Evaluation of the 1988 User-Fee Policy In Lesotho

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ACRONYMS

CHAL	Christian Health Association of Lesotho
GDP	Gross Domestic Product
GNP	Gross National Product
GOL	Government of Lesotho
HPN II	Second Health, Population and Nutrition Project
HS-A	Health Service Area
LFDS	Lesotho Flying Doctors Services
M	Maloti
MEMP	Ministry of Economic and Manpower Planning
MOF	Ministry of Finance
MOH	Ministry of Health
MPS	Ministry of Public Services
PHAL	Private Health Association of Lesotho
PHC	Primary Health Care
QE II	Queen Elizabeth II Hospital
RSA	Republic of South Africa
SACU	Southern African Customs Union
SADC	Southern African Development Community
SAP	Structural Adjustment Program
VHW	Village Health Worker

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ABSTRACT

This report provides a comprehensive evaluation of the factors underlying the evolution, design and implementation of the 1988 fee policy in Lesotho. The chief aim of the study was to conduct a critical appraisal of this policy, focusing on the key factors that might have constrained or facilitated its success. The performance of the policy was assessed in terms of *financial* sustainability in the health sector as well as promotion of equitable access for economically marginalized groups. The investigation involved qualitative interviews of key informers that were directly or indirectly involved and affected by this policy change as well as a quantitative assessment of the policy impact. A broad view, incorporating process, actors, context and content, revealed that the failure of the policy to promote *financial* sustainability and equity in the public health sector, is rooted in the dynamic patterns that shaped the evolution, design and implementation of this policy. The critical features of these patterns, which effectively constrained the success of this policy, were found to be: hasty implementation; failure to clarify goals, objectives and strategies; failure to generate a common vision around and commitment to the policy; failure to modify the policy in response to changes in the economic and political contexts. The analysis yielded pragmatic recommendations for strengthening the 1988 fee policy, which is currently still in place. Recommendations for strengthening established decision-making protocols that have historically shaped the design and implementation of health sector reform policies were also generated.

CHAPTER 1
Aims, Background and Justification

1.0 Introduction

The current chapter seeks to provide an overview of the rationale, aim and the specific objectives of the dissertation. In addition the background on fee policies, justification for the study and the anticipated outputs are outlined. The chapter ends with the overall structure of the dissertation.

1.1 Project Rationale

The study is an attempt to understand the dynamics of policy design and implementation as potential catalysts/constraints to the effective and efficient implementation of the user fee policy in Lesotho, thus highlighting the explanatory links between the policy intention and the actual policy outcome.

1.1.1 Aim

- To conduct a critical appraisal of the user fee policy of 1988, through a detailed analysis of the content of the policy as well as the processes, actors, and context that shaped the design and implementation of this policy in Lesotho.

1.1.2 Objectives

- Review the processes that shaped the policy design and implementation.
- Analyse the roles of the different actors in the design and implementation of the policy.
- Review the context in which the evolution, design and implementation of this policy took place
- Review the content of the 1988 fee policy.
- Determine some of the key factors that may have facilitated or constrained the effective design and implementation of this policy.
- Develop viable recommendations for the formulation and implementation of current reform strategies being undertaken in the health sector (see chapter three)

1.3 Background

The escalating costs of health care delivery are a distinctive menace that has plagued governments throughout the global village. This menace has been most prominent in

developing countries where it has been accompanied by economic growth that is not even close to absorbing these costs (Gilson & Mills: 1995). As a result, for over three decades health sectors in these countries have engaged in different processes of reforming health policies and the institutions that implement those policies. Revenue generation and improved efficiency in the use of scarce resources have been the key focal points of health sector reform (Korte et al: 1992; Creese: 1991; Gilson & Mills: 1995).

One of the main problems associated with health sector reform policies is the widening gap between policy objectives and the actual outcome of policies. Some of the reasons frequently cited for this gap are the poor design of the policy itself and inadequate public sector capacity to implement policies effectively (Creese: 1991; Hilderbrand & Grindle: 1994). The emphasis of policy evaluations, when undertaken, is usually on the technical aspects (content) of policies, often ignoring the influence of processes, actors and context, on the design, implementation and impact thereof (Walt & Gilson: 1994; Cassels: 1995; Macrae et al: 1996; Frenk: 1996). More often than not, the inability to understand the failure of policies stems from the de-politicisation of policy processes in analysis (Walt & Gilson: 1994; Walt: 1994; Hogwood & Gunn: 1984).

A comprehensive evaluation of any policy needs to take into consideration factors such as why a particular policy got onto the policy agenda and why it got implemented when others might not have been, as well as why it got implemented in a particular way (Grindle & Thomas: 1991; Mills *et al.*: 2001). Essentially, one needs to understand the politics of policy agenda setting as well as the politics of policy design and implementation because the policy content is essentially a product of these politics. Thus, to understand why a policy failed or succeeded in realising its stated objectives one needs to understand and incorporate these politics in evaluations.

Oftentimes policies implemented in Sub-Saharan countries and other developing countries are a result of *en vogue* ideologies prevailing in the international arena, mainly because of their economic dependence and the resulting vulnerability to external influences on their policy agendas (Okuonzi & Macrae: 1995; McPake: 1993). Partly as a result of this external influence, policies are often adopted without any attempt to understand why previous policies or strategies failed to realise desired

outcomes and new policies are prescribed and implemented leading to very little desired change. Another factor contributing to the failure to evaluate policies is the lack of resources such as time, to effectively carry out evaluations and the capacity to use evaluation results to inform new policies or even strengthen existing policies (Brijlal *et al.*: 1998). Failure to evaluate policies has meant that new policies are hardly ever based on substantial knowledge or understanding of the critical issues or the baseline situation, which are factors that can potentially affect the policy impact (Walsh & Simonet: 1996).

1.4 Justification

The current study focuses on health financing reforms undertaken in Lesotho in 1988, which essentially involved the increase of user fee charges for health services provided in public facilities. The aim of this policy change was to increase recovered costs and generate revenue. Specifically one seeks to investigate if the user fee policy in this country contributed to its stated objectives and if not, then to try and identify the key constraining factors. Such an evaluation is imperative because since implementation this policy has never been evaluated.

Like other Sub-Saharan countries, the performance of the 1988 fee policy in Lesotho in contributing to financial sustainability in the public health sector has been extremely limited with cost recovery ratios averaging only 6% in 1995. Cost recovery ratios have in fact been falling from 10% since 1988 (Health Expenditure Review, 1996). However, the study aims to generate not only ways to strengthen the fee policy but also mechanisms for strengthening processes of policy development and implementation of reform policies undertaken in the health sector. Currently the health sector in Lesotho is engaged in various organisational and financing reforms aimed at maximising benefits with the dwindling resources currently available. Expanding the resource base and ensuring *financial* sustainability are some of the primary objectives at the forefront of this wave of change. Thus, an evaluation of the fee policy will strengthen not only strategies for cost recovery but will also provide an assessment of problems related to established mechanisms for health sector policy development and implementation.

1.5 Expected Outputs of the Study

- To generate recommendations on how the design and implementation of the user fee policy can be modified such that it is more effective in realising sustainability without perpetuating inequities.

- To provide some of the necessary ingredients for a full review of the overall financing strategies in the health sector and to strengthen these strategies in their pursuit for equity and sustainability.

- To present specific recommendations to guide planning, design and implementation of the health sector reform strategies currently being proposed in this country.

1.6 Overview of Methods and Structure of Dissertation

The research strategy involves a retrospective descriptive assessment of the evolution, development and implementation of the user fee policy in this country. Data collection will be highly dependent on interviews with specific individuals who were directly or indirectly involved in the decision-making around the policy design and implementation, focusing on those both within and external to government.

The evaluation will focus on more than just the policy content to incorporate factors such as the context within which the policy was designed and implemented; the relative role and influence of different actors in the policy arena as well as the nature of decision making processes shaping the policy design and implementation (Walt: 1994; Walt & Gilson: 1994). Because capacity is often cited as an important constraint to effective policy implementation, one will incorporate the role of capacity as a potential constraint in the policy arena (Hilderbrand & Grindle: 1994; Grindle & Thomas: 1991). Nevertheless, one seeks to assess how, if at all, these factors influenced not only the policy design and implementation but equally important is the actual policy impact.

The following chapters provide details of the experience of the evolution, design and implementation of the 1988 user-fee policy in Lesotho. Specifically, chapter two provides a detailed literature review which provides the general background on user fee policies, as well as the different approaches to policy analysis in general and the

analysis of user-fee policies in particular, drawing on both theoretical and empirical literature. Chapter three provides a description of the political, economic, social and demographic settings of the country under study, including background on the organisational aspects of the health sector and the financing strategies of the public health sector. Chapter four provides details of what the 1988 fee policy in Lesotho entailed. Chapter five outlines the details of the research methodology and strategies used for data collection and analysis, while chapter six provides the results from the evaluation of the patterns of the fee policy evolution, design and implementation. The results from the assessment of the policy impact on financial sustainability and equity are presented in chapter seven. Chapter eight provides a discussion of the explanatory links between the patterns of the design and implementation of this fee policy on the one hand and the policy impact on the other. The last chapter outlines specific conclusions and recommendations based on the results.

CHAPTER 2

Literature Review

2.0 Introduction

For a long time public policy analysts have grappled with the problem of widening gaps between policy objectives and the actual outcome of policies. Some of the reasons most frequently cited for this gap include, the poor design of the policy itself and inadequate public sector capacity to implement policies effectively. However, there are other issues that influence policy outcomes (Creese: 1991; Hilderbrand & Grindle: 1994). The emphasis of policy evaluations, when undertaken, is usually on the technical aspects (content) of policies, often ignoring these other issues. Specifically, the processes and actors that shape policy design and implementation as well as the underlying context within which these processes take place are the critical factors that are seldom incorporated into policy analyses (Walt & Gilson: 1994; Cassels: 1995; Grindle & Thomas: 1991; Frenk: 1996). Hence, more often than not, the inability to understand the failure of policies stems from the de-politicisation of policy processes (Walt & Gilson: 1994).

The aim of this chapter is to provide a review of the literature relevant to policy evaluations, focusing primarily on user-fee policies aimed at cost recovery. More specifically, an attempt is made to provide an assessment of the politics of policy design and implementation and how these activities affect the success or failure of user fee policies in realising their stated objectives. The first section outlines the rationale, general objectives and strategies and the problems associated with user-fee policies as well as the criteria for evaluating cost recovery policies. The second section looks at different models for evaluating public sector policies. This section attempts to draw the possible linkages between the problems associated with user fees and the patterns of policy design and implementation. The conceptual framework adopted for evaluation in the current study is briefly outlined in section three, with a particular focus on the relevant questions to be addressed in the analysis, as well as the specific indicators that can be used for performance measurement. All three sections will draw on theoretical and empirical experiences from developing countries that have implemented this policy.

2.1 User-Fee Policies

The implementation of user fees in developing countries is part of the global trend to reform health sector policies and the institutions that implement these policies (Mills & Gilson: 1995). The need for health sector reforms derives from shrinking resource bases for health systems, coupled with health care cost inflation, as well as worsening disease burdens and the associated increase in the demand for health care (Korte *et al.* : 1992). The dominant focus of these reforms has been improving the efficiency of health systems through organisational restructuring and financing strategies for the health sector (Gilson & Mills: 1995). Moreover, limited macro economic performance of developing countries has meant that governments have been forced to search for innovative ways to generate additional resources for the health sector. The main strategies for generating revenue include risk sharing; (social, national and private health insurance) cost recovery through user fees and community financing (Gilson & Mills: 1995). As stated before, the current study will focus only on user fees. The aim of this section is to provide background on fee policies outlining the different rationales for these policies; the criteria for assessing the performance of user fee policies, specific pre-conditions for successful fee policies, typical problems associated with these policies as well as a brief look at the overall empirical experience of fee policies in Sub-Saharan Africa.

2.1.1 Objectives of User Fee Policies

User fee policies can be understood as a conscious effort by governments to set prices for healthcare provided at public health facilities, in pursuit of specific goals. Such policies can imply the introduction or increase of fee levels charged for healthcare in public facilities. The aim of such strategies in the medium term is to generate revenue for the government or for the health sector or sometimes for the facility collecting these fees. The long-term goal is to promote *financial* sustainability in the health system (Korte *et al.*: 1992; Creese: 1991; Goodman & Waddington: 1993). In addition, governments can introduce a system of differential charges that promote rational use of the referral system and curb frivolous use of health services, thus enhancing sustainability and efficiency (Kutzin & Nyonator: 1999; Shaw & Griffin: 1995; Akin *et al.*: 1987). On the other hand, fees can be abolished for specific categories of diseases that fall under primary health care. The long-term goal of this strategy is to ensure equitable access to primary health care, especially for the low-income groups, thus promoting social equity (Shaw & Griffin: 1995). Fee policies are

thus implemented for different reasons and can take different forms. But the primary reasons often cited for the charging or raising of fees for health care services are improved efficiency in, and *financial* sustainability of, the health system through appropriate price signals and resource mobilisation (Gilson *et al.*: 1995; Thomas *et al.*: 1988).

2.1.2 Criteria for measuring performance of fee policies

Although the primary objective of raising or introducing fees for healthcare is the recovery of costs, cost recovery is not an end in itself (Creese: 1991). As mentioned above the long-term goals of cost recovery fee policies are essentially the promotion of efficiency and *financial* sustainability of the health care system. On the other hand, for humanitarian reasons equity goals are often of particular concern when fees are raised or introduced, hence targeted prices and exemption schemes aimed at ensuring distribution of healthcare according to need, as opposed to ability to pay often accompany cost recovery policies (Whitehead: 1992; Gilson *et al*: 1995). Moreover, revenue generated can be used to promote efficiency and equity if it is allocated towards improving quality of care and coverage at the lower levels of the health system (Livack & Bodart: 1993; Gilson *et al*: 1995; Gilson & Russel: 1995).

Where cost recovery fee policies are implemented, health sectors, and indirectly governments are in effect pursuing two sets of goals that are intrinsically contradictory. On the one hand fees are charged to generate revenue to sustain the health sector and to discourage frivolous demand for healthcare, thus enhancing efficiency in the health system (Russel & Gilson: 1995; Gilson *et al.*: 1995; Gilson & Mills: 1995). On the other hand, people who cannot afford to pay cannot be denied services (Whitehead: 1992). In a context where equity is an official goal of government, the implementation of cost recovery fee policies will be successful when a balance is struck between efficiency and sustainability on the one hand and equity on the other. Moreover, although cost recovery is a primary objective, it is generally accepted that in spite of problems of effective policy implementation, total cost recovery is not attainable given concerns with equity and escalating health care costs. Hence on their own user fees cannot achieve overall financial sustainability of a health system (Creese: 1991; Korte *et al.*: 1992; Gilson *et al.*: 1995; Gilson & Russel: 1995).

The primary intent of this section is to provide some detail on the critical criteria for evaluating the impact of user fees, focusing primarily on efficiency, equity and *financial* sustainability. (Kutzin: 1995; McPake & Kutzin: 1997).

2.1.2.1 Efficiency

Efficiency refers to the maximisation of benefits at least cost, thus making the most of the scarce resources available to health sectors in developing countries (Akin *et a*l: 1987; Mills & Gilson: 1995; Gilson *et al*: 1995; Goodman & Waddington: 1993). Efficiency can be understood in terms of allocative and technical efficiency. Allocative efficiency is promoted when resources are allocated such that benefits are maximised. For example, allocative efficiency would be maximised if health care resources (including fee revenue) are invested mainly in primary health care services as opposed to tertiary care since the latter is more costly and benefits fewer clients (McPake & Kutzin: 1997; Gilson *et al*: 1995; Russel & Gilson: 1995; Mills & Gilson: 1995).

Technical efficiency is promoted when activities are undertaken with minimal costs, also known as operational efficiency (Mills & Gilson: 1995; McPake & Kutzin: 1997; Kutzin: 1995). For instance, technical efficiency is compromised if the health care referral system is not effective. For this reason the promotion of technical efficiency depends on factors beyond the user fee policy, factors such as the distribution and use of staff and skills, admission practices and in-patient statistics as well as use of an essential drug list, equipment and facility maintenance (McPake & Kutzin: 1997; Green: 1992; Sahn & Bernier: 1993; Mills & Gilson: 1995). In addition the costs of billing, collection and exemption procedures (for example salaries) might outweigh the actual revenue generated from user fees thus causing inefficiencies in the overall health system (Gilson et al: 1995; Zwi & Mills: 1995).

Efficiency however, cuts across both equity and financial sustainability. For instance, by containing costs through technically efficient use of health care inputs/ resources, revenue generation is effectively promoted. On the other allocation of resources towards lower level services (primary health care) promotes allocative efficiency and therefore equity (McPake & Kutzin: 1997).

2.1.2.2 Financial Sustainability

Sustainability refers to the capacity of a system to survive in relation to a given level of external support (Goodman & Waddington: 1993). The main focus of user fee policies is to promote *financial* sustainability of healthcare systems through mobilising domestic revenue (in this case fees were increased, see section 2.1 for other methods of generating domestic revenue) and reducing costs by improving efficiency. *Financial* sustainability implies that resource mobilisation systems provide reliable and stable financial resources overtime and that there are effective mechanisms in place to contain costs within the available financial resource base (McPake & Kutzin: 1997, Knowels *et al*: 1997; Gilson *et al*: 1995).

Various factors affect the *financial* sustainability of a system. These include the level of fees charged at health facilities, revenue collected relative to recurrent expenditure, the ratio of donor funding for the health sector as whole relative to public finance as well as effective cost containment strategies (Baker: 1996; Goodman & Waddington: 1993; Korte *et al*: 1992; Gilson *et al*: 1995; McPake & Kutzin: 1997).

Equally important to the sustainability of the health system, is the degree of ownership and political commitment to health financing policies by not only political leaders but also implementers as well as other relevant stakeholders (Okuonzi & Macrae: 1995; Grindle & Thomas: 1991).

2.1.2.3 Equity

Equity refers to the distribution of burdens and benefits within the healthcare system as a whole. The introduction or increase of user fees for health care promote equity in health if they are affordable to all groups in the population and do not act as a barrier to utilisation for those who cannot afford to pay. Thus, from this perspective the distribution of health care ought to be based on need as opposed to ability to pay (Gilson & Mills: 1995; Whitehead: 1992; Russel & Gilson: 1995; Gilson *et al*: 1995). Moreover, an equitable user- fee system effectively facilitates cross-subsidisation of the economically marginalised groups by those who can afford to pay. Cross-subsidisation can

also be across different geographic areas where the poorer areas receive a relatively larger budget allocation compared to the better off geographic areas (McPake & Kutzin: 1997; Mooney: 1996). Specifically, horizontal equity implies equal treatment of equals as in the case where a particular income group might be exempted from payment due to inability to pay. Vertical equity refers to the unequal treatment of un-equals in a bid to redress inequities that exist. This is particularly relevant where there are inequities in terms of resource endowments between different geographic areas (Mooney: 1998; Gilson & McIntyre: 2002; Segall: 1983).

User fees charged for healthcare services are notorious for their negative impact on utilisation of healthcare services by the economically marginased groups (Gilson: 1988; Creese: 1991; Korte *et al.*: 1992; Gilson *et al*: 1995; Gilson: 1998). However, if complemented with fee retention at facility level, effective exemption schemes as well as increased investment in quality of care, as well as primary healthcare then the negative effect of fees can be curbed (Litvack & Bodart: 1993; Shaw & Griffin: 1995; Collins *et al*: 1996). An assessment of the performance of user fee policies with regard to equity would require that one considers factors such as, levels of health care facility utilisation before and after introduction of increases in fee levels; mechanisms for resources allocation between different levels of healthcare and between different geographic areas as well as the proportion and criteria for exemptions (Kutzin: 1995; McPake & Kutzin: 1997; Knowles *et al.*: 1997).

The success of user fees in promoting efficiency, equity and financial sustainability depends to a large extent on the organisational structures of health systems (McPake & Kutzin: 1997; Mills & Zwi: 1995; Gilson & Mills: 1995). Some of the critical preconditions for the successful performance of user fees are outlined below.

2.1.3 Pre-conditions for successful performance

Several pre-conditions have been identified for the effective implementation of user fee policies. The critical ones include: decentralised control of fee revenue; sustainable improvements in quality of care before fees are raised or introduced; institutional capacity development, as well as assessments of ability to pay (Collins *et al.*: 1996; Gilson *et al.*: 1995). As stated above fee policies aimed at cost recovery

need to be accompanied by comprehensive exemption and targeting schemes aimed at safeguarding access to health care for disadvantaged groups and pricing which rationalises the referral system (Kutzin & Nyonator: 1999; Akin *et al.*: 1987, Shaw & Griffin: 1995; Gilson & Russel: 1995). Furthermore, these groups in particular, can benefit from fee revenue if this revenue is used to increase investment in primary health care and to improve the quality and coverage of health care services (Litvack & Bodart: 1993; Collins *et al.*: 1996). The following account outlines some of the typical problems associated with these pre-conditions.

2.1.3.1 Decentralised financial control

The management culture of financial and other resources impact on the effectiveness of cost recovery strategies. Decentralised control of fee revenue essentially requires effective structures to be developed in the periphery, to ensure efficient collection of revenue that can be effectively used at the point of collection. This arrangement is said to enhance incentives for revenue generation and to facilitate the development of capacity to improve quality of care and coverage at these levels (Mills & Gilson: 1995; Zwi & Mills: 1995, Gilson *et al*: 1995; Russel & Gilson: 1995).

2.1.3.2 Sustainable quality improvements

In theory, quality improvements will benefit the lower income groups because they are able to change from expensive private healthcare (missionary facilities private-for-profit providers) to more affordable public healthcare (Gilson *et al.*: 1995; Gilson & Russel: 1995). Quality improvements associated with fee revenue usually entail improved availability of drugs, maintenance of facilities and equipment as well as improved staff morale through salary top-ups and/or payment for overtime (Mills *et al.*: 2001). The potential for fee revenue to finance sustainable quality improvement in the periphery is realised only if this fee revenue is complemented with adequate budget allocations from the centre and does not replace these allocations (Gilson & Russel: 1995).

2.1.3.3 Sustainable institutional capacity building

Although the merits of decentralised revenue control are plausible in theory, problems of effective collection and efficient use of fee revenue are experienced at the peripheral level because of inadequate capacity (Gilson: 1988; Creese: 1991; Walley *et al.*: 1991; Gilson & Mills: 1995). The situation is further aggravated when the

centre lacks the capacity to monitor, coordinate, supervise and provide clear guidelines on how revenue should be used. For instance in Zambia, Zimbabwe and Uganda, ineffective coordination in the implementation of the fee policy meant that facilities charged different fee structures and at times revenue was not used efficiently (if at all) to improve local quality or coverage of health services, because of overly bureaucratic procedures for spending monies (Okuonzi & Macrae: 1995; Gilson & Russel: 1995; Gilson *et al.*: 1995).

In some instances for various reasons, such as the capacity deficiencies mentioned above, financial control remains centralised. As a result staff at the periphery have no real incentive to effectively carry out cost recovery strategies, as they have no say in how collected revenue is spent. For example in Zimbabwe the raising of user charges had little to do with health sector objectives (Zwi & Mills: 1995). Hence, not only did cost centres (facility managers) have no say in revenue use, even the Ministry of Health had no say in how fee revenue should be used. In this instance fee revenue was reverted to the overall public sector revenue basket under the Ministry of Finance, for redistribution among the different sectors (Mills *et al.*: 2001 Gilson *et al.*: 1995).

2.1.3.4 Systematic inefficiencies

Efficiency and thus *financial* sustainability has also been constrained by the administrative costs associated with user fee collection and implementation of exemption schemes (Creese: 1991; Thomas *et al.*: 1988). Moreover, rationalisation of the referral system has not always been successful. Problems of strengthening the referral system might occur in cases where the lower levels (health centres and clinics) are extremely under-resourced relative to hospitals and therefore the quality of care in the facilities is lower. In such instances, clients tend to by-pass these lower levels to seek more costly care from facilities at higher levels (Litvack & Bodart: 1993; Akin & Hutchinson: 1999).

2.1.3.5 Informational Constraints

Another reason why fee policies have failed to meet cost recovery targets and equitable access relates to informational constraints. Specifically lacking is information on factors such as affordability and willingness to pay as well as accessible information for identifying the target group. Poor management information

systems mean that the cost of healthcare delivery is unknown. Hence revenue targets are not always based on real data and are thus difficult to monitor (Creese: 1991). Furthermore, fee levels are often set at extremely low levels and are not adjusted to inflation rates (Thomas *et al.*: 1988; Gilson *et al*: 1995; Mills *et al*: 2001). Lack of information and understanding about the referral system, particularly by healthcare consumers, has constrained the objective of rationalising the referral system and therefore efficiency in the health system (Hongoro *et al*: 1998). This problem is aggravated by the existence of targeted prices and exemptions. Details of cost recovery problems associated with exemptions are outlined below.

2.1.3.6 Exemptions and targeted prices

According to a study conducted by Gilson and Russel only two countries (2/28, Zimbabwe and Thailand) granted exemptions based on income (direct targeting) and the rest used characteristic targeting. Exemptions are generally granted for specific characteristics such as type of illness (tuberculosis) as well as demographic details of patients (maternal and child healthcare) and geographic location. Difficulties associated with identifying target groups directly according to income level, have resulted in an over reliance on characteristic targeting. Hence, the focus is not necessarily on ability or inability to pay and the potential revenue base from fees is diminished (Sahn & Berner: 1993; Gilson *et al.*: 1995).

The main problem with characteristic targeting is that there is a higher risk of over-coverage of people who can afford to pay and thus the potential for revenue is compromised. On the other hand with direct targeting there is a greater risk of under-coverage due to the complexity of procedures for identifying the 'right' income bracket (Thomas *et al.*: 1988; Gilson & Russel: 1995; Mills *et al.*: 2001; Gilson *et al.*: 1995). Moreover, the costs of implementing exemption schemes can be overwhelming, not only for the health sector (administrative) but also for clients seeking such services. An example of such would be where the granting of exemptions takes place at central government offices often situated in the city, hence requiring rural patients to travel long distances, which implies significant additional costs for these clients (Mills *et al.*: 2001; Korte *et al.*: 1992; Thomas *et al*: 1988).

The problem of cost recovery relative to exemptions is compounded by the official and unofficial inclusion of civil servants, health workers, as well as the military and

their families, as part of the target group (Gilson *et al.*: 1995; Killingsworth *et al*: 1999), as well as the distortion of these schemes by political factors which encourage exemption of the non-poor (Thomas *et al.*: 1988). For instance, official exemptions granted to MOH employees and their dependents led to a loss of 21% of total revenue for 1986 in Ghana and this does not include other exemptions granted for equity objectives (Shaw & Griffin: 1995).

Section 2.1.3 above has attempted to outline some of the critical problems associated with the preconditions for the realisation of financial sustainability and equitable access to healthcare through user fee policies. Section 2.1.4 below provides a brief general outline of the general performance of fee policies in Sub-Saharan countries that have implemented this policy.

2.1.4 Empirical evidence of performance of fee policies in Sub-Saharan Africa

Given the problems outlined above it is not surprising that the performance record of user fees in realising their objectives has been extremely limited (Gilson: 1988; Creese: 1991). On the issue of *financial* sustainability, cost recovery ratios in most African countries only range from 1-12% with an average of about 5%. Moreover, fee revenue makes up only about 2% of total government recurrent expenditure in Sub-Saharan countries (Vogel: 1991; Korte *et al.*: 1992).

Some of the problems with fee policies highlighted in the previous sections are essentially elements of the content of fee policies. Furthermore, the problems associated with the policy content tend to be rational and to some extent obvious. For example, it is obvious that failure to adjust fees to inflation rates has led to falling cost recovery ratios overtime, given that healthcare costs have been on the increase (Mills & Gilson :1995). The current evaluation seeks to provide an understanding of factors such as why fee schedules are not adjusted accordingly to inflation rates as well as why civil servants continue to be exempted from payment for health services when they are often the main group that can afford to pay (Gilson *et al:* :1995). An assessment of the policy processes including the actors and the context within which the policy is designed and implemented provides the critical background for policy evaluation. Section 2.2 below provides a description of some of the critical factors influencing the outcome of public sector policies.

2.2 Design & Implementation of Government Policies

A comprehensive understanding of the reasons for the failure of any policy to realise its stated objectives, requires more than just a technical review of the content (Walt & Gilson: 1994). This section aims to provide an overview of the policy arena by looking at different types of policies and their implications. An attempt has been made to apply the critical elements of the patterns of policy design and implementation to health policies in general and fee-policies in particular, drawing on experiences of different countries that have (or attempted to) implement user fee policies. This application should provide examples of how the overall policy environment may have facilitated or constrained the success of the policy in the different contexts.

2.2.1 Types of Policies

A policy can be understood as purposive action by governments, aimed at addressing a particular problem. Policies entail decisions relating to the implementation and the enforcement of particular decisions (Walt: 1994). Hence, in the case of user-fee policies the problem identified was defined as a lack of financial resources for the health sector (Ghana) or the public sector (Zimbabwe) (Mills *et al.*: 2001). Thus the policy was implemented with the aim of recovering some of the costs and therefore generating revenue.

The focus of public policy analysis is essentially the formal institutions of government as they provide the structures within which public policy processes take place (Walt & Gilson: 1994). Although public policy development and enforcement are more often than not the responsibility of governments (through policy analysts and technicians), the actual process is not necessarily exclusive of other actors both inside and outside government (Cassels: 1995; Walt: 1994).

In trying to understand who makes policies, Walt makes a distinction between macro- and micro-policies (Walt: 1994). Macro policies (high politics) entail a systematic change, for example health reform policy initiatives such as decentralisation and introduction of user fees for healthcare at public facilities. Hence, the processes of design and implementation of such policies tends to be closed and limited to the ruling elites. Micro-policies (low politics) refer to sectoral changes such as systematic annual increases in fee structures in response to inflation, or changes in treatment

regimes for tuberculosis. The way in which the public responds to a given policy may affect the nature of that policy so that the distinction between micro and macro policies is not stagnant (Grindle & Thomas: 1991; Walt:1994; Walt & Gilson: 1994).

As the political economy (national and international) changes overtime, so too does the nature of particular policies (Grindle & Thomas: 1991). For example, health policies were historically limited to the professional elites hence they evoked little controversy and public reaction. With new ideological values specifically neo-liberal philosophy becoming more pronounced, health policies have become increasingly controversial and the subject of debate in the public arena (Walt & Gilson: 1994). The arena of health policy design and implementation has thus become increasingly complex and the nature of policies (micro or macro) is as dynamic as the environment in which policy processes take place (Grindle & Thomas: 1991).

Policies can also be distinguished according to their effect (Walt: 1994). Four distinct effects can be identified. These include distributive policies, which relate to the distribution of benefits in society and are not controversial, as they do not imply costs for some groups at the expense of other groups. Some policies aim to regulate certain groups (for example private practitioners and healthcare insurance companies) through the imposition of restrictions. Regulatory policies affect particular groups, and as such do not affect the public as a whole. The third set of policies is self-regulatory policies, which apply to individual organisations and do not necessarily include the public. Re-distributive policies are the most controversial, as they imply a conscious effort by government to address socio-economic inequalities in society through taking from some groups and giving to other groups. These kinds of policies can potentially spark vehement opposition or support from the different segments of society (Walt: 1994).

User fee policies in practice are often complemented with strategic concerns for equity in access, in terms of payment according to ability and cost recovery strategies through cross-subsidization, as a result they can be controversial. Fee policies are especially controversial if some people are expected to pay and others not, as well as in the case where the public is used to not paying and then user-charges are introduced (Zwi & Mills: 1995).

2.2.2 Policy Analysis

Oftentimes issues surface in the policy arena but do not make it into the policy agenda, other times issues make it into the agenda but are never decided upon, while some issues might not only make it into the agenda but are debated and decisions made on them but they never get implemented. One of the reasons for these varying outcomes of different societal issues is that the process of setting the policy agenda is itself highly contentious (Mwabu:1996). Issues such as the relative threat of a particular policy to national stability, to the government in power or to particular power structures can kill a potentially good policy even before it gets onto the policy agenda (Frenk: 1996; Hogwood & Gunn: 1984; Thomas & Grindle: 1991; Walt & Gilson: 1994).

Walt and Gilson have developed a framework that provides a basis for understanding the varying destinies of social issues and different policies. This framework draws on different disciplines that focus on the various factors that can impact on the design and implementation of government policies. The different foci include the policy content, in this case the content of fee policies, which has already been described in section 2.1. Process, actors and context factors make up the other three foci of this framework of policy analysis. Furthermore, because public sector capacity is often cited as one of the fundamental causes of policy failure (Creese: 1991; Hilderbrand & Grindle:1994), the framework of analysis will incorporate the role of institutional capacity as an overarching factor in the policy arena. The following account will look at how each factor on its own can influence the outcome of policies, however it is important to note that these factors are contingent upon each other (Walt & Gilson: 1994). Hence, the context with in which policy development and implementation take place will influence the different roles and power structures between the different actors. Similarly, the context determines the nature of processes of decision-making and consensus building around the policy, which in turn influence the ability of different actors to access and influence policy direction and impact. Institutional capacity on the other hand affects the context, process and actors and is in turn affected by these factors (Korte *et al*; 1992; Sahn & Benier: 1993; Gilson & Mills:1995; Mills *et al*: 2001). The account will begin with a brief overview of institutional capacity.

2.2.2.1 Institutional Capacity in the Policy Arena

Capacity can be defined as the ability to perform appropriate tasks effectively, efficiently and sustainably (Hilderbrand & Grindle: 1994), thus lack thereof in the policy arena can constrain not only successful policy implementation but also successful policy design activities. Capacity is understood to incorporate more than just human resources and skills but includes factors such as organisational capacity (job descriptions, management systems and resources), public sector institutional environment (decision-making processes, meritocracy, financial management and planning systems) and external environment (socio-economic and political factors) (Brijlal *et al.*: 1998). Thus the following account includes the role of institutional capacity from the perspective of context, processes and actors.

2.2.2.2 Contextual Factors in the Policy Arena

The context within which policies are designed and implemented is highly influential on the role and relative power of different actors as well as the processes that shape policies (Walt & Gilson: 1994). How issues get placed on the national policy agenda of any country is a primary factor in determining how far a particular policy will go and it is a factor which is determined largely by both the national and international political, economic and ideological environment (Walt: 1994; Grindle & Thomas: 1991). For a comprehensive analysis of contextual factors and how these can shape the design and implementation of user fee policies, one needs to consider national political, economic and social factors, as well as the relative status of a particular state in the international political economy. Other factors which determine context include; socio-cultural values, historical experiences and institutional capacity (Walt & Gilson: 1994; Grindle & Thomas: 1991; Gilson: 2000). The following account considers some of the critical contextual factors that can influence the policy arena.

2.2.2.2.1 The National Political Context

The national political context partly explains the reasons why certain policies get implemented even when they may not necessarily be popular while others may not get implemented, thus the policy agenda depends to a large extent on nature of the political dispensation in place at a particular time (Gilson: 2000). For example, political transition, often from authoritarian to democratic rule can be significantly influential in the policy agenda as well as the design and implementation of different policies particularly because it offers policy analysts opportunities for a wide range of

social reforms including health sector reforms (Gilson: 2000; Macrae *et al*: 1996). An important aspect of the national political context, especially in Sub-Saharan Africa, is the precarious democratic environments where political leaders might be reluctant to implement particular policies because of the fear of loss of power, which can be either democratic or violent (Mills & Zwi: 1995; Chazan *et al*: 1994; Macrae *et al*: 1996; Migdal: 1988). The controversial nature of fee policies make them potential sources of public discontent that can lead to the political downfall of governments.

2.2.2.2.2 The National Economic Context

The prevailing economic status of a nation is often an important determinant of the policy agenda. A good example of this is the structural adjustment programs implemented in most of Sub-Saharan Africa as a response to the economic malaise that prevailed during that time (Sahn & Bernier: 1993). Similarly user fee policies were a response to general economic crisis (Mills & Gilson: 1995) and a crisis in health service financing in particular (Mills: 1998). Moreover, the economic context of policy development and implementation effectively influences the nature of policy design as well as the outcome of policies as one considers feasibility in terms of available resources. Economic malaise also affects the policy outcome because of the way that general public sector working conditions are affected. For example, factors such as low staff morale and shortages of essential drugs and equipment can effectively constrain the success of any health policy including cost recovery policies (Mills: 1998; Gilson *et al*: 1995; Korte *et al*: 1992; Thomas & Grindle: 1991; Macrae *et al*: 1996).

2.2.2.2.3 Institutional Capacity and *Context*

Institutional capacity refers to the overall management culture of the public sector, which is determined to a large extent by socio-political, economic and historical factors. In the policy arena institutional capacity is important as it sets the parameters for the effective performance of government organisations (Brijlal *et al*: 1998; Hilderbrand & Grindle: 1994). For example, in some contexts centralised financial management has contributed to poor cost recovery ratios because of the associated lack of incentive of managers and implementers to effectively collect fee revenue (Gilson *et al*: 1995; Russel & Gilson: 1995; Sahn & Bernier: 1993). Like the economic and political factors largely determine the feasibility of different policies,

these factors also affect the nature of the institutional capacity and thus the design, implementation and impact of policies (Gilson: 2000).

2.2.2.2.4 External Forces

The position of a nation *vis-a-vis* the international political economy is largely determined by the level of development of its economy (Gilpin: 1987). Many developing countries are forced to depend on international financiers because of the poor performance of their economies. As a result of this, most developing countries in Sub-Saharan Africa are extremely vulnerable to external influences where their national political, economic and social policies are concerned (Chazan *et al*: 1994; Migdal: 1988). For this reason, their national health policies are more often than not susceptible to the influence of external financiers such as the world Bank (Mills: 1998; Okuonzi & Macrae:1995; Mills & Zwi: 1995; Moore: 1996; Mburu: 1989). Two of the critical external factors that had a profound influence on Sub-Saharan health sectors in the eighties are outlined below:-

2.2.2.2.4.1 Public Sector Reform

The 1980s represented a time when there was a general consensus that governments of developing countries, especially Sub-Saharan African governments, were highly inefficient thus, in order to make them more efficient, specific policy reforms were prescribed by international financiers (McPake: 1993; Hood: 1991; Mills: 1997). The fundamental principles of new public management included decentralisation of financial management, market competition and privatisation (Moore: 1996; Cassels: 1995; Mills & Gilson: 1995). The economic vulnerability of Sub-Saharan countries during this period meant that neo-liberal political and economic ideologies, including public sector reform and the principles of new public management, were effectively imposed from outside (Moore: 1996; Hiscock: 1995; Okuonzi & Macrae: 1995). It was partly this ideological framework that shaped health sector reforms including financing policies for health sectors in many of these countries.

2.2.2.2.4.2 Structural Adjustment Programs

Structural adjustment was another prescription for developing countries as a response to poor economic performance. One of the critical elements of structural adjustment policies was tight fiscal policies which implied budget cuts in the public sector as a whole, including the health sector (Mills & Gilson: 1995; Bennet *et al:* 1997; Sahn &

Bernier: 1993; Hiscock: 1995). Unlike new public management, structural adjustment was part of financial loan conditions from the World Bank and in effect forced governments to undertake certain policies. User fee policies were part and parcel of these loan agreements (Gilson *et al.*: 1995 ; Mills & Zwi: 1995; McPake: 1993; Korte *et al*: 1992; Mills *et al*: 2001). The economic position of developing countries meant that to varying degrees, the policy was effectively imposed or pushed by international aid agencies.

Fee policies in Sub-Saharan Africa were adopted as a response to macro-economic crises. Structural adjustment had already had an adverse impact on institutional public sector capacity as a whole. As a result, government policies adopted in this context were already constrained by an unfavourable environment (Sahn & Bernier: 1993; Okuonzi & Macrae: 1995; McPake: 1993; Macrae et al: 1996). For example, the morale of civil servants suffered because of tight fiscal policies and the associated problems, such as underpayment and shortages of drugs and materials (Mills: 1998; Moore: 1996; Sahn & Bernier: 1993; Korte *et al.*: 1992). The outcome of these problems was that policy design was undertaken by a select few and more often than not dominated by external technical assistants, thus compromising national ownership and understanding of as well as commitment to policy objectives (Okuonzi & Macrae: 1995).

The contextual factors outlined above play a crucial role in shaping the processes of decision-making as well as the relative role and influence of the different actors in the design and implementation of policies (Walt & Gilson: 1994; McPake: 993; Macrae *et al*: 1996; Frenk: 1996; Gilson: 2000). The next two sections consider the weight of processes and actors in the policy arena.

2.2.2.3 Process Factors in the Policy Arena

A key intermediate outcome of the policy processes is an agreement on a conceptual solution to the problem at hand, specifically this implies building consensus on how to achieve the desired change (Mwabu: 1996). Consensus building essentially means that, problem identification and defining solutions to these problems are hardly ever rational or simple because of the milieu of vested and often competing interests in the policy arena.

Recognition of the importance of policy processes in influencing the design, implementation and impact of policies stems from the realisation that the patterns of policy evolution, development and implementation are essentially political in nature (Walt: 1994; Walt & Gilson: 1994; Macrae *et al*: 1996; Frenk: 1996; Grindle & Thomas: 1991). This is contrary to the rationalist theories, which perceive of policy making as a rational and value-free process that is distinct from policy implementation. Rationalists assume that a policy that is technically commendable automatically gets implemented without any hindrances (Walt: 1994). This however is not the case. Some have gone so far as to say that policy failure to a large extent reflects fundamental failure of policy processes (Hogwood & Gunn: 1984). Some of the critical elements of policy processes are outlined below.

2.2.2.3.1 Consensus Building

Consensus building refers to conscious effort by policy analysts to generate support, commitment and understanding around the policy objectives, thus forging a common vision among the relevant stakeholders (Grindle & Thomas: 1991; Frenk: 1996; Okuonzi & Macrae: 1995; Gilson: 2000). Processes therefore involve extensive consultation and debate about the issues. Needless to say the processes of policy design involve the articulation of clear policy goals and objectives around which functional consensus must be developed (Gilson: 2000; Mills & Zwi: 1995; Gilson *et al*: 1995; Grindle & Thomas: 1991). Moreover, the relevant stakeholders need to be identified depending on the type of policy (see section 2.2.1). In the case of user fee policies the main stakeholders would include bureaucrats from the Ministries of Finance and Health, healthcare managers and providers, policy implementers, community leaders as well as health care consumers and the public at large (Okuonzi & Macrae: 1995; Mwabu: 1996; Grindle & Thomas: 1991; Gilson *et al*: 1995; Gilson: 1998). Thus these different groups would need to be involved to varying degrees in the decision making processes if adequate consensus is to be generated. Consensus can be promoted through active canvassing of support for the policy or appeasing opposing factions (Thomas & Gilson: 2001).

The way in which the policy is communicated to the public is also an important factor for generating consensus as well as managing opposition to the policy (Mwabu: 1996; Grindle & Thomas: 1991). Mwabu suggests that policies should be communicated to

the public as intentions and only once public opinion has been assessed can decisions about implementation be made and publicised as official government policies.

2.2.2.3.2 Managing Policy Implementation

Also important are decisions of how implementation is to be undertaken. For example, implementation can be phased, as in the case of Kenya where the implementation of the user-fee policy was reversed due to public outcry and later re-introduced in a phased manner through implementing user charges at hospitals, but not at the lower levels of the healthcare system (Mwabu: 1996). Alternatively, policies can be implemented through pilots, thus facilitating a test period to assess the impact of the policy. Hence, the way in which a policy is implemented goes a long way towards determining the future of that policy. The advantages of phasing implementation are that the public is given the opportunity to get used to the new modus operandi. Through phased policy implementation, the government is given an opportunity to improve the quality of services at the lower levels of the healthcare system before charging fees at these levels, thus strengthening the referral system. Thirdly, implementers are more able to monitor the implementation of the policy and to rectify unanticipated obstacles that may surface once implementation has taken off (Grindle & Thomas: 1991; Mwabu: 1996; Brijlal *et al.*: 1998).

Because user fee policies require ongoing effort over an extended period of time, means that reaction or opposition from various groups can occur at any point in time once implementation has taken off (Grindle & Thomas: 1991; Walley *et al*: 1991). Even when a policy makes it through and decisions are made to implement it, contingencies associated with the process of implementation (such as severe drops in utilisation, staff shortages etc) might require continuous redesign and sometimes reversal of the policy (Mwabu: 1996). Thus, one of the important aspects of implementation processes is the regular monitoring and evaluation of the policy once it has been implemented (McPake & Kutzin: 1997; Kutzin: 1995)

2.2.2.3.3 Institutional Capacity and *Processes*

Mills et al make a distinction between the capacity to develop policies and to manage transition and the capacity for day-to-day implementation of the policies (Mills *et al.*: 2001). The former aspect of capacity is critical for the overall policy process. For example, tasks such as stakeholder analyses, strategic management of policy

opposition, monitoring of public responses to policy design and implementation require not only the commitment of political leaders but also policy champions with resources such as information and time (Grindle & Thomas: 1991; Mills *et al.*: 2001), which in developing countries continue to be extremely scarce (Sahn & Bernier: 1993; Korte *et al.*: 1992; Gilson *et al.*: 1995).

The internal aspects or day-to-day implementation aspects of capacity to design and implement user-fee policy can be undermined by factors such as, centralised human and financial resources management, poor coordination within the public sector in general and within the health sector in particular, as well as excessively bureaucratic systems (Mills *et al.*: 2001; Hilderbrand & Grindle: 1994). Hence, policy processes also involve modifications of the organisational culture and systems within and between organisations such that they facilitate and support the evolution and success of the policy. For example, where fees have been introduced without decentralised financial control, health facility managers are not inclined to implement cost recovery strategies effectively in order to raise revenue (Russel & Gilson: 1995; Shaw & Griffin: 1995).

Governments in Sub Saharan Africa also need to manage and coordinate the involvement of international agencies, technical assistants, aid donors and advisors in the policy arena, given the close involvement of these stakeholders in their policy arenas. The capacity of these governments to carry out this task is more often than not, grossly limited, especially given their dependence status (Mburu: 1989; Hiscock: 1995; Moore: 1996).

2.2.2.4 Actors in the Policy Arena

In the design and implementation of reform policies the heterogeneity of values between different stakeholders, as well as differentials in their power to influence the policy process, are important factors in constraining rational policy making (Walt: 1994; Frenk: 1996; Walsh & Simonet: 1996). Policy reform often implies a change in the status quo thus established power bases are inevitably eroded and new ones developed (Thomas & Grindle: 1991; Walt & Gilson: 1994). As a result, there are always those groups that will strongly oppose the policy at design and/ or implementation phase, primarily because they have something to lose and groups that support the policy because they have vested interests in change. Hence the suggestion

by Lindblom that policy development and implementation implies 'bargaining, negotiation and adjustment between different interest groups' (Walt: 1994; 49). The critical aspects of actors in the policy arena are outlined below.

2.2.2.4.1 Identifying the Critical Actors

Identifying the stakeholders who might have something to lose from a particular policy reform is an important part of the policy process as it creates an opportunity for policy managers to seek ways to sell the policy to potential opposition and is a task that is largely determined by the type of policy under consideration (Grindle & Thomas: 1991; Walt & Gilson: 1994; Walsh & Simonet: 1996; Thomas & Gilson: 2001). Identifying the critical actors and understanding their relative influence in the policy arena can reveal underlying perceptions of policy elites such as, ideological predisposition, memories of previous experiences as well as institutional commitments and loyalties thus providing explanations for the way a policy is designed and in turn implementation and impact. (Thomas & Grindle: 1991).

In identifying the relevant actors one needs to consider individuals or groups from both within government as well as those external to government including international aid agencies and the different interest groups. Brugha and Varvasovszky make a distinction between primary and secondary actors. Primary stakeholders refer to those individuals or groups that are critical to the success of the policy, whereas secondary actors are those who are indirectly affected by the policy but have no real influence on the success of the policy (Brugha & Varvasovszky: 2000). In the case of the fee policy development the Ministry of Finance and sometimes the Ministers of Health and health care managers are the primary actors, while implementers, consumers and community leaders might be the secondary actors. In decisions about implementation however, health care managers and providers as well as implementers and community leaders may become primary actors (Grindle & Thomas: 1991; Mills & Zwi: 1995; Mills *et al.*: 2001; Gilson *et al.*: 1995; Gilson : 1998; Hongoro *et al*: 1998). Hence, the role of actors is not stagnant in the policy arena.

2.2.2.4.2 Strategic Management of Actors

Policy processes and consensus building involve not only the involvement of and consultation with bureaucrats and implementers but also the strategic management of stakeholders, which necessitates identifying potential allies and building alliances or

alleviating potential threat (Grindle & Thomas: 1991; Brugha & Varvasovszky: 2000). Strategic management of stakeholders, especially those who might oppose the policy, is crucial so that the policy does not fail before it is implemented. (Mills & Zwi: 1995; Grindle & Thomas: 1991; Thomas & Gilson: 2001). Moreover, one needs to undertake an assessment of relative power structures in the policy arena, as well as to manipulate these different power bases to facilitate successful design and implementation of the policy in question (Thomas & Gilson: 2001; Brugha & Varvasovszky: 2001; Glassman *et al.*: 1999). In addition, one needs to be expedient in choosing which stakeholders, including external policy technicians and donors, are involved; the stage at which they are involved, as well as the nature of their involvement (Gilson: 2000; Thomas & Gilson: 2001). Thus some actors might be merely consulted whereas others might be actively involved in decision-making panels.

2.2.2.4.3 Establishing Representativity of Relevant Actors

Consensus around the policy objectives and strategies needs to be generated at more than just the elite level but also among the general milieu of relevant stakeholders. This would entail checking the balance of power and ensuring that the overall outcome of policy design and implementation of the policy is not biased towards the interests of a particularly powerful group at the expense of other groups that might not be as powerful (Gilson: 1998; McIntyre & Gilson: 2002). This is particularly relevant when the effectiveness of the policy depends on the commitment and understanding of unofficial actors such as the public in general and community leaders in particular. For example, in strengthening of the referral system both healthcare providers at all levels of the health system as well as health care consumers, need to appreciate and understand the rationale for differential charges between the different categories of hospitals and health centres (Hongoro et al: 1996; Gilson *et al*:1995).

2.2.2.4.4 Institutional Capacity and *Actors*

The capacity of policy makers to manage the milieu of actors in the policy arena is important for consensus building and generating support and commitment from the key actors. However, also important is the capacity of different actors to access and use information for decision-making, this can be undermined by factors such as literacy, socio-economic and cultural factors (Gilson: 1998; Mooney: 1996; Hongoro *et al*: 1998).

Poor capacity can be aggravated by unpredictable political leaders who make rational planning difficult (Gilson: 2000), as well as cycles of political elections which often derail the progress of policy plans and implementation. For instance, the failure of most governments (e.g. Ghana, Zimbabwe, Zambia) to make annual adjustments to healthcare prices relative to the rate of inflation (Shaw & Griffin: 1995; Mills *et al.*: 2001).

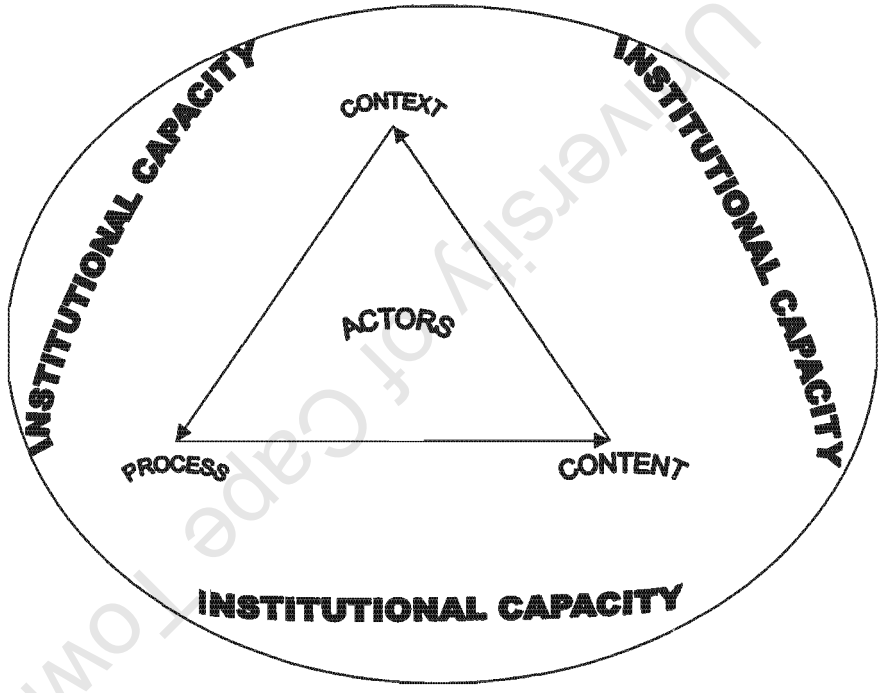
2.2.2.5 Interplay Between Context, Processes and Actors

The above account has attempted to illustrate the potential influence of context, process and actor issues on policy design and implementation and in turn impact. Although each of these factors has been assessed separately, as has been stated before, the overall outcome of the patterns of policy design and implementation is determined by a dynamic interaction of these factors (Walt & Gilson: 1994; Frenk: 1996; Zwi & Mills: 1995; Mills *et al*: 2001; Macrae *et al*: 1996). For instance, the macro-economic context in which the design and implementation of fee policies took place in Sub-Saharan Africa, meant not only that fee levels had to be substantially low, given poverty levels that prevailed at the time (Zwi & Mills: 1995), but also that the institutional capacity to carry out the necessary tasks for policy design and implementation were extremely short (Korte *et al*: 1992; Gilson *et al*: 1995). In addition the economic vulnerability of these countries meant that external forces/ actors tended to play a dominant role in the decisions around especially the policy design and the timing and pace of implementation (Mills & Zwi: 1995; Mills *et al*: 2001). The context of a limited democratic culture meant that decision-making processes were not democratic and thus highly exclusive of various stakeholders (Okuonzi & Macrae: 1995).

2.3 Conceptual framework of the study

The model to be used in evaluating the user fee policy in Lesotho is the one developed by Walt and Gilson, which incorporates all the different aspects of policy design and implementation outlined above including the policy content (Walt & Gilson: 1994). Figure 2.3.1 below illustrates the policy triangle as defined by Walt & Gilson, but also incorporates institutional capacity as an overarching factor.

Figure 2.3.1



Some key questions to be considered in the study have been derived from the literature review and are outlined in table 2.3.1 below.

Table 2.3.1 Aspects of Policy Evaluation

Process : Description of what happened. • What steps were undertaken to facilitate consensus building around the policy? • How was the policy communicated to the public? • How is opposition to the policy from different stakeholders (public and bureaucratic) managed? • How is the policy implemented and monitored?
Actors: Description of who did what. • Who were the critical stakeholders and what role did they play in the design and implementation of the policy? • Who were the main opposing groups and what was their relative power to influence the policy design, implementation and/or outcome? • Did the primary actors understand and appreciate the rationale for the policy? • Values and motives of actors
Context: Potential reasons and explanations • What political and economic factors led to the need for this policy? • What is the nature of these factors relative to the international political economy? • What socio-cultural and historical factors might have influenced the policy? • What was the situation with institutional capacity? • What other reforms were being undertaken and how (if at all) did they impact on this policy?
Content : Nature of objectives, strategies and implementation plan • Do the stated objectives of the policy contradict or complement one another? • What was the basis for setting health-care prices? • Do the objectives of the policy conform to the overall objectives of government? • How does the policy impact on other public sector policies and how do these other policies impact on this policy? • Are roles and responsibilities clearly articulated? • Is the policy accompanied by decentralised control of fee revenue? • Are the criteria and procedures for exemption clearly stated? • Does the policy clearly outline the mechanisms for monitoring and evaluation of policy implementation? • Are there built in incentives for effective collection and use of fee revenue? • Are resources available to implement the policy? • Are the strategies for implementation feasible given time and resources?

2.3.1 Specific Indicators for Performance Measurement

The conceptual framework described above provides the guidelines to be used for evaluation. A detailed account of the criteria for assessing the performance of fee policies has been provided in section 2.1.2. Since efficiency is a function of more than just financial resources (in this case user fees), a detailed assessment of efficiency would require an analysis beyond the scope of this study (see section 2.1.2.1), thus performance of the fee policy has been considered only from the perspective of *financial* sustainability and equity. Recognition is given however to the implications that efficiency has for these two objectives. The aim of this section is

to provide an outline of some of the critical indicators that can be used to evaluate fee policies from the perspective of equity and *financial* sustainability. Specific indicators for efficiency under equity and *financial* sustainability have been starred for each of these components (Mcpake & Kutzin: 1997; Kutzin: 1995; Knowles *et al*: 1997). The list includes both qualitative and quantitative indicators:-

2.3.1.1 EQUITY:

Quantitative indicators

- Utilisation patterns by geographic area
- Proportion and criteria for exemptions by geographic area
- Ratio of exemptions to budget allocation
- ❖ Proportion of budget allocation towards primary healthcare

Qualitative indicators

- Representation of different stakeholders in the decision-making processes
- ❖ Assessment of fee revenue use relative to quality improvement.
- ❖ Methods of budget allocation to geographic areas.

2.3.1.2 *FINANCIAL* SUSTAINABILITY

Quantitative indicators

- Trends in the proportion of revenue to total health sector recurrent expenditure (cost recovery ratio)
- Trends in proportion of government recurrent health spending financed by donors
- Proportion of revenue lost due to exemptions
- Trends in source and percentage of government finance
- ❖ Trends in relative growth rates of health sector expenditure.

Qualitative Indicators

- Degree of consensus building around the policy.
- Degree of commitment by implementers.
- Understanding and appreciation of the rationale behind the policy by different actors.
- The role of donors in policy processes
- ❖ Effective functioning of the referral system
- ❖ Existence of effective mechanisms for monitoring and evaluation.

CHAPTER 3

Country Setting

3.0 Introduction

The following chapter outlines the background to the context within which the fee policy was implemented in Lesotho, focusing primarily on the period leading up to implementation, the time when fees were implemented and after implementation (1986-1994). The account is essentially historical but many of the factors described have not changed since. Specifically one looks at the socio-demographic, economic, and political factors as well as the organisation of the health sector. Particular detail is provided on the patterns of resource mobilisation and allocation in the health sector. Admittedly healthcare financing in the non-government sector is important for an analysis of health sector financing in general, but the scope of the current study will concentrate on the public sector alone. Finally some background on the current health reform initiatives being undertaken by the government will be provided.

3.1 Social & Demographic Context

The kingdom of Lesotho is a small mountainous country with a population of close to two million. The land area is 30,400 square kilometres and it is entirely surrounded by South Africa. The lowest point of altitude is 1433 meters above sea level and the highest point is 3482 metres. Over 80 % of the population is rural. Urban migration and mine employment in the eighties meant that the rural population was made up predominantly of women, the elderly, and children. Only 13% of the land is arable due to extensive soil erosion and land degradation. The scarcity of employment opportunities in the rural agricultural sector has contributed to migration into urban areas for those unable to obtain employment in the RSA mining industry. The human development indices for the country were fairly low in the late eighties and early nineties. In 1986 the population growth rate stood at 2.6%, total fertility rate at 5.8%, with crude birth and death rates at 41 and 13 per thousand respectively. Infant mortality was considerably high at 102 deaths per thousand. Life expectancy at birth for men was 52 years and 57 years for women. Socio-economic indicators are unevenly distributed with the mountainous areas being worst off (Fifth Five-Year Development Plan, 1991-1995; Fourth Five-Year Development Plan; Phalatsi, 1991; Health Expenditure Review Report, 1996).

The climate and altitude of the country insulate it from the tropical diseases such as malaria. The main causes of mortality and morbidity for adults include: maternal mortality due to unsupervised deliveries (60%), tuberculosis, intestinal infections, diseases of the respiratory system and sexually transmitted diseases. Non-infectious diseases such as diabetes and hypertension have also been on the rise. For children, especially under-fives, the main causes of mortality and morbidity include malnutrition, acute respiratory infections, diarrhoea and infective and parasitic diseases (HPN II Project Report, 1988; Report of Workshop on Health & Social Welfare Policies, 1993; Lesotho Health Profile Report, 1993).

3.2 Political Context

Historically, Lesotho was a protectorate of the British Empire from which it gained independence in 1966. The civilian government elected at independence suspended the constitution in 1970 and authoritarian rule prevailed until 1986 when a military coup took place. Military rule was replaced in 1993 when a democratic dispensation was ushered in through multi-party elections, which resulted in a majority win by the Basotho Congress Party. The country has managed to secure a somewhat precarious democracy with occasional political unrest since the onset of the new dispensation (Lesotho Health Sector Reform Plan, 1999; Health Expenditure Review Report, 1996).

3.3 Economic Context

The economy is characterised by a unique dependence on the Republic of South Africa, with over 60 % (although this figure has been falling over time) of government revenue derived from the customs receipts from the Southern African Customs Union (SACU). Lesotho is part of the Rand Monetary Area and the currency (Loti) is on par with the Rand. Hence, any change in exchange rate or inflation in South Africa, directly affects factors such the national debt, the value of real wages, and health related costs of the nation (Phalatsi: 1991; Poverty & Health in Lesotho, 1996).

Other activities contributing to the economy include agriculture, which made up 20% of GDP, migrant labour remittances, which contributed 37 % to GNP. The manufacturing sector contributed a mere 10%, but this has been increasing over-time (Health Financing Study Report, 1988).

Public revenue is heavily marked by elements of external dependency, for example during the financial year 1987/88, 87% of the national development budget came from external sources. (28.3% grants and 31.8% in the form of loans) During the period (1988-1991), the government adopted the Structural Adjustment Programs (SAP), which successfully reduced the public deficit account. Structural adjustment strategies included strengthening of government planning and budgeting capacity, rationalisation of public expenditures as well as civil service reform. During this period the government budget deficit was reduced from 72 million to 20 million (Health Financing Study Report, 1988; Phalatsi: 1991).

During the fourth development plan, 1986-1991 period, economic performance was disappointing with only a 0.5 % increase in GDP per annum because of sustained drought which led to stagnation in agricultural sector productivity. During the period 1985-1995, GDP and GNP per capita rose in real terms by 31 % and 5% respectively. Between 1988 and 1992 GNP fell by 21%. Although macro-economic stability was successfully secured, it was accompanied by uneven growth and distribution in income as well as increasing poverty and rising unemployment. The long-term economic prospects were positive though, because of the project to export water to South Africa, the Lesotho Highlands Water Project, signed in 1986. It was anticipated that this project would bring in substantial revenue for the government, through royalties and customs receipts from levies on imports (Phalatsi: 1991; Health Expenditure Review Report, 1996).

Of the labour force estimated at 800 000 persons in 1988, 30% held formal employment in South Africa (predominantly unskilled miners) or in Lesotho (civil servants, teachers, employees in the domestic manufacturing, construction etc.). Thus over 70 % was employed in agriculture or informal employment. The government plays a significant role in employment creation with civil servants as a group, making up the largest proportion of the formally employed labour force. Unemployment was estimated at 35 % in 1988 but has continued to increase since the onset of a democratic regime in South Africa, which led to the retrenchment of foreign unskilled mineworkers in that country. Unemployment and poverty were and still are critical social problems with half the population considered as poor and over a quarter very poor. In 1986 poverty levels were generally higher in the rural highland areas, this

pattern has not changed significantly overtime (Health Expenditure Review, 1996; Health Financing Study Report, 1988; HPN II Project Report, 1988).

3.4 Organisation of the Health Sector

There are two main providers of healthcare in Lesotho, the Ministry of Health and the Private Health Association of Lesotho (PHAL), which is currently known as the Christian Health Association of Lesotho (CHAL). PHAL is a voluntary non-profit organisation founded in 1974 by several church denominations. These religious orders run various hospitals and health centres around the country. Over 40% of health services (44% in-patient and 48% out-patient) in the country were provided by PHAL in 1988. During the period under study, there were no generalised policy guidelines from the central level that were binding to both government and PHAL. Instead the two institutions existed side-by side with very little collaboration and coordination. The system is also characterised by some degree of for-profit provision by private doctors. In 1988 60% were operating in the capital, Maseru. Traditional healers continue to play an important role in the provision of alternative healthcare, particularly in the rural areas (Health Profile Report, 1993; Health Financing Study Report, 1988)).

In 1978 the government of Lesotho declared commitment to the Alma-Ata declaration. In 1979 the government, in collaboration with PHAL, reorganised health services to facilitate the implementation of Primary Health Care (PHC). Health services were structured so as to enable central determination of health policies with delegated authority to specified Health Service Areas (HS-A), which provide technical supervision and develop plans for health related activities at the district level (Health Financing Study, 1988; HPN II Project Report, 1988).

The system is divided into four-tiers: Tertiary care is provided by Queen Elizabeth II Hospital (QE II), which serves as both the national referral hospital and the district hospital for Maseru district. In 1988 secondary care was provided by the 18 general hospitals (9 government and 9 PHAL) in the different districts. Each of the hospitals is in charge of a given area (HS-A), where HS-A management teams oversee and provide technical supervision to the health centres in that area. The borders of HS-A's and the ten administrative districts do not coincide, but the district is the peripheral budgeting and expenditure unit.

The 19th HS-A covers a series of inaccessible areas that are served by the Lesotho Flying Doctor Service (LFDS). Primary health care in 1988 was provided through 160 health centres and health posts scattered around the country, especially in the rural areas. The fourth tier constitutes a network of voluntary Village Health Workers (VHW). This cadre of healthcare providers performs preventive and counselling functions at the village level. The government also has two other specialised Hospitals (Mental and Leprosy) located in Maseru. Although QE II is the National Referral Hospital, specialised equipment is highly lacking, hence critical patients are often referred to RSA. These referrals are highly subsidised by the government and they absorb a significant proportion of the MOH recurrent budget (Health Expenditure Review Report, 1996).

Attempts have been made to address the inequitable distribution of health facilities through the construction of clinics, especially in the rural areas. Inequity with the distribution of health personnel still persists however. According to 1988 figures a majority of doctors (56%) and nurses (46.7%) and environmental officers (35%) were located in Maseru. Shortage of health personnel is one of the main problems that has historically plagued the health sector (Health Financing Study Report, 1988; HPN II Project Report, 1988).

3.5 Patterns of Resource Mobilisation and Allocation in the Public Health Sector

Although the government allocation to the heath sector has been increasing overtime, problems of healthcare financing continue to prevail in Lesotho (Health Expenditure Review Report, 1996). Inpatient and outpatient fees as well as various taxes and registration fees continue generate government revenue from the public health sector. The current section aims to highlight some of the important sources of finance for the health sector as well as how these resources have historically been allocated to the different cost centres.

Capital expenditure in 1988 was financed predominantly through external aid (grants and loans). Financing of recurrent expenditure was of particular concern during this period because of the expansion and rehabilitation of public health facilities around the country, which commenced in the eighties. The recurrent budget for health in 1988 represented 6.37% of total government expenditure and the actual proportion spent was 7.72%. On the other hand user-fee revenue made up an average of 6% of

MOH recurrent expenditure. The main components of recurrent expenditure were: personnel (45%), drugs and dressings (21.8%), operating costs (14.5%), travel and transport (8.7%), administration (6.5%), subventions to PHAL (3.5%). Health financing patterns are biased toward the capital Maseru, with this district having a markedly higher per capita expenditure on health relative to the other districts (Health Financing Study Report, 1988, HPN II Project Report, 1988; Health Expenditure Review, 1996).

Over 80% of the capital health budget in 1987/88 was financed through external assistance, of which 62.5% was loans and 37.5% was grants. These funds were allocated toward both capital and recurrent costs for some vertical programs. The overall health budget in the 1987/88 financial year was biased towards tertiary care, which absorbed 44.9% of the budget, while 29% went to secondary care, 12.4% to primary health care and 6.4% towards administration costs of the MOH (Health Financing Study Report, 1988). Some progress has been made since. Indeed by the nineties over 70% of the recurrent budget was spent on secondary and primary health care (Health Expenditure Review, 1996).

Although there is some degree of community financing, the proceeds from this form of financing continue to be negligible and the structures highly underdeveloped. Discussions on social insurance as a potential source of finance have taken place but nothing had been done henceforth. Private health insurance was non-existent and there continues to be no private health insurance companies in the country (Health Financing Study Report, 1988).

As has been stated earlier user fees are the primary strategy for generating income from within the health sector. The following account provides some detail on user fees as a source of revenue and will be limited to a situation analysis of user fees in the public sector.

3.5.1 The Role of User Fees

Historically fees have always been charged in public facilities. Fee revenue has always formed part of the Treasury's general revenue and is available neither to the MOH nor to the facilities that collect this revenue. Fees were raised in 1980 and

remained unchanged till 1988 (Health Financing Study Report, 1988; Poverty & Health in Lesotho, 1996).

Fees charged in government facilities have always been significantly lower than fees charged in PHAL facilities and because they were not revised as part of the budgetary process, by 1988 fee levels were worth less than half what they were worth in real terms when gazetted in 1980. As a result, fee revenue contributed little to recurrent expenditure (with cost recovery ratios averaging 6%), especially since the costs of healthcare delivery continued to rise over that period. This, coupled with general inefficiency in the system, ineffective billing systems and unclear roles and responsibilities have constrained efficient collection of fee revenue and cost recovery ratios have tended to remain stagnant or decline overtime (Health Expenditure Review, 1996).

3.5.2 Planning and Budgeting

Budget allocations to the individual districts are essentially determined by expenditure from the previous year. Thus, the more a district spends the more funding it gets. This has proved to be problematic in terms of equity and social justice especially when considered in the light that some of the districts are prone to budget under-spending due to factors such as predominance of vacant posts, while Maseru district (the capital) is prone to overspending. As a result the cycle of resource dis-endowment is perpetuated and there is no incentive for managers to rationalise resource use and to be efficient. The budget process does not include a review of fees nor does it link budget allocations to revenue collected by the individual facilities. Moreover, the planning and budgeting procedures continue to be poorly integrated and coordinated. Poor coordination is aggravated by the dual responsibility of financial staff, who are accountable to the Ministry of Finance but supervised by the Ministry of Health, as well as the irrational boundaries of HS-A's relative to administrative districts (Health Expenditure Review, 1993; Report on National Health & Social Welfare Policies for the Decade, 1993)

3.6 Health Sector Reforms Implemented in the Eighties

The following section provides a brief outline of some of the reforms that were undertaken in the health sector in the mid-eighties. As has been indicated before (see chapter 1), many developing countries undertook to improve public sector efficiency

through implementing decentralisation in its various forms and new public sector management strategies. The implementation of these reforms in Lesotho was quite limited however.

The government of Lesotho selected the health sector as the appropriate sector through which the various forms of public sector reform and new public management initiatives would be tested. In 1985 the government undertook various financial reforms in the health sector, with support from a World Bank technical expert and other forms of support from other external aid agencies. Specifically, these reforms involved the decentralization of the national health budgeting and planning systems. The implication of this was that annual budgets and plans could be developed by each of the health districts or Health Service Areas (HS-A's) instead of being lumped into one budget item under the Health budget. Other forms of decentralization included the contracting out of non-clinical services, specifically catering, to the private sector as well as collaboration with non-government health providers. This collaboration took the form of an annual subvention to missionary providers (PHAL) as an incentive for these institutions to provide free primary healthcare services, and to the Lesotho Planned Parenthood Association for the provision of family planning supplies at affordable prices. The main rational for this collaboration was that these institutions provided services in the areas where government facilities did not exist. The subvention to PHAL has since been modified such that the government pays the salaries of technical health personnel employed by PHAL institutions (Interview Material).

Financial and human resources management remain highly centralized, however the employment of health technical staff, specifically doctors and nurses was decentralized so that they were employed by the Ministry of Health (MOH) as opposed to the Ministry of Public Service (MPS).

Also in the spirit of new public sector management and efficiency, and as a response to severe economic crisis, the government decided to raise health care charges for services provided at public hospitals and health centres in 1988, details of this are provided in chapter four. Many of the reforms implemented during this period have not been evaluated and very little change has been made to strengthen or modify them so that they are more responsive. This is true also for the 1988 fee policy.

3.7 Current Context of Health Policy Reform

Health sector policies are derived from national policy objectives that highlight poverty alleviation, employment generation, income re-distribution, planned population growth, and sustainable economic development. Calls for the current health sector reform initiatives have been brought about by the realisation that health gains that were made in the past, have become increasingly eroded in the past two decades. Some of the main problems characterising the health sector include: ineffective management and planning systems, shrinking resource bases and contracting cost recovery ratios due to escalating costs of healthcare, as well as a deteriorating national disease burden, specifically in the context of the HIV/AIDS epidemic (Health & Social Welfare Sector Plan, 1995).

The key areas of health sector reform identified by the Ministry of Health in 1996 are: the development of a standard district health package; investigation of innovative financing strategies for the sector and instituting measures that promote allocative efficiency; streamlining of human resources management to ensure responsiveness; operational decentralisation coupled with rationalisation of HS-A boundaries; coordination and collaboration with external agencies including donors, the SADC region and South Africa, as well as local non-government providers; rationalisation of planning and management of health sector infrastructure, including maintenance and lastly the review and strengthening of the social welfare system (Health Sector Reform Plan, 1999, Report of Round Table Consultations, 1996).

The current health sector reform program is scheduled to take place over ten years and is presently in the first phase, concentrating mainly on national capacity building to facilitate effective implementation of these reforms.

CHAPTER 4

The User-Fee Policy in Lesotho

4.0 Introduction

As part of a loan condition under structural adjustment in 1988, the government of Lesotho implemented various decisions including the decision to increase user fees at public health facilities, a decision which has since never been reviewed to test whether its intentions are being realised. The purpose of this chapter is to outline a description of the 1988 fee policy in Lesotho, focusing mainly on the rationale and objectives of the policy, the fee schedule, as well as the criteria for exemption. The last section gives a description of how the policy was officially amended after implementation.

4.1 Policy Rationale

Thus far, reference has been made to 'the 1988 user fee policy in Lesotho', however one needs to point out that from the research conducted it has become evident that there was no comprehensive policy articulated and documented. Therefore there was no tangible policy and much of the implied content of this policy (including the policy objectives) was derived from various consultancy reports and interviews with some of the key contacts who were closely involved in the development and implementation of fee increases in 1988. Nevertheless, the rationale for raising fees was based partly on the principles of new public management: promoting and generating revenue to alleviate the macro-economic crisis that prevailed at that time (interview data).

The documents reviewed and interview data reveal that the likely goals for increasing health care charges in 1988, were to generate revenue to finance government programs as well as to instil some degree of efficiency in the health system. At the same time subscription of the Lesotho government to the values of primary health care made it necessary for concerns of equity to be taken into consideration when the policy was designed and implemented. Given these concerns one had to rely on available literature and interviews to generate the implied policy objectives since official objectives were never articulated in the design phase of the policy. The need to generate revenue was an obvious objective of the 1988 fee policy, but even this objective was not clearly articulated especially when considered in the context of other implied objectives of the policy, specifically equity which is implied in the

institution of exemption schemes for 'the destitute', as well as the way in which the policy was implemented (e.g unofficial exemptions- see section 6.2.3.1).

From the analysis of existing literature on user fees (see section 2.1), consultancy reports and interview data, four possible intended outcomes of the policy were identified and these have been summarised below. It is important to note however that these cannot be said to be the official objectives of the policy, since they were generated from different sources and do not appear in any official document as the approved objectives of the fee policy but they are the objectives to be used in the evaluation of the performance of this policy (Phalatsi: 1991; Health Financing Study: 1988; Lesotho Health Profile: 1996; Lesotho Health Expenditure Review: 1996)

- To increase revenue without reducing access
- To shift utilization from government to PHAL facilities
- To strengthen the referral system
- To deter frivolous use of the health system

4.2 The New Fee Schedule

The user fee policy of 1988 instigated an increase of between 200 and 300% in the fees charged at public health facilities for all services except the ones included in the exemption criteria. This increase was targeted to facilitate a recovery of 15% of MOH recurrent expenditure (Phalatsi: 1991). The new fee structures described in the Government Gazette of June 1988 included basic definitions that aimed to facilitate uniform implementation. The gazette also includes a list of criteria for exemptions, price ceilings for ancillary services, general outpatient and inpatient charges for adults and children; charges for various medical exam certificates/affidavits, post-mortems; charges for private patients (outpatients and inpatients); charges for vaccinations, dental, physiotherapy, ambulance, mortuary services as well as environmental health services to businesses and households. This document serves as a government notification of the new fee schedules and does not include official objectives or strategies of implementation.

Historically patients were required to pay for each service rendered per visit and this remained the case with this new policy. For example, separate payment was required for registration, and for each type of service required thereafter such as x-rays,

laboratory tests and a fixed price for drugs etc. Collection mechanisms thus entailed multiple payment points.

Because fees had not been increased since 1980, the increase in 1988 was still marginal and new fee levels were still low compared to fees charged by other providers. Differential charges were implemented at health centre and hospital level, between children and adults as well as between referred and non-referred patients seeking care from hospitals. Services from health centres are half the price of hospital services.

4.3 Official Categories for Exemption

The following list outlines the specific categories that are officially exempted from payment in the gazette:-

- Certified paupers
- Active village workers and their immediate family
- Mental, tuberculosis, epileptic, leprosy patients
- Patients under police custody
- Prisoners
- Maternal and child services
- Tests for sexually transmitted diseases

4.4 Policy Amendment in 1992

In 1992 the management of the MOH reviewed and modified fee schedules so that instead of paying at multiple points, patients had to pay a flat rate charge for consultation at both hospitals (M10) and health centres (M5), hence abolishing all separate charges for ancillary services. The main reason for this policy amendment was to simplify and improve efficiency in the collection of fees. The flat rate charge represented the average of the individual fees initially charged for particular services. All other aspects of the policy, including the criteria for exemptions have remained unchanged since 1988.

CHAPTER 5

Research Strategy and Methods

5.0 Introduction

The research strategies adopted in the study sought to investigate the nature of the processes that shaped the design and implementation of the 1988 fee policy in Lesotho, as well as the critical actors and their roles in these processes. One also sought to understand the overall context in which the policy processes were undertaken. More importantly the methods adopted were geared towards facilitating an understanding of how the processes, actors and context influenced the impact of the policy on equity and financial sustainability. The aim of this chapter is to provide the details of how the research was conducted, in terms of data collection and analysis as well as the unanticipated limitations experienced in the research process.

5.1 Data Collection and Sampling

The aim of this section is to provide a description of the strategies used for data collection as well as the mechanisms for identifying sources. In addition, the account includes a brief overview of the factors relating to the reliability and validity of the data as well as ethical considerations of data collection processes.

5.1.1 Data Collection

Qualitative and quantitative approaches were used to investigate factors that might have influenced the potential impact of the policy. In order to understand the context, processes and actors influencing the design, implementation and impact of the policy, initial data collection processes included the review of official and unofficial documents that were identified through contact persons in the MOH and cross references. These documents included national health policy documents, documentation on public sector rules and regulations including *National Development Sectoral Plans*, related consultancy reports as well as facility records detailing finances and exemptions and where possible utilisation patterns (see references for details). Published literature was also used to guide the data collection process in terms of the relevant foci for policy evaluation and the type of questions to be addressed.

A combination of semi-structured (5) and unstructured interviews (7) was conducted with relevant stakeholders. The development of interview questions was guided by the framework developed by Walt and Gilson, which focuses on context, actors, process and content issues of policy design and implementation (see section 2.3). Thus interviews were aimed at generating discussion about these factors and attaining as close a description of them as possible (see annex 1). In conducting the interviews questions often had to be modified depending on the background of the interviewee. For instance, implementers were asked different questions to those asked senior MOH officials. Interviews also focused on gathering data about perceptions of the actual and potential impact of the policy. The interviews took an average of 30 minutes and most were recorded on cassette and later transcribed into text. Some interviews were not recorded on tape but in point form and later expanded into text, because the interviewees were reluctant to be recorded.

In addition to qualitative data, quantitative data were used to complement the assessment of the policy impact. Qualitative data was collected from government hospitals through telephonic interviews and sometimes one-on-one interviews with the relevant officials.

5.1.2 Sampling

5.1.2.1 Sampling of Interviewees

Subjects were selected through purposive sampling (Katzenellenbogen *et al*: 1997), which essentially involved targeting those stakeholders who were directly or indirectly involved in the phases of policy design and implementation. In the initial stages of identifying interviewees a key informer was identified from the MOH and from her the initial list of potential interviewees was established. Of the eighteen individuals identified as potential subjects for interviews, only five were willing to part-take in the study. Three were only able to provide names of other people who would be helpful and the rest were not available. Snowballing techniques were employed to identify the additional seven subjects who could provide further insight into the policy design and implementation issues (Katzenellengoben et al: 1997).

Because of the limited number of people who were directly involved in the policy processes and available for interviews (see chapter 6) ten of the subjects interviewed were people who were directly or indirectly affected by the policy but not necessarily

involved in the decision-making processes. These stakeholders included policy planners, managers and implementers from the MOH, as well as officials from other sectors (Finance) including the private sector (Missionary health providers). The list of interviewees included retired persons who have first hand experience with some of the issues relating to the study. Representatives of international aid agencies involved in the health sector as well as the media were also approached for interviews but the relevant people were no longer there and could not be accessed. Particular effort was made to get a sample that would be representative of managers and implementers who were placed in the district at the time the policy was implemented as well as those who were at the central level. A list of the various persons identified as potential informers is provided below:-

Summary of Potential Interviewees.

- Senior government officials
- Policy makers
- Implementers (Department heads and fee collectors)
- NGO's, Christian Health Association of Lesotho
- Donors
  - European Union
  - World Bank project manager
- Other sectors
  - Ministry of finance
  - Ministry of Planning
- Media

5.1.2.2 Sampling of Health Facilities

In this case also, sampling was not random. Instead effort was made to select district hospitals in the remote rural areas (3), peri-urban (2) and the one hospital in the capital city. The purpose of this was to facilitate a comparative analysis in terms of equity and cost recovery ratios across the different districts. Although health centres also charge user fees the study was limited to government hospitals. Moreover the study focused only on government district hospitals because they are the ones directly affected by the 1988 fee policy, thus non-government providers were excluded.

5.1.3 Validity and Reliability

Two people, the researcher and an assistant, transcribed interviews independently and the outcomes were compared. The purpose of independent transcribing was to facilitate cross checking and to limit researcher bias thus ensuring validity. The

credibility, dependability and confirmability of interview data were enhanced through triangulation mechanisms to facilitate peer reviews and confirmation of data. (Guba: 1981; Cobb & Hagemaster: 1987; Krefting: 1991). However, triangulation was limited because of the limited number of subjects directly involved in the decision-making processes. More weight was given however to the information from the subjects who had been closely involved in the processes of policy design and implementation, but equal weight was given to different opinions and feelings related to the policy impact. In instances where there was a lack of consistency in the data, repeat interviews were undertaken to confirm data and to explain variations in the data. Data from interviews was crosschecked with reviewed documents to promote rigour and validity. Where the data remained contradictory this was incorporated as part of the analysis.

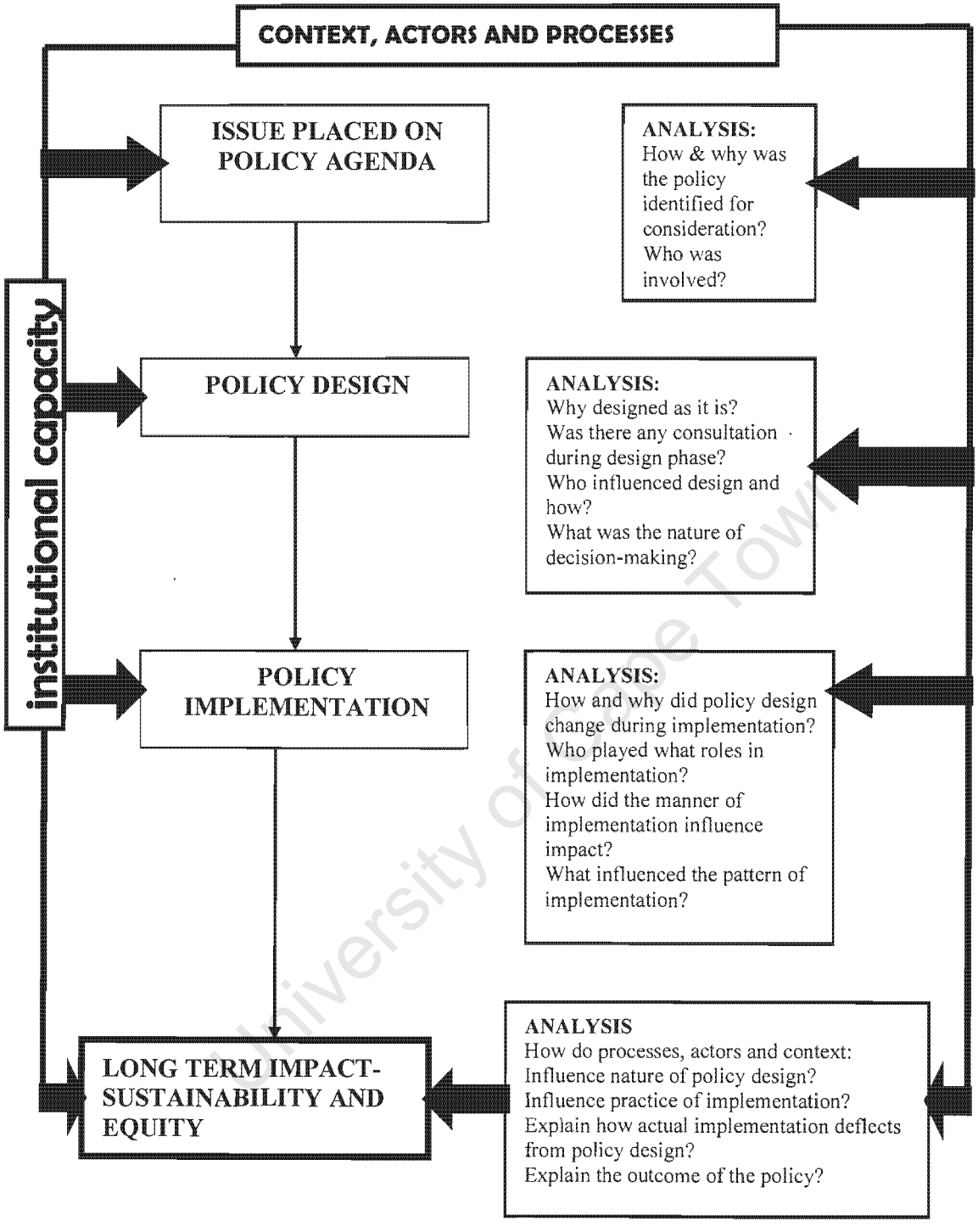
5.1.4 Ethical Considerations

Once the list of potential interviewees was developed, the subjects were contacted through letters that provided details of the objectives of the study and subjects were invited to part-take and to confirm participation by telephone. In some instances, delayed response was followed up by telephone. From the start it was made clear to the potential subjects that they were under no obligation to participate in the study and that the confidentiality clause applied. Moreover, special care was taken to reassure subjects that what ever was said in the interviews would and could not be traced back to them.

5.2 Data Analysis and Measures of Performance

The methodology for data analysis included manual coding of interview transcriptions by identifying themes around design issues on the one hand and implementation issues on the other (see annex II). The two themes were further sub-coded into process, actors and contextual factors as well as content issues. For the analysis of impact the two performance criteria are equity and *financial* sustainability. Coding of data was undertaken by two people in an attempt to reduce researcher bias and establish validity. The analysis and coding of data was adapted from the conceptual framework developed for evaluating financing reforms in South Africa and Zambia (Gilson: 2000) and is an advancement of figure 2.3.1. This model of analysis is illustrated in figure 5.2.1 below.

Figure 5.2.1 Framework for Analysis



Note: Based on Gilson 2000 with amendments

5.2.2 Measuring Policy Performance

Quantitative approaches were used to complement qualitative approaches in the analysis stage of the research. Secondary data (facility records and annual public sector expenditure reviews) were used to assess the impact of the policy. A summary of the quantitative and qualitative indicators for evaluating the policy design and implementation issues, as well as the impact of the policy is provided below. The indicators were developed from the literature reviewed. (McPake & Kutzin: 1997; Knowles et al: 1997; Grindle & Thomas: 1991; Walt & Gilson: 1994). Moreover, the list of indicators was modified during the data collection and analysis processes.

As in section 2.1.2 efficiency indicators have been considered only in so far as they contribute to equity and *financial* sustainability. The main reason for this is that these two objectives are inherently contradictory and since the policy attempted to address both of them, one seeks to evaluate the extent to which they could have been realised through the 1988 fee policy, especially given the circumstances under which the policy was undertaken (see section 6.3). Although efficiency is an important factor, since it cuts across more than just finances its consideration in the overall performance of the policy has considered to a limited extent.

Table 5.2.1 Performance Measures for Sustainability and Equity

SUSTAINABILITY **Indicators**	**Source**
• Proportion of fee revenue to total health sector recurrent expenditure	Health expenditure review doc
• Proportion of government recurrent health spending financed by external sources	Public sector investment plan
• Proportion of revenue foregone due to exemptions	Facility records
• Trends in recurrent health sector expenditure	Documentation
• Effective referral system	Interviews and documentation
EQUITY **Indicators**	
• Proportion and criteria for exemption by Health Service Area	Facility annual reports
• Utilisation patterns	Documentation
• Assessment of fee revenue use relative to quality improvement and service expansion.	Interviews and documentation
• Methods of budget allocation to the different geographic areas.	Interviews and documentation

5.3 Limitations and Problems of Data collection

- Recall bias was a real problem for data collection because the policy was implemented over ten years ago and few of the interviewees were certain about the detailed events and processes that are relevant to a comprehensive understanding of the context in which the policy was designed and implemented. In this case one had to give more weight to the information provided by the subjects closely involved in the policy processes and focus on critical features as opposed to the desired degree of detail.

- Since there were no clearly articulated *official* objectives of the policy, the study relied on the discretion of the author to identify the probable intended outcomes of the 1988 fee policy in this country. Thus, the results and recommendations of the study were susceptible to possible bias, this however was managed through a rigorous review of existing official and unofficial documents as well as triangulation of interview material. The absence of clear official policy objectives has been incorporated as part of the analysis (see chapter 6)

- Interviewee access was also limited because of the time-span between the time that the policy was implemented and the time of this evaluation. As a result of this, there was great difficulty in tracing people as some had left the country and others had just 'vanished'. The problem is further aggravated by the high turnover of senior officials, which is associated with changes in government. The problem of staff turnover is also relevant for facilities at the periphery level, such that none of the people who were present at the time of the policy are there currently. Nevertheless, a quarter of the interviewees were in the districts at the time that the policy was implemented even if they are no longer there at present.

- The nature of the processes of policy formulation and design appears to have been highly exclusive thus the resource base in terms of useful interviewees and triangulation was not as rigorous as one would have liked them to be (see chapter six). In this case one had to rely on available subjects and the exclusiveness of decision-making processes has been incorporated as part of the analysis.

- Availability and access to documents identified proved to be frustrating because of the absence of a reliable resource centre for the health sector. Due to time constraints, one had to rely only on the available documents.

- Data availability from facilities was extremely poor because of poor information management systems. Therefore only one facility that had some data was assessed, thus disallowing cross-sectional comparisons between different geographic areas. The data nevertheless provide a general idea of the patterns of exemptions and hospital debts. The lack of effective data management systems was incorporated as part of the analysis

- Although the focus of the study is the user-fee policy, the policy was implemented within a broader context of public sector reform and aspects of these other reforms have not been addressed in this study.

CHAPTER 6

Results: ***Patterns of Policy Evolution, Design and Implementation***

6.0 Introduction.

The purpose of this chapter is to provide a detailed retrospective description of the patterns of policy design and implementation, focusing on the processes of design and implementation; the roles and relative influence of the different actors and stakeholders in the policy arena as well as the context in which the policy evolved and developed. The analysis of these foci aims to outline some of the underlying factors around the patterns of policy design and implementation that may have inevitably influenced not only the policy content but also the actual and potential impact of the policy, thus the analysis will include a description of the key features of policy content.

6.1 POLICY PROCESSES

6.1.1 Processes of Policy Design

The decision to raise fees was taken at an elite level by the Military Council and the MOF in close collaboration with the World Bank and to a less extent the Ministry of Health. *"The decisions from the top kind of provided a framework for the MOH and we did the groundwork ...but the decision to raise fees was made at a higher level."* (former senior MOH official and task force member). This groundwork involved the technical aspects of the policy such as the calculation of unit cost, from which fee levels were to be set, taking into consideration health specific objectives such as equity in access. Any consultation undertaken was to inform decisions around costing but not necessarily to generate discussion about the policy nor to establish consensus on the objectives and strategies for implementation of the policy.

Of the twelve interviews conducted nine of the interviewees (implementers and managers) said they had not been part of the decision-making processes around the policy. Managers at the different levels of the health system were not involved in decision making nor were they consulted *" ... one day we just got a circular saying that new fee structures would be implemented from whatever date set, that's exactly what happened."* (former district medical officer). Middle managers at central level were also excluded in the design phase of the policy.

Two of the people who were part of the task force established to oversee fee increases said consultation had been undertaken, however a closer analysis reveals that consultations focused mainly on decentralization of the budget system that was being undertaken at about the same time and the new fee policy was communicated as a decision that had been taken but not necessarily for discussion among the different stakeholders, including implementers. The media was used as a tool for dissemination but not a platform for discussion of the objectives and strategies of the policy.

Stakeholders from the private sector, community leaders and other sectors, except the MOF were also not involved in the decisions around the policy. *"... raising of fees in the government facilities was clearly a government issue and it really had nothing to do with us because we were not part of that process...and PHAL facilities have always charged their own independent fee structures."* (senior NGO manager).

The processes of policy design were thus highly exclusive with extremely limited consultation with the relevant stakeholders (health care managers etc.). As a result there was very limited consensus and understanding about factors such as the objectives of the policy. Confusion around the policy is illustrated by the different perceptions about the rationale for raising fees.

" fees were raised because of SAP... we had to generate revenue for the government because it could not afford to fund some of the health programs... hence cost recovery" (MOH program manager)

" the rationale for raising fees was based on the principles of new public management which preached value for money... so patients had to pay...we were also trying to discourage unnecessary use of healthcare services..." (senior MOH official and policy task force)

" the main thing that made fee raising necessary was PHC which promoted self-sufficiency as one of its main principles." (program manager and member of policy task force)

" the main rationale...there was a large gap between fee levels at (missionary facilities) so government realized that it could afford to exploit this gap by increasing fees without reducing demand of healthcare from government faculties." (senior MOH manager)

" fees were raised because the social sectors had to take some initiative so that they appeared (to the donors) to be doing something to help themselves in the context of SAP" (former donor project manager)

"the government needed money and they had to generate it from somewhere...they did the same in the Ministry of education people were forced to pay more for their children's school fees" (policy implementer)

These different perceptions of the rationale for raising fees serve to illustrate the lack of consensus or understanding about the objectives of the policy. The processes of designing the fee policy were quite neat and rational, primarily because they were not open to the various stakeholders, including the different categories of managers and officials from the MOH. The controlled rationality and 'closedness' of the processes of policy design meant that, many of the problems with the actual design became apparent during implementation.

6.1.2 Processes of Policy Implementation

The Government Gazette announcing the new fee schedule came out on the 27th June 1988, and the new fees were to come into effect on the 1st of July of the same year. Hence, the lack of consultation in the design phase meant that most people, including managers and implementers only found out about the impending fee increases in very short notice. *" the change literally took place overnight...today it was this and the next day it was something else"* (MOH program manager). By the time the policy came into effect very few people were on board, and the critical actors on whom the success of the policy depended had not embraced the vision behind this policy. Thus from the beginning commitment to, as well as understanding and appreciation of the policy objectives was very limited.

6.1.2.1 Key Problems with Implementation Processes

The following section outlines some of the problems related to exclusive processes of policy design that surfaced during implementation.

6.1.2.1.1 Failure to develop a comprehensive policy document

The critical factor that makes it difficult to assess changes to the policy once it was implemented is that the intention of the government to raise healthcare charges was never articulated into a comprehensive policy that includes objectives, strategies and implementation plans (see section 4.1). Hence, it is difficult to assess whether what did happen was what was intended. As a result there was some confusion and contradictions about factors such as the policy objectives, procedures for billing and exemptions etc. At times this led to compromised sustainability of the policy because some aspects were left out. For example, once implemented, it was the intention of policy makers that fee structures be reviewed every two years and increased to adjust for inflation, this however did not take place. *"I think it had something to do with the departure of the financial controller from the MOH... when one person leaves they leave with a part of the system...."* (MOH program manager and policy task force memeber). Hence, *"...when you don't have a policy that spells out what should happen"*... problems such as high staff turnover (especially of senior staff), poor leadership and guidance, coupled with a lack of vision around the policy objectives, mean that things could change each time a new person entered the system. The problem is more pronounced if it is not just senior officials (minister or principal secretary) who can change the course of policy implementation. In this particular context it seems anyone can effectively change the course of the policy because of factors such as poor orientation towards MOH objectives, including the fee policy and failure to generate commitment to these objectives.

The absence of a comprehensive policy document clearly outlining the critical elements of the policy has meant that there were many loopholes with the policy and many uncertainties were left to the discretion of implementers. The outcome of this was that faulty implementation of the policy went undetected and sometimes became institutionalised as part of the policy intention, especially since there were no channels for regular monitoring and evaluation of the policy once it was implemented. This problem was aggravated by the failure to involve healthcare managers and the

different categories of policy implementers in the decisions around design and implementation of the policy. Details of this are provided below:-

6.1.2.1.2 Lack of consultation with implementers and managers

The absence of clear and official objectives and the failure to get implementers on board during the processes of design have made some issues of actual policy implementation highly contentious. For example, the charges at health centres are lower than the charges at hospitals. Generally, the reason for this is to make the health system more efficient, through making the referral system more effective. However, contention arises when health centres or filter clinics provide the services of a doctor, *"... the defining difference between a clinic and a hospital as far as fees are concerned is the services of a doctor... if there is a doctor at a clinic then the charge should be ten rand..(same as hospital charge)."* (senior hospital manager), in which case the objective of strengthening the referral system is lost. The other problem related to this loophole is that individual doctors and nurses can take advantage of it for their own benefit. Alternatively it could be that the policy can be interpreted in various ways, so that these people are making honest mistakes, given their understanding of the objectives of the policy. Hence failure to clearly state objectives and to clarify strategies as well as to get implementers on board led to uncertainties about how things should be done.

The lack of consultation with other stakeholders such as community leaders and other persons or groups who are critical for making the policy happen, has limited effective implementation of some of the aspects of the policy. For example, the reliance on the discretion of traditional community leaders (chiefs) in their capacity as agents of granting exemptions to the destitute has meant that the procedures are not transparent because no guidelines were provided to them. Procedures are thus open to abuse by these actors/implementers. *"...with modern politics our have become politicised, so that if you belong to the wrong political party you can be denied exemption whether you need it or not."* (MOH program manager). Thus, certain categories of actors need to be at least consulted so that effective implementation can be facilitated, especially if these actors are the ones expected to further the intended outcome of the policy. Moreover, failure to open policy processes to civic groups and the public at large, have implied that the channels of accountability to healthcare consumers were never developed.

6.1.2.1.3 Hasty implementation

The hasty manner in which the policy was implemented (within three days of the official policy announcement) coupled with lack of consensus resulted in a situation where it was not only implementers and managers who were not adequately prepared for the effective implementation of the policy but the organisational structures were also not conducive. Policy processes did not include attempts to create an enabling environment for effective policy implementation or policy acceptance through sustainable attempts to improve the quality of healthcare... *" there was nothing wrong with the quality of services provided at the time...anyway because of structural adjustment there were no resources to improve the quality"* (member of policy task force). In addition, minor details such as vouchers with new fee schedules were not available by the time the policy was expected to take off, *" ... the new fee vouchers printed took a very long time (over six months and even longer for the districts)... to come through, so during this time receipts were prepared manually, or in some cases the old vouchers were used."* (former senior MOH official and policy task force member). Of course this may be attributed to lack of preparation for the policy or the typical problem of slow responsiveness on the part of government departments, in this case the government printers. Nevertheless, hasty implementation resulted in confusion and delays during the initial stages of implementation and after. Some of the primary problems associated with hasty implementation that may have hindered effective implementation are outlined below.

6.1.2.1.3.1 Failure to undertake affordability assessments.

Perhaps partly due to hasty implementation, policy processes were not based on reliable information about the ability to pay higher charges for public health services. "*There was an assumption that if people could afford to pay for services from missionary hospitals and from traditional healers, then they would be able to pay the new fees...even after the fee increases government charges were still significantly lower than these other providers."* (senior MOH manager). The policy was also not based on an assessment of existing institutional capacity. The next section outlines some of the capacity issues that surfaced during the implementation phase of the policy.

6.1.2.1.3.2 Failure to develop sustainable capacity

There was an underlying assumption by the policy makers that the problem of cost recovery, or lack thereof, was due to low levels that were charged before. There were no attempts to improve capacity and existing organizational structures, nor to clarify roles and responsibilities, and to improve or review traditional billing and exemption systems *"... there was sufficient capacity because we had trained people...if you think about it there was nothing new or challenging about collecting fees'* (senior MOH official and policy task force member). Hence, there was no assessment of whether the capacity in terms of structures, monitoring and evaluation systems, sustainable incentive systems etc, were adequate to facilitate successful cost recovery. Decisions and processes of decision-making were therefore not based on any assessment of baseline problems that might have hindered effective cost recovery before. The main problems related to capacity identified included:

6.1.2.1.3.2.1 Unclear roles and responsibilities

Policy processes failed to establish functional mechanisms for monitoring and evaluation of the policy and, more importantly, who should be responsible for overseeing implementation. The absence of clear, documented objectives and strategies only serves to compound this problem. The example of differential charges between hospitals and health centres (see section 6.1.1.2.1.2), helps illustrate the problem of unclear objectives coupled with unclear channels of accountability..."... *a doctor has no mandate to change fee charges, but... there is no effective baseline which can be referred to legally or otherwise, on top of that...existing management structures are quite impotent when it comes to rectifying things... the most the principal secretary can do, assuming he finds out and cares enough to do something is to send out a circular saying 'stop it'...no real enforcement."* (MOH program manager). Given different possible interpretations around the policy, some implementers are more concerned with facilitating equitable access and strengthening the referral system, while others are more concerned with recovering costs and thus charging hospital rates at those clinics that have doctors. Both camps however are justified in their interpretations. The main problem is the apparent lack of a common vision and poor enforcement, which can be partly attributed to the absence of a policy champion. Thus, even if a problem is identified regarding policy implementation, it is not clear who should take action to rectify it.

Clear roles and responsibilities are also lacking with the actual collection procedures especially as accounts clerks do not work after hours thus opening the system to loopholes that inevitably constrain cost recovery *"...at times you find that a patient pays the cleaning lady because the person who's supposed to collect is not on duty (after hours) and of course everyone takes advantage of this and the wrong people have been known to discharge patients just so they can be the ones to whom patients pay the bill"* (senior implementer). Decision-making processes thus failed to take into consideration these small details, which have effectively constrained cost recovery.

6.1.2.1.3.2.2 Ineffective billing and collection procedures

Perhaps due to poor consultation in the decision-making processes regarding policy design and implementation, policy makers failed to incorporate some of the critical aspects of policy implementation including billing and collection... *"certain categories of people such as prisoners and mental patients do not pay...but even if this is the case I think we should be able to bill the department of correctional services for the services rendered to those patients, similarly with social welfare patients, someone should be responsible for paying those bills."* (senior hospital manager). These are some of the problems that were experienced by implementers and managers during the implementation phase of the policy. These problems are worsened by the fact that it appears that responsibility for checking implementation and executing the necessary rectifications is left hanging. It appears that MOH managers have no real mandate to effectively make cost recovery happen.

Problems also arise with billing patients who are referred from clinics and district hospitals to the national referral hospital... *"when patients are referred from the districts we expect that they will go back and settle the bill there but of course there is no way to follow up...this doesn't make sense because the services are provided here (referral hospital).."* (implementer), these are some of the problems associated with the failure to develop comprehensive strategies that outline what is supposed to happen with billing and **how** it is supposed to happen. A related problem is the lack of effective mechanisms to ensure payment by patients or even follow up of patient debts. Moreover, managers do not have the necessary powers to effect the necessary changes because *"...everything needs to be approved by the principal secretary and the MOH management ...they have their own priorities so a lot of problems are not addressed on time if ever."* (hospital manager). This also brings out the issue of

capacity, regarding the impotence of managers to make effective decisions to facilitate cost recovery, because of established protocols for decision-making within the MOH itself and the public sector in general.

6.1.2.1.3.2.3 Ineffective management information systems

Related to the problem of billing and collection is the absence of effective reporting systems that are standardized, especially pertaining to exemptions granted and inpatient debts. Facility data collection and management systems do not incorporate records of the number and criteria for exemptions granted or revenue lost due to debts, which makes it difficult to monitor, evaluate and to make informed decisions that promote equity and better financial management... *"when I first arrived there were no records whatsoever so I started recording exemptions granted and their criteria and debts of individuals owing the hospital...it was my own initiative not part of my job description so I doubt that other hospitals do it..its not part of the requirement to keep records but I suppose when there's no policy to refer to then we must use our common sense."* (implementer). Out of the five hospitals approached for this data only one (the national referral hospital) had information on exemptions and debts owed to the hospital, although this data had substantial gaps. The other five (district) hospitals kept no such records and one of them had only just started, as an initiative taken by the new administrator there.

6.1.2.1.3.2.4 Failure to Develop Monitoring and Evaluation Systems

Related to the absence of effective information management systems is the neglect by policy developers to put in place systematic channels to check implementation of the policy. In addition, there were no structures such as a policy champion or specific department either in the MOH or the MOF, established to continuously oversee effective implementation of the policy. As a result many problems went undetected and eventually some of them were institutionalised as the norm. Moreover, ineffective management structures meant the regular day-to-day monitoring of revenue collection remained extremely lax.

6.1.2.2 Official Amendment of the Policy

Following numerous problems that surfaced during implementation there was a single occasion on which the policy was amended but this was only to address a small technicality with payment procedures (see section 4.4). This decision was taken

independently by the MOH management team, and was not contented by the MOF possibly because it did not impinge on the established status quo as it relates to the sovereignty of the MOF in issues of public sector finances. No other official amendments have since been made on the fee policy.

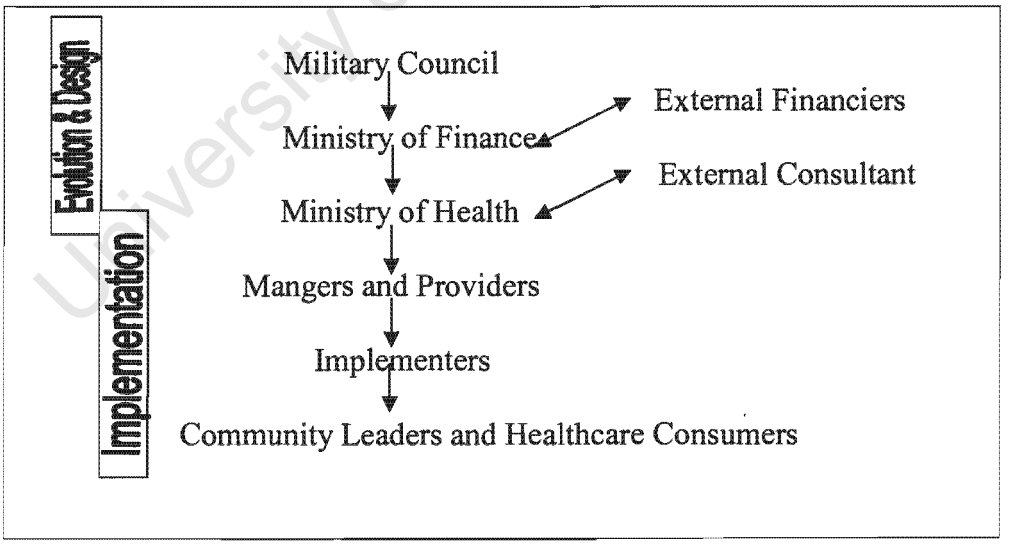
The above account has attempted to outline the critical features of the processes that shaped the design and implementation of the fee policy of 1988, in Lesotho. The next section provides an account of the role and relative influence of the different actors that took part in these processes, thus enhancing a better understanding of the problems outlined above.

6.2 ACTORS IN THE POLICY ARENA

6.2.1 Actors in the Evolution, Design and Implementation of the Policy

Figure 6.2.1.1 below provides a macro-snapshot of the different groups of actors that were involved in the evolution, design and implementation of the fee policy, as well as their relative power in these processes.

Figure 6.2.1.1 Hierarchy of decision-making around the user fee policy in Lesotho



The diagram is an attempt to illustrate the hierarchy of decision-making processes around the 1988 fee policy in Lesotho, as well as to demonstrate the relative power and influence of the MOF in making this policy happen. One can deduce from this that the increase in health care charges was not so much an objective towards the sustainability of the health sector but more an objective for ensuring additional revenue for the MOF and thus the government. The decision to raise fees was

therefore taken at a level beyond the MOH and in the initial processes of decision-making the MOH was not one of the key actors.

6.2.2 Actors in Policy Design

As indicated in section 6.1.1 the processes of policy design were extremely closed with very little consultation with the relevant stakeholders. The aim of this section is to identify the key actors and their relative roles in the processes of policy design. Although the MOH played a marginal role in the decisions that placed the policy on the national agenda, once the decision was made to raise fees, the responsibility of developing mechanisms to make this happen was delegated to this ministry with the close involvement of the MOF.

The main decisions to be taken by the MOH included how the policy should be designed and implemented. A task force (six individuals) comprising the MOH financial controller, the PHC coordinator, a representative from the Health Planning Unit, the MOH Deputy Principal Secretary, as well as a representative from the MOF, was established and it was this core group of officials that made decisions on the design of the 1988 fee policy. Also present and highly influential was an external consultant from the World Bank. *"... close involvement of this consultant was useful for me because it meant I had the necessary support from the top to make and carry out the necessary decisions."* (former senior MOH official and policy task force member)

From the interview material one learns that the external consultant and the financial controller, who had been seconded from the MOF to oversee financing reforms in the health sector, played a central role in the decisions around budgeting, contracting, as well as fee increases. Out of the twelve interviews conducted nine people mentioned the critical role of the consultant in the design of the policy and in the health sector reforms that were being undertaken at the time *"...That man (the consultant)...was so powerful he was the one who decided that we would contract out catering services and who we would contract out to... (the two of them) literally ran this ministry during that time ..."* (senior MOH official). It is not clear what role the other members of the task force played in these processes, except for some who... *"went out to the districts to educate people about the new fee structures."* (policy task force member).

The design phase of the policy was thus highly exclusive with the external consultant and the financial controller playing a central role in shaping the policy design. This extreme elitism meant that managers at all levels of the system were excluded in the decisions around the policy design. Thus many of the pragmatic factors around implementation were not addressed in the actual design of the policy. Some of these problems have already been outlined in section 6.1.1 above. A look at the primary actors in the implementation phase of the policy should add to the analysis on the processes of policy implementation outlined above. The analysis now turns to the role of different actors in policy implementation as well as to assess how they might have constrained the success of the policy.

6.2.3 Actors in Policy Implementation

The following section seeks to outline the role of different actors and how they might have influenced either positively or negatively the policy outcome.

6.2.3.1 The Role of Managers and Implementers

One of the critical features around the design and implementation of the user fee policy in Lesotho is the separation between responsibilities of providing healthcare (technical health workers) and financing of that healthcare. This theme is recurring in the policy design phase and becomes more pronounced in the implementation phase. The processes of collecting and handling monies are handled predominately by financial clerks who are officially accountable to the MOF. Thus, as far as finances are concerned the MOF, through accounts clerks, continued to play a dominant role during the implementation phase of the policy. Because of the centralised nature of public sector decision-making protocols health facility managers are not empowered to make the necessary decisions regarding financial management and the management of the personnel who collect fee revenue. The problem is aggravated by the absence of an official policy document to support managers in their attempts to institute measures that make the policy effective in realising its objectives. For instance, it is not clear how it came to be that civil servants/ MOH employees became exempted from payment. On this issue responses varied considerably:

"... *civil servants are exempted because it was part of an incentive package offered to all government employees...kind of a privilege.*" (MOH program manager),

"... ever since 1988, everybody, including civil servants, had to pay for health services...the only people exempted are the ones listed in the fee schedule document, and that list does not include civil servants, so it is wrong to say they are exempted...they should be paying' (former senior MOH official and policy task force member)

"the practice of exempting MOH employees is unofficial but their exemption I think stems from a typographical error where it says 'health workers and their families'...this was actually referring to village health workers but somehow it has become a norm and... it has become impossible to change this practice but everyone has to pay as far as I know." (senior hospital manager).

The above quotes illustrate some of the problems associated with failure to develop and generate support for, as well as understanding and appreciation of the policy objectives. Whether it is civil servants who are currently being exempted or MOH employees, their exemption is unofficial and it seems as though it is impossible to enforce their payment, especially as some officials in the MOH are under the impression that their exemption is official... *" Numerous principal secretaries and the superintendents here (at QEII) have sent out countless memos to try and enforce payment of this group of people but it has been impossible...I guess people are just used to this way of doing things."* (Hospital administrator). Although managers have the mandate to make decisions on aspects of the policy (as they understand it), such as payment and exemptions, the tools to change the behaviour of fee collectors are non-existent and this group of implementers continues with this practice in spite of the attempts by numerous senior MOH managers and officials to abolish this practice. This can be understood as differing understandings of what the policy entails, it could be rebellion by the fee collectors or it could also be a question of poor institutional capacity. It is most likely that these problems are a result of a medley of these different factors.

Because the policy was an initiative of the MOF and that financial management remains highly centralised, it is not clear who should be responsible for effecting the necessary changes to support the policy... *"at the end of the day it is the MOH and not the MOF that is seen to be failing to recover costs because it is impossible for us (MOH managers) to make and enforce decisions around financial management or*

even the people collecting this money." (senior MOH manager). Of the twelve interviews conducted six of the subjects raised the separation between responsibility and accountability as one of the main constraining factors against effective financial management and thus cost recovery.

To illustrate the point further, there also appears to be a sentiment among MOH employees that they do all the work and someone else reaps the benefits. For example one of the managers state *"...apparently fees were raised to recover costs, but we have no say over how the money is spent. Second, we don't know whose costs we were trying to recover. We just do the work, and somebody else decides what to do with the money."* (MOH program manager). The exclusion of MOH officials and implementers in the decisions about the policy coupled with the separation between responsibility and accountability meant that there was very little commitment, acceptability and appreciation of the policy objectives from the implementing ministry. The problem is worsened by the disempowerment of health facility managers to make decisions that promote effective cost recovery or exemption schemes as well as effective incentive systems.

6.2.3.2 The Role of Community Leaders and NGO Partners

Although community leaders and NGO providers are not official members of either the MOH or MOF they had critical roles to play in the implementation phase of the policy, yet like managers and implementers they were not in any capacity part of the decision-making processes around the policy design and implementation. The role played by both groups is essential for the effective pursuit of equitable access to health care. Community leaders are the primary agents for the granting of exemptions in that they are the ones who identify or confirm eligible recipients. Policy processes did not involve the provision of guidelines for identifying the targets, thus the procedures for granting exemptions depends on the discretion of these agents and therefore open to abuse (see section 6.1.1.2.1.2). The role of non-government providers is to ensure free access for services that fall under the primary health care basket in those areas where government providers are scant (e.g. sexually transmitted diseases and tuberculosis). In the absence of effective mechanisms for monitoring and evaluation it is difficult to conclude how these actors are influencing the effectiveness of this aspect of the policy.

6.2.3.3 The Role of Health Care Consumers (Public)

Ordinarily, the MOH is accountable to the public in terms of ensuring acceptable quality of care. Thus, during implementation it is through the public that the quality of healthcare can be monitored. There is no evidence of effective channels for the public to express their discontent. Perhaps changes in utilization patterns may shed some light on this issue (see section 7.1.2).

6.2.4 Actors and Opposition to the Policy

The exclusive nature of the processes of policy design meant that these processes involved only a handful of like-minded actors. As a result, opposition to the policy during the design phase was not apparent. This however is not to say that there was no opposition to the policy because it could have been covert or there may not have been effective channels for expressing discontent with the policy design. The following account attempts to assess the potential opposition that may have surfaced during policy implementation from the different actors.

6.2.4.1 Opposition from Managers and Implementers

With the role and influence of actors in the implementation phase of the policy, it is difficult to identify what role implementers played in constraining or facilitating the success of the policy, because opposition to government decisions was unacceptable, especially from civil servants. *"Being a civil servant means that you are a tool for implementing government policies.... it is not your place to question or protest against decisions"* (senior MOH official).

Whatever problems experienced during implementation can be understood in various ways. For example, the delay in printing of the new vouchers with new fee levels (see section 6.1.1.2.1.3) may equally have been some form of protest/ 'go-slow' against the policy, or it could have been just that government departments generally respond slowly, in which case it is a public sector capacity issue. From this perspective, it is difficult to ascertain the role of implementers as potential actors in constraining or facilitating the policy either through opposing it, or supporting it.

The persistence of unofficial exemptions of MOH employees might also be a form of protest by this group against the policy itself or even protest against perceptions of being under paid by the government. On the other hand it could be a form of protest

against the dominance of the MOF staff in the issues of management of MOH fee revenue. In addition, continued unofficial exemption of these groups might be an indication of the power of this category of actors to use the system for their own benefit as a group. Thus, many of the problems that surface from the data, can be understood in terms of lacking institutional capacity, poor policy processes that failed to establish consensus and understanding around the policy or some form of protest from implementers, it is difficult to ascertain especially as the channels for overt opposition from civil servants did not exist. There is thus no evidence of any opposition to the policy from managers and implementers.

6.2.4.2 Opposition from the Public

Due to the apparent lack of channels for expressing discontent with the policy, it is difficult to speak of opposition from community leaders and healthcare consumers. If there was any opposition it was effectively covert. With consumers however one way of protesting would be to substitute health care from public providers with care from other providers.

6.3 THE POLICY CONTEXT

Problems such as speedy implementation, identified in the two sections above can also be further understood from the perspective of the context within which the policy was adopted. The aim of this section is to provide a description of the critical features of the context within which the policy was designed and implemented as well as to provide an assessment of the influence of the context on the nature of the policy processes and the roles of the different actors in the policy arena. Some of the critical contextual factors are outlined in table 6.3.1 below:

Table 6.3.1: Critical elements of the context of policy design and implementation

Political	• Government had pledged commitment to equity, social justice, universal coverage. • New military government brought in new individuals in senior positions in 1986 (principal secretaries, Ministers and directors) • Lack of a democratic culture in the policy arena. • Decision-making was extremely elitist and policy development and implementation highly top-down in character. • A history of totalitarian rule meant that what civil society existed was extremely limited • In 1993 military rule ended with democratic elections and senior government officials once again changed.
Economic	• Government was experiencing economic crisis and extreme shortage of resources. • Structural adjustment programs were adopted in 1988 and this led to tight fiscal policies as well as sharp reductions in public expenditure. • Healthcare highly subsidized by government. • Increasing unemployment and poverty. • Lesotho Highlands Water Project promised to inject significant economic gains for the country in the medium and long term.
Organizational Capacity	• Government undertook to reform the public sector adopting the principles of new public management • Structural adjustment led to low staff morale because of salary freezes, suspended promotions and general shortages of resources such as consumables in the health sector. • Financial and human resources highly centralized, with the MOH having very little or no control, especially over fee revenue and financial management. • Predominance of inefficiencies due to a poor management culture and • Absence of effective monitoring and evaluation systems.
External Factors	• Overwhelming economic dependence on international aid agencies. • Macro-economic and other national policies strongly influenced (imposed) by external actors and ideologies (fiscal policies, public sector reform and fee policies) • High presence and influence of external consultants and technical assistants. • Relatively high donor support for health and education sectors to ensure availability of priority services through vertical programs. • The government enjoyed substantial donor support

6.3.1 Context of Policy Evolution, Design and Implementation

The previous sections have outlined the processes and actors that shaped the design and implementation of the 1988 user fee policy in Lesotho. The current section seeks to highlight some of the main features of the context within which these processes took place with the aim of explaining the reasons for their specific nature as well as the actors that part-took in these decisions, thus enriching our understanding of the potential constraints on the success of the policy. The critical contextual factors to be addressed include: external forces, national economic and political factors as well as the institutional capacity underlying the design and implementation of this policy.

6.3.1.1 External Forces and Ideology

Increasing of fee charges for healthcare had been on the national policy agenda for over three years because, before 1988, fees had last been raised in 1980. Fee increases in 1988 were based on the principle of value for money, which is inextricably linked to the principles of new public management. The implication of this was that social services should be provided at a cost to clients through implicit cost sharing strategies. It was only with the adoption of the SAP that fees were raised. One can go so far as to say that the government was forced to implement this policy... *"a lot of decisions by government including the decision to raise fees were largely influenced by the World Bank.. The raising of healthcare charges was linked as a precondition for the renewal of the loan for the Second Health, Population and Nutrition Project."* (former donor project manager). Thus in order to acquire a loan to ease the burden of economic crisis and structural adjustment, the government had to raise user fees for health care and other services such as education (see section 6.1.1 on policy rationales).

Since fee increases were a pre-condition for a loan agreement with the World Bank, it is understandable that this factor influenced not only the form of the policy design but also the timing and pace of the policy implementation. The lack of process and preparation for the policy, particularly in terms of generating consensus among the critical stakeholders as well as creating the necessary institutional capacity in the design phase, can be attributed partly to urgency to sign the loan agreement.

External forces were useful for placing issues like efficiency and the need for internal generation of revenue on the policy agenda, but their role only had an adverse effect on the sustainability of the policy because once the gazette was passed, it seemed there was an assumption on all sides that the work had been completed and everyone had got what they wanted: the World Bank had their pre-conditions met and the government had got the loan it was seeking. As a result of this lack of foresight there was no attempt or commitment on both sides to nurture the effectiveness of the policy, such that since 1988 when it was implemented, the policy has never really been reviewed.

6.3.1.2 National Economic Context

The primary factor that placed the 1998 fee increases on the national policy agenda in Lesotho was the economic crisis that prevailed during this time. As a result of this state of affairs, in an attempt to stabilise the economy, the government adopted the structural adjustment program between 1988 and 1992. One of the critical elements of structural adjustment was tight fiscal policies, which effectively reduced government expenditure, including health sector expenditure. The national fiscal crisis experienced by the government at this time, meant that the government was severely short of resources and thus had to find alternative sources to add to the existing resource base. This was the basis for the objective of cost-recovery hence the increase of health care charges.

Structural adjustment meant that resources (such as training, detailed assessment of affordability, time and skills) necessary to facilitate effective policy design and implementation were scarce. Moreover, the associated freezes of promotions and low salaries meant that everybody, including the people expected to collect fees, was experiencing the economic hardship prevailing at the time. In the absence of effective monitoring and evaluation systems it is not surprising that sinister practices such as drug pilfering, bribery and theft of monies were some of the decisive factors hindering effective cost recovery. Thus, given the level of poverty and unemployment the environment was conducive to the abuse of the system by those who were responsible for collecting fee revenue and granting exemptions. Five of the subjects interviewed alluded to these practices as the main hindrances to effective cost recovery and exemption systems.

The policy was a reaction to economic crisis and as such, was not designed to address the real problem of generating sustainable revenue for the health sector or to broaden the resource base for the health sector. From this perspective policy makers were short sighted about the overall goal of financial sustainability. Moreover given the level of social poverty and unemployment, the increase in fees could not be set at levels that would effectively ensure significant improvements in cost recovery.

6.3.1.3 National Political Context

The context of military rule meant that the decision-making processes tended to be top-down in nature and the channels for expressing opposition to government policies

non-existent. With military rule there was no fear of loss of political power (due to fee increases) by the government because there was no culture of democracy. As one of the senior MOH officials stated *"luckily there was no political pressure saying we are afraid to raise fees because people will not vote for us... it would have been very difficult to implement the necessary changes in a democratic setting ."*

With military rule it is probably not surprising that decision-making processes around the policy design and implementation failed to include consultation with the primary stakeholders and that these processes tended to be top-down in nature. Moreover, the absence of a democratic culture with legitimate channels of expressing opposition, meant that policy makers could afford the arrogance to assume that the decisions made around the policy design would pass uncontested. The 'closedness' of the decision-making processes shaping the policy made it easy for policy-makers to define the problem (severe shortage of government resources) and for technical experts to define the solution to the problem (increase user fees).

Also related to the political context, failure to adjust fee schedules to inflation might also be due to a change in the political regime in 1993, as opposed to the lack of commitment to policy objectives or the absence of an official policy document which spells out the implementation plan of the policy. This transition from military to democratic rule brought new interests and a different political agenda... *"democratic politics are not conducive to rational decision making... it's smoother to (implement such measures) under military rule...with democracy there's always interference from all sides...(especially politicians)."* (former senior MOH official and policy task force member). The new democratic government also brought with it new senior officials who were not necessarily sympathetic to financial reforms that had been undertaken during the previous political era. Hence some of the elements of the policy... *"died a natural death."* (program manager and policy task force member).

6.3.1.4 Institutional Capacity

As indicated above, structural adjustment had a negative effect on the resource base of the public sector, the situation was aggravated by the political context, which affected the management culture and established patterns of decision making, which in turn did not encourage consultative decision-making around the policy design. Poor institutional capacity influenced the role of the different actors involved in the design

of the policy. The absence of the necessary local skills to develop the policy might help us understand the influential role played by the external consultant.

Economic malaise and the related tight fiscal policies meant that the resources to effectively train personnel and implement the necessary institutional and structural changes that would facilitate the success of the policy were not available. Hence, there was a lack of foresight by policy decision makers regarding the potential adverse effects of the structural adjustment program on the overall capacity of the government and the MOH in particular, to effectively implement fee increases towards cost recovery and other changes that were being undertaken at the time. For example, if salaries are frozen, staff morale and dedication are likely to be weak. This coupled with the absence of effective management structures and under-developed mechanisms for monitoring and evaluation means that there is a greater risk of theft of monies collected "*...main problems hindering effective cost recovery* include the fact that*...people responsible for collecting fees hold junior positions and are underpaid, so inevitably they do steal money...this is made worse by the absence of functional disciplinary action.*" (former district medical officer). Hence, these other policies had some influence on the potential for cost recovery and thus sustainability.

6.4 THE POLICY CONTENT

Most of the problems associated with hasty implementation of the policy (see section 6.1.1.2.1.3) make up what can be regarded as the policy content. The following section focuses on the critical features of the policy content that have not surfaced in the previous discussion and seeks to assess the potential of the policy as it is designed to realise *financial* sustainability and equity.

6.4.1 User-fees and Financial Sustainability

Although fees were raised by over 200% the new levels were still low relative to fees charged by other providers and they could not realistically have facilitated the targeted 15% cost recovery. Some of the reasons for this include the fact that in calculating the cost per unit of health care service, the policy makers concentrated only on the expenditure on drugs, and did not look at other inputs. Thus, the new fee schedules were not adequately designed to facilitate improved cost recovery. Moreover, as one manager stated, *" ... the recurrent costs that we are trying to recover (even if it is only 15 %) every year are continuously rising at an alarming*

rate ... with high inflation and stagnant fee structures, there is no way we can recover even 5% of the costs ... The costs to the ministry are extremely high and it is hard to keep up." (senior hospital manager).

6.4.2 User Fees and Equity

Fee structures were set low relative to fees charged by other providers, however one cannot say with certainty that fees were set at low levels to ensure equitable access, especially because these levels were not based on any prior assessment of affordability. The fact that the fee policy was a reaction to a shortage of resources meant that equity was not a primary objective in that context. However, one can deduce from the inclusion of the 'the destitute' and the somewhat low fee levels charged (relative to non-government providers), that policy makers had taken marginal consideration of equity. Failure to develop clear criteria for exemptions aimed at protecting these 'destitute' resulted in the ineffectiveness of exemption schemes.

6.4.3 Inherent Contradictions with the Policy Content

The main problem with the policy content is that it is highly lacking in content. The reliance on secondary data to piece together the intended strategies of the policy makes it difficult to conduct a meaningful assessment of policy content. Nevertheless, as part of an incentive for hospitals to recover costs, at the same time that fees were raised there was a lump sum reward over and above the annual budget allocation, to the highest collecting hospital. *"...the problem with this was that although it was an incentive for cost recovery it was also a (disincentive) for expenditure on primary health care services because they do not generate revenue so PHC programs were effectively marginalized."* (MOH program manager). Although this practice is no longer in place, it serves to illustrate that at the time that the policy was designed, the policy makers responsible were more concerned with cost recovery and instilling a sense of competitiveness than they were with equity. As a result, the strategies to promote cost recovery tended to undermine equity, not only in terms of the resulting dis-investment in primary health care but also in terms of geographic equity.

6.5 PATTERNS OF POLICY DESIGN AND IMPLEMENTATION: WRAP-UP

Thus far the analysis has attempted to provide a detailed description of the processes and actors that interacted to shape the user fee policy in Lesotho as well as the context in which these processes took place. The aim of this descriptive analysis was to identify the critical features of the dynamics underlying the design and implementation of this policy, as well as to provide plausible links between these factors and the policy impact on *financial* sustainability and equitable access. The most striking features of the patterns of policy design and implementation are listed below:

- **Failure to develop a comprehensive policy document outlining clear objectives and strategies.**
- **Ineffective exemption strategies.**
- **Fees set at extremely low levels that were not adjusted to inflation rates.**
- **Considerable influence of external factors.**
- **Lack of commitment to and ownership of the policy by health managers and implementers.**
- **Separation of responsibility and accountability (no policy champion).**
- **Hasty implementation**
    - **Failure to generate consensus and a common vision about policy objectives among the relevant stakeholders**
    - **Absence of effective monitoring and evaluation systems**
    - **Unclear collection and billing procedures**
    - **Unclear roles and responsibilities**
    - **Inadequate institutional capacity**
    - **Failure to undertake assessment of ability and willingness to pay**

The current chapter has attempted to provide a description of the specific nature of the processes, actors and contextual factors underlying the patterns of design and implementation of this policy. Inevitably these factors interacted to not only define the policy content but also to influence the success or failure of the policy to realise its

stated objectives. The next chapter outlines the impact of this fee policy on *financial* sustainability and equity.

CHAPTER 7
Results: *Policy Impact*

7.0 Introduction

The evaluation of the 1988 fee policy in Lesotho has proved to be challenging because it is not clear what the objectives of the policy were and whether these objectives were for the health sector or for the government as a whole. The current evaluation will focus on the policy impact from the perspective of the health sector, thus focusing on how the policy contributed to *financial* sustainability in the health sector as well as equity in access to health care and equitable allocation of resources in this sector. The specific criteria for evaluating the policy have been summarized in table 5.2.1 (see chapter 5). The following account addresses both the qualitative and quantitative measures of impact.

7.1 POLICY IMPACT ON EQUITY

7.1.1 Exemptions

Exemption schemes in Lesotho include both direct and indirect exemptions of specific groups, such as prisoners, village health workers and their families, patients under police custody as well as maternal and child healthcare services. In addition, disease categories including tuberculosis, leprosy, epilepsy and psychiatric patients are exempted from payment. Exemption of paupers does not include criteria for the cut-off income point that defines 'a pauper.' Instead the policy relies on qualitative definitions of poverty, which depend on the judgment of chiefs and village health workers. As it has been implemented, the policy has been highly regressive because MOH workers and their families are 'unofficially' exempted in practice. The outcome of this unofficial exemption is that equitable access is undermined because some of those who can afford to pay are not paying while those who can hardly afford to pay (the under-employed and those working in the informal sector) are required to pay. Furthermore, this exemption of the non-poor has the effect of constraining cross-subsidization of paupers by those who can afford to pay.

The scarcity of reliable data on exemptions granted has made it impossible to evaluate the effectiveness of these schemes in actually protecting those who need to be protected and to undertake a comparative analysis of exemptions between different geographic areas. Nevertheless, some data were collected from the National Referral Hospital (also the Maseru district hospital), which appears to be the only place where

such data were available, but there were considerable gaps. Table 7.1.1 below provides a snapshot of the criteria and number of exemptions granted for inpatient services for the years 1995/96 and 1996/97.

Table 7.1.1.1 Number and criteria of exemptions granted. (Inpatient data QEII Hospital)

Criteria	95/96	96/97
Epilepsy	1008	1398
Blood donors	151	147
Tuberculosis	6	72
Psychiatric	91	10
Malnutrition	54	24
Social Welfare	580	44
Community Health Workers	65	63
No reason reported	25	13

Data taken from Queen Elizabeth II Hospital Records

From table 7.1.1.1 above, one can see that exemptions based on socio-economic status (social welfare) are not the primary reason for non-payment, characteristic targeting is more prominent with epilepsy being the main condition for exemption. In 1995/96 only 28.4% of exemptions were received for inability to pay (social welfare), the following year only 2.5%. These fluctuations are mainly due to the poor quality of data. Nevertheless, the patterns of exemption are the same in that characteristic targeting, which is not necessarily equitable, is the main criteria used for granting exemptions. Furthermore blood donors are exempted even though they are not included in the official list of categories to be exempted.

7.1.2 Impact of fee increases on utilization levels

A study conducted in June 1990 concluded that fee increases had had a negative impact on utilization of government hospitals. The results were questionable however because there were concerns that the study was conducted in winter and generally utilization levels especially in the mountain districts tend to be significantly lower than during other seasons because of difficulties reaching health facilities in the snow. The absence of reliable data has made it impossible to reach any conclusions on whether the increase of user fees led to marginalization of those groups that are unable to afford.

7.1.3 Use of fee revenue

The centralized nature of financial management has meant that revenue from user fees is sent to the central treasury of the MOF. As a result neither the MOH, nor the facilities that collect have any control over the revenue collected. In theory, equity is

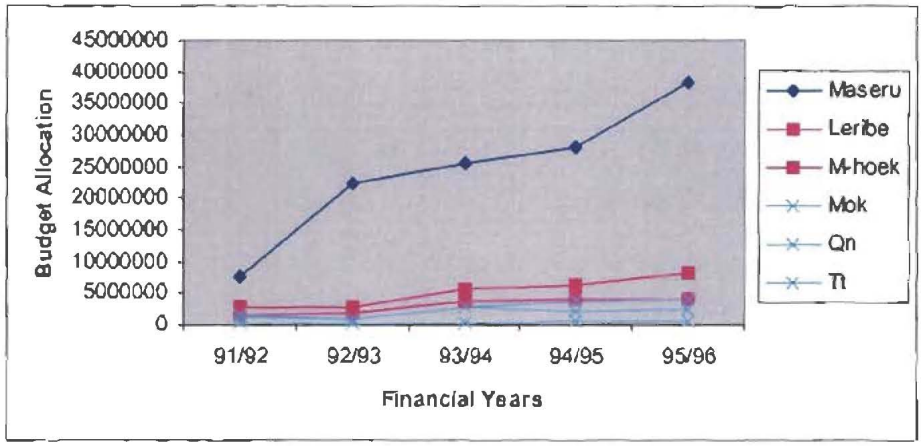
enhanced if fee revenue is retained and used at the point of collection to improve the quality of health care as well as to finance primary healthcare programs. It is believed that quality improvements will benefit the poor because they will not have to seek expensive private health care if they can get good affordable quality care from government facilities (see section 2.1.2.2). In the case of Lesotho, centralized revenue control means that fee revenue cannot be effectively used to realize the potential quality improvements at facility level. Hence from this perspective the policy has not contributed positively to equity in health care.

7.1.4 Geographic allocation of Resources

The relevance of trends in resource allocation by geographic area is that the control of fee revenue is centralised, thus all cost centres revert fee revenue to the central treasury where it is reallocated through the MOF to different sectors and further reallocated by the central MOH to the different districts. Consideration of these trends seeks to illustrate that the methods for allocating resources (including MOH fee revenue) are not designed to redress inequities because the allocation of budgets is incremental (Health expenditure review). The implication of the incremental resource allocation system is that those districts that spend the most are allocated the most while under-spending districts get relatively low budget allocations. Thus the mechanisms for allocating resources tend to perpetuate geographic inequities. (Green: 1992; Gilson: 1988).

Figure 7.1.4.1 below illustrates the inequities of trends in budget allocation between 1991/92 and 1995/96 among selected districts located in different parts of the country. One learns from this figure that budget allocations consistently vary significantly between districts with Maseru receiving the highest throughout the years studied. These variations are reflected in the per capita allocation rates with Maseru having the highest figure, 90 Maloti (US$20)per capita and Thaba Tseka and Mohale's Hoek having the lowest at 25 (US$6) and 24 (US$5) Maloti per capita respectively, thus revealing acute inequities in the patterns of resource allocation. This pattern stems partly from the fact that referral services are provided in Maseru only (Health Expenditure Review, 1996). However, the trends reveal that little attempt is being made to reallocate resources to primary and curative care services in the districts, thus equity is not promoted (see section 2.1.3)

Figure 7.1.4.1 Trends in resource allocation by geographic area



Data taken from *Lesotho Estimates 1991/92 – 1995/96*

Table 7.1.1.2 below provides a summary of the conclusions on the impact of the fee policy on equity, based on the indicators that have been identified.

Table 7.1.1.2 Summary of user fee policy impact on equity

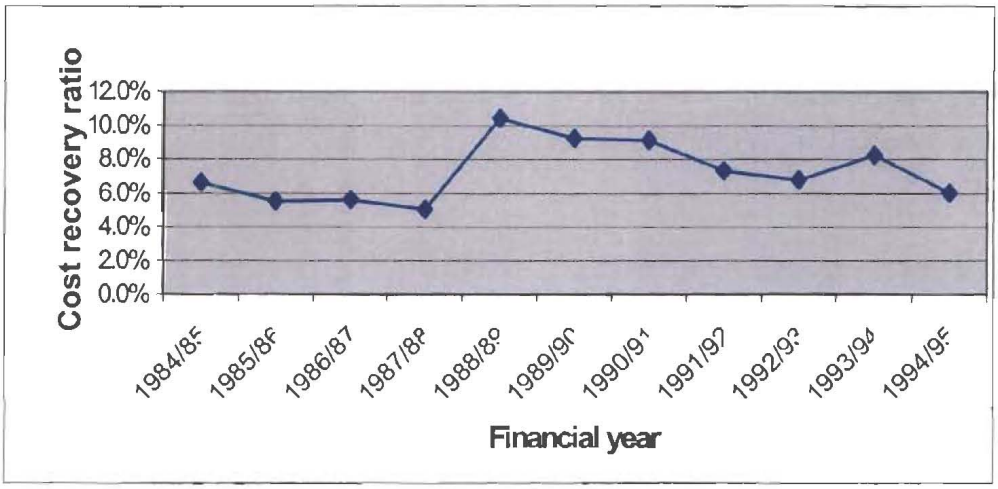
Indicators	Results	Effect on equity
• Exemptions	inclusion of the non-poor ineffective exemption schemes	Negative Negative
• Utilization	Ambiguous	-
• Revenue use	highly centralized revenue control	Negative
• Resource allocation	incremental budget system	Negative

7.2 POLICY IMPACT ON *FINANCIAL* SUSTAINABILITY

7.2.1 Trends in MOH Cost Recovery Ratios

Diagram 7.2.1.1 below indicates that the cost recovery ratio hit its lowest in 1987/88 at 5%. It was also during this year that user fees were increased and the following year the cost recovery ratio increased by over 100% to 10.4% but after that cost recovery fell gradually in percentage terms. In fact since the time that fees were raised until 1994/95 there was only an overall 1% improvement in the cost recovery ratio. Note also that the 19984/85 cost recovery ratio (6.5%) is higher than the 1994/95 ratio (6%), which indicates that the fee policy has had a marginal impact on sustainable cost recovery and thus *financial* sustainability.

Figure 7.2.1.1 Trends in MOH cost recovery ratios



Data taken from Phalatsi, 1991 and *Health Expenditure Review Document*, 1996.

7.2.2 Expenditure, Revenue and Cost Recovery Ratios by Geographic Area

Due to difficulties of accessing data from 1988/89, when the policy was implemented, the analysis has had to rely on data beginning from 1992/93. Since it is trends being considered conclusions could be made about the impact of the policy in terms of cost recovery across different geographic areas. Table 7.2.2.1 below provides absolute figures of expenditure and revenue from 1992/93 to 1995/96 across the different districts.

The table reveals that expenditure has generally been on the rise across the districts especially Maseru, with exceptions being Leribe and Mokhotlong where expenditure fell in 1994/95 and in Mohale's Hoek in 1995/96. Fee revenue increased in absolute terms between 1992/93 and 1993/94, in all the districts except Mohale's Hoek. This improvement can perhaps be attributed to the policy amendment that came into effect in 1992 (see section 6.1.1.2.2). From 1994/95, fee revenue started to fall in Maseru but continued to rise in the rest of districts except Thaba-Tseka and Qach's Nek where it fell 1995/96. These patterns of fee revenue may be due to inefficient billing and collection systems in Maseru and worsening disease burden in the other districts (*Lesotho Health Profile Report*, 1993 and *Poverty & Health in Lesotho*, 1996), which increased demand for health care.

Table 7.2.2.1 Revenue and Expenditure in Absolute Amounts (Maloti, 00)

District	92/93		93/94		94/95		95/96	
	Expend	Revenue	Expend	Revenue	Expend	Revenue	Expend	Revenue
Maseru	19669740	918000	24731020	2100120	29735550	1797500	31731790	1452160
Leribe	3075440	401100	7963160	685770	5627570	761020	7195820	926750
Mohale's Hoek	1855060	571410	3438890	355580	4799280	409600	4014340	499180
Thaba-Tseka	203090	8380	360960	15100	457420	21940	655900	16980
Mokhotlong	1074390	145300	2418690	166260	2132060	196950	2628100	251830
Qacha's Nek	1126990	160050	2192330	117340	3198520	155530	3814700	118830

Data taken from *Estimates of Lesotho 1992/93 – 1995/96*

Table 7.2.2.2 below provides a summary of the cost recovery ratios, comparing the rates for Maseru with the average of the other districts.

Table 7.2.2.2 Cost recovery ratios by geographic area

YEAR	92/93	93/94	94/95	95/96
Maseru	4.7%	8.5%	6%	4.6%
Average for districts (Rural and Peri Urban)	12.4%	5.8%	8.2%	8.12%

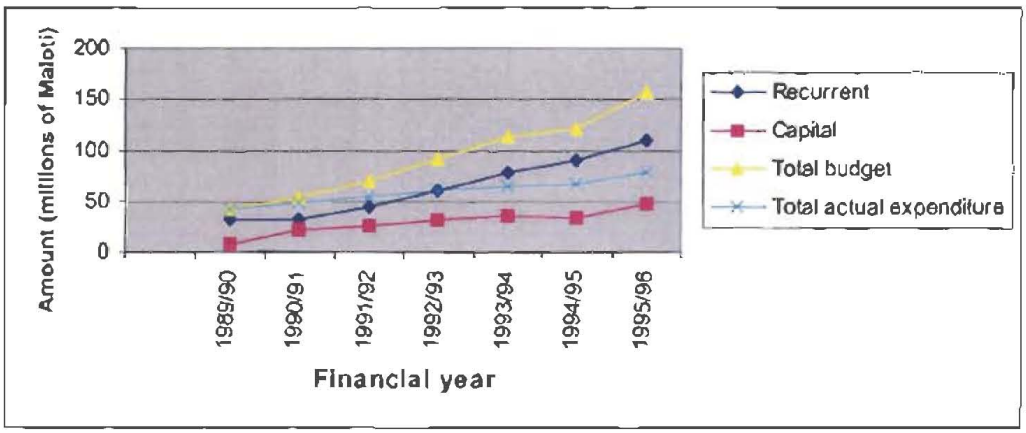
Data taken from *Estimates of Lesotho 1992/93 – 1995/96*

Maseru is prone to overspending (Health Expenditure Review Document, 1996) hence costs recovered are very low. A possible explanation for the higher cost recovery ratios in the other districts is that they are more susceptible to under-spending and therefore appear to be recovering more costs. The assessment on expenditure, revenue and cost recovery ratios across the different geographic areas proves that cost recovery across the different geographic areas is generally poor, with Maseru recovering the least costs, mainly because it spends more. The situation with the other districts appears to be more positive because of perpetual budget under-spending.

7.2.3 Trends in MOH Recurrent Expenditure

A look at the trends in MOH expenditure is useful for assessing the possibility of sustainable cost recovery through user fees. Figure 7.2.3.1 below reveals that over the period under review there was a steady but slow increase in the capital budget. Recurrent expenditure growth was marginal from 1989/90 to 1990/91 most likely due to the structural adjustment program (see section 6.1.3.1.2), after which time there was a definite steady but marked increase. The diagram also reveals persistent under-spending of the total MOH budget with the gap between total budget and actual expenditure becoming increasingly wider overtime. Nevertheless, with rising MOH recurrent expenditure and stagnant fee levels, it is not surprising that cost recovery ratios have been falling overtime.

Figure 7.2.3.1 Trends in Health Sector Expenditure 1989-1995/96

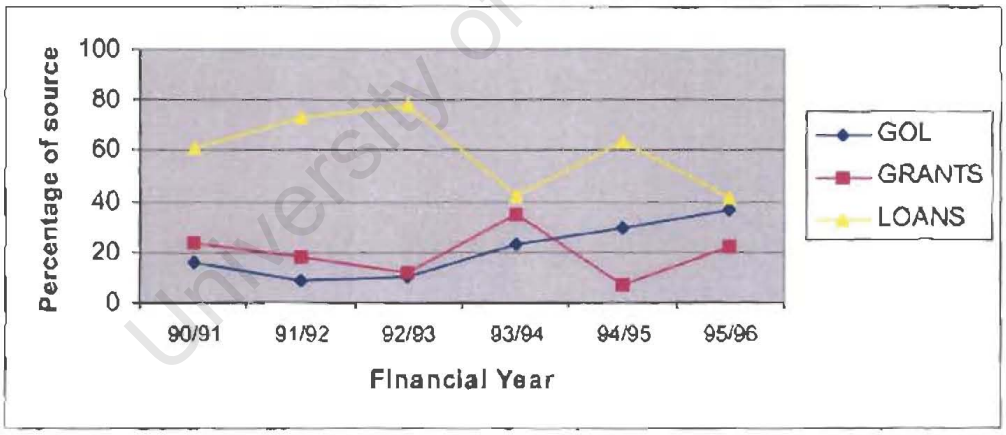


Data taken from *Health Expenditure Review Document*, 1996

7.2.4 Trends in Sources and Volume of Health Sector Finances

MOH finance from external sources illustrates the relative dependence of the MOH on these sources, hence one seeks to assess whether the fee policy effectively reduced dependence on injections of finances from loans and grants. Figure 7.2.4.1 below summarises the trends in sources and volume of MOH finances from the government as well as from loans and grants.

Figure 7.2.4. 1 Trends in source and volume of Health Sector Financing

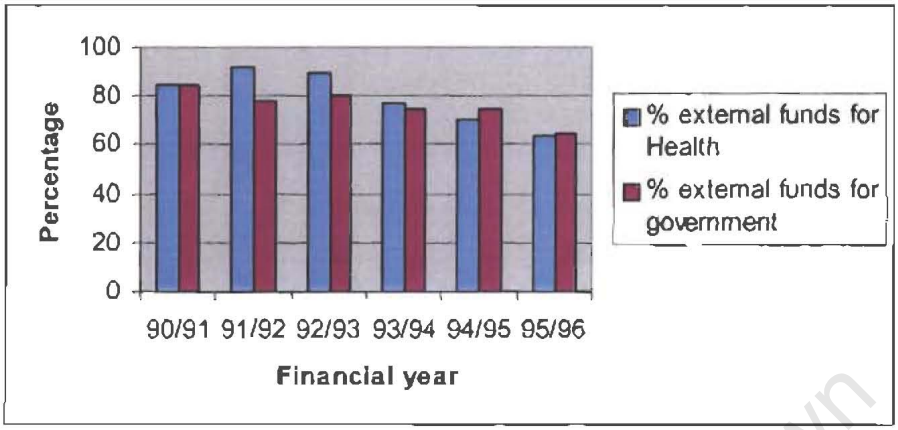


Data taken from *Lesotho Estimates 1990/91 – 1995/96*

During the period reviewed, there appears to be a synchronized relationship between loans and grants, between 1990/91 and 1995/96, in that a fall in the proportion of MOH grants is consistently accompanied by a rise in the proportion of loan financing. In the first three years until 92/93 there is a slight decline in the proportion of health expenditure financed by government. This may be a result of structural adjustment, which limited overall government expenditure including MOH expenditure (see section 6.1.3.1.2). However, from 92/93 the proportion of government financing for the health sector increases steadily and actually increased from 15.6 to 36.5% over this period. Over the same time total external funding fell from 82 to 63%. Figure

7.2.4.2 below shows the patterns of external funding for the health sector relative to external funding for the public sector as a whole.

Figure 7.2.4.2 Comparison between level of MOH and GOL external dependence



Data taken from *Lesotho Estimates 1990/91 – 1995/96*

The percentages of external sources of funding for both the MOH and GOL indicate a slight decrease over time but the figures are still over 60%, which is still considerably high. This apparent reduction in dependence on external financiers cannot be attributed to the fee policy, given the trends in cost recovery (see figure 7.2.1.1) The pattern of increased government contribution to public sector expenditure and MOH expenditure in particular, relative to loans and grants can be understood if one considers the positive change in economic activity due to the Lesotho Highlands Water Project (see chapter 3, section 3.4), the benefits of which were reaped in the early nineties.

7.2.5 Effective Referral System

In theory differential charges for services provided at different levels of the system encourage rational use of health services and thus enhance efficient use of healthcare resources (see section 2.1.3). The 1988 fee policy of Lesotho caters for this pre-condition as charges are different between health centres and hospitals, although they are not different between district hospitals and the national referral hospital. Whether or not health service use is rational or not, is questionable however, especially if one considers the lack of clarity on policy goals (see section 6.1.1.2.1.2). The evidence available points to limited effectiveness of the referral system, hence inefficiencies, which in turn compromise *financial* sustainability.

Table 7.2.3 below summarises the impact of the fee policy on *financial* sustainability.

Table 7.2.3 Summary of the fee policy impact on *Financial* Sustainability

Indicators	**Results**	**Effect on *Financial* Sustainability**
MOH cost recovery ratios	Decreasing overtime	Negative
Cost recovery by geographic area: **Maseru** **Districts (average)**	Decreasing overtime On the increase/stable	Negative Positive but not conclusive
MOH expenditure financed by external financiers	Decreasing	Positive, but not linked to the fee policy
Trends in MOH recurrent expenditure	Increasing	Negative
Rational use of referral system	Ineffective	Negative

7.3 CONCLUSIONS ON POLICY IMPACT

One can conclude from the above account that the success of the policy in contributing towards *financial* sustainability of the public sector and the health sector in particular, has been highly limited. Similarly the performance of the policy from the perspective of equity has been especially poor. The next chapter provides an assessment of the linkages between the policy impact and the critical features of the patterns of policy design and implementation.

Chapter 8

Discussion: *Linking Policy Patterns and Impact*

8.0 Introduction

As indicated in chapter two institutional capacity and the technical aspects of policy contents are often cited as the main causes of poor performance of public sector policies in developing countries. An analysis of the patterns that shaped the 1988 fee policy in Lesotho has revealed that the policy content is essentially a by-product of the underlying dynamics of the processes of, and the actors in the decisions around policy design and implementation, as well as the context within which these processes take place. Hence a broader focus was adopted for this evaluation. The following discussion seeks to establish explanatory links between the critical features of the patterns of the design and implementation of this policy on the one hand, and the policy impact on equitable access and financial sustainability in the health sector, on the other. Specifically these features can be summarised into: Speedy design and implementation of the policy; closed decision-making processes and lack of commitment; failure to clarify goals, objectives and strategies, as well as changes in the national political and economic contexts. The effect of each of these factors on both equity and sustainability is outlined below.

8.1 Speedy Design and Implementation of the Policy

Since the policy was a direct response to the economic malaise experienced by the government during that time, and it was also a precondition for a government loan from the World Bank, both the design and implementation of this policy were undertaken with a sense of urgency. This provides a plausible reason why preparation for the uptake of the policy was wholly inadequate. With regards to the policy design, the content was not based on informed knowledge of factors such as the prevailing institutional capacity, affordability assessments and it was not based on consultative processes with the primary stakeholders. The assumption that an increase in user fee levels would yield the desired improvement in cost recovery meant that policy makers neglected to review the established systems and to consider how these might have historically constrained effective cost recovery or revenue generation. For instance, if adequate consultation with implementers and health care managers had been undertaken, then perhaps problems associated with actual implementation may have surfaced during the decision-making phase, so that effective strategies could be

developed and clarified in the early stages. Thus, speedy adoption of the policy contributed to the failure to define specific strategies for effectively implementing the policy. Moreover, policy processes failed to develop effective channels for checking the policy once it was implemented, as well as to create the necessary capacity to make the policy effective. For instance, managers directly dealing with fee collection and exemptions were not adequately empowered to effect necessary changes and there was no policy champion identified to do this.

Hasty uptake and specifically hasty implementation was the primary constraint of the fee policy as a whole. Since fee increases were implemented at one time throughout the health system, without any attempt to phase or pilot aspects of implementation it was difficult to strategically manage implementation so that desired outcomes could be achieved. As a result, faulty implementation went undetected and consequently became institutionalised as part of the norm, even when it appeared to have contradicted the intended outcomes of the policy. Unofficial exemption of MOH employees provides a good illustration of this point.

Finally, speedy uptake of this policy contributed significantly to policy implementation in the absence of structures that were necessary for executing the policy. Moreover the stakeholders, both primary (implementers and managers) and secondary (other departments such as the government printers) responsible for taking the policy forward were not ready because of poor consultation. Until the present no attempt has been made to rectify this problem, such that problems such as unclear goals and objectives of the fee policy, inadequate institutional capacity and management culture, as well as lack of commitment to the policy objectives continue to severely constrain the achievement of financial sustainability and equity in the health sector.

8.2 Closed Decision-Making Processes and Lack of Commitment

Perhaps due to the urgency of implementing the policy, as well as the prevailing political and management culture of the time, policy makers neglected to consult with health care managers and providers, implementers and other relevant stakeholders in the decisions around the policy design and implementation. As a result implementation of the policy was not accompanied by a common vision, commitment or appreciation of policy objectives/ intentions, especially within the MOH, since they

were excluded from the initial policy discussions. Inadequate consultative processes meant that not only was there confusion about policy goals and objectives during implementation (see section 8.3), but the resultant lack of commitment severely undermined the ability of the policy to realise its intended outcomes. Since the implementation of the policy in 1988, it appears that neither the MOF nor the MOH was committed to effective implementation of the policy, especially because nobody was charged with the responsibility of overseeing effective implementation. There was an assumption that all that was necessary was to raise fees and pass the fee schedule gazette.

The implementation phase of the policy revealed numerous problems, which can be attributed to the failure to generate consensus around the intended policy objectives. This is especially true since the primary stakeholders were not consulted, thus interpretation of the desired outcomes of the policy including the strategies were left to the discretion of implementers. For example, the procedures for granting exemptions to 'paupers' were open to manipulation by traditional leaders not only because there were no transparent criteria for granting exemptions but also because these agents were not consulted and thus did not fully appreciate their role in promoting equity in the health sector. Closed decision-making processes also dis-empowered health care consumers, because of the resultant lack of knowledge about exemptions.

An important outcome of this lack of commitment especially by those directly responsible for the daily implementation of the policy was an extremely poor management culture, which was aggravated by overall poor institutional capacity in the public sector. Lax management is in part responsible for the poor performance of the policy particularly where cost recovery is concerned. Factors such as drug pilfering increase overall recurrent costs for the MOH and thus compromise cost recovery, while unofficial exemptions not only reduce the revenue base but also undermine equity, especially as cross subsidisation of paupers can only be realised if those who can afford to pay actually do so (see section 2.1.3). The persistence of sinister practices and unofficial exemptions do not go unnoticed by managers. However, ineffective management structures coupled with a general lack of commitment from the chief owners of the policy (the MOH at one level and the MOF

at another), have meant that these inefficiencies have become entrenched in the system overtime.

A significant factor that can help explain the somewhat laissez-faire attitude towards the achievement of both *financial* sustainability and equitable access in the health sector, is the dominant roles played by donors and external policy technicians in the 1988 fee policy arena. The need to generate consensus and understanding around policy objectives, as well as to prepare adequately for policy implementation was significantly superseded by the need to raise fees so as to acquire the World Bank loan. External factors were instrumental in bringing to the attention of policy makers the urgent need to seek alternative strategies to generate domestic public sector revenue. However, their dominant role in the decision-making processes undermined any opportunity for sustainable commitment to the intended outcomes of the policy, especially financial sustainability, since revenue generation was the primary rationale for this group of actors. Equitable access was a priority from the perspective of the MOH, thus from the point of view of the top elite policy decision-makers, including external actors equity assumed a secondary status to financial sustainability (see figure 6.2.1.1 and 6.4.2). Failure to institute bi-annual fee schedule adjustments to the inflation rate clearly illustrates the lack of commitment to sustainable cost recovery.

8.3 Unclear Policy Goals and Objectives

The persistence of unclear policy goals and objectives can be partly attributed to the hasty manner in which the policy was adopted. More than just defining the objectives of the policy, the decision making processes shaping the policy failed to clarify how the intended outcomes of the policy were to be achieved and who would be responsible for what. As stated above, there was an assumption that fee increases would improve cost recovery and this is illustrated by the absence of a comprehensive fee policy document legally representing the 1988 fee policy. As a direct result of these factors and the failure to consult with the primary stakeholders, implementation was characterised by confusion around the policy objectives and the strategies for achieving these objectives and this often led to contradicting interpretations. This is particularly problematic in the absence of regular channels for monitoring and evaluating policy implementation. For example the confusion which arose because of differential charges between health centres staffed with doctors and hospitals (see section 6.1.2.1.2) clearly illustrates how failure to clarify goals and strategies

effectively constrains the achievement of policy objectives, in this case the rationalisation of the referral system towards efficiency and thus financial sustainability.

The problem of unclear roles and responsibilities extends to factors such as billing procedures, for example billing of patients who have been referred from district hospitals. Partly due to dysfunctional billing and collection procedures, the national referral hospital lost at least 12% and 15% of revenue from patient debts in 1995/96 and 1996/97 respectively (hospital records). These proportions do not include the revenue lost from official and unofficial exemptions. Although there is consensus within the MOH that real problems exist with the system as it is, it seems there is nobody responsible for rectification. This may be a problem of lacking commitment but also failure to clarify roles and responsibilities as well as billing collection procedures. The situation is further aggravated by the lack of control that the MOH has over financial clerks who are responsible for collecting fee revenue but are accountable to the MOF. As a result, theft of monies cannot be appropriately dealt with and cost recovery is effectively constrained, especially if one takes into account that both the MOH and the MOF have no disciplinary powers over government employees.

From the onset cost recovery was more an initiative of the MOF and the processes of both the policy design and implementation illustrate this (see section 6.2) while equity in access to health care is a responsibility of the MOH. As a result of this dual ownership of the policy and the fact that these objectives are not in essence complementary (see section 2.2.2), overall management of the policy was not taken into account, such that decisions necessary to make the policy effective have been left hanging. For example, although MOH facility managers are aware that much revenue is lost from the exemption of prisoners, they have no real mandate to effect the necessary change and bill the Department of Correctional Services (see section 6.1.2.1.3.2.2). Similarly, the MOH management team seems to have no real powers when it comes to making the policy work.

Policy processes failed to clarify policy goals and objectives as well as to address how these objectives are to be pursued and achieved. Thus, confusion around policy objectives and strategies coupled with failure to streamline factors such as billing and

collection of revenue, exemption procedures, roles and responsibilities, monitoring and evaluation systems as well as incentive systems have opened the system to all kinds of abuse and inefficiencies, which in turn has hindered the ability of the policy to realise financial sustainability and equitable access.

8.4 Changes in National Political and Economic Context

The national economic context in 1988, coupled with dependence on external sources of finance made it necessary for user fees to be increased while the political context allowed for this change to take place without any overt opposition and for decisions to be implemented with limited delay. As mentioned before, since implementation the 1988 fee policy was never reviewed or strengthened. Thus it did not effectively respond to the changes in the national context. This lack of responsiveness was a significant constraint on the performance of the policy. Specifically, one looks at the economic and political contexts.

The economic context of structural adjustment was highly conducive to cost recovery. For instance, tight fiscal policies (from 1988-1992) coupled with fee increases in 1988 led to some improvement in cost recovery ratios: from 5% to over 10% and remained above 8% until 1991/92 (see figure 7.2.1.1). During the same period recurrent expenditure remained low (see figure 7.2.3.1) and the policy appeared to be performing well in terms of financial sustainability. After this period however, recurrent expenditure started to rise, possibly because of the completion of the structural adjustment program and the change to a democratic political dispensation in 1993. Needless to say the rise in recurrent expenditure combined with failure to adjust fee schedules to rising inflation rates led to the fall in cost recovery ratios. On the other hand given increased poverty, unemployment and general economic hardship (see section 3.3), it is not surprising that inflationary fee increases were not implemented. Moreover, economic malaise coupled with the severely inadequate institutional capacity increased the risk of theft of fee revenue and other rent seeking behaviour that effectively undermined both equity and financial sustainability.

Political change from military to democratic rule provides part of the explanation for the rise in recurrent expenditure in the overall public sector including the public health sector. The change in government entailed replacement of senior government officials with new ones and more importantly a new understanding of government

priorities. Perhaps because they were closely associated with military rule, some policies adopted during the previous the political dispensation were implicitly renounced, others like the fee policy were neglected either because from their conception there was little commitment to them (see section 6.3.1.3). As stated in section 8.2, failure to adjust fee schedules to inflation can be understood in terms of lacking commitment due to closed decision-making processes. This factor might also be explained by the political threat to democratic governments (especially new democracies), associated with regular fee increases (see section 2.2.2.2.1). Political change thus compromised what little commitment there was to the fee policy and made it more difficult to institutionalise some of the pertinent changes that would facilitate sustainable cost recovery.

8.5 Conclusion on Linkages

The fee policy was reactionary and a result of external pressure. Thus the processes shaping the policy design and implementation were geared towards adopting the policy as quickly as possible in order to get the loan from the World Bank. The decisions around the policy design and implementation failed to generate consensus through consultation with the relevant stakeholders including implementers. Failure to address the strategies for policy implementation meant that decisions were not viable and perhaps even naive. In the absence of a common vision on the objectives of the policy, not only did confusion become rife once the policy was implemented but practices that effectively undermined the achievement of the policy objectives became deeply embedded in the system. In addition, the dominant role played by external forces had the unfavourable result of undermining the sustainable commitment to the policy from national bureaucrats, managers, and implementers, especially after the loan was signed. The problem was further aggravated by the absence of mechanisms for regular monitoring and evaluation of policy implementation.

Failure of the 1988 fee policy to realize *financial* sustainability can be understood in terms of rising costs associated with the increases in recurrent expenditure and the failure to adjust fee schedules regularly. More than this however, the policy was a reaction to a specific macro-economic problem as opposed to an attempt to generate sustainable recovery of costs. The fact that the policy was a response to macro-economic crisis faced by the public sector at the time meant that equity was not the

primary concern. Thus, exemption of 'the destitute' may have been included for reasons not related to a fundamental concern for equitable access to health care. Because it was a loan precondition, the policy was not effectively designed to survive beyond structural adjustment programs or even the loan agreement. Failure to develop an official policy document serves as evidence of this. The lack of concern about the implementation strategies indicates the assumption by policy makers, that policy change is a function of policy decree only. The sections preceding this have attempted to emphasise that this is mistaken.

CHAPTER 9

Conclusions and Recommendations

9.0 Introduction

The preceding chapter has attempted not only to provide details of the patterns of the design and implementation of the 1988 user-fee policy in Lesotho but more importantly to illustrate how these patterns constrained or facilitated the success of the policy. The aim of the current chapter is to generate plausible recommendations for forging the way forward given the problems with the fee policy mentioned in chapter six. The chapter will begin with a set of general conclusions on the overall patterns of fee policy development and implementation, followed by recommendations aimed specifically at strengthening the processes of policy design and implementation and thus facilitating successful health sector reform. The chapter will close with specific recommendations on the improvement of health financing strategies in general and the improvement of the overall performance of the fee policy.

9.1 General Conclusions

The poor performance of the fee policy can be attributed to a large extent to the underlying process, actor and contextual factors that shaped the design and implementation of this policy. The current section provides a list of the critical features of the patterns shaping the fee policy that effectively influenced the impact of the policy:-

- Decision-making processes around the policy design and implementation were extremely elitist with very little interaction with the healthcare managers and policy implementers, civic groups, community leaders and the public at large.

- Policy processes failed not only to establish clear policy goals and objectives but also to generate consensus around these policy objectives among the critical stakeholders, specifically managers and implementers.

- Close association of the fee policy with structural adjustment programs severely compromised the local ownership and commitment and thus sustainability of the policy. This association also meant that the fee policy

was a reaction to a specific problem in a specific context, thus the focus on equity and *financial* sustainability was tremendously myopic.

- Hasty implementation denied opportunities for sustainable development of a solid foundation from which the policy could evolve because there was limited thought given to strategies through which policy objectives could be effectively achieved. Moreover, the overall organisational and institutional capacity to make the policy happen, were not taken into account when the policy was designed and implemented and these gaps hindered the effective implementation of the policy. Specifically here one is referring to the failure to empower the relevant managers to carry out the necessary decision-making that would strengthen the policy.

- Policy development and implementation was based on the rational approach, which assumes (wrongly) that policy implementation is a matter of policy proclamation and fails to recognise the role of different actors in the policy arena. As a result there was no attempt to develop regular monitoring and evaluation systems that would facilitate effective management of policy implementation and in turn successful achievement of policy objectives.

9.2 General Recommendations for Policy Development and Implementation

Based on the above account on the conclusions related to the problems underlying the fee policy in Lesotho, the current section seeks to provide a summary of specific recommendations aimed at strengthening the development and implementation of health sector and other government reform policies. A list of these recommendations is provided below:-

9.2.1 Clear Goals and Objectives

In the context of the user fee policy, the pursuit of *financial* sustainability on the one hand and equity on the other is essentially contradictory, thus the clarity of these objectives and their strategies cannot be overstated. The clarity of goals goes beyond just declaring commitment to equity or *financial* sustainability but actually being clear on how these objectives are to be pursued, what the anticipated trade-offs are, as well as who is responsible for what. Also related to the clarity of objectives is consideration of how these objectives fit into the established status quo. Needless to

say, the clarity of goals and objectives applies to all policies undertaken by the government including the health sector.

9.2.2 Getting Stakeholders on Board

Policy reform essentially involves a change in the status quo, thus some stakeholders in the established dispensation may be adversely affected by the proposed policy change. It is important that all potential stakeholders are consulted in the early stages of policy development. Some stakeholders are more critical to the success of the policy than others and the role they play in policy development will differ to the role played by peripheral stakeholders. Recognising the role of different factors also helps with the process of generating the support that might be necessary for the success of the policy. Moreover extensive consultation in the early stages of the policy design facilitates a process of gathering essential information about feasible options in so far as effective implementation of the policy is concerned. The process of getting stakeholders on board is not limited to the early stages of policy development but implies the establishment of channels of feedback and dialogue with the critical stakeholders throughout the processes of decision-making.

9.2.3 Articulating and Promoting a Common Vision

In addition to extensive consultation with the relevant stakeholders in decision-making processes, a clear message about the objectives of the policy needs to be disseminated to the critical actors, such as the public, implementers and managers once the final decisions have been made. This is so even if these groups were consulted in the earlier processes of decision-making. The idea here is to generate some degree of support and commitment from the people on whom the success of the policy depends. The dissemination of the policy message needs to be backed with a comprehensive policy document that is legally recognised and accepted. At the stage of policy dissemination opposition to the policy must be anticipated and mechanisms put in place to manage this opposition, even if it means modifying certain aspect of the design or the implementation plan of the policy.

9.2.4 Pro-Active versus Reactive Policy Change

One of the biggest downfalls of the fee policy in Lesotho was that it was a reaction to a specific crisis and was not adequately designed or implemented to achieve *financial* sustainability or equity. Although in pragmatic terms policy making is often

reactionary, for effective policy development the process needs to be pro-active, which essentially implies decision-making based on information about the prevailing status quo and generating comprehensive ways of ironing out problems through effective policy change. Thus, a one off increase of user fees was not sufficient for enhancing *financial* sustainability. To realise equity and *financial* sustainability, a more comprehensive health-financing package incorporating various options for resource mobilisation and allocation mechanisms would have been necessary. The next section explores modes of implementing policies in a more responsible and 'do-able' manner.

9.2.5 Managed Policy Implementation

Admittedly much of public sector policy making is reactionary, primarily because managers and bureaucrats constantly have to deal with regular activities and priorities from day to day. However, reactionary policy change means that policies are often undertaken without adequate preparation for facilitating effective performance of the policy. Specifically, factors such as organisational capacity and resources are often inadequate for the objectives that reactionary policies aim to achieve. Thus when policy change is pro-active, an attempt can be made towards phasing implementation so that all the necessary support structures and resources can evolve with the policy. Hasty implementation thus needs to be avoided at all costs.

9.2.6 Monitoring and Evaluation

An integral part of managed policy implementation is monitoring and evaluation. Once a policy is implemented it becomes open to manipulation by the different actors either because they oppose it or because of differing understandings of the policy objectives. Alternatively, policy implementation might be derailed because of pragmatic issues that may have been overlooked in the policy design. Hence regular monitoring of the policy allows for backlogs to be effectively ironed out in the early stages of implementation and facilitates adaptation and strengthening of the policy in response to experience. Related to monitoring and evaluation is the development of data collection and management as well as feedback mechanisms aimed at informing policy decision-making processes.

9.2.7 Dealing with External Actors

Although it is easier said than done, the role of donors and external policy technicians needs to be managed such that the policies undertaken with or without a donor push, can still generate the benefits for which they are being implemented. Exported policy prescriptions can also be manipulated such that they fit into the overall plans of health sectors. Even if they are prescribed, effort needs to be made to sell the policy to the local stakeholders and some degree of commitment forged. With regards to the role of external technicians in the policy arena, like the other critical stakeholders, their involvement in decision-making processes needs to be managed thus ensuring that the policy outcome is not exceedingly foreign to local understanding and commitment.

9.3 Recommendations for Strengthening Financing Strategies

This section aims to outline recommendations aimed at strengthening the user fee policy in the short-term and health sector financing strategies in the long-term. The recommendations are based on the awareness that any modifications on the user fee policy and health sector financing, are at present beyond the mandate of the MOH and dialogue would have to be undertaken with the MOF. Thus the following recommendations aim to establish the foundation for this dialogue.

9.3.1 Strengthening the Fee Policy

Many problems have been identified with the strategies for cost recovery and exemption schemes. Some of these problems can be addressed from within the organisational structures of the MOH, but others such as accountability of financial clerks and the overly centralised management of financial revenue require extensive consultation with not only the MOF but also the MPS. Nevertheless, factors such those mentioned in section 6.1.4 can be done in the medium to short term. Specifically one is referring to the need to review established billing and collection procedures, clarification of roles and responsibilities, standardised reporting systems (debts and exemptions) as well as putting in place mechanisms for monitoring the collection of fee revenue. Moreover, this review would have to be done with extensive consultation with implementers and managers at the different levels of the system. Equally central to this review, is the need to develop a comprehensive manual that outlines the basic objectives of the policy and how these objectives should be pursued given the current limits of management structures and established decision-making protocols. Lastly, regular monitoring and evaluation as well as

feedback mechanisms need to be put in place. A summary of these recommendations is provided below.

- **Conduct a comprehensive review of established practices related to the policy including:**
  - **Collection and billing procedures**
  - **Clarify roles and responsibilities**
  - **Monitoring and evaluation**
  - **Exemption schemes**
  - **Standardised reporting systems**

- **The above review to be undertaken with extensive consultation with all the relevant stakeholders.**

- **Develop a working document with legal backing to serve as a baseline tool for monitoring and evaluation.**

9.3.2 Development of a Comprehensive Health Sector Financing Strategy

As indicated before (see section 2.1.2), user fees should be part of a broader package for generating resources for the health sector. In the development of such a broad financing strategy the recommendations on policy development and implementation outlined in section 9.2 apply. The current section touches on some of the critical aspects of a comprehensive health financing policy that can effectively facilitate a solid foundation for *financial* sustainability and equity in the health sector. Once again one needs to point out that the mandate for this kind of change is beyond the MOH, as it involves not only the MOF but the MPS and the MEMP and it will take a long time. Some of the central factors for consideration are listed below.

- Given the poor cost recovery ratios associated with the current fee policy, alternative mechanisms for resource mobilisation from within the health sector need to be explored. These alternatives need to be investigated taking into consideration their feasibility within the broader framework of public sector organisational capacity as well as political, economic and social feasibility.

- The fee policy as it is, is inadequate for effecting cost recovery and protection of low-income groups, thus the whole policy needs to be reviewed and modified to make it more effective. Specifically, this would include establishing functional criteria for direct exemptions as well as a review of the current list of official exemptions with a view to maximising payment of those who can afford to pay and effectively protecting those who cannot afford to pay. More importantly is the need to instil systematic evaluation of the policy that will allow for regular review and adjustment of fee schedules. Basically all the problems that have been identified with the policy, as it presently exists, need to be ironed out taking into consideration the recommendations outlined in section 7.2. This revamped policy should be part of a broader strategy for resource mobilisation and allocation.

9.4 End Note

Many of the recommendations that can make the fee policy effective depend on forces outside the MOH. This constraint applies also to most health sector reforms currently being undertaken in the MOH. This however does not mean that health sector reform policy managers ought to feel chastened but rather that policy change will have to be undertaken one step at a time.

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ANNEX I

Some Guideline Questions for Interviews

- Do you know of a written fee policy document that outlines the objectives and strategies of the user fee policy?
- What were the factors that made it necessary for user fees to be raised?
- Do you have any idea how the decisions regarding the policy content etc. were reached?
- Do you think there was adequate consultation with implementers and managers, especially in the districts? What about community leaders and NGO's?
- What kind of preparatory work was done to facilitate successful implementation?
- What changes were undertaken to change the content or implementation plan of the policy? What were some of the reasons for these changes?
- In your opinion what are the main factors that hinder cost recovery in the public health system?
- Do you think the established procedures for exemption effectively protect paupers?

ANNEX II

Coding tree illustrating categorisationused for analysis