Introduction

A common set of health system reforms has been promoted for implementation in low- and middle-income countries since the early 1990s. These reforms include changes in the financing and organization of health systems as well as new approaches to health care priority setting, and have often been driven by economic analysis (Berman 1996; Mills 2000). However, little is yet known about the experience of implementing these reforms or about the factors explaining why initial goals are often not achieved and why policy change often results in unexpected impacts (Walt and Gilson 1994). Indeed, ‘[T]he tendency in public health is to portray policy reform as a technocratic or economic process. Both economists and health policy analysts tend to provide detailed prescriptions on what should be done, but without clear instructions on how to do it and without good explanations of why things go wrong’ (Reich 1996: 60). Yet international evidence of reform efforts in other sectors clearly highlights the range of actor and process influences over reform implementation (Nelson 1990; Grindle and Thomas 1991; Toye 1992; Crosby 1996).

This two-country study, therefore, explicitly adopted a policy analysis approach (Walt 1994; Parson 1995) in investigating the experiences of health financing reform in South Africa (1994–99) and Zambia (1991–99). The specific reforms considered were: resource re-allocation mechanisms (both

The SAZA study: implementing health financing reform in South Africa and Zambia

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This paper explores the policy-making process in the 1990s in two countries, South Africa and Zambia, in relation to health care financing reforms. While much of the analysis of health reform programmes has looked at design issues, assuming that a technically sound design is the primary requirement of effective policy change, this paper explores the political and bureaucratic realities shaping the pattern of policy change and its impacts. Through a case study approach, it provides a picture of the policy environment and processes in the two countries, specifically considering the extent to which technical analysts and technical knowledge were able to shape policy change.

The two countries’ experiences indicate the strong influence of political factors and actors over which health care financing policies were implemented, and which not, as well as over the details of policy design. Moments of political transition in both countries provided political leaders, specifically Ministers of Health, with windows of opportunity in which to introduce new policies. However, these transitions, and the changes in administrative structures introduced with them, also created environments that constrained the processes of reform design and implementation and limited the equity and sustainability gains achieved by the policies. Technical analysts, working either inside or outside government, had varying and often limited influence. In part, this reflected the limits of their own capacity as well as weaknesses in the way they were used in policy development. In addition, the analysts were constrained by the fact that their preferred policies often received only weak political support. Focusing almost exclusively on designing policy reforms, these analysts gave little attention to generating adequate support for the policy options they proposed. Finally, the country experiences showed that front-line health workers, middle level managers and the public had important influences over policy implementation and its impacts. The limited attention given to communicating policy changes to, or consulting with, these actors only heightened the potential for reforms to result in unanticipated and unwanted impacts.

The strength of the paper lies in its ‘thick description’ of the policy process in each country, an empirical case study approach to policy that is under-represented in the literature. While such an approach allows only a cautious drawing of general conclusions, it suggests a number of ways in which to strengthen the implementation of financing policies in each country.

Key words: health care financing, resource allocation, resource mobilization, policy analysis, policy process, South Africa, Zambia
countries; primary care user fee removal (South Africa) and user fee implementation (Zambia); prepayment mechanisms (Zambia) and social health insurance (South Africa).1

Despite important differences, most notably the 10-fold greater per capita national income of South Africa compared with Zambia,2 the two countries were selected because they shared features of particular importance to this analysis. In both cases, health reform followed substantive political change: the return to multi-party politics in Zambia in 1991 and the removal of the apartheid regime through democratic elections in South Africa in 1994. In both countries the health reform processes were wide-ranging, combining health care financing changes with institutional change. Substantive health management authority was decentralized to districts and hospital boards in Zambia. In South Africa the wholesale bureaucratic re-structuring that followed the 1994 elections involved the creation of a quasi-federal structure with one national and nine provincial legislatures and bureaucracies. The establishment of a district health system also involved some decentralization of decision-making powers in the health sector. These broader organizational changes clearly influenced the pattern of financing change, particularly in Zambia, and so were an important element of the context of financing reform. Nonetheless, and particularly in South Africa, financing policy changes were an independent focus of health reform.

The detailed findings of each country study are already available (Gilson et al. 1999; Lake et al. 2000) as well as a comparative analysis of their experiences (Gilson et al. 2000). These experiences show how the design of policies shaped some policy impacts. For example:

- in Zambia, retention of fee revenue supported quality improvements within facilities and graduated fee levels promoted use of lower level facilities, but the use of revenue to fund staff bonuses in some cases discouraged the use of exemptions;
- in South Africa, the removal of primary care user fees prompted substantial increases in utilization; and
- in both countries, the use of the available but inaccurate population data in resource allocation formulae may have undermined the promotion of equity in budgetary allocations and, in South Africa, the initial pace of re-allocation made it very difficult to translate large budgetary re-allocations into real service delivery improvements.

However, the more important factors influencing the countries’ experiences of health care financing reform during the 1990s were rooted in the influence of context, actors and processes over reform design and implementation. This paper provides a summary analysis of how these factors influenced policy change in the two countries, with a particular focus on whether and how technical analysts and technical knowledge shaped policy change. The nature of financing reforms provided a particular opportunity to examine these issues, but the use of this lens has inevitably shaped the way in which the broader organizational changes, and the forces surrounding them, are interpreted in this analysis.

Section 2 provides a detailed outline of the study’s methodological approach, including the analytical framework for this paper. Section 3 then introduces the reforms of focus in each country, and section 4 presents the analysis of these experiences. Finally, based on this analysis, section 5 provides suggestions for how to strengthen the provision and use of technical inputs in these two countries – suggestions that also offer pointers for those working in other settings.

2 Methodological approach

The overall approach guiding investigation in each country identified the importance of considering who or what causes an issue to be placed on the policy agenda and why specific reforms are designed in particular ways (Gilson et al. 1999). Acknowledging that the design and even objectives of a reform may change in unexpected ways through the process of implementation, it also allowed such changes themselves to become a focus of inquiry to understand why and how they came about. Overall, this framework suggests four broad groups of factors influence the process and impacts of any reform: the contextual factors that influence the nature of policy-making and policy change within a country, including parallel policy changes; the actors involved in policy change; the processes through which policies are identified, formulated and implemented; and the nature and design of specific reforms (Walt and Gilson 1994).

Given the particular settings of the two country case studies, it was specifically assumed that:

- the context in which reform occurred would be an important influence over their experiences, as political transitions had opened a window of opportunity for wide-ranging policy reform in which technical concerns were likely to be of secondary importance to political imperatives (Kingdon 1984; Zaharadis 1999);
- policy change would be driven by policy elites, ‘those formally charged with making authoritative decisions in government’ (Grindle and Thomas 1991: 19), including politicians with formal political power, the senior civil servants with whom they work, and other civil servants with technical knowledge relevant to health financing reform (government technical analysts);
- other social actors would be present but would be more influential when tied to these elites, and would include groups outside government having both relevant technical expertise and ties to the government network, such as non-government technical analysts based in universities, as well as donor agencies and their employees, including technical advisers working within government (Porter 1995); and
- the process and pattern of change would be shaped more by political imperatives and processes than by the needs of rational planning (Grindle and Thomas 1991; Walt 1994; Reich 1996).

In this paper we focus particularly on the actors involved in the reform processes under investigation, in relation to both their political and technical roles and how these roles affected the policy-making process. The framework guiding the analysis presented here, therefore, considers the influence of
political and technical factors in policy change, and their influence relative to each other, as well as how the context shaped these factors. Table 1 highlights the key elements of this framework and their main links to the analysis presented in section 4 of this paper. Overall, the paper’s primary contribution lies in its ‘thick description’ of these factors. Its conclusions, however, also seek to highlight some approaches that this examination of the country experiences suggests might strengthen future implementation of health financing reforms. Although policy change is always likely to involve a process of ‘muddling through’, policy analysis seeks to provide understandings, approaches and tools that help to illuminate this process in ways that support the achievement of public policy goals (Hogwood and Gunn 1984; Parsons 1995).

The country studies deliberately took a case study approach to understanding the policy process in relation to financing reforms. Case studies are particularly useful when contextual conditions are central to understanding what happens (Yin 1994), and when, because of the nature of the phenomena being studied, the potential for rival interpretations exists (Keen and Packwood 1995). Indeed, it has been argued that case studies are ‘the only way to illuminate the policy process itself . . . that in the long run will permit the building of theory about the policy environment in developing countries’ (Foltz 1995: 220).

Three phases of research were undertaken (see Annex 1). In phase 1 an overview of key issues concerning the reforms of focus was undertaken by developing an initial description of the chronology of reform evolution with reference to key features of context, actors and design. This chronology was developed from a comprehensive review of relevant documents as well as key informant interviews with a first set of policy-makers and policy analysts, selected because they were directly involved in the reforms of focus and were easily accessible. Interviews were open-ended in nature, guided by a broad series of questions derived from the study’s basic conceptual framework. The information collected in this phase also allowed the questions guiding further data collection to be revised and fine-tuned. Phase 2 then involved assessment of reform impacts and identification of the factors shaping the pattern of reform development, implementation and impact. A second set of key informants, identified in a snowball process by the initial interviewees, was interviewed using a revised open-ended interview schedule, and parliamentary debates and relevant media reports were also reviewed. Impact assessment was conducted using available evaluation reports and secondary data. Equity impacts were assessed using criteria particularly relevant to the reforms of focus: the financial equity of budgetary allocations between geographical areas (resource allocation mechanisms), and changing patterns of utilization over time and across population groups (user fees, prepayment). Drawing on Olsen (1998), judgements about sustainability impacts were made by considering resource mobilization levels and potential, the allocative efficiency of resource use, the acceptability of reforms to different stakeholders and the contribution of reforms to the health system’s organizational capacity. Finally, in Phase 3 the draft country reports were subject to extensive peer review (see Annex 1) before being revised and published.

Each qualitative data set was initially analyzed primarily using a grounded approach (Corbin and Strauss 1990), in

<table>
<thead>
<tr>
<th>Category of influencing factor</th>
<th>Key political factors</th>
<th>Key technical factors</th>
</tr>
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<tbody>
<tr>
<td>Context</td>
<td>Influence of the context of political transition over the balance of power between actors, and over the nature of processes &gt;&gt; See section 4.1</td>
<td>Key technical analysts (considering nationals working within government, nationals working outside government, expatriate advisers and other available international analysts)</td>
</tr>
<tr>
<td>Actors</td>
<td>Membership of policy elite</td>
<td>The specific roles played by the policy elite in reform process</td>
</tr>
<tr>
<td></td>
<td>Levels and sources of influence to the policy elite</td>
<td>Levels and sources of influence available to technical analysts</td>
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<tr>
<td></td>
<td>Balance of power between actors within elite</td>
<td>Balance of power between technical analysts and (other) members of policy elite</td>
</tr>
<tr>
<td></td>
<td>Other factors facilitating or constraining influence &gt;&gt; See section 4.2</td>
<td>Other factors facilitating or constraining influence &gt;&gt; See section 4.3</td>
</tr>
<tr>
<td>Process</td>
<td>Processes established by the policy elite to draw technical analysts into policy development</td>
<td>Strategies used by technical analysts to influence (other) members of policy elite, and success in influencing elite &gt;&gt; See section 4.4</td>
</tr>
<tr>
<td></td>
<td>Use of technical analysts within these processes &gt;&gt; See section 4.3</td>
<td>Strategies used by technical analysts to influence implementation, and success in influencing implementation &gt;&gt; See section 4.5</td>
</tr>
</tbody>
</table>
combination with a simple deductive framework. This combined approach allowed the richness of the country experiences as revealed in the various data sets to be explored in full, rather than focusing analysis on specific issues and prior understandings, as required in a more deductive approach. In practice, a broad coding structure derived from the study’s overall conceptual framework was initially used in analyzing documents, media, parliamentary debates and interviews. This coding structure was then adapted and refined as material was analyzed. Information derived from each of these sources of data was then triangulated within and between data sets with the aim of identifying common understandings of the experiences of focus, as well as differences of opinion. Following triangulation, the data sets were then used to develop specific analyses, such as timelines summarizing the chronology of policy change, descriptions of particular processes used in developing or implementing policy change, and stakeholder analyses of actor positions on specific reforms at specific times. These specific analyses were, finally, drawn into the overall analyses presented in the draft country reports. Preparation of these reports was, therefore, an iterative process in which the country research teams met frequently to reflect and review their evolving understanding of the experiences being analyzed. Lastly, reviewers’ inputs were considered when finalizing the country reports that have since been made widely available both nationally and internationally. Drawing on the material presented in the country reports, this paper then analyzes the country experiences using the framework outlined in Table 1.

Despite this careful and thorough analytical process, three main factors are likely to influence the analysis presented here. First, in both countries difficulties were experienced in accessing and interviewing senior politicians and senior civil servants. To some extent this was offset through the review process, in that it allowed some senior civil servants who had not been interviewed to critique the initial analyses. In addition, published evidence of this group’s views were sought and used in analysis. Secondly, each research team included some people who had been involved in the policy processes being examined. Their influence was, however, limited by interviewing them before the study got under way, and then by ensuring that processes of reflection allowed all research team members, as well as peer reviewers, to bring their perspectives to bear on analysis. Thirdly, in presenting a summary of the two countries’ experiences this paper inevitably loses some of the detail and richness of each country report as well as some of the differences between the two countries. Overall, therefore, this paper, like the country studies on which it is based, inevitably reflects the interpretation and judgements of the researchers involved. Its publication, however, supplements the dissemination activities already undertaken in allowing those judgements to be tested and debated.

One final comment on the analysis style of this paper is necessary. While the full range of data was used in developing the interpretive analysis presented here, some specific quotations were selected from the interviews to illustrate particular issues and perceptions. They were deliberately chosen to provide examples of views commonly expressed or to reflect the view of key actors. In presenting these quotes the anonymity of the respondent is preserved although the respondent category (such as ‘civil servant’ or ‘technical adviser’) is identified. Where relevant and possible these interview quotes are validated by documentary data, including previously published quotations by key figures.

3 Overview of country experiences

In South Africa, the African National Congress’s (ANC) Health Plan, published shortly after the 1994 elections, foresaw change in each area of financing policy examined in this study. It proposed the use of a needs-based resource allocation mechanism by the central health ministry in distributing health budgets between geographical areas, the removal of public sector fees for pregnant women, nursing mothers and children under six, and the development of some form of national or social health insurance (African National Congress 1994).

The first two of these policies were speedily implemented after the elections, with a second free care policy, the removal of fees for all public primary care services, implemented in 1996. However, the provisions of the new constitution that came into effect in 1996 overtook the application of the health sector resource allocation formula. Under the structures of the subsequent fiscal federal era, the national Department of Finance (DOF) (now known as the national Treasury) has responsibility for allocating a block grant to each province – which the provincial government, under advice from its Treasury, then allocates between sectors. Over time various changes to the formula used by the national Treasury have been introduced through the routine budgetary processes of government.

The speed with which these policies were implemented can be contrasted with the slow processes of developing a revised and uniform public hospital fee structure and defining the parameters of social health insurance (SHI) after 1994. Both these policy issues were identified as important not only within the 1994 ANC Health Plan but also the 1997 White Paper for the Transformation of the Health System in South Africa (Republic of South Africa 1997). Specific proposals on both were developed by a range of special structures, particularly a series of ad hoc advisory committees, comprising mainly technical analysts from within and outside government. Yet by 1999 both SHI and a new, uniform public hospital fee schedule remained unimplemented.

Zambian experiences mirror aspects of the South African patterns of policy change. Financing reforms were broadly outlined in the main policy documents guiding health system change, the 1992 Zambian National Health Policies and Strategies (NHPS) document (Ministry of Health 1992a), and subsequent Corporate Plan (Ministry of Health 1992b). A formula was first introduced to guide health resource reallocation in 1993 and subsequent changes to it were
implemented though the annual budget process. In contrast, resource mobilization policy implementation involved the introduction over time of several different fee, exemption and prepayment policies. The 1993 proposals to develop an in-kind prepayment mechanism for use by districts (the Mwase Mphangwe scheme), for example, had by 1994 been changed into a cash-based prepayment scheme initially implemented only at third-level hospitals. Finally, despite its repeated consideration within the Health Care Financing Working Group (HCFWG) – an ad hoc advisory group bringing government planners, non-government technical analysts and expatriate technical advisers together – a comprehensive health care financing policy that would guide all financing reform had not been finalized by 1999.

In comparing the financing reforms of focus between countries, the clearest differences relate to their resource mobilization policies. Whilst South Africa removed primary care fees and debated the possible role of SHI, Zambia reintroduced fees and experimented with prepayment schemes. In addition, where the South African fee reforms emphasized access and equity, the Zambian fee policy and, to some extent, prepayment schemes were apparently more oriented towards promoting financial sustainability. However, in Zambia fees also had the wider objective of promoting partnership between users and the health system, and some exemptions to protect equity were introduced. The initial objectives of the South African SHI proposals encompassed equity (through cross-subsidization) and revenue generation, as well as seeking to tackle private sector problems such as cost escalation and cream skimming.

In both countries, the introduction of population-based resource allocation formulae, with specific components directed at hospital funding, had the twin objectives of promoting financial equity and allocative efficiency. The health sector formulae promoted equity by allocating health budgets between geographical areas (provinces in South Africa and districts in Zambia) on the basis of population and proxies of health need. Although the formula used by the South African national Treasury since 1996 in determining provincial block grants includes components representing various proxies for socioeconomic circumstances, it is strongly shaped by broader macro-economic goals and policy (McIntyre and Gilson 2000).

The country studies (Gilson et al. 1999; Lake et al. 2000) provide details of the available, and limited, evidence about the impacts of these financing reforms. In terms of the policies’ stated objectives, the broad success of the South African health care financing reforms of 1994–99 was in confronting the apartheid inheritance by making strong and early moves towards re-orienting service provision towards the needs of the population at large. Yet these considerable achievements went hand in hand with increased instability in certain parts of the health system. The initial budget re-allocation within the health sector occurred so quickly that provinces were not able to absorb losses or gains effectively. As a result, the re-allocations of expenditure across provinces promoted by the policy were less than the budgetary re-allocations. The extent of expenditure re-allocation between levels of care was probably also less than the increase in primary care budgets suggests. Where hospitals did experience pressure on their budgets this led to declining provider morale and increased user dissatisfaction with public care. Equally critically, the process of global budgeting (provincial block grants), introduced in 1996, overtook the initial moves towards the equitable allocation of budgets and resulted in slower, and sometimes reversals of, resource shifts.

The notable successes of health care financing policies in Zambia similarly included the equity gains consequent on the use of a resource allocation formula. In addition, allocative efficiency gains resulted from the deliberate shift of resources from the tertiary level to the more cost-effective primary health care level. These achievements of resource re-allocated were accompanied by gains in some aspects of sustainability due to the reinforcement effect of resource re-allocation on decentralization. Whereas past attempts to devolve management responsibilities had not brought a commensurate increase in resources, the reforms undertaken after 1993 generally improved the financial situation at the district level. At the same time, the broader programme of decentralized support for financing reforms, for example by providing training in financial management. Finally, although household data suggest that demographic exemptions worked reasonably well to protect the young, the old and many of the poorest from paying for health care, they show that some higher income households, across all age ranges and against policy guidance, also benefited from exemptions. In addition, a range of small-scale studies as well as analysis of national data sets suggest that utilization levels fell in many parts of the country, and particularly amongst the poorest, as a result of fee implementation. Some studies, however, suggest that utilization levels may have stabilized and even increased in at least some areas over time, particularly where drug availability was secured.

Overall, therefore, the initial successes of financing policy change in South Africa only partially addressed the complex set of health system problems inherited from the past. In addition, the slow pace of SHI development between 1994 and 1999 meant that no action was taken in this period to improve cross-subsidization of health care for the lower income groups dependent on the public sector by the well-off who use the private sector, or to raise extra budgetary revenue for the public health care system. Similarly, despite some sustainability gains, the impact of the Zambian reforms included important, at least initial, negative equity impacts that were themselves partly a reflection of weaknesses in the technical design of policies (such as the lack of income-based exemptions). However, the key sustainability problem of the Zambian health system, resource constraints, is reflected in the 12% reduction in real terms in the absolute level of public funding allocated to the Ministry of Health (MOH) budget between 1995 and 1999. The delayed finalization of a comprehensive health financing policy document meant that a consistent and coherent approach to tackling this critical issue was not developed in the period of focus.
4 The key factors influencing the pattern and impacts of policy change

4.1 “The political momentum often outstripped the technocratic” (Zambian civil servant)

Reflecting broader experience (e.g. Reich 1996), the context of political transition was a major influence over reform opportunities and experiences 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 also meant that health policy frameworks were already available to guide implementation in both countries. Political change thus provided the opportunity for radical health policy change. In Zambia, for example, the health sector was the first sector permitted to withdraw from the pre-existing system of allocating budgetary resources through the provincial administrations. This allowed the national Ministry of Health to allocate budgets directly to district health management teams on the basis of a health sector resource allocation formula.

In South Africa, in particular, political change also created a demand for speedy change. The implementation of free care and resource re-allocation after 1994 were, therefore, widely seen as politically symbolic gestures. Indeed, in his opening speech to parliament in 1997, then President Mandela commented “arguably, nowhere is the fact of democratic transition felt more keenly than in the area of universal access to health facilities . . . [The new health policies] are practical and new qualitative steps that have transformed the majority of South Africans from being neglected outcasts into beneficiaries of a compassionate health policy” (Government of South Africa 1997: 5). Perhaps as a result, a senior health official later commented that “we could neither afford nor justify the inactivity that would attend any preoccupation with the stages of a rational planning process” (Ntsalubu 1996: 5).

But speedy implementation only contributed to the reforms’ unanticipated impacts. The way the initial resource allocation formula was developed, for example, was “incredibly rushed with people working on computers and hand held calculators . . . It was done in a pretty ad hoc way. The decisions were basically made over a week-end” (non-government analyst). The continuing uncertainty over how to fund major referral hospitals and at what level to fund them helped, in turn, to constrain the extent of transformation and resource re-allocation within the public health system during the ANC’s first term of office. Similarly, free care implementation was not preceded by relevant preparation such as assessment of the available levels of capacity to implement the reform or the development of guidelines to support implementation. The editor of the South African Medical Journal was one among many to comment that, as a result, the first free care policy ‘. . . provided a spectacular demonstration of how easy it is for a noble idea to turn into a nightmare if all ramifications are not anticipated and provided for’ (Ncayiyana 1994: i).

The problems of speedy implementation were exacerbated in South Africa by the massive transformation of governance and administrative structures, reflecting the broader change in the relationship between the state and society that accompanied political transition. 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 civil servant). In some ways, the new Zambian government leaders faced a similar situation: “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” (former Minister of Health).

Government health managers also had to deal with a continuing process of change in administrative structures. This resulted from decentralization within the health sector in both countries, and from the broader process of political decentralization in South Africa. Understandably, South African health policy-makers did not clearly foresee how structural changes would impact on their policy goals or affect their implementation capacity. Thus, the initial equity gains achieved through implementation of health resource allocation formulae were reversed by the implementation of provincial block grants after 1996. In Zambia, meanwhile, broader organizational change directly influenced the design, pattern and pace of financing reforms. Resource allocation processes, which were intended to strengthen the newly created district level and user fee policy, left key decisions, for example about the level and use of fees, in the hands of district health management teams. Subsequent financing reforms, including the comprehensive financing policy, were inevitably caught up with the changing political fortunes of the broader decentralization programme (see next section).

4.2 “This is very personalised decision-making” (South African civil servant)

The imperatives of political transition also help to explain why the key actors in health care financing reform in both countries were generally the Ministers of Health (Table 2). The main exception to this rule was the important role played by the South African national Treasury after 1996, particularly in relation to resource allocation policy.

The national Minister of Health throughout the ANC’s first term of government in South Africa was, for example, instrumental in ensuring that both free care policies were implemented, and was very supportive of the health resource allocation formula. On the other hand, her broad opposition to the various SHI proposals was a critical factor preventing their implementation. As a health civil servant noted when interviewed, “If you know what the Minister wants you can see what will go through . . . it’s much more difficult to get her support for things she’s not interested in”. In Zambia, meanwhile, the frequent change-over in Ministers during the 1991–99 period led to considerable waxing and waning in
Table 2. Key actors’ roles and positions in health care financing policy development

<table>
<thead>
<tr>
<th>Actor</th>
<th>Use of resource allocation formula</th>
<th>Resource mobilization</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>SA</td>
<td>ZA</td>
</tr>
<tr>
<td>Minsters of Health</td>
<td>Strongly supported implementation</td>
<td>First Minister strongly supported implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central economic ministry</td>
<td>Directly responsible for global budget formula</td>
<td>Supported use of formula by MOH</td>
</tr>
<tr>
<td>National Health Ministry</td>
<td>Sought equitable resource re-allocation and coordinated debates among provincial health departments</td>
<td>Implemented formula</td>
</tr>
<tr>
<td>Analysts working inside government (civil servants and technical advisers)</td>
<td>Played little role until end of 1990s</td>
<td>Planning Unit and expatriate technical advisers designed and adapted formula over time</td>
</tr>
<tr>
<td>Analysts working outside government</td>
<td>Directly involved in policy development around 1994; afterwards provided independent analyses of policy impacts</td>
<td>Little role</td>
</tr>
<tr>
<td>Business sector</td>
<td>No position</td>
<td>Not relevant</td>
</tr>
<tr>
<td>Social sector</td>
<td>Unions concerned about lack of transparency in overall government budget process; no stated position on health resource re-allocation</td>
<td>Little influence</td>
</tr>
<tr>
<td>Donors</td>
<td>Not relevant</td>
<td>General support for principle of re-allocating towards primary health care within decentralized structures</td>
</tr>
</tbody>
</table>

ANC = African National Congress; MOH = Ministry of Health; SHI = Social Health Insurance.
policy fortunes – particularly with respect to cost sharing. The first Deputy Minister, who subsequently became the third Minister of Health, was widely accredited as the architect of the overall health reform programme, and was supportive of both resource re-allocation and cost sharing. The first Minister also 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 for this action. He also introduced a prepayment scheme intended to use in-kind contributions (the Mwase Mphangwe scheme). The second Minister subsequently turned this idea into a hospital prepayment scheme. Finally, the fourth Minister’s limited support of the draft comprehensive financing policy prepared by a group of analysts from within and outside government (including expatriate assistants) appears to have been one obstacle to its finalization before 1999. Overall, therefore, “the political process was driven by who was Minister of Health at the time, and quite often made no reference to the technocratic process” (Zambian civil servant).

Such personalized decision-making by key political figures or public officials is not uncommon in African countries, given the relatively closed public spheres and centralized government systems (Grindle and Thomas 1991; Porter 1995). In both countries examined here, Ministers of Health, as individuals, derived strong influence from their formal and pre-eminent role in the process of health policy development during a moment of major political change (Figure 1). Although the South African national health minister must work with provincial health ministers, she is a member of the national Cabinet and has specific responsibilities in policy development. During the period of study, the 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” (former Minister of Health).

Two additional factors, therefore, gave political strength to the Ministers in both countries. First, they received the clear backing and political support of the President and party of government in the reforms they pursued. This was sometimes at a personal level but also because health reforms were seen, in both countries, as an important leader of policy change during political transition. Ministerial positions on these reforms, therefore, often apparently reflected the positions of their party and its senior leaders. Secondly, as individuals all the Ministers brought strong values and behaviours to the task of reform. The first Zambian Deputy Minister of Health was seen by those supporting decentralization as a visionary

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<table>
<thead>
<tr>
<th>Actor</th>
<th>Overall level of influence</th>
<th>Source of influence$^a$</th>
<th>Values/behaviour$^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Political:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minister of Health</td>
<td>high</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td><strong>Government:</strong></td>
<td></td>
<td></td>
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<tr>
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Notes:

$^a$ Number of ticks indicates relative level of influence derived from source: 3 ticks = high influence; no tick = no influence derived from this source; a bracketed tick = indirect influence derived from this source, for example the influence of the national Treasury derived from economic status was due to its influence over economic policy rather than from its own position within the national economy (whereas the insurance industry derived direct economic influence from its control of two-thirds of total health expenditure: McIntyre et al. 1995).

$^b$ Values/behaviour refers to the differing behaviours of the actors (e.g. rooted in clear principles or values, tactical and strategic, expressing commitment).

$^c$ DHFE = Directorate of Health Financing and Economics, Department of Health.

$^d$ COSATU = Congress of South African Trade Unions.

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Figure 1. The sources of actors’ influence over health care financing policy development in South Africa.
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 technical adviser). Although the South African minister 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 civil servant). The tactical ability of the second Minister in Zambia was also noted. His sudden announcement of a hospital-based prepayment scheme in 1994, for example, was seen as a clear move to raise his political profile. It both represented 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 decentralization programme.

The strong influence of the Ministers of Health was, however, also a function of the relative position and influence of other actors within the relatively narrow band of policy elites (Table 2; Figures 1 and 2). For example, the potential influence of the South African insurance industry over SHI debates was undermined by both its weak political position (Figure 1) and its divided response to SHI proposals (Figure 2). Meanwhile, although rarely involved in health policy or health financing debates due to its primary concern with issues such as labour market policy, the ANC-aligned trade union movement effectively supported the Minister of Health in her opposition to the 1997 SHI proposals (Figure 2).

Similarly, donor support for Zambian health sector reform facilitated its health sector policy changes. Key figures in the donor community were “instrumental in facilitating the networking, the selling of the new policy reform ideas to the other players” (former Minister of Health). Donor funding also directly supported the reforms, whilst the preferred macro-economic policy frameworks of the international financial institutions created an environment supportive of the principle of revenue generation.

Finally, the role of the central government economic department was particularly important in both countries. The South African national Treasury’s opposition to SHI policy proposals placed it with the Minister and the Trade Unions on this issue, and it came to play the central role in overall resource allocation policy in the fiscal federal era. In Zambia, the Ministry of Finance and Economic Development (MOFED) facilitated key aspects of policy implementation. In particular, it 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 facility and district level.

The different roles of the central economic departments in each country seem partly to reflect differing perceptions of their own capacities and those of the health ministry. The Zambian MOFED, thus, perceived itself to have too little capacity to become directly involved in health financing policy debates, and anyway had “a confidence and a feeling that, you know, Health knew what they were doing, they had a much better focus on the issues than we had, so we were quite willing to play ball with them, to let them, you know, take the lead and initiate” (expatriate technical adviser). In contrast, in South Africa, “there was definitely an incredible arrogance in the [Treasury] 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” (non-government analyst). As Figure 1 indicates, however, the influence the national Treasury derived from this behaviour was backed up both by its formal position in policy change, directly influencing the policy and actions of spending agencies such as health, and the high level political backing its views and actions received as a result of the government’s commitment to the 1996 national macro-economic strategy it had developed. This strategy also established the principles by which the Treasury judged or determined policy proposals, namely, efficiency in public sector resource allocation and use as part of a broader strategy for controlling public sector expenditure levels, and reducing the government deficit. Treasury, therefore opposed the various SHI proposals on the grounds that they would inappropriately raise tax levels, and also sought to allocate higher budget levels to the more productive and efficient provinces through the resource allocation process (Figure 2).

4.3 “Health financing was never thought of as an important issue” (South African non-government analyst)

In both countries, as also in Egypt (Nandakumaar et al. 2000), technical analysts from inside and outside government had varying and often only limited influence over financing reforms. This was a further factor giving the Ministers of Health of both countries, as well as the South African national Treasury, influence over these policy changes. Table 2 does, however, suggest that government analysts played a slightly stronger role in health financing policy development in Zambia than South Africa. Officials from the Zambian MOH Planning Unit were involved in policy debates even before 1991 and then continued to be central actors in the reform process within the new government. The chief planner was, in particular, a key member of the reform team. Members of both the Planning Unit and the Central Board of Health (CBOH), established in late 1996, played central roles in resource allocation policy decisions, and were sometimes brought into cost-sharing policy development. Indeed, the Planning Unit coordinated the preparation of a comprehensive financing policy document from 1997.

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 Department of Health (DOH). Although it is widely accepted that the Directorate played an important role in keeping health care financing discussions alive over the 1990s, its main impact on health financing policy was through its involvement in the development of the 1998 Medical Schemes Act to re-regulate the private insurance industry. Other actors largely drove other processes of policy development. The DHFE was, for example, brought in after the key
decisions on free care had been made, sought primarily to coordinate other groups’ inputs into the budget process, or played only a supporting role in SHI proposal development.

In both countries, the influence of these technical analysts was limited both by capacity constraints and the weaknesses of their power base. In Zambia, there were only a few people working in the Planning Unit and very few, even within the wider group of people working within the CBOH, had health economics expertise. More importantly, however, their influence was linked to the Minister in power and to the fortunes of the broader decentralization reform programme with which they were associated (and which had pre-eminence over health financing reforms). They took a particularly low profile during the second Minister’s period of office, for example, as he sought to build a power-base amongst the hospital managers who felt threatened by decentralization and its supporters. They were also unable to secure the fourth Minister’s support for the comprehensive financing policy document. As another Minister of Health

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<tr>
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<td>Other groups</td>
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</tbody>
</table>

Notes:

a This table indicates the degree of support or opposition expressed by actors in relation to the 1997 SHI proposals, derived from analysis of interview and documentary data. The actors highlighted by dark boxes played the most important roles in blocking further policy development.

b Not mobilized = did not play identified role in debates though may have played a role ‘behind the scenes’; for example, despite the opposition to these proposals of Treasury officials, the national Minister of Finance was never brought into the debates because the proposals were never discussed within Cabinet.

c DOH = Department of Health; although the technical analysts were directly involved in policy development, more senior officials were apparently not mobilized to support these proposals at higher political levels.

d RAMS = Representative Association of Medical Schemes, one component of medical insurance industry.

e COMS = Concerned Medical Schemes group, a second component of medical insurance industry.

f COSATU = Congress of South African Trade Unions, politically aligned with the ANC.
from this period noted, “The building of the HRIT [a small team, including Planning Unit officials, that was charged with implementing decentralization], and . . . the existing visibility of people in this team who were considered by people in the hospitals as juniors, was also a very big problem”.

In South Africa, health economists were brought into policy development for the first time in 1995 with the inclusion of the DHFE within the re-structured national DOH. As Figure 1 summarizes, it could derive only limited influence from its formal policy position and knowledge base. Initially established at a relatively low organizational position within the DOH, its staff were not formally involved in the Department’s strategic decision-making nor easily brought in to update the Minister on policy matters on a regular basis. Although some senior civil servants did draw them into policy debates (giving them indirect political influence), the sporadic nature of this support did not allow the DHFE to establish a clear position and role within policy-making. Indeed, the general lack of understanding of financing issues within the DOH led DHFE staff to be treated more often as accountants responsible merely for managing budgets, rather than as analysts whose technical knowledge could contribute to health system transformation. As a result, “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” (non-government analyst).

The limited numbers of health economists working within government in both countries led to the involvement of non-government analysts in policy development (Table 2). In Zambia this group included long-term expatriate technical advisers working within the civil service, short-term technical advisers undertaking consultancy work and economists from the University of Zambia. In South Africa the non-government analysts were predominantly drawn from national research groups. Working within existing government structures, long-term technical advisers in Zambia were directly involved in resource allocation decisions. In contrast, short-term technical advisers in Zambia and national researchers in both South African and Zambia were primarily drawn into the development of resource mobilization policies (user fees and insurance).

The influence of these non-government analysts appeared to be greatest when they worked within routine government structures and so were directly involved in decision-making – particularly around resource allocation. Technical advisers in Zambia, therefore, usually had full responsibility for taking pieces of work forward. In part this was due to the small numbers of technical analysts within the MOH, as well as the development of trust between technical advisers and their government counterparts. Zambian academics were initially largely involved in policy development through a special committee, the Health Care Financing Working Group, although some were subsequently commissioned by government to undertake analytical work that would inform policy development. However, the acceptance and status of all non-government analysts varied between Ministers, in response to the fluctuating status of their government colleagues. As a Zambian non-government analyst noted, “. . . there was too much interference from the Ministry. The whole reason why [the Working Group] sort of flapped was the minister trying to interfere”. Other factors undermining the influence of non-government analysts included the relatively short time periods for which technical advisers stayed within the country, mis-matches between the thinking of the analysts and government thinking, and the production of indigestible reports.

In South Africa, national researchers were largely drawn into policy development through special committees. However, as Figure 1 indicates, the influence they derived from their technical skills and knowledge, commitment to supporting the new government in its policy development, political links from their previous involvement in the anti-apartheid movement and direct involvement in policy processes was inadequate to offset the combined opposition of the Minister, the Unions and the national Treasury to the various SHI proposals they were instrumental in developing. Although three out of four of these committees were established by the then Minister of Health, at no point did she meet with committee members to discuss their proposals or explain her own position. As in Zambia, a key issue seems to have been trust – in this case an apparent lack of trust in these non-government analysts on the part of the Minister of Health. From her perspective, the continuing process of developing the SHI proposals may have represented 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 number 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” (non-government policy analyst).

4.4 Analysts “concentrated on policy and forgot the power and the politics” (South African non-government analyst)

The influence of technical analysts (both within and outside government) over policy development was also constrained by their apparently weak understanding of how policy objectives and design could provoke opposition, and so derail implementation (Grindle and Thomas 1991). This problem was clearly seen within the South African SHI debates and, to a lesser extent, in the efforts to develop a comprehensive financing policy in Zambia.

The South African SHI proposals, therefore, never really addressed the first Minister of Health’s abiding concerns about SHI. She 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. The Minister’s publicly stated bottom lines started with universal and non-discriminatory access to quality care for all. She wanted to create a “health service that is accessible and more equitable” (interview with Minister Zuma, The Star, 3 November 1997). 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. Thus, her reputed reaction to the 1995 SHI proposals 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” (health civil servant). At the same time, the various SHI proposals also overlooked the concerns of the Trade Union movement. The largest federation of trade unions, for example, opposed the 1997 SHI proposals because they “couldn’t convince themselves that members should pay for services that they haven’t paid for in the past” (health civil servant).

In contrast, the technical analysts did adapt the SHI proposals in response to the concerns of the national Treasury. The 1997 SHI proposals, thus, proposed a lesser degree of cross-subsidization 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 (an expressed Treasury view). Nonetheless, the Treasury continued to oppose SHI because of its concern that the proposals would contradict the imperatives of the country’s macro-economic policy – for example by increasing the national tax burden.

Overall, therefore, as highlighted in Figure 2, these three different actors came together for different reasons in their opposition to the 1997 SHI proposals. But in each case, it appears that the technical analysts overlooked or mis-read the political requirements of policy change around SHI. Perhaps most importantly, because many of the non-government analysts had been directly involved in developing the insurance proposals included in the ANC Health Plan, they apparently assumed that they were the natural allies of the political analysts had been directly involved in developing the political requirements of policy change around SHI. It appears that the technical analysts overlooked or mis-read opposition to the 1997 SHI proposals. But in each case, it may itself have constrained the programme’s potential success – most obviously in the delayed efforts to tackle drug supply problems (MOH/WHO/UNICEF/World Bank 1997). Avoiding controversial issues does not lessen their influence over the pattern and impacts of policy change.

4.5 “They had great difficulty translating that vision into everyday operational guidelines” (Zambian technical adviser)

Finally, the two countries’ experiences indicate that policy impacts are critically shaped by the experience of implementation, over which national policy elites have only limited influence. The key actors at this stage of policy change are, rather, those tasked with implementing any policy, such as frontline health care workers, and the beneficiaries of any policy, that is the public (Tendler 1997). Thus the utilization responses of patients to the user fee policies of both countries critically explain their positive (in South Africa, a utilization increase) and negative (in Zambia, a utilization decline) equity impacts. At the same time, the responses of health workers to the removal of fees in South Africa apparently contributed to the deterioration in the perceived quality of public health services (Gilson et al. 1999), whilst the practice of exemption implementation in Zambia contributed to equity problems (Lake et al. 2000).

Although inputs were obtained from district and hospital officials in developing policies in the early days of health reform in Zambia, the more common experience across both countries was of inadequate communication and consultation with implementers and the public. Thus, in Zambia, “staff 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 implementers, or not effectively communicated” (expatriate technical adviser). Similarly, in South Africa a common criticism of health policy development was that “...complex reforms are often implemented in a haphazard manner, with little consultation and nowhere near an adequate level of planning and research or pilot programming” (Gevisser 1996: 33). Communication with the public was equally weak. Although one of the South African committees that considered SHI called for, and received, comments on its proposals, “the public stuff influenced us not one iota” (committee member). And in Zambia, the end users “had very little knowledge about all of this. All they were told is that you have to pay so much, so the consultation came very late” (non-government analyst).

Another common implementation problem across the countries was that policies were often developed without ensuring that adequate capacity was in place to enable effective implementation. The necessary capacity included financial and human resources, as well as information and other
management systems. Although the parallel programme of decentralization did support relevant and necessary training in Zambia – for example, in financial management – weak budgeting and accountability systems remained an obstacle to implementation, together with the absolute scarcity of resources. And in South Africa, speedy and wide-ranging change only exacerbated problems, as one provincial health official noted: “I find it difficult to implement all the things and I'm fairly skilled . . . to expect this from [untrained staff] is unfair. We're making them frustrated, we keep on giving them more and we hammer them if they don't give it. It's just plainly too much” (provincial civil servant). Finally, neither country developed a monitoring and evaluation approach through which to draw lessons from those involved in implementation that could fine-tune policies. Although these planning weaknesses might be seen as inevitable given that policy change was pushed forward during a window of political opportunity, just a little more preparation and evaluation and, in South Africa, prioritization, could have broadened the policy gains achieved. One South African province was, for example, able to support implementation of the second free care removal policy simply by delaying implementation 3 months and undertaking an inclusive, if not comprehensive, planning process.

5 Lessons for health financing reform: combine political and technical analysis in support of policy change

Although the experiences of the two countries presented here differed in important ways, they provide further evidence that ‘policy analysts cannot continue to ignore the how of policy reform’ (Walt and Gilson 1994: 366). Health care financing reform has, in particular, often been seen as the preserve of health economists, yet it has frequently floundered because too little attention has been paid to the contextual, political, personality and strategic factors that always shape policy change. Thus, the experiences of South Africa and Zambia clearly demonstrate:

- the diverse ways in which the changing context of reform, including parallel policy reforms, can sustain or constrain financing reforms;
- the critical influence of policy elites (politicians and senior civil servants) over which policy proposals are taken forward into implementation and which not;
- how little valued technical analysis can be in the face of political imperatives and opportunities;
- how limited capacity to provide technical analysis itself serves to weaken the influence of analysts;
- how the nature and design of policy proposals can generate opposition and so block change, and how difficult it is to adapt design in ways that secure adequate support for change; and
- that failing to even communicate policy changes to frontline health care providers and the public can undermine policy implementation.

For analysts in both countries, the conclusions drawn from these experiences focus on the need to develop both technical capacity and strategies that support policy change. It is important to: increase the numbers of analysts working within government, provide in-service training to develop their technical skills, and strengthen the links between government and non-government analysts to enable more effective use of all available technical capacity. In parallel, efforts must be made to build demand for technical analyses (Paul 1995). Equally important, however, is to develop the strategic awareness and skills of all analysts. Tools such as stakeholder analysis (Crosby 1997; Varavavszky and Brugha 2000), for example, can be helpful in developing awareness of actors and their concerns, and specific attention must also be given to developing strategies that can support change (Crosby 1996; Glassman et al. 1999). For policy development, such strategies might include identifying and working with key individuals who can support proposals at the highest political levels, countering, for example, possible opposition from the national economic ministry; as well as identifying and working with social actors, such as trade unions, whose power bases complement the technical knowledge of analysts. To support policy implementation, technical analysts might consider working with middle managers and health workers to ensure adequate consideration is given to implementation realities in proposal development. They might also suggest trialling interventions in order to identify and tackle potential implementation obstacles rooted in the public’s reactions. It is particularly important that analysts strengthen the communication of complex policy designs, for example, by spelling out key objectives and how different policy options would allow their achievement, and using the media to promote widespread debate and awareness of proposed reforms.

At the same time, the country experiences presented here indicate that the health reform leaders in both countries must consider how best to use the technical analysts advising them. The experiences particularly highlight the need, first, for these leaders to balance political and technical considerations in developing policy changes. It may not be feasible to implement a politically symbolic policy in ways that promote the desired policy outcomes. Speedy changes initiated during windows of political opportunity may be unsustainable over the longer term. A second critical task of reform leaders is to establish an environment that enables technical experts to undertake the analytical work necessary to develop policy approaches that tackle priority health system problems. Mapping out future financing problems and issues at the country level would provide guidance on research priorities, whilst clarification of the intended objectives of specific policy changes would indicate political ‘bottom lines’ of policy change. Analysts also need opportunities to interact with policy-makers during the course of reform design, to better understand this guidance and the reactions of policymakers to their proposals. Finally, a key input into implementing more effective change is the development of monitoring and evaluation systems that allow experience in implementing reform to be fed back into policy change. Such systems could build on recent national initiatives to develop National Health Accounts, as well as drawing on detailed household utilization and expenditure data and focused evaluations.
Although all policy change is inevitably shaped by political moments and imperatives, policy elites and technical analysts who seek to bring about policy change in pursuit of public policy objectives in any country must, above all, work as a team, developing a common vision, bringing different inputs to the table and seeking ways of reconciling those inputs in support of their common goals. Recognizing that policy change is neither rational nor linear, a key aim of such teamwork is to keep track of the changing pattern of policy change in order to adapt and revise the strategies used to maintain its direction towards its objectives. As Brinkerhoff has commented, ‘successfully pursuing long-term reforms in democratizing environments involves not just knowing in which direction to move, but paying attention to how to get there’ (1996: 1395).

Endnotes
1 Financing-related reforms that were not yet under consideration at the start of the study, or which did not have equivalents in the other country, were not included. Examples are changes in the way church health facilities were funded in Zambia and hospital fee reform in South Africa.
2 The World Bank estimates that the South African average per capita gross national income (GNI) in 2000 was US$3102, in contrast to the Zambian figure of US$300 (World Development Indicators found at web site http://www.worldbank.org/data/databy-topic).
3 Expatriate analysts only came to serve within government towards the end of the 1994–99 period.

References


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### Annex 1. Data collection methods used in each country study

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<th>Zambia (ZA)</th>
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<td>• official post-1994(SA)/ 1991(ZA) policy documents and policy input papers;</td>
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<td>and annual Minister of Health budget speeches</td>
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