Republic of Zambia/United Nations Development Programme 1996).

The country’s economic problems also had direct bearing on the state of the health system. Despite the expansion of infrastructure during the pre-MMD era, macroeconomic decline meant that in 1991 the new government inherited a health system that was characterised by serious deterioration. In common with other countries in the region, reduced social sector spending had resulted in dilapidated buildings; shortages of drugs, transport, and equipment; and shortages of funds for fuel and allowances. There were significant imbalances in the availability of health facilities between rural and urban areas, and health professionals were unmotivated and in short supply.

Table 2.3: Key Components of Zambian Health Reforms from 1992

Date	Type of Reform		
	Institutional	Systems Development	Legislative/Policy
1992	Establishment of autonomous hospital management boards at general and central level hospitals on basis of Medical Services Act 1985		
1993	Creation of district health boards from 1993, legitimised in 1995 through the National Health Services Act		
1994		Initial development and implementation of Financial and Administrative Management System (FAMS) at district level and below. Work continuing on hospital-level FAMS development.	
1995	Creation of the District Basket ³ and associated steering committee Definition of essential package of services for up to first-level referral services (1995/96)		National Health Services Act establishes legal basis for district health boards
1996	Creation of CBOH, which includes four regional offices to replace the former nine provincial structures Institution of regular programme of twice yearly consultative meetings with partners (on hold since change of minister in 1998)		
1997	Issuing of an external management contract for the running of Medical Stores Limited		Initiation of process to develop Comprehensive Health Financing Policy
1998	Reestablishment of National Malaria Control Programme	Development and implementation of Health Management Information System at district level	Cabinet approval of National Drug Policy Cabinet approval of National Laboratory Policy
1999	Removal of regional offices and reestablishment of provincial structures (on paper – not implemented by 1999) Restructuring of CBOH		Cabinet approval of Reproductive Health Policy

³ The "basket" mode of funding refers to the "co-financing of district health services by a number of donors and the government using a single set of procedures" (Lake and Musumali 1999: 256).

To tackle the problems, the new government introduced radical change in the health sector, involving a wide array of actions as summarised in Table 2.3. The table indicates that in many cases institutional reform and systems development preceded the legislative or policy action that legitimised them, demonstrating the “learning by doing” principle that was central to the overall health reform process. Within this package of reforms, decentralisation was clearly identified as the overall strategy for restructuring the health sector and, therefore, financing policy reform took place in the context of a system that saw a progressive increase in the authority devolved to the district level.

The process of health financing reform in Zambia can be divided into three phases. Starting with the enactment of the Medical Services Act in 1985, which allowed fees to be reintroduced, Phase 1 ended in 1991 with the articulation of the MMD manifesto and its election victory. The reform programme then entered a second phase in which a number of studies were undertaken and more detailed ideas were developed and articulated in a Ministry of Health (MOH) policy document. This phase came to a close when the MMD government put into practice some of the ideas developed during Phase 2 by embarking on an ambitious programme to reform not only the health system but the entire civil service as well. Phase 3 can therefore be seen as the implementation phase, beginning in 1993 and continuing up to and beyond 1999. In terms of financing policy, phases 2 and 3 saw the gradual strengthening of resource allocation policy through the use and development of a needs-based formula. In contrast, and despite the radical transformation of the organisational structures of the health system, resource mobilisation policy change during these phases was both more diverse and more limited. Sporadic and multiple changes to the fee system as well as the introduction of various prepayment initiatives had not been consolidated into systemwide financing change by 1999.

2.4 Taking Forward the Analysis

This overview of the two countries’ experiences emphasises that in each case health financing reform occurred within a broader context of political and policy change, as well as within a set of inherited economic and health system problems. From this perspective, health care financing reform was a relatively minor theme within the two countries’ experiences. Yet this report places it at the centre of its analysis on the grounds that, for the health sector, health financing policies have a critical influence over health sector performance. The next steps of the analysis are to better understand the roots of the particular financing policies considered in each country, other key dimensions of the experience of financing policy change, and its impacts on health sector performance (Chapter 3). With this understanding it will then be important to reconsider how the broader context influenced the pattern and pace of change in each country, as well as to identify other factors explaining their experiences (Chapter 4).

3. The Key Dimensions of Health Care Financing Policy Change

Building on the overview of country experiences outlined in Chapter 2, this chapter describes some of the most critical aspects of health financing reform in South Africa and Zambia. The analysis highlights the need to better understand the factors underlying the patterns of policy change and of impacts in each country, both of which are further investigated in Chapter 4.

3.1 The Roots of Health Reform: Debates in the Pre-Election Periods

3.1.1 Common Features and Striking Differences

The health reform programmes undertaken in both countries during the 1990s were rooted in the policy debates that occurred before the coming to power of new governments. The South African debates generally involved a much wider group of people and a more open process of discussion than those in Zambia. Nonetheless, even in South Africa, debate of health care financing issues was largely confined to the limited group of people who had some familiarity with health economics issues. The range of views drawn into health care financing policy initiation in both countries was, therefore, limited. At the same time, a core group of those involved in developing Zambian health care financing policy before the change of government held key positions of power in the health sector after the political transition and continued to work as a team, unlike in South Africa. These Zambian reformers, again unlike their South African counterparts, were able to draw lessons derived from some early experimentation with health care financing change into their initial discussions. However, the MMD's health reform proposals were less clear on health care financing policy than the ANC's National Health Plan was – even while the latter did not resolve all of the debates over the particularly contentious issue of social health insurance.

3.1.2 Debates in Zambia

During the pre-1991 election period, two parallel processes of health policy development were undertaken within the Zambian health sector. First, within the MOH, a group of senior officials and some representatives from the donor community had increasingly come to accept that the health system in its current form was not meeting the needs of the Zambian population. They therefore began to consider what forms of institutional restructuring could strengthen the health system, including considering decentralisation. As part of this process, a discussion paper (Musambo 1989) advocating the need to change the policy of free care due to budgetary constraints, and outlining various cost-sharing options, was presented and discussed at a policy development workshop in Livingstone. At the same time, Dr. Katele Kalumba was charged with developing a health policy framework for the newly formed MMD. Dr. Kalumba was then an academic but a member of an informal MMD policy advisory group. He subsequently became Deputy Minister and then the third Minister of Health in the new government. His initial policy framework was also debated among a small group, later to become the MMD Health Committee, which included two other subsequent Ministers of Health. With the coming to power of the MMD in 1991, the two groups that had

previously worked inside and outside government made concerted efforts to propose solutions to the structural and organisational problems of the health system and to tackle the constrained resource base. Indeed, the MMD health policy paper (Kalumba 1991) provides the vision and core values upon which the subsequent reform programme was built, focussing on local participation and the extension of democratic values to health service development and management. The paper emphasised the need for Zambians to commit themselves to building a health care system that guaranteed equity of access to cost-effective, quality health care as close to the family as possible, a vision carried forward into Cabinet-approved policy documents.

Even while future policy was debated among these groups, two important financing policy developments were being tested within the health system. In 1988, following failed efforts to secure reliable funding for running mission facilities, the Churches' Medical Association of Zambia, an umbrella organisation for church health care providers, used the 1985 Medical Services Act as the legal basis on which to introduce fees at the point of service. Although minimal levels of revenue were generated, the experience demonstrated that fees could be both instituted and supported by the community.

The second broad stream of work on cost sharing during this period was documented in work undertaken by the Planning Unit of the MOH and supported by UNICEF during 1989-1990. This showed that community financing initiatives were in place in a number of localities around the country and had the potential to provide an alternative tool for mobilising finances from the community. While not necessarily raising substantial amounts, one particular advantage of such schemes was that the revenues were retained at the point of collection and used to supplement the meagre government revenues filtering through to that level in order to improve service quality (Bennett and Musambo 1990). Although such community financing schemes were generally taking place outside the government realm, the evaluation findings provided input into the further development of a cost-sharing policy. As a member of the small group of MOH officials, donors, and other interested parties who met to discuss the findings of the community financing study and other related work, Dr. Kalumba provided an important channel into the emerging MMD health policy proposals. Indeed, a range of cost-sharing options was included in the MMD policy framework paper, together with a proposal to develop a study group to research further financing options (Kalumba 1991).

In addition, and in response to problems experienced with the system of allocating resources through provincial administrations, in 1990 the MOH decided to work with three districts to explore the possibility of bypassing the province and directly funding districts. This built on the MOH/UNICEF work on community financing and the strengthening of district functioning (Bennett and Musambo 1990) and drew on the technical support given by the Swedish International Development Agency (SIDA) to strengthen planning and management within the health system. Although the initial release of funds to the pilot districts only took place in early 1992, the modalities of the pilot were worked out in 1991 as part of the budget preparations by a small group comprised of officials from the Ministries of Health and Finance and from SIDA and UNICEF. By the time of the elections they had already begun to think through how to strengthen the capacity of health district structures to manage financial resources.

3.1.3 Debates in South Africa

Towards the end of the 1980s, as the likelihood of real political change drew closer, those concerned for the future "post-apartheid South Africa" became increasingly engaged in debating the macroeconomic, social, and health policies that would enable reconstruction and development. The

“progressive health movement,” which brought together exiled and internal members of the various liberation movements (most notably the ANC), progressive health worker organisations and networks, and academics, specifically undertook a range of research and analysis to identify health policy options for post-apartheid South Africa. This fed into a variety of briefing papers, conferences, meetings, and discussions. Of particular importance was the 1990 Maputo Conference, which took place shortly after the ANC and other liberation movements were “unbanned.” At the conference, the issues of focus included mechanisms for funding health care and the role of the private sector in the future health care system. These discussions then fed forward into the development of the ANC’s National Health Plan (African National Congress 1994), which itself stimulated further policy debate. Draft versions of the plan were discussed within ANC structures and published for public comment, drawing responses and formal submissions from individuals, community organisations, representative associations of private providers, and the private insurance industry. Through the development of the plan, even potentially antagonistic stakeholders were engaged in health policy debates, in line with the broader negotiation process that preceded the 1994 elections. However, the pool of those directly involved in health care financing debates was quite small, and very few from this group took positions within the new government after 1994.

Perhaps the most contentious policy debate of the time focussed on consideration of the relative merits of moving towards a tax-funded national health system (NHS) in the United Kingdom mould, versus a national health insurance (NHI) system. A critical issue in this debate was the role of the private sector. Where the NHS model envisaged almost no role for the private sector, the NHI proposals all accepted that the private sector role would continue to exist and even allowed for it to take on additional roles as contracted primary care providers or, perhaps, administrators of the insurance funds (de Beer and Broomberg 1990a,b; Picard 1992). Some of those who favoured the NHS option argued that an approach that drew the private sector into health system development in any way would undermine the public system. Rather, the private sector should be left to self-destruct through its cost-inflationary practices and every effort should be made to develop a financing plan to strengthen the public sector in isolation from it (Zwarenstein 1990). In contrast, the primary proponents of NHI at this time (de Beer and Broomberg 1990a,b) argued that, as health care already absorbed a relatively high proportion of the gross domestic product (around 6 percent: McIntyre and Dorrington 1990), a tax-funded NHS would be neither politically nor financially feasible and that the private sector was simply too extensive to disappear. They suggested that the only politically feasible approach was to work with the private sector (Centre for Health Policy 1990; de Beer and Broomberg 1990a,c). They argued that such accommodation was also inevitable as the central requirement of future financing policy would be to bridge the enormous resource gap between the public and private sectors (Centre for the Study of Health Policy 1989; de Beer and Broomberg 1990c).

Although the final version of the ANC Health Plan (African National Congress 1994), completed just before the 1994 elections, laid out the policy agenda of the new government, it did not fully resolve this debate. Its four health care financing policy recommendations were to introduce the following:

- > Free health care for pregnant women, nursing mothers, children under six, and other “vulnerable groups” (such as the elderly, disabled, and some chronic patients)
- > Full-cost charges for those with medical insurance treated in public hospitals and partial retention of fee revenue at the hospital level
- > A process, to be driven by the national DOH, for reallocating health sector resources, geographically taking account of relative need and local revenue-generating potential

- > Some system of national or social health insurance, with the specific recommendation that a committee be established to investigate the appropriateness and economic feasibility of such a system through consultation with all interested parties, and to undertake detailed planning for this option if it should have sufficient consensus.

3.2 Post-Election Health Reforms and Health Care Financing Policies

In South Africa and Zambia, health care financing change during the 1990s occurred within, and was in many ways subservient to, the broader programmes of reform introduced to tackle the two countries' health and health system problems (see Table 3.1). The apartheid legacy of the new South African government included massive health and health system inequities, as well as significant allocative inefficiencies in both the public and private health systems. Similarly, in Zambia, the first government of the MMD had to address the problem of increasing levels of ill health in the face of significant declines in the quality and coverage of the health system experienced over the 1970s and 1980s as well as growing poverty. For both countries the HIV/AIDS epidemic continues to represent a critical challenge that has already contributed, at least in Zambia, to reductions in health status levels.

Table 3.1: The Health and Health Care Context of Financing Reform

	Zambia	South Africa
Health status	Deteriorating health status indicators over the 1990s The HIV/AIDS epidemic represents a critical challenge and obstacle to improving health status	Despite its relative wealth, the South African population suffers a relatively poor average health status and there are huge health inequalities between population groups The HIV/AIDS epidemic represents a critical challenge and obstacle to improving health status
Health system	The deterioration of the health system by 1990 provided a spur to, and justification of, radical health policy change The inequities and inefficiencies within the health system included unacceptable geographical disparities in resource availability and allocations biased towards higher level care The allocation of resources through provincial administrations created many obstacles to accessing resources by the health sector, and health budgets were often not transferred in full Church institutions play an important role in the delivery of health care in rural areas and are subsidised by government	The critical inequities and inefficiencies within the apartheid health system included unacceptable differences in resource allocation between the public and private health sectors, between levels of care (biased towards higher level care), and between geographical areas Tackling the fragmentation of the inherited health system provided an enormous, immediate challenge to new health managers at national and provincial levels Political decentralisation created a quasi-federal structure that intensified health system restructuring through the creation of semi-autonomous provincial departments of health Private health care providers and financiers play important roles in the health system
Health policy	The MMD's health policy programme represented a radical and internationally accepted reform programme that also generated strong political support within the country. The emphasis on decentralization within the MMD's post-1991 health reform programme ensured the creation and strengthening of lower level structures that would be responsible for financing policy implementation	The ANC's overall health policy package represented a radical reform programme that generated strong political support within the country, rooted in redressing the apartheid legacy of disadvantage through strengthening public primary health care Implementation of the district health system as the vehicle of health care integration and improved health care delivery moved slowly

The radical health policy reform programmes introduced by the new governments during their first term of office had the common goals of improving the equity and efficiency of health care delivery. In Zambia particular emphasis was placed on improving services for the rural and peri-urban populations (Ministry of Health 1992a), while in South Africa the goals were couched in the symbolic language of improving access to health care for population groups previously disadvantaged under the apartheid regime.

These goals were translated into activities in the 1992 *Zambian National Health Policies and Strategies (NHPS)* document (Ministry of Health 1992a) and subsequent *Corporate Plan* (Ministry of Health 1992b), and in the 1997 *White Paper for the Transformation of the Health System in South Africa* (Republic of South Africa 1997). Both documents built on the earlier policy proposals, and both gave emphasis to the district health system (DHS) as the key vehicle through which health care would be delivered. Not only was the DHS in line with the primary health care approach, but it was also seen as the central element of an overall strategy for restructuring both countries' health sectors in pursuit of the stated goals. Both policy visions received high-level political backing within their countries, and the *Zambian reforms* have also received international attention as an example for other countries.

Yet despite these outward similarities, there were significant differences of emphasis and practice between the health sector reform programmes of the two countries. In Zambia the dominant thrust of reform focussed on institutional change, including not only decentralisation of significant authority over both government and church health care providers to district management boards, but also referral hospital management autonomy. The associated national-level structural change involved the separation of the political and executive functions of the MOH, through the creation of a new executive arm of central government, the CBOH. The MOH remains responsible for policy formulation, strategic planning, and overall coordination, legislation, budgeting and resource mobilisation, and external relations. There was also a broad split between the MOH as purchaser of services and the autonomous boards as health service providers. The MOH now contracts with the CBOH, while individual district and hospital boards sign annual service contracts with the CBOH in which they undertake a range of specified services to a given population in return for monthly grants from government and donor funds (Ministry of Health 1998). These organisational reforms were institutionalised with the passing of the *National Health Services Act* in August 1995, which provided the legal framework for the boards.

In a context of massive societal and public sector structural change, the package of reforms actually introduced in South Africa between 1994 and 1999 was less coherent in terms of its primary focus. It included legislative and management reforms affecting specific disease/condition-focussed programmes as well as initiatives focussing on particular aspects of the health system. Thus, in South Africa, the termination of pregnancy was legalised, new legislation supported the introduction of an essential drugs policy, and a clinic upgrading policy sought to extend primary care coverage in rural areas. In contrast, however, the establishment of the South African DHS moved forward slowly, partly as a result of the massive fragmentation of health care delivery and administration inherited from the apartheid regime. In addition, by 1999 the government had not succeeded in passing through parliament the *National Health Bill*, which, building on the *White Paper*, was intended to provide the legal definition of the powers and functions of national, provincial, and district health authorities. Continued evolution in the general definition of local government authority was a particular obstacle to the development of the DHS. The decentralisation thrust also had yet to be extended to public hospitals despite the existence of proposals for greater autonomy of management.

Table 3.2 outlines the objectives established for the specific health care financing reforms introduced within the broader health reform programmes of the two countries. The clearest

differences in the financing policies between the two countries relate to their resource mobilisation reforms. While South Africa removed primary care fees and discussed social health insurance (SHI) policies, Zambia reintroduced fees and prepayment schemes. The South African fee reforms emphasised access and equity. In contrast, the Zambian fee policy (and, to some extent, prepayment schemes) was apparently more oriented towards promoting financial sustainability, but it was complemented by exemptions policies aimed at protecting equity of access. Fees also had the wider objective of promoting partnership between users and the health system. The South African SHI proposals had the widest range of objectives, encompassing revenue generation and equity. The initial intention of using SHI to tackle private sector distortions reflected the important role of private health care within the South African health system (see Table 3.2).

In both countries, the introduction of population-based resource allocation formulae, with specific components directed at hospital funding, had the objectives of promoting financial equity and allocative efficiency. Reflecting the different administrative levels newly empowered through decentralisation, the South African formula used provinces as its geographic basis and the Zambian reforms used health districts. Provinces became the key subnational level of governance in South Africa after 1994 as part of the post-apartheid government restructuring even while a DHS began to be constructed for the first time. In contrast, the DHS was the primary focus of institutional reform and budgetary allocations in the Zambian health sector, and its development preceded wider government decentralisation. District allocations were also complemented by parallel budgetary reform within the health sector that emphasised resource reallocation between levels of care, and this was in turn complemented by reforms giving greater autonomy to referral hospital management structures.

Interestingly, in Zambia, the allocation of health budgets directly to the district level was partly a reaction to the previous experience of allowing provincial administrations to allocate global budget funds between sectors. These administrations not only underfunded the health sector, but also went out of their way to make it difficult for the health sector to access budgeted resources so that funding would be left for the provinces. To tackle these problems and the concern that health allocations between provinces were not equitable under this system, the new health reforms sought to promote greater transparency and equity through a formula-based, central allocation of health budgets directly to districts. In contrast, between 1994 and 1999, South Africa implemented the type of resource allocation process abandoned in Zambia. In the immediate post-election period, the national DOH had responsibility for allocating health resources between provinces, but this approach was overtaken in 1996 by the provisions of the new constitution. Under the new structures of the subsequent fiscal federal era, the national Department of Finance (DOF) has responsibility for allocating a block grant to each province, which the provincial government, under advice from its treasury, then allocates between sectors. Although, in both periods, the national department responsible for allocating resources to the provincial level used a resource allocation formula, the DOH formula primarily accounted for health needs whereas the DOF's formula was shaped by broader macroeconomic goals and policy. However, allocations to what were identified as national assets (i.e., academic training and super-specialist services) continued to be protected through conditional grants – allocations dedicated to these services, channelled through the national DOH, and supposedly conditional on the development of business plans and other management actions to ensure their efficient use. Other conditional grants in the fiscal federal era were targetted at the primary school nutrition programme, the creation of tertiary level services in provinces lacking capacity at this level, and hospital rehabilitation and construction.

Table 3.2: Stated Objectives of the Health Care Financing Reforms of Focus

(A) Resource Mobilisation Reforms					
South Africa	Classification		Zambia	Classification	
	Equity	Sustainability		Equity	Sustainability
Free care 1 (free care for pregnant and nursing women and children under six)			Introduction/expansion of user fees		
To improve access to health services for pregnant and nursing women and children under the age of six	✓		To generate additional resources		(✓)
To reduce maternal and infant mortality rates	✓		To foster partnership between users and the health system	(✓)	(✓)
To improve the health status of women	✓		Introduction of poverty-related exemptions (as a pilot)		
To promote family planning	✓		To remove financial barriers to access for the "vulnerable"	✓	
Free care 2 (free primary care for all South Africans)			Introduction of prepayment in urban districts		
To improve access to basic health care for all South Africans	✓		To improve financial access to health care for all Zambians (though restricted in practice to those selected districts)	(✓)	
Social health insurance proposals					
<i>To improve coverage and cross-subsidisation</i>	✓				
<i>To address the distortions of the private sector</i>	✓	✓			
<i>To mobilise additional resources for the public health sector in a politically accepted way</i>		✓			
(B) Resource Allocation Reforms					
The Department of Health's resource allocation formula			The Ministry of Health resource reallocation formula		
To distribute financial resources equitably between provinces	✓		To distribute financial resources equitably between districts	✓	
To shift resources away from higher towards lower level services	(✓)	(✓)	Budgetary reform in the health sector		
The Department of Finance's resource allocation formula			To shift resources away from higher level services towards PHC	(✓)	(✓)
To allocate public funds equitably and efficiently	✓	✓			
To ensure the sustainability of public expenditure		✓			

Note: Bracketed ticks indicated an objective implicit in policy documents rather than one explicitly stated.

3.3 The Broad Pattern of Health Care Financing Policy Change

As Figures 3.1 and 3.2 illustrate, resource allocation policy was implemented in both countries through the existing, routine government budgetary structures while resource mobilisation policies were taken forward either through “one-off” actions, such as ministerial announcements, or through committees specifically established for this purpose. In addition, some policy actions were speedily implemented, such as those resource allocation developments that were taken forward through routine structures, or those resource mobilisation policies seen as being relatively simple. In contrast, more complex policy changes were frequently delayed within the structures considering them.

Thus, in South Africa, the changes to the health resource allocation mechanism and the removal of primary care user fees proposed within the ANC Health Plan were quickly implemented after the 1994 elections. Fee removal involved two special “one-off” policy actions: taking advantage of a particular window of political opportunity and involving only some consultation with a limited group of actors. In contrast, the implementation of resource allocation policy through the routine government budgetary process and structures evolved over time. The initial action of implementing a health sector formula in pursuit of financial equity was overtaken by the devolution of considerable authority to provinces, including the authority to allocate resources between sectors. Within this changed policy environment, the development of health-related resource allocation policy has become more complex and been much slower than in the earlier period. By 1999 little progress had been made in taking advantage of constitutional provisions that allow for the application of sectoral norms and standards to influence health sector resource allocations within provinces, although various health sector conditional grants had been allocated. In contrast, various changes in the elements of the central government (DOF) formula used to allocate global budgets to provinces were speedily and smoothly implemented through the routine budgetary process of government.

The speed with which primary care fees were removed and an initial health sector resource reallocation formula created stood in stark contrast to the slow progress that occurred in developing a revised and uniform public hospital fee structure and to the uneven process of agenda setting for NHI/SHI after 1994. Both were identified as important within the ANC Health Plan and the 1997 White Paper. Specific proposals on both were developed within a range of special structures that involved health economists from within and outside government. As shown in Figure 3.2, these included three committees: the 1994 Health Care Finance Committee, the 1995 Committee of Inquiry into a Social Health Insurance System, and the 1997 Social Health Insurance task team, as well as one consultancy project, the 1995-96 Hospital Strategy Project (implemented by a consortium of South African consultants and research units). Yet by 1999 both SHI and a new, uniform public hospital fee schedule remained unimplemented. This represented a missed opportunity to improve cross-subsidisation of health care for the needy by the well off and to raise extra budgetary revenue for the public health care system. In contrast, despite initially being seen as part of the same policy package as SHI, the 1997 Medical Scheme Working Group’s proposals to reregulate the private insurance sector were implemented through the 1998 Medical Schemes Act.

Figure 3.1: Chronology of Health Financing Policy Development and Implementation in South Africa, 1991-1999

	1991	1992	1993	1994	1995	1996	1997	1998-1999
RESOURCE ALLOCATION				<i>CONTROLLED WITHIN HEALTH SECTOR</i> Health formula developed & applied				
							<i>ERA OF FISCAL FEDERALISM</i> Provincial unconditional block grants with phased introduction of health conditional grants	
USER FEES				Free care 1			Free care 2	
	Hospital fee policy debated and developed							
HEALTH INSURANCE	Debates about the merits of a national health system versus national health insurance system				Debates over nature of "social" health insurance			
								1998 Medical Schemes Act
GENERAL POLICY PROCESSES	<i>ANC Health Plan Development</i>			<i>Development of White Paper for the Transformation of the Health System in South Africa</i>				
FINANCING POLICY PROCESSES				<i>Health Care Financing Committee</i>	<i>Committee of Inquiry</i>		<i>SHI Working Group</i>	
						<i>Hospital Strategy Project</i>	<i>Medical Schemes Working Group</i>	

Notes: bold = implemented policy change; italics = policy process

Figure 3.2: Chronology of Health Financing Reform Development and Implementation in Zambia 1985-1999

	1985-1989	1990	1991	1992	1993	1994	1995	1996	1997	1998-1999
RESOURCE ALLOCATION		Funding for provincial health services through provincial administration				Pop. based district formula and bed-day for hospitals	Revision of district formula			Discussion of move to population-based funding for hospitals
COST SHARING:		Community financing debated		Flat fee proposal	Circular permits fees in govt hospitals (with certain exemptions)	Charging for drugs stopped	Circular on exemptions issued			
Fees							Health Care Cost Scheme pilot			
Prepayment					Mwase Mphangwe debated	Prepayment in selected third-level hospitals and then districts (stopped in third-level hospitals in mid-1996)				
Insurance				Insurance consultancy						Pilot of pre-purchase discount card
								Public Servants Medical Aid Scheme debated		
POLICY PROCESSES – GENERAL		<i>MMD health policy proposals</i>	<i>Development and Cabinet approval of National Health Policies and Strategies (NHPS)</i>				<i>National Health Services Act</i>			<i>Drug, Lab, Repro Health policies</i>
POLICY PROCESSES – FINANCING		<i>Debate on financing feeds into NHPS</i>				<i>First attempts to develop financing policy by HCFWG</i>		<i>Debate about Statutory Instrument</i>	<i>Development of National Health Care Financing Policy</i>	
				HCFWG		HCFWG				HCFWG

Notes: **bold** = implemented policy change; *italics* = policy process; the Mwase Mphangwe Initiative was a pre-payment scheme for primary care levels based on payments in-kind rather than cash; HCFWG = Health Care Financing Working Group.

As in South Africa, Zambian resource allocation policy evolved incrementally after 1991 in response to experience and wider health policy change. The move towards a health formula, therefore, responded both to concerns about allocating resources through provincial administrations and to the development of district management bodies. Changes in formula design also responded to experience in its use and the growing availability of information while the transfer to district management structures of funding for first-level referral services within higher level hospitals in 1998 reflected the growing authority given to the districts. The plan was for districts to enter into contractual agreements with higher level hospitals for the purchase of first-level services.

In contrast, resource mobilisation policy implementation involved the introduction over time of several different fee, exemption, and prepayment policies in an apparently uncoordinated manner. In some respects, it is difficult to judge what actually constitutes resource mobilisation policy. What is included in the NHPS may be considered official policy, but actual implementation has been very different, at least in terms of cost-sharing reforms. Beyond the few circulars or policy statements that did reach implementors, much health financing policy development has been undertaken in Lusaka and has not progressed beyond the draft document stage. In the words of one long-term advisor articulating a commonly held view, *“[s]taff at the centre might well describe the financing policies in a particular manner, as would documents disseminated to donors and central staff. However these policies had often not been communicated to the implementors, or not effectively communicated”* (interview data). Thus, although being raised as an area for investigation in the NHPS document, insurance remained simply a topic of debate rather than a matter of policy development.

There were also two important gaps in Zambian resource mobilisation policy. First, although circulars issued by the Principal Secretary in 1993 and 1995 sought to spell out the range of groups that could be exempted on the basis of demographic criteria, health conditions, or services being sought, there was little clarity on whether and how to exempt on the basis of income. The Health Care Cost Scheme piloted in 1995-1996 could have provided a mechanism for funding care on the basis of indigence, but was not taken to scale during the period of focus. Second, despite the repeated efforts of the Health Care Financing Working Group (HCFWG), a group bringing government planners, technical assistants, and nongovernment health economists together, the proposed comprehensive health care financing policy had not been finalised by 1999. This policy gap represented a missed opportunity for developing an overarching policy framework that could ensure more coherent policy development and implementation across all areas of financing policy change.

3.4 Impacts on Equity and Sustainability

As noted in Section 3.2, equity and sustainability were key objectives of the financing reforms of focus in both countries. The impact of the reforms on these objectives was partly assessed using the broad criteria identified in Table 3.3; however, assessing the impacts of health reforms is always problematic. It is difficult to disentangle the impact of one policy change from that of others implemented at the same time, or from broader contextual changes in circumstances that can influence the criteria of focus. The impacts experienced in Zambia might, therefore, have resulted from the combination of financing and institutional change that was implemented rather than solely from financing policy change. In addition, utilisation changes may have been influenced by changes in the economic circumstances of households as much as by changes in access or prices. The period of assessment may also make it difficult to identify any impact. Thus, it is difficult to assess the extent to which real shifts in expenditure (as opposed to budgets) occur because these require parallel and longer term shifts in personnel availability, drug provision, and even facility location. In Zambia, it was also particularly difficult to assess the impacts of resource mobilisation policy changes because the practice of implementation varied across the country and there was no single or clear time of

implementation. A final, important constraint on the assessment of impacts in both countries was the paucity of available information and formal evaluations.

Table 3.3: Criteria Used in Assessing Reform Impacts

Equity	Sustainability
<p>User fees/prepayment: Change in pattern of access to health care benefits by different groups Change in level of utilisation at health facilities over time</p> <p>Geographic resource allocation: Equal budget/expenditure per head of the population in different geographical areas (and between levels of care)</p> <p>Noting that it was not possible to develop per capita estimates weighted for relative need; In South Africa, the “population” was determined only as the uninsured population, in line with the public health system’s primary intention to provide care to those who cannot afford private insurance.</p>	<p>resource mobilisation levels; e.g., cost recovery ratios (financial sustainability) the allocation of resources between levels of care (allocative efficiency) the acceptability of reforms to different stakeholders (political acceptability) strengthening the health system’s “organisational capacity”; e.g., evidence of improved skill availability, enhanced accountability, and greater decision-making authority</p>

3.4.1 South Africa

Given the inheritance of apartheid, the broad success of the South African health care financing reforms of 1994-1999 was in the reformers’ ability to make strong and early moves towards reorienting service provision towards the needs of the population at large (see Table 3.4).

This was achieved mainly through the provision of free primary health care (PHC) services, which promoted increased utilisation, particularly of curative services. The only large-scale evaluation of the policies, undertaken after the first free care policy and using a national sample, reported utilisation increases of between 20 and 60 percent within facilities after the removal of fees (McCoy 1996). Smaller scale studies, undertaken after the second free care policy, also showed similar levels of utilisation change (e.g., Schneider and Gilson 1999). Given the relatively low reported levels of utilisation before fee removal, these substantial increases may well reflect previously unmet need rather than simply frivolous or unnecessary use. This judgement is supported by data on maternal and child health care services. After the first free care policy, the early national evaluation reported a nearly 15 percent increase in antenatal care attendance rates as well as an increase in the number of first antenatal visits and an increase in the proportion of deliveries that were preceded by an antenatal care visit (McCoy 1996). However, researchers expressed concern that free PHC led to a crowding out of preventive services by curative services (Wilkinson *et al.* 1998), and one study suggested a decline in antenatal attendance over time, but because this was conducted in an urban area, it cannot be generalised to less well-served rural areas (Schneider and Gilson 1999). Overall, the paucity of available data prevents full assessment of these utilisation impacts.

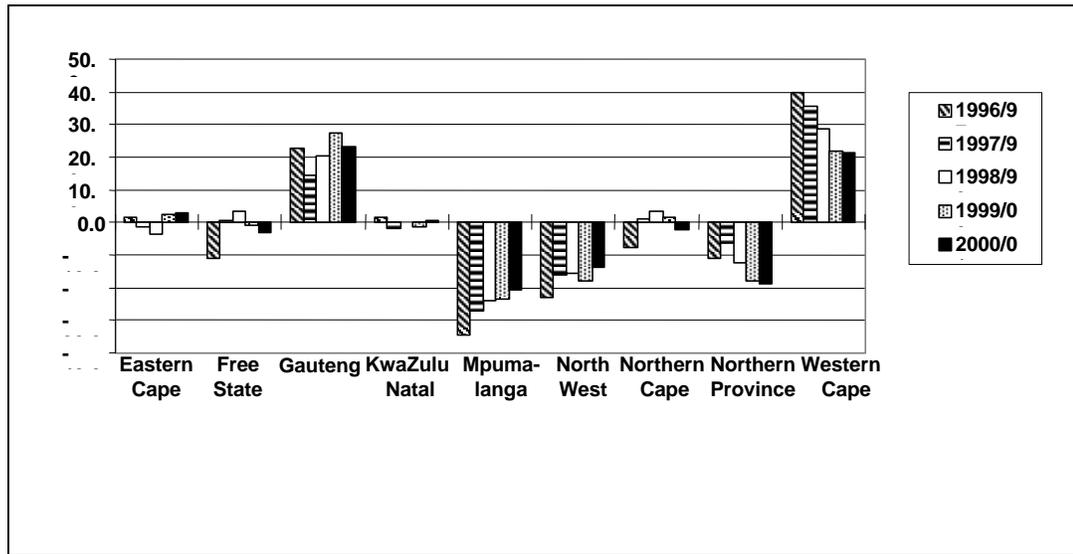
The second facet of the equity gains achieved in South Africa was the early moves to reallocate public budget towards previously underresourced provinces, reflecting the clear policy intent to promote geographical equity. Figure 3.3 shows that expenditure/budgets in provinces such as

Northern province and Mpumalanga with allocations below the zero line (representing equal budget/expenditure per head) moved towards this line in the initial years, even as relatively overresourced provinces, particularly Gauteng and Western Cape, also did. Although there are some signs that budgets, at least, were also shifted towards primary care (de Bruyn *et al.* 1998), the available evidence is weak because of problems in disaggregating and comparing data in a consistent fashion across the years.

Table 3.4: Impacts of Health Financing Change in South Africa and Zambia during the 1990s

	Equity		Sustainability	
	Gains	Losses	Gains	Losses
<i>Resource allocation</i>				
South Africa	The health resource allocation formulae contributed to some redistribution of health budgets between provinces 1994-96. Budget reprioritisation towards PHC improved geographical access to these services.	From 1996 global budgeting reduced or reversed interprovincial shifts in health spending. Reprioritisation of PHC, as supported by the resource allocation formulae, may not have been effective in realising improved PHC services in the worst-off areas of the country.	Reprioritisation of budgets may have led to greater spending on PHC.	Since 1996 spending on health care has become dependent on political jockeying at the provincial level. The reforms led to some dissatisfaction with public health services, especially hospitals. Contributed to worsening provider morale and declining quality of care.
Zambia	Improved geographical equity		Bold resource shift from tertiary to PHC level Devolved budget control supports decentralised management Basket funding and joint allocation procedures has improved donor coordination	Transparency and accountability not yet firmly established
<i>Resource mobilisation</i>				
South Africa (free care)	Financial barriers to access, especially to PHC, were reduced	The broader (e.g., transport) costs of accessing health care not addressed.	The policies garnered popular support for the broad reform agenda of the government.	
Zambia	Demographic exemptions working well	Utilisation falls across population groups, though becoming less severe over time The broader (e.g., transport) costs of accessing health care not addressed.	Culture of paying for care established Revenue generation enabled important, if largely symbolic, quality improvements	Revenue generation still inadequate to fully address problems

Figure 3.3: Percentage Difference Between Real Per Capita Provincial Health Expenditure (1996/97) and Budgets (1997/98 - 2000/01) (excluding Academic Hospitals) and the National Average (South Africa)



Source: McIntyre et al. 1998

Finally, the free care policies also generated substantial public support for the new government because they were seen as signalling the new government's commitment to the previously disadvantaged population (McCoy 1996). In the press, both policies – but especially free care 2 – were consistently held up as the then Minister of Health's hallmark achievement. Public recognition of these reforms helped to endorse DOH's broader reform agenda, giving credence to its ongoing activities, as well as bolstering the popularity of its leaders.

Yet these considerable achievements went hand in hand with increased instability in certain aspects of the health system. The free care policies had some negative impacts both on provider morale and perceived quality of care. Many health care workers complained that patients overused services as a result of zero costs to the patients, and that their workloads had increased without any complementary attempts to support them in their work (McCoy 1996; Magongo and Cabral 1996). Household surveys also found evidence of patient dissatisfaction with the quality of health care after the removal of fees (Hirschowitz and Orkin 1995; McCoy 1996; Magongo and Cabral 1996). Finally, efforts to reallocate resources towards underresourced areas and the primary health care level went hand in hand with a perceived deterioration in the quality of public hospital care. These byproducts of reform have made the task of further reducing inequities that much harder.

Even with respect to reductions in inequity, the initial resource reallocation in the health sector occurred so quickly that provinces were not able to effectively absorb budget losses or gains. As a result, the real resource reallocations (as reflected in expenditure patterns) across provinces promoted by the policy were less than the budgetary reallocations and there was only a limited degree of reallocation between levels of care. It proved particularly difficult to reallocate human resources and physical facilities between provinces at the early speed of budget reallocations. Equally critical, the initial moves towards the equitable allocation of budgets were jeopardised by the process of global budgeting introduced in 1996. Although this is not a clear trend across all provinces, there are clear signs that budgetary allocations since then have favoured some of the more wealthy provinces,

especially Gauteng, while some of the poorest provinces (such as Northern province) have seen their budgets fall over time. As shown in Figure 3.3, allocations to these provinces have included moves away from the zero line in some years. These trends are even clearer when the budgets/expenditures of the academic hospitals located in provinces with better resources are included (Gilson *et al.* 1999). The additional failures to implement a revised hospital fee schedule, to agree on SHI proposals, and to develop the public sector organisational capacity necessary to implement any financing (or other health system) change were also serious weaknesses of the health sector reform programme.

Overall, the initial gains that resulted from the more successful aspects of financing policy change may represent only a weak foundation for the longer term changes needed to address the complex health system problems inherited from the past. The continuing need to tackle not only the geographical inequity in public sector resource allocations, but also the resource maldistribution between public and private health care sectors relative to the populations they serve and the weaknesses of the public hospital system (see Table 3.4) remain major concerns.

3.4.2 Zambia

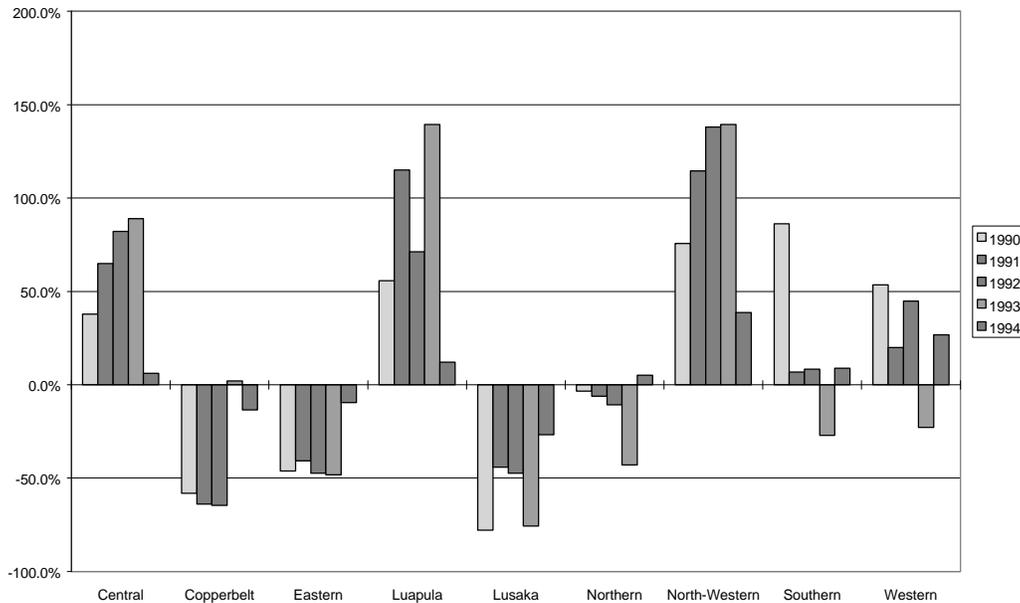
Like South Africa, the notable successes of health care financing policies in Zambia included the equity gains resulting from the use of a resource allocation formula, but also included the efficiency gains resulting from the deliberate shift of resources from the tertiary level to the more cost-effective PHC level. The introduction of the per-capita-based district formula in 1994 resulted in a more equitable distribution (compared with 1993) of the government budget among the provinces in all but two provinces⁴ (see Figure 3.4). Although the inclusion of central hospital budget/expenditure would inevitably bias the allocation towards urban areas, the introduction of the formula for district allocations still resulted in an improvement in the distribution across most provinces (Lake *et al.* 2000). Moreover, between 1990 and 1999 there was a sustained increase in the approved and authorised budget (reflecting policy intent) allocated to district health services and a parallel decrease in the amount allocated to third-level referral hospitals. Data also show that this intent was translated into practice in that the proportion of MOH recurrent expenditures incurred at the district level increased from 40 percent to 52 percent between 1995 and 1998.

The gains promoted through resource reallocation were accompanied by gains in some aspects of sustainability resulting from the cost-sharing policies. By introducing a culture of paying for services, cost sharing has promoted a strong concern for the quality of health care among the population, and this may provide a foundation for demanding greater accountability from the health system. Through their reinforcement effect on decentralization, Zambian financing policies also had a more positive impact on sustainability than did South African policies. Whereas past attempts to devolve responsibilities had not brought a commensurate increase in resources, the reforms undertaken since 1993 generally improved the financial situation at the district level. It is estimated that, on average, the equivalent of about 10 percent of recurrent costs is now generated from cost sharing (Daura *et al.* 1998), although there are substantial variations between urban and rural districts (Lake *et al.* 2000). Cost sharing also enhanced district decision-making power by reducing the complex bureaucratic procedures required to solicit funds from the provincial level and by creating the district basket mechanism acted to strengthen management. Donor resources came to be pooled

⁴ Although the Zambian formula is intended to improve the equity with which financial resources are allocated between districts rather than provinces, it is not possible to determine the district breakdown of resources prior to use of the resource allocation formula. Rather, this analysis examines the impact of the formula on inter-provincial allocations through a comparison of the pre- and post-1994 scenario.

with government resources at the district level, which allowed one system of financial reporting. These gains were, in turn, supported by the broader programme of decentralization. It was through this programme that district and hospital board managers and health workers were trained in financial management. Thus, the sustainability gains of the Zambian reforms cannot be attributed solely to either financing or institutional change.

Figure 3.4: Provincial Distance from Equity, Excluding Central Hospitals, 1990-1994 (Zambia)



Source: Lake *et al.* 2000

Notes: 1994 district figures were based on provisional census estimates while the equity calculations used final census figures. Budget figures exclude personnel emoluments and centrally procured items for all years.

Despite these gains, available Zambian data point to a particularly important equity problem resulting from the reforms. Although some data suggest that utilisation rates may have stabilised over time in some places (Daura *et al.* 1998; Sukwa and Chabot 1996), a wide range of studies suggest that the introduction of cost-sharing measures reduced access to health care services. The data in Table 3.5, drawn from the Food Security, Health and Nutrition Information Surveys, indicate widespread declines in health service utilisation. Data from the 1996 Living Conditions Monitoring Survey (LCMS) also show that 57 percent of individuals who were sick during the two weeks preceding the survey did not seek any form of care and that the probability of not seeking care was 28 percent higher among those in the lowest income quintile than in the highest (Lake *et al.* 2000). These utilisation patterns are likely to reflect the combined influence of cost sharing and other factors, including declining household income levels and the decrease in quality of services, particularly drug shortages.

Table 3.5: Pattern of Utilisation in 39 Randomly Selected Health Centres in Zambia (1993-1997)
Source: Lake et al. 2000

Users	Decline in utilisation	No significant change in utilisation	Increase in utilisation	Total
Under fives (%)	27 (69.2%)	9 (23.1%)	3 (7.7%)	39 (100%)
Others (%)	28 (71.8%)	8 (20.5%)	3 (7.7%)	39 (100%)

Importantly, the LCMS survey data also indicate that the financial access of some groups was partially protected as a result of exemptions. Just over 70 percent of the under fives and slightly less than 70 percent of the over 65 year olds surveyed indicated that they had not paid for care received at public facilities in the previous week. However, exemptions targeting the lowest income groups (and based on ability to pay) were never fully implemented. As a result, while the lowest income group was more likely not to pay than the highest income group across all age ranges, slightly less than 10 percent of the 15 to 44 year olds employed in the private sector, and around 20 percent of those in this age group employed in government, also received exemption from payment. The exemption policy seems to have been more successful in promoting demographic equity than in ensuring payment according to ability to pay for health care (as measured using income).

In summary, the Zambian reforms that this study considered had varying impact (see Table 3.4). Notable successes include the initial equity gains resulting from use of a resource allocation formula and the protection of some groups through exemptions. Efficiency gains resulting from the deliberate shift of resources away from the tertiary level to the more cost-effective PHC level represent an important sustainability gain. At the same time, utilisation reductions and the limited effectiveness of income-based exemptions are key problems. In addition, the nearly 13 percent reduction in the public funding allocated to the MOH budget between 1995 and 1998 has serious implications for the overall sustainability of the health services.

3.5 Conclusions

The positive gains that health care financing change achieved in a relatively short time in both countries were important, although, in Zambia particularly, they are difficult to disentangle from the impacts of broader health sector reform. In broad terms, these gains offer the hope of future positive change. Nonetheless, the uneven pattern of policy change in each country and the negative impacts of some of the implemented actions are cause for concern. They point to the need to understand why and how the particular patterns of policy change and of policy impacts came about in each country as a basis for implementing corrective action. They trigger such questions as the following:

- > Why were there missed opportunities to implement policy change in each country (e.g., SHI in South Africa and a comprehensive financing policy in Zambia)?
- > Why were so many different forms of cost-sharing policies introduced successively over time in Zambia?
- > Why were some policy changes (e.g., resource reallocation in Zambia and South Africa, the

removal of fees in South Africa) implemented relatively easily, and yet others were not (e.g., cost sharing in Zambia, SHI in South Africa)?

- > Why was reregulation of the private insurance industry successfully carried into legislation in South Africa while there remained inadequate support for any set of SHI proposals?
- > Why did the changing resource allocation policies of South Africa have different equity impacts?
- > Why did individual various policies have both positive and negative impacts (such as free care in South Africa and cost sharing in Zambia)?

The factors explaining these experiences are considered in detail in Chapter 4.

4. Explaining the Patterns of Policy Change and Impacts

This chapter presents an analysis of the key factors that explain the pattern and impacts of financing policy change (as described in Chapter 3). It is rooted in the systematic and detailed analysis undertaken within each country study, and it applies the conceptual framework outlined in Chapter 1 in comparing and contrasting the country experiences.

4.1 Context and Policy Change

4.1.1 The Key Contextual Influences

Contextual factors are commonly recognised to have an important influence over the pattern of policy change (e.g., Collins *et al.* 1999; Gilson and Mills 1996; Grindle and Thomas 1991; Leichter 1979; Walt 1994). The inherited problems of the health system, for example, specifically influenced the objectives and nature of health care financing reforms in both South Africa and Zambia (Section 3.2). Table 4.1 summarises other key features of context that influenced financing policy development in each country.

Political transition was important in both countries. Such transition brought specific support for speedy health policy change in recognition of the significance of health problems and the important, and very visible, role of health care in people's lives. Policy development work undertaken before elections (Section 3.1) meant that health policy frameworks were already available to guide implementation. Political change, thus, provided the opportunity for radical health policy change, such as the withdrawal of the Zambian health sector from the system of allocating budgetary resources through the provincial administrations or the South African removal of primary care fees. Yet, as one Zambian health official noted, "*the political momentum often outstripped the technocratic.*" Political change created a demand for speedy change and an environment in which it was difficult to implement coherent and careful policy action (Section 4.4).

This problem was exacerbated in South Africa by the massive transformation of governance and administrative structures that accompanied political transition, reflecting the broader change in the relationship between the state and society. Within health administrations, new officials, most working in government structures for the first time, sought to implement new policies. Not surprisingly, "*it was a hell of a learning curve. You get into power and then it hits you like a thunderbolt: you don't know the rules and regulations.*" (provincial health official). Similar views were expressed initially by the new health reformers in Zambia. South African health managers also had to deal with a continuing process of change in administrative structures resulting from decentralisation within the health sector, as in Zambia, and from changes driven from outside the sector as part of the broader political transition. This made the task of bringing about health policy change much more difficult. Initial moves towards equity in health budget allocations among provinces were, for example, undermined by the introduction of provincial global budgets in line with the devolution of significant power to provincial governments (Section 3.4). Health policy makers were not very effective in foreseeing how structural changes would impact on their policy goals or

affect their implementation capacity, or in responding to such changes. The inevitably political nature of resource allocation only made such action more difficult. Overall, therefore, “*the act of restructuring undermined the development of functional policy*” (health policy analyst).

Table 4.1: Key Features of Context Influencing Health Care Financing Reform

Category	South Africa	Zambia
Political and administrative Context	<p>The election of the first democratic government in 1994, led by the ANC, enabled and required speedy and radical social policy change</p> <p>The health sector was seen as a leader of social policy change</p> <p>The massive restructuring of the apartheid bureaucracy after 1994 introduced new mechanisms and modes of intergovernmental relations, initially undermining rational policy development</p> <p>The new quasi-federal structure brought with it new allocation procedures for all public resources, and a stronger role for the Department of Finance in policymaking at all levels (Section 4.2)</p> <p>The new government catapulted inexperienced individuals into positions of power where they were faced with the obstacle of a heavily centralised, inefficient and outmoded bureaucracy</p> <p>The dominance of the ANC within government limited, but did not prevent, the effectiveness and openness of political debate on health and other policy change (Section 4.2)</p> <p>Civil servants received employment guarantees as part of the political settlement, limiting the new government’s human resource policy options (Section 4.4)</p>	<p>The change of the political system to a multiparty system, and the election of the MMD in 1991, created an impetus for radical policy change</p> <p>The health sector was seen as a leader of policy change</p> <p>The new government brought some new individuals into positions of power, as in the health sector, working alongside more experienced civil servants</p> <p>The lack of an effective political opposition precluded policy debate of health reforms (Section 4.2)</p>
National environment and culture	<p>The “post-apartheid transformation” required a complete re-conceptualisation and reorganisation of the state and its relationship with society. This was reflected in the passing of the new 1996 constitution, which included a Bill of Rights to provide legal protection for the human and social rights abused under the apartheid regime.</p>	<p>General MMD support for health reform was also interpreted as popular support from the society for change in the health sector (although the previous free care policy may have limited initial popular support for new cost-sharing policies).</p>
Economic context	<p>US\$3,160 1995</p> <p>Despite being a middle-income country, the resources available to effect health system change were limited by previous patterns of underdevelopment and a new economic policy framework (introduced in 1996)</p> <p>The high political acceptance of the new economic policy framework gave legitimacy and power to the policy positions of the central Department of Finance (Section 4.2)</p> <p>The upward pressure on public sector salaries generated through central bargaining arrangements further tightened resource limits on all public sector activities (Section 4.4)</p>	<p>US\$330, 1998</p> <p>Overall levels of resource availability were constrained considerably by economic decline after 1970, prompting consideration of alternative health care financing policies by the mid-1980s</p> <p>The implementation of the New Economic Recovery Program in the late 1980s (before political change) provided an enabling environment for prioritising the health sector and its policies as important to broader development</p> <p>Economic performance did not improve over the 1990s, while the extent of poverty worsened</p>
External factors	<p>Apparently of limited explicit influence, though international pressures may have influenced the adoption of a relatively orthodox economic policy framework post-1994</p>	<p>Macroeconomic policy strongly influenced by external factors</p> <p>Substantial donor support for the new government ensured the availability of financial and human resources to assist health reform development and implementation</p>

Economic factors also shaped the impact and nature of health care financing change in both countries. Growing levels of impoverishment among the Zambian population (Section 2.3) helped explain the utilisation reductions that followed the implementation of cost sharing. For some, the cost-sharing policies may have even exacerbated the situation (e.g., Booth *et al.* 1995). Yet, the limited availability of resources in Zambia placed a very tight constraint on health system development. The government budget was particularly burdened by the need to allocate resources to debt servicing. Thus, although the government increased the percentage of its budget allocated to health from 6.4 percent in the early 1980s to 14 percent in 1998, government funding for health care declined in real terms over the 1990s, and by 1999 it had not regained its 1995 level. These economic circumstances, as well as the changing macroeconomic policy frameworks of the country, gave support to the broad emphasis on revenue generation within the health reforms.

South Africa had a much greater overall level of resource availability than Zambia; the ANC's initial guiding policy document, the RDP, strongly supported policies such as those of the health sector that would directly tackle the inherited socioeconomic disparities within the population. Despite this, South Africa's health care financing policies were also shaped by macroeconomic policies. In 1996, the ANC introduced a new macroeconomic policy framework, the Growth, Employment, and Redistribution Strategy (GEAR), which sought to promote economic growth through a fairly conservative policy stance. In containing public spending and taxation levels as part of its overall strategy, GEAR placed budgetary constraints on the health sector, thereby making the process of resource reallocation among provinces both technically and politically more difficult. This, in turn, prompted a growing focus on revenue generation as the primary objective for SHI policies (Section 4.5). At the same time, GEAR's overall taxation limits provided a critical barrier to the development of SHI, as this was construed by the DOF as an additional tax (Section 4.2).

Finally, a critical difference between the two countries' contexts concerns the relative importance and influence of external factors. Although some suggest that concern for its international standing influenced the ANC government's adoption of a relatively orthodox macroeconomic policy, the direct influence of external funding and technical assistance is quite limited in South Africa. In contrast, Zambian macroeconomic frameworks were strongly influenced by international financial institutions (following the reestablishment of relationships between them and the Zambian government in the late 1980s). External funds also became increasingly important to the financing of the Zambian health sector over the 1990s, increasing from one-third of the combined total of government and donor resources in 1995 to two-thirds of this total in 1998 (Daura and Mulikelela 1998). With this level of financial contribution, donor representatives inevitably had influence within health policy debates (Section 4.2).

4.1.2 Conclusions

The following conclusions were drawn concerning the influence of contextual factors over policy change:

- > Contextual factors can directly influence the scope and design of policies as well as actors' interests and roles within policy decision-making processes. Such factors can, therefore, shape both the pattern of policy change and the level and nature of impacts resulting from it. Managing these influences requires careful consideration of the interests and concerns of actors and how to involve them in policy change, as well as how to design the policies (Sections 4.2-4.5).
- > Political factors, in particular, can affect the timing and pace of policy implementation,

providing windows of opportunity to move policy change forward but also making successful implementation more difficult. Managing such factors requires that clear priorities for policy action be established and that attention be given to the prerequisites of successful implementation (Sections 4.4-4.5).

- > Contextual factors, particularly wider economic changes, may also have a direct and independent influence over impacts. This influence needs to be considered in the design of policies and in the evaluation of their impacts.

4.2 The Central Influence of Actors

Although contextual factors provide opportunities for and obstacles to policy change, actors always play a central role in shaping such change (Grindle and Thomas 1991; Gilson *et al.* 1999; Muraskin 1998; Walt 1994; Walt and Gilson 1994). Thus, both in South Africa and in Zambia, health care financing policymaking was seen to be quite personalised. A Zambian official noted that, “*when [the second Minister] came there he was in a hurry for whatever reason, to put his mark on it,*” while a South African health official commented that, “*if you know what the Minister wants, you can see what will go through ... this is very personalised decision making and it’s much more difficult to get her support for things she’s not interested in.*” The clear consequences of actor influence included the ever-changing pattern of cost-sharing policy development in Zambia and the speedy removal of fees and the failure to move the SHI debate beyond the development of proposals in South Africa.

4.2.1 The Roles and Relative Influence of Different Actors

The actors lying at the heart of the processes of initiating, designing, and implementing health care financing reforms in South Africa and Zambia are summarised in Tables 4.2 and 4.3. Two actors that are particularly noteworthy because of their lack of influence in both countries are the general public and health care workers.

In each country Ministers of Health played critical, often dominant, roles across all areas of health care financing policy development. In South Africa, Dr. Zuma, the national Minister of Health throughout the first term of government, was instrumental in ensuring that free care policies were implemented and was very supportive of the health resource allocation formula. However, her broad opposition to the various SHI proposals was a critical factor in preventing their implementation. In Zambia, meanwhile, Dr. Kalumba, initially Deputy Minister and subsequently (the third) Minister of Health, was widely accredited as the architect of the overall health reform programme and was supportive of both resource reallocation and cost sharing. Other ministers also played critical roles in relation to specific financing policies. For example, the first minister, Dr. Kawimbe, strongly supported the move towards per capita funding for districts, and through his personal links was able to gain the support of the Minister of Finance in this action. He also introduced the Mwase Mphangwe prepayment scheme, which was subsequently adapted by the second minister, Mr. Sata, as a hospital prepayment scheme. The fourth minister’s (Professor Luo) limited support of the comprehensive financing policy prepared by the HCFWG appears to have been an obstacle to its finalisation before 1999.

The central economic ministry was also generally important in policy change – though in different ways in the two countries. In South Africa, the DOF came to play the central role in overall resource allocation policy in the fiscal federal era and its opposition was a second critical obstacle to implementation of SHI proposals. In contrast, in Zambia, the Ministry of Finance and Economic

Development (MOFED) facilitated key aspects of policy implementation. In particular, MOFED supported the MOH in its withdrawal from the system of allocating resources through provincial administrations, in its development of a criteria-based resource allocation formula, and in allowing it to retain cost-sharing revenue at the facility and district levels.

Although health managers and technicians also played roles in health financing policy development in both countries, they perhaps had more influence in Zambia. Officials from the Zambian MOH Planning Unit were involved in policy debates even before 1991 and continued to be central actors in the reform process within the new government. The chief planner was a key member of the reform team. The creation of the Health Reform Implementation Team (HRIT) early in the new government's life also drew a wider group of managers into reform implementation. Intended to oversee speedy reform implementation, the HRIT was established as an interim structure to spearhead district development, separate from the Ministry of Health, which would therefore be able to work outside the bureaucracy associated with government. It was replaced by the CBOH in late 1996. These different groups of technicians played central roles in resource allocation policy decisions, and they were sometimes brought into cost-sharing policy development. Thus, the Planning Unit coordinated the preparation of a comprehensive financing policy document from 1997. One group of health professionals noted for its opposition to many of the health reforms, including aspects of the comprehensive financing policy document, was the managers and staff of hospitals, particularly those based in higher level referral hospitals.

The key technical group charged with supporting health care financing reform in South Africa was the Directorate of Health Financing and Economics (DHFE), located in the national DOH. Although it is widely accepted that the directorate played an important role in keeping health care financing discussions alive, its main impact on health financing policy was through its involvement in the development of the 1998 Medical Schemes Act. Other policy development processes were largely driven by other actors. For example, the DHFE was brought in after key decisions on free care had been made, was sought primarily to coordinate other groups' inputs into the budget process, or played only a supporting role in SHI proposal development. In contrast to the DHFE, the senior managers of provincial DOHs played critical roles in all policy debates, particularly in resource allocation discussions. They held important policy positions and, as a result, political status as key actors within the provincial governments that became the accountable unit for government expenditure after 1996.

The dearth of health economists within governments led to analysts from outside government becoming involved in policy development in both countries. In Zambia this group included both long- and short-term expatriate technical assistants (TAs) as well as economists from the University of Zambia, but in South Africa the external technicians were predominantly drawn from national research groups. Working within existing government structures, long-term TAs were directly involved in resource allocation decisions within Zambia whereas short-term TAs and the South African external analysts were primarily drawn into resource mobilisation policy development. These groups not only examined the actual or potential effects of new policies but also participated in various special committees established to advise policy development. However, the work of external analysts had limited direct influence on resource mobilisation policy in either country during the period investigated. Thus, neither the South African SHI proposals nor the Zambian comprehensive financing policy had come to fruition by 1999. The only exceptions to this common experience were their roles in developing and implementing cost-sharing guidelines in 1999 in Zambia (with the support of USAID) and in the development of the 1998 South African Medical Schemes Act (with the support of the then Minister of Health: Section 4.4).

The other, key *nongovernment actors* who had influence in South Africa, although only directly on SHI policy development, were the trade unions and the private health sector. The trade unions, as represented by the Congress of South African Trade Unions (COSATU), broadly supported the 1995 SHI proposals when directly consulted, but then opposed the 1997 SHI proposals. It appears that COSATU may have used its close political links with the ANC to add weight to opposition to the 1997 SHI proposals. Amongst the diverse range of private health sector interests in South Africa, the private insurance industry played the clearest role in SHI debates using a dual strategy of direct participation in special structures and informal lobbying in pursuit of its commercial interests. Overall, however, the private sector primarily shaped financing policy proposals over the period of focus through reformers' concern for their potential responses (Section 4.6)⁵.

⁵ Although after 1999, the opposition of some insurers to the reregulation of medical schemes led to legal confrontation with government.

Table 4.2: Summary of Key Actors and Their Roles in Health Care Financing Policy Development and Implementation, South Africa 1994-1999

	Resource Allocation Policy	Primary Care and Hospital Fee Policy	SHI Policy Development (including Medical Scheme Reregulation)
Political sector	<p><i>Minister of Health</i> expressed strong support for equitable resource allocations</p> <p><i>Cross-party</i> support for budget reform, while fiscal federalism accepted as byproduct of negotiated settlement</p>	<p><i>President</i> announced Free Care 1</p> <p><i>Minister of Health</i> pushed for Free Care 1 and announced Free Care 2; involved in hospital fee discussions</p> <p><i>ANC</i> support for Free Care 1, and likely for Free Care 2; no clear role on hospital fees</p>	<p><i>Minister of Health</i> unconvinced by most proposals but provided support within Cabinet and in discussions with DOF for medical scheme reregulation</p> <p><i>ANC</i> favoured investigation of broader social security options after 1997 SHI proposals</p> <p><i>Main opposition parties</i> concerned about some SHI proposals and about aspects of medical scheme reregulation</p>
Government sector	<p><i>National DOH DG</i> involved through formal structures</p> <p><i>National DOH units</i> played limited roles</p> <p><i>Provincial DOHs</i> strongly involved in all discussions through formal structures</p> <p><i>DOF</i> strongly involved in fiscal federal era</p>	<p><i>National DOH DG</i> supported Free Care 2, involved in hospital fee discussions</p> <p><i>National DOH units</i> played limited role</p> <p><i>Provincial DOHs</i> had limited role in free care policies but directly involved in hospital fee discussions</p> <p><i>DOF</i> in general not directly involved</p>	<p><i>National DOH DG</i> involved in support of all special committees</p> <p><i>DHFE</i> participant in all special committees, most active in 1997 Medical Schemes Working Group</p> <p><i>Provincial DOHs</i> only involved through discussion of SHI proposals in formal structures</p> <p><i>DOF</i> member of 1995 COI and involved in discussion of 1997 SHI and Medical Scheme Working Group proposals</p>
Business sector	No position taken	No position taken	<p><i>Medical schemes industry</i> directly involved in special committees 1994-1995 and consulted by 1997 Medical Scheme Working Group; split over medical scheme regulation</p> <p><i>Other private sector interests</i> made submissions to 1995 COI and were consulted by some other committees</p>
Independent researchers	<i>SA analysts</i> provided independent evaluation of policy proposals, or acted as consultants to parliamentary committees or other government bodies	<i>SA analysts</i> directly involved in early primary care discussions and in developing early hospital fee proposals, but otherwise limited role	<i>SA analysts</i> directly involved in all committees
Social sector	<p><i>COSATU</i> called for more transparency in budget process in fiscal federal era</p> <p><i>Media</i> often dramatised the resource allocation issues through reporting on 'negative' impacts</p>	<i>Media</i> raised concerns about implementation practice and effects of free care	<p><i>COSATU</i> consulted by 1995 COI and 1997 SHI Working Group; opposed to 1997 proposals</p> <p><i>Some media</i> expressed opposition to some SHI proposals and to 1998 Medical Schemes Act</p>

Abbreviations:

ANC = African National Congress;
 COI = Committee of Inquiry into Social Health Insurance (1995)
 COSATU = Congress of South African Trade Unions;
 DOF = Department of Finance;
 DG = Director General (equivalent to Principal/Permanent Secretary);
 DHFE = Directorate of Health Financing and Economics (national DOH);
 DOH = Department of Health;
 PHRC = provincial health restructuring committee (coordinating body across provinces)

Table 4.3: Summary of key actors and their roles in health care financing policy development and implementation, Zambia 1991-99

Actors	Resource allocation	Cost sharing
Political sector: Ministers of Health	First – strongly supportive of move to per capita basis Others – limited involvement	First - strongly supportive of fees; proponent of prepayment in-kind Second - felt fees too high; strongly supportive of cash prepayment Third - strongly supportive of concept of cost-sharing generally Fourth – opposed to some aspects of comprehensive financing policy
Government sector – central level	MOFED – supportive of use of criteria for geographical resource allocation, and of MOH withdrawal from system of allocating resources through provincial administrations MOH – strongly supportive of decentralised budgets and objective criteria for allocation	MOFED – supportive of retention of cost-sharing revenues within the MOH (1992 onwards)
Government sector – implementors	Districts – Generally supportive of greater transparency although some districts felt that formula did not adequately reflect their needs	Referral hospitals - Directors favoured fees but opposed (privately) to 1994 prepayment
Independent researchers	Little evidence of any interest	UNZA Participatory Assessment Group – early work suggested negative impact on financial access; more recent work less conclusive UNZA Dept of Economics – 1996 and 1998 work highlighted need for communication and consistency in cost-sharing policy implementation
Expatriate technical assistants (TA): long and short term	SIDA short term - proposal in 1993 for use of more rational basis for allocations SIDA long-term – strong proponent of budgetary reform DFID - concern over basis for hospital allocations WHO short term – proposed reallocation through growth	Short-term WHO consultants - early proponents (1991-92) of formal health insurance, but more supportive of informal prepayment/insurance since 1996 Short term USAID (PHR) – concern with strengthening cost-sharing at operational level (1997-8)
Social sector	CMAZ - Individual churches against move to population based funding for hospitals (1997)	CMAZ – supportive initially though concerns later about population affordability Catholic Secretariat – opposed in context of widespread poverty
Donors	General support for principle of reallocating toward primary health care	UNICEF - concern in early years of implementation about financial barriers to access for priority services such as ante-natal care, immunisation

Abbreviations:

CMAZ = Churches' Mission Association of Zambia
DFID = UK's Department for International Development
MOFED = Ministry of Finance and Economic Development
MOH = Ministry of Health
PHR = Partnerships for Health Reform
SIDA = Swedish Development Agency
TA = technical assistants
UNICEF = United National Children's Fund
UNZA = University of Zambia
USAID = United States Agency for International Development
WHO = World Health Organisation

In Zambia two completely different nongovernment actors had roles in policy development: church health care providers and donors. The Church Medical Association of Zambia (CMAZ), the umbrella body acting on behalf of all church health institutions, was directly involved in many policy development fora. Although broadly supporting the thrust of government policy, CMAZ did act to protect its own interests on some occasions. For example, in 1995 CMAZ opposed the decision to fund church institutions through districts and instead secured an agreement that the MOH would continue to pass funds for these institutions through CMAZ. Amongst donors, international financial institutions were important because they promoted macroeconomic policies that favoured specific health care financing policies such as user fees. However, many of the bilateral and multilateral donors that provided financial support to the health sector initially came to the health reform process with relatively open ideas about what package of reform elements would be most appropriate. This openness to alternative financing approaches allowed the government to explore different forms of cost sharing in different parts of the country and to consider financing policies other than cost sharing. However, their waning support for the reform programme contributed to a broader call for more direct action to strengthen the quality of care (Section 4.3).

In summary, those actors who had the greatest influence within the process of South African health care financing policy change were the Minister of Health, DOF, and trade unions. The senior managers of provincial DOHs and the private insurance industry also played roles but had varying degrees of impact, while health economists working inside government had only limited influence. Ministers of Health were also very influential in Zambia, receiving tacit support from MOFED, backing from some groups of government managers, and, at least initially, explicit support from donors. In neither country were external analysts particularly influential.

4.2.2 Understanding the Balance of Power Between Actors

The position of actors within policy processes is partly a function of their influence relative to other actors, which is, in turn, partially dependent on the particular sources of influence they can marshal. Also important is the effectiveness of the strategies that actors apply to support their policy or personal positions within policy processes (Sections 4.3 and 4.4).

In both countries, Ministers of Health derived strong influence from their formal and pre-eminent role in the process of policy development. Although the South African national health minister must work with provincial colleagues, he or she is a member of the national Cabinet and has specific responsibilities in policy development. During the period of study, this position was also relatively powerful due to the newness of provincial governments and administrations.

However, as noted in Zambia, *“the effectiveness with which you could sell a policy” as Minister of Health “was influenced by the political strength you held. If that was weakening, it became very difficult to sell any new policy initiatives actively”* (interview data). Two factors gave political strength to the different ministers. First, the ministers received the clear backing and political support of the president and party of government. This was sometimes on a personal level (as with Dr. Zuma and Dr. Kalumba), but also because the health reforms were seen as an important leader of policy change during political transition. Second, all the ministers brought strong principles and characters to the task of reform. Many saw Dr. Kalumba as a visionary and charismatic leader: *“all of us involved in the process at that time were given the chance to change things – the sky was the limit and nothing was impossible”* (expatriate adviser). Although Dr. Zuma offered a more combative style of leadership, she too commanded respect: she was *“a hatchet man and a bulldog – I wouldn’t have wanted to work under anyone else”* (provincial health official). Some also saw her as an excellent tactician, who recognised the need to make limited gains in specific areas, and by demonstrating gains

for the population, generated political support for further action. The free care policies, for example, had this kind of effect. Similarly, the tactical ability of Mr. Sata in Zambia was noted. For example, his sudden announcement of a hospital-based prepayment scheme in 1994 was seen as a clear move to raise his political profile. It represented both a direct reversal of his predecessor's in-kind prepayment approach (the Mwase Mphangwe initiative) and an attempt to build a power base amongst the hospital staff, who perceived that their position was being eroded by the broader health reform programme.

The strong influence of the Ministers of Health was, however, also a function of the relative position of other actors in health care financing policy processes. Thus, the South African minister was supported by the trade unions in her opposition to the SHI proposals, while the initial donor support for Zambian health sector reform facilitated policy change. Critically important in both countries was the role of the central government's economic department. MOFED's support specifically enabled financing policy change in Zambia, while the South African DOF (though for very different reasons) combined with the Minister of Health and trade unions to block SHI development.

Government economic departments are always important in health financing policy change because they directly influence the policy and actions of "spending" ministries, such as health, through their direction of macroeconomic policy and control of government budgets. In South Africa, the DOF's status was heightened after 1996 by the political backing given to the macroeconomic strategy (GEAR) that it had developed. This strategy also gave the DOF clear principles on which to base its policy positions – efficiency in public sector resource allocation and use as part of its broader strategy for controlling public sector expenditure levels and reducing the government deficit. As a result, DOF sought to allocate higher budget levels to the more productive and efficient provinces through the resource allocation process and opposed the various SHI proposals on the grounds that they would inappropriately raise tax levels (Sections 4.1 and 4.5).

A further source of influence for the South African DOF was its knowledge base and success in policy development, especially in relation to what it perceived as the technically weak DOH. *"There was definitely an incredible arrogance in the DOF and they viewed themselves as a kind of level above other government departments. And people came to them for approval, and they said yea or nay, and then the other people went back and they did things accordingly"* (health policy analyst). In contrast, the Zambian MOFED perceived itself to be too limited in capacity to become directly involved in health financing policy debates; in addition, it had confidence in a health ministry that *"had a vision, they knew what they wanted, it was all very well thought out"* (MOFED adviser).

The South African DOF's views, however, point to the final factor that gave Ministers of Health influence in both countries: the relative weakness of technical capacity within the health sector. The DHFE was established in South Africa only as part of the restructured national DOH in 1995 and only really became a functioning unit in 1996. The broader lack of understanding of financing issues within the DOH led the DHFE's staff to be treated as accountants who were merely responsible for managing budgets and were required to educate colleagues on financing matters, as well as to do analysis, through the process of policy development. The DHFE's lowly organisational position within the DOH also meant that its staff was not formally involved in the department's strategic decision making nor was the staff brought in to update the minister on policy matters on a regular basis. The limited number of relatively inexperienced DHFE staff was inevitably stretched almost beyond staff members' capacity in response to these various pressures and constraints, and their influence was linked to the sporadic support given to them by members of the health department's senior management team.

Like their South African counterparts, and despite the important roles they did play in financing policy change, the influence of this small group of highly committed pro-reform civil servants in Zambia was partly constrained by their limited numbers and limited expertise in health economics within the group. In addition, because they too did not have a policy champion who could articulate the reform programme in political settings, their influence was linked to the minister in power. A related dynamic that affected the influence of the pro-reformers was their position relative to the group of hospital managers who felt their status was threatened by the reforms. As noted, Mr. Sata sought to build a power base amongst this group during his time of office and, not surprisingly, the pro-reformers took a particularly low profile at this time.

Although analysts based outside government were also involved in policy processes in both countries, their influence was relatively limited. Their influence was greatest in situations where they worked within routine government structures and were, therefore, directly involved in decision making. In Zambia, TAs usually had full responsibility for taking pieces of work forward. This was partly due to the lack of capacity within the MOH, but their place in decision making also reflected the willingness of virtually all the long-term advisors to use their technical skills to further the vision of the health reforms. TAs, therefore, became trusted members of the government team: “*SIDA had people placed within the ministry, they were not functioning from outside and they were very much trusted and seen as part of the team*” (former technical advisor). However, the acceptance and status of expatriate advisors in Zambia varied between ministers, as the status of their Zambian colleagues also waxed and waned. In South Africa, only one or two expatriate analysts played such roles within government, and external analysts were more often drawn into policy development through special structures. However, even from this position, their work had little immediate influence in South Africa or Zambia, again, in part, because of the lack of a policy champion within government that would take their policy recommendations forward (Section 4.4).

4.2.3 Conclusions

The following conclusions were drawn regarding the influence of actors over policy change:

- > Three sources of influence were particularly important to the most influential actors in each country: political status, formal policy position, and values/behaviour. In contrast, technical knowledge was relatively unimportant.
- > Ministers of Health are inevitably powerful within policymaking by virtue of their formal positions. This power is, however, strengthened when charismatic and tactical personalities fill the post and during times of political transition when other actors have relatively weak positions. Other health reformers must always consider the position of the minister, develop effective strategies for working with him or her, and take account his or her concerns.
- > Economic policy makers always have an interest in health financing policy. Their power may be harnessed in support of policy change within the health sector if health policies and philosophies are congruent with their own. Health reformers can strengthen their own position in relation to economic policy makers through the development of credible technical arguments, and they must also consider when and how to engage policy makers in policy development.
- > The influence of health analysts is strongly dependent on the presence of a policy champion at the political level (for internal analysts) or within government (for external analysts) who

can translate their analysis into policy action. When technicians have limited influence, politicians are likely to have more power. To enhance their role, technicians need to develop strategies to heighten perception of their technical competence and their position within decision-making processes.

4.3 Engaging Actors in Developing Policy Options

Actors' roles within, and influence over, policy debates can also be shaped by the way in which they are brought into policy development. Thus, the extent to which actors were inserted into decision-making processes in both countries, as well as their potential to exercise power outside existing structures, had a strong bearing on their influence over policy actions. The general weaknesses of the strategies used in resource mobilisation policy development in both countries offer experiences to illustrate these general points. The South African experience is particularly rich in this respect – perhaps because of its repeated attempts to develop an SHI policy over the period of focus.

4.3.1 The Strategies Used to Involve Key Interest Groups

Although some attention was given in both countries to the need for actor alliances to support change, pro-reformers did not sufficiently think through which interest groups they should work with, which they should oppose, and how best to co-opt support or offset opposition. As a result, the extent of involvement of some groups, including some possible opponents of change, may have given them too great an influence over the process, thereby slowing down the process of change or even generating opposition to it.

South Africa

Table 4.4 outlines the strategies applied over time to the three actors who had particular influence over SHI debates in South Africa: one internal government actor, the DOF, and two actors outside government—the trade unions and the private insurance industry.

The Health Care Finance Committee (HCFC) and the Committee of Inquiry (COI) had the broadest representation of different groups, whereas the SHI Working Group was a much smaller, primarily technical body. Despite the former minister's publicly stated concerns about the private sector, the Representative Association of Medical Schemes (RAMS) from the private insurance industry was deliberately invited to participate in both the HCFC and COI. During the HCFC, perhaps rather naively, all members were invited only in their personal capacity rather than as representatives of the group from which they came. In contrast, the COI actively sought representation from key interest groups (including employer groups) in an attempt to develop a set of proposals that had wide support. RAMS' involvement was seen as particularly important in offsetting the industry's potential opposition to SHI proposals that would benefit the public sector. Through COI's direct engagement with the private sector, some suggest that it was "*able to present the philosophy in a consultative manner and it won the hearts and minds, as it were, of the [private sector] constituency of the time*" so that "*when the documentation came out...the medical schemes movement was generally one hundred percent behind it*" (committee member, interview data). In contrast, the trade union movement was not represented on either the HCFC or the COI, despite its broader political importance and potential role within a pro-reform alliance. The DOF only participated directly in the 1995 COI, making its opposition to various proposals, and particularly to the notion of an earmarked tax, very clear. It was the only one of the three key actors to be formally consulted by the 1997 SHI Working Group.

Table 4.4: Engaging Key Actors in Formal Policy Structures, South Africa

Actor	Strategy of Engagement by Committee			Actor Position on Policy Proposals
	Health Care Finance Committee (HCFC) 1994	Committee of Inquiry (COI) 1995	SHI Working Group 1997	
Department of Finance	not yet active	representation	consultation	opposed
Trade Unions	none	consultation	marginal consultation	generally unclear, but opposed 1997 proposals
Medical Schemes (specialist, health insurance)	personal involvement	representation	consultation only through medical schemes regulation process	broadly supportive
Life Assurers (offering profit-making health insurance products)	n/a	n/a		opposed

The overall weakness of these differing strategies of actor engagement is evident in the failure to develop an adequately strong alliance of pro-reform actors with political influence in support of any one set of SHI proposals. The private insurance industry's support, particularly for the earlier SHI proposals, was ultimately not enough to counter opposition from the DOF, the trade unions, and the former Minister of Health. This failure ultimately reflected weaknesses in the functioning of the special structures and in the political skills of the analysts working within them. For example, there may have been no need for private sector *representation* in policy development structures. The successful implementation of the 1998 Medical Schemes Act rested, instead, partly on a process of deliberate and careful *consultation* with the private insurance industry that exploited disagreement within the insurance industry towards its regulatory proposals (with the medical schemes supporting them and the life insurers opposing them). Yet, although most SHI proposals reflected consideration of political acceptability, there was little systematic analysis of stakeholder views as an input into SHI policy development. The COI, for example, was criticised by some for making glib assumptions about how the unions would respond since no one on the committee had detailed knowledge of industrial relations' issues. The SHI Working Group's strategy of seeking to offset DOF concerns by adapting design to respond to its criticisms backfired because ultimately it did not gain DOF support and, at the same time, it promoted the trade unions' (and the then minister's) opposition (Section 4.5). In contrast, DOF opposition to the 1998 Medical Schemes Act was countered by the Medical Scheme Working Group's recruitment of Dr. Zuma's personal support for the bill when it was discussed in Cabinet.

Zambia

Such matters of strategy concerning actors were less clearly identified as an important feature of resource mobilisation policy development in Zambia. A key reason seems likely to have been the general support among a range of actors, including MOFED, for the main thrust of the Zambian health reforms. Political support for the chosen policy option was already in place. In addition, the ministers' dominant influence over the process perhaps meant that limited attention was given to strategising around other actors.

Wide-ranging support for the reform agenda is evidenced by the fact that, despite some tensions, even donors formed an early alliance with mid- and high-level reformers in the MOH and CBOH in supporting policy change. On some occasions this alliance deliberately worked together to offset constraints on the reform agenda imposed by the domestic political environment. For example, when the government moved too slowly, reformers turned to donors to provide external pressure to support the decentralisation of funding to the districts. Donors, therefore, implemented basket funding to districts in July 1993, providing a background of experience to spur government action. In the words of a former MOH official:

“We, and by we I mean the Ministry of Health and the donors, had a series of meetings at which we decided that we needed to demonstrate to the MOF that putting money in the district was a better alternative than controlling money from the headquarters in Lusaka. So we decided that the donors themselves were going to initiate the budgeting of funds directly to the districts.”

The substantial interest that the reforms generated among the donor community, and the consequent funding that came into the Zambian health sector as a direct result of the reform programme, also helped to bolster broad political support for reform over most of the period of analysis. There were signs, however, that over time, particularly as the reforms became higher profile, that there would be more competition between donors and less willingness to be guided by Zambian ideas.

“So there has been a shift, and I wouldn't say that the Zambians are being pushed around, but I think they do have less leeway and that the amount of in-fighting amongst donors was never there before; everyone was supporting the process that was going on and they still are in the sense that they will all say that they are committed to the Zambian reforms but there is more territorial struggle going on between neighbours [donors] than there was before” (former technical adviser).

This territoriality went hand in hand with increased concern within the donor community about the need to consolidate existing reforms by refocussing health care services and health care practitioners on service delivery issues. A different alliance of interests was then established to slow down reform. The minister at the time, Professor Luo, picked up the donor concerns, perhaps to bolster her own reservations about the reform programme, and then deliberately slowed down reform implementation. She not only delayed the finalisation of the financing policy document, but also introduced changes in some of the organisational structures, such as the CBOH, that were central to the reform agenda. Given their reliance on ministerial support, the pro-reformers were unable to offset this new donor/minister alliance.

The pro-reformers' limited attention to issues of strategy also can be seen in relation to the group of hospital consultants and managers. As noted in Section 4.2, this group largely opposed the reform programme, but their influence waxed and waned with ministerial changes. Initially they were ignored in policy development when the health reform implementation team (HRIT) was formed to guide and support district development. Hospital consultants considered members of HRIT to be

their juniors, however, and this caused problems, as Dr. Kalumba noted. He saw the way in which this cadre was developed as a “*strategic mistake*” because it caused jealousy between the two groups and promoted the hospital-based staff’s opposition to the reform program. The HRIT was given prestige and rewards, thereby promoting the hospital-based staff’s opposition to the reform programme. Although hospital managers were eventually brought into aspects of policy development, the nature of their involvement gave them influence despite their broad opposition to the reform process. For example, they were directly involved in the 1997-1999 process of developing the health care financing policy, and this involvement helped to delay its completion when they introduced objections to specific elements of the policy that touched on hospital financing (such as the fact that hospitals could not charge fees for referred patients). Initially the development of the policy

“...was seen as being fairly straightforward; it wouldn’t be that difficult to come up with a financing policy that everyone could agree on. But, after some time, say November-December when we came into the final draft discussions, when it was actually a document with proposals, the organisations that were affected maybe started looking a bit more thoroughly at the content of the policy, and then it became a bit more controversial” (technical advisor).

4.3.2 Using Special Structures to Involve External Analysts

In both countries resource allocation policies were developed and implemented through the structures routinely involved in budgeting processes. In South Africa, budget and resource allocation issues quickly became a regular and central focus of debate within the new structures established to bring together the national and provincial Ministers of Health and the heads of health departments at national and provincial levels. Several other structural mechanisms also evolved to allow more effective debate of the issues between civil servants in the health sector and those working within the DOF and provincial treasuries. In Zambia, the budget cycle linked the Planning Unit and Principal Secretary of the MOH with MOFED colleagues, on the one hand, and the CBOH and district and hospital boards on the other. Even TAs from outside the countries played a role in resource allocation policy development because of their involvement in these budget structures.

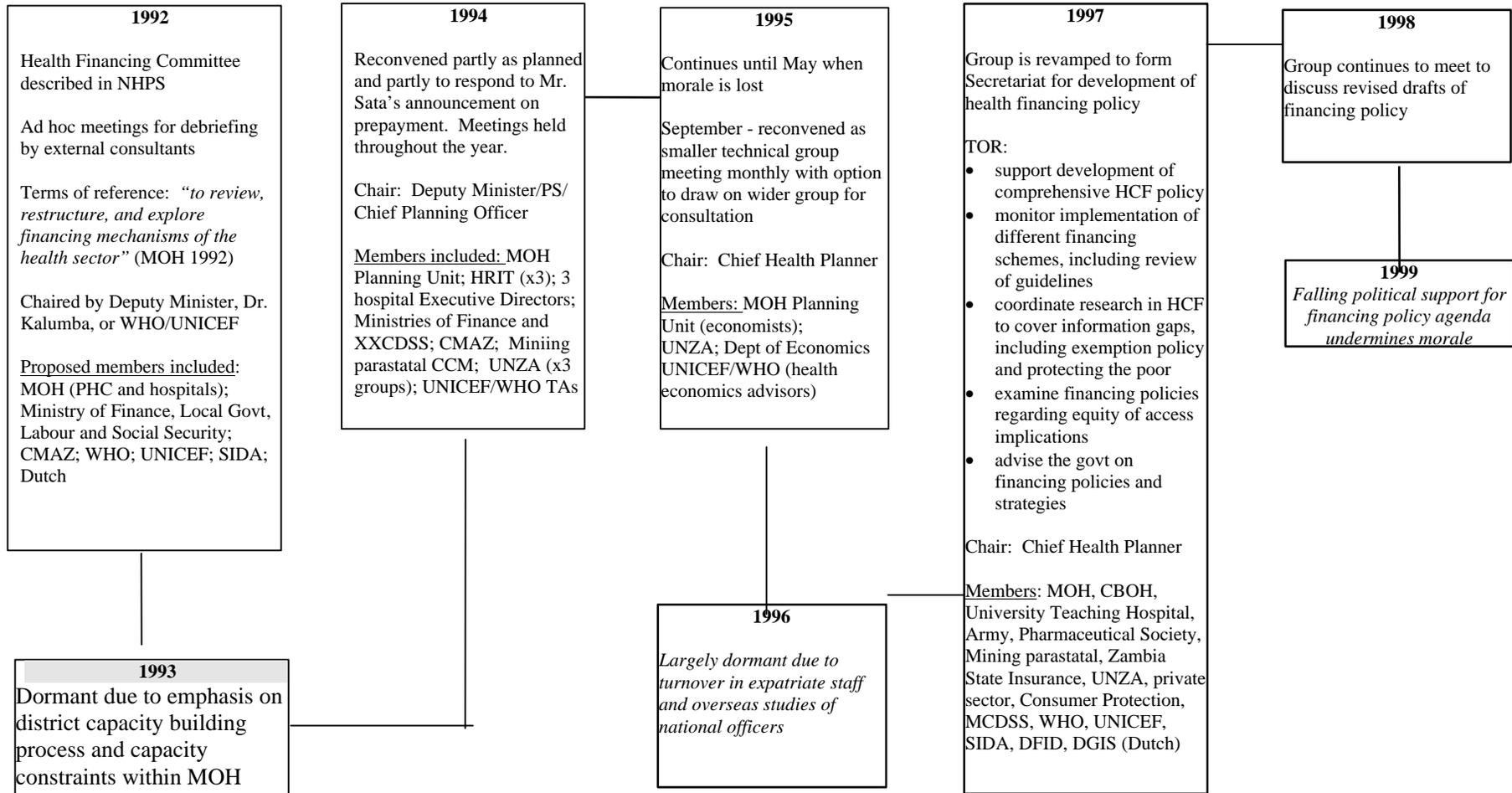
In contrast, neither country had internal government structures through which new ideas on resource mobilisation policy could be developed easily, and the internal government capacity to undertake such analysis was, in both cases, limited. Instead, special structures were established – the three special committees that considered SHI policy in South Africa and the HCFWG in Zambia – for the purpose of drawing external analysts into the process of policy development. However, none of these structures were effective in harnessing technical advice in support of policy change during the period of focus. Rather, their products were apparently ignored or overlooked by policy makers. Although their work may feed more indirectly into policy change over a longer period of time, the minimal direct impact these structures had on policy change represents a missed opportunity to bring political and technical resources together.

Country Structures

In Zambia, the HCFWG had its roots in the financing study group proposed in the early MOH policy document (Kalumba 1991). Its remit was quite broad as arguably the only formal process for overseeing the development and implementation of health financing policy reform, but it varied considerably in focus over time (see Figure 4.1). Growing out of the informal gatherings of MOH officials, Zambian academics, and TAs/donors who met to review the early work undertaken by the

Planning Unit/UNICEF/SIDA in the late 1980s, HCFWG met on a largely *ad hoc* basis during 1992. It served primarily as a forum for the debriefing of visiting consultants and brought together a range of stakeholders from the government, nongovernmental organizations (NGOs), and the private sector. Largely dormant in 1993 due to the absorption of the limited number of central technicians within the district capacity building process, it was reestablished in 1994 and met regularly to discuss policy options around prepayment and exemptions and to undertake early work to develop a comprehensive financing policy. Attendance waned over time, however, and towards the end of 1995 it was revamped as a smaller, more technical group. A further turnover among expatriate economists meant that HCFWG was again dormant until the process of developing a comprehensive health financing policy document restarted in earnest in early 1997, when it took on the role of coordinating inputs to that document. That process stalled, however, and the HCFWG rarely met in 1999.

Figure 4.1: The Evolution of the Zambian Health Care Financing Working Group, 1992-1999



The first two South African committees (HCFC and COI) were relatively large, each having more than 10 members drawn from various groups, and they were established by the DOH with wide-ranging terms of reference but only a short lifetime (several months). HCFC tackled SHI, user fees, resource allocation, and aspects of human resource policy; COI was charged with developing proposals for how to fund an expanded and strengthened public primary care system. In contrast, the third committee, the SHI Working Group, was much smaller, with six members, more “internal” to the DOH, and focussed purely on the development of SHI proposals⁶.

Factors Influencing the Effectiveness of Special Structures

Although each of the three South African committees had a different primary purpose (see Table 4.5), the first two were clearly primarily driven by the political needs of the new policy makers. HCFC was tasked with considering the same set of financing issues previously discussed in the ANC Health Plan, working as an advisory, rather than a policymaking body. While the analysts complained that this was “*reinventing the wheel*” (committee member), the process was strongly driven by the political objectives of the new minister: “...*for the better part of the debate she [the minister’s special adviser] didn’t bother about the technicalities. She had a political objective, she wanted to see clever people deliver the mechanism, but at the end of the day she wanted to know that the political objective was achieved*” (committee member). In pursuit of this end, as Table 4.4 indicates, various explicit steps were taken to shape the design and functioning of both the HCFC and COI. For example, membership of both was controlled, a senior ministerial advisor was appointed as cochair to the COI, and efforts were made to define the terms of reference of each committee in ways that reflected the political goals and needs of the “new” policy makers. In contrast, technicians from the DOH established the SHI Working Group as a much more focussed, low-profile body. Nonetheless, its terms of reference were also adopted to reflect the concerns of the then Minister of Health.

⁶ There were two other special structures involved in health financing policy development between 1996 and 1999. The ‘Hospital Strategy Project’ was paid for through European Union funding to the national DOH and implemented by a consortium of four consultant and academic groups. Over a one-year period, it undertook a broad review of management and resourcing in the public hospital sector, including specific assessment of the public hospital fee structure. The 1997 Medical Schemes Working Committee was, in contrast, a three-person working group that developed the 1998 Medical Schemes Act.

Table 4.5: Factors Shaping the Special Committees' Design and Functioning, South Africa

Mechanism	Health Care Finance Committee 1994 (HCFC)	Committee of Inquiry 1995 (COI)	SHI Working Group 1997
Primary purpose	advisory/technical (range of issues)	consultative/political (systemwide reform)	policy development/technical (specific proposals)
Selection of the members	members picked by Minister/Special Adviser (*)	members picked by Minister/Special Adviser (*)	members picked by Health Financing and Economics Directorate/Deputy Director General
Selection of chair	chair picked by Special Adviser (*)	Special Adviser (*) picked as cochair (with nongovernment analyst)	by Deputy Director General
Framing of issues in the terms of reference (TOR)	broad TOR	attempt to limit TOR defeated by technicians, but DOH agenda (universal access) made clear	TOR focus on SHI based on public hospitals but also tasked with reassessing some other issues
Report publication	original report to Minister alone (and only made public some time after submitted, and after press leaks)	draft report made public for comment and then revised before final release	no official publication of report, but version of report published on the internet
Access to Minister	through Special Adviser (*0 only, no direct access	through chairs only, no direct access	through Deputy Director General only, no direct access
Acceptance or Rejection of Findings	free primary care accepted, SHI recommendations largely ignored	free primary care accepted, other recommendations largely ignored except by other analysts (which influenced medical scheme regulation proposals)	accepted by provincial Ministers of Health, but rejected by 1997 ANC conference and remain unimplemented

Note: On moving into office in 1994, the then Minister of Health appointed two special advisers to assist her in the process of restructuring both the health system and the Department of Health. One who was directly involved in these committees went on to become the first Director General in the DOH.

Perhaps the most critical factor shaping the effectiveness of all committees was the lack of interaction with the former minister. Although senior advisers reported the committees' deliberations to the minister, Dr. Zuma never met with the committees themselves despite their requests for such interaction. This lack of interaction undermined the functioning of all committees and, in the end, only those aspects of the committees' recommendations that fitted Dr. Zuma's own policy preferences – and, specifically, free primary care – were taken forward into policy action.

In part a reflection of the nature of special committees divorced from routine decision-making processes, the lack of interaction also seems to have reflected the former minister's growing distance from the external analysts involved in the committees. Perhaps the root of the problem lay partly in these analysts' assumption that the health care financing policy agenda for the new government had, in effect, been established through the ANC's National Health Plan. Some of them had played central roles in developing the financing proposals of the plan and, therefore, may have assumed that the new government's first steps in this policy area would be to develop more detailed designs and implementation plans. In contrast (and unlike what happened in Zambia), those who became the health policy makers of the new government had had little or no engagement with the pre-1994 financing debates and brought different understandings to the post-1994 debates and specific political goals. As one analyst commented, "A huge issue which underlies recent history is to do with that kind of break point, of 'outsiders' being appointed to the top... positions [in the DOH] and really having to start again because they didn't really trust the people or the work that had been done." Perhaps because they assumed that they were the natural allies of the new government in this policy area and they shared an understanding of how SHI could contribute to their common goals, the analysts neglected to develop the political support necessary to justify and enable the more detailed technical work that was the major focus of their input to SHI policy development.

One health policy analyst described the resulting "stalemate" between these two sets of actors over SHI, from the perspective of Dr. Zuma, in the following words:

"...a serial experience of putting this [SHI] back to experts, whomever they be – at times they change the composition of the team – and they keep coming back with stuff she doesn't like. So what I think has happened as a result is that she's increasingly developed a distrust for technical experts and even for a large numbers of her officials for, as they've been in the job they've learned the job – they've gone native – so to speak, they've gone along with what the technicians have said."

At the same time, from a different analyst's perspective, the experience was very frustrating because:

"you could go on analysing the options until you're silly – there's so many options, so many directions that you could go in, that you need say here, in concept, we've got a direction, can we get agreement that this is the way to go, so we can actually analyse the detail of the option – but until somebody actually gives you a go ahead, there's no point doing any further analysis, or going into any depth, it's a complete waste of time because enormous amounts of work will be cast away at one decision."

Although the last description of the SHI policy development process appears to suggest that this analyst felt that its critical weakness lay with the failure of senior policy makers to provide adequate guidance, it also points to a critical weakness on the part of the analysts who "concentrated on policy and forgot the power and the politics" (policy analyst). In assuming they would have political support, they failed to take into account the minister's concerns and thereby ensure such support.

In Zambia, former members of the HCFWG also overwhelmingly identified the distance between the minister and external analysts as the key reason for its lack of effectiveness in influencing policy direction and implementation during the period 1994-1996 (see Box 4.1)⁷. It was

⁷ A similar distance was also identified as limiting the impact on policy of short-term consultants brought in by donors to support financing policy development. For example, sometimes their thinking was not adequately in tune with that of Zambian reformers.

“outside of the power structures.” In addition, its role was undermined by the personalities of individual ministers and, in particular, the personal relationship between Minister Sata and Deputy Minister Kalumba. The impression among the technical staff and advisors was that the HCFWG was seen as Kalumba’s “baby” and therefore was not respected by Minister Sata. Indeed, Sata established his own parallel advisory group on prepayment, involving primarily the executive directors of several large hospitals, and this undoubtedly reduced the influence of the HCFWG. Despite meeting regularly and involving a number of senior policy makers, local academics, and representatives of the private sector, members of the HCFWG at this time generally felt impotent and frustrated.

Box 4.1: Former Members’ Views on the Lack of Effectiveness of the Zambia HCFWG, 1994-1996

“I think the environment in which the Financing Working Group was working was not the type that would respect the approaches. The approach of the Financing Working Group is to discuss through issues, to structure, and to introduce them stepwise. We have had four changes of minister, and in all cases, the ministers at the top were not process people. They were immediate result kind of persons...” (former MOH/CBOH official)

“The driving process behind the technocratic process was the health reform process with which it was moving in tune – since the Financing Working Group was an integral part of the HRIT. The political process was driven by who was Minister of Health at the time, and quite often made no reference to the technocratic process.” (former MOH official)

“One negative thing was, nothing to do with the [HCFWG] as such, but I think there was too much interference from the Ministry. The whole reason why it sort of flopped was the Minister [Sata] trying to interfere, so yes, I think that was sad.” (Zambian academic)

“The health care financing group was not given the mandate it should have had to serve as a useful advisory group and to develop and propose a health care financing policy.” (former long-term TA)

After Dr. Kalumba was appointed minister, the HCFWG was reconstituted and reactivated in 1997 to oversee the process of developing the official health financing policy. Although broad terms of reference were developed and agreed on, as shown in Figure 4.1, the group primarily concentrated on one element of the TOR, i.e., review of the successive drafts of the health financing policy. Early on in the process (between June and September 1997) small working groups, involving people not formally members of the HCFWG, were established to draft or redraft particular parts of the policy. But during 1998, separate working groups were established within both the MOH and CBOH to look at specific issues without any overall coordination from either the ministry or CBOH. Although there was some common membership in these groups, there was no formal recognition of the role of the HCFWG as the overall coordinating and advisory body seeking to ensure cohesion and comprehensiveness in the area of financing. As the change in ministers sidelined the broader health financing policy development process, the central purpose of the meetings evaporated:

“... it felt like that development of financing policy was a high priority, something that needed to be done fairly urgently, and therefore they had meetings maybe every three weeks or so, between the workshops, and then also for some time after the second workshop in September. After that, other things became more important I think to the Ministry, and the Ministry is still the coordinator of the working group, so things were sort of left a little bit, or it took longer” (TA).

Two final sets of factors also influenced the effectiveness of the South African committees. First, as the external analysts concentrated on offsetting the proposals apparently preferred by the minister, they inevitably gave less attention to the development of a coherent set of SHI proposals that could generate a critical mass of support. Second, aspects of all three committees’ operations appear

to have prevented the analysts from thinking through their strategies. In contrast to the SHI Working Group, both the HCFC and the COI were weakened by significant disagreements among members. In the HCFC these were rooted in the pre-1994 debate between those who favoured a NHS and those who favoured SHI, while in COI there was simply a wide range of actors with very different interests represented. There was also considerable tension in both committees over an international economist's proposals, which, although they caught the minister's eye, were opposed by South African analysts. At the same time, different people in each committee were tasked with undertaking specific analyses and reporting back to the main committee. Given the time constraints, these analyses were inevitably rather rushed and limited. In each case, therefore, there appears to have been little opportunity and/or attempt to review the broader policy picture and develop clear lines of argument on the basis of the analyses undertaken. As one analyst noted, they could not "*see the woods for the trees.*"

Operational problems, such as the failure to clearly define the role of the HCFWG and how it should relate to the MOH and CBOH, also undermined the effectiveness of the Zambian HCFWG. The fact that it did not have an agreed role or place within the newly defined organisational structures meant that it was easier for policy makers to bypass the group, if they chose to do so, even though it was consistently the main repository of health economics and financing skills in the country. In addition, its internal functioning constrained its work, particularly during the process of developing the comprehensive financing policy document. For example, some of the technicians involved in working groups supporting the document's preparation were not also involved in the HCFWG's own meetings. Also, there was a constant pressure to deliver quickly, and some technicians believed that led to decisions without supporting evidence and pressure to develop consensus among the group's diverse members rather than identify and tackle the very different perspectives among the group.

4.3.3 Conclusions

The following conclusions were drawn concerning strategy for engaging actors in developing policy:

- > The potential influence of actors over policy processes requires that those seeking such change always consider whether actors are likely to support or oppose the proposed change and they develop strategies that build alliances of support for change.
- > Even where political support for change is quite extensive, reformers need to be vigilant in identifying interest groups whose opposition, if mobilised, could block or delay reform.
- > Careful thought should be given to if and when to allow potential opponents to participate in policy development, but some consultation with opponents is likely to be desirable.
- > Policy development structures established on an ad hoc basis to offer support to policy development will only be effective if they have adequate political support and a policy champion within government is identified to move the work forward.
- > In developing such structures, attention should also be given to factors that influence their operational effectiveness (such as chairing style, differences among members, and time available).

4.4 Engaging Actors in Policy Implementation

As with the process of policy development, the strategies through which actors were engaged in implementation activities had a critical influence over the patterns of policy implementation and their impacts. The Zambian experience is particularly rich in this regard as it not only offers the experience of implementing changes to resource allocation policies but also various experiences of implementing resource mobilisation policies.

4.4.1 Overall Policy Development

The coherence of the overall policy framework within which reforms occurred had an impact on the progress of implementation. A key element of the Zambian health reform experience was the establishment of a vision as a guide to action and a source of inspiration to many of those involved in the reforms. This vision was then captured in the NHPS and the Corporate Plan.

“When I took over the Ministry of Health, it was really like being in a jungle, it was like somebody parachutes you into the middle of some tropical rainforest and you really don’t know what to do. Did you begin by bringing in more drugs, improving the conditions of service, retraining people? You know, it was a jungle of problems, and my feeling at this point in time was one needs a compass...we need a map, we need a road map, to guide us, ok. And this compass or road map was really what we thought the reforms were all about” (former Minister of Health).

In some respects, the ANC Health Plan may have offered similar guidance to the South African reformers, and certainly many of its elements were the subject of implementation or debate after 1994. Yet it was not used as a clear vision to guide implementation, and its translation into an official government document was also a much slower process. The White Paper for the Transformation of the Health System took three years to publish, and by 1999 the government had still not passed the National Health Bill through parliament. Although this did not preclude a wide-ranging programme of policy change being implemented in South Africa, it may have encouraged a rather piece-meal approach to implementation (Section 3.2). In addition, the failure to establish the legal basis for the restructuring of the health system by the end of the government’s first term of office may have limited the effectiveness of all policies, including financing change.

Although the Zambian reformers were strong on vision initially, over time they encountered problems in translating this vision into reality – particularly in relation to health care financing. A number of Zambian health officials mentioned in interviews what they perceived to be an increasing tendency in the reform process to get bogged down in discussions of policy. As policy makers examined one particular issue more deeply, it fragmented before them and gave rise to a chain of associated policies. This might explain the proliferation of small working groups tasked with different aspects of financing policy development. Yet, at the beginning of the reform programme, policy documents served to set out a vision and build consensus. At that point, policy makers tended to be more concerned about just getting something off the ground, rather than perfecting the whole policy. These early policy documents were viewed very much as working documents that could be amended as experience on the ground was gained.

“And what we were also conscious of was the fact that this reform process, these health reforms have to be dynamic, because the challenges, the problems that you’re facing are dynamic, you can’t approach them with a nondynamic or a static programme. So we actually expected continuous refinement of the reform process. After all, we’re beginning with a set of ideas which we actually don’t know whether they will stand the test of time in the field” (health official).

In contrast, the health financing policy document developed between 1997 and 1998 perhaps aimed to achieve too much – and more than in many other countries. Although the small group of committed reformers was able to manage the policy development process initially, as implementation progressed, so did the number of policy agendas that needed to be debated and agreed. Frequently, there were not enough knowledgeable people to carry forward all the policy agendas at any one time. Given the increasing complexity of policy documents and the limited capacity to work on such policies, a more selective approach was needed in choosing which policies to work on. Yet policies that gained precedence were not necessarily those that addressed areas commonly seen to be the highest priority. Rather, choosing policies to develop was probably influenced by donor support and financing, as well as the presence of individuals with both the technical skills and the interest to take policy development forward. Thus, the lack of economic expertise inside government probably reduced the likelihood of work being done on financing policies.

Some external observers argued that the problem was not so much one of too much time spent in policy discussions but rather too little time discussing key aspects of the overarching reform framework, leading to lack of clarity on specific aspects of reform:

“With the health care financing policy during the time I was in Zambia, I think many decisions that should have formed parts in a health care financing policy were rushed and introduced in a somewhat ad hoc way without the necessary evidence at hand and a comprehensive policy was therefore never really developed. The process was led by ad hoc decisions and rushed implementation of various parts of a financing policy that did not exist and could not be developed as the direction was changed and new decisions and new policies were implemented all the time” (technical advisor).

This view also hints at a further problem for policy development. As time progressed there was an ever-accumulating history of reform, which circumscribed future reform options, or at least created significant opposition to certain reforms, such as that of hospital managers to the proposal that hospitals should not charge fees to patients who have been referred from lower levels of the system.

4.4.2 Leadership and Central Capacity

Strong political leadership was a second strategy affecting the pattern of policy implementation. It was not only important in prioritising particular financing policies in both countries, but at the same time, it created obstacles to implementation. In South Africa, Dr. Zuma’s overall management style, for example, represented a weak approach to policy implementation. Described as *“the combat mode of progress: advance now and count the casualties later”* (Gevisser 1996: 33), it not only provoked opposition from groups that might have been prepared to support particular policy changes, but also undermined the communication and planning that could have eased implementation. In Zambia, politicians sometimes used the health sector reform programme more for their personal goals rather than to support needed change.

A further leadership problem experienced in South Africa was the national DOH’s failure to think through how it could support provincial health departments to implement policy changes. For example, some of the actions that were required to support the removal of fees, such as ensuring adequate drug availability across the country, required coordination across provinces while other actions, such as permitting nurses to prescribe drugs, required changes in national regulations. *“It would have been good for the national level to have identified those policy issues and just changed them – changed the regulations, just do something to make it easier for provinces. The support we could get from the national level wasn’t there”* (provincial official).

A second aspect of the national DOH's weak leadership for implementation was its failure to set priorities over the 1994-1999 period. Understandably, the former minister and the DOH took advantage of a window of political opportunity by speedily implementing new policies with political value, such as free care. In doing so, however, they precluded the planning that would have eased their implementation and overlooked some of the basic changes required within the health system as a foundation for further, more substantial change. The very slow progress in tackling public hospital management problems will, in particular, continue to constrain further health financing and system change after 1999.

In both countries the scarcity of skilled health staff, particularly in the field of health economics, was one of the key factors contributing to the substantial influence of ministers. At the simplest level there appeared to be too few people in the Zambian MOH and CBOH who fully understood the more technical dimensions of health financing reform. As noted above, this constraint became more evident as the reforms progressed and the number of areas in which solid technical input was required increased. Similarly, in South Africa, *“it was clear that the few people with extensive technical skills, as well as skills in strategic planning and management, were being stretched to their limits by the demands of health departments. It was also clear that most planners were preoccupied with the business of managing daily problems and were less concerned with issues of long-term strategy”* (health policy analyst).

The internal functioning of the South African national DOH only exacerbated the capacity problems in that organisational divisions separated technicians working on the same sets of issues. For example, the Directorate of Health Financing and Economics was distanced from the discussions of hospital fees and revenue retention that were taken forward by the unit responsible for hospital planning issues. Yet, at the same time, the Directorate coordinated the development of SHI proposals that could only be implemented on the back of improvements in hospital billing systems and revenue retention. One official commented that, *“The biggest problem is not knowing what another chief directorate is doing and either leaving gaps in work or duplicating work, so, communication about what we are doing is still a problem”* (national health official). Some of these problems were addressed over time, particularly as the national DOH team developed skills and experience and became accustomed to working together. In 1999, new organisational structures and working relationships were established within the national department to facilitate greater coordination amongst those working on different aspects of the same broad area of policy.

4.4.3 Consultation and Communication

A further factor influencing the practice of implementation and its impacts was the degree and nature of consultation and communication conducted. The Zambian Ministry of Health prided itself on the consultative nature of its health sector decision making over the 1990s. One former technical advisor described the typical consultative process in the following terms:

“Generally, most issues in the health reforms were developed in a very democratic way, which became typical for the Zambian health reforms. In a first step, an idea was born, either introduced by someone at the MOH or HRIT, or in some cases introduced by a donor. This idea was then discussed at the central level, i.e., within the MOH and HRIT. These ideas or concepts were thereafter introduced to representatives from the provider side, i.e., from districts, provinces, hospitals, and in many cases also involving representatives from other interest groups such as the CMAZ and sometimes the ZCCM [Zambia Consolidated Copper Mines]. In the next step, the policy would be finalised at the central level, with aspects and opinions from the other levels taken into account.”

This pattern of consultation is confirmed by other respondents and experiences. For example, during the process of finalising the early NHPS document, views were solicited from a broad range of players, both from within and outside the MOH, and from the central to district level. District health management teams (DHMTs) were also asked for their own views and to consult with and get feedback from other district and subdistrict stakeholders during the HCFWG work on prepayment schemes. Work on the health financing policy (1997-1998) followed a similar pattern but with more limited consultation with districts. Although the extent of consultation was generally quite wide, as Table 4.6 indicates, in some cases (such as the introduction of hospital prepayment) the intended processes of consultation were overridden by ministerial action.

Table 4.6: Consultation Processes for Selected Individual Financing Reforms, Zambia

Reform	Time Period	Process
Initial introduction of user fees	1993	Some discussion during district capacity-building workshops, but no formal meetings specifically targeted at soliciting views on this issue.
Introduction of hospital-based prepayment	1994	HCFWG discussion paper sent to all districts, but proposed implementation process overruled by ministerial decree. Ministerial decree based upon consultation with small advisory group composed mainly of senior-level hospital staff.
Resource allocation formulae reforms	1994-5	Discussion with district, provincial, and hospital managers about possible criteria for inclusion in a formula for each level. Figures based on formula presented to MOFED.
Health financing policy	1997-1998	Substantial consultation with different interest groups (e.g., insurance companies, donors, private providers, other ministries) through Kafue Gorge meetings. Less consultation with district and hospital level staff. No consultation with user population.
Cost-sharing guidelines	1997-1998	One large consultative meeting with health care providers from all different levels of system, community representatives, MOF, Ministry of Community Development and Social Services, etc., then guidelines circulated to all districts for comment prior to finalisation.

In general, the *Zambian* experience contrasts with the *South African* experience in which there was limited consultation (primarily between national and senior provincial health managers). In the *South African* experience, *“the people who develop policies are not the people that develop budgets...They do them with very little recognition of the resource implications of the policies...Nobody has taken account that the provinces don’t have the skills”* (budget analyst). As a result, health workers expressed great discontent with the free care policies, which they perceived had been implemented without consultation or preparation and which, ultimately, contributed to an overall problem of poor morale. Despite some examples where provincial health departments did widen the process of consultation, health sector critics generally suggested that *“..there should be more substantive process; that complex reforms are often implemented in a scattershot manner, with little consultation and nowhere near an adequate level of planning and research or pilot programming”* (Gevisser 1996: 33).

Perhaps the greater barrier to the effective implementation of reforms in Zambia and South Africa was the process of communication. Several Zambian interviewees highlighted the lack of effective communication with health care workers and the general public regarding the reform programme in general and financing policies in particular (Box 4.2; Atkinson *et al.* 1996; Booth *et al.* 1995; Daura *et al.* 1998).

Box 4.2: Communication Problems in Zambia

“The users, the end users, they had very little knowledge about all this. All they were told is that you have to pay, you paid nothing yesterday, today you have to pay so much, so the consultation came very late” (Zambian academic)

“Another concern that the Financing Group had was the lack of information that was going out to people at district level. There was never any formal health financing policy. It was these ad hoc circulars that were sent out and there was confusion at that level as to what the policy was since nobody had explained about user fees being introduced at district level and sub-district level...no guidelines were given on how fees should be set, what type of fees should be set...” (former long-term TA and HCFWG member)

“More broadly, both in the financing and the institutional reforms, there’s been a real failure to communicate to two key groups of stakeholders: the public and the health workers, which was kind of surprising, given the efforts to make sure that the private sector was on board, that traditional practitioners were represented. And even looking at the financing policy now, I was struck when I thought about it, that there was no one from the regional level, no one from the district level, and no one from the health centre level who participated in any of the groups discussing the financing policy...” (former TA)

The Zambian MOH and CBOH used various approaches to inform health staff about policy changes and there did not appear to be any overarching communication strategy. In 1994 and 1995, an annual general meeting was held in Lusaka, where districts met to get feedback on their draft plans and to receive any additional information for the coming year. This was one forum through which reformers attempted to communicate changes:

“Towards the end of 1994 was the first time we had a national annual general meeting with all the district directors, and at that point they were given verbal guidelines on what the policy was and some ideas of how not to do it and some ideas of who should be exempted, but we were still working without any written document signed off by the PS. So we could at least be confident that everybody had had the same information but they were really under no obligation to take any notice of that.” (former long-term TA and HCFWG member)

Subsequently, interdistrict meetings took on this role. On other occasions, senior members of the CBOH or MOH travelled around the country attempting to explain and advocate reform strategies. For example, one CBOH official conducted a tour of mission hospitals in Southern Province to explain the rationale behind new resource allocation mechanisms that linked allocation to ideal bed numbers (based on population) rather than actual bed numbers. However, the failure to develop a comprehensive financing policy, and the delayed development of cost-sharing guidelines, undoubtedly adversely affected attempts to communicate central government policy to both health staff and the general population.

4.4.4 Sequencing Implementation

The relatively smooth implementation of new resource allocation formulae and the associated reforms in planning and budgeting in Zambia largely followed a rational sequence of events that facilitated implementation. Not only were they rooted in the original reform vision (notably

decentralisation and the prioritisation of peripheral services), but they were also integrated into routine government budgetary decision-making procedures. In addition, policy makers recognised the considerable problems of lack of capacity at the district level and developed a planned and phased approach to increasing district capacity. There were, finally, some attempts to refine the resource allocation formulae over time in the light of experience and new information, even if these efforts were perhaps less systematic than would have been appropriate.

In contrast, the sequencing of cost-sharing reform was much more problematic. In particular, the following occurred:

- > Circulars announcing that cost sharing was allowed preceded any broader framework setting out the principles for cost sharing.
- > Cost-sharing strategies were expanded prior to capacity-building measures to strengthen accounting for and managing cost-sharing revenues.
- > Prepayment schemes at the hospital were announced prior to a proper assessment of their potential being conducted.
- > Cost-sharing guidelines were formulated and disseminated prior to the finalisation of the overarching health financing policy.

Policy makers appear to have implemented changes when a need for change was brought to their attention, when they found the means to address an existing concern, or when change fitted their political needs. Thus, a critical difference between the implementation of resource allocation and resource mobilisation (cost sharing) policies occurred, as was summarised by a senior health manager:

“When you look at resource allocation, it ties in quite closely with the decentralisation programme. The cost sharing...the tendency is that it is by decree so that the minister issues a circular and activities pick up and because it is a circular, it goes everywhere at the same time, it means there is no attempt to build a process countrywide which can monitor or help introduce or whatever; I mean everyone implements it the way they understand it. Whereas resource allocation issues tend to be introduced in a structured manner.”

As noted in Chapter 3, the consequences of these differences between policy areas were, on the one hand, the development of a resource allocation formula that has promoted gains in line with its objectives and that has evolved in response to experience. On the other hand, the cost-sharing revenues have not been used effectively nor have exemptions been based on income, and there remains a general lack of understanding about cost sharing within the community. A key underlying reason for these problems appears to be the view that cost sharing was not part of the broader package of organisational reforms but a separate and parallel reform.

The South African experience is broadly similar, although reformers were inadequately prepared for the implementation of new resource allocation approaches and resource mobilisation policies. First, while resource allocation policy changes were effected through routine budgeting procedures, the equity problems for the health sector generated by the implementation of fiscal federalism were not tackled through relevant policy action. Indeed, it appears that the implications of fiscal federalism for the health sector were not adequately foreseen and addressed – perhaps because the huge contextual changes of the time constrained any form of rational planning. Second, although only two resource mobilisation policy changes were implemented in this period (the two free care policies),

they were both implemented without adequate preplanning in a speedy and top-down manner. Some preparatory analysis of the limited impact on revenue generation levels of the second free care policy was undertaken. However, neither policy benefited from formal risk analysis of issues such as the adequacy of available capacity and funding to respond to increased utilisation and the potential for resistance and even opposition. In addition, little consideration was given in the policy development phase to practical questions of implementation. For example, guidelines were not prepared to assist provincial DOHs in implementing either of the two free care policies, and reforms were implemented simultaneously across the country, without phasing or piloting.

The Zambian MOH has generally avoided piloting particular reforms. Although the reasons for this are not clear, they may have included the need to generate quick benefits through large-scale implementation, as well as the concerns that piloted activities would not be affordable on a national scale or might give the impression of political favoritism. Consequently, pilot implementation of financing reforms was conducted for only two aspects of reform: namely, decentralised district budgeting (1991-1993) and the exemption mechanism, the Health Care Cost Scheme (1995). While both were at least partially successful during the pilot phase, district budgeting was rapidly expanded to all districts, whereas the Health Care Cost Scheme had not moved beyond a pilot basis by 1999. On one hand, piloting and evaluating decentralised budgeting was applied as a deliberate strategy for gaining donor support and demonstrating to MOFED that such an arrangement would work. This in turn strengthened the hand of the MOH when it argued in favour of shifting all districts to a system of decentralised funding. On the other hand, evaluation of the Health Care Cost Scheme pilot was undermined by the difficulty of coordinating action between the Ministries of Health and Community Development and Social Services, which were jointly responsible for its implementation.

4.4.5 Monitoring and Evaluation

As noted in Chapter 3, a critical problem for evaluators of policy change in both countries is the dearth of relevant data. Annual reviews of budget allocations and, when possible, expenditure trends across provinces were conducted by nongovernment analysts in South Africa, and these did allow some reflection on the success of resource reallocation efforts. Yet, although two evaluations of the first free care policy were undertaken (Health Care Finance Committee 1994 and McCoy 1996) and both noted that inadequate consultation and preparation had caused problems in implementation, both appeared to be largely ignored by the DOH. The second free care policy had not been comprehensively evaluated by 1999, and, indeed, no government unit had by then been given particular responsibility for policy evaluation.

In Zambia, the resource allocation formula was initially implemented without any system of monitoring or evaluation being in place. Although substantial efforts were made after 1995 to develop systems within the MOH/CBOH to review disbursements to, and spending within, districts, the data were not always made public because of their highly political and sensitive nature. Indeed, the sporadic functioning of the Budget Steering Committee, which had formal responsibility for monitoring budgetary allocations, was in part a consequence of the political sensitivity of actual budgetary allocations, but obviously also, in turn, weakened the monitoring process.

In terms of cost sharing, although a monitoring and evaluation (M&E) plan was never integrated into the reform process, a number of evaluations of cost sharing were conducted (e.g., Booth *et al.* 1995; Kahenya and Lake 1994; Kalyalya and Milimo 1996; Kalyalya *et al.* 1998; Daura *et al.* 1998). The impact of these evaluations has depended partly on timing, and they often had little impact. For example, recommendations by Booth *et al.* 1995 suggesting that fees should be linked to drugs rather than less tangible aspects of service were made shortly after the very public abolition of fees for

drugs, and so they were ignored. Similarly, while the need to communicate the purpose and form of cost-sharing reforms to the general public was frequently identified in the recommendations of evaluations, its implementation was hampered by the lack of an overall financing policy and uncertainty as to exactly what should be communicated. There even has been little clear impact from a comprehensive and high-profile evaluation conducted during 1996, supported by the World Bank and UNICEF (Ministry of Health/World Health Organisation/United Nations Children's Fund/World Bank 1996).

4.4.6 Conclusions

The following conclusions were drawn regarding policy implementation:

- > The effective implementation of policy change requires that implementation concerns become a central element of policy development.
- > Clear vision and clear leadership are critical in establishing the foundations for implementation, and they must be backed by adequate capacity to develop and implement reforms.
- > Consultation and communication strategies must be developed to gain the support and understanding of groups (such as health workers and the public) that are essential in allowing implementation to proceed smoothly.
- > Sequencing the implementation of reforms in a structured manner is critical in moving from policy development to implementation, and must both respond to capacity limitations and at the same time seek to build further capacity.
- > Only by monitoring and evaluating policy change can problems in implementation be identified and tackled as part of the implementation process, but such action is always likely to be constrained by political sensitivities.

4.5 The Broad Influence of Policy Design

The design details of each financing policy of focus in both countries directly influenced the level and pattern of their impacts, and these are discussed in more detail in Gilson *et al.* 1999 and Lake *et al.* 2000⁸. This section instead examines the influence of goal clarity over policy design and impacts, how policy design impacted on actors, and the extent to which financing and organisational reforms were combined to promote equity and sustainability gains.

4.5.1 The Clarity of Policy Goals and Objectives

Across countries similar patterns emerge with respect to the certainties and confusions over the policy goals and objectives of different types of reforms. Both in Zambia and South Africa, a health

⁸ Although comparisons could be made of the experience of implementing resource reallocation mechanisms, the differences in the resource mobilisation policies of the two countries (SHI in South Africa vs. user fees and prepayment in Zambia) prevent direct comparison of their experiences.

sector resource allocation mechanism was implemented in order to promote equity, in terms of the geographical distribution of resources, with some concern for allocative efficiency (in the form of level of care reallocations). In contrast, the objectives of the different resource mobilisation policies of the two countries were much less clear. A meeting of the Zambian HCFWG in mid-1994 thus identified four potential objectives for cost-sharing policy, without prioritising them. The objectives were as follows:

- > Raise revenues by mobilising additional funds for the health sector
- > Promote efficiency by developing fee structures that would provide an incentive to use more cost-effective levels of care
- > Foster equity by allowing fee retention at local facilities, which would improve services and thus benefit poorer households
- > Create partnership between the users and providers of health services.

Not surprisingly, a 1996 evaluation of the Zambian health reforms noted that: *“The user fee policy in Zambia has been controversial and inconsistent, oscillating between considering charges as a cost-sharing tool for revenue generation and viewing them as an exclusive strategy to foster popular responsibility/involvement”* (Ministry of Health/World Health Organisation/United Nations Children’s Fund/World Bank 1996: Volume 1, page 19; see also Janovsky and Cassells 1996).

Similarly, a diverse range of objectives was associated with the various South African SHI proposals developed over the 1994-99 period (Table 4.7). Although concern for equity appears frequently in documentation, the exact nature of the equity goal being sought was seldom spelt out, and who would be the beneficiaries of improved services often remained murky. The 1997 SHI proposals ultimately proposed a lesser reduction in inequity than earlier proposals on the grounds that higher income earners were already unfairly required to pay both towards tax-funded and insurance-funded health care. At the same time, sustainability, in the form of revenue generation, appears to have become a more fundamental objective underlying these proposals. By not initially formulating clear objectives, it then became impossible to benchmark policies systematically to assess whether the changing design proposals still ensured that the original goals could be achieved. In effect, the complexity of SHI design may itself have diverted the proponents of the different proposals from systematically examining their likely impact on equity.

Table 4.7: The Changing Objectives of SHI Proposals in South Africa

Objective	The proposals of 1988-1989	The proposals of 1990-1994	The proposals of 1995-1999
Further the ideological aim of controlling the private sector, and creating a centrally funded system	Yes	No	No
Increase horizontal equity through expanding privately funded coverage of older, sicker, and poorer beneficiaries	Yes	Yes	Yes
Increase horizontal equity through expanding public sector coverage through diverting resources currently spent in the private sector (i.e., diverting premiums from medical schemes)	Yes	Yes	Yes for 1995 proposals; No for 1997 proposals.
Increase vertical equity through improving cross-subsidisation of the poorer by the richer	Yes	Yes	Yes (but to a much lesser extent in 1997 proposals)
Improve the cost-effective use of resources by creating appropriate incentives for the private sector (i.e., allocative and technical efficiency)	Yes	Yes	Yes
Find additional resources for the public health sector	Yes	Yes	Yes
Prevent unexpected and unnecessary burdens on the public sector, i.e., dumping	(only implicitly considered)	Yes +	Yes ++
Find a politically acceptable way of raising additional resources	Yes	Yes	Yes (very influenced by this need)
Pave the way for an eventual state-funded system	Yes +++	Yes ++	Yes + (extent of commitment unclear)

Note: The greater the number of +, the greater the importance of the objective compared to other proposals

4.5.2 Policy Design and its Influence over Actor Positions

Policy objectives, together with the details of policy options, are also important as they influence whether or not actors will support or oppose proposed policy changes. Policy design may, therefore, be adapted in an attempt to generate the support of particular actors or to offset opposition. Thus, the changing nature of the South African SHI policy objectives outlined in Table 4.7 strongly reflected the way policy design evolved to tackle the DOF's concerns. However, the difficulties of using design as a strategy of developing support are also clearly demonstrated by this South African experience.

First, despite the adaptations, the DOF remained opposed to the last (1997) set of proposals. It remained concerned that these proposals continued to represent simply another form of tax and would

lead to an increase in the national tax burden that contradicted the imperatives of the country's macro-economic policy. It also expressed concerns about the lack of conceptual coherence between health insurance proposals and other social security benefits, as well as specific questions about SHI. These questions included whether it effectively represented an unacceptable earmarked tax for the health sector, would raise the effective tax burden on what was identified as an already highly taxed middle income group, and would impose too great a burden on the government as employer given public spending restraints. Second, while seeking to offset the DOF's position, the policy designers nonetheless failed to tackle some of the then Minister of Health's abiding concerns with all SHI proposals. The minister consistently objected to the proposals because they would introduce "tiering" within the public health system, offering the insured a different level of care from the uninsured. Yet her own publicly stated "bottom lines" started with universal and nondiscriminatory access to quality PHC for all. Her concern about tiering also appeared to be associated with great caution about the direct role proposed for the private sector within most of the post-1994 proposals. Given that Dr. Zuma was said to regard making a profit from health care as repulsive, it is not surprising that her reaction to the SHI proposals of the 1995 COI was to ask, "*how on earth do we get people to buy the package through medical schemes which are falling apart, are very costly, and we don't even like them ideologically*" (government analyst, interview data). Dr. Zuma probably reflected concerns within the trade union movement regarding this issue. For example, the 1997 SHI proposals were specifically criticised because "*COSATU couldn't convince themselves that members should pay for services that they haven't paid for in the past*" (government official). In addition, the proposals may not have offered adequate levels of benefit to those insured.

The Zambian efforts to develop a comprehensive financing policy seem to reflect some similar experiences. First, a wide range of groups were involved in the discussions – including not only the representatives of large hospitals but also the faculty of private medical practitioners. Second, the process of developing the policy proceeded relatively smoothly during discussion of the broad outline, but became bogged down in discussion of the smaller details, which had clearer impacts on different actors (see also Section 4.4). A particular issue of controversy was the proposal that patients should only be charged once when entering the health system, preventing hospitals from charging a referred patient, and generating much concern over the potential impact on hospital income levels. The representatives of the large hospitals made their voices heard in these debates and the proposal was adapted to take account of their concerns. Yet the policy was neither finalised nor approved by 1999. As also noted in relation to user fees, their politically sensitive nature meant that they were "*never quite synchronised into the bigger picture because it's something that attracts attention*" (donor representative).

4.5.3 Reform linkage and policy impacts

In each country the impacts of policy change were influenced by the extent to which financing reforms were linked with each other, or seen as a combined package and linked with other policies necessary to support their implementation.

First, particularly in Zambia, there were limited links between individual financing policies. Thus, despite the levels of poverty within the population, cost-sharing policies were implemented without establishing an effective exemption mechanism for the indigent. In addition, a mismatch between prepayment premium levels and existing fee levels created perverse incentives. The lower premia level of the hospital prepayment scheme encouraged the bypass of less costly primary care facilities and promoted its use only at times of need, rather than as a risk-sharing mechanism (Atkinson *et al.* 1996). Similarly, the unimplemented South African SHI proposals gave little

attention to the need for links, for example, between revenue generation through hospital fee reform and SHI and resource allocation approaches.

Second, the links between financing and other resource policies were also inadequate in both countries. The impact of the South African free care policies on utilisation and equity and the translation of budgetary shifts among provinces into real shifts in human and physical resources were constrained by the slowness of implementing other policies to support primary health care. Geographic barriers, for example, continued to limit the access improvements resulting from removing financial barriers, and they were exacerbated by the problems resulting from greater levels of utilisation, such as drug shortages and long waiting times (although these problems also resulted from the pattern of implementation; see Section 4.4). The Zambia experience only emphasises the problem. The failure to develop an efficient drug system that would ensure drug availability in primary care facilities was a key reason for the population's dissatisfaction with the introduction of fees. The resource reallocation approaches of both countries also failed to adequately consider the need for supportive human resource policies. The two most critical constraints on South African resource reallocations were the negotiation at the central level of civil servants' salaries and civil service restructuring policies. The increasing wage bills that resulted from the centralised salary negotiations made it particularly difficult for provinces whose budgets were being cut as part of the process of resource reallocation to maintain spending levels in line with budgets. Continual overspending by such provinces may have undermined the achievement of overall resource allocation equity targets. At the same time, many of the most highly skilled personnel in these provinces were lost to the civil service by choosing to receive highly favourable voluntary severance packages rather than being encouraged to move to relatively underresourced geographic areas and facilities.

Third, the two countries' different experiences demonstrate the importance of linking financing policy change to relevant organisational change. In Zambia, the 1994 decision to allocate government funds directly to districts was an essential component of the decentralisation strategy, backing the intention to decentralise roles and responsibilities with resources. Establishing a more equitable approach to, and greater transparency in, resource allocation was an important component of this strategy. At the same time, the programme of decentralisation was spearheaded by major initiatives to strengthen district level capacity to manage the newly available resources: *"before 1993 [before decentralisation], we had no bank account, accounts office; we never kept registers and receipt books. Later on [under decentralisation] the issue of accountability came in and receipt books were printed, started developing systems, and things started to change"* (health manager).

Accounting departments at districts and hospitals were increasingly staffed by trained accountants and clerks, and their accounts are now routinely checked by CBOH technical staff. More broadly, there were changes in the whole culture of management at the health facility level leading to enhanced accountability for resource use in the face of considerable MOH budgetary cuts. For example, district hospitals began to engage the services of a professional accounting firm to scrutinise their accounts. District health management boards and hospital boards now produce annual financial and activity reports, which influence the release of donor funds from the CBOH. The development of FAMS has also helped to enhance accountability and to monitor the flow and use of funds in the decentralised system.

In South Africa, too, the allocation of resources to provinces was a critical element of the decentralisation of implementation authority and responsibility to this tier of government. However, the delay in developing health resource allocation policies that can be effective in the new fiscal federal context helps to explain the slower pace of interprovincial health care resource reallocation

and the reversal of some health resource redistribution gains after 1996⁹. In this instance organisational reform was not matched by the necessary development of health care financing policies, specifically the development of norms and standards to influence provincial budget allocations between sectors in support of geographical equity.

At the same time, and unlike Zambia, the experience of health managers at provincial and lower levels demonstrated the continuing centralisation of authority within the bureaucracy and, in some cases, even a growth in centralisation at specific levels of the system. As already noted, civil service salary negotiations were conducted centrally over the period of focus. Provincial DOHs' capacity to manage resources was also sometimes undermined in some provinces by the relationship between the DOH and the Provincial Treasury. In one province, for example, financial management difficulties within the province led its treasury to take much of the financial management power previously lying with sectoral departments. Not surprisingly, some provincial officials felt that the Provincial DOH was really only an administrative unit with real power lying elsewhere in the province. The impact of these two factors on resource management was also exacerbated by the centralisation and weaknesses of basic administrative systems and procedures inherited from the apartheid era. Such problems tended to be greatest in the provinces that were disadvantaged by apartheid in terms of resources and were faced with amalgamating the bureaucracies of former homelands and provinces (Presidential Review Commission 1998) after the 1994 elections. As a result, these provinces had particular difficulties in translating their budgetary gains into service delivery improvements. Despite these experiences, the various SHI proposals barely considered the need to sequence implementation steps to ensure that weaknesses in public hospital management were tackled as a first step towards SHI implementation.

4.5.4 Conclusions

The following conclusions were drawn regarding the influence of policy design over policy changes and impacts:

- > Establishing clear policy goals and objectives, particularly in relation to equity, is critical to effective policy development.
- > The details of policy design have a strong influence over actors' positions in relation to reforms and, therefore, support for policy might be generated through the adaptation of design. However, such adaptation needs to be undertaken carefully and with adequate information to secure support and avoid provoking unanticipated opposition.
- > The ways in which reforms interact influence their impacts, and, therefore, building synergies between reforms can enhance their positive impacts.
- > Organisational reforms, in particular, play a critical role in strengthening the capacity to implement financing policy changes.

⁹ Also important is the design of the formula through which global budgets are allocated to provinces, which both emphasises the productive capacity of provinces and gives relatively limited weight to their level of inherited deprivation or limited capacity (McIntyre and Gilson 2000; McIntyre *et al.* 2000).

4.6 Summary

This chapter provides explanations of the overall pattern of policy change in health care financing reform within South Africa and Zambia in the 1990s and its impacts (as outlined in Chapter 3). Although the details of each country's experience differ, there are some strong, common themes within these experiences. One such experience is that the pattern of change differed between policy areas in each country. Tied to routine budgetary procedures, proposals concerning resource reallocations were more easily channelled into policy change than were proposals concerning new resource mobilisation mechanisms that were largely developed through structures distanced from political support and government decision making. However, because they were internal to the government, the influences over resource allocation policy development were more hidden in both countries than were those that shaped resource mobilisation policy development. The battles over resource allocation policy change may, therefore, simply have not been revealed. For example, in South Africa, behind the reversal of health sector geographical equity gains in the era of fiscal federalism lay differing national approaches to resource allocation as well as intersectoral competition within provinces.

A second common experience is that the various influences over policy change in each country were, in practice, interconnected. For example, the nature of the political transition in each country was an important driving force of health policy change, but it did not override the influence of other factors. It provided support for health sector change, and, particularly in South Africa, constrained the implementation of change by demanding speedy change even while promoting the continued evolution of governance and management structures. In both countries, however, the way in which key actors managed the process of change, working within the unique features of each country's context, was an equally critical factor that influenced why, when, and how policy change came about – and what impact it had. In particular, the leadership and management style of the different Ministers of Health was an important explanation of which policies were developed and implemented, and which were not, as well as the manner in which policies were developed and implemented. These, in turn, had consequences in terms of their impacts on equity and sustainability.

In both countries, the ministers' strong influence was itself partly a function of the limited technical capacity available within government to support health care financing reforms, as well as of the broad national political support for health policy change. In South Africa, health financing reforms were partially offset by the often opposing stance of the DOF, and in Zambia, the broad reform programme was initially supported by the donors, although towards the end of the period of focus their support became fragmented. The weaknesses of available technical capacity in each country also led to analysts from outside government, both from national research groups and, in Zambia, international technical assistants, becoming involved in policy processes. Their role and influence over policy change was, however, strongly mediated by the mechanisms through which they were drawn into decision making and by the degree of trust between themselves and key decision makers. Their level of involvement varied over time and in relation to the topic of policy development. Their influence was stronger when they were directly involved in resource allocation decision making, as in Zambia, than when they were involved in resource mobilisation policy development through special structures outside the structures of power (as occurred in both countries). Other actors were also involved in resource mobilisation policy development, which made policy change in this area of reform particularly difficult. Managing a wide range of actors is a complex task, and in both countries there are indications that limited thought was given to the strategies through which policy development could best be effected. Similarly, features of the pace, pattern, and manner of policy implementation in both countries indicate that limited thought was given to how best to link policy change to real change in service delivery. Even the design of these policies, particularly the clarity of goals and the extent to which individual financing changes were

complemented by supporting policies, suggests that inadequate attention was paid to how to achieve policy objectives.

These common experiences of health care financing change across countries provide a foundation from which to draw lessons about how to strengthen the process of change, as presented in Chapter 5.

5. Strengthening Health Care Financing Policy Change

This chapter presents 10 principles based on the experiences discussed in Chapters 2–4. Application of these principles is intended to strengthen the process of health care financing policy change by encouraging new financing policies to be translated into service delivery improvements.

This study examined the process of financing reform development in South Africa and Zambia in the 1990s. Notwithstanding the considerable achievements of policy change in both countries, there were some clear weaknesses in the processes used to develop and implement the policies and in the aspects of their design. These experiences suggest that promoting the equity and sustainability of health systems is not simply a function of better policies, but rather requires better policymaking. Recognising that “*policy analysts cannot continue to ignore the how of policy reform*” (Walt and Gilson 1994: 366), the following 10 principles seek to promote stronger processes of financing policy development and implementation. The principles are interdependent and overlap, but each adds a different dimension to an understanding of how to bring about change in health care financing policies. Several also have relevance to other areas of health policy change. Together they address the role that financing policy can best play in system reform, its link to other reforms, tips for more effective decision making, ways to manage the policy process, and strategies for building stronger alliances in support of reform.

5.1 Financing Policy Change Should Be Made an Integral Part of Health System Development

It may be unusual in international experience, but financing policy appeared to be given less importance than other aspects of health system development within the broader health reform programmes of South Africa and Zambia during the 1990s. In South Africa, priority was given to aspects of organisational change and to particular interventions, such as drug policy, rather than to a combined package of institutional and financing reforms. In Zambia, organisational change took precedence over all other aspects of policy development, and efforts to generate a Cabinet-approved comprehensive health care financing policy document were unsuccessful. The equity and sustainability gains consequent to combining organisational and financing change were at least partially seen in Zambia, but were lost to South Africa; and Zambia failed to capture the improved coherence in policy change that could have resulted from establishing an overarching financing framework. The resource maldistribution, relative to population served, between the public and private sectors remains a major problem for the South African health care system. In addition, there continue to be problems of resource allocation within the public sector. Zambia must find stronger ways of tackling the negative utilisation impacts of cost sharing while still continuing the search for mechanisms of improving financial sustainability within the health system. At a more micro level, resource allocation and resource mobilisation policies must be brought into harmony with each other, even as they continue to evolve.

The experiences of Zambia and South Africa reflect that of other countries. For example, the wide-scale implementation of single-focus user fee changes in many African countries also demonstrated a failure to develop a coherent policy package in support of financing change (Gilson

1997a). However, broader packages of health sector reform are now being promoted internationally. Such packages recognise that wide-ranging change is required to tackle deep-rooted, systemic problems. Such change can, in turn, only be implemented through a coherent policy package that is rooted in clearly articulated policy goals and builds a link between individual financing reforms and between financing reforms and organisational change (Cassels 1995; Gilson and Mills 1996; Frenk 1996; Londono and Frenk 1997).

Financing reforms are of particular importance within such a package because financing mechanisms have a wide-ranging influence over the provision of health care. They influence critical elements of the health system, such as the following:

- > Balance between different levels of care within the system
- > The mix of inputs used in producing care (such as the balance between personnel and other items, or the relative weight given to technology within the provision of care)
- > Spread of authority within the health system, and the degree of effective decentralisation
- > Health provider behaviour and performance
- > Level and pattern of demand for different types of health care.

Equally important is the fact that financing reforms, particularly resource mobilisation policy changes, are often the public face of any health sector reform programme and, therefore, impact on popular perceptions of that programme. While the South African free care policies contributed significantly to popular support for an array of health policy changes, the implementation of cost sharing without quality improvements and exemption mechanisms created popular dissatisfaction in Zambia, as in other countries (e.g., Kenya: Mwabu 1996).

Giving attention to the wide-ranging influence of financing flows and financial incentives does not, mean, however, that they should be the only focus of efforts to improve health system performance. Rather, this allows consideration of how to support broader systemic change through financing change and how to ensure that financial flows and incentives do not drive the nature of health care provision in undesirable directions. When well designed and implemented sequentially, financing change can even be the spur to the broader organisational change required within health systems. For example, it can prompt the decentralisation of authority required to manage funds effectively and to ensure accountability for their use (Bennett and Gilson 2000).

5.2 Financing Policy Change Should Pay Attention to the “Art” of Politics

Health care financing reform has often been seen as the preserve of the few with relevant technical knowledge. As a result, it has frequently floundered because too little attention has been paid to the political, personality, and strategic factors that always shape policy change. This general lesson derived from international experience provided the impetus for this study, but the South African and Zambian experiences confirmed it. Technicians generally had less influence than politicians over policy design and implementation practice. The strategies of policy development and implementation shaped the details of policy design as well as which policies were implemented and which not, and the impacts of policies on equity and sustainability. To achieve their objectives, technicians and analysts often have to do more than just technical analysis to make an effective contribution to the policy process.

In paying attention to the “art” of politics, various issues are important to consider, including the value of strategy and tactics in promoting policy change (see principle 5). It is particularly important for those seeking policy change to understand the relative power and values of the major groups interested in change. This is the first step in considering how to influence policy development. As Grindle and Thomas (1991: 32) note: “*Policy elites play major roles in the process of policy and organisational change. Because of this the skills, values, and experiences they bring to reform situations are important, for they shape the perceptions of what problems need to be addressed through public sector action and how they should be addressed.*”

Where the basic values of the two groups are largely aligned, simply clarifying and exploring policy end points through technical analysis may promote better dialogue. A stronger approach might be to identify explicitly how a new approach/proposal fits in with dominant values as well as what it adds to current approaches to addressing known problems. Where political objectives are nonnegotiable and analysts disagree with them, technical analysis will have to be complemented by careful strategies to build support for alternative objectives and proposals. Promoting open debate on societal goals and their pursuit through health care systems may, for example, shape elite values and help prevent these values from dominating debate (see also principles 3 and 4). Other strategies might include tailoring information to specific audiences in ways that explicitly take account of their perspectives and interests, or standing back from policy design processes to promote and allow broader discussion around the policy of focus (see also principle 5). The following are three analytical techniques that can be used in understanding and addressing elite and other actors’ positions:

- > Stakeholder analysis – an analysis to identify key actors likely to support or oppose a particular policy action, their individual interests and concerns, and the nature and source of their influence (Crosby 1997)
- > Policy characteristics analysis – an analysis to identify the features of any policy that are likely to cause opposition or garner support (Gustafson and Ingle 1992)
- > “Policymaker” programme – a computer programme that includes a variety of individual techniques (Glassman *et al.* 1999).

Reformers must also pay attention to the way in which they communicate policy goals and design matters, especially in relation to complex policies such as prepayment, social health insurance, or the development of norms and standards for use in fiscal federal environments (see also principle 7). In South Africa, the technical complexity of some policies seemed to result in a breakdown in communication between analysts and policy makers. International experience clearly suggests that analysts need to improve the language of their own reports, adapting it to the perspective of policy makers (Trostle *et al.* 1999; Walt 1994). A policy that cannot be expressed simply and clearly will be difficult to sell. Careful thought about the words used in describing a policy may even help to gain support for it (Parsons 1995). In South Africa, former Minister Zuma, for example, captured support for some of her policies by the use of “symbolic language.”

Presenting policies clearly and simply is also important in promoting public debate about societal goals and their pursuit through health care systems. Such debate is itself an important part of the democratic process. As reforms evolve, they also have to respond to different sets of concerns. Initially, it may be important for analysts to dwell on the major thrust of policies, ignoring the details, and using nontechnical and popular language to justify them in terms of meeting health sector needs and matching the political agenda. Then the feasibility of policies must be judged against technical criteria and actor concerns. Following popular debate and political buy-in, the details of policy and

appropriate methods of implementation are legitimate areas for presentation and debate. Thinking through what information to present and when is an important strategy in developing reform (see also principle 9).

5.3 Financing Policy Should Be Developed Through a Balanced Mix of Open and Closed Processes

In both countries, financing reforms were largely developed either by politicians acting behind closed doors or by technicians (civil servants, external analysts, technical assistants, and donor representatives) sitting behind closed doors. Although there was interaction with some interest groups in some of the processes, wider, public debate – in the media, with a wider range of interest groups, with frontline health care workers, or with the public – was very limited. To some extent, the different political structures of each country precluded broader political debate.

From a governmental perspective, opening up decision-making processes might have two possible dangers: slowing down decision making and losing control of the decisions. These are clearly important concerns for those seeking to drive quick changes in order to redress inherited problems. Others might argue that, in both countries, broad support for the basic principles and lines of policy development was secured through the democratic election process. Following elections, the job of the respective governments was to then implement the plans approved by the electorate. Some might even suggest that technical matters like health care financing policy development can only be undertaken by those with appropriate technical knowledge, on the grounds that the issues are simply too complex to be widely debated.

There are various counterarguments. The electorate's views are always seen as important in a democratic system, and election debates rarely focus on the detail of any particular aspect of sectoral policy. In social policy development, no group has the monopoly on "the only correct approach"; rather, there are different views and perspectives of appropriate action (see also principle 4). In addition, although all processes must aim for speedy action when appropriate, action for action's sake is likely to produce some unexpected, and perhaps unwanted, results (as with the initial free care and resource allocation policies in South Africa or the hospital prepayment scheme in Zambia). Closed processes may become blocked or even generate opposition to change, as shown in the South African SHI debates.

In general, a combination of open and closed processes is likely to be important in generating sound and acceptable proposals for policy change. Open processes can have a particular role in allowing focussed debate about the following:

- > Overall values and goals that should underlie health policy development and their interpretation into aspects of system design, e.g., what does the pursuit of equity mean in relation to health care financing policy?
- > Acceptability of the various policy trade-offs that might have to be made in the pursuit of values such as equity; e.g., does the pursuit of equity require a "one-tier system" in the short term, or is it acceptable to allow some sort of tiering within public facilities as part of a strategy of strengthening the system? Is the implementation of user charges an acceptable way of promoting accountability within the health care system, given its potential negative effects on utilisation?
- > The nature of the health care system that might best allow personal and societal goals to be

achieved, e.g., what is an acceptable balance between the public and private (for-profit or not-for-profit) sectors?

The approaches that might be used to open up public debate on policy issues could include the following:

- > Establishing a stronger role for parliamentary committees charged with monitoring health sector issues and strengthening the links of such committees to community/citizen interest groups
- > Developing consultative health bodies at all levels of a health system as places for debate among a wider range of stakeholders on key issues – such as the neighbourhood committees emerging in Zambia
- > Giving specific voice in these bodies to NGOs that represent less powerful groups (and taking steps to enhance their capacity to do this)
- > Supporting processes initiated by NGOs themselves – such as the “Speak Out on Poverty” campaign conducted by the South African NGO Coalition in 1998, which allowed citizens and community groups in all nine provinces to share their experiences of poverty (Budlender 1998)
- > Using citizens’ “juries” to debate specific issues, perhaps with a link to the media in order to publicise and promote that debate; for example, during the 1999 South African election campaign, one newspaper established a representative panel of citizens who were asked their views on a range of specific issues, and these were then reported in the newspaper
- > Establishing open committees of inquiry as mechanisms for public debate of specific issues
- > Developing participatory monitoring approaches within routine M&E systems – such as Zambia’s Annual Participatory Poverty Monitoring exercise (see also principle 10).

Such approaches clearly could not be tied solely to a debate of health care financing issues, perhaps not even to health issues in some cases. However, specific financing questions could be debated within them and in relation to other aspects of systems’ development – generating views both on the specific issues and on the links between financing and broader systems’ change. Government support for any or all of them would affirm their importance and value, helping to establish a climate of transparency and inclusion in relation to policy debate. It could also provide a signal to encourage civil society groups to initiate action themselves and to ensure that in more open processes of policy debate the voices of citizens are heard, rather than just the voices of powerful interest groups.

Closed processes, in contrast, may be useful in identifying policy options on the basis of publicly debated goals, as an input into further public debate, or in developing detailed design proposals in relation to specified options. Closed processes may also have value as part of a strategy to offset the power of specific vested interests. In developing any policy there will always be a point at which debate must turn into action if change is to be implemented. In pursuing its broad mandate, a government must ultimately take responsibility for ensuring implementation of its preferred policy proposals (or for allowing and accepting no action). At this point, a government will need to strategise around how to include different actors, and such strategy should be developed with awareness of the interests each actor is likely to pursue and his or her potential support or opposition for specific lines of policy or proposals (see also principle 5). It will also need to recognise when

smaller technical groups need to be established to undertake the analysis necessary to allow policy development and/or to develop detailed and careful policy proposals.

5.4 Developing Wide-Ranging Strategies of Information Gathering Is Critical to Financing Policy Development

Although policymaking is ultimately a political act, policy development can be informed, shaped, and strengthened by information. International experience, therefore, emphasises the need to “inform the reform process” (Frenk 1996; Gilson 1997b). Yet both countries had only limited data available with which to shape decisions and made limited attempts to generate relevant information. For example, the existing patterns and levels of cross-subsidisation, taking into account the full range of public subsidies to different groups and the incidence of expenditure supporting these subsidies, has not been fully investigated in South Africa. Yet, in opposing SHI proposals, some groups have asserted that middle-income groups cannot bear further taxation. Both countries also need to know more about the cost of health care provision, particularly at higher levels of care, to be able to inform resource allocation policy development. They also need to know about a range of community preferences and views that should frame health care provision. These include which groups should benefit most from public health care provision and how much more than other groups they should benefit, as well as the existing weaknesses of service delivery.

To some extent the information needed to guide policy development will come from improved monitoring of routine services and evaluation of policy changes (see principle 10). However, in developing new visions to guide health system change, it is also critical to look beyond past and current experience – to consider other countries’ experiences, to consider the new ideas and developments being debated, and to generate ideas from people other than analysts. This range of inputs is perhaps particularly important in a supposedly technical and complex policy area such as health care financing. When they are not available, decision making may be monopolised by so-called experts using technical data only. Indeed, the closed nature of decision making in both countries is only emphasised by consideration of the main type of information used – studies by technical analysts. Information gaps were a critical constraint on policy development.

A broad overview of the various sources of information that a government could draw into policy development is summarised in Figure 5.1. In quadrant 1, decision making involves the use of formal sources of information from within government only, whereas in quadrant 2, information is generated almost wholly outside government but through formal processes. Quadrants 3 and 4 point to the range of informal sources of information available to government decision makers.

Figure 5.1: Sources of Information for Governmental Decision Making

Formal Sources			
	(1)		(2)
	departmental research/inquiry internal think-tank report reports from internal experts		committees committees of inquiry judicial review reports from the legislature commissioned research formal consultation
sources internal to government	informal discussions between decision makers gossip/rumour informal use of advisers	discussions consultation reports informal information/advice	sources external to government
	(4)		(3)
Informal Sources			

Source: Parsons 1995

Figure 5.1 highlights the potential role of some of the “open” processes highlighted in principle 3 (such as committees of inquiry) as sources of information for decision making and the range of roles that technicians inside and outside government may play in relation to information generation (see also principle 7). Although it does not specifically identify information from routine systems as a source of information, this is clearly important in monitoring the implementation of new policies and in developing ideas about how to strengthen or adapt such policies (see also principle 10).

5.5 Strategy and Tactics Must Be Used to Strengthen Financing Policy Development

Whether and how actors are involved in health financing reform is almost always a critical determinant of the outcome of any reform (Crosby 1996; Gilson 1997b; Glassman *et al.* 1999; Walt and Gilson 1994). As a result, the strategies used in South Africa to engage the national DOF, trade unions, and the private insurance industry failed to build adequate support for the further development of SHI proposals. Similarly, the Zambian reformers failed to offset the concerns of hospital professionals, allowing them to become the natural opponents of many changes.

Thinking through the strategy and tactics to be applied in implementing policy change is a critical step in any programme of policy change that specifically recognises the importance of the art of politics (principle 2). When and which particular strategies of engagement should be used will depend on different actors’ potential to influence policy development and the sources of this

influence, the character of policy supporters and opponents, the broader ethos of policymaking, and the stage of policy development.

Knowing who has what level of influence helps to prioritise which actors should be considered most carefully in the process of policy development. Understanding their sources of influence may prove useful in shaping strategies to offset their influence or gain their support. Such analysis might, for example, have pointed to the need for a consistent process of active engagement with the South African DOF across all health care financing areas or with the Zambian hospital professionals. Understanding each actor's position and concerns about the reform of focus is a further important input into strategy development, allowing identification of potential allies as well as opponents. Such analysis might have indicated that engaging the trade unions more actively in SHI policy development in South Africa could have addressed some of the former minister's concerns on this policy, and thus provided the basis for a pro-reform alliance of critical actors.

Appropriate strategies will, however, differ between actors within and outside government. For example, routine structures usually exist to bring together governmental actors in the budgeting process, whereas they have to be developed to engage nongovernment actors. In addition, although government ministries, and even units within a ministry, may have different views, they work within common policy frameworks that guide their actions and shape policy development. Macroeconomic policies, such as GEAR in South Africa, often provide examples of such frameworks, and the proposed comprehensive financing policy document of Zambia could have served this purpose within the health sector. Nonetheless, there may be less commonality of interests between different actors within the same government than between members of the same policy community working inside and outside government structures. Thus, at times the relationship between the Departments of Health and Finance in South Africa seemed to be soured by different understandings of the overall goals of policy change and this, in turn, generated some distrust between the two that slowed aspects of policy development. In contrast, at particular times there were signs of trust in Zambia between government civil servants and expatriate technical assistants, and even between government civil servants and donor agency representations, that enabled coordinated action in pursuit of health policy goals.

Which actors should be engaged and how may also depend on the configuration of power available to the reformer. Recognising their lack of technical capacity, the Zambian MOFED allowed the MOH to move ahead in its reforms. It perceived the health sector's vision of its reform programme to be strong enough to support effective implementation. In contrast, the South African DOF not only perceived itself to have greater technical capacity than the DOH, but had a clear sense of its goals. It, therefore, blocked SHI policy development. The technicians of both countries were also particularly unsuccessful at creating a pro-reform alliance to offset their own lack of power, except where ministerial influence led or supported their actions. To engage effectively with other actors, therefore, reformers need to be very aware of their own level and sources of power, and must seek to bring in other actors who can complement them in these respects. Yet they must still recognise the potential of other actors to derail reform or to hold an agenda that does not match the main reform's goals. Where either of these two possibilities exists, the reformer must analyse how to minimise the risks while capturing the actor's influence. For example, the "arm's length approach" to the private insurance industry during the development of the South African 1998 Medical Schemes Act allowed the DOH to draw on its knowledge without allowing it control over the design itself.

Special processes, such as committees of inquiry, can play important roles in policy development but must be considered carefully. Concern about their potential products may lead them to be emasculated from the start, either by their terms of reference or by their membership. They can, however, be useful in specific circumstances and for specific tasks, including in the following instances:

- > The reform of focus is not part of government's routine administrative tasks and duties
- > Government's own technical capacity is insufficient to tackle the reform of focus
- > Developing a broader range of options may be useful in bringing new insight to old problems
- > Interest group representation and buy-in is important for the reform's credibility and success
- > Government needs to be seen as consulting with other groups.

Such processes may, therefore, be aimed at getting technical advice and/or the strategic engagement of actors. Clarifying the primary objective of the exercise will obviously be important in further developing its operational functioning in ways that support it in fulfilling one objective (see also principle 7). However, as the experiences of both countries demonstrate, if such structures are intended to support policy development, it is always important to ensure that they have clear and direct links to the routine decision-making structures of government. Such links could be through reporting mechanisms, the nomination of a government actor responsible for taking forward their work, or their own efforts at engaging a policy champion who is willing to push their work within government structures. Policy champions might be individuals or special implementation units. The champion's organisational location must give access to relevant, key points within government structures and processes, and he or she must have both political status and adequate technical capacity to fulfill his or her task (Gilson and Travis 1997).

Finally, the role of formal mechanisms for engaging actors must be considered in relation to more informal strategies. For example, when groups are powerful and oppose the basic rationale of the reforms, their presence on special policy processes or on high-level decision-making fora may be counterproductive. To give such groups drafting rights to policy may be to confer on them too much power, allowing them to shape or even block reform implementation. Thus, hospital managers sitting on the HCFWG who opposed aspects of the Zambian comprehensive financing policy document slowed its development considerably. At the same time, to ignore or overlook groups that have interest and influence in any policy debate is to invite failure – as experienced in South Africa. Instead, the directed and controlled exchange of information plus negotiation with powerful groups may allow some control of their agendas and contain their influence. Box 5.1 outlines a range of strategies that could be used to engage actors, again emphasising the importance of principle 2.

Box 5.1: 19 Strategies for Working with Actors

1. Create Common Ground:
 - Seek common ground with other organisations, identify common interests, link different interests, invent new options, make decisions for opponents easier.
2. Create a Common Vision:
 - Keeping in mind that the principal obstacles to reform are not only technical, create an atmosphere of shared values and unified leadership, and articulate a common vision of equity and the respective roles of the public and private sectors
3. Define the Decision-Making Process (around a particular reform):
 - Formalise who does what in making a decision and who approves what type of decision; legalise formal processes if relevant
4. Mobilise and Prepare Key Actors for Their Roles in Reform Debates:
 - Identify who can take leadership positions and provide them with appropriate information, identify who can influence support/opposition by taking a strong and clear position, and provide them with appropriate information—the most critical issues for discussion—and focus debate on them
5. Meet with Political Parties:
 - Meet with politicians and their technical staff, attempt to integrate health reform policies and specific policy ideas into political debate and discourse, identify their specific concerns on reforms, and seek to offset them through technical argument and debate
6. Initiate Strategic Communications:
 - Initiate strategic contacts with the press, respond to attacks on reforms immediately, feed information and technical findings to the press, and place key decision makers in the media
7. Initiate Pilot Studies:
 - Select pilot study sites according to technical and political exigencies, focus pilot study work on issues critical to technical understanding and/or political support, and preserve neutrality of those involved in pilot study to maintain integrity of findings
8. Manage the Bureaucracy:
 - Involve different groups in designing reforms and in developing implementation strategies
9. Strengthen Alliances with International Organisations:
 - Request technical-political assistance from international financial institutions and other donors in order to respond to criticisms of reforms, work together with supportive donors in some areas, ask for donor support for vision of reform, and define their active participation in influencing key actors in the health sector
10. Involve “Friends” in Planning:
 - Hold informal consultations with “friends” of the reform on the sequencing of actions and political strategy; bring together key “friends” to formulate specific agendas in some reform areas
11. Create Strategic Alliances:
 - Create alliances with key actors not usually involved in health sector policy debate (e.g., unions, NGOs, etc.)
12. Use Backdoor Channels:
 - Bypass formal procedures and meet with those in power to try and influence the development of reforms and/or gain useful information about the future course of events for use in their own activities
13. Establish Independent Committee of Inquiry to Create Support:
 - Identify relevant “experts” whose opinions and views will be valued publicly to sit on committee, establish balance between declared supporters and opponents of reform in committee membership to maintain neutrality and independence of committee, provide technical support to committee to gather additional ideas and/or generate additional analysis, and create link between committee and “policy champion” within government
14. Establish Independent Committee of Inquiry to Block Opposition:

- Establish balance between declared opponents and supporters of reform in committee; delay consideration of committee report/findings after publication until no longer newsworthy
15. Establish Parallel Processes During Formal Committees:
- Use informal parallel processes to gain guidance from constituencies on positions to take in debates and/or to generate information to feed into debates
16. Use Technical Information to Offset Opposition:
- Identify key arguments of opponents to reform; undertake technical analysis to offset their arguments
 - Use technical analysis to support alternative line of policy development; feed technical analysis into relevant decision-making processes; make technical analysis widely available to policymakers, media, etc.
17. Divide and Rule:
- Put “high bid” policy document forward for debate; through reactions to “high bid” document, identify lukewarm opponents and hard core opponents, isolate hard core opponents by developing detailed policy design that offsets the concerns of lukewarm opponents; proceed with policy implementation with support of previously lukewarm opponents
18. Mobilising a Third Party:
- Seek to bring a potentially powerful but as yet unmotivated actor into the debates to support own position
19. Create Tailored Information for the Public and Policy Leaders:
- Tailor policy information to different target audiences to seek their support and to influence their understanding

Sources: Gilson *et al.* 1999; Glassman *et al.* 1999; Lake *et al.* 2000.

5.6 Strong Political Leadership Must Be Balanced with Effective Technical Capacity in Supporting Financing Policy Change

Strong political leadership was important in initiating wide-ranging policy change in both South Africa and Zambia during the 1990s. In addition, the personal influence of the two countries’ various Ministers of Health sometimes ensured action that was sensitive to the political needs of the moment. However, the limited use of information and technical analysis for policy development also undermined priority setting and design development in relation to health care financing policy, and this was sometimes exacerbated by the personalised approach of decision making. Clear examples of these problems are seen in the experiences with the Zambian hospital prepayment scheme and the limited progress in South Africa in developing the norms and standards required to promote health resource allocation equity in the fiscal federal era.

Information and analysis are particularly important as societal objectives like equity and sustainability may be undermined by policies that are politically attractive but have some undesirable effects. Both the South African free care policies and the Zambian hospital prepayment scheme, for example, had some negative impacts on sustainability. More open processes of decision making – i.e., processes involving more actors and thereby allowing more views to be heard – may also help to ensure that relevant information is available to decision makers at the right time, even though these processes may slow down policy development (see also principle 3). At the very least, there needs to be closer coordination between policy makers and those groups inside or outside government that can provide necessary analyses. As one Minister of Health in Zambia noted, to sustain processes of policy change, “*it’s not political leadership as such that must count, it’s the continuity of technical leadership which I think must count.*”

To provide relevant technical analysis, however, it is necessary to have technical capacity; yet in the countries examined, as is also common elsewhere, such capacity, particularly within government, was limited. In part this problem resulted from the limited number of people trained in health economics working in government. The steps that were taken to address this problem included government recruitment of more staff and support of various capacity development programmes within academic institutions in South Africa. In Zambia, since the mid-1990s, skills' development among available government staff has been complemented by Swedish support for the development of health economics in the University of Zambia as an additional resource available to government. However, the capacity problem was not simply a shortage of people with technical skills in either country. Also important was the broader failure to incorporate health economics analysis into policy development, leading to the suboptimal use of the available health economists. This may, in turn, have stemmed from policy makers' limited familiarity with the importance and use of health economics in reform processes. In South Africa, the organisational location of the main unit with health economics capacity within the national DOH also constrained its influence. In other words, as is common in low- and middle-income countries (Paul 1995), neither the demand for, nor the supply of, health economics analysis is, as yet, adequately developed within South Africa or Zambia.

Although there are no quick or easy solutions to these problems, it is clear that coordinated action must be taken to stimulate both a pull and a push for health economics' expertise. Demand might be stimulated by establishing structures that allow economic analysis to be fed routinely to policy makers and into policymaking processes at appropriate times, rather than on the more ad hoc basis seen in each country. Such structures could also allow the face-to-face engagement that is necessary in building the politicians' trust of their technicians and the technicians' understanding of their political leaders' concerns, perspectives, and styles. The value and contribution of particular pieces of health economics' analyses must also be trumpeted, even marketed, to policy makers at all levels of the system in a broader strategy for enhancing understanding of the role of such analysis in policy development. At the same time the supply of economists to government and other groups must be supported through formal and in-service training, providing environments that offer challenging opportunities and career development possibilities, as well as by drawing economists outside government into providing policy advice through structures like the Zambian HCFWG (see principle 7). Balancing political leadership with effective technical capacity inevitably requires long-term and sustained strategies of capacity development.

5.7 The Roles of Different Groups of Technicians and Analysts in Policy Processes Must Be Clear

As noted, one strategy for strengthening health economics' capacity used in both countries was to create links between the health economists working inside government and those supportive of government but based outside it. In both South Africa and Zambia, however, the structures created to draw these groups together were undermined by problems, including the varying support of policy makers for their work and the operational functioning of the bodies. In addition, analysts were sometimes not involved at all or only provided informational inputs.

The differing experiences suggest that the role of the external analysts in these processes was determined in a rather ad hoc way with little clarity about the role they were expected to play relative to technicians working within government. A foundation for mutually acceptable collaboration may include, therefore, discussion of topics where collaboration may be possible, as well as clarification of the different roles that the two groups may play in different policy debates.

The role of technicians working inside government is relatively clear. They are the government's primary advisors on health care financing issues, seeking to inform and guide relevant policy development in pursuit of government objectives. Such actions may require coordination or negotiation among different groups of advisors (for example, those based in different ministries), as well as coordination with other arms of government in implementation. These technicians are "inside" both the formal and informal processes of decision making.

The role of analysts outside government – and of expatriate technical assistants working inside government – is, however, less clear. The first step is to clarify the objectives of their involvement. These might range from strengthening the analytical capacity available to government, providing technical information, adding credibility to a process, or co-opting into policy development. Based on the established objectives, the relevant role of analysts might then be incorporated into terms of reference for contracted or commissioned research, leaving them to decide whether or not to become involved. The objectives and the related roles also might result from a process of dialogue with the analysts. Indeed, wherever analysts are brought in to support a particular line of thinking, this may need to be discussed with them in advance. Although there may be strategic gains in getting "impartial advisers" to support a particular policy, they may react negatively to efforts to influence their views.

In thinking through the role of either group of analysts, it is, therefore, important to consider the following questions:

- > What specific informational or other inputs to policy processes can they provide, and at what stage of the process?
- > To what extent should they become directly involved in developing policy, hand in hand with government officials?
- > To what extent should they accept government policy lines and to what extent should they provide constructive criticism of these lines from their own perspectives?
- > What other roles can they play in supporting policy development and implementation?

Perhaps some responses are more obvious than others. Analysts based outside the government may have the advantage of having more time to review, analyse, and categorise information in ways that are useful for policy makers. Trostle *et al.* (1999: 104), using the words of a Mexican government health official, suggest that research is valuable to policymaking because "...*what is needed for decision-making is the organisation of knowledge in such a fashion that allows us to see the options.*" Such analysts may also be able to take a longer view of needs rather than having to respond to the pressures of daily events and political cycles. They may play broader roles in raising understanding of issues and in formal training in relevant skills to develop demand for the products of all technicians (Paul 1995). Technical assistants might also play similar roles, but it will always be particularly important to carefully think through how they work with counterpart staff in order to ensure skills transfer takes place. This may also be important in preventing them from having an undue influence, although, if trusted, they might be encouraged to take on more direct policy development roles to alleviate capacity constraints.

External analysts also need to think through the terms on which they are prepared to be closely involved in policy processes, and the circumstances under which they might prefer to remain outside or disengaged from them. The potential alignment or conflict between their opinions and those of the policy makers is likely to be important in this decision, as well as the need for independent groups to

retain their perceived objectivity. To be effective in their role, however, those from outside government cannot maintain too great a distance from the policy-making action. They cannot take on the archetypal role of “researcher as impartial adviser” – indeed, all researchers must recognise and make clear the values and biases that inform their analyses. In addition, they must engage in current policy problems and issues and understand the operations of, and constraints on, government. Yet they must also learn how to balance the provision of support to government with constructive criticism provided at an appropriate time and in an appropriate manner. To undertake these tasks, they need technical, communication, and strategic skills (Trostle *et al.* 1999; Walt 1994). Perhaps, above all, they must accept that “*empirical data from researchers are only one force among many, and therefore do not and cannot have the weight that outsiders – especially researchers – might want them to have*” (Trostle *et al.* 1999: 104).

The impact of any group of technicians is, however, always dependent on

“a strong degree of ownership or patronage for [their] output; the existence of a strong linkage to a dominant or significant policy-maker; the capacity to deliver high quality and technically sound analysis; a close congruence with the political and policy environment or a sense of what is politically, economically, and socially feasible; a relatively low degree of hostility from existing and/or competitive analytical units in other agencies; and sources of finance willing to adopt a neutral stance regarding the unit’s policy analysis agenda or methodology” (Crosby 1996: 1413).

5.8 The Development of Financing Policies Must Take Account of Implementation Needs

Implementation is often seen as a separate step of the overall policy process and one that somehow automatically follows policy formulation. Resource mobilisation policies in both countries provide examples of the assumption that implementation is simply a matter of policy proclamation. Similarly, the reallocations promoted by resource allocation mechanisms were constrained in both countries by the difficulty of translating financial reallocations into human and physical resource reallocations. However, even a well-designed policy may not be effectively implemented because guidelines are not concurrently developed to support implementation (as with cost sharing in Zambia). Implementation may also be limited by an initial failure to develop adequate support for it among those responsible for its implementation (as with free care in South Africa).

Any policy process must, therefore, include implementation issues as part of its focus, rather than targeting only the development of a policy. Such issues include more technical matters such as clarifying organisational design, mobilising resources, and developing monitoring systems, as well as how to gain legitimacy for the policy and how to build constituencies to support it (see also principle 5). The tasks of policy implementation are, thus, “*all strategic, not operational*” tasks, the critical “*first steps in either programme or project implementation*” (Crosby 1996: 1405). For example, Sabatier and Mazmanian (1979) suggest that the following six issues should be considered during policy formulation to establish the preconditions for effective implementation:

- > A clear and appropriate understanding of how change can be brought about through the policy
- > Clear and consistent objectives against which to evaluate policy change
- > Identification of implementation structures that can motivate implementers to consider policy targets, and thereby implement effectively

- > Involvement of committed and skillful implementers, ensuring that they have adequate discretion to realise policy objectives
- > Support of interest groups, government, and members of legislatures
- > Adequate assessment of socioeconomic conditions to avoid a situation in which unexpected changes in these conditions undermine support for the policy or subvert the basis on which it was developed (i.e., the underlying understanding of how to bring about change).

A critical element of the leadership required to support implementation is, therefore, one of facilitation. The importance of this leadership style is emphasised within the context of decentralised structures, such as those that exist in South Africa and Zambia, in which implementation is a joint responsibility at national and subnational levels. Leadership for implementation must also specifically enable the involvement of implementers in the design of policies. Again this may be especially important in politically decentralised systems in which implementers have to reconcile national policy decisions with local imperatives. It may be more appropriate, however, for implementers to act as advisers in the policy design phase given the many other issues that must be considered at that time, whereas in planning for implementation, they must have a more central role. In either case it is also important to acknowledge that health care managers and providers – the implementers – have interests and concerns just like other actors and these may differ from those of policy makers and policy designers. Managing providers and, in particular, building the degree of implementor support required to enable change can be equally as important in effective policy development as developing strategies to engage interest groups (see principle 5). Management options, therefore, should also include adaptation of policy design in ways that promote support (e.g. by giving incentives to implementers) as well as the development of careful strategies to work with this group.

Other aspects of the leadership required for financing policy implementation include the need to do the following:

- > Foresee future policy needs rather than tackle only today's crises (unlike in South Africa)
- > Develop change in line with precedence-setting broader reforms (unlike in Zambia)
- > Establish the enabling legislation necessary to allow implementation (unlike in South Africa)
- > Maintain equity within decentralised systems given the potential for wealthier areas to capture more of the available resources (Collins and Green 1994).

Effective implementation is rooted less in control, however, and more in coordination. As noted from wider experience, *“Although control over the actions of all agencies involved in implementation may be unnecessary (or indeed impossible), nevertheless, it is important that agencies be aware of what the others are doing and that they coordinate their actions – both to avoid being at cross purposes as well as to provide information concerning important results which may affect the implementation strategy and actions of another agency”* (Crosby 1996: 1411).

5.9 The Pattern of Policy Implementation Must Itself Enable Further Change

In South Africa and Zambia, wide-ranging health reforms were initiated in response to a “window of opportunity” for change resulting from political transition. In other countries, similar opportunities may result from political cycles that bring new governments to power, or affirm the position of an existing government (Glassman *et al.* 1999; Reich 1996; Walt 1994). Using such opportunities to further policy change is one element of the leadership required to support implementation.

The pace and wide-ranging nature of change during a “window of opportunity” may, however, as it did in South Africa, force mistakes in implementation. It may even cut away government support if it is seen to have negative impacts. Public concern about the impact of the free care policies and, more importantly, perceived declines in the quality of public hospital care have detracted, to some extent, from earlier support for health policies in South Africa. Short deadlines tailored to meet the demands of political cycles may be particularly counterproductive in developing complex reforms that involve the creation of new institutions or new ways of performing tasks, as with SHI and the development of norms and standards. They may also encourage policy changes to be implemented without any clear plan for implementation or monitoring, as was the case with cost sharing in Zambia. In both countries, speedy action also prevented adequate consultation and communication with key actors, particularly implementers and the broader population. In South Africa, this was compounded by a failure to develop the necessary capacity to allow implementation. Such capacity problems are common across countries and settings (Bennett *et al.* 1996; Hilderbrand and Grindle 1994; Leighton 1996). They are exacerbated by structural change and institutional flux, as seen in South Africa or as may result, if to a lesser degree, from civil service restructuring involving retrenchment or reconfiguration of roles (Cassels 1995). In contrast, in Zambia such capacity was being developed in parallel through the decentralisation programme (although a valuable opportunity to strengthen implementation capacities was lost by the failure to link the reintroduction of cost sharing in 1993 with the district strengthening exercise).

Although taking advantage of windows of opportunity for change may prevent opposition to change becoming entrenched over time, these experiences indicate that taking too much, or too careless, advantage of such windows can bring its own problems. Paying attention to the art of politics at such moments (principle 2) should not imply speedy implementation of many changes. Rather it requires that a judgement be made about which changes are likely to be most controversial, which can promote political support for further change, and which will cause the least problems to the health system through speedy implementation (see also principle 5). Even at such moments, it is important to consider the features of an implementation strategy that allow that strategy to enable further change rather than generate obstacles to such change. Such strategies include the following:

- > *Prioritising policy actions on the basis of clear analysis and understanding* of key health problems, how reforms might address these problems, and what level of political support can be built for a broader reform agenda. In a changing structural environment it will be particularly important to recognise the costs of “trying to do too much too quickly,” even while accepting that problems demand urgent action. When institutions are being reformed and new lines of management and roles and responsibilities are being developed, policymaking must begin with those changes that can be accomplished and will generate positive impacts.
- > *Working towards complex reforms in stages* through the sequencing of individual actions that taken together represent the overall reform. Given the danger that the policy environment may change and leave the complex reform only partly implemented, reformers

must ask whether the individual steps toward the reform meet objectives in themselves. If not, then the cost or risk of failing to implement all the steps must be considered beforehand. Similarly, it may be necessary to plan well in advance for future steps, particularly in terms of capacity development and available resources.

- > *Planning for implementation* even while taking advantage of opportunities for initiating change. For example, conducting risk analyses of the adequacy of capacity and the potential for opposition, identifying key potential obstacles and ways of tackling them, and preparing guidelines to support implementation.
- > *Creating a clear division of responsibilities between government institutions at different levels* (e.g., national, provincial, and district). Key groups at each level must be informed about what is expected of them, and responsibilities need to be backed up with the necessary human resources, management systems, and other resources (see also principle 8).
- > *Developing a communication process that supports implementation* not only by informing implementers and the public about the proposed changes but also by enabling them to feed back into the process of adapting and strengthening reforms. Such communication might occur through special activities, such as media campaigns, or through routine meetings between policy makers and implementers (as initially established in Zambia), or between managers and the public (as through the Zambian district boards) (see also principle 8).
- > *Applying flexible and gradual implementation approaches* that allow policies to be adapted and strengthened in response to experience (Leighton 1996). Piloting aspects of reforms may generate lessons for further implementation, while phasing reform implementation can allow problems to be identified and addressed even during implementation.
- > *Developing capacity* through a gradual implementation process that allows the necessary skills and systems to be developed as part of the process of implementation (Gilson and Mills 1996; Gilson 1997b; Kohlemainen-Aitken and Newbrander 1996; Mogedal *et al.* 1995).

5.10 Monitoring and Evaluation Are Central Components of Any Implementation Strategy

Well-functioning M&E systems are essential for any health financing reform, providing data that allow policies to be improved over time and thereby strengthening their potential to meet their goals (Crosby 1996; Gilson 1997b; Leighton 1996). The absence of M&E, and limited use of available evaluation data, was highlighted as a barrier to past implementation of health financing reforms in both South Africa and Zambia. Evaluation of the first free care policy could, for example, have benefited implementation of the second free care policy in South Africa. Although governments are often reluctant to develop M&E systems (Pollitt 1995), particularly when they involve the use of sensitive information such as budget and expenditure data, M&E must be a central element of effective implementation. Information is critical to effective policy change, as highlighted by principle 4, and understanding reform experiences can only be fully achieved through the routine and regular gathering of relevant information.

M&E systems intended to support policy implementation, particularly the implementation of complex systemwide change, must allow assessment both of the progress towards objectives achieved

by any policy change *and* of the factors influencing the progress achieved. Understanding the relationships between a policy change, consequent processes, and final outcomes “*provides a better basis for making useful recommendations to policy-makers...[and]...enhances the validity and credibility of the data and thus the probability of making an impact*” (Gross *et al.* 1998: 107). In any case the complexity of system reforms, which are usually initiated in a context of broader change, not only make it very difficult to draw causal links between policy change and impacts but also point to the need for comprehensive methodological frameworks (Janovsky and Cassels 1996).

This type of evaluation could, for example, clarify the skills, systems, and procedures required to support implementation, as well as inform the development of information, communication, or tactical strategies. A critical element of further evaluation in support of equity-promoting policies is to develop a better understanding of the public’s views on reforms (Gilson 1998) through surveys or participatory monitoring exercises (see also principle 3). For example, were the South African free care policies seen as positive because they improved access or because they strengthened the government safety net provided to the poorest groups in society? To what extent were these potentially positive views offset by problems experienced in accessing care? Did the population see the Zambian introduction of fees more as a positive step in developing partnership and accountability, or more as a further barrier to access? Such analysis can both inform understanding of the impact of reforms and provide important, and often overlooked, input into future policy development.

The framework and approach of this study provide one structure within which to develop the type of M&E strategies that take into account the dual needs of determining policy impacts and the factors mediating those impacts. Inserting such an M&E approach into the heart of policy implementation practice would be the culmination of the application of the 10 process principles proposed here.

5.11 Summary

Based on analysis and consideration of the Zambian and South African experiences, this chapter offers the following 10 principles to strengthen health care financing policy change:

1. Financing policy change should be made an integral part of health system development.
2. Financing policy change should pay attention to the “art” of politics (rather than just the “science” of technical analysis).
3. Financing policy should be developed through a balanced mix of open and closed processes.
4. Developing wide-ranging strategies of information gathering is critical to financing policy development.
5. Strategy and tactics must be used to strengthen financing policy development.
6. Strong political leadership must be balanced with effective technical capacity in supporting financing policy change.
7. The roles of different groups of technicians and analysts in financing policy development must be clear.
8. The development of financing policies must take account of implementation needs.

9. The pattern of policy implementation must itself enable further change.
10. Monitoring and evaluation are central components of any implementation strategy.

The application of these 10 principles together would allow health reformers to take account of the fact that

“Successfully pursuing long-term reforms in democratising environments involves not just knowing in which direction to move, but paying attention to how to get there” (Brinkerhoff 1996: 1395).

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