

**Managing Actors in South African
Health Financing Reform:
Testing a Conceptual Framework**

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Thesis Presented for the Degree of
DOCTOR OF PHILOSOPHY
in the Department of Public Health,
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Reform: Testing a Conceptual Framework**

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Health financing reforms, especially those aimed at improving equity, are prone to opposition. Those driving health reforms frequently find themselves pitted against vested interests. The thesis explores how best a reform driver might manage other actors in the reform process to achieve key goals. This involves creating and testing a conceptual framework. A review of the international health care reform literature identifies key gaps in knowledge. Additional bodies of theory, mainly from economics, are selected for review on the basis of their potential insight into relationships between reform drivers and actors. Their findings are compared and contrasted and taken forward into a conceptual framework. This is then tested against four case studies of health financing reform in South Africa: geographic resource allocation, health insurance and the removal of user fees, largely between 1994 and 1999, and the reform of the Conditional Grant for Tertiary hospitals, from 2000 to 2002.

Two different approaches are used for testing the conceptual framework. First, key themes about managing actors are drawn from actor interviews in three case studies of health financing reform. With the second, more deductive, approach reform drivers in an additional case study were questioned on every element of the conceptual framework to see whether it provided an adequate description and understanding of how reform processes occurred. These two very different approaches acted as a check against each other but produced similar findings.

The thesis suggests that an awareness of actor characteristics (such as resources, constraints, reputation and interests) can help a reform driver better manage reform development to achieve desired change. Reform drivers should build up teams of actors that can at the very least bring power, technical skills and specialist knowledge to the reform effort. Team building will also require careful consideration of the different forms of motivation appropriate to each actor. Ideally reform drivers should avoid opposing actors. Yet the prevailing context may indicate this is not possible. In such case reform drivers should limit information exchange, present and discuss reforms at a conceptual level, undermine technically any counter-reform design and choose carefully in which arena to fight.

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Abbreviations

AHR	Annual Health Review
ANC	African National Congress
CD	Chief Director
CoI	Committee of Inquiry
COMS	Concerned Medical Schemes (Group)
COSATU	Congress of South African Trade Unions
DG	Director General
DHFE	Directorate of Health Financing and Economics
DoF	Department of Finance
ESA	Eastern and Southern Africa
ESS	Evolutionary Stable Strategies
EU	European Union
FFC	Financial and Fiscal Commission
FTA	Foreign Technical Adviser
GEAR	Growth Employment and Redistribution (Strategy)
GDP	Gross Domestic Product
GNU	Government of National Unity
GP	General Practitioner
HCFC	Health Care Financing Committee
HSP	Hospital Strategy Project
HST	Health Systems Trust
IDASA	Institute for Democracy in South Africa (formerly Institute for a Democratic Alternative for South Africa)
MEC	Member of the Executive Council (Provincial Minister and member of Provincial Cabinet)
MINMEC	Shorthand name for decision-making body consisting of the National Minister of Health and the nine MECs for Health
MS	Medical Schemes
MSR	Medical Schemes Reregulation
MTEF	Medium Term Expenditure Framework
NAMDA	National Medical and Dental Practitioners Association

NDoF	National Department of Finance
NDoH	National Department of Health
NGOs	Nongovernmental Organisations
NHA	National Health Accounts
NHCC	National Hospitals Coordinating Committee
NHI	National Health Insurance
NHS	National Health System
NIE	New Institutional Economics
NITER	National Increment for Teaching, Education and Research
NUD*IST	Non-numeric Unstructured Data, Index Searching and Theorising (Qualitative data software programme)
OECD	Organisation for Economic Cooperation and Development
PDoH	Provincial Department of Health
PHC	Primary Health Care
PHRC	Provincial Health Restructuring Committee
PPI	Public Private Interactions
RDP	Reconstruction and Development Programme
SAZA	Shorthand name for research project: “Evaluating health care financing reforms in South Africa and Zambia.”
SHI	Social Health Insurance
ToR	Terms of Reference
UNICEF	United Nations International Children’s Fund (formerly United Nations International Children’s Emergency Fund)
USA	United States of America
USAID	United States Agency for International Development
VAT	Value Added Tax
WG	Working Group
WHO	World Health Organisation

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Executive Summary

Health reform is inherently political. It often causes significant conflict because it redistributes resources. Health financing reforms, especially those aimed at improving equity, may be especially contentious as they challenge vested interests. Over the last twenty years countries throughout the world have embraced health reform as they battled with limited resources and growing needs. The results have been mixed. Powerful opposition groups often shape and even defeat reform. Consequently, the process of reforming a health system cannot be properly understood without reference to the impact, actual or intended, of the reform on key actors and their likely response. It is crucial that those who are in charge of reform have an appropriate understanding of reform processes to be able to offset opposition and push through valuable change.

The aim of the thesis is to understand reform from the perspective of a reform driver wishing to pursue change in the face of potential opposition. A reform driver is defined as an individual or institution that takes responsibility for coordinating the development of a reform towards a desired outcome. Thus the thesis sets out to evaluate how a reform driver can best manage other actors to attain the desired end goal. To achieve this aim a conceptual framework is developed and tested against the experience of health financing reform in South Africa. This explores the options available to a reform driver to bring about reform in the face of opposition and evaluates alternative strategies.

The conceptual framework is derived from both international health reform experience and a comparison of relevant bodies of theory. First, the existing literature on health reform and health care financing reform is reviewed to establish what is currently known, and not known, about managing actors in health reform. Key gaps in knowledge are identified and additional bodies of theory are selected for review on the basis of their potential insights into these issues. Each theory is explored and their insights compared, contrasted and taken forward into the development of the conceptual framework. Three of the four bodies of literature chosen are drawn from economics (Principal-Agent Theory, Transaction Costs literature and Game Theory).

Each highlights different aspects of relationships and their comparison is useful in thinking through the range of alternative strategies available to reform drivers. Such an economic approach to what is essentially the politics of health financing reform is unusual but economics offers valuable insights into behaviour. It explores how individuals and institutions behave under certain conditions and how they react to different types of relationships and incentives. Nevertheless, economics does not explicitly model power and this proves ultimately to be an important omission.

The conceptual framework presented sets out to explore the strategic choices available to a reform driver and the key factors that will influence his or her decisions and relationships. It assumes that there exists a reform driver who is responsible for change in health financing reform development. The reform driver proceeds to decide, and act, on how best to bring about this change by engaging with other actors, keeping in mind:

- the resources needed to take forward reform
- his own constraints in taking forward the reform
- the characteristics of other actors (including their resources, constraints, interests and reputation)

The model then considers the dynamics of relationships between reform drivers and actors in health reform development. Eight working hypotheses are derived to be tested against four case studies of health financing reform in South Africa (Chapters 7 and 8).

Before testing the conceptual framework, the thesis outlines the overall experience of health financing reform in South Africa. In response to the appalling legacy of apartheid the new government in 1994 undertook a broad package of health reforms on top of institutional change. Key priorities were to improve the equity and efficiency of health care delivery. Three strands of health financing reform (user fees, geographic resource allocation and social health insurance) were seen to be important vehicles for change between 1994 and 1999 and form the case studies explored in Chapter 7. Policy proposals concerning user fees and health insurance were developed largely through a series of committees, while the resource allocation reforms emerged from routine budget processes. From 2000 to 2002 changes to the Conditional Grant

funding of Tertiary Hospitals were developed and this forms the fourth case study in Chapter 8. Despite early gains with free health care and the redistribution of resources across geographic areas, progress towards improved equity slowed and proposed health financing reform started to meet substantial opposition in the late 1990s from several actors, including National Department of Finance, better-off provinces and Medical Scheme Administrators.

The thesis then tests the working hypotheses of the conceptual framework against the South African case studies by using different, but complementary, methods. The first approach, in Chapter 7, draws out key themes on managing actors from actor interviews in three case studies of health financing reform: resource allocation, health insurance and user fees. This grounded approach allows ideas to emerge from interviews with key policy makers, analysts and actor representatives. These ideas are then tested against the elements and working hypotheses of the conceptual framework. The second approach (in Chapter 8) uses the components and expected findings of the conceptual framework as a foundation for interviewing. In this case the reform drivers of the Conditional Grants reform are questioned on every element of the conceptual framework to see whether it provides an adequate description and understanding of how reform processes and actor management occur.

These two very different methods act as a check against each other. Yet, their findings agree on very many issues. The case studies paint a more complex picture of the realities of the reform process. Some of the basic tenets of the conceptual framework reflect actual practice in reform management. For instance, both sets of findings agree that reform drivers do take responsibility for reform processes and often engage with other actors to offset their own weaknesses. Nevertheless, reform processes are also hostage to the prevailing context and other processes that are already in existence. The framework thus over-simplifies the process of reform and its omission of power is a key weakness.

The thesis produces several insights into both the methodology of conducting health reform research and the practice of managing actors in health financing reform. Key methodological findings are:

- Comparing and contrasting relevant bodies of theoretical literature to fill gaps in existing knowledge may allow for the generation of more useful conceptual frameworks for understanding health reform and health policy processes.
- Ideally a conceptual framework should be tested using different methodologies to allow crosschecking. Where time and resources do not permit this, then researchers need to be clear about the potential weaknesses in their methodology.
- Economics can provide insights into actor management, which requires an understanding of information, strategic behaviour and motivation and an exploration of alternative courses of action. Nevertheless, a solely economic approach will miss key forces and fail to understand policy processes in all their complexity. In particular issues of power and context are important determinants of behaviour and reform development.

The testing of the conceptual framework produced the following findings:

- Reform drivers must recognise when there are windows of opportunity for the pursuit of successful reforms. However the case studies caution against trying to do too much in such times because of limited resources for reform.
- Reform drivers differ and, consequently, their actor management strategies will also vary. The case studies highlight three different kinds of reform drivers: powerful policy makers, government analysts and academic analysts, each with different characteristics and requirements.
- To build effective coalitions and teams reform drivers must combine power, technical skills and specialist interest, from the team members, along with any other characteristics needed for the policy task.
- It is also important for reform drivers to consider different forms of motivation of the actors on the team, to guarantee their effective collaboration, whether relating to the outcome of the reform, the ideology of the reform or its process.
- It is important to undermine opposing streams of reform by weakening their power and undermining the technical worth of the competing reform design
- Ideally reform drivers should avoid engaging with opposing actors, but where this is not possible they should limit the sharing of information, debate the reform at a conceptual level and be prepared to negotiate away peripheral areas of the reform to secure buy in.

The thesis provides a detailed investigation of the characteristics of reform drivers and actors and the effect that these characteristics have on engagement strategies, the form and rules of relationships and strategic behaviour in developing reforms. This thesis suggests that an awareness of actor characteristics can help a reform driver better manage reform development, through building teams, to achieve the desired change.

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Chapter 1: Introduction and Rationale

1.1 The Political Economy of Health Care Financing Reform

Of fundamental concern to health economics is the distribution of limited health sector resources to meet infinite wants and needs. In developed countries an ever-increasing proportion of national resources is being consumed by health care infrastructure (McCarthy and Hoffmeyer, 1994). This has raised concern about cost escalation, efficiency and the equity of the distribution of these resources (Maynard and Hutton, 1992). In developing countries, many governments struggled with structural adjustment and a shrinking domestic resource base, prompting them to consider new mechanisms of financing and providing health care services (Gilson and Mills, 1995; Hotchkiss *et al*, 1998; Collins *et al*, 1999; Hearst and Blas, 2001). As countries battle with a shortage of resources and ever growing and changing needs they will reform their systems of health financing and provision (Cooper, 1994; Ogunbekun *et al*, 1999; Maynard and Kanavos, 2000).

The scope of health care reform is broad. It covers four major areas (Berman, 1995): the package of benefits, financing, organisation of provision and consumer demand/behaviour. While financing reform is the main concern of this study, there are essential links between the four reform elements. Financing can never be isolated from the other components. Indeed, it must be at the heart of a health reform process (Gilson *et al*, 1999). Financing affects what can be provided and how, through incentives. It also impacts on consumer demand (e.g. through pricing policy). Financing reform itself covers the adoption or amendment of a range of financing mechanisms which include general taxation, user fees, private health insurance, social health insurance and community prepayment schemes (Sorkin, 1978; Mills, 1983; Akin, Birdsall and De Ferranti, 1987, Kutzin 1995i; and Hsiao, 1998, amongst others). Such financing reforms are often combined in a package or with other, non-financial health reforms (Gilson *et al*, 1999). Indeed, it may be that the art of health financing is to choose a package of complementary reforms to meet key objectives (Hsiao, 1998).¹

¹ For instance, the collection of user fees at lower levels of care is widely seen as being a form of health financing which often contributes little to the pursuit of equity (Yoder, 1989; Sauerborn, Nougara and

However, trying to change the status quo costs. First, there are the expenses involved in changing and implementing the design of a financing package (Gilson and Thomas, 2003). These may relate to training of staff and the development of new systems and so on. Other costs may arise from dealing with broader concerns and interests than the purely technical (Walt and Gilson, 1994; Berman, 1995; Reich 1994 & 1995; Barker, 1996). Grindle and Thomas (1992) note:

"Solutions to any given set of policy problems are not obvious ... because the logic of economics and the logic of politics frequently do not coincide, and because real costs are imposed on specific groups in society when policies and institutions are altered." (p2)

Indeed, Barker (1996) notes that the design and implementation of policies are all about allocating resources, distributing power and deciding whose needs come first. As reform embraces wholesale change, it will reallocate resources and therefore cause conflict (Grindle and Thomas, 1992; Reich, 1995). Reform is therefore inherently political (WHO, 1993). Financing reform - dealing with who pays and who benefits - is especially contentious. This potential for conflict is often conveniently forgotten in the practice of reform development. For instance, the World Development Report, 1993, with its emphasis on allocative efficiency, tends to consider reform only from a technical perspective (World Bank, 1993). Issues around implementation and the management of opposing stakeholders are ignored (Reich, 1995; Gilson, 1998; Hearst and Blas, 2001).

Indeed a small but growing body of literature, particularly for developed countries, is documenting opposition to reforms and the effects of resistance on the reform process. In the developed world, Swenson and Greer (2002) note the withdrawal of support from big business as a major contributor to the failure of the Clinton health reforms. Oliver and Dowell (1994) consider the failure of health insurance reforms in California because of strong opposition. The importance of the medical profession as an opponent to financing reform is noted in Australia (Duckett, 1996) and Canada

Latimer, 1994; UNICEF, 1995; Nolan and Turbat, 1995; Gilson, Russel and Buse, 1995). To introduce such a reform into a package focussed on pursuing equity may be unhelpful and possibly even counter-productive.

(Williams *et al*, 1995). In Sweden, market-based reforms unravelled in the face of opposition from politicians, administrators, health professionals and the public (Harrison and Calltorp, 2000). There is less literature for reform processes in developing countries but opposition has also been noted (Hotchkiss *et al*, 1998; Nandraj *et al*, 2001; Blas and Limbambala, 2001).

Concerns about likely opposition to reforms will be uppermost in the minds of political leaders. They will want to know how reforms affect different groups in society and will tend to favour reforms which produce the least opposition. Jean Baptiste Colbert, the French chancellor, is reported to have said that:

“the art of taxation is so plucking the goose to extract the maximum number of feathers with the least possible amount of hissing” (Sargent, 1899).

Minimising “hissing” is also a priority for those managing reforms. Indeed, some reforms appear to be more politically dangerous than others. Both Olson (1965) and Nelson (1989) note that redistribution to the poor often meets the most opposition. Urban middle classes tend to be organised, with a loud voice. In contrast, rural and low-income populations are usually dispersed and lack the economic means to influence policy. Consequently, the concerns of the rich and influential are seldom overlooked (Grindle and Thomas, 1992, p3). For instance, Peters *et al* (1999) note the bias in many African countries toward financing health services for the benefit of the better off. Further, in one of the few published studies of the politics of health financing reform in the developing world, Glassman *et al* (1999) comment on the obstacles facing government in dealing with powerful interest groups who stand to lose from change.

“One of the most important and complex problems in the process of health reforms is the management of these short-term, concentrated costs, and of the powerful groups affected.” (p115)

Under such circumstances financing reform, and particularly that directed toward equity, needs very careful handling. Reforms which tend to shift resources away from the organised wealthy to the marginalised poor are likely to meet loud opposition.

What strategies are available to those seeking to drive reform in such circumstances? Bloom (2001) highlights the importance of the government in such a process to “manage change” toward the achievement of equity objectives. This involves an ability to negotiate with stakeholders and build coalitions. Collins *et al* (1999) note the importance of understanding the interests, ideologies, strategies and activities of actors involved in the reform process. Indeed, significant recent effort has been put into “stakeholder analysis”, which involves mapping out the power and interests of actors in the health sector (see Crosby, 1992; Brugha and Varvasozszky 2000; Varvasozszky and Brugha, 2000). Nevertheless, this work often stops short of proposing strategies for managing actors. While some authors maintain that these concerns are only relevant when actually implementing reforms (Reich, 1994), others see that the setting of a policy agenda and the development of policy proposals is also a time for dealing with actors (Burns, 1969; Kingdon, 1984).

“Policy may be the outcome less of carefully considered analysis and decision making than of political bargaining in complex and crowded arenas.” (Jenkins, 1978)

The way policy is *formulated* is critical in creating support and silencing opposition (Schattsneider, 1960)². Managing actors is important at all stages of policy development. One approach to this problem presents policy makers with a choice from a toolbox of generic strategies (Reich and Cooper, 1996; Glasmann *et al*, 1999). However, this menu approach does not indicate the appropriate conditions for implementation of different strategies. Indeed, without a better understanding of some of the theory behind strategic choices and tools, the best efforts of policy makers may be ineffective.

Nevertheless, there is room for hope even if there is currently little common knowledge in this area. Bloom (2001) argues that there are examples where equity-based reforms have been successfully pursued even in the face of opposition (see also Moore, 1999a; Birdsall and Hecht, 1997). Reich (1995) notes the achievement of

² “All forms of political organisation have a bias in favour of some kinds of conflict and the suppression of others because organisation is the mobilisation of bias. Some issues are organised into politics while others are organised out.” (Schattsneider, 1960)

equity-based health reform in relation to essential drugs in three developing countries, Sri Lanka, Bangladesh and the Philippines, all in the face of vocal opposition. Such examples are explored in Chapter 2 to discern both winning strategies and gaps in the existing health care financing reform literature in relation to managing actors in financing reform. As argued above, it is important for any manager of health financing reforms to understand these issues when planning and implementing reform. Strong opposition will shape and even defeat reform if not handled well, particularly where equity goals are paramount. While there are some success stories there are more of failure, and probably even more cases where reforms were not even attempted because of anticipated opposition and a lack of support.

The topic of managing actors is then the focus of this thesis. I will derive a conceptual framework for managing actors in health financing reform, then test it against the experience of the South African health financing reform programme in the post-apartheid era. While there are many potential sources for deriving such a conceptual framework I choose to take the unusual approach of utilising bodies of economic theory. As noted, economics deals with issues of scarcity. In particular it examines different methods for allocating scarce resources in the face of many needs. One of the key issues facing reform drivers is how to handle scarcity and the reactions of actors to proposed changes in resource allocation. While neoclassical economics may be less helpful because of its restrictive assumptions (Mills *et al*, 2001), one recent branch of economics, New Institutional Economics (NIE), may be particularly useful. As the name implies NIE focuses on institutions. It examines relationships within the context of institutional structures and relationships across different institutions within a societal context (Benson, 1975; Weimar and Vining, 1996). It explores how the *structure* of relationships and their environment impacts on the allocation of resources and subsequent behaviour. The insights offered into behaviour within institutions, and interactions between institutions, may be helpful in understanding the challenges faced by reform drivers in managing other actors in the reform process.

1.2 Research Question and PhD Structure

The key question addressed by the thesis is how can actors driving health financing reform best manage other actors? Specifically, the thesis explores the range of

strategies that can be employed to bring about reform in the face of opposition. Reform managers, whether within or outside government, must often tackle weaknesses in the current financing of health care. They do this by developing new policies. As noted, however, such changes often produce conflict because of their potential to redistribute power and resources. My approach to this problem focuses on key stakeholders in reform development and explores their decision-making processes, motivating factors and behaviour.

It is useful at this stage to clarify definitions of important terms that will be used throughout this thesis. First, a reform driver is an individual or institution that takes responsibility for coordinating the development of a reform towards a desired outcome. There are thus two elements to the job of a reform driver. One is to oversee the processes involved in reform development and the other is to have in mind some sort of end-goal or design for the policy. The latter may not be particularly clear but nevertheless should guide the interventions of the reform driver in coordinating the reform processes. Second, the terms actors and stakeholders are taken to be the same, though actor is more frequently used. An actor is an individual or institution which has an interest in a policy or reform and who is able to influence its design or implementation through his or her actions. The focus of the thesis is thus how reform drivers take forward reforms and deal with other actors in the process.

Following this introduction, Chapter 2 contains the Literature Review. This explores the nature and scope of health care financing reform, and reviews what is and what is not currently known about managing actors in such reform processes. Chapter 2 ends with a summary of important features that must be part of a conceptual framework for managing actors in health financing reform. Chapter 3 explores key bodies of literature from new institutional economics and management to see what light they can throw on management of actors in reform from a theoretical perspective. The literature's focus on incentives, forms of engagement, information and objectives provides a foundation for the development of a conceptual framework. The findings of each theory are then compared to feed into the conceptual framework. This is derived in Chapter 4 from the findings of Chapters 2 and 3. The conceptual framework models the range of options available to the reform driver in managing other actors. Chapter 4 also contains a discussion of the predictions of the conceptual framework, to allow for their testing against the South African evidence. Chapter 5

pauses to discuss the strengths and weaknesses of the different methods used to test the conceptual framework. Chapter 6 focuses on the broad experience of health financing reform in South Africa. It maps the important actors involved in health financing reform and outlines the major policy processes and methods of engagement between these actors. This contextualises the research question within the health reform process of South Africa. In Chapters 7 and 8, the predictions of the conceptual framework of Chapter 4 are tested against actual experience. Chapter 9 then discusses the changes that need to be made to the conceptual framework; draws conclusions, and makes recommendations.

1.3 Contribution to Academic Literature

The underlying aims, objectives and methods of policy processes within the health sector are often unknown. Nevertheless, for those wishing to influence government, they are important. One of the key aims of the thesis is to understand reform from the perspective of a reform driver wishing to pursue change in the face of potential opposition. Such a perspective would provide new understanding of the health reform process and health policy dynamics for analysts; for those wishing to monitor and evaluate reforms, and for those charged with developing and influencing health reforms. In particular, it stresses key barriers to the successful implementation of financing reform and - perhaps more importantly - evaluates the strategies available to the reform driver in response. The review of South Africa's experience in health financing reform then provides an important test for the framework while also allowing an analysis of financing reform processes in one setting. Further the use of bodies of economic theory to derive the conceptual framework links together economics and health policy in an unusual way. It seeks to allow more recent insights from the economics of institutions, behaviour and motivation to illuminate dimensions of health reform and actor management. This is a quite different approach to the analysis of health policy and reform processes.

The specific contributions of the thesis are:

- Improved knowledge of the policy processes that may inhibit or promote the development of health financing reform.

- A better conceptual understanding of the range of options open to reform drivers in managing other actors in health financing reform development.
- A strategic tool, grounded in both theory and practice, that can be used to help reform drivers manage actors in financing reform by outlining the strengths and weaknesses of different choices.
- Insight into the management of competing agendas in the development of health financing reform.
- Understanding of the most effective strategies to manage actors in different types of health financing reform.
- New insights into the power of economics to explain and highlight key strategies for the management of health reform.
- Improved knowledge of the South African health care policy process, with an assessment of strategies used by the government in its development of health care financing reforms.
- Recommendations for future management of actors in policy processes in South Africa and other countries engaged in health financing reform.

1.4 Specific Objectives

The specific objectives of the thesis are to:

1. Explore the need to manage actors in health financing reform development (*Chapters 1 and 2*).
2. Explore the tools available for managing actors in health financing reform (*Chapters 2 to 4, 7 and 8*).
3. Explore the conditions under which such tools work well (*Chapters 3, 4, 7 and 8*).

4. Develop a conceptual framework that highlights the choices available in managing actors in financing reform and that can predict the likely impact of such choices under specific conditions (*Chapters 4 and 9*).
5. Develop a conceptual framework that can guide best practice in the management of actors in South Africa and other countries involved in health financing reform (*Chapters 4 and 9*).
6. Investigate appropriate methods for constructing and evaluating the conceptual framework (*Chapters 1 and Chapter 5*).
7. Test and refine the model against the practical experience of health financing reform in South Africa (*Chapters 6, 7 and 8*).
8. Develop recommendations for managing actors in South Africa and, more generally, for the international community (*Chapter 9*).

1.5 Overarching Methodology

It is useful to examine in this introduction some general methodological issues of the thesis. (A more detailed discussion of sampling, data collection and verification of results is presented in Chapter 5.) In developing and testing the model of managing actors in health financing reform I have chosen to rely mainly on qualitative research. The latter involves methods of naturalistic enquiry to observe people in their social settings, describing in words (rather than numbers) the qualities of social phenomena (Bowling, 1997). Qualitative methods include interviews, focus group discussions, observation and analysis of records and documents. They are better able to gain insight into complicated issues and are more useful in studying new topics (*ibid*). The data often have a wealth and complexity lacking from quantitative data.

The research uses qualitative analysis both to build up and test a conceptual model for managing actors in health financing reform. As such the research shares some standard methodological steps with other qualitative studies (Miles and Huberman, 1994). These are shown below:

1. Development of an initial conceptual framework, along with research questions
2. Development of a sample frame and selection of data collection tools
3. Collection of data
4. Coding of data
5. Presentation of interim conclusions (including both descriptive and explanatory displays)
6. Verification and revision of interim conclusions
7. Presentation of conclusions and results, with implications for theory, policy and action.

Such a qualitative approach is, in this thesis, linked with an exploration of South African case studies in health financing reform. A case study can be defined as a form of intensive research to examine causal processes (Connolly, 1998; Thomas, 1998). Typically, the case study approach deals with only a few cases, and often just one (Carroll and Johnson, 1990; Thomas, 1998; Hammersley and Gomm, 2000). The aim is to understand the phenomena in all their richness and context (Carroll and Johnson, 1990; Yin, 1994; Hammersley and Gomm, 2000).

The current research question lends itself particularly well to the case study approach for the following reasons:

- The complexity of health financing reform means that policy makers are beset by many concerns in their decision-making (see Chapter 2). Qualitative research is an appropriate tool for exploring this complexity.
- The topic is new and little conceptual groundwork has been done. The flexibility of qualitative research allows theories to emerge and be tested (Glaser and Strauss, 1967). Case studies often allow the unanticipated to be recorded (Carroll and Johnson, 1990). Nevertheless, after Silverman (1993), I take care not to rely solely on the *grounded theory* approach as this may hide the conceptual biases of the researcher and miss existing useful bodies of literature. (My approach is discussed further in the next section.)

- In any policy elite there may not be many actors and even fewer reform drivers. This is exemplified by the South African case studies; see Chapters 6, 7 and 8. The typical small sample size of interviewees within case studies and qualitative analysis (Miles and Huberman, 1994; Thomas, 1998) may fit neatly with the investigation of health policy dynamics in a relatively small circle of players.

It might be argued that generalisation may be less justifiable outside the South African context. However, the conceptual framework, set out in Chapter 4 and tested against the South African case studies, is derived both from international experience and bodies of theory. It is therefore hoped that the conclusions and recommendations can and will be further tested in different contexts.

1.5.1 Deductive vs Inductive Approaches

It is useful to contrast deductive and inductive reasoning and consider what role each plays in the methodology of the thesis. Deductive methods begin from theory and lead to the development of hypotheses that can be tested. Inductive methods start with data collection and analyses; from these ideas and theories are then generated. Much qualitative research employs primarily inductive reasoning (Silverman, 1993; Bowling, 1997; Miles and Huberman, 1994). Researchers observe phenomenon and derive theory from what they see (Glaser and Strauss, 1967; Merton, 1968). Nevertheless, there are dangers in this approach. First, there is question of the legitimacy of generalisation from case studies. This objection to inductive reasoning can be traced back to Hume (1894), who argues it is invalid to move from the specific to the general. Further, Kuhn (1970) notes that what researchers see depends not only on what they examine but what they have been *taught* to see by prevailing schools of thought and culture. Researchers are affected by the scientific paradigm in which they are situated. Others go further to say that such influences may be highly personal (Chalmers, 1995). The perceptions of the researcher always shape the interpretation of data, to make conceptual leaps and synthesise results (Wolcott, 1982). Bowling (1997) comments that what qualitative researchers *can* do is to make their assumptions explicit and within that constraint be as rigorous as possible³.

³ Such issues can be traced back to the classic historical debate in philosophy between the British Empiricists and the European Rationalists. The former have no place for the activity and workings of the mind, merely allowing sensory data to imprint themselves on the mind as complete and intelligible (Locke, 1976; Hume, 1888 & 1894). The latter are concerned with the synthetic ability of the mind not

The deductive approach, starting with the theory, opens the inquirer to the charge of bias in findings i.e. making the facts fit the theory. This is, on the face of it, a valid concern. Deduction risks missing fresh insights offered by the data (Yin, 1994). The way round such a potential problem may be not to attempt to validate a theoretical model but to see where it can help explain findings and where it needs to be refined or set aside. By grounding the theory in a literature review and consideration of key questions, relevance can be maintained. As long as care is taken to explore other avenues that may emerge from the data and to test the theory honestly, then the charge of bias can be refuted. Noting where the theory is less useful and where findings contradict expected outcomes is good practice.

The thesis employs a combination of deductive and inductive approaches. This may well be good practice for policy analysis (Thomas, 1998) and the application of economics (Hodgson, 1998).

The research is *deductive* in that:

- General concepts and ideas for managing actors have been taken from relevant bodies of literature.
- A conceptual framework has been developed from these ideas.
- The conceptual framework and its predictions are tested both against the data and with reform drivers.

The research is *inductive* in that:

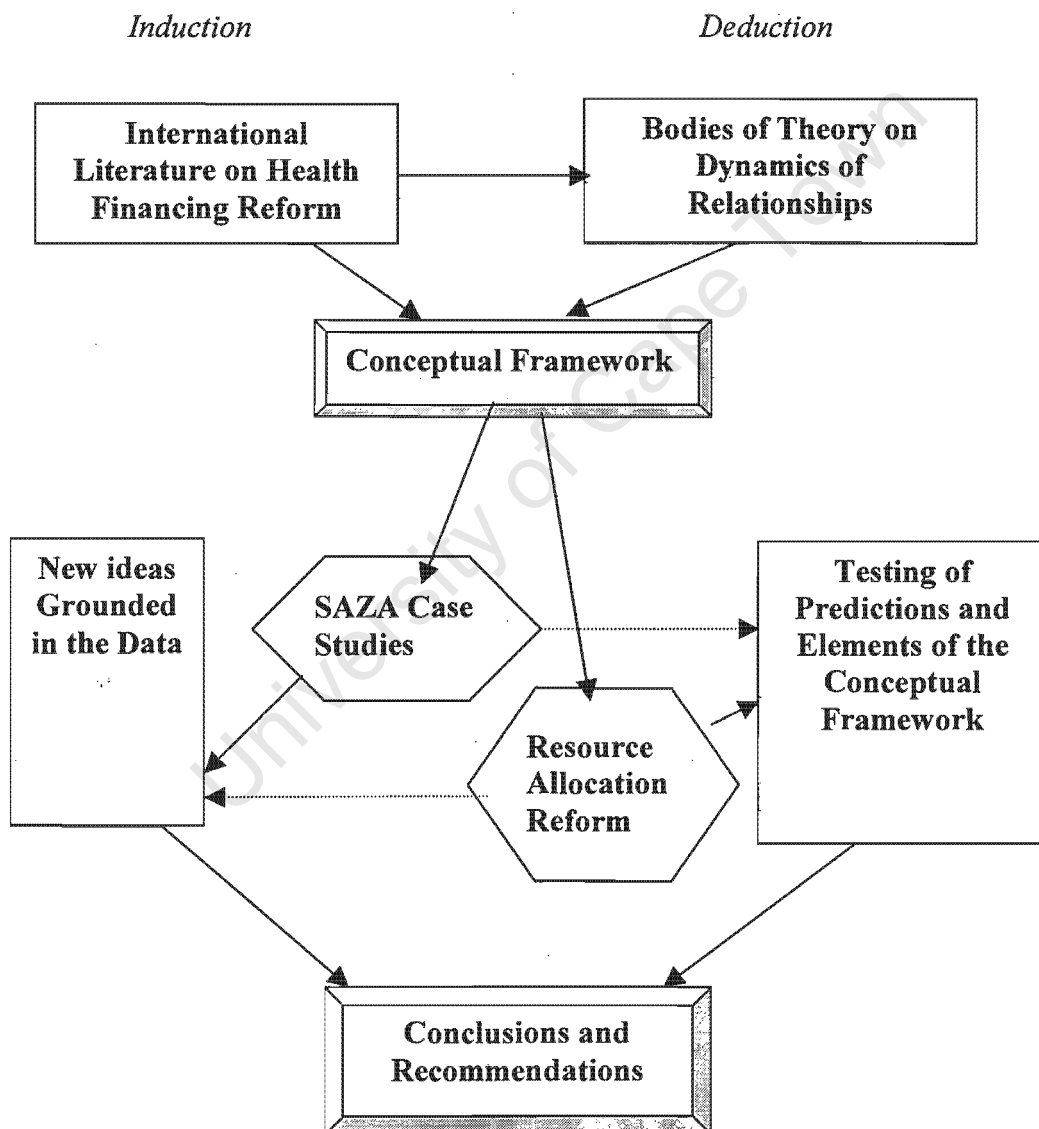
- The key issues to be addressed in the conceptual framework are based partly on a review of experience of international health financing reform.

only to combine different sensory perceptions to make sense of them, but to see things in certain ways in the first place (see Kant, 1969). This school of thought permeated the philosophy of Wittgenstein and modern discourse around the social sciences (Wittgenstein, 1978). For instance, a phenomenological approach maintains that reality is socially constructed and meaning is derived from how individuals react to others and their environment (see Berger and Luckman, 1967). The implication is that the qualitative researcher, relying on a grounded approach, must be careful to deal with his or her own intellectual baggage.

- Where the South African experience suggests the need, factors outside the conceptual framework are considered.

Thus the conclusions and recommendations on managing actors in reform, presented in Chapter 9, have been both deduced and induced. Such practical treatment should allow a comprehensive and useful presentation of strategic tools for reform drivers. Diagram 1.1 represents this overall methodological approach to the thesis.

Diagram 1.1: Methodological Approach to the Thesis



Key:

Arrows indicate flow of analysis

Dotted lines indicate weaker links

It is noteworthy that two key methods are used to test the conceptual framework. The first method examines the SAZA case study material (see later for a description of the SAZA project), and employs a grounded, or inductive, approach. I reviewed the SAZA interview data around actors and reform processes to explore what they reveal about actor management. I then compared the findings of this approach with the components of the conceptual framework. The SAZA case studies offer much material and fresh insights to challenge the conceptual framework, but are not able to test every element of the conceptual framework because of data gaps.

The second approach involved testing predictions of the conceptual framework by putting specific questions to the reform drivers of a resource allocation reform⁴. This more deductive approach enables core elements of the conceptual framework to be tested directly. At the same time, open-ended questions in the interview allowed new ideas to emerge. It is hoped that by combining these approaches I develop an effective test for the conceptual framework (see also Chapter 5 for a fuller discussion of methodology).

1.5.2 Development of Conceptual Framework

The conceptual framework is presented in Chapter 4 both as a diagram and text. The diagram shows the important links between key elements of the framework (Sanderson *et al*, 1996). The text provides more detail on its structure and application. Both together represent the choices facing a reform driver deciding how to take forward health financing reform through engaging with other actors.

Conceptual frameworks are more useful where they are more specific (Miles and Huberman, 1994). This allows for more exact testing leading either to refutation, adoption or refinement. The conceptual framework developed in Chapter 4 sets out different steps and issues for a reform driver to consider in reform coordination. It has been arrived at through a rigorous review (see also Diagram 1.1 above), in relation to:

- Empirical literature on the key elements of health financing reform - its objectives, scope and challenges - drawing out the relevant issues faced by reform drivers who wish to manage actors (Chapter 2)

- Theoretical literature which can illuminate the dynamics of relationships, in this case between reform drivers and other actors (Chapter 3). The harmony and tensions produced by a comparison of these bodies of literature are explored. Key issues which emerge define the form of the conceptual framework.

The conceptual framework has been developed in this way for two reasons. The first is to produce the most useful theoretical model possible that can help address the problem. Chapter 2 uses the inductive approach to draw out key findings from experience with health financing reform. Chapter 3 employs a deductive approach to derive from theory what can be in practice. By combining both inductive and deductive approaches, it is hoped a more relevant conceptual framework has been secured than would have been developed by either approach in isolation.

Second, it is hoped that grounding the conceptual framework in both theory and practice removes, at least partly, my own biases. This is part of deriving and testing the theory as honestly as possible. Indeed, the testing of the conceptual framework using different methodological approaches also helped to remove my biases. Further, while much was invested in the conceptual framework, I took care to highlight areas where its hypotheses were challenged by the data, as shown in Chapters 7 and 8. Again, it is hoped that this process neutralised my own predispositions as far as is possible.

1.5.3 Forming of Research Questions

Traditional scientific discourse maintains that scientists should develop testable hypotheses. Predictions are made and tested. The ability to make correct predictions is thought to be one of the most important features of science (Bowling, 1997). Theories must be disprovable if they are to be more than just “beliefs”. This thesis endeavours to develop testable predictions from the theory (see end of Chapter 4). It is highly unlikely, however, that the data will support or refute the *entire* conceptual framework. Breaking it down into elements therefore allows a closer inspection of which features of the framework appear to work best. These elements guide the data

⁴ This reform is additional to that observed and analysed in the SAZA material.

collection and analysis process. At the same time, it is important not to be constrained by such questions, should alternative ideas emerge. Indeed, it is possible that the research questions may alter as data are collected and analysed. (This iterative process among the seven steps of qualitative analysis is common and, indeed, essential, when trying to develop and refine theory.) Furthermore, even if the data appear to support a prediction, it is not possible to prove that the causality exists (Rothman, 1986), since “proof” is onerous and some would argue unattainable (Popper, 1959)⁵. At the very least all other causes must be dismissed (McPake and Kutzin, 1997). Nevertheless, agreement of data and prediction may remove the need for amendment in revising the conceptual framework and provide grounds for further testing and application.

1.6 Ethical Concerns

A note of caution is needed. Using case studies to explore how to manage actors risks drawing attention away from the processes adopted and towards the technical merits of the policies. While I attempt to be as objective as possible towards these policies I am not wholly successful. Perhaps, ideally, I should adopt a neutral stance toward the health financing reforms in South Africa, seeing them, in this thesis, as a means to explore strategies for managing actors and nothing more. Nevertheless, the quest for redistribution and improved equity in the South African health financing system (see Chapter 7) is a strong personal motivating factor. Without this goal I risk advancing nothing more than the dubious art of politics.

Indeed, it is worth questioning why I should write about the management of actors in health financing reform at all. In doing so, I risk identifying good strategies for reform drivers to pass inappropriate policies. Certainly, this is a cause for concern and not my intent. There are perhaps two responses. First, strategic management of actors is no substitute for sound technical analysis. On the contrary, the two should go hand in hand to find the most appropriate policy. Further, to retreat to the purely technical is to risk developing good policies which never get implemented. Reform drivers, public

⁵ Probing deeper the concept of causality presents further problems. Kant (1969) claims that our minds impose causality on the world in order to make sense of it and therefore causality exists only in relation to ourselves. Relatedly, Garfinkel (1981) notes that explanation and causality have much to do with our own viewpoint and the type of answer we are looking for. Quoting Allison (1971), out of context: “Where you stand, is where you sit.”

sector managers and researchers are all forced to deal, to varying degrees, with the politics of health financing reform. Knowing how to deal with such politics may rather make technical input into reform processes count for more.

Another objection to my research may be that the strategies proposed tend to use people as means rather than ends. If the research question is viewed in the light of “what do I need to do to others to get my policy through?” then it is clear that the “others” may be reduced to a vehicle of reform development. Were the health sector policy elite to consist of the poor and marginalised I would have much sympathy with this objection. As it is, the influential actors tend to be those who can look after themselves. For instance, in South Africa the Medical Scheme Administrators and the Department of Finance are actors with significant resources at their disposal. I shed few tears for such groups. The development of health financing reform may involve a lot of blood on the floor. This may be a worthy price to pay for effective and equitable health financing reform.

1.7 The SAZA Project

1.7.1 Aims, Scope and Methods

It is worth locating this thesis in relation to a larger research project. The thesis has been conducted in parallel with a joint research project: “Evaluating health care financing reforms in South Africa and Zambia” (SAZA), on which I was the principal investigator at the Health Economics Unit. This project was financed by USAID and the European Union and conducted by the Centre for Health Policy, University of Witwatersrand; the Health Economics Unit, University of Cape Town; the Economics Department, University of Zambia, the London School of Hygiene and Tropical Medicine and the Institute for Health Economics, Lund University.

The first phase of the South African component of this study (Gilson et al, 1999) examined three areas of financing policy change over the 1994-99 period:

- the removal of fees for:
 - (i) Pregnant women, nursing mothers and children under six;

(ii) Primary Health Care;

- the reallocation of government budgets across provinces, and
- the development of proposals for Social Health Insurance (which linked with the introduction of new legislation to regulate the private insurance industry)

The SAZA study's primary focus was detailed investigation of factors that influenced policy development of the above reforms, and that shaped the nature and extent of change achieved. After studying the design of the reforms, their formulation and implementation were investigated, along with the key people involved. Following the policy analysis approach of Walt and Gilson (1994) factors influencing the steps in each of reform were grouped into four broad categories:

- **context** – the environment in which health financing reforms are developed and implemented (macro-economic, political, demographic, socio-cultural, etc.);
- **actors** – the key stakeholders in health financing reforms, both within and outside the health sector, and their agendas and power bases;
- **process** - the way in which policies are developed and implemented,
- **content** – the technical design of the reforms.

These factors, and their interactions, were explored fully to investigate the development of policies. Data were drawn from reviews of policy-relevant documentation; broader literature concerning the reform areas and the context of South African policy development; newspaper analyses of health issues, and parliamentary speeches. Detailed interviews were conducted with key informants from both inside and outside government.

1.7.2 The interrelationship between this thesis and the SAZA project.

The thesis draws on some of the data and analysis of the overall SAZA project. In particular, the interviews conducted by the SAZA team with key policy makers and actor representatives are used as data sources. While I was involved in some of the

interviews, others were conducted by colleagues. I am extremely grateful to them and the transcribers for their help. Furthermore, a general understanding of time frames for different policies, key contextual events, actors and their stances on reforms, was developed by the whole SAZA team. Hence Chapter 6, the evaluation of the overall financing reform programmes, owes much to the analysis contained in the SAZA phase 1 report, "The Dynamics of Policy Change: Health Care Financing in South Africa, 1994-1999". Supplementary data on impact have been added from more recent evaluations, such as the National Health Accounts exercise (see Thomas and Muirhead, 2000; Doherty *et al*, 2002; Cornell *et al*, 2001). Finally, key SAZA team members have been invaluable in reviewing preliminary findings of the thesis.

Nevertheless, the main body of research of this thesis is entirely my own work. The rationale for the research; the literature review; comparison of relevant bodies of institutional economics and management theory; the conceptual framework; the development of methods for testing and refining strategies; data collection from the additional resource allocation case study; analysis of results and the conclusions and recommendations are all my independent research. Where this proved useful to SAZA it was fed back into the larger project. I hope and believe that this reciprocity has been mutually beneficial.

Chapter 2: Literature Review

2.1 Introduction

Health reform is about finding, or at least initiating, solutions to multi-dimensional problems (Frenk, 1994; Berman, 1995; Mills *et al*, 2001). While such problems often relate to technical or economic issues, health reform must also deal with broader concerns, such as institutional capacity and the agendas of actors (Walt, 1994; Walt and Gilson, 1994; Cassells, 1995; Barker, 1996). Consequently, solutions are often complex, and may involve risk and uncertainty (Grindle and Thomas, 1992) as policy makers cannot know the real impact of their policies until well after the event. Reform development therefore requires careful management.

This literature review explores the scope, types and objectives of health *financing* reform before assessing the choices that face reform drivers as they manage actors in these reforms. This review pools what is known about the management of actors, from the health reform literature, and thus identifies existing gaps in knowledge. It may be objected that the focus on the health reform literature may be too narrow and that a broader review of policy reform may be more appropriate. There are two justifications for my approach. First, health reforms and health financing reforms need to be understood in their own complexity and history. Some of the issues and debates are specific to this body of experience and will shape the issue of managing actors. Relatedly, many of the actors and their interactions are unique to health financing reform; a wider review of policy reform may not offer insight here. Second, the need for a broader perspective is, nevertheless, understood and I consider, in the last section of this chapter, how additional bodies of literature should be selected to help bridge the knowledge gaps to develop a coherent framework for managing actors. Consequently, the analysis contained in Chapter 3 allows a focussed review of other material to provide additional understanding around managing actors in health financing reform.

I begin by reviewing alternative definitions of health reform and health financing reform. As noted earlier, health financing reform is best understood within the

context, and as a central component, of more general health care reform (Berman, 1995; Gilson and Mills, 1995; Gilson *et al*, 1999).

2.2 Health Care Reform and Health Care Financing Reform: What are they?

2.2.1 Broad Definitions

Health reform has no universal definition, reflecting both its complexity and many dimensions. Indeed, different definitions highlight not only different aspects of reform but also different sets of problems facing reform managers.

Dictionary definitions of reform include:

"an improvement or change for the better, especially as a result of correction of legal or political abuses or malpractices." And " a principle, campaign, or measure aimed at achieving such change."
The Collins Concise Dictionary of the English Language (1990).
Collins. London. (p972)

"the amendment or altering for the better of some faulty state of things." The Compact Edition of the Oxford English Dictionary,
Volume II, Oxford 1971. (p2465).

Reform is concerned with achieving improvement and correcting what is seen to be wrong. Berman (1995), following WHO (1993), asks whether reform is really reform unless it actually achieves corrective change i.e. can reform that does not meet its goals really be reform? As the Collins' dictionary definition notes this is an illegitimate concern as reforms may aim to achieve change without necessarily being successful. Such a view is confirmed by Grindle and Thomas (1992) who explain reform as:

"...deliberate efforts on the part of government to redress perceived errors in prior and existing policy and institutional arrangements". (p4)

Building on this, reform can be seen as signalling major change in policy direction. New policies and practices are frequently adopted over the adjustment of old ones (Berman 1995). This element of major change points towards the political dimension of reform. As change implies shifting resources and challenging the status quo, reform becomes political in that it alters who gets what (Lasswell, 1958; Lindenberg and Crosby, 1981). While this may reflect domestic political battles (Reich, 1995) it may equally be caused by international forces. As different political philosophies gain vogue internationally then the content of health reform changes across countries (Mills *et al*, 2001). This is called 'policy transfer', where lessons and strategies are transferred voluntarily, or coercively, from one institution or country to another (Dolowitz and Marsh, 1996).¹

2.2.2 Scope of Financing Reform

If reform is about *trying* to achieve substantive change, what sort of changes are legitimate concerns for health financing reform? The scope of financing reform covers both the raising of revenue and its subsequent allocation (Leighton, 1995). Issues around the generation of resources deal with the adoption, amendment or removal of the following key financing mechanisms²:

- *General taxation-based financing* - This tends to be the major form of government financing of the health sector in many countries (Sorkin, 1978). Revenues from general taxation are used to fund budget commitments across all sectors, including health. Hsiao (1998) sees this as a potentially unstable form of revenue, given the frequent low priority of health in national budget negotiations; the low tax-base in

¹ A key example of this is the way that the liberal pro-market ideology of the 1980s, originating in the UK and USA, left its mark on the market-led health reforms of many developing countries in the late 1980s and 1990s (Jowett, 2000; Mills *et al*, 2001).

² The first four mechanisms outlined match the key sources of finance identified by Van Doorslaer and Wagstaff (1993). Their focus on OECD countries accounts for their omission of community prepayment schemes, though even in developing countries such schemes do not typically generate significant funds (Abel-Smith, 1994).

many developing countries (see also Abel-Smith, 1994); the domination of expenditure policy by macro-economic concerns and the fragility of growth in developing countries (Jowett, 2000). Such instability may, however, be overlaid, as taxation-based funding is part of the status quo and may attract less opposition than new financing schemes (Abel-Smith and Creese, 1989).

- *Out of Pocket Payments* – These are fees paid by the patient on use of health services and include both user fees for public sector services and payments to private providers at the point of contact. Proponents of public sector user fees argue that they can both improve financial sustainability and referral patterns and dissuade consumers from unnecessary use of services (Akin, Birdsall and De Ferranti, 1987; Shepard and Benjamin, 1993; Kutzin 1995b). Such arguments have been challenged by others who maintain that in practice the cost recovery potential of user fees is limited without associated administrative reform and that equity often suffers, especially through the failure of adequate exemption policies (Abel-Smith, 1994; Nolan and Turbat, 1995; Gilson *et al*, 1995; Russell and Gilson, 1995). Indeed, in some countries exemptions appear to be given to those who need them least, such as military personnel (Killingsworth *et al*, 1999).³ Out of pocket payments are generally recognised as an extremely inequitable source of financing (Wagstaff and Van Doorslaer, 1993; Nabyonga *et al*, 2002)
- *Private Health Insurance* – Private Health Insurance is voluntary and mostly restricted to the very few in developing countries (Abel-Smith, 1994; Ensor and Jowett, 2000), though South Africa is a notable exception (see Chapter 6). Consumers choose insurance products covering a range of benefits and conditions, according to their willingness and ability to pay. To compensate for the tendency that only the unhealthy will choose insurance, insurers often force consumers to pay differentially in relation to their own characteristics, i.e. the higher the risk of a consumer the higher the premium (Abel-Smith, 1994; Ensor and Jowett, 2000). While private health insurance is often criticised as being highly inequitable, some authors argue that government regulation to ban risk-rating practices may in fact

³ User fees have been implemented in many developing countries (Gilson, 1995). Their adoption may owe much to “inappropriate” exemption policies that protect the influential rather than those who are in genuine need. Policy makers thus avoid organised opposition by ensuring that the costs are borne by the marginalized.

improve welfare and the equity of financing of private health insurance for those within the risk pool (Feldman *et al*, 1998; Van der Heever and Brijlal, 1997), if not for the system as a whole.

- *Social Health Insurance* - Unlike private insurance Social Health Insurance is compulsory across certain segments of the population (when the entire population is covered it is often termed National Health Insurance) and organised by the state (Mills, 1983; Criel, 1998). It is distinct from general tax funds in that revenues are usually earmarked for the health sector (Hsiao, 1998). By pooling risk across different individuals and population groups it can increase the access of the poorest and neediest to health care (Abel-Smith and Rawal, 1994). Nevertheless, there is also a danger that Social Health Insurance reform covers only those groups in the formal sector whose need is not the greatest (Normand and Weber, 1994). Thus it may subsidise those sections of the population which are already better off and increase inequity.
- *Community Prepayment Schemes* - These schemes provide community members with the opportunity to give a flat payment in advance, in return for free or reduced cost health care if they fall ill. It can be useful in protecting communities against catastrophic care and cash constraints due to seasonal income (Abel-Smith and Dua, 1988; Abel-Smith, 1994; Lambo, 1998). Nevertheless, it often requires high local motivation of communities and there are precious few examples of schemes which have been replicated countrywide (Carrin and Verecke, 1992; Abel Smith, 1994; Jowett and Ensor, 2000).

Such financing reforms are often combined in a package or with other, non-financial, health reforms (Gilson *et al*, 1999). Indeed, it may be that the art of financing is choosing an appropriate mix of the above reforms to meet key objectives. Each has its own features and will therefore be more or less useful depending on the specific objectives and context. Furthermore, it may be expected that different reforms have different implications for managing actors. This is a theme to which we will return in this chapter and also in later chapters.

The second component of health financing reform relates to the allocation of resources to, and across, health sector activities (Leighton, 1995). This can be achieved through resource allocation mechanisms (Green, 1992) designed to achieve key health system performance criteria (see next section). Often formulas for resource allocations are devised to ensure fairness in distribution in relation to population covered and socio-economic indicators of need (McIntyre and Muirhead, 2002). Such decisions can be taken at different levels of government. Indeed, a popular reform in recent years has been decentralisation of spending and, less-frequently, revenue-raising powers to subnational levels of government (Ter-Minassian, 1997; Bird and Vaillancourt, 1997, Brijlal *et al*, 1998). Economic theory argues that this may make the allocation of resources more efficient as subnational levels of governments are likely to be more responsive to local needs (Tiebout, 1961). Nevertheless, decentralisation may threaten the equity of resource allocation across geographical population, both generally (Prud'homme, 1995) and in relation to the health sector (Collins, 1996). As decentralisation progresses to lower levels of the system local financing sources become increasingly important. If there is no effective vehicle for cross subsidy between wealthier and poorer populations, then inequities are likely to increase. This points to the need for government oversight and redistribution, involving either transfers from central government or from other governments at the same level to governments of poorer areas (Ter-Minassian, 1997; Thomas *et al*, 2003).

It is generally agreed that, within decentralised systems, increased spending responsibilities should be matched by the assignment of own sources of revenue to encourage fiscal responsibility (Ter-Minassian, 1997). Failing this central government must correct any imbalances between spending and revenue (Ahmad and Craig, 1997). Such imbalances can be of two sorts:

- Vertical - when revenues and expenditures of different levels of government are unequal.
- Horizontal - when the fiscal capacities of government differ across the same level.

Both can be corrected by inter-governmental transfers which can be done through sharing tax revenues or a system of grants (Ahmad and Craig, 1997; Ter-Minassian, 1997)⁴. Further, grants can be either general purpose or specific purpose or block. General purpose grants are not tied allowing the recipient discretion over their use, while specific purpose grants include conditions around fund deployment or performance. Specific purpose grants are often pursued to help meet distributional goals and policy objectives such as minimum standards. Nevertheless, they may undermine regional autonomy and create conflict in the process. Finally block grants fall in between general and specific purpose grants, often relating to broad areas of expenditure, such as health.

2.3 Objectives of Reform

It is useful to review the typical goals of reform and measures of their success. It might be expected that different objectives create different conditions for managing actors. (The interaction between reform objectives and managing actors is explored later.)

Berman (1995) notes that:

"Health sector reform is the process of improving the performance of existing systems and of assuring their efficient and equitable response to future changes. ...Health sector reform requires the successful management of political and social forces, as well as the application of sound technical analysis in the development of policies and actions." (p30)

This elaboration of health sector reform contains several crucial points. First, reforms should focus on improving the impact of the health system, using benchmarks such as efficiency and equity. Such a view is endorsed by Murray (1995) and Hammer and Berman (1995) and is also the basis of the influential analysis set out in the World Development Report, 1993 (World Bank, 1993). Second, reforms should improve

⁴ Technically, subnational governments can also increase their debt to correct the imbalance. However, such a strategy may well undermine macroeconomic goals.

existing systems, institutions and policy development (see World Health Organisation, 1993; Frenk, 1994; Cassells, 1995; Mills *et al*, 2001). Third, and of most concern to this study, reforms must deal with actors in the health sector, their agendas and power (Walt and Gilson, 1994; Reich, 1995; Barker, 1996; Glasman *et al*, 1999). All are necessary for successful reform. For instance, improvements in institutions and processes are only worthwhile if they lead to improved equity and efficiency in health care financing, an argument that is pursued by both Berman (1995) and Frenk (1994). The problem here is that there is no guarantee that a good policy process or a better-functioning Ministry of Health will lead to improved service delivery (Brijlal *et al*, 1998). Nevertheless, there is consensus that health care reform is primarily concerned with the achievement of technical goals (Maynard and Hutton, 1992; Berman, 1995). It aims to achieve:

"sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector" (Berman, 1995, p16)

What are the key technical goals for reform? Most authors would agree on equity and efficiency as fundamental objectives, though beyond this there is a range of alternative technical criteria, such as quality, acceptability and sustainability (Abel-Smith, 1994; Kutzin, 1995a; Berman, 1995; McPake and Kutzin, 1997; Frenk, 1994; WHO, 2000; Mills *et al*, 2001). The focus here is on equity and efficiency, with some discussion given also to financial sustainability, as these are key areas of debate (World Bank, 1993; WHO, 2000). Indeed, there are often trade-offs between these objectives (McPake and Kutzin, 1997). Choices between technical goals and objectives must appeal to ideology and political philosophy (Green, 1992). Specific goals often relate to the underlying political values of those in charge of the reform and their agenda for change (Walt, 1994; Reich, 1995; Gilson, 1998; Wagstaff and Van Doorslaer, 1993; Kutzin, 1995a).

2.3.1 Equity

There is considerable and persisting confusion over the concept of equity (Mooney, 1983; Whitehead, 1992; Donaldson and Gerard, 1993; Kutzin, 1995b). Nevertheless, most definitions relate to fairness of distribution (Mooney, 1983; Donaldson and Gerard, 1993) though Whitehead (1992) stresses that differences must also be seen as *avoidable* before being labelled inequitable. There are two general approaches to equity which can be applied both to the provision and financing health care (Mooney, 1983; Donaldson and Gerard, 1993):

- Horizontal equity, implying the need for the equal treatment of equals
- Vertical equity, implying the unequal treatment of unequals

The translation of these approaches into working definitions of equity may take several forms relating to the equity of inputs, access, utilisation and outcomes (Mooney, 1983; Whitehead, 1992; Kutzin, 1995b). For instance, Kutzin (1995b) argues that equity in health care financing relates to payment according to ability and treatment according to need, though the operationalisation of this is open to significant interpretation (see Culyer and Wagstaff, 1993). Mooney (1996) notes that while horizontal equity is more popular with policy makers, it may fail to narrow the gaps that exist between different groups in society⁵. Certainly, vertical equity creates more upheaval to the distribution of resources, challenging vested interests, and as such may attract more opposition (see *Managing Actors in Reform* section).

One interesting application of equity to health financing is the assessment of the progressivity of different financing methods in ten OECD countries by van Doorslaer and Wagstaff (1993). A financing method is said to be progressive when higher-income groups spend a larger proportion of their income for health care than lower

⁵ McIntyre (1997) argues that the concept of vertical equity is particularly relevant in a context such as that of South Africa. Where there are vast inequalities in access and financing of health services radical redistribution is needed and hence an equity concept is required that spans a broad range of needs.

income groups. This fits in with the notion of paying for health care in accordance with ability to pay i.e. vertical equity. The results are summarised below:

- Direct taxes (personal income tax) were progressive in all countries.
- Indirect taxes (such as VAT) tended to be regressive.
- Social insurance schemes were regressive in those countries where they formed the major financing source (France, the Netherlands and Spain) because of design features such as a ceiling on own contributions, which placed a limit on how much the well-off pay. Where it was a “top-up” for other sources the results were mixed.
- Private health insurance was highly regressive where it formed the main financing source (Switzerland and USA). Nevertheless, it was found to be progressive *where* it was supplementary to other sources as it allowed those who were well off to pay disproportionately more for their health care.
- Out of pocket payments tended to be a highly regressive means of financing health care.

In a more recent study Wagstaff *et al* (1999) refined their methodology and revisited the same countries as well as three other high-income countries. Their results were similar to the earlier study, but social insurance appeared to be more progressive (perhaps reflecting refinement of the designs of social insurance in many countries), while private insurance appeared more regressive. Indeed, it is interesting to note that most forms of health financing, apart from direct taxation and, possibly, social insurance, tend to be regressive. This places policy makers in developing countries in a difficult position. Not only are they faced with a “double burden” of scarce resources and disease (Abel-Smith, 1994; WHO, 1995) but any attempt to boost financial sustainability with extra health financing sources may damage the equity of financing. This may be particularly the case as income tax is difficult to collect in developing countries and indirect taxes tend to be more important but also regressive (Abel-Smith, 1994; Ensor and Jowett, 2000).

2.3.2 Efficiency

There are two central approaches to efficiency in health economics. *Allocative efficiency* is concerned with maximising the impact of health promoting interventions across a broad range of activities (McGuire *et al*, 1994; Witter 2000a). It relates to prioritising some activities over others in relation to how they will meet set objectives, such as aggregate health status improvement. Many commentators believe that improving allocative efficiency was the primary objective of health reforms in the 1990s (Murray, 1995; Hammer and Berman, 1995; Gilson, 1998). Indeed, the movement to introduce essential packages of health services in many developing countries was an example of the pursuit of allocative efficiency (World Bank, 1993; Bobadilla *et al*, 1994). This approach deployed a macro cost-effectiveness analysis to the prioritisation of health sector activities to meet the prevailing disease burden in each country.

Nevertheless, there has been much recent criticism of this approach in that it ignores welfare effects and is biased against the poorest groups (McGreevey *et al*, 1997; Gilson, 1998; Goudge and Govender, 2000). In effect, the goal of solely maximising aggregate health status is controversial. Paalman *et al* (1998) also maintain the approach does not consider non-health sector interventions, or even causes of ill-health, and that the cost-effectiveness calculations in the World Development Report (World Bank, 1993) are spurious, ignoring joint costs and effects. Furthermore, Gilson (1998) argues that the approach trivialises implementation, ignoring existing patterns of service delivery.

Technical efficiency, in contrast, looks at the optimal combination of resources in any *one* activity to produce maximum output at minimum cost (McGuire *et al*, 1994; Abel-Smith, 1994; Witter, 2000b). While allocative efficiency focuses on which activity to pursue, technical efficiency is concerned with getting the right mix of inputs into a specific activity (Brown and Jackson, 1987; Smithson, 1996).

Nevertheless, both are needed to improve overall efficiency in the use of resources in the health sector.

Concern for technical efficiency, by definition, is associated with a more micro-economic perspective on reform, often concentrating at the facility level or on specific activities. Areas of application in relation to technical efficiency oriented reform are hospital autonomy (Barnum and Kutzin, 1993) and the cost-effectiveness of disease specific interventions such as tuberculosis (Floyd *et al*, 1997) and sleeping sickness (Politi *et al*, 1995).

2.3.3 Financial Sustainability

Another common objective for financing reform is *financial sustainability*. There are two prevailing definitions. The first discusses the financing of the health sector in relation to its dependency on *external* resources (LaFond, 1995). Of major concern here is the flow of foreign donor funds into the health system. The second definition is concerned with the sufficiency, predictability and regularity of sources of finances in the health sector (McPake and Kutzin, 1997). Such an interpretation of financial sustainability is less concerned with the source of funds for financing a health sector, and more interested in a steady future flow of finances. In many ways the search for alternative financing mechanisms has been a bid by developing countries to raise sufficient revenue to finance their desired health care provision now and in future (Abel-Smith and Creese, 1989; Abel-Smith, 1994). This quest in many developing countries (see Gilson and Mills, 1995) is largely fuelled by concerns about financial sustainability.

2.4 Managing Actors in Reform

Having examined the scope, types and objectives of health financing reform I turn to the management of actors involved in such reforms. First I review what is known about this issue from international health sector literature and specifically research which deals with health reform processes. I do not explore literature from other sectors which examine similar issues as the health reform literature is substantial and to cast the net wider would go well beyond the scope of this thesis. Following the review of health sector literature I then identify the gaps in knowledge and consider where some answers may be found.

2.4.1 What we know

A growing body of evidence shows that health reform produces opposition in both developing countries (Reich, 1995; Birdsall and Hecht, 1997; Moore, 1999; Ogunbekun *et al*, 1999; Blas and Limbambala, 2001; Nandraj *et al*, 2001) and the developed world (Oliver and Dowell, 1994; Klein, 1995; Williams *et al*, 1995; Duckett, 1996; Elze, 1998; Harrison and Caltorp, 2000; Gould, 2000; Swenson and Greer, 2002). In many cases this opposition proved too much for the reform process which was either watered down or abandoned (for example Harrison and Calltorp, 2000, and Blas and Limbambala, 2001). In some cases reform leaders were able to push their reforms through largely intact (see Reich, 1995, and Klein, 1995). Even in these cases, though, there were associated costs and risks. Klein (1995) notes that health reforms in the UK in the early 1990s were pushed through in the face of almost unanimous dissent. The political implications of this were large; disaffected doctors and nurses were able to shape public perceptions and create strong opposition, a key factor in the landslide election losses for the government in the mid 1990s. Reich (1995) documents that initial success in pushing through pharmaceutical reforms in Sri Lanka, Bangladesh and the Philippines was subsequently challenged and is at risk from powerful interest groups. Indeed, reforms that challenge the powerful always risk being either derailed or reversed.

Walt (1994), Reich (1994) and Barker (1996) note that the design and implementation of policies are all about allocating resources, distributing power and deciding whose needs come first. As reform embraces change it will reallocate resources amongst different actors and produce conflict (Grindle and Thomas, 1992). Reform is therefore inherently political (WHO, 1993). Financing reform, dealing with who pays and who receives, is especially contentious. Reich (1994) notes that reforms will promote competition between the potential winners and losers as they seek to influence the changes. This in turn can affect a regime's political stability. Such concerns are paramount to political leaders. While health reform must deal with the problem of how to get to reach the desired state of affairs (Cherchinovsky and Chintz, 1995), political leaders will want to know how reforms affect different groups in society and will tend to favour reforms which produce the least opposition. Waterbury (1989) argues that the most important concern for any government engaged in transition is to avoid injuring the interests of all its support groups at once. Further, in one of the few published studies of the politics of health financing reform, Glassman *et al* (1999) note the difficulty a government faces in dealing with powerful interest groups who stand to lose from change. They describe the handling of such opposition as "one of the most important and complex problems in the process of health reforms..." (p115). Grindle and Thomas (1992), note:

"The ranks of opposition to change (are) filled with the beneficiaries of the status quo: economic elites supported by existing policies; ethnic, regional and religious groups favoured in allocative decision making; bureaucrats and bureaucratic agencies wielding regulatory power; political elites sustained through patronage and clientele networks; military organisations accustomed to spending generous budgets with few questions asked." (p3)

Consequently, the most difficult reforms are likely to be those directed at challenging the powerful. Both Olson (1965) and Nelson (1989) note that it is redistribution to the poor which often meets most opposition, as it involves moving resources away from the powerful and well-off. Urban middle classes tend to be more organised, with a louder voice. In contrast rural populations are usually dispersed and lack the economic means to influence policy. Consequently, the concerns of the rich are seldom ignored. Redistribution to the poor will create major conflict. Hence, health

financing reforms targeted at improving equity are likely to face more opposition than those aimed at better efficiency, sustainability and so on, and are more likely to be sidetracked. Conversely, vested interests may encourage health financing reform toward non-redistributive objectives. As Blas and Limbambala (2001) note of hospital reform in Zambia:

“...unless a formula is found to activate and empower those who have been treated unfairly by the historical distribution of resources, the political forces of decentralisation will likely work against a fairer distribution of access to health services.” (p41)

Is there any more specific mention of precisely which groups oppose reform and act as a brake against the achievement of equity? Most articles merely allude to opposition from those with vested interests in the current, or former, health system design: usually the rich and influential. Nevertheless, other studies zoom in on particular actors. Health professionals have been, or were anticipated to be, a key block to health reform in several countries (Williams *et al*, 1995; Klein, 1995; Reich, 1995; Duckett, 1996; Ogunbekun *et al*, 1999; Harrison and Calltorp, 2000). In addition, public health sector managers, hospital boards, big business and politicians also were noted as obstacles to reform (Harrison and Calltorp, 2000; Blas and Limbambala, 2001; Swenson and Greer, 2002). Nevertheless, identifying who are likely opponents is an important first step in thinking through an appropriate strategy for reform development (Crosby, 1992).

Despite opposition from powerful interest groups, there is some evidence to suggest that health financing reforms concerned with redistributing resources are not necessarily doomed before they start (Reich, 1995; Bloom, 2001; Grindle, 2001).

What are the critical factors that appear to guarantee, or at least, facilitate success?

Grindle (2001) notes that strategic leadership and action were important in many Latin American reforms of social services. Grindle (2000) also notes the importance of “change teams” or “state reformers”. These groups consist of technical analysts and high level officials, all within government, who shepherd reforms from initial idea to implementation. Grindle (2000) also maintains that who is on the team may be of critical importance to the reform’s development, though this area is underexplored.

The implication, though, is that these actors will contribute to strategic leadership and the guidance of reform.

Bloom (2001) stresses how important such leadership is for actors in government:

“Governments...need to become managers of sectoral change. This involves...an ability to negotiate with stakeholders and regulate their performance.”(p221)

Key strategies available for dealing with opposition and managing change in health financing reform appear as follows (from Waterbury, 1989; Nelson, 1989; Blair and Fottler, 1990; Crosby, 1992; Baier *et al*, 1994; Reich, 1995; Collins *et al*, 1999; Brugha and Varvasozszky 2000; Varvasozszky and Brugha, 2000):

- Understand the motivating factors, power and positions of different actors on reforms
- Build alliances and coalitions with powerful actors who are for the reform
- Identify opponents and exclude them from coalitions
- Reward those powerful groups who stand to lose from reform with compensatory benefits
- Cloud the precise nature of the reform with general principles which groups may be more ready to support.

2.4.2 What we don't know

There are, of course, dangers in some of these strategies. By exploring them, holes in the current understanding of actor management start to emerge. First, while it may be possible to buy off different groups in order to ensure a pro-poor policy is accepted, this may well destabilise reform programmes, particularly where it becomes the norm (Jenkins, 1978; Grindle and Thomas, 1992).

“Such incentives... can cause inherent instability, since they may be routinised into the system, demanding no loyalty and often merely whetting the appetite.” (p218-9, Jenkins, 1978)

Thus, vested interest groups may come to expect pay-offs for supporting policies and this may create problems for reform managers. Second, clouding may win initial support but create dissent once policies become specific in order to be implemented. It is therefore crucial to ascertain the circumstances in which such strategies will work. This is far from clear in the existing literature. Similarly, while the use of change teams to manage reforms may be important (Grindle, 2000), little is known about how such teams should be composed. Further, it is not clear how a team's composition or organisation might affect the reform.

One important case study in the literature highlights the problem of insufficient knowledge in this area. Glasmann et al (1999) document an experiment in the Dominican Republic where reform managers derived strategies from "Policy Maker" (Reich and Cooper, 1996), a computer software package to manage actors in health reform. The strategies were selected from a "toolbox" of 32 prescribed solutions, derived from expert opinion. The initial reform failed in the Dominican Republic. This perhaps highlights that fact that care must be exercised when applying generalised solutions into a specific context. Further, a more theoretical understanding of options may help guide application. Finally, there is a dearth of experience in how different strategies combine.

Key questions, or gaps in current knowledge, that remain are:

- When should particular actor management strategies be applied?
- Are there other strategies that would be useful?
- How should different actors be involved in the reform process to produce the desired reform?
- On what does appropriate involvement depend?
- How should change teams be composed and managed to help reform development?

In addition, is it reasonable to expect those who wish to pursue reform to be able to do so? Some models of society give little room for individual decision-making outside broader social forces (see Tucker, 1969, for a Marxist perspective) while others restrict the role of the state to simple self-preservation through the management of

competing legitimate interests (Hamilton, Madison and Jay, 1961) or rent-seeking agendas (Krueger, 1974; Colander, 1984; Srinivasan, 1985). Given such models of society, a reform driver has little or no independent ability to pursue a reform agenda.

Whether there is room for individual decision-making may be an empirical issue. Certainly, Grindle and Thomas (1992), in their survey of 12 countries in Africa, Latin America and Asia, maintain that policy makers do initiate change, do have problem-solving skills and are interested in solving technical problems. They argue the focus of attention should, therefore, be on the policy maker. This is not to underemphasise the importance of social forces but that there is “policy space” to make decisions. The capabilities of policy makers and the resources at hand to perform policy tasks are then of critical importance. The capacity of the public sector to develop and implement reforms is essential (Hildebrand and Grindle, 1994; Mills *et al*, 2001).

While this thesis generally supports this viewpoint it is a factor which needs to be reviewed. Further, it may be important to note that other actors and not just government officials have policy space to become policy entrepreneurs (Kingdon, 1984) and influence and, perhaps even, drive reforms. The *interactions* of policy makers with other health sector actors, their “task networks”, or possibly teams, are then critical for capacity to develop policy (see Hildebrand and Grindle, 1994). At times the space for decision-making will be larger than at others. Windows of opportunity will be important to grasp (Reich, 1995). Hence, to be able to manage actors appropriately reform drivers must understand their own capabilities, constraints and the context within which they are operating.

The existing literature does not make clear what is the right environment for managing change and what capabilities a reform driver must possess to push through a reform successfully. Collins *et al* (1999) note the importance of understanding the prevailing context when managing change. Yet, reform drivers may face significant uncertainty in understanding not only the context of reform but also the reactions of other actors. Given the plethora of unknowns in reform processes, managing it is inherently risky. The literature is silent on strategies for dealing with such risk.

2.4.3 The need for theoretical development

It has been shown that there are significant gaps in the health care financing reform literature in relation to managing actors. To be able to construct a relevant conceptual framework it may therefore be useful to examine a range of theoretical literature to fill the gaps. Yet, what are the key elements of the problem that such literature must illuminate? As a first step, it may be useful to recap some of the main components of health financing reform as presented in this literature review:

- **Scope - Health Care Financing Reform** involves the pursuit of substantial change to meet technical goals. Reforms are often complex and their outcomes uncertain. Their adoption and implementation can therefore be risky.
- **Objective-based** – Efficiency, equity and financial sustainability are all key goals of recent health financing reform initiatives. Behind the technical reform objectives lie ideologies that support different directions for health sector design and can give rise to conflict between actors.
- **Inherent Conflict** - Reforms involve the redistribution of resources and power, which will create winners and losers in reform. Particularly where equity is concerned, this may then create substantial opposition to the reform process.
- **Strategic Management** - Health care financing reform requires strategic management of actors in the reform process. Reform drivers must guarantee there is sufficient support for their actions. Alliances, collaboration and teams may be important to build support, as may the use of incentives in directing health sector actors under specific, but not fully understood, conditions.
- **Context and Capacity to Manage Reform** – Reform drivers may have room to make decisions on the direction and processes of reform. Yet they may also face constraints to their actions and decisions, based on the prevailing context or their own limitations.

From these points it is clear that reform drivers pursue radical and sometimes complex change in the financing and allocation of health resources to achieve key goals. Nevertheless, the environment within which they operate is difficult, the information and resources available are limited and they are likely to meet opposition. Yet reform drivers need to know how to deal with these circumstances. Additional bodies of literature must help fill the gaps and speak to the relationship between the reform driver and other actors in such conditions. As noted in Chapter 1, my focus is to explore how economics can throw fresh light on reform management. In particular economics may be helpful in responding to five generic issues that are raised by the literature review in the context of reform drivers and the challenges they face:

1. Different types of relationships and their strengths and weaknesses in terms of achieving desired tasks.
2. How conflicting interests, between reform drivers and other actors, affect the achievement of desired tasks.
3. The constraints and capabilities of reform drivers and other actors.
4. The incentives and motivating factors that might change behaviour and produce support for a reform.
5. The reform driver's reaction to uncertainty and risk faced in the course of the change process.

Chapter 3 draws together several strands of literature, primarily from economics, that help analyse appropriate reform management strategies and processes. The theories are able to offer insights into relationships, strategic behaviour, uncertainty, conflict and motivation and thus relate to the five issues above. While, no one theory is sufficient, elements of each are useful for the development of the *Conceptual Framework* in Chapter 4.

Chapter 3: Insights from Economics

3.1 Introduction

The aim of this chapter is to explore different bodies of literature that can throw light on the management of actors in health sector financing reform, as explored in the previous chapter. First, the rationale for the choice of the theories is discussed. Then, the basic ideas and underlying assumptions of each theory are put forward. Key applications of each theory are explored alongside their potential application to the main elements of health financing reform and the management of actors. At the end of the each section, I note the contribution of each body of literature to the five factors identified at the end of Chapter 2, and shown again in Box 3.1.

Box 3.1: Points to be addressed by Additional Bodies of Literature

- Different types of relationships and their strengths and weaknesses in terms of achieving desired tasks.
- How the compatibility of objectives, or lack of it, for reform drivers and other actors affects the relationship and the achievement of desired tasks.
- The constraints and capabilities of reform drivers and other actors.
- The incentives and motivating factors that might change behaviour and produce support for a reform.
- The reform driver's reaction to uncertainty and risk faced in the course of the change process.

The insights that each body of literature offers into the above factors are then taken forward and explored for agreement in the final section of this chapter. This comparative analysis is fed into the conceptual framework, presented in Chapter 4.

3.2 Choice of Bodies of Literature

Chapter 2 derived important features of health care reform that will determine the management of actors. The bodies of literature, outlined in this chapter, have been chosen because they can provide insights into these key features, shown in Box 3.1.

For instance, the bodies of literature:

- deal with types of relationships between two or more parties;
- highlight choices to be made by decision-makers in such engagements, and
- propose strategies to achieve desired tasks.

Their emphasis on information imbalances, constrained rationality and issues around motivation is promising to the study of managing of actors in health financing reform, since they explore current gaps in understanding identified in Chapter 2 and shown in Box 3.1.

The bodies of literature that are to be investigated are:

1. **Principal Agent Theory** – an economic theory, traditionally related to contracting, which has a typically ill-informed principal hiring a well-informed agent to perform certain tasks. The theory deals with appropriate incentives, effective monitoring and risk.
2. **Transaction Costs Theory** – an economic theory, associated with contracting and often principal agent theory, which focuses on the costs of exchange and contracts, the resulting behaviour of organisations and the strategies that can be used to avoid such costs, such as changing the form of organisations.
3. **Collaboration Theory** – a management theory that examines the motivation, preconditions, benefits and common features of organisations working together, typically for a common goal.

4. **Game Theory**¹ – an economic theory focussing on competition for resources, best possible outcomes and the pay-offs to various actors of players facing interaction within a specific context and set of rules.

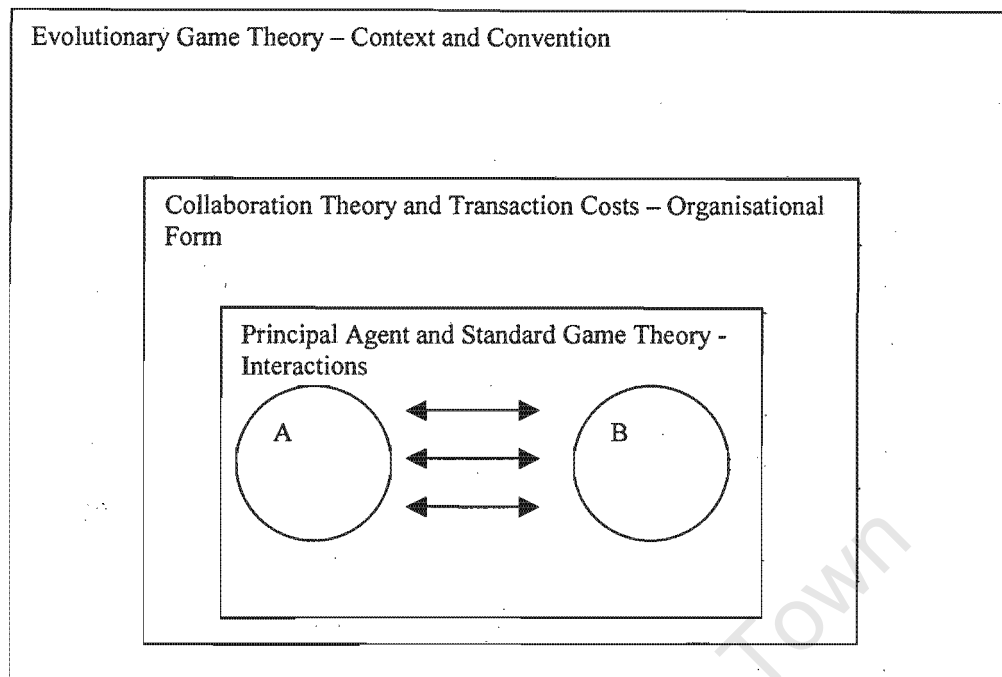
A comparison of the different foci of the four bodies of literature is useful. They do not highlight the same aspects of relationships and interactions and it is interesting to explore these differences. Principal Agent Theory and Standard Game Theory tend to be the most “micro” in focus. They scrutinise the incentive structures, beliefs and interactions of players and the likely outcome of their relationship. Collaboration Theory and the Transaction Cost literature step back to analyse appropriate types of relationships, comparing options and exploring preconditions to effective interactions. Finally, Evolutionary Game Theory zooms out to locate the interactions of players, and different types of relationships, within a societal context with established conventions of behaviour. Diagram 3.1 highlights the different emphases of the bodies of literature. Their complementarity should prove useful to the development of the conceptual framework.

Interestingly, three of the four bodies of literature are drawn from economics (1, 2 & 4), though they have applications in other disciplines². Such an economic approach to what is essentially the politics of health financing reform is unusual and needs to be justified. Economics offers valuable insights into behaviour. It explores how individuals and institutions will behave under certain conditions and how they react to different types of relationships and incentives. Further, its abstraction and simplification facilitate the construction of models that investigate decision-making: that relate action to motivation and available information. The following sections explore further the rationale for this primarily economic approach and the specific choice of theories.

¹ While Game Theory is counted as one body of literature, the “standard” and “evolutionary” forms have different emphases (see later and in Diagram 3.1).

² Game Theory has been used extensively in biology and political science, while Principal-Agent Theory has both roots and applications in political science and sociology.

Diagram 3.1: The focus on relationships of each body of literature



Key:

A, B – Actors

Arrows denote information flows, actions and incentives

3.2.1 The contribution of economics

Traditional economic theory emphasises the importance of the rationality of individual economic agents in decision-making. Individuals have full information on what they gain from their actions and purchases, are able to order their preferences completely and choose the option that maximises their utility. The rational actor model of public sector decision-making (Killick, 1976; Robinson and Majak, 1967) applies such neoclassical concepts to government decision-makers. It assumes full information, plentiful resources and no constraints facing government policy makers choosing among different reforms. Yet these assumptions are the exceptions rather than the rule for policy makers (March and Simon, 1958; Braybrooke and Lindblom, 1963; Jervis, 1968; Witter, 2000ii; Mills *et al*, 2001). Indeed Bunce (1981) argues that the rational actor approach is unconvincing as an explanation of how decisions get made. Correspondingly, the contribution of neoclassical economics to the

understanding of the actual practice of health reform choice is negligible (see Mills *et al*, 2001).

Nevertheless, it is premature to dismiss all elements of economics. As was argued in Chapter 2, there is evidence that there is room for individual decision-making within a social environment and for policy makers to impact on society (Vickers, 1973; Grindle and Thomas, 1992). While the restrictive neoclassical assumptions do not hold, an economic approach to selection of an optimal path of health reform, focusing on the decisions of a driver of reform, may still be warranted. More recent branches of economics explore what happens when the neoclassical straightjacket is removed. The concept of bounded rationality notes that decision-makers always operate with limited information, but do the best with what they have. Game Theory models how actors behave, and interact, under limited information and how this changes when extra information becomes available. Further, economics can also provide insights into the interactive nature of policy development. Policy is not solely the domain of the policy maker. Individual decision-makers involve other health sector actors, within or outside government, to develop policy (Benson, 1975). Networks of contacts and inter-organisational relations are very important for policy making (Allison, 1971; Benson, 1975; Smith, 1993; Mills *et al*, 2001). Public management literature emphasises the importance of such interactions (Bozemann and Straussman, 1991; Elwood, 1996; Kettl, 1996; Peters, 1996). New institutional economics (NIE) has been recognised as insightful in interagency dealings by the public management literature (see Weimar and Vining, 1996; Elwood, 1996). Within NIE are housed theories of property rights, transaction costs and agency. (While Game Theory has different origins it has a similar focus in terms of relationships, interactions and incentives and is entirely consistent with this approach.) While devised to understand the internal workings of institutions, particularly firms, NIE has now provided important insights into the functioning of government (Klitgaard, 1988). Further Benson (1975 and 1982) highlights that inter-organisational relations are dependent on shared resources, compatibility of interests and “rules” of the game. These are some of the key concerns of NIE which seeks to relax many of the binding assumptions of neoclassical economics and focus on the interactions of institutions and individuals within institutions (Simon, 1991; Ostrom *et al*, 1993; Kiser, 1999;

Mills *et al*, 2001)³. Policy makers face limited information, uncertainty and conflict in pursuing policy change and reform (Burns, 1969; Majone, 1975). These are key concerns for this stream of economic thought (Eggertsen, 1990).

3.2.2 Collaboration Theory – Economics in disguise?

Collaboration theory dovetails well with economic theories despite being developed from the management sciences. Collaboration theory deals with the organisation and combination of resources across institutions to achieve a common task (Alter and Hage, 1993; Huxham, 1996; Himmelman, 1996; Cropper, 1996). This mirrors economic concerns around efficiency. Collaboration theory also highlights the importance of institutional structures to efficiency, a key message of NIE. Further, Huxham's (1993) use of the term "collaborative advantage", to describe the potential for improved efficiency through network activities, emulates the term "comparative advantage" in economics. Collaboration theory also focuses on the appropriate foundations for effective relationships, noting the constraints that can wreck them. In so doing it parallels recent initiatives in economics to review contracting and trust between agencies (Deakin and Michie, 1997; Gilson 2002).

In particular, collaboration theory has important links with principal agent theory. Collaboration moves the traditional principal away from being an arms-length manipulator to a hands-on player. Nevertheless, the insights of principal agent theory into the compatibility of objectives and the importance of information can be seen to underpin collaboration theory. Indeed, collaboration theory can be seen as one type of principal agent interaction where the principal and agent have similar objectives and the principal decides that the best way to monitor the agent's behaviour is to collaborate with them, thus promoting a more easy exchange of information. Collaboration may then create a forum for exchanging information and resources which is less contractual and, perhaps, less threatening (DePree 1989, Nanus 1992). Further, an analysis of collaboration fits neatly with Williamson's exposition of hybrids as a potential solution to the problem of transaction costs (see later). Collaboration theory can provide insights into how hybrids can work effectively.

³ Simon (1991) describes NIE as "appropriately subversive of neoclassical economics".

3.2.3 The absence of Power

It may be objected that none of the theories has an explicit focus on power and that power is critical to the determination of allocation of resources in the political arena. Crozier (1964) claims that it is essential to understand the distribution of power before attempting to assess the performance of institutions. Hargreaves Heap and Varoufakis (1995), give a standard definition of power:

“the ability to secure outcomes which favour one’s interests when they conflict in some situation with the interests of another.” (p221)

Himmelman (1996) maintains that this definition can be subdivided. Power is, therefore, both:

- the ability to do, act or produce;
- the ability to control others.

The first relates to the “capacity to produce intended results” after contemporary feminist theory (Hartsock, 1985). This more positive view of power is, Himmelman claims, reflected in Lukes (1974) who notes that the most effective use of power is in preventing and not pursuing conflict. Nevertheless, the line between Himmelman’s elements of power, noted above, may well be blurred. For instance government may be tempted to manipulate others in the execution of policies precisely because it has the ability to act (De Jong, 1996). Further a closer examination of the three dimensions of power outlined by Lukes (1974) show that control is in fact inherent, even where it is exercised with subtlety.

1. In political or economic arena actors may secure decisions which favour their interests over others - overt exercise of power
2. Actors exercise their power by keeping certain items off the agenda and maintaining the status quo – covert power

3. Actors may mould the preferences and beliefs of others so that a conflict of interest is not latently present.

How do the selected theories relate to issues of power and authority? In principal agent theory the principal certainly has power over the agent. This can either be through a formal contractual process (e.g. Sappington, 1991) or through an implicit contractual relationship (e.g. Mooney and Ryan, 1993). The principal seeks to secure decisions that favour his interests (dimension 1 of Lukes's classification). He may also do this by changing the incentive structures available to the agent and "moulding his preferences" (dimension 3). The agent may also exercise his power by holding back negative information and so moulding the beliefs of the principal (dimension 3). The transaction cost literature also explores dimension 1 of power by examining opportunism and the exertion of authority in the interaction of parties (Williamson, 1989). Further, the exercise of power in governance is a critical issue to new institutional economics in relation to the optimal distribution of resources whether through markets, hierarchies or networks and clans (Williamson, 1975; Ouchi, 1979). Nevertheless neither principal agent theory nor transaction costs focus on dimension 2 of power, keeping items off the agenda.

Collaboration theory deals with power in several ways. First, one of the main reasons collaborations are pursued is because of the extra ability to be able to do things together (which speaks to Huxham's first point). Second, the relative power of partners in collaboration is an important determinant of success. If power is lopsided then collaboration will be difficult, as one party may attempt to control the other (O'Toole, 1996). Third collaboration can be used as means of coordination and control, exercising power over those both in and outside a collaborative forum (Challis *et al*, 1994). Certainly dimensions 1 and 3 of Lukes's categorisation are encompassed here. Collaborations could also be examined in relation to dimension 2.

Game Theory maps out a feasible set of actions and what can be achieved from different options. More importantly it notes how players behave within the rules of the game to achieve their own ends and in some applications even discussions how players may set up the rules to achieve desired ends. As North (1990) notes institutions set the rules or framework of the game in society.

All theories dealing with some aspects of power – certainly in terms of ability to do and selectively in terms of overt dominance. Yet, only principal agent theory explores in any detail more subtle forms of coercion. Further, the notion of power being exercised to keep things off the agenda is largely absent across all the theories. Perhaps the explanatory power of these bodies of literature, to be tested in Chapters 7 and 8, will identify whether the omission of an explicit theory of power and a failure to incorporate all of its dimensions has caused substantive weaknesses. This will then allow review of the scope and limitations of the application of such theories to the question of managing actors in health financing reform development.

3.3 Principal Agent Theory

3.3.1 Basic Description

The traditional model involves a principal who delegates responsibility to an agent to act on his behalf (Coast, 2001; Mills *et al.*, 2001). Both the principal and the agent are assumed to act as rational economic agents pursuing utility maximisation, in line with traditional neo-classical economic theory (MacDonald, 1984). They decide to form an arrangement, often an explicit contract, in which the agent acts for the principal in return for remuneration. Specific conditions exist which must hold for this arrangement to work. First, the principal has to arrange a contract which motivates the agent to choose activities that will benefit the principal. This is called the *Incentive Compatibility Constraint* (MacDonald, 1984; Arrow, 1986; Weimar and Vining 1996). The principal is, thus, concerned to affect the “type” of agent by the specification of the contract, so that only productive agents will apply. Second, the contract facing the agent must be sufficiently attractive for the agent to accept it rather than doing something else (the *Viability or Participation Constraint*). Such incentives are required as the objectives of the principal and the agent are typically assumed to be independent or unrelated (Mooney and Ryan, 1993).

The principal agent paradigm usually also involves the principal having no information on the agent’s actions, only on the outcome produced by the agent’s

actions (Sappington, 1991) and a given state of nature. The presence of this information asymmetry allows the agent to engage in opportunistic behaviour (Williamson, 1989; Mills *et al*, 2001). He is keen to pursue his own agendas and avoid extra effort in conducting the agreed tasks (Holmstrom, 1979; Arrow, 1986). He may, therefore, do little to bridge the information gap. The principal would ideally reward the actions of the agent but he doesn't know what these are. Two strategies are then available to the principal to solve the problem of asymmetric information:

- gaining extra information on the actions of the agent through monitoring (Holmstrom, 1979).
- designing the contract to provide optimal incentives.

In deciding whether or not to monitor an agent's actions, the perceived costs and benefits need to be compared. While information can be useful (Dewatripont and Maskin, 1995) too much may be problematic particularly where there is data "garbling" or inconsistencies (Gjesdal, 1982; Rajan and Sarath, 1997) or where there are no incentives for the agent to tell the truth (Maggi and Rodriguez-Clare, 1993). Where there is more than one agent, monitoring may become easier as the principal can compare the outputs of each agent, under the same conditions, and reward appropriately (Holmstrom, 1982; Dewski and Sappington, 1984; Ma, 1988; Ma, Moore and Turnbull, 1988; Gupta and Romano, 1998). Nevertheless, where only team outputs are observable there may be an incentive for some agents to free ride (Dixit, 1999).

If monitoring of an agent's actions is too costly, then the principal must reward the agent according to the outcome of his actions (Hart and Holmstrom, 1987).

Nevertheless, the agent's action is only one component that affects the observed outcome. Other factors in the environment may also affect what happens and thus uncertainty creeps into the contracting relationship. The agent faces the risk that the outcome is compromised by the environment, despite his best efforts. The more observed performance is the basis for payment the more risk will be carried by the agent (Sappington, 1991; Hammer and Jack, 2000). Contracts may need to take into account the attitude of each party toward risk. According to Shavell (1979), if the agent were risk neutral – indifferent to the presence or absence of risk - the principal would retain a fixed amount and the residual (conditional on the outcome) would be

given to the agent, a franchise arrangement (Sappington, 1991). The agent would thus bear all the risk, with no dilution of incentives. Such a solution is not optimal, though, if the agent is risk averse, i.e. willing to lose some of his expected pay-off in order to have lower risk (*ibid*). In general, the fee will be a function of the outcome, in order to supply incentives, but the risk will be shared (Shavell, 1979). Where the agent's action is observable a two-stage incentive structure is then useful (see for example Hammer and Jack, 2000): a constant component (so that all desired agents participate) and a variable component related to the agent's efforts against a yardstick.

The case of multiple principals has also been examined in the literature (see Bernheim and Whinston, 1986; Holmstrom and Milgrom, 1988 and Dixit, 1997). In the simplest case one agent has two principals with separate objectives. This may blur incentives for agents, especially where the tasks of the agent specified by each principal are not complementary (Holmstrom and Milgrom, 1990 and 1991). Yet this may be a common occurrence in public sector environments where there may be a variety of agency relationships within and across institutions (Dixit, 1997). It has also been proposed that the prospect of a relationship over time may improve the effort of the agent and the behaviour of the principal. This occurs because agents cannot continually hide their inactivity by appealing to bad luck for poor outcomes (Radner, 1995). The promise of future rewards, beyond the existing contract, may also be an extra incentive (Holmstrom, 1982; Gibbons, 1997). Finally, a principal will risk gaining a bad reputation if he does not pay the agent appropriately and this will prejudice future contracts (Dixit, 1999).

3.3.2 Applications

There are a wide variety of applications of principal agent theory: the vertical integration of firms; employer-employee relationships; owner-manager interactions; policy maker and bureaucrat; regulator and firm interactions; landlord and tenant contracts, doctor-patient relations; citizens and their agents in government (Klitgaard, 1988; Perry, 1989; Holmstrom and Tirole, 1989; Riordan, 1990; Sappington, 1991; Mooney and Ryan, 1993; Coast, 2001, amongst others). Some of these deal with explicit contracts between parties while others deal with implicit contracts within

organisations or society. For instance, in the health sector the principal agent relationship has often been used to analyse the relationship between doctor and patient, even though no formal contract exists between the two (Mooney and Ryan, 1993). Further, Dixit (1999) has tried to explore the interactions in government hierarchies through the principal agent lens even though there are rarely formal contracts for specific tasks, while Public Choice Theory has explored the relationship between politician and bureaucrat (Jensen, 1983). Additionally, no formal contract exists between citizen and government, though there is much discussion of it in political philosophy (after Rousseau, 1935), whether it is in relation to policy makers, members of parliament or civil servants. Principal agent theory has also been used to analyse these relationships (Mooney, 1998; Coast, 2001).

In some ways, the utility of agency theory in application is unclear. Holmstrom and Tirole (1989) note that formal principal agent models often do not provide predictions that can be tested empirically. Stiglitz (1987) adds that predictions from incentive theory are often not borne out. Further, optimal contract design is often difficult. Finally, modelling of anything beyond the two-party case is difficult and somewhat esoteric. For instance, Jensen and Meckling (1976) see the firm as a nexus of contracts, while Savedoff (1998) characterises hierarchies as constellations of principal agent relationships. Little progress has been made to model such viewpoints.

Yet the basic *insights* of agency theory: the presence and effects of information asymmetries on behaviour, the importance of incentives and the need to counteract strategic behaviour has invited many applications. In application there has also been a relaxation of assumptions to improve relevance⁴. First, the nature of incentives facing the agent has been explored. In some applications of the principal agent paradigm there is overlap of interests between a doctor and a patient (Evans, 1984, Mooney and Ryan, 1993) and a citizen and health sector manager (Coast, 2001). Further, incentives may neither be pre-specified nor material, as in agency's traditional formulation. For instance ideological values, professionalism and career advancement are all possible drivers of behaviour for agents (Wilson, 1995; Dixit, 1999 and

⁴ Kiser (1999) argues that agency theory becomes more fruitful when the traditional economic parsimony is jettisoned.

Dewatripoint *et al*, 1999)⁵. In political science additional motivating factors in agency relationships include psychic costs of misbehaviour, as well as power, glory and serving a good cause (Banfield, 1975). In sociological applications, culture may also be an important driver of motivation (Hamilton and Biggart, 1985). Health sector actors engaging to develop policy may have a variety of motivating factors from interest in the policy, to gaining utility in participating in policy development and interest in blocking the policy (see later sections). Understanding the range of motivating factors and incentive structures would appear to be key to developing effective policy.

3.3.3 Key Elements of Principal Agent Theory for Managing Actors

In relation to the issues raised in Box 3.1, the key insights for principal agent theory are as follows:

- **Relationship type** – Traditional principal agent theory is restricted to analysing formal contractual relationships where interests are independent. Yet more recently there has been a move to understand implicit contracts where interests may overlap.
- **Compatibility of Objectives** – Traditionally the interests of principal and agent are independent and financial incentives are required to motivate the agent. In more contemporary applications such assumptions are relaxed with agents deriving motivation from a variety of different sources. Nevertheless, in both forms, agents must be faced with incentives that guarantee they will not only participate but also work in the interests of the principal, or reform driver.
- **Constraints to Action** - The principal needs or wants to hire the agent to conduct tasks because of his own limitations. He is also concerned to attract the right kind of agent who will work productively. Nevertheless, there is an information imbalance between the principal and the agent and the former is only indirectly aware of the efforts of the latter.

⁵ For critiques of the narrow focus of neoclassical economics on outcomes or goods as being the only source of utility see Hahn (1982) and Margolis (1982).

- **Incentives available** – The theory emphasises the importance of getting the incentives right as a key condition for participation in the contract and effective cooperation (guaranteeing sufficient effort from the agent). Traditional theory relates to financial incentives. More recent principal agent theory highlights non-monetary forms of incentives derived from participation in the process, as well as the outcome of the reform and effort incurred. Hence, the driver of the reform needs to understand the incentives facing each actor in order to be able to respond strategically and alter incentives to produce better outcomes. There are problems with incentives when contracts cover more than one principal and more than one agent. The multiple principal models show that incentives for agents may be particularly weak where there are competing demands from different principals. Further, risks associated with a team of agents relate to the problem of free riders and need special incentive structures.

The theory notes that the promise of future rewards (whether it be a better reputation for the principal or further contracts for the agent) can be a motivating factor to improve current behaviour. Consequently, fewer current incentives may be required to motivate good behaviour. Thus the prospect of interactions over time may tend to improve incentives for agents and principals to cooperate with each other.

- **Uncertainty and Risk** – The principal faces uncertainty as he is not typically aware of the agent's efforts, and thus may not know how to reward the agent appropriately. He can try to reduce the information asymmetry using monitoring but this is often costly and he may have difficulty interpreting the monitoring information. The risk of a less than desirable outcome to the contract is usually shared between the parties through the specification of the pay-off (with a fixed and variable component).

3.4 Theory of Transaction Costs

3.4.1 Basic Description

While agency theory offers some potential insights it also has weaknesses. Most notably it ascribes all contracting costs to the cost of *observing* variables while ignoring all costs associated with *developing* and *renegotiating* contracts which may be substantial (Coase, 1960; Williamson, 1989; Deakin and Michie, 1997; Mills *et al.*, 2001). In response the transaction cost approach pioneered by Williamson (1975) focuses on the costs of exchange and their implications for organisation. The approach has its roots in the analysis of law, economics and organisations in the 1930s (Williamson, 1989). This stream of thought maintained that exchange is costly (Coase, 1937) and transactions, rather than production, should be the key focus of economics (Commons, 1934)⁶.

Transaction costs appear, first, because parties must act under conditions of bounded rationality (Williamson, 1989). Neoclassical economics assumes that individuals are fully informed and fully rational. Agency theory adds an information imbalance, so that the principal is no longer fully informed based on his inability to monitor the agent and the agent's unwillingness to tell the principal what is going on. Bounded rationality goes further in its restrictions on information availability. The theory assumes that there are inherent limitations on the ability of humans to have complete information not only about what the current situation is (Braybrooke and Lindblom, 1963) but also, more importantly for contracts, what the future will hold. March and Simon (1958) note that:

"Choice is always exercised with respect to a limited, approximate, simplified 'model' of the real situation." (p139)

Information is limited. Koopmans (1957) notes uncertainty may be due both to the uncertain state of nature and failure of parties to communicate. Consequently, contracts can never be fully complete, in that they cannot specify everything that

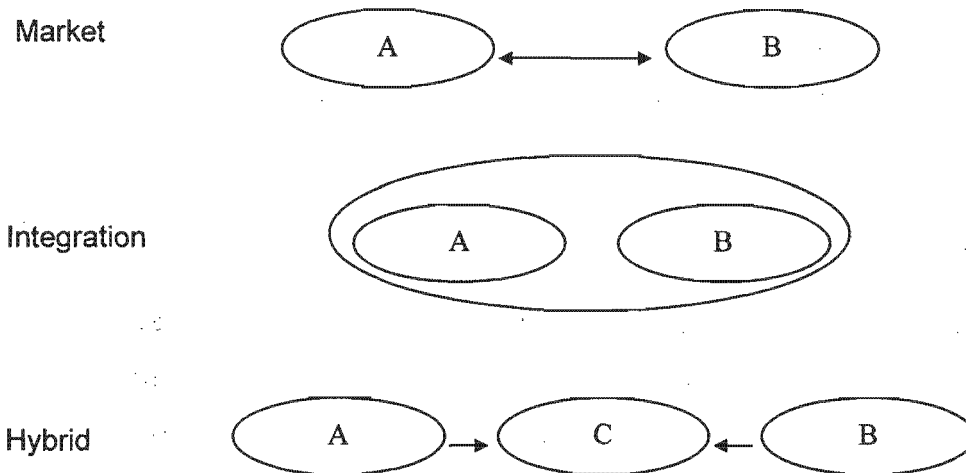
⁶ Indeed, North (1990) maintains that a significant portion of economic activity in industrialised countries is made up of transaction costs.

might happen (Hart and Moore, 1988; Noldeke and Schmidt, 1995). Still, bounded rationality maintains that actors will behave rationally according to the information that they have (Simon, 1961; Klein, Crawford and Alchian, 1978; Williamson, 1985). The supply of information to both sides is therefore critical to behaviour.

The other element of the transaction cost approach is that bounded rationality opens up the possibility of strategic behaviour, or “guile” (Williamson, 1989; Deakin and Michie, 1997). Thus not only is there insufficient information but parties may engage in distortion of information and strategic activities based on information scarcity and imbalances (*ibid*). Such unproductive behaviour may be important for extracting rents in renegotiation. This is sometimes referred to as the “hold-up” problem (Goldberg, 1976; Perry, 1989).

Transactions cannot happen in a costless way. To a greater or lesser extent there is evidence of market imperfections. Costs may be incurred in relation to seeking an agent, drawing up a contract, monitoring the contract, taking sanctions where necessary, preparing for renegotiation and engaging in strategic unproductive behaviour (Dahlman 1979; Coase, 1988; Mills *et al*, 2001). The theory of transaction costs examines how institutions respond to this problem, drawing implications for organisation and efficiency. Diagram 3.2 outlines the different reactions of parties to transaction costs. The first form is that of the *market* where separate institutions exchange but experience transaction costs. In response the institutions can offset informational imbalances, process costs and strategic behaviour either by absorbing the other party, by *integration*, or by creating a new distinct organisation, a *hybrid*.

Diagram 3.2: Representation of Williamson's Forms



Adapted from Williamson (1986)

One claim of the literature is that the risk of the contract falling apart will make both sides cautious about investing in a market-based relationship, a natural response to risk (Heckathorn and Maser, 1987; Deakin and Michie, 1997). Alternatively, Coase (1937) suggests that firms will act to internalise transaction costs where the costs of organising internal transactions are lower than through a market exchange (p55). Indeed, where a long-term relationship is envisaged it may well be wise to attempt *integration* i.e. absorb both parties into one organisation, so to reduce the risks of information failure and strategic non-cooperation (Williamson, 1975; Riordan and Sappington, 1987; Riordan, 1990). Integration allows the development of a common corporate culture that may ease the resolution of unforeseen problems (Holmstrom and Tirole, 1989; Kreps, 1990). Nevertheless, there may still exist information barriers and strategic behaviour even with integration, due to persistent divergent interests (Olsen, 1996), see also section on *Collaboration*. Williamson (1986) provides another possible response to transaction costs: hybrids or networks. In effect, this creates a new organisation to act as the forum for liaison and activity of the two parties (Buckley and Chapman, 1997). The internal rules of management and organisation will be critical for the effective performance of this organisation.

The other strategic response to the problem of transaction costs is to develop trust between the different parties (Tirole, 1986; Coulson, 1998; Offe 1999; Moore 1999b;

Taylor-Gooby, 1999; Deakin and Michie, 1997; Mills *et al*, 2001). Trust is quite an elusive concept (Landa, 1998). Gilson (2003) reviews the broad literature outlining several approaches. Applying the concept to transaction costs, trust involves individuals and institutions suspending their opportunistic behaviour to build up trust and secure better long-term goals. This application of trust is based on self-interest and involves calculation of costs and benefits (Lyons and Mehta, 1997). Thus trust tends to minimise immediate strategic behaviour and so reduce the need for monitoring. It also helps promote effective communication, limiting the prospect of strategic actions behind a veil of ignorance.

3.4.2 Applications

Unlike agency theory, the transactions cost literature is less concerned with formal mathematical models⁷. Its focus on institutional forms makes it difficult to specify mathematical models of behaviour (Deakin and Michie, 1997; Williamson, 1996). Perhaps because of this there have been fewer areas of applications than with agency theory. Key topics which have been examined through the lens of the transaction cost approach are industrial policy and integration; buyer-seller negotiations; employer-employee relationships and contracting out of services (Williamson, 1975; Jensen and Meckling, 1976; Hart and Moore, 1988; Dewatripont, 1989; Laffont and Tirole, 1990).

Important insights from the transaction cost approach are that exchange of products, skills, information and time are not costless. Likewise developing policy and managing other health sector actors is not a costless process for a reform driver. The act of negotiating agreements and dealing with the strategic behaviour from other actors may absorb considerable resources. The transaction cost approach offers insights into the strategic response of a reform driver. First, the reform driver can develop contracts with individuals or institutions for the provision of certain services to help policy development (market). Second, it can employ individuals, with the required skills to counteract transaction costs (integration). This is, in effect, a general

⁷ A notable exception is Williamson (1989)

contract and reduces the cost of contracting out every task that is required (see Simon, 1991). However this may be difficult for government reform drivers because of limited resources and uncompetitive salary scales. Alternatively, it can formulate committees or working groups to develop policy, involving a range of health sector actors (hybrid). The choice may depend on the level of trust, the alignment of goals and perceived threat of transaction costs. The literature implies that informal ties and policy processes are better suited to trusted actors.

3.4.3 Key Elements of the Theory of Transaction Costs for Managing Actors

The transaction cost literature offers the following insights to the issues highlighted in Box 3.1:

- **Relationships** – The theory usually relates to formal contracts but also introduces the idea that contracts are incomplete and costly to maintain and that other features of relationships, such as trust, must underpin contracting.
- **Compatibility of Objectives** – The alignment of interests isn't specified. Nevertheless, the more closely aligned are interests the fewer the transaction costs.
- **Constraints to Action** – Actors have only limited information available on which to make decisions. Some transaction costs will arise in communication between parties, information gathering and planning. Other transaction costs will be the result of more strategic behaviour. Hidden from view by limited information, actors will try to claim more resources and power.
- **Incentives available** – These are assumed to be built into the contract or negotiation about future contracts. Typically the incentives are taken to be financial. Key disincentives are the costs associated with the contracting process and the threat of the contract falling apart. The prospect of future contracts produces both the threat of additional transaction costs and the promise of future rewards.

- **Uncertainty and Risk** - Actors will act rationally with the information they have (bounded rationality). The supply of information between parties becomes critical to behaviour and both sides may use information imbalances for strategic behaviour in renegotiation of contracts. The risk of future contracts falling apart may mean that both sides do not want to invest in the relationship. Nevertheless, an important strategic response to transaction costs, uncertainty and risk may be:
 - The development of appropriate organisations through integration or the creation of hybrids. Often constrained resources in the public sector may make hybrids more attractive.
 - The development of trust between parties. This is most effective where the trust has been derived from common values, a history of interaction and interpersonal ties. It is not restricted to those whose interests align but may be stronger for it.

3.5 Collaboration

3.5.1 Basic Description

Collaboration theory evaluates cooperative practices between institutions.

Contemporary management theory (DePree 1989, Nanus 1992) suggests that contracts between individuals and groups are at best limited. As DePree notes they induce “an atmosphere of spiritual mediocrity”, involved as they are with issues of conditions and compensation (see earlier sections). In contrast, a “covenant” type agreement involving both *shared vision* and a *stake in the process and outcome*, can encourage participation and commitment. Such a collaboration can potentially lead to a better product (Huxham, 1996b). In the ideal, collaboration produces something beyond what could have been produced had the parties been working in isolation. This is referred to as ‘collaborative advantage’ by Huxham (1993, p603). Specific benefits from collaborations can relate to: the completion of a task, the resolution of conflicts; the achievement of sufficiently strong power-bases; increased legitimacy and the empowerment of communities, (Pettigrew, 1977; Eden, 1996; Huxham, 1993; Barr and Huxham, 1996).

Huxham (1996b) provides the following definition of collaboration:

“ ‘collaboration’ is taken to imply a very positive form of working in association with others for some form of mutual benefit.” (p7)

There are a variety of collaborative practices from which to choose (Cropper, 1996). Himmelman (1996) claims that collaboration can range from sharing information to altering activities, sharing resources and enhancing the capacity of one another.

Common reasons for collaborating are listed below. It is interesting that material incentives do not usually feature in voluntary collaborations, but they may be a factor where institutions are mandated to collaborate.

- *Collaboration as resource-sharing or resource-augmentation* - There are many types of resources which can be shared. As well as finances, actors may bring to a collaboration information or expertise or even credibility and legitimacy (Challis *et al*, 1994; Cropper, 1996; Pettigrew, 1977). Alter and Hage (1993) claim that the need for expertise and the sharing of risks is one of the key drivers of collaboration between organisations.
- *Collaboration as a means to minimise transaction costs* - By creating trust across parties, through collaboration, the costs of strategic behaviour in negotiations may go down and improve the efficiency of policy development (Williamson, 1986; Cropper, 1996). Further, the longer such collaborations exist the more they reduce transaction costs as parties learn to trust and work with each other (Thrasher, 1983). Nevertheless, establishing and maintaining an effective collaboration may also be costly (Cropper, 1996; Huxham 1996a). Hence collaborations may also be subject to transaction costs.
- *Collaboration as control* - While collaboration is often viewed as partnership (Himmelman, 1996) it also can be used to control other parties (Challis *et al*, 1994; Rhodes, 1981). Some control, as coordination, may be justified since there may be specific problems, to solve and tasks to be performed. Often government

planning bodies must exercise such control in pursuing objectives, allocating resources and implementing programmes (Green, 1992; Glennester *et al*, 1993).

“..coordination is not merely a neutral technique. It can be a crucial element of any strategy to overcome - or to enhance - the bias in favour of dominant interests and ideologies which is inherent in...every... system of government. Coordination is itself about power and the purposeful use of power.” (Challis, *et al*, 1994, p184)

Conversely, while collaboration is about working with some actors it is also about excluding others. The aim of this is to isolate opposing actors, controlling their access to resources and power.

Nevertheless, collaboration can slip into inertia, where forward progress is extremely slow (Huxham, 1996a). This may happen for several reasons:

- *Differences in visions, power and culture* – The more dissimilar the parties the more difficult it is to agree on appropriate action and the means of coordination (O’Toole, 1996);
- *Tensions between autonomy and accountability* – Each of the members needs to account for his actions to his base organisation. At the same time, each member will have his own views and values which he wishes to put forward on top of those that he is mandated to bring to the committee as a representative of another institution.
- *Time needed to manage logistics* – Given the separate work places of all members, meetings cannot be called immediately and communication is not straightforward.
- *Protection of Turf* – Organisations may view that they have an “exclusive domain of activities and resources” (Bardach, 1996, p177) that they do not wish to share for fear of: loss of job security; challenges to professional expertise; loss of policy direction; undermining of self-worth and credibility, and undermining of

traditional practices. Focussing on new turf to be gained through the collaboration and the importance of end-goals may help, as will good interpersonal skills.

- *Barriers to Information Exchange* - There may be processes for screening information (Steinbruner, 1974) or standard operating procedures (Allison, 1971) for making sense of information and relaying it. These processes are to help decision-makers make satisfactory judgements when faced with limited time and resources (March and Simon, 1958). Important points to note are that there must be an investment in such systems for them to work and that these systems might *impede effective coordination* by making direct information exchange more difficult (Challis et al, 1994; Arrow, 1974). The more refined such systems are with esoteric language and symbols the more difficult is open and unambiguous communication.

3.5.2 Applications

Collaboration theory's major focus on the general determinants of effective cooperation, has invited a range of applications. These include government and non-government actors in policy development and implementation; internal government cooperation; empowerment of communities and NGOs; management of political issues, agendas and power among competing factions and management of human resources in a firm (DePree, 1992; de Jong 1996; Himmelman, 1996; Eden 1996, Bardach, 1996). As noted earlier, collaborative relationships may be important in the development of health financing reform as reform drivers engage with other health sector actors both within and outside of government. Particular insights of this body of literature may relate to:

- **Augmenting resources**

Reform drivers seldom have the capacity to push forward reform by themselves. For instance, government rarely has the resource base to incorporate the extra technical resources it needs (see Gilson and Thomas, 2003). Reform drivers may well pursue collaboration in relation to augmenting their own resources to develop health

financing reform. Governments may collaborate with other actors on the basis of their perceived *characteristics*⁸. As issues and the environment change then the characteristics that the actors have may be less desirable or may change. Just as there are different purposes for pursuing collaboration there will be different characteristics needed for each task. Hence continued collaboration is not always necessary or good. The essence of effective government may well be change and adaptability (Selznick, 1957) and collaborations will come and go.

- Barriers to information exchange

By entering into a collaboration actors must learn different methods of communication. They must also act as representatives of their base organisations and provide communication back and forth between the collaboration and their bases. There is, therefore, significant potential for information to be distorted even where actors are attempting genuine communication. Where they are not there is ample opportunity for strategic behaviour.

- Conditions for successful collaboration

When government enters into collaborative practices with non-governmental institutions, it is often difficult for it to be an equal partner (Raelin, 1980; De Jong, 1996). “Weaker” partners may feel more exposed and may be less willing to share resources. In contrast, government may find it easier to get its own way by being heavy-handed and authoritarian. Conversely, in genuine collaboration, the government risks losing control of policy direction if it is an equal partner. Yet, it risks undermining the value of collaboration by exercising too much control. Arguments around whether or not to collaborate are summarised in Table 3.1.

⁸ Similarly, Lancaster (1956) explored the notion that consumers purchase goods not for the goods themselves but for the characteristics that such goods have for the particular consumer.

Table 3.1: Choosing when to collaborate

For	Against
<ul style="list-style-type: none"> • Harnesses broader technical expertise than may be available in one organisation. • Helps create consensus. • Helps create participation in and ownership of the reforms. • Allows blame to be shared between the parties if it goes wrong or is unsuccessful (also collaborative organisation might possibly be used as a scapegoat). • By harnessing all the resources of the collaborating institutions it may achieve something greater than would have otherwise been the case (whole is greater than the sum of the parts). 	<ul style="list-style-type: none"> • Collaboration tends to be slow (because of difference in cultures between organisations and questions of accountability between the collaboration and each of the represented parent organisations) • Government may lose control. (By creating partners of other institutions, government can no longer dictate the agenda) • Collaboration is unlikely to work where major interests conflict (best to have shared or similar visions). • Collaboration often eats up money, because it is slow and unwieldy.

Sources: Raelin, 1980; De Jong, 1996; DePree, 1992; Himmelman, 1996; Eden 1996, Bardach, 1996; Challis et al, 1994; Cropper, 1996; Alter and Hage, 1993; Huxham, 1993

In summary, the more important are consensus development and technical resource augmentation and the less important are time and funds, the more *useful* collaboration can be. The more similar the visions, objectives and cultures of the organisations the *easier* collaboration will be and the greater the potential for more sophisticated collaborative arrangements. This is not to say that collaboration and control cannot proceed hand-in-hand but it is less clear what factors determine that balance. The art of collaboration for government may well be in knowing under what conditions it can “control” to good effect and when it should let collaboration run free.

3.5.3 Key Elements of Collaboration Theory for Managing Actors

In relation to the issues raised in Box 3.1, the key insights from collaboration theory are:

- **Relationship** – The theory focuses on informal cooperative activities such as information exchange, coordination of activities, sharing resources and enhancing each other's capacity to achieve common purposes. Effective collaboration is founded on trust, shared values and good communication.
- **Compatibility of Objectives** – Usually interests align toward a common general purpose for the collaboration. Collaboration is much more difficult where interests compete. Nevertheless, collaborations can be useful for controlling other actors. Those actors invited into collaborations can be guided toward certain activities, views and outputs that are favourable to the convenor. Those outside can be excluded from positions of influence in policy development.
- **Constraints to Action** - For reform drivers, collaboration may be a critical means of augmenting constrained resources for policy development. By collaborating with other actors reform drivers can gain or strengthen their reform development characteristics, such as technical knowledge, power and credibility. Yet collaborations can also be slow and costly, as a result of a failure to communicate and concerns about turf protection. Conversely, collaborations work best where there is equal power and similar organisational cultures across all parties.
- **Incentives available** – These typically relate to the likely outcomes of collaboration such as the achievement of a common purpose, augmentation of resources, limiting transaction costs, controlling other actors and disempowering others. There is occasional use of financial incentives where the collaboration is compulsory. The key disincentive is usually the collapse of the collaboration (where the collaboration is voluntary) or punishment for non-cooperative behaviour (where the collaboration is mandatory). Incentives over the long run are not a focus of the theory, as collaborative activities are often limited to the task at hand.
- **Uncertainty and Risk** – Collaboration aims to both reduce uncertainty by bringing organisations together and reduce the risk of failure for a reform driver through cooperative activity. Still, internal information processing for each party

may make information exchange problematic and create information imbalances and uncertainty. A reform driver may risk losing control of a policy through collaborative activity. Also if the collaboration drifts into inertia the reform driver risks not completing the policy development.

3.6 Game Theory

3.6.1 Basic Description

Game Theory is a branch of mathematical analysis developed to study decision-making in situations of conflict (Krippendorf, 1986). It attempts to model interactions, potential strategies, best possible outcomes and the effects on behaviour of different kinds of rules (Gibbons, 1992). It analyses strategic interactions between parties in a situation of competition for resources (Aumann and Hart, 1994) and explores pre-conditions for cooperation and conflict (Krippendorf, 1986).

A game is defined by Hargreaves Heap and Varoufakis (1995), drawing on von Neumann and Morgenstern (1944), as

“any interaction between agents that is governed by a set of rules specifying the possible moves for each participant and a set of outcomes for each possible combination of moves.”

The typical representation of a one-off game, with complete information, includes a specification of the players, strategies available to them and pay-offs for each combination of strategies that could be chosen. Significant effort is devoted in the literature to identifying in each game the best possible outcome, or equilibrium endpoint. This is termed the Nash Equilibrium. This is where each player's predicted strategy must be that player's best response to the predicted strategies of the other players. Hence, the optimal strategy for each player is to assess the optimal strategy for the other and choose the best action in response. Nash (1950) showed that in any finite game (i.e. a game in which the numbers of players and the strategy sets are all finite) there exists at least one Nash equilibrium. While a game can have multiple

Nash equilibria, where there is only one solution that must be a Nash equilibrium (Gibbons, 1992).

There are different *types* of games that can be modelled (Gibbons, 1992) and these relate to:

- *Each player's knowledge of the payoffs of the other* - Here payoff refers to the rewards for different outcomes. Where each player's payoffs are common knowledge the game has *complete* information. If at least one player is unsure of his opponent's payoff function then the game is characterised by *incomplete* information.
- *The number of games played* - Where one round is played, only, the game is termed *static*. Where more than one round is played the game is called *dynamic*.

3.6.1.1 Incomplete Information and Beliefs

For games with incomplete information there is no common knowledge and hence the *beliefs* of each party about other players' pay-offs are extremely important in that they will determine the strategies developed (Kreps and Wilson, 1982). One of the interesting features of games of incomplete information is their focus on strategic information exchange and its effect on belief. In *signalling* games there is communication from informed to uninformed players, about either a player's type (Spence, 1973,) or pay-offs (Myers and Majluf, 1984). In this case, the message is assumed to be verifiable, and hence there is little point in being untruthful. The key factors which determine the likelihood of this information being transmitted are any *costs* associated with the signal and the *complementarity of interests* of the two parties (Gibbons, 1992). In confirmation, Myerson (1979) implies that for one player to find out accurately what the other player's pay-offs are it is best for him to make it in the other player's best interests to do so. One option is to reward the player according to his revealed preferences, thus guaranteeing accurate revelation.

The major distinction between *signalling* games and *cheap-talk* games is that in the latter the message is non-verifiable and non-binding. For the message in this case to be of use it must change the beliefs and actions of the player who receives it. This in turn requires that the goals of each actor are not diametrically opposed (or known to be) or the message will have no credibility. In a related point, Crawford and Sobel (1982) derive from their model the following results:

- The better the alignment of preferences the more communication can occur.
- Perfect communication can only happen when preferences are perfectly aligned.

3.6.1.2 Dynamic Games, Learning and Reputation

One of the key differences between static and dynamic games is the potential for actors to *learn* from the history of the game. Issues of threats and reputation then become important (see Kreps *et al*, 1982). The most effective way to force a desired action from another player is to administer the strongest *credible* punishment possible should the player not take that action (Abreu, 1988). This will involve the first player threatening to play the subgame-perfect Nash equilibrium⁹ strategy that yields the lowest payoff of all such equilibria for the player who deviated. The interesting thing to note here is that the first player must threaten to play a *subgame-perfect* Nash equilibrium if faced with deviation. This guarantees credibility. Threats and promises may imply costs and given this, credibility becomes even more important. Where credible threats and promises are made then future expected behaviour could influence current behaviour¹⁰. A related issue is the greater potential for cooperation that might arise through repeated interactions between players. Where there are credible threats or punishments for deviation it is more likely that it is in a player's best interests to collaborate (Axelrod, 1984).

Hence game theory suggests that perceptions about the pay-offs and behaviour types of other actors in the game are important drivers of action. Further, where there is incomplete information about these factors the flow of information between parties is

⁹ A Nash equilibrium is subgame-perfect if the players' strategies constitute a Nash equilibrium in every subgame or round.

¹⁰ There are various applications in economics which explore this, such as wage bargaining (Leontief, 1946; Rubenstein, 1982), duopoly (Stackelberg, 1934) and monetary policy (Barro and Gordon, 1983).

very important. This importance of information flow matches similar themes from earlier sections.

3.6.1.3 Evolutionary Game Theory

Nevertheless, there has been significant unease with some of the standard assumptions of Game Theory. While Kurz (1994) looks to Game Theory as an analytical device which can help fill the gaps left by the standard neoclassical model, others believe that standard Game Theory is undermined by its neoclassical type assumptions (see Hargreaves Heap and Varoufakis, 1995). First, Game Theory relies on instrumental rationality; agents are assumed to have completely ordered preferences and are able to know which options will yield different degrees of satisfaction. Yet ends may not be the only driving goal. Process utility or means may also be important (see earlier in the chapter). Further, Game Theory may ignore the multiplicity of utility types or forms. In this it has similar weaknesses to the traditional agency model (see earlier in the chapter). Second, the standard Game Theory approach may make overambitious claims on the rationality of agents. A controversial assumption in Game Theory is the "Common Knowledge of Rationality". This assumes that player A is rational and that player A knows that player B is rational and that player A knows that player B knows that player A is rational and so on. The purpose of this is to place constraints on people's expectations of each other's actions and so help Game Theory's predictions of outcome. Further players are assumed to have the same beliefs and therefore when presented with information will react the same. Standard Game Theory tries to get round such unrealistic presumptions by stating people are of certain types and that there are probabilities that people are from each type, so that predictability can be maintained in some form.

In the face of such extreme assumptions Evolutionary Game Theory has been developed derived from Maynard Smith (1982) to provide a more realistic picture of choice. This has the players adjusting their behaviour on a trial and error basis towards the action that yields the highest pay-off. In effect players blunder about and while they may learn from experience in a rational way, they may also have

idiosyncratic initial beliefs (Hargreaves Heap and Varoufakis, 1995). Further the social context may well affect the initial beliefs, ability to learn and/or provide direction toward a specific end-point (Schelling, 1960). Instead of Nash equilibria, in Evolutionary Game Theory there are Evolutionary Stable Strategies (ESS). The selection of one ESS over another embodies a convention and may be determined by the social context (Lewis, 1969). Hence identical games in different social contexts may yield very different conventions. Consequently, an analysis of a game must be based on its context, prevailing conventions, the beliefs of players and their ability to learn, as much as an understanding of pay-offs and potential options.

3.6.2 Application

There has been a wide variety of different applications of standard Game Theory in economics-related areas, ranging from entry regulation to markets; industrial competition and the duration of coalitions to public-sector decision making; leadership in government institutions and civil law disputes (for instance Greenberg, 1994; Kurz, 1994; Kim, 1996; Koremenos and Lynn, 1996; Kim, 1997; Sutton, 1997). The application of game theory to assessing leadership in government by Koremenos and Lynn (1996) is especially illuminating. In particular, the authors examine what impact leadership has on whether other actors in a government hierarchy will cooperate or not. Their formulation of cooperation and non-cooperation is interesting, particularly in relation to previous sections on the viability of collaboration type mechanisms versus more contractual methods of management.

- *Cooperation* concerns behaviour that is dedicated to fulfilling the organisation's broad missions and that is characterised by openness, trust and forthrightness. It is potentially risky because it exposes an actor to exploitation by other actors who are noncooperative. For leaders it means delegating authority, when appropriate and for subordinates it requires the use of discretion and to meet the goals as well as full disclosure of facts and decisions and activities.
- *Noncooperation* emphasises monitoring and control or formal procedural compliance. For those higher in the hierarchy this means retaining authority and

enforcing formal compliance through the threat of imposing sanctions. For subordinates it means a willingness to conceal information and misrepresent the facts (but not necessarily overt defiance)

The advantage of this classification is that it appreciates the subtlety of control or conflictual practices. Collaboration means going beyond the tasks set or the mechanisms imposed to being creative and fully open and accountable. The authors find that for the leader vision and credibility are key to cooperative practices in the organisation. Similarly Weimar and Vining (1996) emphasise the importance of managers or leaders selecting or identifying a focal equilibrium point and communicating this to subordinates (after Miller, 1992):

“An effective leader provides a vision of one of the desirable equilibria and communicates it to the members of the organisation. She thus facilitates effective coordination by giving members consistent expectations about each other’s behaviour. Symbols may play a role in creating the shared expectations; so too might the personal interaction achieved through ‘management by walking around’.”
(Weimar and Vining, 1996: p110)

In essence this may relate to the importance of convention and context highlighted by Evolutionary Game Theory. It may be the job of a good leader to develop certain conventions. In addition, the leader needs to solve the coordination problems necessary for the equilibrium strategy to be chosen by other actors. This may involve the leader developing a reputation for monitoring activities and enforcing punishments for uncooperative behaviour where necessary. However, as Bianco and Bates (1990) note where activities of actors cannot be monitored, leaders may struggle to meet these conditions (a finding not dissimilar to agency theory).

Turning to health financing reform development and the management of actors, Game Theory implies that there are critical qualities needed by those that lead. First, they must develop a vision of where they want the reform to go. Second they should guide other actors towards this using, and in turn establishing, conventions. To do this they must have credibility and may need a reputation for enforcing punitive actions where

there is non-cooperation. Third, monitoring where possible is important as part of the ability to steer actors toward the chosen vision.

3.6.3 Key Elements of Game Theory for Managing Actors

The insights Game Theory offers to the key issues in Box 3.1 are highlighted below:

- **Relationships** - Game Theory explores the nature of interactions between players under specific conditions and rules, often in competition for scarce resources. Nevertheless, it can be applied to different types of relationships. Evolutionary Game Theory helps look at culture, convention and learning ability to shape these interactions.
- **Compatibility of Objectives** – The interests of each player are usually assumed to be independent if not divergent, though the literature examines where interests can converge. In situations of leadership, vision and credibility are important to guarantee cooperation and achievement of stated goals. This may require communicating desired equilibria, providing appropriate incentives, enhancing capacity and creating credible reputations for punishing uncooperative behaviour.
- **Constraints to Action** – The choices available for actors are specified by the rules of the game. Standard Game Theory does not explore issues around constraints, taking them as given. Evolutionary Game Theory stresses the importance of social contexts, conventions and learning ability and these factors may be more helpful to understanding the different constraints on actors.
- **Incentives available** – Pay-offs are available for choices of action dependent on the behaviour of opponents. Different types of incentives are implicitly considered but are lumped together to form one pay-off for each option. Disincentives relate to the threat of punishment for uncooperative behaviour.

Over repeated interactions incentives may change. In standard Game Theory prospects of repeated interactions increase the likelihood of cooperation, rather than conflict, particularly where there are strong and credible threats of punishment for deviation and where actors are able to learn. In Evolutionary

Game Theory, learning may be constrained by context, convention and idiosyncratic beliefs.

- **Uncertainty and Risk** - One of the advantages of Game Theory is that it tackles head-on issues around *uncertainty* about goals and behavioural types of each actor. It stresses the importance of players' beliefs about pay-offs and types to identify action. Strategic information exchange, as it affects belief about goals and types, is important, but may be constrained by costs, verifiability and divergent interests.

3.7 Comparison of Theories

The selected four bodies of literature presented have important similarities. They all address issues of relationships between players or agents and the form which such relationships may take to achieve certain goals. They focus on issues of motivation and information and the effects these factors have on the behaviour of the actors in the relationship, whether strategic or collaborative. While the theories are consistent with a new institutional economic approach they are not bound by the narrow confines of self-interest and rationality. This provides them with a flexibility to be applicable outside the normal realm of economics, including the current task, developing a conceptual framework for managing actors. Nevertheless, there are important differences in the theories, for instance their understanding of rationality; their treatment of risk and their analysis of specific factors of motivation or incentives. It is important to explore such conflicts as they may provide further insight into the question of managing actors in reform.

Five key concepts were derived in Chapter 2, concerning the management of actors in health financing reform (see Box 3.1). Each body of literature has been reviewed with these factors in mind. In this section, I compare the insights from each. The results are summarised in Table 3.2, where the final column highlights what can be taken forward to the conceptual framework. The commentary below supplements Table 3.2 by highlighting common, complementary or divergent strands of argument between

the theories. This analysis is used as a foundation for developing the conceptual framework.

3.7.1 Types of Relationships

Each theory is suited to exploring particular types of relationship. Both Principal Agent Theory and Transaction Costs often relate to formal contracting mechanisms where interests are “independent” or unrelated. Still, both theories can be used to investigate more informal relationships through a contracting lens. Collaboration theory is best suited to examples of informal cooperative behaviour, though its insights into complementary power and culture for effective communication and interaction are relevant for contracting. Game Theory is a more general tool for investigating interactions between players based on rules and rationality (and culture and convention in its evolutionary form).

3.7.1.1 Implications for the Conceptual Framework

Reform drivers thus have a range of different types of relationships to choose from. The choice of these relationships may depend on shared values, trust and context.

3.7.2 Compatibility of interests

The full range of potential alignments of interest are presented by the four theories in Table 3.2, from conflict to cooperation. Game Theory starts from the premise of competition for, or conflict over, resources though it also examines conditions under which cooperation will occur on the basis of self-interest. The Principal Agent theory in its traditional form assumes independence of objectives. From this starting point various refinements have been proposed which explore what happens when interests overlap. In contrast, Collaboration theory assumes that collaborators must have a certain degree of convergence of interests for cooperation to be viable, but also explores what happens when interests conflict. Indeed, while the theories begin from different starting points they tend to converge on the same ground. Alignment of interests helps produce cooperative behaviour, foster trust and reduce the need for

additional incentives or over-formalisation of agreements. Divergence of interests may require more formal contracting and a greater emphasis on material incentives.

3.7.2.1 Implications for the Conceptual Framework

It will be important for the reform driver to evaluate how compatible the interests of other actors are with his own. This will help the reform driver in the appropriate choice of engagement.

3.7.3 Constraints to action

The theories have much to say about constraints to action and are largely complementary in approach, albeit with slightly different emphases. Both Collaboration theory and Principal Agent theory, to a lesser extent, note the limitations of the driver of reform¹¹. In Collaboration theory, augmenting resources is a key rationale for collaboration. Reform drivers seldom have all the required characteristics to take forward reform. Similarly, the hiring of the Agent by the Principal implies that the Principal is unable or unwilling to perform certain tasks. Hence in both cases, engagement with other actors is pursued in order to alleviate constraints.

The theories also note the limitations to which the reform driver is exposed as a consequence of engagement. The Transaction Cost literature assumes as a starting point that engagement with others is advisable for some perceived benefits. Its focus though relates to potential problems of that engagement, which are rooted in bounded rationality, i.e. uncertainty and imperfect information. Such concerns are echoed by the Game Theory analysis of incomplete information. Hence only some of the constraints faced by the party in isolation may be alleviated by engagement. The search in Agency Theory for appropriate incentives is also a recognition of continuing constraints in engagement, related to the lack of information available to the Principal on the Agent's effort and actions. Integration and/or the creation of hybrids are offered as strategies for alleviating problems by the Transaction Cost literature, as is

¹¹ This may also be implied by Game Theory in that choices are often limited and subject to the strategic intervention of others.

the development of trust. Collaboration theory supplements this with conditions to avoid the pitfalls of inertia in engagement. These relate to common vision, trust, similar cultures, equal power and sufficient authority of members for independence.

3.7.3.1 Implications for the Conceptual Framework

The reform driver must be aware of his own constraints in relation to the task ahead. He may choose to develop relationships with other actors to relieve these constraints and gain more resources, but must consider beforehand the compatibility of interests, resources and constraints.

3.7.4 Incentives

Three of the theories imply that moving from a one-off interaction to a longer-term relationship will affect the incentive structures required for cooperative behaviour. Hence in this section, and Table 3.2, I draw a distinction between present and future incentives.

3.7.4.1 Present Incentives

Getting incentives right is the essence of Agency Theory. It is both a condition for participation in any arrangement and the key to promoting productive behaviour. Yet, a full analysis of different *types* of incentives is missing in standard Game Theory, Transaction Cost literature and the traditional Principal Agent formulation. More recent developments of Agency theory in different disciplines reveal a whole range of different types of incentives for the agent (rather than just financial rewards).

Collaboration theory also suggests different forms of motivation as rationales for engagement. Drawing together the different incentives from each theory, the following categorisation can be developed:

- **Payment for participation in the relationship** – This refers to those things that are offered as an incentive for the party to participate in the relationship. Specific examples include finances, career advancement, power and glory (Agency Theory).

- **Value from the process of a good relationship** – This refers to the process utility gained from good practice in a relationship and may relate to professionalism, psychic costs of good or bad behaviour, prevailing cultural beliefs (Traditional and more recent Agency Theory).
- **Ethical value derived from the goal of relationship** – This relates to the psychic benefits of pursuing a cause that is of value to the actor. This may relate to ideology and serving a good cause (Agency Theory and Game Theory).
- **Value from the outcome of the relationship** – Expected benefit that can be got from the outcome or output of a relationship. Specific examples are bolstering resources, gaining information, expertise, credibility and legitimacy (Collaboration Theory).

Disincentives tend to relate to the promise of punitive action and/or the threat of the relationship ceasing, which can be related to the discussion of risk earlier. Game Theory notes the importance of credibility and reputation for enforcing such punishment as a disincentive to uncooperative behaviour.

3.7.4.2 Future Incentives

Principal Agent Theory and Game Theory concur that the prospect of future contracts, with associated rewards, may make both sides more likely to cooperate with one another. This may be sufficient to guarantee both sides behave well. Game Theory does add the proviso that there must be a credible threat of punishment for uncooperative behaviour and that the sides have reasonable reputations for cooperative behaviour. If the basic argument is correct then the implication is that fewer additional incentives are needed to guarantee cooperative behaviour over the long term, as a major existing incentive is future rewards.

The Transaction Cost literature notes an additional point. It implies that actually the prospect of future negotiations and contracts may actually increase the cost of bargaining and strategic behaviour in the present. Nevertheless, if trust can be developed this can solve such tensions and reduce the need for formal incentives.

3.7.4.3 Implications for the Conceptual Framework

The reform driver must consider what incentives are needed for different actors to involve them in reform and guarantee their effective participation. Different types of incentives may be necessary for different actors. The prospect of repeated interactions may lessen the need for incentives, but must be weighed against additional transaction costs. Repeated interactions may help players learn about each other, as players develop reputations for certain types of behaviour.

3.7.5 Uncertainty and Risk

All theories note that some or all actors face *uncertainty*. There are often imbalances in the holding of information between parties. Further, the flow of information between parties, or lack of it, is critical to beliefs and behaviour. Analysis of the *exploitation* of such information asymmetries by one actor is conducted in the Transaction Cost literature and the Agency literature. In contrast, Game Theory and Collaboration theory focus more on *conditions* for information transmission.

Problems that impede effective communication are noted as follows:

1. Goals may diverge or conflict (All theories, at least by implication)
2. Turf may be under threat (Collaboration Theory)
3. Lack of trust (Transaction Cost Literature, Collaboration Theory)
4. Messages may be costly to send (Game Theory)
5. Messages may be difficult to understand and require translation (Collaboration Theory)
6. Monitoring of other actors may be costly and must be worth it in terms of the improvements in output (Agency Theory)

The first three issues relate to the interests of the actors. Points four and five relate to problems with information exchange. Even where parties agree to reduce information imbalances there may be impediments to transmission.

The formulation and treatment of *risk* across the four theories is perhaps the least consistent and underdeveloped theme. Some theories relate risk to probability of an expected outcome, while others deal with risk of failure. The theories envisage risk both in relation to the outcome and processes of the relationship and specifically:

- Risk of the relationship failing to produce the desired outcome (Agency Theory, Collaboration)
- Risk of the relationship falling apart or becoming inoperative (Transaction Costs, Collaboration)
- Risk of others behaving badly in the relationship (Agency, Transaction Costs, Game Theory)

3.7.5.1 Implications for the Conceptual Framework

The beliefs of reform drivers about other actors are the foundation of engagement. It is important for reform drivers to discern the trustworthiness and values of actors. Where actors can be trusted and have similar objectives engagement will be easier, with better communication and information sharing. Reform drivers will want to minimise risk and this can be done by carefully choosing whom to engage with and the most appropriate form for, and rules of, that relationship.

Table 3.2: Summary of Key Elements of Theories and the Implications for the Conceptual Framework

	Principal Agent	Transaction Costs	Collaboration	Game Theory	Conceptual Framework
Types of Relationships	Traditional theory is restricted to analysing formal, legal contractual relationships between parties whose interests are independent. Nevertheless, there have been more recent applications that analyse implicit contracts between parties, where interests overlap.	The theory usually relates to formal contracts, but also introduces the idea that contracts are incomplete and that other features of relationships, such as trust, must underpin contracting	The theory usually emphasises the importance of informal relationships towards a common goal. This may take different forms: information exchange, coordination of activities, sharing resources and enhancing each other's capacity to achieve common purposes. Effective collaboration is thus founded on shared values, trust and communication.	The standard theory can be applied to different types of relationships. It has players acting within the confines of rules and rational choice on the basis of self-interest, knowledge or belief about pay-offs and the other player's type or likely behaviour. Evolutionary theory draws in notions of culture and convention and learning ability to shape the above relationships.	Reform drivers have a range of different types of relationships from which to choose, ranging from contracts to information sharing and coordination. The choice will depend upon alignment of interests, trust and effective communication. Formal contractual relationships may be better suited to conditions where interests do not align. Nevertheless, behind any formal relationships between reform drivers and actors there are informal issues of trust, context, shared values. These often shape the effectiveness of the relationship.

	Principal Agent	Transaction Costs	Collaboration	Game Theory	Conceptual Framework
Compatibility of Interests	In traditional theory the interests of principal and agent are <i>completely</i> independent. Financial incentives are required to motivate the agent. In more recent developments this independence is relaxed.	Not specified. The more closely aligned the fewer the transaction costs.	Most often a vision is shared even if precise objectives are not. Collaboration is much more difficult (more costly and slower) where interests do not align or even where they compete.	Interests are usually assumed to be divergent i.e. there is competition, but applied literature examines how leaders can make interests converge. This is done through communicating desired equilibrium; providing appropriate incentives, changing capacity, creating credible reputation for punishment	The compatibility of interests between a reform driver and actors will vary. The interests of each actor must be considered before engagement to ensure effective cooperation (see also incentives)
Constraints to Action	The theory assumes the principal needs or wants to hire the agent to conduct tasks, because of his own limitations. Yet, typically the principal is only indirectly aware of the efforts of the agent.	Bounded rationality places constraints on the knowledge of each party. It is impossible to plan for all circumstances and contracts are thus never complete. Consequently, resources are used up in developing,	Resource augmentation is a key reason for undertaking collaboration to strengthen the chances of success. This suggests that the collaboration convenor has insufficient capacity for the task at hand. Different cultures, objectives, languages,	Choices for action are prespecified, implying there are constraints or boundaries, but they are not typically explored in standard Game Theory. In Evolutionary Game Theory the prevailing context may explain the limited range of choices and conventions may place further restrictions on actions.	The reform driver must consider his own limitations in accordance with the policy that needs to be developed and the prevailing context. Developing a relationship with other actors may help augment resources and relieve constraints but the compatibility of other actors to the reform driver must also

	Principal Agent	Transaction Costs	Collaboration	Game Theory	Conceptual Framework
		monitoring and renegotiating contracts	management styles may make collaboration more difficult as will battles over turf. Also members may have limited authority in collaboration which may impede effectiveness (i.e. they need to report back to their home institutions)		be considered in terms of interests, resources and constraints. Also resources will be used in developing the relationship

	Principal Agent	Transaction Costs	Collaboration	Game Theory	Conceptual Framework
Incentives (Static)	<p>A key focus of theory is the importance of getting incentives right (key condition for participation and effective cooperation). Incentives are traditionally built into the contract and are material. Developments of theory expand the analysis to other forms of utility, such as career advancement, serving a good cause and professionalism.</p> <p>A key disincentive is the effort needed to participate in the contract to be balanced against the disincentive of the termination of the contract.</p>	<p>This is less of a direct focus. Incentives are built into the contract and negotiation process around future contracts. Incentives appear to be financial, but the importance of trust at least implies that other factors may determine behaviour and utility.</p> <p>Disincentives are either the costs associated with renegotiation of contracts or the threat of the contract falling apart.</p>	<p>Incentives usually relate to likely outcomes of the process of collaboration. There is occasional use of material incentives where the collaboration is compulsory. Specifically, rationales for collaboration are: achievement of common purpose; augmentation of resources; limitation of transaction costs; controlling some actors and disempowering others.</p> <p>The key disincentive is the threat of collapse of the collaboration. Occasionally mandated collaborations may have an implicit punishment associated with non-cooperation.</p>	<p>Incentives relate to pay-offs and how the behaviour of opponents will affect these. Different types of incentives are implicitly considered in the theory, but are lumped together to form one pay-off for each option.</p> <p>Disincentives most often relate to collapse of cooperation or punishment. Indeed, <i>credible</i> threats of punitive action for uncooperative action are extremely important in dynamic games in producing cooperative behaviour.</p>	<p>It is critical that correct incentives are offered to other actors to involve them in reform and guarantee their continued effective participation. Appropriate incentives will relate to actors' interests and how they coincide with those of the reform driver. Different types of incentives will be financial/material, outcome related and process related.</p> <p>Disincentives for reform drivers and actors may relate to the costs of developing and continuing the relationship, the direct costs of effort in developing the reform and the potential costs associated with the relationship falling apart.</p>

	Principal Agent	Transaction Costs	Collaboration	Game Theory	Conceptual Framework
Incentives (Dynamic)	The prospect of future contracts (and rewards) reduces the need for incentives for the agent and increases the likelihood of good behaviour by the principals to get a better reputation.	It is the prospect of future contracts which produces the threat of additional transaction costs but also the promise of future rewards.	Not really discussed. The lifetime of a collaboration may be limited to the task at hand. Specific collaborations, especially in the policy arena, may not be needed outside the medium term.	In standard Game Theory, there is more likelihood of cooperation with repeated games. Where actors learn, reputation for being trustworthy and credibility for punishing uncooperative behaviour will be important factors for dynamic interactions. In Evolutionary Game Theory players may not learn with repeated interactions because of prevailing context, conventions or idiosyncratic beliefs. This may weaken the prospect of dynamic cooperation	Repeated contracts or relationships affect incentives for actors. Likely future rewards need to be weighed against likely costs. Repeated relationships may lessen uncertainty about player's types, as they start to gain a reputation for certain forms of behaviour, where learning occurs.

	Principal Agent	Transaction Costs	Collaboration	Game Theory	Conceptual Framework
Uncertainty and Risk	<p>Uncertainty typically relates to the principal who is not aware of the agent's efforts. The latter may try and exploit this information imbalance. This may be countered through gaining extra information through monitoring but is seldom cost-effective.</p> <p>The risk of a less than desirable outcome to the contract is usually shared between the parties through specification of pay-off. The concept of risk relates to the idea of dispersion around a mean expected outcome.</p>	<p>Uncertainty is a product of bounded rationality. Both sides may use information imbalances for strategic behaviour in renegotiation</p> <p>The risk of future contracts falling apart may mean that both sides do not want to invest in the relationship. This can be countered by building trust or hybrids/networks</p>	<p>Uncertainty may be less of a problem as the parties are working together. This will depend on trust, turf and common objectives. Nevertheless internal information processing may make information exchange problematic and therefore produce information imbalances</p> <p>Parties may risk losing control of the outcome, depending on the goals and power of other actors. There is also a risk of collaborative inertia. This depends on: differences in power, vision and culture; logistics; turf; information processing and autonomy.</p>	<p>When faced with uncertainty, the theory stresses the importance of players' beliefs about pay-offs and types to identify action. It examines conditions for trading of information to alter these beliefs through messages. Conditions for effective communication are that messages are not costly to send and that there is an alignment of objectives</p> <p>Risk is not explicitly handled.</p>	<p>When deciding with whom to engage, the beliefs of reform drivers are important in relation to the type and likely behaviour of actors. Also the prior development of trust with other actors will help alleviate uncertainty and assist effective working together. Similarity of objectives will also help communication.</p> <p>Reform drivers may risk losing control of reform if they engage with actors with different goals and power of their own to influence the reform.</p>

3.8 Conclusions

The review of the four bodies of literature has provided much material for the conceptual framework. Key issues appear to relate to the importance of understanding the interests of different actors and being able to motivate them with appropriate incentives of different types to guarantee their effective participation in reform. Further, a reform driver will find useful engaging with other actors to benefit from their resources and in so doing to relieve his or her own constraints in taking forward policy reform. The type of relationship offered between the reform driver and the actor may be important depending on how closely interests match. In addition, the level of trust and the reputation of each party is an important foundation of an effective relationship. This is particularly the case in a dynamic setting, where repeated interactions and relationships may reduce uncertainty as actors and reform drivers learn from past interactions. Such learning may help the reform driver engage with reliable actors and choose the most appropriate type of relationship.

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Chapter 4: The Conceptual Framework

4.1 Introduction

In this chapter, I outline a conceptual framework that explores the decisions that a reform driver makes in managing actors in health financing reform development. Key features of the model are that it:

- Highlights strategic choices that face the reform driver.
- Isolates the key factors that will drive decisions on whether to engage with other actors and how best to manage that engagement.
- Explores a dynamic relationship between the reform driver and other actors.
- Assumes the reform driver behaves rationally in relation to available information i.e. that the reform driver will change beliefs and behaviour when presented with new credible information.

The framework draws on the key findings from previous chapters. Chapter 2 highlighted the deliberate nature of reform to achieve improved performance of the health sector. The reform driver must build support for his reform and deal with the likely opposition. At the same time he may be hampered by constraints, including a lack of resources and information. To inform the strategies available for a reform driver in this situation Chapter 3 interrogated several bodies of literature drawn from economics and management. The results of the comparative analysis, shown in Table 3.2, are particularly important to the development of the conceptual framework, as is the associated commentary. They allow a fresh theoretical perspective on managing actors.

The description of the conceptual framework is set out below. To help develop the rigour of the model, I also discuss, in the last section of the chapter, what empirical results the conceptual framework might predict or point towards. These are then tested against the actual experience of health financing reform development and the views of

key reform drivers (Chapters 7 and 8). On the basis of this, the usefulness of the conceptual framework can then be evaluated.

4.2 Description

The conceptual framework assumes that there exists a **reform driver**¹ who is responsible for change in health financing reform development. The reform driver proceeds to decide, and act, on how best to bring about this change by engaging with other actors, keeping in mind their goals and other characteristics. The stages of this process are outlined below. (Diagram 4.1 also provides a schematic representation).

First, the **reform driver** considers his goals in health financing reform development and determines necessary **policy tasks** for policy development. Such tasks will be affected by the **reform context**. Indeed, all the interactions between reform driver and actors take place within this reform context and may be conditioned by it. Specific policy tasks may also be affected by the demands or pressures exerted by other **actors**.

For each policy task, the reform driver needs to consider the set of **characteristics** available to get it done. These characteristics come from both the reform driver and other actors. Then the reform driver must consider how to combine these characteristics together through engagement. Under characteristics are included:

- the **resources** that each actor and the reform driver can bring to the policy task;
- the **constraints** faced by each actor and the reform driver in conducting the policy task;
- the compatibility of **interests** of each actor and the reform driver,
- the **reputation** and **trustworthiness** of each actor and the reform driver.

¹ Text in bold relate to the concepts shown in Diagram 4.1

Each of these characteristics is explored in more detail. First the reform driver must consider what **resources** are needed to take forward the policy task. This may include: technical skills; information or knowledge; ability to get the reform into legislation or through implementation; credibility or status, and financial or material resources. The precise resources required vary depending on the policy task ahead and the reform context within which it is to be done. The reform driver must consider these required resources alongside his own. From this he identifies his **constraints to action** i.e. his key weaknesses or deficiencies in characteristics to perform the required task. In the face of such constraints, he must look to other actors to augment his own resources. This will require a relationship with that actor for the policy task to be completed.

Nevertheless, before proposing a relationship with another actor the reform driver needs to review the characteristics of that actor. In particular, what negative characteristics will the actor bring to the relationship? Are there critical **constraints** that the actor faces? Are the actor's **interests** compatible with those of the reform driver? Does the actor have a good **reputation** for cooperative behaviour? Can the actor be **trusted**? The answers to such questions will determine whether and how to establish and manage a relationship. While an actor may have good technical skills he may also have poor credibility or he may even be opposed to the reform. Such characteristics may impede the progress of the reform. Hence an understanding of all the characteristics that an actor has with reference to the task ahead is an important foundation for deciding whether (and how) to engage. Negative characteristics do not necessarily mean that engagement is not possible but they may add **risk** to the process. They may mean that any relationship developed between the reform driver and actor may be difficult to maintain and that the desired outcome is hard to achieve. This may in turn threaten the policy objective to be achieved. The reform driver needs to decide whether any negative characteristics held by an actor risk derailing the policy process and whether or not they can be appropriately managed.

Where a **relationship** is viewed to be profitable it still has to be decided by the reform driver what **type** of relationship to have. The choice ranges from a formal contract to an informal, even verbal, agreement. A key element in the decision about the appropriate form will be the previous interaction between the reform driver and the actor. Does the actor have a **reputation** for cooperation with government? Does **trust**

exist between the reform driver and the actor? A review of **characteristics** is essential. Do **interests** align? The more trust and the more similar are objectives, cultures and resources are, the more an *informal* collaboration among the actors will be the most appropriate reform development. This will help empower and motivate everyone to produce the best possible outcome. The less trust or the more dissimilar are resources, culture and goals across the actors the more formalised and hierarchical a relationship needs to be. Hence the choice may most depend on the reputations of both reform driver and actor from previous interactions and their perceived complementarity of characteristics (particularly in relation to interests, culture and resources).

Once a decision about the most appropriate form of engagement has been made, its precise nature needs to be specified and communicated in prescribed **rules**. The specification involves deciding what the responsibilities of each party should be. Under a collaboration broad guidelines may be sufficient for actors who trust each other and can then themselves specify the required activities for the group. Under a more formal contract activities may need to be more fully set out in advance. This specification of rules will include at least the tasks that need to be done by the actors, or jointly, and the role of the reform driver. Indeed, there may well be different types of activities in the engagement; ranging from information exchange to planning for common goals and mutual capacity enhancement.

In addition, the reform driver must decide the **incentives** that need to be offered to the actor for participation in the engagement and effective activity and/or completion of the specified tasks. Incentives will relate to the outcome of the reform, the process of the reform and compensation for participation in the reform. Appropriate incentives will be determined by the form of engagement chosen: a collaboration may need few extra incentives as actors may already derive utility from the value of expected outcome (in terms of self-interest and ideology) and the process of collaborating with the reform driver. In more formalised arrangements there will need to be more of an emphasis on making sure there are sufficient incentives to guarantee cooperative behaviour and perhaps even threats of punishment for non-compliance. Nevertheless, the form of the relationship is not the only factor that will determine the incentive structures. Again an understanding of the **characteristics** of each actor and in

particular their goals will help identify where extra incentives are needed for cooperative behaviour.

The model then considers the response of the **actor** to the proposed engagement and the subsequent rounds of interaction. The actor will decide² whether to accept the **rules** of the relationship along with its **incentives**. Nevertheless, these are not the only considerations. The **reputation** of the reform driver will be important to assess. Has the reform driver cooperated in previous instances or has he tried to control the actor's behaviour? This information will be very useful to the actor as he seeks to assess the integrity of the offer made to him and whether he can **trust** the reform driver in their interaction. For instance, an offer of open collaboration may be treated with some suspicion if previous encounters have been poor. Hence, the actor's response to the proposed relationship will be determined by the incentives faced, the proposed rules and the reform driver's reputation.

The actor may try and change the **form, rules and incentives** of the relationship to fit his own interests. Alternatively, he may try and change the policy task to be conducted again based on his own interests. Hence there may be significant transaction costs in the establishment of the relationship through negotiation. With rejection, the reform driver may need to consider other actors for engagement with similar characteristics. Where a relationship is agreed upon, the reform driver and actor will produce an **outcome**. This will to a greater or lesser extent meet the specification of the policy task. Where the outcome falls short it may require a respecification of the policy task, a new round of characteristic review, relationship building and action.

The relationship and its outcome will provide the actor and the reform driver with better information on each other's characteristics, where uncertainty may have been present. For instance, by his action the actor may effectively signal his interests and degree of likely cooperation in current and future engagements. This information flow can improve the reform driver's understanding of the nature of the actor's **characteristics**. This will affect the trust between them (either positively or

² The actor usually has a choice of whether or not to accept the proposed engagement. (The exception is where, in the same hierarchy, the actor has no choice but to comply).

negatively). It may also lead in subsequent rounds, where relevant, to the reform driver reconsidering any of the following (based on his better understanding of characteristics and reputation):

- Whether to continue the **relationship**.
- Whether to change the **type** of the relationship
- Whether to change the **rules**.
- Whether to change **incentives**.

Hence actions, whether activities or communication, send signals about likely behaviour and such signals can be used by each party to re-evaluate their future strategies. Hence parties can learn about each other³.

4.3 Expectation of Findings

The validity of the conceptual framework may be demonstrated by its ability to predict behaviour. If it is correct what should we expect to find? Eight working hypotheses have been derived from the conceptual framework:

1. Key reform drivers coordinate health care financing reform through policy processes, or tasks, to achieve the desired outcome.
2. Reform drivers are aware of their own resources and constraints in conducting tasks to develop financing reform.
3. Reform drivers engage with actors to alleviate their own constraints, by utilising the resources of those actors, and avoid other actors with risky negative characteristics.
4. Different resources will be needed by different reform drivers, depending on their own constraints and the policy task.

³ Evolutionary Game Theory and Standard Game Theory are in tension on the issue of whether learning will naturally occur. Indeed, Evolutionary Game Theory presents various factors that may impede learning such as established convention and personal beliefs and traits.

5. The type and rules of a relationship offered by a reform driver to an actor is dependent on their combined characteristics and the policy task. The more complementary are the characteristics (resources, constraints, interest, reputation and trustworthiness) of the actor and the reform driver, the more likely is collaboration and partnership.
6. Incentives will affect the behaviour of actors and insufficient incentives will lead to uncooperative behaviour.
7. Actors may actively:
 - Negotiate the form and rules of a relationship
 - Try and change the goals and tasks of the reform driver where they are strongly opposed to the reform.
8. Learning can occur from past behaviour. More specifically;
 - Reform drivers and actors change their perceptions of characteristics and reputation in response to each other's actions
 - Reform drivers review engagement and incentives in response to the behaviour of actors
 - Reform drivers and actors are less likely to collaborate where the other has a poor reputation for collaboration.

These hypotheses form the basis of the testing of the conceptual framework in Chapters 7 and 8. The framework is tested against the experience of selected reforms in South Africa including a discussion of its relevance to different types of reform, specifically resource generation and resource allocation policies.

Chapter 5: Methodology

5.1 Introduction and Aims

The purpose of this chapter is to outline the strategy and details of the methodology for data collection and analysis. In effect, this covers the testing of the conceptual framework. (The methods for the initial derivation of the conceptual framework were discussed in Chapter 1 alongside the presentation of the overall methodological approach of this thesis.) Consequently, this chapter focuses on four aspects of the methodology:

- an evaluation of the different methods chosen to test the conceptual framework;
- an overview of the data collection strategies;
- a detailed exploration and justification of steps in data collection and analysis,
- a discussion of potential problems and biases in the methodological approach, and action taken to address them, where appropriate.

5.2 Discussion of alternative approaches

As noted in Chapter 1 two complementary approaches have been used to test the conceptual framework (though both approaches use case study material). The first involves drawing out key themes about managing actors from actor interviews in the SAZA case studies of health financing reform. This grounded approach allows ideas about the health financing reform process and its management to emerge without the imposition of other ideas. These ideas were then tested against the key components and predictions of the conceptual framework. It provides a very interesting and unusual test to see where the components of the conceptual framework do or do not match the perceptions of actors who have been involved in the process of health financing reform. In addition, the advantage of this approach is that it reveals extra factors important to the exploration of actors, which are not part of the conceptual framework.

The second approach used the conceptual framework as a foundation for interview questioning. This more deductive approach involved interviewing the reform drivers of a specific resource allocation reform to test whether the predictions and elements of the conceptual framework were valid. The strength of this approach is that it can test precisely the ideas of the conceptual framework. Nevertheless, while the interviews were more structured and guided than in the SAZA study, some open-ended questions and reflection were also allowed to pick up additional factors and allow room for inductive inference.

It must be noted that the use of qualitative analysis and case studies is not without its critics. Case studies frequently produce a wealth of qualitative data and are very time-consuming. Researchers have to be careful not to be overloaded by data (Carroll and Johnson, 1990; Yin, 1994). The frequently unstructured nature of case study research (Carroll and Johnson, 1990; Yin, 1994) has led to some arguing that researchers make data fit their theories or tell stories to fit their own preconceptions (Campbell, 1979; Carroll and Johnson, 1990; Yin, 1994, Thomas, 1998). Yin (1994) argues this is unfortunate but unavoidable. A further attack comes from those who maintain that the results of qualitative research, especially from a single case study, are not generalisable (Hammersley, Gomm and Foster, 2000). Arguing inductively from the specific to the general is deemed invalid. Yet Mitchell, 2000, (in Hammersley and Gomm, 2000) maintains that generalisability is beside the point in case studies and instead understanding within a particular context is all that is attempted.

Yet, the case study approach also has strong support. Cronbach (1975) favours the development of “working hypotheses” to be tested in other cases, thus avoiding the problem of claiming too much from the single case study. Yin (1994) goes much further and argues that the qualitative analysis combined with the case study approach is different from quantitative analysis and the two methods should not be confused. The generalisation in case studies is analytical and not empirical and is therefore valid. Similarly, Thomas (1998) maintains case studies are important for confirming or throwing out theories and therefore their results must be generalisable. The debate continues about the appropriate handling of case study qualitative data.

As a safeguard against the objections raised above, the thesis employs different methods with different datasets: the more grounded SAZA material and the more deductive analysis of the resource allocation reform, as discussed above. In addition, as noted in Chapter 1, the derivation of the conceptual framework from theory and international experience will do much to aid generalisability. The research methodology is thus eclectic, in line with good practice (Thomas, 1998). McGrath (1982) notes that every method has its drawbacks and it is trusted that the combination of methods employed in this thesis acts as a useful check and produces increased rigour.

5.3 Overview of Data collection strategies

Three stages of data collection have contributed to this thesis. The first two relate to the phases of the SAZA project, and involve the development of three case studies, and the last to some specific data supplementation and confirmation undertaken for the sole purpose of the thesis, in the form of the additional case study on resource allocation. Each phase is discussed below.

5.3.1 SAZA Phase 1

The main period of focus for the initial work was 1994-1999, to coincide with the first democratic government of South Africa. There were three reforms of focus; user fees, resource allocation and national/social health insurance. The aim of the investigation was to understand the impact of these reforms and explore the relationship between the impact and the stages of policy development and the key elements of the policy process (context, actors, process and content) after Walt and Gilson (1994):

Data gathering focused initially on:

- Understanding how the content of reforms evolved over time;
- Identifying the key actors in reform and their views of reform;
- Identifying contextual factors that might have relevance for reform development;
- Understanding the stages of design and implementation for each reform.

This was informed through capturing the knowledge of researchers in the team; an extensive review of policy documents and evaluations, and some interviews with selected key-informants, policy makers and analysts, based on their accessibility and knowledge. From this it was possible to map out timelines for each reform and understand the basic characteristics of each policy.

After this initial analysis, further interviews with policy makers, representatives of key actors and managers were then conducted. These data were supplemented by a media analysis of how major newspapers had covered the health reforms. An analysis of parliamentary proceedings was also conducted to understand the political dynamics around the reforms. Stakeholder analyses were used to understand actor positions on reforms. Secondary data were also collected on the impact of the implemented reforms.

The aim of such data collection activities was to facilitate a more detailed analysis of the factors that supported or constrained the reforms and to understand the impact, potential or actual, that the reforms had, or would have had. A report of the findings was produced as the main output of the first phase of the project, Gilson *et al* (1999) "The Dynamics of Policy Change: Health Care Financing in South Africa, 1994-1999". This report was reviewed by government officials, analysts outside government and international specialists with subsequent revisions to the document.

5.3.2 SAZA Phase 2

The aim of the second phase of the SAZA project was to explore further some of the themes identified in the first phase through: monitoring and evaluating more recent events and conducting more in-depth analysis of the 1994-1999 period events. Rather than one product, separate smaller studies were conducted in parallel. In particular, products related to:

- A formative monitoring and evaluation tool, examining strategic methods of ensuring effective and democratic evolution of health financing reforms
- Additional analysis of the equity of resource allocation and budgeting

- Understanding the factors that influence the role of health economists in supporting policy-making
- An initial exploration of the tools used by reform drivers to deal with opposition
- Better understanding of the role, power and views of trade unions in health sector reform

To this end, additional interviews were conducted with key policy makers, managers and actor representatives, alongside an additional document review. The interviews tended to be more structured than in Phase 1 reflecting more specific themes and questions arising from the more focussed research interests.

5.3.3 Additional case study

Many of the SAZA interviews, but not all, were conducted before the conceptual framework for this thesis had been drafted and developed. While, the data collected as part of the SAZA project was reanalysed using the conceptual framework, it was thought that additional verification of the approach and its findings was needed (see discussion in Chapter 1 and earlier in this chapter). The final phase of data collection involved interviewing reform drivers of a resource allocation reform. This reform happened after the time-period for analysis of the SAZA project. The questions were derived directly from the conceptual framework to test some of its key ideas, concepts and predictions. This additional data gathering helped act as a further test of the relevance of the conceptual framework for a reform driver managing actors in a reform process.

5.4 Detailed Methods of Data Collection and Analysis

5.4.1 SAZA Case Studies

5.4.1.1 Sampling - Which relationships?

A sample frame is important in that it helps bound the data collection process specifying the sources to be utilised in relation to the key objectives of the study, or as Miles and Huberman (1994) note:

“to define aspects of your case that you can study within the limits of your time and means, that connect directly to your research questions and will include examples of what you want to study.”

(Miles and Huberman, 1994)

Kuzel (1992) and Morse (1993) note that qualitative samples tend to be purposive rather than random (also Miles and Huberman, 1994). The sampling, therefore, needs to be driven, at least initially, by the theory. Our conceptual framework and research questions will guide the things to look for and the sources of data to use. Yet precisely what sources will provide data that will adequately answer the research questions?

One of the critical questions for the methodology of this thesis is which relationships need to be analysed in detail. Should all relationships between reform drivers and policy actors be considered as a suitable testing ground for the conceptual framework? The main focus of the data collection in the SAZA case study was the key policy processes and the management of important actors by Government in health care financing reform, in the post 1994 period. The three reform areas of focus were user fee pricing policy, social health insurance and resource allocation. This effectively bounds the range of relationships to be explored to make the task more feasible. (A full picture of the overall health financing reform process is painted in Chapter 6.)

The range of policy processes connected to the key health financing reforms involved both government and non-government actors in:

1. A series of ad-hoc policy committees;
2. Routine budget discussions and negotiations;
3. Decision making within the senior management committees of the National Department of Health; and
4. Informal, back-room conversations and negotiations on policy development.

Within each of these types of policy process there were relationships between reform drivers and policy actors. The first of these policy processes was central to the development of financing reforms around health resource mobilisation (i.e. insurance and user fees). Four policy committees were charged with developing health financing policies, with a key focus being health insurance (see Chapter 6 for more details). These ad hoc committees were the major vehicles for developing and refining the design of health financing policies and the relationships in and around them are a central focus of investigation. In contrast, routine budget discussions proved important for resource allocation issues (see Table 5.1, where X marks the judged importance of policy processes to specific reforms). The senior management committees played a role in SHI and user fees, but were less important to the reforms than the ad hoc committees (see Chapter 6 for more details). Rather than being a separate type of activity, the informal, back-room policy development pervaded the three other more formal policy processes and thus is not considered *separately* in Table 5.1 or in the data collection.

Table 5.1: Policy Processes, the Reforms of Focus and Actor Involvement

	Ad hoc Policy Committees	Routine Budget Discussions	Senior Management Committees
Health Insurance	XXX		X
Resource Allocation		XXX	
User Fees	XXX		X
Actors	Internal and External to Government	Internal to Government	Internal to Government

Note: The number of 'X's denotes the importance of that policy process to each reform

While the ad hoc committees involved relationships across both government and non-government actors, the routine budget processes and senior committees within the National Department of Health only included government personnel. Hence not only were there different types of processes for different reforms but different sets of actors. Indeed, there may well be distinctions between managing actors within the hierarchy and managing them across institutional boundaries. (Such issues are picked up in Chapters 7 and 8.) Hence, the sampling needs to examine these different groups and processes.

Several sampling strategies are suggested by the literature for qualitative analysis, including:

- *Convenience sampling* – This is used where respondents are easy to recruit, near at hand and likely to respond, but the use of this method has problems in that it raises doubts about the generalisability of the findings.
- *Purposive sampling* – This is a deliberate non-random technique aiming to sample a group of people or settings with a particular characteristic (in our case representation of key sector actors or participation in a key health sector process). This can also be termed “criterion” sampling (Patton, 1990). A related technique is “quota selection” sampling where a minimum number of respondents are required for a category for adequate representation.
- *Snowballing* – This is used in the absence of a sample-frame; where researchers don’t know who to interview. The researcher asks the initial group of respondents to recruit others they know are in the target group. Anyone so identified is contacted and asked if they want to participate. The main problem with this method is that, if used by itself, it may include only members of a specific network.
- *Theoretical sampling* – This sampling technique aims to locate data to develop and challenge emerging hypotheses (Glaser and Strauss, 1967). First, a small number of similar cases of interest are selected and interviewed in depth in order to

develop an understanding of the particular phenomenon. Next, cases are sampled that might be exceptions in an attempt to challenge the emerging hypothesis.

An eclectic approach has been taken in the use of different sampling methods to try and strike a balance between the need for small samples, for manageability of data, and adequate representation of key groups and processes. Hence there is both a purposive and theoretical sampling of specific policy processes and types of relationships, alongside convenience sampling and snowballing which, at least initially, were important for interviewee selection.

Interviewees were identified as they provided information about the processes in Table 5.1. The first interviewees were from within the SAZA team; members revealed their own knowledge of the events and relationships. Subsequent interviewees were identified in relation to their involvement in the policy processes, as noted by key policy documents (the “criterion” sampling strategy, Patton 1990) and approachability, or from the SAZA team interviews. These contacts were then asked to suggest others who would know about the process or would be important representatives of key stakeholders (a combination of “snowballing” and “purposive” sampling strategies, Kuzel 1992). Finally, any new and interesting leads from interviews were explored (opportunistic sampling). Given the importance of stakeholders to the understanding of the effectiveness of the policy reforms it was also important to have all the major actors sampled at least in two interviews (quota selection sampling, Goetz and Lecompte, 1984, in Merriam, 1988). Likewise each major policy development process needed at least three and possibly more interviewees who had first-hand experience of the process (quota selection sampling). Whether the minimum is sufficient in these cases depends on the wealth and complexity of each interview/case.

Such criteria proved more difficult to meet in the processes internal to government. In particular, the interviews gave little information on the workings of the senior committees of the National Department of Health, perhaps because they were less important to overall health financing reform development during the period of focus. The sampling, then, focused on comparing the relationships within the ad hoc policy committees to those in the resource allocation and budgeting discussions.

5.4.1.2 Coverage of actors

In all, the SAZA project team in South Africa conducted 58 interviews with 58 interviewees. (Note: the two numbers were not necessarily the same as in some cases repeat interviews were conducted where interviewees were willing and seemed to have more to say. Also, occasionally two actors were jointly interviewed.) The precise breakdown in terms of the number of interviews and interviewees from different health sector actor groups is shown in Table 5.2.

Table 5.2: SAZA Interviews by different actor groups

	No of Interviews	No of Interviewees
Academic Analysts	16	13
National Department of Health	8	8
National Department of Finance	3	2
Provincial Departments of Health	13	15
Medical Schemes	2	3
Trade Unions	4	4
Politicians and Former Activists	5	6
Other	7	7
Total	58	58

Note: Where interviewees represent more than one category of interviewee they were placed in the category whose feature was of most importance to the interview. Alternative categorisation might have changed marginally the numbers across the following categories: *Academic Analysts, Provincial Department of Health and Politicians and Former Activists.*

Table 5.2 notes the number of interviews conducted with specific actors that featured most prominently in the processes around health care financing reform development. It is important to ensure that there is a minimum number from each group so that a fair representation of the views of each actor can be derived from the qualitative data about the policy processes and the strategies for managing actors. It is important to note that actors can and do comment on each other's constraints, agendas and capacities and this is a vital source of information. Yet, it is important also to hear from actors about themselves. An inside view is not always fairly reflected by other

actors with their own interests and concerns. Conversely, drawing a picture about an actor solely from the opinions of representatives of that actor is to allow the research to be hostage to propaganda (see potential biases later). A healthy balance was sought.

It is apparent from Table 5.2, that there has been a tendency toward interviews with academics and representatives of the Provincial Departments of Health and the National Department of Health. In so much as the research is focussed on how government managers and reform drivers can manage other actors the focus on the National Department of Health is warranted. The reliance on academic analysts may also not be unduly of concern. First analysts were used extensively, and perhaps with a higher turnover than other groups, in the development of health financing reform policies. Second, their views are not homogenous. Indeed, they are perhaps the most disparate of the actor groupings noted above (with the potential exception of the trade unions). The use of many academic analyst voices may also relate to the composition of the original SAZA research team and their contacts, as well as ease of access. The large number of interviews with Provincial Department of Health representatives reflects a concerted attempt, in SAZA phase 2, to understand better the internal government workings around resource allocation and budgeting. Initial interviews contained less material on these processes and the relationships within government.

The potentially weakest information would appear to be around the Department of Finance (from Table 5.2). Nevertheless, even here one of the independent analysts (categorised under "other" in Table 5.2) actually was employed as a DoF consultant in relation to health issues and so was able to reveal insider knowledge of DoF values and activities. Further, several civil servants in the NDoH and other academic analysts comment on the role, power and activities of the DoF. Even with the two DoF key informants interviewed a substantial amount of information was gleaned. As Table 5.3 shows over three thousand lines of transcribed text were recorded in direct interviews with DoF representatives (equivalent to over 5 hours of speech).

Table 5.3: Transcribed text from Interviews with Key Health Sector Actors

Actor Group	Lines of Transcribed Text	Proportion	Approx. Interviewing Time (Hrs)
Provincial Departments of Health	10,961	33%	18.3
Academic Analysts	9,364	28%	15.6
National Department of Health	6,220	18%	10.4
National Department of Finance	3,180	9%	5.3
Trade Unions	2,243	7%	3.7
Medical Schemes Administrators	1,730	5%	2.9
Total	22,737	100%	56.2

From Table 5.3 it would appear that there might be least information about Medical Scheme Administrators. This is mainly due to the fact the Medical Scheme Administrators were only involved in one of the three reforms of focus, Social Health Insurance. This partially also reflects the time constraints, and therefore limited availability, of private sector actors. Nevertheless, three Medical Scheme voices are heard, alongside several academic analysts who have studied the industry closely. Still, the sufficiency of data collection will only really be apparent in the analysis of the interviews as they relate to the conceptual framework and research questions.

5.4.1.3 Coverage of Key Policy Processes

The second question relates to the extent to which the interviewees were involved in the different policy processes. In other words can the data recreate the engagement between reform drivers and other actors in and around these processes and cast light on managing actors?

Ad hoc Committees

The four committees that were most important in the post-apartheid era were the Health Care Financing Committee, the Commission of Inquiry into a National Health Insurance Scheme and the parallel working Groups on Medical Scheme Reregulation and Social Health Insurance (Gilson *et al*, 1999; Thomas and Gilson, 2000). The membership is shown in Table 5.4 along with the number of members who were interviewed¹. As can be seen, several key informants from each committee provided interview data. This allows for significant verification of events and strategies in these committees. In the case of the smaller working groups almost all members were interviewed.

Table 5.4: Membership of Committees

	HCFC	CoI	SHI WG	MSR WG
Members	16	17	7	6
Interviewed	6	6	5	5

Key: HCFC – Health Care Financing Committee

CoI – Committee of Inquiry into a National Health Insurance scheme

SHI WG – Working Group for the development of a Social Health Insurance scheme

MSR WG – Working Group for the Reregulation of the Medical Schemes Act.

Hence it appears that the data concerning these committees may allow us a very good window into the practical management of actors in health financing reform. Further, the high proportion of interviews with academic analysts and NDoH officials actually does justice to the frequency of committee membership from these actors on the committees. For example, on the HCFC, 50% of members were academic analysts and 33% were from national and provincial government.

Routine Budget Negotiations

There were two main eras of budgeting process between 1994 and 1999, the “Function Committee” era and the “Fiscal Federalism” era. In the former the Function Committee decided the formula for allocating health sector resources across the

¹ It must be noted that all members are given equal standing regardless of the number of meetings they attended, as long as it was at least one, and regardless of the extent of their contribution to the overall debates. The interviewees tended to be the more prominent and present of committee members. Hence the apparent representation indicated in Table 6.3 may well be an effective underestimate.

provinces. The committee contained national and provincial health department representatives. The second era related to the move to a fiscal federalist system. This move increased the influence of Department of Finance in resource allocation decisions. Other key institutions were the advisory body, the Financial and Fiscal Commission, and the intersectoral coordinating mechanisms:

- The Medium Term Expenditure Framework task team, consisting of Finance and Health representatives, charged with reviewing health budgets from an efficiency perspective.
- The “four by four”, a joint forum for dialogue and coordination between national and provincial Finance and Health representatives.

Further, Health Ministers and health department civil servants at national and provincial levels also participated in key groupings.

Representatives from both eras are interviewed. The voices of national and provincial finance and health departments are also heard, especially those involved in the coordinating mechanisms. Perhaps a key failure is the lack of an interview with the Minister of Finance or the Minister of Health. Nevertheless several other officials, including the second Director General of Health report on the actions of the Ministers as well as their own.

5.4.1.4 Instrument Use

The first instrument used was a content analysis of existing official policy documentation on South Africa. (The advantages of document reviews include their relative non-reactivity with the investigator, their convenience and low-cost in comparison with other research methods, Bowling 1994.) This includes an analysis of policy documents (in draft and final form), ministerial speeches and input papers into policy formulation. Nevertheless, care must be taken in extracting data from official policy documents. Robson (1993) stresses the relationship between the content of the document and its context. Included under context are such issues as purpose of the document, institutional, social and cultural framework. The purpose of each document

will be essential to its understanding as the data in it will have been structured toward specific goals. As Pickin and St Leger (1993) agree it is vital to attempt to ascertain the source and aims of any documents used in research and any potential biases. By doing this it may be possible to identify propaganda and glean “unwitting” evidence from the document, which is not biased.

From this a picture of major events, actors and processes was drawn in the development of health care financing reforms in South Africa. A more focused review of literature was conducted in relation to the policy development processes. This involved obtaining and evaluating documents from specific committees to yield information on the position and power of key stakeholders, the process of policy development and the strategies to influence outcomes used by interest groups. Such documents as the original and revised Terms of References for different committees, minutes of meetings, technical input papers and workshop proceedings were useful in this process. This helped isolate some of the general strategies used by government in managing actors as it pursued health care financing reform. It also helped in determining specific questions and lines of inquiry.

Still, the inherent biases of such documents required triangulation with other sources to ensure a validated picture. Further, since much of the required data related to issues of policy and interactions between institutions, an analysis of official publications is only of limited use. This was particularly the case when the author’s agenda is prominent in driving the style, composition and content of each official document, as is notable in official government press releases and policy documents.

Instead, one-on-one interviews were the main source of qualitative information, particularly relating to the testing of the conceptual framework. The first step in interviewing was to capture important knowledge of the reforms and related processes held by three members of the SAZA research team, who had been involved in the reforms. The aim was to identify these researchers’ understandings and perspectives independently of other data collection efforts. It also provided vital information to test some of the initial conclusions drawn from the document review and provided more detail on the policy processes employed by the government, their key features and the reactions of different actors. It further helped identify important individuals to

interview for their representation of key actors or their membership of key health financing policy committees (as noted in the *sampling* section).

The interviews were *semi-structured*, in that there were some issues and areas that had to be covered but the presentation of questions and their wording was flexible (to allow for modification of language in line with the interviewee and create a more relaxed interview environment). This more flexible form of questioning was probably more appropriate when trying to capture general information from the perspective of the interviewee and to build up the case study (Carroll and Johnson, 1990; Hammersley and Gomm, 2000). Indeed, the use of open-ended questions was important (Hammersley and Gomm, 2000), as it allowed the possibility of new ideas that were previously unanticipated. The flexibility of the semi-structured interview also allowed room for following up interesting areas of inquiry that might not be fully fleshed out in more structured methods, such as a self-administered questionnaire. This was in the form of probes to seek more information or clarification to confirm facts (see Box 5.1) The disadvantage of the semi-structured interview is that there is more scope for interviewer bias (as discussed later), which may well be the flip side of achieving greater depth in the interview.

Box 5.1: Lines of questioning in semi-structured interviews

- The **Main** questions: open-ended general questions providing the boundaries of topic for the interviewee
- The **Probe**: asking for more information directly or just repeating back what has been said in the expectation that something else will be said (though care is required so as not to be seen as an inquisitor)
- **Reflection and Clarification**: this is where the interviewer returns to themes later in the interview or in a subsequent interview in order to clarify the facts.

Source: Rubin and Rubin (1995)

In the first phase of interviewing the interviews were particularly open-ended focussing on the following questions, and trying to gain information on key events, actors, context and policy processes on top of the technical debates:

1. What factors facilitate or constrain the likely effectiveness and impact of financing reforms?
2. How can the impact of reforms be enhanced?

In the second phase of interviews more detailed topics and questions were developed from an analysis of data in the first phase. (Those of relevance are shown in Annex 1). As a result the interviews were more structured than in the first round but through the use of probes and reflection and clarification interviewers were able to explore interesting areas.

Most interviews were fully recorded on audiotape and transcribed (all with the consent of the interviewee – see later section on *Interview Protocol*). Although, this was time consuming and exhausting it was thought to reveal better and richer information than hand-written notes. Nevertheless, some interviews were only recorded through note taking (see Table 5.4). This was either because of time constraints on the part of the interviewers, because of concerns about time available for transcription, or because a government official was wary about being recorded on tape. Even here, what the interviewer deemed as important quotations were written down in full. (Hence, some of the advantages of verbatim text were preserved, though what is quoted relied on the judgement of the interviewer). Also occasionally a telephone interview was conducted where it was not possible to meet with the person physically. Here interviewer notes were made. The statistics of the mode of recording of interviews are set out below (Table 5.5). It should also be noted that in two cases where the interview was being recorded the interviewee asked for the tape to be switched off before more sensitive information was revealed. This *extra* information was recorded by taking notes.

The interviews for both phases of the SAZA project were carried out by team members either from the Health Economics Unit, University of Cape Town or from the Centre for Health Policy, University of Witwatersrand and sometimes together. I was involved in fourteen of the interviews in the first two phases of SAZA. The recorded text or notes from each interview were written up by the relevant interviewer (or one of the interview team). The text from each interview was then made available

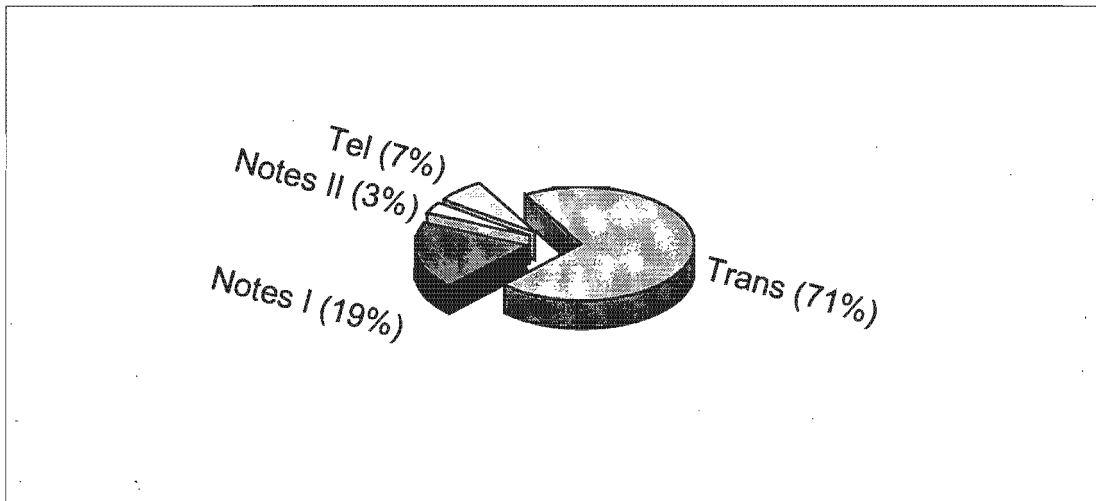
to all the team in the form of a text document. The analysis of the interview texts in relation to the PhD thesis was conducted entirely by the author.

The candidate attempted to keep both interviewees and the key players in reform processes that they referred to anonymous wherever possible. Rather than refer to an individual, or their precise position, the respondents were labelled by type such as “academic analyst” or “senior policy maker” which was thought to be a useful categorisation. This convention was agreed upon in the SAZA study and was carried over to this thesis. Furthermore, it was thought that if anonymity were offered interviewees then more information would be forthcoming, allowing richer analyses. Finally, I know and have to work with many of these actors and there may well be sensitivities about naming names in terms of relations, further research and policy input. Nevertheless, in the case of the Conditional Grant reform, where masking the identity of the authors was virtually impossible, the respondents were comfortable being directly quoted on their opinions.

Table 5.5: Mode of Recording of Interviews

	Frequency
Recorded Interview (with verbatim transcription)	41
Notes with selected quotations – due to time constraints on interviewer	11
Notes with selected quotations – due to interviewee preference of not being recorded	2
Notes from telephone interviews	4
Total no of Interviews	58

Diagram 5.1: Mode of recording of Interviews



Key:

- Trans - Transcriptions from face-to-face interviews
- Notes I - Notes from face-to-face interviews (due to interviewer constraints)
- Notes II - Notes from face-to-face interviews (due to interviewee preference)
- Tel - Notes from telephone interviews

5.4.1.5 Interview Protocol

It was necessary, before interviewing, effectively to enter into an agreement with the interviewee. It was important to develop a climate of trust to avoid the withholding of information. The scope of the agreement covered the following:

Prior to the interview

1. Interviewees were faxed or given an outline of the study, its aims and research methods and told that their understanding of the policy process was of interest to the research.
2. The approximate time for the interview was given, between 30 minutes and one hour. Longer interviews were welcomed and shorter ones discouraged.
3. It was stressed that the participation of the interviewee was purely voluntary.

At the beginning of the interview:

1. The main aims of the study and the interview were restated

2. The anonymity of the interviewee was guaranteed.
3. The interviewee was asked whether their interview material could be quoted, but without any reference to the author.
4. The interviewee was asked whether it was acceptable to tape-record the interview. (If not, notes were taken.)

At the end of the interview

1. The interviewee was asked whether they wanted to read through the transcription of the interview and amend, delete or supplement the material, if on reflection it was inaccurate or incomplete. (In practice, this only occurred twice with minor edits to the transcriptions. The changes related to issues of contextual events and not to any substantive issues related to the purposes of this research.)
2. The interviewee was asked whether they wished to see copies of the final report of the first phase of the SAZA project. Most were interested and copies were forwarded.

5.4.1.6 Use of print media

An additional source of information in the SAZA study was the print *media*. A content analysis was conducted for newspaper articles on health care financing reforms. The research used information from the South African Medical Journal, the Citizen, the Mail and Guardian, the Star, the Sowetan, Business Day, Finance Week and the Sunday Times. A classification of each article was then performed in relation to actors and processes already identified in interviews and document reviews. This proved to be a valuable source of extra data on views and strategies, though only confirming what had been picked up in interviews.

5.4.1.7 Data Collection and Verification

Data under the SAZA project were collected in two phases, beginning in May 1998 and finishing around October 2000. First an initial phase involved the review of general documents and conducting of interviews in line with establishing the sequence of events of health care financing reforms between 1994 and 1999. This was also complimented by a directed media analysis around certain topics i.e. where there was less clarity around events or contradictions between sources the media was examined to see whether it would throw light on issues.

The second phase involved more focused document review and interviews on managing actors in health financing reform. The methods used for selection of interviewees were discussed earlier as was the development of the questions. Given the soft nature of much of the qualitative data, triangulation was important. Iterative processes of confirmation of findings were vital in reconstructing past decisions, strategies and sequencing of events. Second interviews were employed for clarification in seven cases. It was decided that single-source evidence would not carry the same weight as verified data. Further, where used single-source information was to be labelled and no conclusions could be drawn from it.

5.4.1.8 Analysis

To assist the qualitative analysis, a computer software model was used, NUD*IST. The advantage of this computer software was that it facilitated the following:

1. *Coding* – it can attach key classifications to segments of text, for later retrieval
2. *Storage* – it keeps a large quantity of text in an organised database
3. *Search and Retrieval* – it allows easy location and display of text strings and ideas
4. *Data “linking”* – it allows for the creation of networks of connected segments of text
5. *Content analysis* – it can count frequencies and location of words and phrases
6. *Data display* – it can build a network of coded data for display and further analysis
7. *Theory building* – it allows hypotheses to be tested

Nevertheless, the computer model is less helpful in not being able to isolate concepts which are discussed in different words, or sequences of words. For example, a researcher might want to analyse to what extent “learning” occurred across case studies. A word search for “learn” in the transcribed text will not reveal all occasions where interviewees do or do not learn. The process of line by line coding of documents by the researcher has no substitute. Still, the ability of NUD*IST to be able to store and display coded text is particularly useful and relieves the problems of mountains of paper.

5.4.1.9 Coding

Coding is essential for analysis of qualitative data. It reflects the theoretical understanding of the model being developed and attempts to categorise data according to the key elements in the model. It is thus an important first stage of analysis. Fielding (1993a) states that if the research stems from a theory then the codes should be chosen to represent the theory and the data coded to fit the categories (coding down) – otherwise categories should be developed from the data (coding up). As noted before I have created room for coding up to occur even while testing the conceptual framework, through the general to specific line of interview questioning (see next paragraph). Nevertheless, there is always the danger of coding down inappropriately and losing the context of what has been said.

The coding of the qualitative data developed in three phases. First codes were derived from a general understanding of the elements of health care financing reform. Then a more detailed investigation of the dynamics of managing actors around committees was conducted before finally an examination of the key elements of the conceptual framework. It is hoped the first two steps allowed issues not captured in the conceptual framework to become evident and thus avoid the potential problems of deductive approaches. The three phases of coding are set out in Table 5.6 below. (Annex 2 contains the more detailed final coding tree for the qualitative analysis that included both the components of the conceptual framework and other factors that arose from the data)

5.4.1.10 Data displays and conclusions

Out of the classification process came reduced and reorganised data. It is important to display these data in order to be able to start answering some of the research questions. First, descriptive displays are presented about what happened (Chapter 6). An initial picture of the management of actors in health care financing policy in South Africa is developed, both in relation to specific policy development process and particular actors. This preliminary analysis leads to more investigative and explanatory analyses where the conceptual framework is tested against South African experience.

Triangulation between and across interviews, document reviews and the media was essential to developing and testing themes and results (after Thomas, 1998). It is hoped that this process of validation and triangulation secured the most rigorous data set possible given the subject area. From the emerging data it was then possible to test the utility of the conceptual framework proposed taking into account the actual practice within South Africa.

Table 5.6: Development of the coding of data: Main branches of coding

<i>Phase 1: General Health Care Financing Reform in South Africa</i>	<i>Phase 2: Managing Actors around Policy Committees</i>	<i>Phase 3: Testing Elements of the Conceptual Framework</i>
<p>Context</p> <ul style="list-style-type: none"> - Legacy of apartheid - Key events - Key trends <p>Process</p> <ul style="list-style-type: none"> - Main policy development processes - Announcement of Reforms <p>Actors</p> <ul style="list-style-type: none"> - National Department of Health: Minister and Directorate for Health Financing and Economics <ul style="list-style-type: none"> - Interests, Capacity - Department of Finance <ul style="list-style-type: none"> - Interests, Capacity - Trade Unions <ul style="list-style-type: none"> - Interests, Capacity - Medical Schemes <ul style="list-style-type: none"> - Interests, Capacity - Academic Analysts <ul style="list-style-type: none"> - Interests, Capacity <p>Content</p> <ul style="list-style-type: none"> - Evolution of design of financing reforms - Impact of implementation of reforms 	<p>Health Care Financing Committee</p> <ul style="list-style-type: none"> - Incentives - Interests - Conflict - Influence - Negotiation Strategies - Decision-making - Feedback - Working <p>Committee of Inquiry into a National Health Insurance Scheme</p> <ul style="list-style-type: none"> - (sub-categories same as HCFC) <p>Working Group for Social Health Insurance</p> <ul style="list-style-type: none"> - (sub-categories same as HCFC) <p>Working Group for Medical Schemes Reregulation:</p> <ul style="list-style-type: none"> - (sub-categories same as HCFC) 	<p>Decision to Engage</p> <ul style="list-style-type: none"> - Constraints - Characteristics - Reputation - Trust - Non-engage <p>Form of Engagement</p> <ul style="list-style-type: none"> - Control - Collaboration - Reputation - Trust <p>Parameters of Engagement</p> <ul style="list-style-type: none"> - Incentives - Roles - Cooperation - Formality - Information <p>Dynamic</p> <ul style="list-style-type: none"> - Response - Information - Reputation Change - Characteristics Change - Roles Change - Incentives Change

5.4.2 Resource Allocation Case Study

In addition to the SAZA case study material that was collected and analysed a further case study was developed, testing the conceptual framework against the perceptions of reform drivers involved in a single resource allocation reform, the revision of Conditional Grants to tertiary hospitals (see Chapter 8 for more details). The two reform drivers from the National Department of Health were jointly interviewed, in one interview of 3 ½ hours, on their behaviour and understanding of the progress of the Conditional Grants reform. Some of the methodology employed was similar to that discussed in relation to the SAZA case study and therefore only those issues which are significantly different are discussed in this section.

The interview with reform drivers involved:

- Questions that were derived directly from the conceptual framework, its components, ideas and predictions to which the reform drivers responded in relation to their experience with the resource allocation reform
- Questions that allowed the reform drivers to reflect on the key issues in managing actors in health financing reform and to compare different types of health financing reforms.

The questions are presented in Box 5.1. The reforms covered were resource allocation, primarily, and Social Health Insurance as a contrasting line of inquiry for reflection. These reforms were selected on the basis of their relevance to up-to-date policy issues and their linkage with the SAZA case study reforms. The reforms also allowed investigation of managing actors within government (resource allocation) and outside (Social Health Insurance) to explore the different strategies and factors that might be relevant across different reforms and different groups of actors. While the reform drivers of the Conditional Grant reform had not themselves been drivers of resource generation reforms they had first-hand experience of dealing and negotiating with private sector actors, such as Medical Schemes, that would be involved in an SHI. They also had previously developed a plan around taking forward SHI when

they thought that it would become their responsibility. Consequently, it was thought that they could provide some insight into comparative reform management dynamics.

The questions related to the core components of the conceptual framework: the assessment of the reform driver's resources and constraints; the assessment of the characteristics of other actors; the decision to collaborate; the development of the terms on which such relationships happen; the reaction of other actors, and the learning that occurs through reform processes.

The interviewees were chosen on the basis of:

- Their responsibility for taking forward the Conditional Grants reform
- Their representation of the National Department of Health at a senior level
- Their expertise in issues of health financing reform
- Their ease of access
- Their involvement in the SAZA case study reforms

The objectives of the study were presented to the reform drivers in advance of the interview. The questions were also forwarded to allow time for reflection. At the meeting the standard protocol for interviews was followed (noted earlier). The questions were then reviewed in order and answers were recorded and transcribed by the author.

No other interviews were conducted for this case study. This was done for two reasons. First, the point of the case study was to test the conceptual framework against the perspectives of a reform driver. There were no other reform drivers for this reform and other actors would not be able to provide the same perspective. Second, time and resources prohibited further interviews. This may have introduced some biases into the recreation of some of the material around interactions of the reform drivers with other actors and this limitation must be kept in mind in later analyses.

Box 5.2: Managing Actors in Financing Reform - Key Questions

1. Review of Conditional Grants Process

- Would you say you acted as the driver of the Conditional Grants Reform? Briefly, what responsibilities did that involve?
- Did you collaborate with other individuals and/or institutions on the basis of:
 - their technical expertise,
 - specialised knowledge
 - their power
 - their interest in the reform
 - their reputation
 - something else?
- When you collaborated with other individuals and/or institutions was it to alleviate your own limitations and constraints in taking forward the reform? Did you consciously review your own resources and constraints?
- Was trust an important issue for you?
- If you had undertaken the reform two years before you did would you have collaborated with different individuals and/or representatives?
- What sort of relationships and rules of interaction did you develop with the individuals (such as informal meetings, formal ToR, contracts, delegated tasks for each actor)?
- How did the following factors affect your relationships:
 - Complementary strengths
 - Common interests
 - Good reputation
 - Trust
- Did any of the individuals/groups you were working with try and change the goals of the reform or tasks to be done? How? What was your reaction?
- What sort of factors motivated the other people to collaborate with you? Did anyone refuse? Did you need to offer incentives to any of the individuals/groups? What sort of incentives were they? Did insufficient incentives affect anyone's performance?
- Do you think you have learnt from the process?
 - What would you have done differently?
 - Would you have collaborated with the same people? Why/Why not?
 - Would you have developed the same relationships and provided the same incentives? Why/Why not?
 - Has any actor's reputation changed in your eyes (comparing before and after)?
 - Are you less likely to collaborate with actors who have earned a poor reputation for collaboration?

2. Reflection

- If you had been responsible for Social Health Insurance rather than the Conditional Grants reform, would you have handled it differently?
- What are the most important points to consider when managing actors in health financing reform?

5.5 Methodological Concerns and Remedial Action

The following section highlights potential problems with, or biases that arose from, the methods chosen. It investigates how these may impact on the results and notes what action was taken to remedy the situation.

5.5.1 Acquiescence response set: “saying yes”

Respondents are more likely to endorse a statement than disagree with its opposite (Sackett, 1979). This is always going to be a problem in a semi-structured interview. Initial questions were generally phrased in a way so that yes/ no answers were not applicable, but the use of probes and going over the same ground often required some confirmation or negation. Nevertheless, the aim of probes, for example, was to seek more clarification and more information. The interviewer was likely to repeat at least partially what he has heard, or what he thinks he has heard and this *may be* more likely to receive a yes answer. Nevertheless, by providing a fairly relaxed atmosphere, and reasonable trust, for the interview it is hoped that there was not inappropriate “yes-saying”. Indeed, practice interviews were organised to help the SAZA team develop relaxed but focussed lines of questioning. There does not, therefore, appear to be any obvious bias in this matter. Further, given the justified use of clarifying lines of questioning it may not be a problem even where there is significant agreement in specific interviews.

5.5.2 Interviewer Bias and Social Desirability Bias

These potential problems are quite closely related. The first implies that interviewers can bias respondents to answer in certain ways: by identifying themselves with certain values or by asking leading questions. The second bias relates to the fact that interviewees want to be seen in a good light and to give desirable, if not always, accurate responses (see also *Reporting bias* below).

In the initial phase of interviews the focus was particularly on gathering information on what happened. For later interviews, when questioning became more complicated,

all lines of questioning were subject to the input and editing of the SAZA team. This was important, as no one person could conduct all the interviews and thus questions needed to be agreed and set out beforehand.

At no stage was any method of managing actors presumed to be morally or strategically correct. Again the emphasis was either on directing the interviewee toward a topic that needed to be covered or clarifying what had been said/probing for more. Further, by practising interviews the team hoped to remove such problems. If they did remain then the use of several interviewers across the range of interviews may have removed any individual bias. Were such a bias still to be prevalent we might expect to see that interviewees favoured greater collaboration than strategies emphasising control and conflict.

Nevertheless, two further biases are possible in this regard. First members of the SAZA team had been involved in the reform processes and they may have had their own agendas which could influence in some way the answers given in interviews and/or the analysis of the data. Second, the reputations of the institutions involved in the research may have impacted on access to interviewees and their responses. These issues are explored in turn.

Within the timeframes of this research the author was never involved in the reform development processes nor made any research input into them. Nevertheless, one of the author's colleagues from the Health Economics Unit was substantially involved in some of the early policy processes, specifically around the development of the first free health care policy and the workings of the Health Care Financing Committee. One other member of the SAZA team from the Centre for Health Policy had also been involved in some of the reforms. To avoid potential biases these two team members were interviewed first to establish their recollections of events and opinions as part of the SAZA project.

In relation to the issue of institutional reputations, it is not known whether the fact that the author worked in the Health Economics Unit had any effect on interviewee access or response. The Health Economics Unit and the Centre for Health Policy probably have good track records with the National Department of Health in terms of policy

related research and this may have allowed easier access to some interviewees, including the former Director General of Health. As to whether interviewees were biased in their responses because of the institutional reputations, it is difficult to tell.

5.5.3 Recall or memory bias

This is perhaps the most likely form of bias in some of the interview data. With some of the events happening five or six years from the time of interview it is quite possible that people had forgotten what had happened precisely or had false or selective memories of what occurred, a common problem in case studies (Carroll and Johnson, 1990). By providing an introduction to the interview along with a faxed description of the project it was hoped that interviewees would start to recall some events in advance. Where an interviewee appeared to be struggling occasional use of non-controversial materials from documents was used to help stimulate recall, see Box 5.3. (Where two interviewees were questioned together this also helped recall.) Where this did not work the subject was introduced from a different angle, Box 5.4, or another topic was introduced. Care was taken in such cases not to put words into the interviewee's mouth other than those they had already been said by that interviewee. Finally, care was taken to verify interview data against material from documents or other interviews (after Thompson, 1988). This will have helped remove any selective memory bias.

Box 5.3: Use of written documents to aid interviewee – an example from an interview with an academic analyst

Q: Could you tell me a little bit about the content, the Terms of Reference?

A: I honestly don't remember them. I must be quite honest. I think it's in this report (holding a copy of the HCFC report). It would have been the sort of stuff which said...Yeah, here, revised TOR page 1. Praise the Lord. Here they are. Revised Terms of Reference. OK there was an original and these were revised. OK. These are the revised version. You can see it on page 1 and consult it there.

Q: The version here is how...

A: I approved this report, so I'm sure this wouldn't have been changed.

Box 5.4: Change of emphasis of line of inquiry when faced with interviewee recall problems – an example from an interview with an academic analyst

Q: Can you tell me a little bit about the composition of the team?

A: We're now going back five or six years. Five years? Well it feels like it?

Q: Well, perhaps just the rationale behind the selection...

A: The people on the team was a group of people put together by (*senior health policy maker*). I had suggested the name of (*academic analyst*) as (*he*) and I had been jointly involved under NAMDA, on previous work on health care financing and I knew that he was very knowledgeable. He's the Professor of Actuarial Sciences at UCT. So I had suggested (*him*). I regret to say I was also the person who suggested the (*foreign academic analyst*). I regret to admit that...I seem to remember I was the person that mentioned his name. I mentioned his name...ah...it would have come up anyway. He had visited South Africa on behalf of NAMDA in previous years at a previous point in time and at the time I had been interested in his ideas...

5.5.4 Reporting Bias

This relates to a deliberate failure by the respondent to reveal information that they wish to hide. This may bias the findings. This type of bias can be quite difficult to detect at the time unless previous interview material or documentation suggest something different from what is being said. While clarification is a legitimate interview strategy it may fail to provide more information where the respondent is trying to hide something. The importance of comparing and contrasting accounts is highlighted here. Where other health sector actors were involved in the same processes triangulation was conducted to try and develop an accurate picture of events.

5.5.5 Interviewee access

Access to the right people is a key concern for case study researchers (Yin, 1994). The interviewee balance itself reflects some problems in accessing pre-identified high-level government policy makers. Most importantly, it proved impossible to arrange interviews with either the Minister of Health from the time of the SAZA analysis, or her first Director General in the National Department of Health. (Nevertheless, an interview with the second Director General was conducted, who was Deputy Director General under the first Director General). To offset this gap at least partially, efforts were made to draw into the analysis publicly available interview data or materials produced by these individuals, who were not interviewed.

5.5.6 Summary

In testing the conceptual framework different approaches and sources have been utilised across four case studies in South Africa to ensure maximum rigour. These safeguards are important, as qualitative analysis of this nature is open to a variety of limitations and biases. First, there may be recall problems for interviewees, where the events were several years prior. Second, access to some interviewees, especially high-level officials, can be problematic and the representation of actor voices unequal across institutions. Third, the bias of interviewers may infiltrate the design, conduct and analysis of interviews. In response, I have taken great care to develop rigorous methods. Two different methods of testing the conceptual framework have been employed, allowing each to check the other. Opinions and events related in interviews were always checked against other sources, both from interviews and from written documents and the print media, where relevant. Where data could not be confirmed and are used in the text, they are treated with circumspection. Where interviewee access proved impossible, other interviews and relevant written documents were utilised to fill the gap. Thus triangulation and validation have been important for all the analysis and results have been crosschecked across the different methodological tests.

Chapter 6: Developing Health Financing Reform in South Africa

Managing actors in policy development is only one component of taking forward health financing reform. In this chapter, I attempt to paint a broader picture of the whole reform process within South Africa. I set out the context for reform, the key technical debates, the main actors and their viewpoints and the principal policy processes. Much of this information and analysis is drawn from the SAZA project and supplemented by more recent data. This sets the backdrop for the testing of the conceptual framework in Chapters 7 and 8.

6.1 The context for Health Financing Reform

6.1.1 The apartheid health sector

In the health sector the apartheid regime entrenched inequity in the provision and financing of services. On one hand resources were allocated without regard for basic needs, producing a lack of access to essential services for the majority of the population. On the other hand, a small minority had access to first-world health care provided by well-resourced tertiary services.

The public health sector was fragmented into a large number of overlapping administrative systems. Each of the four racial groups had its own national department of health; every homeland and provincial administration had a department of health; and 400 local authorities also had health departments. Services were concentrated in urban areas, and focused on curative, hospital-based, specialised care. In 1992/93, more than three quarters of all recurrent public health expenditure went on acute care hospitals, with academic and tertiary hospitals accounting for 44% (McIntyre *et al*, 1995). Only 11% of funds were spent on Primary Health Care outside of hospitals. It is perhaps not surprising that South Africa's health care indicators were so poor (World Bank, 1999).

Concurrently, the private sector had been allowed to blossom, to provide quality care for the white privileged. In 1992/93, more than 60% of health care finances were derived from private sources (see Table 6.1) and the majority of health personnel worked in the private sector. Yet, less than a quarter accessed private sector health care on a regular basis (McIntyre *et al* 1995). The combined effect of a fragmented and skewed public sector for the many and a burgeoning private sector for the few was appalling inequities in health care financing and provision. The differences between the poorest and richest districts, grouped by average per capita income, indicate to some extent the inequalities (*ibid*):

- The richest districts had almost seven times as many doctors per head of the population.
- The richest districts had ten times as many pharmacists per person.
- The richest districts received almost four times as much public health funding per capita.

Table 6.1: Sources of finance for the health sector (1992/93)

Source of finance	Expenditure (R million)	Proportion (%)
General tax revenue	11,447	38.0
Local authorities revenue	225	0.7
Total public sector sources	11,672	38.7
Medical schemes	12,064	40.0
Medical insurance	923	3.1
Industry	1,162	3.8
Out-of-pocket	4,184	13.9
Total private sector sources	18,333	60.8
Donor funding	145	0.5
TOTAL	30,150	100

Source: McIntyre *et al* (1995)

6.1.2 Economic Legacy

In 1994 the new democratic government in South Africa inherited an economy in poor shape. From 1980 its GDP had lagged behind population growth by an average 0.8% per year (de Bruyn *et al* 1998). Trade and investment had suffered at the hands of international sanctions. Consequently, there were high levels of unemployment and poverty. (ANC, 1994b). Debt was also a significant problem. Government expenditure had outstripped revenue from the mid-1980s (Fallon and da Silva, 1994) and by 1992/93 the budget deficit was R27.4 billion¹ or 7.8% of GDP (Department of Finance, 1994). By 1997/98 interest payments on this debt were 20% of the government budget, second only to spending on education in size (May 1998). Two-thirds of this debt was created after 1990 as a result of 'the unravelling of the apartheid state, in particular paying off the old civil and military services, together with the dynamic effects of paying interest on that growing debt' (Duffy 1998, Swilling and Woolridge, 1996). At the same time, the government inherited a bloated and inefficient civil service with about 1.2 million people (Sidloyi, 1996) and this accounted for over 50% of the government budget, excluding debt payments.

6.1.3 The Challenge Ahead

The legacy of the new government in 1994 was frightening: an inequitable, inefficient and fragmented health system alongside an unwieldy civil service with an economy saddled with huge debt. Against this reality the government had to deliver in all sectors to meet the unrealistic aspirations and desperate needs of the majority of its population.

McIntyre *et al* (1995) summarised the following challenges for the health sector in the post apartheid era. These challenges highlight the need for specific reform measures to help the South African health system tackle the inequities and inefficiencies

¹ In 1992/93, the exchange rate was approximately R3 = US\$1.

inherent in the apartheid health care system. The tasks relate, either directly or indirectly, to the redistribution or reallocation of resources to those in need:

1. Develop effective and affordable primary care services;
2. Ensure a more equitable distribution of public sector health finance between provinces and between localities within each province;
3. Reduce the share of the public health budget spent on tertiary and academic hospitals (by reducing expenditure and/or increasing revenue generation);
4. Improve the efficiency of public health services without reducing the quality of health care;
5. Make resources currently located in the private sector accessible to a greater proportion of the population;
6. Control costs in the private sector and address the financial crisis facing medical schemes.

6.1.4 ANC National Health Plan

In anticipation of change of government, a broad research agenda was developed to identify policy options for the post apartheid South Africa in the early 1990s. This led to the development of the ANC National Health Plan, which involved an iterative process of proposal development and debate. A range of issue-specific 'commissions', composed of analysts and activists, drafted policy proposals (interview data), which were then debated within the ANC "rank and file" and consolidated for public review (African National Congress 1993). There was a huge response to the proposals from individuals, community organisations, representative associations of private providers and the private insurance industry, with thirty three formal submissions from

institutions alone (African National Congress, 1994a). Every effort was made to build *consensus* across these diverse groups:

“once we got the second draft, we then sat down with almost every organisation that gave an input and took them through the process of saying this is what you said, this is what we’ve incorporated for these reasons, so we went through a whole process of debating with them until we won them over. And they really appreciated this. To them they weren’t so much concerned about what was coming out of the document but that the ANC was seen to be taking them seriously.” (ANC Health Department Official).

Through the development of the Health Plan even potentially antagonistic stakeholders were engaged in health policy debates:

“We always spoke about how that period from 1990 to 1994 was a window of opportunity, where in a way both State structures and the private sector were going to be made more amenable to ideas about change than before or after that period”
(Health Activist)

At the end of the consultation process a small editorial team from the ANC’s Health Department, WHO and UNICEF spent two intense weeks combining all the different inputs into a coherent final document. As a member of the final drafting team noted,

“I have this picture of (team member) wielding this enormous pair of scissors, cutting and pasting”

The Plan was published just before the 1994 elections.

6.2 The Health Financing Reforms

6.2.1 The Policy Response

The first democratic Government in South Africa set out to face the immense challenge left by its predecessors in every sector. Following on from the official Health Plan of the African National Congress (African National Congress, 1994i) there were various initiatives to develop health policy (see policy processes, later). This culminated in the White Paper for the Transformation of the Health System in South Africa, published in 1997, which is effectively the national health policy statement, before the National Health Bill is passed. Its vision embraces a unified health system where all actors (including the private sector) are coordinated in pursuit of the fundamental goal of *equity* (Republic of South Africa, 1997, Gilson *et al*, 1999). Health care is to be provided in accordance with the Primary Health Care Approach and the District Health System is to be the main service delivery vehicle for primary care. Table 6.2 sets out the main characteristics of the new policy in comparison to that of the previous regime.

Table 6.2: Key elements of the White Paper

	Characteristics under the previous regime	Characteristics of the new policy
Health policy formulation	<ul style="list-style-type: none"> • Racially divided • a focus on diseases • hospital and urban bias 	<ul style="list-style-type: none"> • attends to the needs of all South Africans, especially the most vulnerable • comprehensive PHC based • proposes a Charter of Patients' rights
Management	<ul style="list-style-type: none"> • highly centralised • bureaucratic 	<ul style="list-style-type: none"> • decentralised • participatory
Organisation	<ul style="list-style-type: none"> • fragmented and ethnic-based • public and private sectors acting independently 	<ul style="list-style-type: none"> • single national health department focusing on policy and setting of norms and standards • nine provincial departments • a major shift to establish functional districts • better co-ordination between the public and private sectors within a single national health system
Financing mechanisms	<ul style="list-style-type: none"> • racially divided and inequitable • private sector characterised by unsustainable cost escalation and perverse incentives driving the delivery side 	<ul style="list-style-type: none"> • equity driving budgetary allocation • aims at promoting efficiency
Drug policy	<ul style="list-style-type: none"> • irrational prescribing patterns • doctors dispensing for profit • differential pricing between state and private sector 	<ul style="list-style-type: none"> • essential drugs programme • greater use of generics • transparent pricing with single exit price • no mark-up on drugs by professionals, only a professional fee • aims overall to reduce the cost of drugs
Human resource development	<ul style="list-style-type: none"> • ad hoc • racial • compartmentalised between professions • institutional focus 	<ul style="list-style-type: none"> • planned • facilitates entry of students from disadvantaged backgrounds • promotes a multidisciplinary approach • community focus

Source: Gilson *et al* (1999), Ntsaluba (1998).

6.2.2 The Evolution of Selected Health Financing Reforms

Within the overall policy framework the new government set out on an ambitious range of health financing reforms. In this section, I focus on the three strands of health financing reform which form the SAZA case study materials for the testing of the conceptual framework. As noted in Chapter 5, the three reform streams are: health

insurance and the regulation of Medical Schemes; user fee policies and resource allocation. The period of focus is 1994-1999, or the first term of office of government after the democratic transition. (The Conditional Grant reform occurred after 1999 and is documented in detail in Chapter 8.) Below I discuss some of the key issues and events in the three streams of reform as they unfolded. This is summarised in Table 6.3.

6.2.2.1 Health Insurance and the Private Sector

Issues around National and Social Health Insurance and the regulation of medical schemes were debated in a series of policy committees from 1994. Indeed discussions of possible forms of health insurance date back to the early 1990s and were reflected in the ANC Health Plan. Yet despite much activity there has been little progress, with no proposal gaining sufficient backing for implementation. The Health Care Finance Committee, the first key policy committee, deliberated over three options, differentiated by the beneficiary group (the whole population vs. contributors only) and by the package of services covered (primary care only vs. a package of primary and hospital care). Ultimately, the Committee suggested that the most technically and politically feasible option was a SHI scheme ensuring coverage of a package of primary and hospital care for contributors only (Health Care Finance Committee, 1994). Faced with a policy drive toward free Primary Health Care, the 1995 Committee of Inquiry proposed that the SHI scheme focus only on the provision of hospital care (Republic of South Africa, 1995). Finally, the 1997 policy proposals from the SHI Working Group further restricted the policy, limiting it to hospital cover for employees who did not have private health insurance.

Interestingly, the proposals became less and less equitable. The 1997 version allowed for little cross-subsidisation between high and low income groups (Department of Health 1997). It also dropped the 1995 plan to develop a 'risk equalisation' mechanism between existing private insurance schemes that would seek to spread the risk of providing cover across the entire insurance industry, and excluded the medical scheme industry as a candidate for administering the fund. This "policy drift" away from equity (senior government official) may well confirm the political difficulties

(noted in Chapter 2) of pursuing financing reform to benefit the less well off. While this drift may have been designed to make SHI *more* acceptable to key parties, it failed (see Chapter 7).

A key component of the health insurance models was the role and functioning of the private sector. The most radical proposal was the 'Deeble option' of the Health Care Finance Committee (see more details later), which effectively proposed a nationalisation of private general practitioners to support universal primary care coverage. In contrast, the 1997 proposals envisaged that the insured population would be primarily served by public hospitals (inferring that these hospitals might be supported by a limited number of private hospitals contracted to provinces). All proposals, except the Deeble option, also allowed for additional cover from the private sector, for those who could afford.

The operation of the private insurance industry became the subject of the 1997 policy development process undertaken in parallel to SHI, the process that resulted in the 1998 Medical Schemes Act and regulations developed in 1999. The roots of the new legislation were the proposals of the 1995 Committee of Inquiry. This recommended three broad areas of new regulation for Medical Schemes which formed the basis of the eventual act (Söderlund *et al*, 1998):

- Enforcement of risk pooling between high and low-risk enrollees
- Requirement that all cover include at least a minimum package of hospital care
- Specification of standards around oversight, amount of financial reserves and reporting requirements to boost the financial sustainability of the market

Consequently, the Medical Schemes Act outlawed the practice of excluding members due to previous or current health status. Its aim was to prevent cream-skimming by some schemes to the detriment of others and the "dumping" of expensive patients on the public sector. It also encouraged cost containment by both funders and providers (Goudge, 2000).

6.2.2.2 Resource Allocation

The development and implementation of resource allocation reforms occurred within and through the normal process of government budgeting and so had to adapt to the broader evolution of these budgeting processes. This had an important effect on reform management as will be seen in Chapter 7. Indeed, there were two very different phases of resource allocation policy within the 1994-99 period.

The first phase was characterised by a health sector formula that supported re-allocations of budgets between provinces on the basis of population and weighted by need. Under the direction of the Director General, National Department of Health, the Function Committee devised and oversaw the formula which was to achieve its goals of equitable resource allocation within five years. Substantial redistribution was planned for the first year (interview data). The weighting process took account of differences in socio-economic status between provincial populations (initially based on per capita income level and then medical scheme membership levels). These differences were assumed to reflect the differential health needs of provinces, assisting previously disadvantaged areas. At the same time, through the 'top slice', funding for specialised academic hospital services, seen as a 'national function', was protected.

The second phase, the era of 'fiscal federalism', resulted from the introduction in 1996 of the new constitution, which finalised the governance structure of the country after transition. The change in resource allocation practice was accompanied by major changes in the budgeting process. Since 1997/98 the National Department of Finance has determined the framework for budgeting, including the available resources, through its medium-term expenditure framework. This is shaped by government's macro-economic policy, 'Growth, Employment and Redistribution' (GEAR). From 1997/98 the National Department of Finance (NDoF) allocated block grants to provinces on the basis of a formula intended to reflect differential levels of overall provincial 'need', though there has been disquiet about its weightings and limited redistribution effects. Provincial Departments of Finance then have responsibility for allocating these resources between sectors. This process has effectively undermined

the NDoH, which cannot determine health resource allocations across provinces and health allocations are subject to competition from other sectors at the provincial level (see also Chapter 7 discussions).

One way of preserving some control over allocations has been the development of 'conditional grants' under the management of the NDoH, that earmark funding for specific purposes. Several health conditional grants were introduced in 1997/98 but primarily relate to higher level services (see Box 6.1). Although health officials initially expressed a clear preference for protecting primary over hospital care (interview data), the conditional grants finally agreed primarily focus on, and so protect the funding of, certain types of hospital services. Grants 1 and 2 also reflect the understanding that academic hospitals are a national resource and so should be controlled at national rather than provincial level. They build on the Function Committee's inclusion of a national increment for teaching, education and research (NITER) in its formula. Grant 3 is intended to work hand in hand with the second grant in supporting the development of appropriate levels of tertiary care services in all provinces. A critical requirement for the effective implementation of these grants was, however, the determination and costing of national and tertiary functions (see Chapter 8), and such activities were only carried out after 1999.

Box 6.1: Health conditional grants introduced since 1997/98

The health sector conditional grants cover grants for:

1. research and training of health professionals (all provinces);
2. central hospital specialist services situated in Gauteng, Western Cape, Free State and Kwa-Zulu Natal to cover the costs of the use of these services by residents of other provinces;
3. hospital rehabilitation and construction (the 'redistributive' grant);
4. the primary school nutrition programme.

The NDoH releases these funds to provincial health departments only when they meet certain conditions: the submission of business plans detailing how the resources will be used and demonstration of appropriate use of the previous year's conditional grant funding

6.2.2.3 User Fees

Free Health Care

In Nelson Mandela's first speech to parliament as President of the new Government of National Unity (GNU) on 24th May 1994, he announced a series of 'Presidential Lead Programmes' representing the GNU's top priorities for its first 100 days of office. Drawn from the RDP but with inputs from all departments, the speech included the announcement of free health care for pregnant women and children under six to become effective on 1st June 1994. In practice, however, the legislation for the policy only came into effect in July 1994 (Government Gazette, Notice 157 of 1994). The speed of the announcement took everyone by surprise and, although the new national Minister of Health did discuss it with provincial counterparts there was little time for careful planning of its implementation.

The decision was taken before the establishment of the Health Care Financing Committee in 1994. Nonetheless, this Committee was charged with developing fee proposals for the new government. Drawing both on international and South African evidence of the very small contribution made by primary care fees to total revenue (McIntyre 1994; McIntyre *et al.* 1995), the Committee affirmed the proposals of the ANC's Health Plan. It recommended that primary care services should be free at the point of service, except for those with insurance (Health Care Finance Committee 1994). Similar recommendations were also made by the Committee of Inquiry into a National Health Insurance system (Republic of South Africa, 1995). Finally, the Minister announced the second free care policy, free primary care for all South Africans, in a parliamentary budget debate in April 1996.

Despite the findings of an evaluation of the first free care policy (McCoy 1996), and against the recommendations of the Health Care Finance Committee, the second policy was again implemented speedily and with little prior consultation, especially within provinces and with service providers. Although the policy was discussed and agreed in the PHRC (interview data), to other managers within provinces the announcement:

“was very abrupt, very sudden and the provinces didn’t have time to position themselves” (Provincial Official).

Hospital Fees

Hospital fees were considered in three policy processes: briefly as part of the ANC Health Plan and more comprehensively by the Health Care Finance Committee in 1994 and within the Hospital Strategy Project (HSP) in 1995/96. Specific issues of design related to levels of fees, market segmentation by income of the patient and protection of the poor, retention of fees at facilities, cost recovery procedures and fund utilisation. One problem with the retention proposals was that regulations required revenue generated through health care fees to be returned to provincial revenue funds. Nevertheless, there has been a more recent move away from this in at least one province. The HSP project was concerned with broader issues of strengthening hospital management and within that detailed recommendations on implementation procedures – such as the need for dedicated staff, for co-ordination across provinces and on the timing of key actions. Its proposals were also seen as a stepping stone toward SHI. It also recommended that fees should be tied to visible quality improvements to encourage payment and to allow ‘private wards’ with better hotel facilities to be opened to encourage use of public hospitals by medical aid patients. ‘Private patients’ could then be charged at full cost or higher rates, generating greater revenue than otherwise possible, whilst private wards would encourage medical staff from the private sector to work in public facilities (Monitor Company *et al.* 1996; interview data).

Despite all these recommendations progress was slow toward both improved hospital management and the development of a national uniform hospital fee system. Eventual agreement was achieved for the latter but not implemented in the study time frame. Further, policy issues around revenue retention were decentralised to the provincial level.

Table 6.3: The Evolution of Health Financing Reforms

YEAR	REFORMS OF FOCUS		
	Resource Allocation	User Fees	National/ Social Health Insurance
Early 1990s-1994	<p><i>Agenda setting through ANC health plan development:</i></p> <ul style="list-style-type: none"> • makes proposals across all reform areas 		
1994	<p><i>Policy actions:</i></p> <p>Function Committee establishes policy for health resource re-allocations across provinces in 94/95 budget</p>	<p><i>Policy actions:</i></p> <p>Free care 1</p>	<p><i>Agenda setting/policy formulation:</i></p> <p>HCFC presents three N/SHI options; recommends that wider Commission be established to take forward policy development</p>
1995	<p><i>Policy implementation:</i></p> <p>Function Committee continues with revision & application of formula for 95/96 FY</p>	<p><i>Agenda setting:</i></p> <p>Minister of Health budget speech accepts principle of universally accessible PHC</p>	<p><i>Agenda setting (policy formulation?):</i></p> <p>negative reactions in press to leaked 'Deeble option' of HCFC; COI recommends establishing committee to develop greater detail of SHI & medical scheme re-regulation</p>
1996	<p><i>Policy implementation:</i></p> <p>application of health formula for 96/97 FY; era of fiscal federalism brings unconditional block grants for provinces from 97/98 FY</p> <p><i>Policy formulation:</i></p> <p>health conditional grants established to be applied from 1997/98 FY;</p>	<p><i>Evaluation:</i></p> <p>of free care 1 published</p> <p><i>Policy action</i></p> <p>Free care 2</p> <p><i>Policy formulation:</i></p> <p>HSP hospital fee proposals published</p>	<p><i>Policy formulation:</i></p> <p>Medical Schemes Working Group established</p>

YEAR	REFORMS OF FOCUS		
	Resource Allocation	User Fees	National/ Social Health Insurance
1997	<p><i>Policy implementation:</i></p> <p>evolution of health conditional grants;</p> <p>MTEF introduced for 98/99 FY;</p> <p>health MTEF task group established;</p> <p>continued development of formula for determining unconditional block grants;</p>	<p><i>Policy formulation:</i></p> <p>continued discussion of hospital fee issues in PHRC</p>	<p><i>Agenda setting:</i></p> <p>White Paper on the Transformation of the Public Health System published endorsing SHI;</p> <p>SHI Working Group established;</p> <p>SHI Working Group publish proposals</p> <p><i>Policy formulation:</i></p> <p>Medical Schemes working group meeting</p>
1998	<p><i>Policy implementation:</i></p> <p>evolution of health conditional grants;</p> <p>health '4x4' initiated;</p> <p>continued development of MTEFs and formula for determining unconditional block grants;</p>	<p><i>Policy formulation:</i></p> <p>continued discussion of hospital fee issues in PHRC</p>	<p><i>Agenda setting/policy formulation:</i></p> <p>initial discussion on development of social security including SHI</p> <p><i>Policy implementation:</i></p> <p>Passing of Medical Schemes Act</p>
1999	<p><i>Policy implementation:</i></p> <p>evolution of health conditional grants;</p> <p>continued evolution and application of unconditional block grants</p>	<p><i>Policy formulation:</i></p> <p>continued discussion of hospital fee issues in PHRC</p>	<p><i>Agenda setting/policy formulation:</i></p> <p>Social security discussion continuing; Publication of ANC manifesto endorsing SHI importance</p> <p><i>Policy implementation:</i></p> <p>Regulations to implement developed</p>

Source: Gilson *et al* (1999)

Abbreviations:

ANC = African National Congress; COI = Committee of Inquiry; HCFC = Health Care Finance Committee; Free Care 1 = free care for pregnant women, nursing mothers and children under six; Free Care 2 = free primary care; FY = financial year; MTEF = medium term expenditure framework; NHI = national health insurance; NHS = national health system; PHRC = provincial health restructuring committee; SHI = social health insurance

6.3 Key Actors and Values

It is useful to outline the key actors, and their broad concerns, in the health financing reform debates in the post-apartheid era. While views and power-bases changed slightly over the time period the information provides a useful orientation to actors in the debates. The list deals both with actors who were reform drivers and key actors involved in the reform (see Chapters 7 and 8).

6.3.1 The National Minister of Health

The Minister had a critical role in many aspects of health financing reform between 1994 and 1999, particularly in relation to resource generation reforms. This was partly due to her formal role but also because the lack of systems and structures in government after the change-over and because of the dominant position of government. She was personally and strongly committed to the goal of improving access to health care for the poor and rural populations and particularly for women and children. This led her to taking a strong pro-equity stand in all of the health financing reforms that she managed or became involved with. Box 6.2 demonstrates the variety of reactions to her and her reform agenda:

Box 6.2: Views of the Minister and her reform programme

“Dr. Nkosazana Zuma’s Health Department is systematically revolutionising South Africa’s health-care system” (electronic Mail and Guardian, May 26th 1997)

“I think that health is one of the Ministries that has come out best in terms of biting the bullet on some very untenable things” (former ANC official).

She seeks *“a complete socialisation of our health care services”* (Democratic Party spokesman in parliamentary records. Republic of South Africa 1996: 2224¹),

“...failed Marxist health policy” (Member of Parliament from the Inkatha Freedom Party in The Star, March 23rd 1998).

She took on several important *“vested interests and admirably fouled up their featherbed”* (Weekly Mail and Guardian, November 13th 1998)

Attracting a strong reaction from many quarters there was a lot of personal criticism of the Minister. Nevertheless, she had firm backing from the President and Deputy President and the ANC consistently gave her public support (e.g. 'ANC Again Gives Backing to Zuma', Citizen, April 7th 1998).

In the initial reform period the Minister worked hand-in-hand with the first Director General on many health financing reforms. One policy committee member remarked:

"I saw the (Director-General) and (the Minister) as one."

Later tensions surfaced between the Minister and the Director General, which eventually led to the Director-General resigning toward the end of the SAZA study period, apparently because of their conflict. As one analyst noted, they were:

"...both strong women with aggressive styles in a positive sense"

It is often difficult to determine from the interview data and reports whether and to what extent the Director General had a separate picture of reform from the Minister. The Director General was "always actively involved" in the early reform processes, a key reform driver, specifically around the health insurance debates, resource allocation and free Primary Health Care, with a very hands-on management style. She appeared to be motivated by a concern to secure her own position and do a good job on top of any personal ideology. Yet the interview data do not present a clear picture on these issues.

6.3.2 The Directorate of Health Financing and Economics in the National Department of Health

Although the Directorate was involved in all stages of SHI development, it only played a leadership role toward the end of the study period. Initially created as a Unit in 1994, it only became properly functional in 1996 and did not have that much influence in early debates. This was partly due to limited human resources but also to

the fact that it was new and other actors within NDoH did not understand its importance or potential. One of the first actions of the second Minister of Health was a review and overhaul of the existing organisational structure of the national DOH, resulting in the creation of the Directorate of Health Financing and Economics to lead policy development in this field.

Nevertheless, it played a critical role in developing the Medical Schemes Act and the 1997 NDoH proposal. It was largely in favour of health financing reforms with an equity bias but its priorities and efforts were shaped by a series of Directors. Hence the development of SHI and the reregulation of the Medical Schemes Industry was important in the later 1990s. More recently, with new personnel, issues around the need for reform of resource allocation and conditional grants have become more important (see Chapter 8).

6.3.3 Academic Analysts

These technicians, often with activist backgrounds, were mostly based in South African universities. In 1994 the role of analysts from outside government changed from developing and driving processes, to supporting the new government's personnel within its own-initiated processes. Analysts have acted both as reform drivers and "guns for hire" in reform development processes. They typically had close links with the National Department of Health and while not politically powerful tended to gain influence from their general support of the redistributive policies of the government, coupled with their own technical expertise. They have been broadly supportive of free primary health care; supportive of geographical redistribution in resource allocation, supportive of fee reforms in hospitals, opposed to National Health Insurance and generally supportive of SHI. Nevertheless, there was disquiet about the equity impact of the 1997 SHI proposals and analysts were divided on its merits (interview data).

6.3.4 Administrators of Medical Schemes:

Medical Schemes are the principal financial intermediaries in the private sector, accounting for 40% of total expenditure on health in South Africa in 1992/93 and 42% in 1998/99 (McIntyre *et al*, 1995, Doherty *et al*, 2002). They are non-profit, voluntary associations funded primarily out of contributions from employers and employees. Medical schemes reimburse medical expenses incurred by members, sometimes with a co-payment by members. Health service providers are paid on a fee-for-service basis, a system that is recognised across the globe as encouraging over-provision of expensive services (Normand and Weber, 1994).

It is important to note that the large companies that *administer* Medical Schemes are profit-making. Consequently, the administrators are concerned to protect their commercial interests and profit margins. They warmed towards initial discussions of Social Health Insurance by the ANC in 1994, which envisaged a significant role for the private sector, and for the medical schemes industry in particular. As one interviewee commented, the medical schemes industry

'was a movement well-aligned - in the way it conducted its affairs, in the nature of its leadership, in its vision of its own future - ... to government thinking. Also, it was caught up in the euphoria of the new government and in the vision of expanding access to health care and the vision of the private sector supporting that health care initiative ... So there was a general feeling of "right, we're now ready to make our mark on the new society"'

Hence the medical schemes administrators showed willingness to be involved in the transition and in policy dialogue about SHI in 1994 and 1995. They have been generally supportive of this policy, though a split emerged in relation to the reregulation of Medical Schemes in 1997 and 1998. One part of the industry, specialising in selecting low-risk and wealthy individuals, was especially opposed to the new legislation. Nevertheless, the industry was united in its opposition to National Health Insurance, though careful about how its opposition was expressed.

6.3.5 The Provincial Departments of Health

Provincial Departments of Health were created after the elections in 1994. While they had an active voice on the Function Committee, the move to a system of fiscal federalism under the new constitution reduced their power substantially in the resource allocation processes, as has already been noted. Nevertheless, they had more direct engagement, and perhaps influence, with reform drivers in the review of the Conditional Grants.

It is worth examining the interests of Provincial Departments of Health in the resource allocation reforms to understand some of the inter-provincial dynamics. Interests were partly determined by historical funding patterns. In relation to public funding per person in each province, a basic indicator of needs-based resource allocation, Gauteng and the Western Cape received far more than the national average throughout the study period (Thomas and Muirhead, 2000; Doherty *et al*, 2002). The funding of public health care in the Free State and KwaZulu Natal was close to the national average, whereas the other provinces were substantially underfunded (Gilson *et al*, 1999, Thomas and Muirhead, 2000). Hence resource allocation reforms targeted to improve equity promised both winners and losers. While no province wished to be seen to be overtly anti-equity it was clear that the better-resourced provinces were resistant to change. Such tensions appeared to increase further into the study period. They were often manifested in discussions about the phasing in of planned reforms, such as in the Function Committee and with the review of Conditional Grants. Better resourced provinces pushed for longer phasing-in periods for the reform to allow time for adjustment.

6.3.6 Trade Unions

COSATU (Congress of South African Trade Unions) was, and is, a key member of the political alliance headed by the ANC. It is also the largest grouping of trade unions in South Africa, with 1.2 million members at the time of transition.

Nevertheless its influence in government policy development has been on the wane, as has its membership. Indeed, from the mid 1990s trade unions have accused the ANC of being persistently and unduly influenced by business.

The health sector policy of the unions has not been clear-cut. Perhaps this reflects a tension between concerns for general redistribution and guarding the interests of its members. It may also reflect the fact that health has not really been a priority issue for unions. The union movement has certainly done little to be engaged in many of the health reform debates, though its opinion on SHI has been courted and proved to be an important element in the development of SHI within a social security framework.

6.3.7 National Department of Finance²

Through its power to set the macro-economic agenda and control the government budget, the DoF is probably the most powerful government Ministry. In 1996 it introduced the Government's macro-economic policy, GEAR (Growth Employment and Redistribution), a fairly orthodox structural adjustment programme, to continued acclaim from multilateral institutions. Economic growth is to be achieved through: the promotion of private (particularly foreign) investment; the encouragement of export competitiveness; and the achievement of productivity improvements (DoF 1996, Marais 1997, Heintz and Jardine 1998, May 1998). Key targets for the DoF relate to the reduction of the tax to GDP ratio, the reduction of government debt, to promote business confidence, and the control and cost-effectiveness of public sector expenditure.

The NDoF's control of the resource allocation process allows it to determine the formula underlying the geographic allocation of resources across provinces and between different levels of government. This may have undermined the push for equity in health sector resource allocation. First there is no direct focus on equity in budgeting (despite the health sector policies described earlier). Second, the formula used for allocation between provinces includes components and weightings that

favour richer provinces. Third, efficiency is seen to be the main driving force in the allocation of conditional grants (McIntyre *et al*, 1999; Thomas and Muirhead, 2000). The DoF has also objected to SHI on the basis that it is an earmarked tax and that it will raise the tax-burden for the middle class, who are already paying too much (interview data).

6.4 Main policy processes

6.4.1 Routine processes

6.4.1.1 Decision-making Fora

Two government bodies are particularly important for debating and approving health policy. Both involve representation from each province and thus facilitate coordination and the appropriate distribution of responsibilities. The health ‘MINMEC’, like its counterparts in other sectors, brings together all nine provincial MECs (equivalent to provincial Ministers) for health and is chaired by the national Minister of Health. Its counterpart is the Provincial Health Restructuring Committee (PHRC) which brings together the heads of the Provincial Departments of Health, and is chaired by the national Director General (equivalent to a permanent or principal secretary). Both bodies meet regularly and while the PHRC is never attended by politicians, senior civil servants often accompany MECs to the MINMEC. The PHRC establishes smaller working groups to address specific issues, when required, and is itself supported by other inter-provincial committees which co-ordinate action in particular policy areas. Such committees report to the PHRC and MINMEC from time to time, and identify policy issues for discussion and action at these higher levels.

² The National Department of Finance changed its name to the National Treasury in 2001. Under, the SAZA case studies the institution is referred to as the National Department of Finance, while in the Conditional Grant case study it is National Treasury.

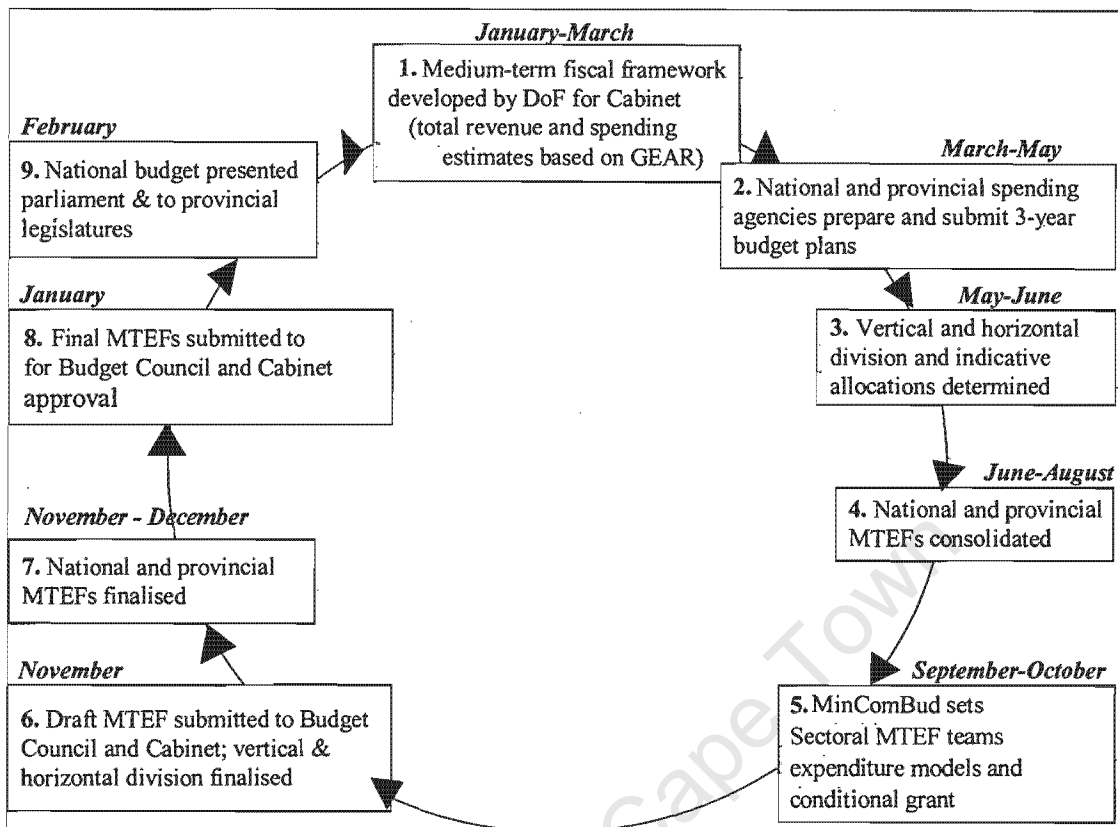
6.4.1.2 The Budget process

As well as key decision making bodies it is useful to consider the budget process as many decisions about resource allocation policy in the health sector are effectively taken here, and outside of the health MINMEC and PHRC. Diagram 6.1 sets out the annual budget cycle that was in place from 1996/97.³ Following the introduction of the new constitution, a system of fiscal federalism was effectively adopted, where significant budgetary authority over sectoral allocations was decentralised to provinces. Budgetary allocations were, and are, made through *vertical* and *horizontal* divisions of the total government budget. The *vertical* division is intended to reflect the responsibilities of the three spheres of government (national, provincial and local). In 1999, excluding debt service costs and a contingency reserve, over 44% of government resources were allocated to national, about 54% to provincial and 1.3% to local government (DoF, 1998). The *horizontal* division relates to the block grant funding across provinces. The formula used for the division includes population-based weights and other factors intended to allow for differential needs between provinces.

These divisions have to be reconciled with provincial and sectoral budgets. This occurs with the development of the provincial and sectoral Medium Term Expenditure Frameworks (MTEFs), which are three-year rolling budgets. Initial budget estimates are developed by all spending agencies at provincial and national levels (Step 2, Diagram 6.1). Provincial Treasuries later develop consolidated provincial budgets on the basis of these initial estimates (Steps 4 and 7). They also ensure that the final figures fall within the guideline allocations determined through the vertical and horizontal divisions (Steps 3 and 6). They must also comply with a DoF requirement introduced in 1998, that 85% of the total provincial budget should be allocated to social services. Subject to subsequent negotiations (Step 8), the estimates developed then go on to form part of the final national budget presented to parliament (Step 9) (McIntyre *et al*, 1998).

³ Subsequent to 1998/99 the *timing* of the stages has changed slightly, as the Budget is currently announced in February. However, the stages themselves are the same.

Diagram 6.1 Annual budget cycle, post-1996



Notes: DoF = Department of Finance; MinComBud = Ministers Committee on the Budget; MTEF = Medium Term Expenditure Framework

Source: McIntyre *et al* (1998), Information from Presidential Review Commission (1998)

What are the implications of these procedures for decision-making about resource allocation in the health sector? First the initial decisions about vertical and horizontal allocations lie with the Budget Council (at least in theory, though the NDoF tends to get its way). The Budget Council is made up of the National Minister of Finance and the nine MECs for Finance accompanied by their senior civil servants. It is, in effect, the equivalent of the Health MINMEC. Second, the subsequent distribution of funds across sectors is decided at a provincial level. In neither case can the National Department of Health influence allocation through any formal mechanism. This led to the concern that the health sector would be left hostage to politics at the provincial level, given the decentralisation of the sectoral allocation (McIntyre *et al*, 1999, Gilson *et al*, 1999). To redress the balance a little, a series of health ‘conditional grants’ were introduced from 1998/99 which focus on the protection of funds to certain health services, in particular highly specialised hospitals. However, the use of

conditional grants emphasises issues around funding flows to higher levels of care and not equity. Further, they only account for approximately 20% of the public health sector budget (Thomas and Muirhead, 2000).

6.4.1.3 Coordination between NDoF and NDoH

The health sector MTEF task team, co-ordinated by the NDoF, was established in 1997 as one of several sectoral task teams charged with developing expenditure models for their sector, considering policy choices, developing norms and standards and making recommendations on conditional grants. The health MTEF team initially focussed on reviewing health budgets from an efficiency perspective, assessing the allocation of resources between programmes within provinces as well as differences between provinces in unit costs (Department of Finance 1997). This task team was strengthened in 1998 and a new body created to support it, called the “four by four”. The “four by four” brings together one official each from the National Departments of Health and Finance, as well as three provincial health and three provincial finance officials. It seeks to improve co-ordination on budget issues particularly at provincial level. Joint finance and health MINMECs are also being held to improve co-ordination and communication (interview data).

6.4.2 Special processes

A range of health financing committees and working groups were established from 1994. While routine budget processes were important for the development of resource allocation policies, special one-off policy processes were critical for user fees and health insurance. Such committees tended to involve health sector actors outside government instead of being exclusively confined to civil servants, as with the routine government processes.

Table 6.4: Details of health care financing special committees, 1994-99

	1994 Health Care Finance Committee (HCFC)	1995 Committee of Inquiry into a National Health Insurance system (CoI)	1997 Social Health Insurance Working Group	1997 Medical Schemes Working Group
Terms of Reference	<ul style="list-style-type: none"> • Cost free MCH care & extension of free primary care to all uninsured. • Make recommendations on fees for all levels of health system • Make recommendations on fee levels for insured and revenue retention rates • Examine appropriateness and feasibility of establishing an NHI system, or for other models to enable all South Africans to have access to comprehensive health services at an affordable cost • Explore compulsory service for medical graduates • Provide recommendations on a needs-based resource allocation process of allocating budgets to provinces 	<p>Initially intended to prepare a detailed, phased and costed plan for the introduction of a national health insurance system, or a publicly supported alternative, with the aim of ensuring access to PHC services for all South Africans.</p> <p>BUT later revised to allow broader investigation of NHI options; Committee also investigated regulation of medical schemes although not part of TOR</p>	To develop detailed proposals for a SHI scheme supporting public hospital use	To prepare new legislation on medical schemes regulation
Duration	June-November 1994, five meetings	Jan-April 1995	Jan-May 1997 (but subsequent ad hoc meetings)	Late 1996 – late 1997
Chair	Two chairs, a health policy analyst (3 meetings) and a health service manager (2 meetings)	Co-chairs: Special adviser to Minister of Health and a health policy analyst	Financing Adviser to DoH (funded by EU)	Member, DoH DHFE
Membership	<p>17 members</p> <ul style="list-style-type: none"> • 7 South African analysts • 6 national/provincial government officials • 1 private sector analyst • 3 international analysts 	<p>13 members</p> <ul style="list-style-type: none"> • 3 South African analysts • 3 national/ provincial government health officials • 2 national Department of Finance officials 	<p>6 members</p> <ul style="list-style-type: none"> • 3 South African analysts • 3 national health officials 	<p>6 members</p> <ul style="list-style-type: none"> • 2 South African analysts • 4 national health officials

		<ul style="list-style-type: none"> • 3 international analysts • 2 private sector representatives 		
Reporting Point	Special Adviser to Minister of Health	Director General, DoH	Deputy Director General, DoH	Deputy Director General, DoH
Activities	Technical analysis and debate within committee only	<ul style="list-style-type: none"> • Call for submissions • Technical analysis and debate within committee • Commissioned research • Consultation with stakeholders 	<ul style="list-style-type: none"> • Technical analysis • Unofficial sounding out of stakeholders 	<ul style="list-style-type: none"> • Technical analysis • Consultation with stakeholders
Products	Report to Minister, December 1994 (aspects leaked to press)	Initial report to MINMEC & Cabinet Draft report published mid 1995, finalised 1996	Report to MINMEC, released as DoH policy document September 1997	Medical Schemes Regulation Act, 1998

Source: Adapted from Gilson *et al* (1999).

Outside the routine structures of government, six special structures were *established* over the 1994-99 period to address aspects of health care financing policy development. Of the six, five were committees and one a project. Table 6.4 details four of these committees and makes clear that there were considerable differences in their terms of reference, membership, size and operation⁴. The first two were large, formal committees, established by the DOH with wide-ranging terms of reference, particularly the Health Care Finance Committee, and a short time span. In contrast, the latter two were much smaller in size, focused on specific aspects of health insurance design, and more 'internal' to the DOH.

The Health Care Finance Committee and the Committee of Inquiry were less concerned with technical analysis than with the internal politicking particularly associated with interventions from Dr. John Deeble, an Australian economist. Deeble first introduced into the Finance Committee discussions the proposal that universal PHC cover could be achieved by contracting both private GPs and public facilities

into a NHI scheme. Debates within the committee came to focus more on the pros and cons of the 'Deeble option' than on any other element of their analysis and work.

There was considerable discontinuity in membership across the committees. Although the first head of the NDoH's Directorate of Health Financing and Economics was involved in all four committees, the non-government health policy analysts involved in the latter two committees were different from those involved in the first two. Whilst an official of the Representative Association of Medical Schemes (the main private insurers' body of the time) participated in both the Health Care Finance Committee and the Committee of Inquiry, only the Committee of Inquiry had representation from the Department of Finance (see Table 6.5). Dr. Deeble's presence was also felt throughout the sequence of committees. Initially invited to participate simply as one of international advisers to the Health Care Finance Committee, he quickly gained the ear of the Minister and became the only international health economist to be involved over a longer period of time. He participated directly in the first two committees and then, although not a member of the SHI Working Group, continued to offer advice to the Minister at that time (interview data).

Special pieces of analysis were undertaken for all committees, either by individuals on the committee or, in the case of the Committee of Inquiry, commissioned from outside analysts (interview data). There were varying degrees of consultation across the committees – from none in the case of the Health Care Finance Committee, to wide-ranging consultation in the Committee of Inquiry – the only body that called openly for submissions on its terms of reference or conducted public hearings across the provinces (Table 6.4). The Medical Schemes Working Group, in contrast, conducted an intensive consultation process with different stakeholders, within a deliberate strategy. Although SHI was not an element of its terms of reference, this also provided a vehicle for some consultation around the SHI Working Group's proposals, especially given that the two working groups had overlapping membership.

⁴ Table 6.1 does not include information on the Committee of Inquiry into Social Security as, at the time of writing the committee, was still sitting, and its main activities have occurred outside the 1994-1999 period. Nevertheless, commentary on key aspects of the committee is provided later.

Table 6.5: Engaging key actors in formal policy structures

Actor	Strategy of Engagement by committee				Actor position on policy proposals
	Health Care Finance Committee	Committee of Inquiry	SHI Working Group	Medical Schemes Working Group	
Department of Finance	Not yet active	Representation	Consultation	Consultation	Opposed to N/SHI. Opposed to reregulation of Medical Schemes
Trade Unions	None	Consultation	Marginal Consultation	None	Generally unclear, but opposed 1997 SHI proposals
Medical Schemes	Personal involvement	Representation	Consultation only through medical schemes regulation process	Strategic Consultation	Broadly supportive of SHI. Split over reregulation of Medical Schemes
Analysts	Personal Involvement	Personal Involvement	Personal Involvement	Personal Involvement	Generally supported SHI and reregulation of Medical Schemes

Note: Personal Involvement implies that the members were there in their own capacity and not as representatives of actor groupings, though some interviewees debated whether such a distinction could hold.

Although the Health Care Finance Committee report was not initially made public, aspects of it were leaked to the press and so became publicly debated. In contrast, the draft Committee of Inquiry report was made publicly available for comment before it was finalised. A briefer document was also prepared and submitted to the health MINMEC and then Cabinet (interview data). The reports of both the SHI and Medical Schemes Working Groups were both discussed within formal structures, such as the MINMEC and disseminated through consultation with selected stakeholders, but were not distributed for public debate. Across all committees, only the Medical Schemes

Working Group resulted in actual policy and legislative change – in the form of the Medical Schemes Act of 1998.

One last special committee process that has relevance to the health sector, but is not included in Table 6.5, is the Committee of Inquiry into Social Security. By August 2002, which marks the cut-off point of inquiry for the thesis, the commission was still underway and it was therefore not possible to analyse its activities in full. Its roots date back to the decision taken by the ANC to discuss SHI proposals within a social security context, at the 1997 annual conference in Mafikeng (interview data). The rationale for it was that there should be one integrated proposal of all the new social taxes that were being proposed (interview data). The Minister of Welfare was put in charge of the process. Initially an inter-departmental task team was set up to examine the issue. Progress was slow to such an extent that the task team was replaced by a Committee of Inquiry into social security (interview data). This was established at the end of 1998 and beginning of 1999, when a TOR was drafted for the approval of the social security Ministers (health, welfare, labour, transport) (interview data).

Interestingly the process was initially opposed by the Department of Finance which preferred a case-by-case investigation of options. The Committee had a core team or main committee of about 19 members with sub-committees for each sector, including health. Strangely, the Department of Health had initially no direct representation on either the main committee or the sub-committees. The Committee of Inquiry was open to submissions and held hearings into the key areas. Nevertheless, there were complaints from the private sector that no-one was listening to their perspective and that the hearings counted for nothing (interview data).

The sixth and final special structure that developed health care financing policy proposals in the 1994-99 period was the Hospital Strategy Project (HSP), paid by European Union funding to the NDoH. The HSP was primarily a technical assistance project implemented by a consortium of four consultants and academic groups: Monitor Company, Health Partners International, the Centre for Health Policy and the National Labour and Economic Development Institute. Working within a defined set of parameters, the Project undertook a broad review of management and resourcing in the public hospital sector, including specific assessment of the public hospital fee structure (Monitor Company *et al.* 1996). Its work was mostly conducted over a one

year period from August 1995, and involved an intensive process of technical analysis as well as consultation with national and provincial health officials (interview data). Between February and June 1996, for example, four drafts of proposals for a national fee schedule were circulated for comment to national and provincial officials, and three presentations were made to PHRC meetings. The bulk of the proposal was, finally, approved at a MINMEC meeting in March 1996 - although some specific modifications were requested for re-submission to the July 1996 meeting. Nevertheless, there appears to have only been limited progress in its implementation, with some provincial managers claiming it was unrealistic in scope (interview data).

6.5 Policy Impact

The main achievements and limitations of financing reforms over the 1994-99 period are summarised in Table 6.6 according to their contribution to health equity and health system sustainability. Early gains were made in re-orienting service provision towards the needs of the population at large. This was achieved mainly through the provision of free services and supported in the early years by resource allocation policies that were needs-based. Thus, the explicit objectives of the reforms were attained to some degree. In addition, free care generated substantial public support for the new government as it improved financial access to health care for needy groups (McCoy 1996). In the press, both policies - but especially the free Primary Health Care policy were held up as Minister Zuma's hallmark achievement. The public recognition of these reforms helped to endorse the National Department of Health's broader reform agenda, giving credence to its ongoing activities, as well as bolstering the popularity of its leaders.

Yet these initial achievements have to a certain extent been undone. The current process of global budgeting has seen a reversal of the early gains to promote equity in resource allocation (Thomas and Muirhead, 2000). Poor provider morale, declining quality of care and some public disaffection with parts of the public health system are all by-products of reform which make the task of tackling inequities that much harder. It is clear that health sector reform has a long way to go before it brings benefits to the poorest of the poor. Further, there are murmurs from provinces that the financial

sustainability of free health care is in question (interview data). This is all extremely worrying and appears to suggest that the government's reform programmes have been stalled (see also Thomas *et al*, 2000).

Table 6.6: The main achievements and limitations of public sector health financing reforms

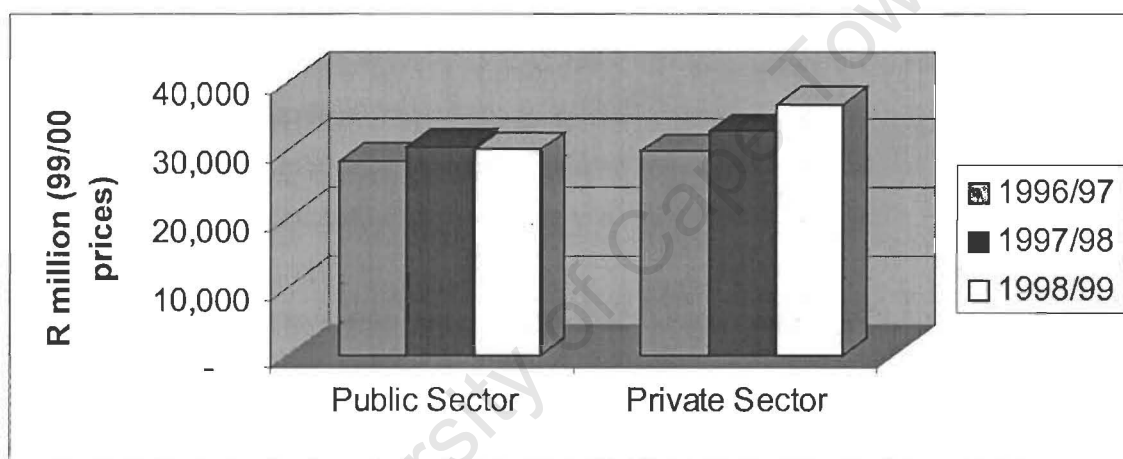
MAIN ACHIEVEMENTS	MAIN LIMITATIONS
<i>Reductions in inequity</i>	<i>Persistent inequities</i>
<ul style="list-style-type: none"> • The resource allocation formulae contributed to some re-distribution of health budgets between provinces, before fiscal federalism • Financial barriers to access, especially to PHC, were reduced through the two free health care policies. • Budget re-prioritisation towards PHC improved geographical access to these services. 	<ul style="list-style-type: none"> • Global budgeting increased inequities in inter-provincial health spending. • The free health care policies did not address the broader (e.g. transport) costs of accessing health care. • Re-prioritisation of PHC, as supported by the resource allocation formulae, may not have been effective in realising improved PHC services in the worst-off areas of the country.
<i>Improved sustainability of aspects of the health system</i>	<i>Persistent problems with sustainability</i>
<ul style="list-style-type: none"> • The free health care policies garnered popular support for the broad reform agenda of the government. • Re-prioritisation of budgets (supported by the resource allocation formulae) led to greater spending on PHC up until 1997/98 	<ul style="list-style-type: none"> • The reforms led to some dissatisfaction with public health services, especially hospitals. • Spending on health care has become dependent on political jockeying at the provincial level. • Spending on PHC has fallen from 1997/98 in favour of spending on tertiary hospitals, indicating problems with the conditional grant system • Key problems are worsening provider morale and declining quality of care.

Sources: Gilson *et al* (1999); Thomas *et al* (2000)

Have the attempts to improve access to the *private* sector been any more successful? Thomas (2000) notes that the private sector expanded rapidly (see Cornell *et al*, 2000)

at the same time that the public sector was moving into stagnation. Diagram 6.2 compares the financing of the public and private sectors between 1996/97 and 1998/99. The private sector grew by almost R7 billion in this time, with Medical Schemes accounting for R5 billion of that growth. At the same time this growth was not mirrored by a sizeable expansion in membership. Hence access to private sector health care was not being broadened in any meaningful way. Given the government's continuing commitment to equity in financing (Republic of South Africa, 1997) it is further surprising that regulation of the Medical Schemes was not implemented until 1999, a full five years after the democratic elections. Its impact remains to be seen.

Diagram 6.2: Funds flowing through the public and private sectors, 1996/97-1998/99, (R million, 99/00 prices)



Source: Thomas (2000)

Progress toward the desired reforms has not been as fast as planned and in the case of the pursuit of equity in public sector health financing would appear to have stalled altogether. The reasons for this are complex but it may well be that health financing reform has been slowed down by the agendas of other actors. While the need for reforms in financing of the health sector are generally agreed, there is less consensus on the optimal speed or nature of those reforms. Gilson et al (1999) identified that opposition from key actors may well have held back the reform process. Some actors in particular had agendas which conflicted with the pursuit of equity in health financing reform, such as the National Department of Finance and the Medical Schemes Administrators. A key issue for testing the conceptual framework is how

reform drivers dealt with such difficult actors and this issue is explored in subsequent chapters.

6.6 Summary

In response to the appalling legacy of apartheid the new government undertook a broad package of reforms on top of institutional change. Key priorities were to improve the equity and efficiency of health care delivery and the three strands of health financing reform (user fees, resource allocation and social health insurance) were seen to be important vehicles for change. Despite early gains with free health care and the redistribution of resources across geographic areas, progress towards improved equity has slowed and proposed health financing reform started to meet substantial opposition from several actors, including National Department of Finance, better-off provinces and Medical Scheme Administrators. Nevertheless, the reregulation of the medical schemes industry demonstrates that change is still possible to improve equity within the health care system.

Chapter 7: Testing the Conceptual Framework against the SAZA Case Study Material

7.1 Introduction

In this chapter I test the relevance of the initial conceptual framework, shown in Chapter 4, with the case study material. I explore whether the key factors in the conceptual framework, and its predictions and working hypotheses, are relevant for managing actors. The data are presented and examined to see whether they fit the model or whether an alternative explanation is required. Care is taken to explore those cases where the conceptual framework does not seem to provide adequate prediction or explanation. Where there are inconclusive results or where data are insufficient to test adequately the conceptual framework this is also noted.

The beauty of the case study approach is that it can carefully recreate a picture of health financing reform that is rich in detail. The open-ended questioning employed in SAZA provides a useful test for the conceptual framework in that actors are allowed to voice their own opinions on what they think are important factors. The challenge of the case study approach for the researcher is in letting actors speak for themselves without filtering the data through the researcher's own preconceptions. Chapter 8 provides an alternative test for the model – a deductive case study analysis, with questions directly related to the examination of the conceptual framework. While the latter approach provides an easier and more direct test of the conceptual framework it can suffer from placing insufficient emphasis on context. A comparison of the two approaches and their results will allow for discussion of the relevance of the conceptual framework in Chapter 9.

As discussed in Chapters 5 and 6, the financing reforms of focus were social health insurance, resource allocation and user fees, providing three case studies for testing the conceptual framework. Social health insurance and user fee reforms relied chiefly on ad hoc policy committees which involved members from government and non-government institutions. In contrast, resource allocation processes were conducted

primarily within government structures and usually as part of the routine budget process. Hence, policy processes concerned with raising resources for the health sector followed different paths to those relating to resource allocation. This distinction is worth noting and exploring in the testing of the conceptual framework. Thus in addition to testing the overall utility of the conceptual framework to explaining what happened in the case studies, I also compare the relevance of the conceptual framework to these two types of health financing reform: resource generation and resource allocation.

The eight working hypotheses developed from the Conceptual Framework are presented in Box 7.1 below. For ease of testing they are grouped under the four headings also shown in Box 7.1 and repeated at the head of each section. The first deals with “reform drivers”, their task ahead and their reflection on their own strengths and weaknesses. The second, “seeking out characteristics from other actors”, examines to what extent, and on what basis, reform drivers engage with other actors to alleviate their own constraints. The third, “establishing the relationship”, deals with the reform drivers’ choice of the form and rules of relationships and the incentives available to actors from engagement. Finally “interaction and learning”, examines the response of actors to the reform driver and the extent to which reform drivers learn and change their strategies.

For each hypothesis the evidence for all the reforms is scrutinised as a whole to consider the general application of the conceptual framework to the overall health financing reform programme in South Africa. Subsequently there is a comparison of the relevance of the conceptual framework for resource generation and resource allocation.

Box 7.1: Grouping the Working Hypotheses

The Reform Drivers

- Key reform drivers coordinate health care financing reform through policy development processes, or tasks, to achieve the desired outcome.
- Reform drivers are aware of their own resources and constraints in conducting tasks to develop financing reform.

Seeking out Characteristics from other Actors

- Reform drivers engage with actors to alleviate their own constraints, by utilising the resources of those actors, and avoid other actors with risky negative characteristics.
- Different resources will be needed by different reform drivers, depending on their own constraints and the policy task.

Establishing the Relationship

- The type and rules of a relationship offered by a reform driver to an actor are dependent on their combined characteristics and the policy task. The more complementary are the characteristics (resources, constraints, interest, reputation and trust) of the actor and the reform driver, the more likely is collaboration and partnership.
- Incentives will affect the behaviour of actors and insufficient incentives will lead to uncooperative behaviour

Interaction and Learning

- Actors may actively:
 - Negotiate the form and rules of a relationship
 - Try and change the goals and tasks of the reform driver where they are strongly opposed to the reform.
- Learning occurs from past behaviour. More specifically;
 - Reform drivers and actors change their perceptions of characteristics and reputation in response to each other's actions
 - Reform drivers review engagement and incentives in response to the behaviour of actors
 - Reform drivers and actors are less likely to collaborate where the other has a poor reputation for collaboration.

Note:

The term 'incentives' covers a range of motivating factors, as noted in Chapter 4. These relate to gain from the outcome of the reform, agreement with the ideology of the reform, value from the process of the reform and direct material compensation for participation in the reform.

7.2 The Reform Drivers

From the conceptual framework it is predicted that:

- Key reform drivers coordinate health care financing reform through policy development processes, or tasks, to achieve the desired outcome.
- Reform drivers are aware of their own resources and constraints in conducting tasks to develop financing reform.

7.2.1 Overall

The first issue to address is evidence for the existence and nature of reform drivers. The model proposes that in relation to key goals and tasks a reform driver will take forward the policy processes. Table 7.1 identifies the main reform drivers, for each of the major strands of health care financing reform development, and is derived from Chapter 6. This is done on the basis of those actors who took responsibility for developing a reform in response to a perceived problem. This usually consisted of managing other actors in the reform development process and pushing a certain vision or end-point for the new policy.

There are several interesting findings that emerge from this descriptive table (Table 7.1). First, over the period in question the reform driver was not one single institution or individual. There are at least eight (sets of) reform drivers who took principal responsibility for developing particular reforms around health care financing; several of whom were not located in the National Department of Health. For instance, it appears that analysts and the National Department of Finance have acted as reform drivers. This diversity of reform drivers is interesting. The conceptual framework does not say who the reform drivers will be but what the reform drivers will do. The reform drivers are not limited to government or even the health ministry. Different reform drivers will have different characteristics and thus their engagement with other actors will be different. Further, the diversity of reform drivers allows a better testing of the conceptual framework because of the different starting points of each reform driver (see Box 7.1, fourth bullet point)

The second result to emerge from the data was that different people or institutions were driving the same reform at different times. Sometimes in the policy development literature there appears to be an emphasis on linearity i.e. there is a set reform driver and a set order of events or stages (for example see Laswell, 1958) from agenda setting to policy implementation and evaluation. Nevertheless, the debates around Social Health Insurance and Medical Schemes showed different reform drivers taking the initiative at different times and for different stages. For instance, the Minister, having been convinced of the benefits of Medical Schemes reregulation, championed the policy through the Cabinet and secured implementation. Nevertheless, analysts and government technicians drove prior work on the design of the policy.

Relatedly, reform drivers often worked together. In addition, to the teamwork noted above for the Medical Schemes reregulation, the former Minister and the former Director General worked together both on the second free health care policy and the move to develop national health insurance. Further, the President, ANC activists and according to one source, the Minister, pushed through the first free health care policy. The conceptual framework outlined in Chapter 5 highlighted the need for reform drivers to work with others in order to get the tasks done. Here we see reform drivers themselves teaming up to take forward policy development.

The case of National Health Insurance highlighted that reform driving is perhaps not as precise as conveyed by the conceptual framework. Both the Minister and the Director General had broad goals to be achieved in the health sector. When the design of a NHI system was presented to them by an analyst they pounced on it as a useful vehicle for getting them to their vision. Thus, the Minister and the DG did *not* have definite ideas about the design of an NHI system but they did see it as the right mechanism. Policy makers may have vision but often lack detailed knowledge of design issues. In contrast, analysts may understand the intricacies of design but be less in tune with political vision. This may indicate that different types of reform drivers need to work in teams so that knowledge and power can be combined.

The final point to note from Table 7.1, and perhaps the most interesting for the conceptual framework, is the possibility of open competition between reform drivers. Contradictory policy strands can be pursued at the same time. The debate around the

appropriate form of health insurance actually involved conflict between different sets of reform drivers. The Minister and Director General drove, at least initially, a National Health Insurance scheme. In direct opposition, some analysts aligning with technicians in government were promoting a Social Health Insurance package. The differences related to the coverage of the population to be insured and the package of benefits and services available (see Chapter 6).

The implications of this example are that a reform driver needs not only to be aware of his own task, constraints and need for engagement but also other reform drivers and their processes. There may be an important lesson for the conceptual framework here. Reform drivers will need to react to, or even pre-empt, other reform drivers if they are to be successful in pursuing their line or version of reform. While a reform driver may need to be constructive in seeking out other actors and collaborating to develop policy, he may also need to be destructive in relation to competing reform processes. For instance, the Co-chair of the Committee of Inquiry set up an unofficial committee in parallel to its main workings (according to one of its members and the Co-Chair of the CoI). The aim of this group was to discredit the “Deeble” option favoured by the Minister of Health. This was done by “costing the gap” i.e. showing how much money would need to be raised to fund the proposal. Once this was done, the “Deeble” option was seen to be unaffordable and the Committee of Inquire went on to consider an alternative line of reform favoured by the co-Chair. Thus in this case the reform driver was conscious of another line of reform and acted to thwart its progress in order to help his own version of the reform.

This may well be an oversight of the conceptual framework. There is no assessment of competing streams of reform. This omission may relate to the derivation of the conceptual framework mainly from *economic* theories. The complexity of economic modelling may mean that anything beyond the study of two parties is very difficult to map. Numerous interactions with multiple parties are often avoided. Further, the theories tend to focus on the conditions for effective contracting or collaboration. They do not normally speak of strategies to destroy relationships that may be in competition.

Table 7.1 Reform drivers of health financing reform in South Africa (1994-2000)

	National Dept. of Health				Dept. of Fin	Analysts	Other
	Minister	Director General	DHFE	Other			
Free Health Care I (92-94)	X?						X (President, ANC Health desk)
Free Health Care II (94-96)	X	X					
Resource Allocation I (94-97)		X		X			
Resource Allocation (97+)					X		
National Health Insurance (94-98)	X?	X?					
Social Health Insurance (94-98)			X (later)	X (later)		X	
Social Security (98+)						X (SHI component)	X (Ministries of Labour and Welfare)
Medical Aid Reregulation (96-98)	X (later)		X			X	

Notes:

X indicates the individual/ unit was a reform driver

“later” implies that the reform driver did not initiate the reform process.

DHFE – Directorate of Health Financing and Economics

? – denotes weaker evidence (see discussion in text for each actor)

The conceptual framework claimed once reform drivers identified the policy task ahead, they would assess their own limitations in achieving this task. This would then

act as a springboard for engaging with other actors (see next section). There are two immediate questions to consider. First, what sort of constraints faced reform drivers when trying to take forward policies and reforms? Second, did reform drivers consciously recognise their own weaknesses in taking forward reform? Did they actively understand their own resources and constraints? The conceptual framework presents a picture of deliberate reflection and action on behalf of the reform driver. Did this occur? Even if it didn't, did reform drivers understand the need to engage with other actors anyway? This "purposive" element of the conceptual framework is important to keep in mind not only when considering the reform driver reflecting on his own constraints but also for the other conceptual framework elements.

I present below data relating to three sets of reform drivers: senior civil servants in the NDoH, the Directorate for Health Financing and Economics¹, National Department of Health, and academic analysts. Full information on the constraints facing all reform drivers was not available from the interviews. These three reform drivers were ones for which there was more information. Further, these reform drivers were responsible for driving many of the health financing reforms, for both resource generation and resource allocation:

- the former Director General drove the free PHC policy, the first resource allocation formula and NHI policy development;
- the DHFE strongly supported the development of SHI and the Medical Schemes Reregulation, as well as more recently proposing a revision of the Conditional Grants mechanism
- the academic analysts drove SHI and the Medical Schemes Reregulation.

Table 7.2. portrays the limitations faced by each of these sets of reform drivers according to data from the interviews. Some of the data are based on self-reflection while others are the opinions of other actors commenting on a specific reform driver. Key points that emerge from Table 7.2 were the low understanding of health financing issues among senior officials in the *National Department of Health* alongside a general lack of capacity. One senior policy maker in the NDoH admitted

in an interview that there was no overall strategic plan for health financing within the Department, five years after the democratic elections. There was also evidence of some, but not all, senior managers in the National Department of Health being aware of their own capacity constraints in general, and specifically in relation to health financing issues.

The *Directorate of Health Financing and Economics* initially suffered from low visibility and power. While this situation appeared to be improving, according to the later interviews, it still had insufficient skills and numbers of human resources for its tasks. The limitations of the DHFE for taking forward reform tasks were well articulated by its current and former staff. *Academic analysts* had relatively more technical skills but their financial constraints and limited interests outside their academic field restricted their ability to drive, and participate in, reforms. Further they suffered from a lack of power and access to senior policy makers within the National Department of Health. Again some, but not all, analysts were aware of these constraints, though there was general agreement on problems of access to senior policy makers.

The constraints identified for each actor were recognised by some individuals within the reform drivers (indicated by bold text in Table 7.2). Indeed, DHFE staff appeared to be particularly aware of their collective shortcomings and limitations. Nevertheless, it is interesting to note that some managers and analysts did not voice their limitations. This may be a product of the data captured but it may also indicate a lack of awareness. Interview data from different sources on the former Director General of the NDoH indicates she was not aware of the importance of financing issues and therefore may have underestimated capacity constraints in the NDoH. According to the conceptual framework, if reform drivers are unaware of their constraints and/or misjudge their capacity they are unlikely to bring sufficient resources to policy tasks through appropriate engagement with other actors. This in turn will undermine the reform effort.

¹ Included as a part of DHFE is the EU external technical assistant who worked alongside the Director Health Financing and Economics and who joined the NDoH in 1998, toward the end of the study period.

Table 7.2: Identified Constraints in policy development tasks for selected reform drivers

National Department of Health (senior management)	Directorate of Health Financing and Economics	Analysts
General lack of capacity (4 sources)	Low profile and limited support from rest of NDoH (2 sources) but this had improved by 1999 (2 sources)	Low profile and limited access to power and policy makers (2 sources)
Lack of economic capacity (2 sources)		Limited interest in policies outside technical/ academic arena. (3 sources)
Lack of understanding of health financing issues – particularly at the level of middle/senior management* (5 sources)	Limited skills in health economics and financing (4 sources)	Funding constraints (2 sources)
Lack of management experience – particularly shortly after the 1994 elections (3 sources)	Inadequate numbers of human resources in the DHFE (3 sources)	Shortage of health economists (2 sources)
<i>Lack of policy skills</i> (single source)	Reliance on foreign consultants (2 sources)	<i>Limited skills in drafting government documents</i> (contradictory evidence)

Notes:

Bold indicates that individuals in the actor group also identified that constraint.

Italics indicate unverified or inconsistent data.

*The current DG is a notable exception to this (3 sources)

Table 7.2. also provides some less clear-cut findings. One source maintains there is a lack of policy skills in the NDoH as a whole, with reference to negotiation and compromise. This is not supported by other interviews. Nevertheless, four other sources (both inside and outside of NDoH) do identify a lack of leadership coming from NDoH on strategic issues. This particularly relates to not having a clear overall picture of the priorities.

“The national role is key in looking at overall policy and standards and norms, strategic planning and putting through legislation to effect fundamental change. This role is clear now but there are concerns that it doesn't play this role and tends to be dealing with non-issues. This is due to the volume of work, and ineffective prioritization on issues ... and management of time.” (Provincial Department of Health Manager)

“What the National Department of Health is just not doing is developing a sort of strategic planning framework both for use nationally and to be used by provinces.” (External Adviser to NDoH)

“...At National level it seems to be driven by crisis after crisis and I don't think any appreciation of the real problems on the ground has percolated through. So neither have they been strategic in taking on the main issues or the way that they have taken on the issues has not been strategic. There hasn't been a focus on strategic issues. And when they've got strategic issues they haven't dealt with them strategically.” (Analyst and Former Provincial Department of Health Manager)

This lack of leadership capability may speak to important contextual issues for the conceptual framework, in particular about a problem of defining goals and prioritising appropriate tasks for reform. This is taken as a given in the conceptual framework, which starts from the position that a reform driver is aware of the necessary policy task ahead. The conceptual framework doesn't discuss which streams of reform are to be taken up, and as discussed earlier, it doesn't say anything about competing or even complementary lines of reform. Conversely, that fact that there were competing health financing reform streams around health insurance, noted earlier, may itself indicate a lack of leadership.

One cause of this lack of leadership may have been too many tasks, resulting from the need to change the public health system radically after apartheid. Indeed, the period after the democratic elections in 1994 was a time of great upheaval and transition. This may have exacerbated problems of limited capacity:

“...the repeated restructuring of departments intervened and reduced the ability to produce functional policy...” (Analyst and Member of Policy Committee)

“...(this) led her (senior policy maker, NDoH) to rush off headlong down twenty different paths, all at the same time, ill-conceived, bang her head very often...it certainly fed into a failure to implement even the most basic stuff...But they could have done more. They could have chosen six issues to handle in five years and just hammered in all their resources. Things could have been different.”(Analyst)

While engagement strategies may be used to try and alleviate such problems, by bringing in additional resources, there may well be a ceiling. There may be only finite resources which can be directed at health policy tasks. For instance, even among the analysts there is an acknowledged shortage of health economists. Therefore, there may well be need for prioritisation of tasks in relation to the aggregated characteristics of all relevant actors. The reform driver must understand the aggregate supply of characteristics available when considering the prioritisation of tasks.

Table 7.3: Summary of identified constraints for selected reform drivers

	Power	Understanding of health financing	Technical Skills in Financing	Nos. of Human Resources	Limited Interest in Policies	Lack of Funding
NDoH		XX**	XX	X		
DHFE	X*		X	XX		
Analysts	XX			X	X	X

Notes:

* - While access to power was a constraint for DHFE, evidence suggested the DHFE enjoyed a higher profile and more support from the rest of NDoH at the end of the study period

** - While problems of a lack of understanding of health financing issues were present in NDoH, evidence suggests there was improvement over the study period.

Number of 'X's denotes relative size of constraint

Table 7.3. summarises the constraints, identified in Table 7.2, faced by each of the reform drivers. One important point to note is that the some of the constraints changed over time, at least in terms of their degree. For instance, access to power became less

of a problem for the DHFE and there was better understanding of the importance of health financing in the National Department of Health later in the study period. Hence constraints were not static and will change over time as personnel move and/or the context changes. Interestingly, power was identified as a critical constraint for DHFE and analysts, indicating that this concept will need to be incorporated into the conceptual framework, at least as an important constraint or resource. An interesting example was around the Committee of Inquiry where analysts worked on a version of SHI that the Minister just did not like and was not going to act on. Yet the analysts pushing SHI design did not themselves have power to approve the design and take it forward. Indeed policy makers bypassed SHI recommendations, implementing only selected findings of the CoI report.

The problem with the CoI was they tried to reach consensus within it rather than raising policy choices for the politicians then to consider. This was a mistake. (The Minister) never believed the report. (She) was suspicious and unsupportive of the findings and it was never endorsed by a formal MINMEC but was rather implemented in a piecemeal fashion – they only moved on to implementing aspects of it (the CoI report) that she was comfortable with. (Senior Policy Maker, National Department of Health)

The conceptual framework implies that the constraints faced, and resources needed, will be dependent on the task to be performed. Nevertheless the data considered thus far has been presented without reference to any particular reform or committee. Unfortunately, information on reform specific constraints is less easy to find, though the analysis of engagement strategies undertaken later in this chapter, throws more light on this issue.

7.2.2 Resource Generation vs Resource Allocation

Were there any substantial differences between drivers of resource generation and resource allocation? The latter, at least in the South African context, tended to come from government (the National Department of Health or Finance), according to Table 7.1. Indeed, as noted the resource allocation reforms went ahead, in the main, as part

of normal government budget processes. In contrast, resource generation reform drivers were more diverse; both analysts and politicians drove reforms as well as civil servants. Interestingly the Minister appeared only to have driven resource generation reforms, possibly because these have been of a higher profile in the media and in public debate.

In terms of key constraints, analysts reported more problems of access to power and tended to be more involved as reform drivers in resource generation reforms. This may have impacted on the ability of such reform drivers to see through the policy task if they were unable to gain power from engagement with other actors (see later sections). The data do not reveal any differences between the self-awareness of reform drivers in resource generation and resource allocation.

7.3 Seeking out Characteristics of other Actors

From the conceptual framework it is predicted that:

- Reform drivers engage with actors to alleviate their own constraints, by utilising the resources of those actors, and avoid other actors with risky negative characteristics.
- Different resources will be needed by different reform drivers, depending on their own constraints and the policy task.

7.3.1 Overall

Having outlined the constraints, what evidence is available that reform drivers saw that they must engage with other actors to alleviate these constraints? In general, the whole range of policy committees established and discussed in Chapter 6 gives an indication that government thought it wise to pursue engagement with other actors in health care financing reform development. More specifically, Box 7.2. provides the best example from the data about the importance of engagement for a reform driver, the case being the DHFE pursuing Social Health Insurance.

Box 7.2: The need for engagement - the Directorate of Health Financing and Economics with respect to Social Health Insurance (SHI)

“But the Directorate as it currently stands could never cope with anything like this in SHI. There isn’t a sectional division or an individual in Department of Health that can actually take something like SHI.” (*Analyst and policy committee member*)

“...we can’t do it alone.” (*Senior official, DHFE*)

“...first of all there was uncertainty on the part of the Minister and (former Director General) about what they should do about selling Health Insurance committee recommendations. If they had been dead certain that they had all their facts, they would have gone ahead and done it...So I think they weren’t feeling confident in the area. The civil servants they had in the Department didn’t feel confident either, they, I think the (*senior official, DHFE*) and (*senior official, DHFE*) kept saying we can’t do this on our own without outside help. But also I think particularly (a key analyst) has repeatedly said to them, you need outside help. He wants to be involved in the processes happening there.” (*Analyst and policy committee member*)

“So, (the Directorate of) Health Financing and Economics has one of the skills that is necessary at this point in time...That’s not to say that we have all the skills to answer all the issue, but I think we have sufficient skills to put together a fairly decent proposal given support from (*academic institutions*) to be able to do that.” (*Senior official, DHFE*)

Note: The tag “Senior official, DHFE” is applied to several individuals in the Box 7.2 and subsequent analysis. For the sake of anonymity no further differentiation is given.

An interesting counter-example to this is the Health Function Committee that handled the first resource allocation reform. Coordinated by the Director General of the National Department of Health, membership was based on representation of each Provincial Department of Health (according to two Provincial Department of Health representatives). The structure of the committee itself was a legacy of the apartheid era rather than chosen by the Director General. This raises two issues for the conceptual framework. First, the representation of certain groups can be important on policy processes. This may relate to the power or authority some individuals, or more precisely their positions, have which then creates legitimacy for the process. The other point is that some policy processes are inherited and thus determined by context, rather than by a reform driver considering his, or her, own constraints and engaging appropriately. The latter point tells of the realities of government at a time of massive transition and emphasises the importance of the role of context. Perhaps, it implies

that context may impede the actions of the reform driver and his or her planning of the ideal route for reform development. Certainly, the chaotic nature of the initial Function Committee's allocation of resources was far from an ideal process. According to two members of the committee it was conducted "over a weekend" with "hand-held calculators".

The above examples contrast sharply. What further evidence was there that engagement was conducted to offset constraints with resources? First, what sort of resources were commonly believed to be possessed by key actors? In other words what do they have to offer a reform driver seeking to take forward health financing reform? The set of identified resources and constraints, are displayed in Table 7.4 for five key actors in the South African experience.

These five actors have the most data in the interviews relating to their strengths and weaknesses and general characteristics. Nevertheless, there is a tendency to favour actors involved in resource generation reforms. Medical Scheme Administrators, analysts and unions were almost entirely involved only in questions of insurance and user fees. The Directorate of Health Financing and Economics and the National Department of Finance were involved in both types of reform. This bias is related to the lack of data on resource allocation actors from the interviews, which may partly be due to the fact that the actors in resource allocation reforms were internal to government and engagement strategies were less thought through. This issue is considered more fully later.

Table 7.4: Identified General Resources and Constraints of Five Actors

National Department of Finance	Medical Scheme Administrators	Academic Analysts	Unions	Directorate of Health Financing and Economics
<p>Over-confidence / arrogance (5 sources)</p> <p>Significant power to take forward or block reform (4 sources)</p> <p>Resistance to change/ conservative outlook (4 sources)</p> <p>Limited capacity in health and health financing (2 sources)</p> <p>Successful in achieving aims (2 sources)</p> <p><i>Like to control policy through centralisation</i> (single source)</p>	<p>Driven by a strong profit motive (6 sources)</p> <p>Reputation for strategic behaviour (4 sources)</p> <p>A good source of information and feedback on policy proposals (3 sources)</p> <p><i>Powerful in policy development (contradictory evidence – changed over time)</i></p> <p><i>Bring credibility to processes</i> (single source)</p> <p><i>Unknown commodity for government</i> (single source)</p>	<p>Strong technical skills (5 sources)</p> <p>Important source of specialist knowledge (4 sources)</p> <p>Competing workloads and interests (3 sources)</p> <p>Source of additional human resources (2 sources)</p> <p>Funding constraints (2 sources)</p> <p>Create dependency (2 sources)</p>	<p>Retain some power to influence policy (3 sources)</p> <p>Health not a high priority concern (3 sources)</p> <p>Uninformed on health issues (2 sources)</p> <p><i>Divergent views may rock the boat (single source)</i></p>	<p>Some skills in health financing and economics (4 sources)</p> <p>Some human resources available for health financing, but heavy workloads (4 sources)</p> <p>Limited access to power but has been improving (4 sources)</p> <p>Potential source of funding for policy work (2 sources)</p>

Note:

Bold indicates that individuals in the actor group also identified that characteristic.

Characteristics are ordered by the frequency of citation in interviews

Italics indicate unverified or inconsistent data

There was a surprising amount of consensus in the way each actor was viewed by others. This is perhaps unexpected as it may be thought that different actors would be valuable in different ways according to the aims of different reform drivers, the reforms to be completed and the context of the reform initiative. Perhaps, only for the Medical Scheme Administrators was there evidence of uncertainty on some points, and contradictory statements on others. This may indicate that different reform drivers in different contexts viewed the Medical Scheme Administrators differently. It may also indicate a lack of specific knowledge about this actor, which may have caused problems for reform drivers in knowing how to handle them. I explore each actor from Table 7.4 in turn.

The *National Department of Finance* had a reputation for being powerful and successful but also of being resistant to change, arrogant and even controlling. Two interviewees independently noted the National Department of Finance's reputation as "Big Brother". In an interesting comment one NDoF technician, in an interview conducted in 1999, noted that their conservative approach was produced by a lack of capacity in technical areas. While this may have been partly true, the National Department of Finance was largely perceived to be strong and successful in pursuing a neo-liberal agenda through its GEAR policy, announced in 1996. Its macro-economic strategy may also have been a driving force for conservatism in reform. One external adviser to the NDoH considered in 2001 that the NDoF was largely interested in consolidating its policy gains and giving little ground to new policies which might upset its macro-economic successes.

The *Medical Scheme Administrators* were seen to be motivated by profits, perhaps unsurprisingly. They were treated with some suspicion by some analysts and union representatives, who poured scorn on their motives and noted their strategic behaviour.

“(Medical Schemes Representative) *and the backdoor!* (Medical Schemes Representative) *had himself put on the committee by lobbying the Minister directly, I’m told. Yeah, and I would say that his attitude within the committee was a mixture of delaying, diverting and starting new initiatives and he did it brilliantly. It was a lesson in political strategy that I have benefited from enormously. Well, in seeing how it works. I have never had quite the skill to carry it off. But it was masterful.*” (Analyst and Policy Committee Member)

Interestingly, strategic behaviour of a different form, was confirmed by one private sector representative.

“First of all, I advised my constituency that it was better to be part of a process where in the event that decisions were being made on the basis of no facts or there was no information in the making of those decisions, or there was no appreciation of some of the implications within the private sector, it’s better to be there so that one can participate in that than to be out of it; than to allow a process just to go ahead.”
(Private sector representative)

In contrast, some in government were more trusting, noting Medical Scheme Administrators as a *“very important and useful resource on technical information”* and for getting feedback on policy ideas. This may have been important as one analyst implied that government had little understanding of the mindset of the private sector. One private sector representative on government policy committees thought that his presence may actually have added legitimacy to the process, convincing the private sector to go along with government policy. Such views were not corroborated elsewhere, but this was an interesting perspective again implying the importance of representation of a group as an important factor for some reform processes.

Academic Analysts were viewed as an important source of technical health economic skills, specialist knowledge and skilled human resources. Specialist knowledge tended to be in relation to the reform being developed. For example, one government official noted that academic experts in law and tax were brought into the Social Security committees. Further, according to three sources, an analyst was brought into the Health Care Finance Committee because of her specialist knowledge of the unions

and the private health sector. Nevertheless, academic analysts faced constraints because they had limited core funding; their own jobs were reliant on generating funds for, and conducting, research and teaching. This may have restricted the amount of time that they could give to policy development initiatives. Indeed, one analyst noted that he had to withdraw from the work on Social Health Insurance because of a lack of funding of his time. The analyst had already inputted significant time on a government run policy committee and his employee had not been compensated for this and his diversion from his formal responsibilities.

The *unions* appeared to be relatively uninterested in, and less informed about, health issues. While they sometimes displayed concern for social solidarity, their knowledge of reforms appeared limited to those which directly affected their members. Some complained that this was due to government keeping them out of policy negotiations. Yet for several years COSATU struggled to develop a health policy and to have a spokesperson on health. Nevertheless, there was evidence that the unions had some power to influence reforms, particularly COSATU with its historic alliance with the ANC. COSATU's support for a Social Security Package may have been a factor in the 1997 SHI proposals being incorporated into Social Security reform development and not proceeding alone.

The resources identified in Table 7.4 and discussed above are categorised to produce a preliminary *actor characteristics map* in Table 7.5. This builds on Table 7.2 to provide a more comprehensive overview of actors in the South African context from 1994 to 1999. This outlines for each of the actors their major positive and negative characteristics as identified by themselves, reform drivers and other actors. According to the conceptual framework, the value of each characteristic should be different according to the specific reform driver, their particular task and the context for reform. Nevertheless there seems to be much consensus across the case studies in this context. Again it is interesting to see that despite not being explicitly mentioned in the conceptual framework, power is included as an important resource.

Table 7.5: Preliminary Actor Characteristics Map within the South African context

	NDoF	MS Admin	Analysts	Unions	DHFE
<i>Resources</i>					
- Power	XX	X*		X	**
- Specialist Knowledge		XX	XX		
- Technical Financing Skills			XX		X
- Human Resources in Health Financing & Economics			XX		X
Funding Source					X
<i>Constraints</i>					
- Conservative	XX				
- Over-confident	XX				
- Profit Motive		XX			
- Competing Workloads	X	X	X	XX	X
- Financial Constraints			XX		
- Uninformed				X	

Notes:

The number of "X"s indicates the relative size or degree of the characteristic.

* Interviewees imply that the Medical Scheme Administrators had some power in the years just after the 1994 elections but this power declined sharply when the industry effectively split around 1997/98 (2 sources).

**DHFE while having had little of its own power was a point of access to senior policy makers in NDoH for those outside government. One senior official in the DHFE boasted an excellent personal relationship with a top policy maker. Further, over time the improved visibility of DHFE improved its access to key decision makers (4 sources).

The conceptual framework implies that the engagement of actors will depend upon their ability to provide resources, such as found in Table 7.5, to alleviate the constraints faced by the reform driver. Can examples be found of engagement to alleviate each of the constraints highlighted in Table 7.3 for the reform drivers noted (senior NDoH managers, DHFE and analysts)? Evidence of engagement by each reform driver to alleviate the identified constraints is contained in Tables 7.6 - 7.8. Each constraint of each reform driver, identified in Table 7.3, is noted in the first

column, while the engagement to relieve that constraint is shown in the second column, where relevant. Only direct quotations from the interviews are used to show the engagement strategies.

Table 7.6: Engagement to relieve constraints – examples for senior managers in the NDoH

Identified Constraint	Engagement for Characteristic Augmentation
<p>Understanding of Health Financing</p>	<p>With DHFE: <i>“It has been educational, I’d say, bringing the department on board so that they understand some of these issues, and the links between issues, tax financing, social health insurance, user fees, as major sources of funding.”</i> (Senior official , DHFE)</p> <p>With DHFE: <i>It’s the understanding when the department was structured that health financing was never thought of as an important issue. It’s only now when people are getting caught up in a lot of things where they are looking at the financing and budgeting issues as a key element of managing. The health department is run by health professionals who never thought about budgeting issues and so forth. It’s a new thing everybody knows...If there’s anything they say: “Hey! Go talk to (Senior official, DHFE).”</i> (Senior official, DHFE)</p> <p>With DHFE: <i>“I mean we made the presentation on the costing of the PHC package and people basically said, well that’s what it’s going to cost us. ...They had no question about the result because that was clear...They understood exactly how you are coming across. I think that is important.”</i> (Senior official, DHFE) (author’s bold)</p> <p>See also “Technical Skills in Financing” below.</p>
<p>Technical Skills in Financing</p>	<p>With DHFE: <i>“they become so dependent on us (DHFE), that when it comes to doing the presentations at PHRC and MINMEC and things like that, (foreign technical advisor to DHFE) has to go and do them because they do not understand the issues fully but recognising that they’re not at a stage to do it themselves and</i></p>

	<p><i>rather use the skills that are there to do it.</i>"(Senior official, DHFE)</p> <p>With analysts:</p> <p><i>"I got a strong impression that particularly on critical issues...the Minister in particular (both Ministers current and previous) would tend to go sort of direct to a favoured group of external researchers, and this is by no means only health economists...often bypassing the resources they have in their department."</i> (External Adviser to the NDoH)</p> <p>With analysts and DHFE: (early in reform programme)</p> <p><i>"Well, the Minister said she had appointed these committees to advise her.. and that this was an advisory process."</i> (Analyst and Committee Member, speaking on the Health Care Financing Committee)</p>
<p>Inadequate Human Resources in Health Economics and Financing</p>	<p>- see also Table:7.7</p> <p>Hiring additional staff for DHFE</p> <p><i>"One of the changes, as (Director 3, DHFE) probably told you, is that (official) will be joining us specifically to handle the SHI and sort of private type brief."</i> (External Adviser to the NDoH)</p>

Table 7.7: Engagement to relieve constraints – examples for DHFE

Identified Constraint	Engagement for Characteristic Augmentation
Power	<p>Attempted, but unsuccessful, engagement with the Minister:</p> <p><i>"It was difficult to engage because of (the former DG). The SHI process is much more difficult. There was a lack of access to the Minister."</i>(Senior official, DHFE).</p> <p>With DG:</p> <p><i>"(Senior official, DHFE) sometimes fast-tracks this process by skipping certain levels if the people don't understand the issues or if the issues are too contentious...(he) asks the DG to put the issue straight to the PHRC."</i> (Senior official, DHFE)</p> <p>With Chief Director:</p> <p><i>"Myself and (External Adviser to the NDoH), in particular, started to realise</i></p>

	<p><i>that there's actually a benefit in not bypassing some people and one of those things was that if you informed people adequately they become your biggest fan. One of these people is someone like (Chief Director)...now, if we convince (Chief Director) that this is a priority we know that he's got a semi-open line to the DG and because he reports directly something is going to happen."</i> (Senior official, DHFE)</p>
<p>Technical Skills in Financing</p>	<p>With analysts:</p> <p><i>"Most of our work has been developed with colleagues from the (research) units otherwise if there was no outside capacity we wouldn't have moved the way we moved."</i> (Senior official, DHFE)</p> <p>With analysts:</p> <p><i>"Q: Can I go back to the relationship between the advisors and (DHFE representatives). When it comes down to it, who actually did the technical work (on the SHI and Medical Schemes Working Groups)?</i></p> <p><i>A: ...The research, what little was done was mine and (another analyst).."</i>(Analyst and Committee Member)</p> <p>With analysts:</p> <p><i>"That's not to say that we have all the skills to answer all of the issue, but I think that we have sufficient skills to put together fairly decent proposal (on SHI) given support like from (academic units), to be able to do that."</i> (Senior official, DHFE)</p> <p>With analysts:</p> <p><i>"It is useful to consider what sort of relationship has existed between the (research) units and DHFE and how it can be strengthened...also need a proper system of mentoring"</i>(Senior policy maker, NDoH)</p>
<p>Inadequate Human Resources in Health Economics and Financing</p>	<p>With analysts:</p> <p><i>"I would say, in terms of our work, the research units remain the most important groups we would want to keep linkages with, because of capacity problems and a lack of junior research posts. So I think they are very important people that we would want to keep interested in capacity."</i> (Senior official, DHFE)</p> <p>With analysts:</p> <p><i>"I think if you talk about academic health economists, that's (academic units),</i></p>

	<i>I think we'd say supportive, fairly interested in policy relevant issues."</i> (External Adviser to the NDoH)
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Table 7.8: Engagement to relieve constraints – examples for analysts

Identified Constraint	Engagement for Characteristic Augmentation
Power	<p>Unsuccessful engagement with Minister and DG, through DHFE: <i>"We didn't meet with them, either of them. In either of these processes of working groups (SHI and Medical Schemes)... We did request meetings with them on a number of occasions to try and kind of solve bottlenecks in the process."</i> (Analyst and Committee Member in seeking political input into, and endorsement of, financing reforms)</p> <p>With Minister (unsuccessful) and with DG (successful): <i>"A1: Also that she never participated in the Commission (of Inquiry)...the timing was scheduled in order for her to come because it became clear to us in the Commission that we had to talk with her, that she needed to understand it.</i> <i>A2: That's been a consistent theme also...every time we met (the current DG) we said, we've got to have a full working day with the Minister. Or he said, yes, yes, yes, and it never happened.</i> (Analysts and Committee Members)</p> <p>With Minister (unsuccessful): <i>"...the whole problem was that the Minister was not involved – (senior committee member of CoI) did try and the four options were put up to MINMEC even before the report came out."</i> (Senior official, DHFE)</p>
Interest/ Workload	No evidence found of engagement to relieve this specific identified constraint
Funding	<p>With DHFE: <i>"Since then nothing. It's partly – I myself, earlier than (analyst), indicated that we couldn't participate any more until they started coming up with payment. I think they would have been very limited without having certainly (analyst) on board to get the work done."</i> (Committee Member discussing work on Social Health Insurance and Medical Scheme reregulation)</p>

Did the pattern of engagement reflect what would be expected from Tables 7.3 and 7.5? The findings are generally supportive. There was significant evidence that analysts were engaged for their technical skills and extra human resources, which is what would be expected. Further, the DHFE proved to be an important source of understanding of the issues for the NDoH. They provided some technical skills, funding support for analysts and were a channel for analysts in approaching key policy makers in the NDoH. Interestingly, while analyst reform drivers tried hard to engage with the Minister of Health and the DG of the NDoH, in a bid to access power, they were not very successful. The Minister of Health was particularly elusive. Such problems were initially faced by the DHFE. However, it appears that access to power became easier for DHFE over time.

However, there were some unexpected findings. First, there was no evidence of analysts engaging to alleviate their own constraints related to limited interest in reforms and pressing workloads. It may be that such a problem might prevent some analysts from actually being reform drivers. This point is, however, not apparent in the data. Conversely if analysts agreed to be reform drivers it may well be less of a problem because they were already committed to the reform.

Second, NDoH chose occasionally to boost the number of people with health financing and economics expertise in DHFE, not through engagement with outside analysts but through direct hiring of personnel. This contrasts the notion of specific reform-related engagement and general contracting of personnel to relieve constraints. There was far less evidence of the latter. One interesting line of inquiry is whether a reliance on analysts creates dependency. The work may be contracted out to analysts. They do the work satisfactorily but the underlying capacity problem in government is not resolved. One senior official in DHFE noted the large number of vacancies in his directorate. Another government manager pointed to the importance of foreign consultants to the DHFE in increasing capacity and profile. One source from the National Department of Finance commented:

“The NDoH relied a lot on external assistance but maybe at the expense of internal capacity building.” (NDoF official)

Hence there are alternative courses of action for a reform driver in government. He or she can bring in external support, often donor-funded, or recruit local personnel rather than form temporary networks or alliances with non-government actors. Still, government bureaucracy and cost constraints may undermine the local hiring of personnel. In contrast, while foreign experts come with funding they may substitute for actual capacity development. The appropriate approach may well be an issue of context as to whether reform specific and temporary engagement is more useful than general hiring of local staff or use of foreign technical advice.

Even within resource generation processes, little has so far been said about three key actors: the Medical Schemes, the unions and the National Department of Finance which all have some relevant resources as identified in Table 7.5. Indeed, from Chapter 6 it is clear that National Department of Finance and Medical Schemes were engaged on some if not all of the policy committee processes. Are there other constraints, not identified by the three specific reform drivers, which have nevertheless been important in determining engagement strategies? Two additional resources appear to be “information” and “credibility”. The former was highlighted in the preliminary actor characteristic map (Table 7.5). Discussion of the importance of the Medical Scheme Administrators in this regard is contained in Box 7.3.

Box 7.3: Engagement to Acquire Information - The case of the Medical Schemes

“To me they were a very important and useful resource of technical information and getting access.” (Policy committee member on SHI and Medical Schemes working groups)

“But the private sector’s very useful in these things because they provide you with very direct feedback.” (Analyst and reform driver of SHI)

“So the government was fortunate at the stage to have moved in quickly before the new legislation has taken effect and by virtue of the position that I held, unlocked a very strong flow of knowledge and cooperation at the time.” (Private Sector representative)

Interestingly, the presence of a representative of the Medical Scheme Administrators on government policy committees may not only have been useful for providing information but also as a representative of a certain actor grouping and lending

“credibility” to the process, according to that representative. Indeed, the issue of “credibility” may be linked with the role of committees. The members who were chosen to be on such committees may be important not only for their technical support, information and power but also their standing with others. Their endorsement may be important in winning over key groups that might otherwise oppose the reform process. There was a strand of evidence in the interviews that may support this view, though it is less clear-cut than some of the other characteristics. Indeed, in the Committee of Inquiry there was special focus on getting a more representative group of people, than on the Health Care Financing Committee, and “creating consensus” within the Committee (according to a senior NDoH policy maker). Also the act of forming a committee may in itself give credibility to a process see Box 7.4. Hence it may be that not only do actors have certain characteristics but processes have characteristics too and perhaps also that processes affect or mediate the characteristics that belong to actors.

Box 7.4: Adding credibility to reforms through committees

“Oh yes you asked me why was the (Health Care Financing) Committee set up. I think in a way what I’ve just said answers that. I think, I suspect that the Minister and/or the Director General had clear ideas in mind. They weren’t ideas that were a clear sense of what a National Health Insurance or other financing scheme should look like but they had a number of fixed points that they wanted it to be. And what they wanted was for someone to join the dots that they had already outlined. That’s my impression. And so the reason for the closed committee would be that they wanted to make sure that the dots were joined in the picture they liked.” (Analyst and HCFC member)

“She (the former DG) had a political objective. She wanted to see clever people deliver the mechanism, but at the end of the day, she wanted to know that the political objective was achieved.” (Private Sector Representative)

What about the lack of engagement with the unions? Is this to be expected from the preliminary characteristics map developed earlier. The only “positive” characteristic identified in Table 7.5 for the unions is that they have some power, though not as much as the National Department of Finance. Otherwise, they are seen to be ill-informed and suffering from competing workloads which made health a low priority. It is perhaps, then unsurprising that the unions were not engaged, as reform drivers did not think that they could offer resources to alleviate any of their constraints. Nevertheless, the power of the unions combined with their opposition to SHI (three

sources), which was not identified by DHFE or analysts at the time, contributed to the stalling of the 1997 proposals (according to one analyst and one government official). Indeed, the failure to push through the 1997 SHI proposals might be seen as a failure by reform drivers to get sufficient “power” for the task:

- the Minister had avoided meeting with the Working Group and was known to be luke-warm at best,
- the National Department of Finance had repeatedly opposed it and had barely been engaged in the SHI WG and
- the unions had been ignored.

In effect, the reform drivers failed to mobilise sufficient power from the available resources. Perhaps as one analyst noted technical detail had been the focus rather than political support. An illuminating comment from a senior official in the DHFE highlights the issue:

“part of the problem is that one get short-sighted about how decisions are made.”

Reform drivers need power to get their reforms into place even if they have engaged to get the right technical skills and information.

There seems to be significant evidence within the resource generation reforms to support the idea that engagement occurred in relation to acquiring resources to offset constraints. Most of the evidence implied direct identification of constraints and characteristics by the reform drivers (except for senior NDoH management, some of whom could not be interviewed, see Chapter 5). Hence data show to a certain extent a conscious awareness of constraints and the need for engagement by reform drivers. Nevertheless, some constraints were only identified once actual engagement patterns were explored. Positive characteristics related to information, specialist knowledge, technical skills, extra human resources and, interestingly, to power and even, perhaps, credibility. Where engagement was not done to alleviate constraints then it seems that the reform driver encountered problems (as in the case of the SHI working group, noted above).

7.3.1.1 Problematic Actors

The counter side to engaging with actors with beneficial characteristics is not engaging with actors with problematic characteristics, or at least limiting their involvement. The conceptual framework implies that negative characteristics of actors will be important in the consideration of whether or not to engage with certain actors (and this is shown by the failure to engage with the unions, noted above). What examples are there of actors with high-risk negative characteristics? Returning to the preliminary actor characteristic map, Table 7.5, we might expect reform drivers to be wary of National Department of Finance (for their conservative attitude to reforms and their over-confidence) and Medical Schemes (for their profit motivation and their strategic behaviour). Further both actors had distinct interests, which didn't often match with reform drivers from NDoH or even analysts. Yet at the same time both groups had significant positive characteristics. The National Department of Finance was powerful and the Medical Schemes Administrators had specialist knowledge. How did reform drivers cope with these risky actors?

National Department of Finance

The significant power of the National Department of Finance coupled with its negative characteristics placed reform drivers in a dilemma. Several senior officials in the DHFE noted that it was important to engage with Finance, at least in theory. Yet close engagement was not successful. For instance when on key financing reform policy committees the National Department of Finance tended to be obstructionist. One analyst noted, of the NDoF representative on the Committee of Inquiry, that he:

“attacked every proposal, then threw water on alternative proposals”.

This was confirmed by other committee members. A reform driver and analyst of SHI through the Social Security Task Teams commented that: *“they're there to observe and stall”*. The coordination mechanism set up between the two Departments on issues around budgeting, conditional grants, revenue retention and policy development, the “4x4”, also did work well. There was difficulty getting key players together. There was insufficient support at a high level from NDoF and a lack of

clarity about objectives and overall direction. At the same time NDoH officials had to deal with the over-confident approach of NDoF. The following quotations from one senior official of the DHFE tell of the awkward relationship between the National Departments of Health and Finance:

“I think the Department of Finance is made up of different actors. Some of them are bullies and some of them are quite good people actually. They are not terribly unsympathetic to health but at the same time they constantly ask the question, do we need to spend so much money on health and within that we try to have good relationships with them...

They have a syndrome that they suffer from, the big brother syndrome, that they have to tell everybody else what they need to do and because of that to some extent they can't accept that somebody knows better in certain areas... We can always complain that a department of finance is just not cooperative, but if you are understanding where they are coming from...it's much easier to motivate.”

Indeed, there was not a consistent strategy of engagement with NDoF. While the NDoF was represented on the CoI, it was only involved in limited consultations with the working groups on SHI and Medical Aid Reregulation². As one senior policy maker noted about the Medical Schemes reregulation:

“Sensing the NDoF's probable opposition to the NDoH on this matter, the technicians backed out of discussion with NDoF technicians allowing her (Former Minister of Health) to take the battle to the political ground with the Ministry of Finance.”(Senior policy maker, NDoH).

This proved to be the more successful strategy, as the Minister was able to push the legislation through Cabinet and into the statute books despite NDoF opposition. Hence it appears engagement with NDoF is problematic. Indeed, the evidence suggest that direct engagement with NDoF was not successful in persuading them of the merits of NDoH's reforms. Their “power” appeared to be largely unavailable to the health reform drivers because of their resistance to change. This may well have

² This may well represent learning by the health reform drivers, as will be discussed in a later section.

stemmed from a conflict of objectives between the NDoF and the NDoH. Anything but very limited engagement appeared to be counter-productive for reform drivers from the National Department of Health (see also section on Establishing the Relationship).

Medical Scheme Administrators

The profit motive of administrators and their interest in preserving and expanding the role of the private sector might well be seen to be in opposition to the equity focus of many NDoH reform drivers. Engagement with such groups may risk compromising the equity basis of reforms. Nevertheless, the specialist knowledge and perspective of the medical aid administrators was a positive characteristic for government (as noted in Box: 7.3). Indeed, on early committees the positive characteristics appeared to outweigh the negative ones as a representative of the Medical Schemes Administrators was invited onto the committees. This is perhaps surprising. One analyst claims that government did not know how to handle the private sector and that they were largely an unknown commodity. Indeed, lack of knowledge about the characteristics of a representative of Medical Scheme Administrators would cause inappropriate engagement according to the conceptual framework. Nevertheless, it is clear that the objectives of the private sector have always been pro-profit and it is perhaps surprising that the government did not engage in more arms-length negotiations. The data do not provide a clear picture of why this happened. Still, a more distanced approach was adopted for the working Groups on SHI and Medical Schemes reregulation. This is more in line with the predictions of the conceptual framework.

7.3.2 Resource Generation vs Resource Allocation

The engagement patterns of the resource generation reforms seemed to fit the conceptual framework reasonably well, with noted exceptions. There was however, much less evidence for the resource allocation reforms. Key contextual events seemed to have been very important in triggering resource allocation reforms and the amount of premeditation and conscious planning appeared limited. For the Function

Committee, the first resource allocation reform, membership was established on the basis of representation and as hang-over from previous processes.

“Then what happens at 1994 stage...was to systematise these informal type of budget meetings, and the different groupings of people. Turn them into function committees, with the new structure in place.” (Analyst)

The move to global allocation of funds, the second resource allocation reform, from the function committee system was primarily political (according to two PDoH managers), to give more power to the provinces. Indeed, the constitution effectively created a system of fiscal federalism where provinces should make their own decisions about resource allocations between sectors, as discussed in Chapter 6.

“...the constitution was saying that the NDoH did not have the responsibility and (National Department of) Finance and Provincial Treasuries twigged onto this very quickly.” (Analyst)

From that time National Department of Finance took control of the slicing of resources across the spheres of government and the block allocation to provinces. The division of funds across provinces was, and still is, done through a formula which is annually reviewed by the National Department of Finance, coordinating feedback from Provincial Treasuries and national sectoral departments.

“In decision-making, national level has lots of influence.” (Provincial Department of Health Manager)

“What is problematic is the tendency to be dictatorial from their (National Department of Finance) point of view, extensively they give you one line and they say plus this is conditional, this is conditional that’s fine we can handle that, then they no, no..., we want this here, we want that there, you think you have freedom but you really don’t have a lot of freedom.” (Provincial Department of Health Manager)

The National Department of Finance directed the provincial allocation processes with clear guidelines to provinces, through the Provincial Treasuries, such as the

stipulation that a minimum of 85% must be spent on social services, according to several national and provincial sources. At the provincial level debates were held at a political level taking heed of the national guidelines.

“So it is a Cabinet decision, a provincial decision if you like, on how the budgets are allocated.... it is a Cabinet decision to allocate and to approve the guidelines that have been gone through between Treasury and the department.” (Senior policy maker in a PDoH)

“(the) premier has lots of influence” (Provincial Department of Health Manager)

“So resource allocation is a very much a political thing now and not a technical thing. It’s all about political pressure on the provincial Treasury. There is no systematic approach by which the (Province name) Cabinet allocates its resources.” (Provincial Department of Health Manager)

The ability of health to get a large slice of the provincial cake was largely down to power and politics.

Resource allocation policy development was as much about developing a system for allocating resources, as it was about determining actual resource allocation. The reform process was thus linked in with the budget process and it may be this that complicated the equation for any reform driver, as the budget process is fixed at any one time and reforms must be fed into its processes. Interestingly, contextual events produced periods of upheaval such as the change of government and the implementation of the new constitution all of which had knock-on effects for resource allocation and the budget process. Yet, in many ways they also determined the path of the reform. Indeed, the process of resource allocation reforms seemed, on the evidence available, to have been less about conscious and thought through design than reacting to events. This stands clearly in contrast to the deliberate engagement strategies of the reform driver in the conceptual framework.

7.4 Establishing the Relationship

From the conceptual framework it is predicted that:

- The type and rules of a relationship offered by a reform driver to an actor are dependent on their combined characteristics and the policy task. The more complementary are the characteristics (resources, constraints, interest, reputation and trust) of the actor and the reform driver, the more likely is collaboration and partnership.
- Incentives will affect the behaviour of actors and insufficient incentives will lead to uncooperative behaviour

Reform drivers are expected to look closely at each actor to see which form of engagement is the most appropriate. The choice ranges between control through more formal processes and an informal partnership relying on a common cause and collaboration to achieve the stated aims. Still, as noted in Chapter 3, there may well be elements of both control and collaboration in any engagement process.

7.4.1 Trust

Not much information was available from the interviews on the matter of trust. It is impossible to say whether that means it was unimportant or just unrecognised as a factor in relationships. Nevertheless, the scanty data are reviewed to see whether they throw any light on how actors view trust, where they make reference to it, and its role and importance.

One opinion expressed by four interviewees (from the private sector, unions and government) was that trust leads to cooperative activities. Such cooperation tended to involve informal processes of information exchange, outside of formal committees, and sometimes even over the phone:

Yes, you see, the politics of governance work differently....My own personal experience is that you don't get much in formal meetings. You only get to know more in informal times of contacts with people working in government, either at a level of

DG, or deputy minister or minister himself. But it means he or she must have confidence in you, to say these things to you. (Trade Union representative).

It is useful to explore precisely what having “confidence in you” related to and what it was that built trust. Several interviewees emphasised:

- (i) quality and integrity of work and
- (ii) an openness, perhaps even honesty, in dealings:

One member of the Committee of Inquiry noted how effective one of the co-chairs was in “rebuilding trust” with the private sector through being open:

“What he did was he was prepared before the decisions were taken...to show various options and some direction and he was able to articulate the thinking behind the thinking and he came across as transparent and open.... And even if the policy didn’t fall on the side of (the private sector), that cleverly it was debated in the policy document, and the merits were examined and the route towards reaching a decision was clear in that articulation. It added enormously to the credibility of the people that had compiled that, number 1; credibility to the debate which was originally questioned.” (Private Sector Representative)

Another element of trust implied in the above text, and emphasised specifically by one government official, is its personal nature. While institutions may be historically aligned, it is personal interaction that forges confidence and trust. The same government official added that this may be reinforced by being available to help with tasks and open to considering different perspectives. Such a viewpoint may reveal the particular requirements of that government official but they also reinforce the personal nature of trust i.e. that it has to be tied to the ease of relationship between individuals. Indeed, there was some evidence that the appointment of one analyst as co-chair of CoI was done on the basis of ease of personal relationships:

“At the same time the Hospital Strategy Project was being put together and (analyst) happened to be on a TV panel with (former Minister). She liked him and he built a positive relationship with the NDoH. So she put him forward for the CoI.” (Analyst)

The corollary to the above is that poor quality work and closed and secretive activities should create distrust and this will in turn remove incentives for cooperation. There was some evidence for this also. One private sector representative noted that the private sector's suspicion toward the former Minister was earned by her secretive dealings around the HCFC.

"They believed there was a vendetta against the concept of profit and they believed that it was misunderstood. They believed that when one talked about NHI that meant the demise and the end of the private sector, based on the way the way the Minister handled the previous finance committee's information, by keeping it secret and not disclosing it and not explaining where the TOR had come from. That built suspicion around the Minister and distrust...let's put it this way that the minister remains somebody in whom the private sector is generally suspicious."(Private Sector representative)

Certainly, also the mistrust between the NDoF and DHFE at the time of the Medical Scheme Reregulation Working Groups (as confirmed by two analysts) severely restricted engagement.

Q: *"The Dept of Finance - do you know how the NDOH linked with them over the discussions, from 1997?"*

A: *"Very badly. I think the level of mutual suspicion was substantial. (Analyst) and I kept indicating from early on that they needed to involve the Dept of Finance in the process, but first of all the Dept of Finance were very dismissive of anything the NDoH came up with, around any issue basically."*(Analyst and Policy Committee Member)

From the above two examples it appears that mistrust puts a strain on free and open interaction between parties. Indeed, the evidence suggested that mistrust limited engagement altogether. This is different to the prediction from the conceptual framework that a lack of trust may well result in more formal or even contractual engagement processes. Instead mistrust undermines any engagement. The analysis is

clouded, however, by the fact that in both cases the interests of the actors were in conflict and it may be that an actor's interest in a reform is a more important determinant of engagement. Alternatively, it may be difficult to disentangle the two factors. Trust between actors may be closely linked with their interests and the degree to which such interests match. Nevertheless, there was insufficient evidence to take the analysis further here.

7.4.2 Opposition and Reputation

Perhaps the factors which appeared, more than any other, to have prompted less collaborative strategies by health reform drivers were direct opposition to reforms and a reputation for opposition caused by past activities. This link between opposition and control was particularly noticeable in and around the early policy committees of the HCFC and the CoI. Several points of control are evident:

- Once the former DG had learnt of the HCFC's opposition to the NHI she attempted to control their findings. She intervened (unsuccessfully) in the final stages of the HCFC to change their recommendations to favour an NHI, despite the HCFC favouring other options (three sources).
- The Director General applied a "careful filter" to the HCFC members when selecting who should be on the next committee, the CoI. Those who had been openly against a NHI scheme were dropped (four sources).
- The original Terms of Reference for the CoI reflected the implementation of a NHI scheme (despite the opposition from the HCFC). When the newly appointed chair objected to this the TOR were revised but the DG was appointed as co-chair, as a check on the Committee's activities (two sources).

These provide examples of where opposition to the goals of the reform driver was met with controlling behaviour from the reform driver. A closer examination of the first two policy committees reveals many potential control points. Table 7.9. derives such control mechanisms from the views of committee members and one co-chair.

Table 7.9: Potential Control Points on Government Committees

Area	Control Points
Workings of the Committee	<ul style="list-style-type: none"> • Time limits, • Consultation procedures, • Selection of the members, • Selection of chair and/or co-chairs
Technical Deliberations	<ul style="list-style-type: none"> • Framing of the issue in the TOR, • Fixed points to be met in recommendations, • Interventions to alter the findings
Implementation	<ul style="list-style-type: none"> • Acceptance or Rejection of Findings, • Decision over whether and how to publish report (timing, slant, press coverage)

The HCFC was subject to tight time limits. It was conducted behind closed doors. Several analysts suggest the HCFC had to meet specific goals, regardless of technical deliberations. Several committee members noted that the chair made interventions to alter the committee's findings in the latter stages of the HCFC. The subsequent treatment of the results of the committee revealed further control through it only being released at a much later date.

Subsequently, the members and chairs were carefully selected for the CoI, filtering out problematic characters (according to members both of the HCFC and the CoI). The TOR was used to frame the CoI deliberations to the agenda of the Minister in the CoI. The CoI was also expected to reach certain conclusions, i.e. free PHC, according to several policy committee members. Further, the use of committees gave senior policy makers in the National Department of Health the freedom to accept or reject what they liked from their conclusions. A more recent example of such a strategy was shown in relation to the group of committees developing Social Security. As an external advisor to the NDoH noted:

"...this commission of inquiry is fairly free standing, so what it comes up with is by no means necessarily the policy of departments of health, welfare, labour, etc. So, it's therefore perfectly reasonable for us also at certain points to take a step back, quite

possibly just say to the Minister: 'No, we do not think this is an appropriate policy.' We are duty bound to participate in the process to be constructive and to make sure that isn't necessary... (but) that's always an option to just stand off and torpedo it from the side."

Nevertheless opposition to the agenda of reform drivers did not seem to be the only factor that determined the controlling behaviour of reform drivers in some committees. In the HCFC, it might be seen that opposition was produced as a *result* of control and not the other way round, according to several committee members. Hence it would appear that there must be another factor causing the controlling behaviour. Just as trust was an issue of personalities, it is possible that control was also a *personality* issue and that some individuals were more prone to controlling others in the face of opposition (see Box 7.5). The need to drive policy toward agreed political goals in a short space of time may also encourage some reform drivers to try and control policy development. Thus there may also be *contextual* factors that precipitate controlling behaviour, as well as personality traits. For instance, two sources maintain that the former DG needed to consolidate her power base in government and she did this by controlling the HCFC and putting her personal mark on it. Other actors noted the need for the Government of National Unity to make a mark by delivering quickly on its promises to the electorate.

Box 7.5: Actor views of senior government health officials – some illustrative quotations

The former DG

“And if your got on the wrong side of (senior policy maker, NDoH) you were marginalised or discredited and that certain inputs were uninfluential or irrelevant, and they needed to be engineered to support a particular line of thinking, otherwise they were given no hearing.” (Private sector representative)

“...a tremendously strong character that just had a bloody-minded viewpoint and went for it.”

(Private sector representative)

Possible competitors were screened out of policy processes so she could take personal charge... (senior policy maker in NDoH) got very involved in specific committees which is unusual. (Analyst)

The former Minister

“She’s a hachet-man and a bulldog – I wouldn’t have wanted to work under anyone else. Once she’s convinced she’s right and done the work, she’ll fight for it.” (Former provincial DG)

“Zuma is a freedom fighter. Someone else said that what matters to her is ‘not what people think, but what the truth is’.” (Analyst)

“...she was prepared to take on powerful players like the tobacco lobby and the pharmaceuticals who nobody in the world has the courage to touch...” (Senior government official)

From the above discussion what were the determinants of the form of engagement?

The following four issues appeared to be determining whether to control or collaborate with other health sector actors:

- The actor’s reputation for cooperation (related to the previous history of interactions)
- The apparent alignment of interests between the reform driver and the actor (as perceived by the reform driver)
- The personality type of the reform driver
- The context in which policy is developed.

Contrary to the conceptual framework it did not appear that complementarity of characteristics was in itself a factor which drove collaboration (other than the

alignment of interests mentioned above). Also it was unclear whether trustworthiness could be separated out from alignment of interests and reputation as a determining element.

The above factors appear to explain when reform drivers try to control other actors in health financing reform development. Yet under what conditions were controlling strategies effective? The conceptual framework implies that in the absence of trust and a reputation for cooperation, as well as alignment of interests, collaboration will be hindered by suspicion and divergent goals, and may fall into inertia. Personality types, and even a certain policy context, might not be an effective foundation for successful control of policy processes. While such factors might lead to a reform driver pursuing controlling strategies they are not sufficient for achieving the goals of the reform drivers. What evidence is there for or against these assertions of the conceptual framework?

Certainly there appeared to be evidence that the controlled process of the HCFC produced suspicion and unease with both analysts and the private sector. The leak of the HCFC's findings to the media (four sources) may have been a signal of unhappiness with the government's processes. As noted before the level of control exercised on the HCFC would appear to be unwarranted given the largely supportive group of analysts and government officials hand-picked for the task. Rather than getting endorsement for a NHI strategy the controlling behaviour exhibited by the reform drivers may well have backfired through the hardening of opposition and the strategic response of different actors. As discussed the controlling strategies may have had more to do with personalities of the key reform drivers and the policy context.

Interestingly, it appeared that there was another strategic response to opposition evident in the interview data and that is not to engage and just push forward with the reform. The first example of this comes in relation to the first Free Health Care policy. The need for fast delivery of tangible policies may well have been behind its speedy implementation (2 sources). Nevertheless, the lack of consultation meant that neither was there sufficient planning nor goodwill from providers (3 sources). This undermined the implementation and perhaps the policy's sustainability. The second example was from the interactions between the National Departments of Health and

Finance. Here strategies of avoidance pursued by the NDoH with the NDoF appeared to have paid dividends. The following quotation from a NDoF technician spoke of an increasing tendency of health officials to try and bypass the NDoF at lower levels of the hierarchy on critical issues:

“...Health seems to get away with a lot, quite often, partly because (current DG) is very good at playing the Medium Term Expenditure System...I think also what seems to have happened, especially on this Levy Bill for the Medical Schemes Act, the delay in getting that through has made (the current DG) quite negative about Finance. So he's decided well I'll go to cabinet because people are obstructionist.” (NDoF technician)

Indeed, as noted earlier there was a tendency on the issue of the Medical Schemes Reregulation to limit the NDoF's input and influence, which ultimately proved useful to the successful development of the policy. The first example of avoidance seemed to be dictated by context and the need for speed. It however proved less effective and seemed to actually produce opposition. The second example shows that avoidance may be more appropriate where opposition is pronounced and trust is absent.

In this light it is interesting to look at the collaborative engagement pursued through the “4x4”, to link regularly NDoH and NDoF in areas of mutual interest. A failure to post sufficiently high-ranking personnel to the 4x4, a lack of strategic focus and differing goals appeared to undermine the attempted collaboration. A senior official of DHFE claimed that this was not due to a lack of trust but differences in organisational culture. Nevertheless, the driving factor behind this may have been the different goals of the organisations. Interestingly, a senior manager in NDoH suggested that the way NDoF was viewed depends on the issue at hand. This again would suggest that alignment of objectives is important for cooperation, especially in the absence of trust and a history of cooperation. Where all these factors are absent strategies of limiting engagement may be more effective.

7.4.3 Rules

Much of the preceding discussion has dealt implicitly with the issues of rules as the precise form of each relationship was developed. Indeed, it is through the setting of the rules of a relationship that the reform driver attempts to establish the extent of control over the behaviour of others. As noted in Table 7.3, and discussed by committee members, the Terms of Reference of the committees acted to set, at least partially, the rules of engagement. Such rules were largely determined by the reform drivers and directed to the policy task at hand. Nevertheless, it is less clear whether there was differentiation of rules according to each actor and their specific characteristics. A closer examination of the functioning of committees reveals that there were groups within and around the committees that seemed to be operating under different rules: for both the HCFC (the drafting team) and the CoI (the anti-NHI team). Differentiation of rules related to issues around trust, common interests and particular skill areas and depended on whether committee members were trusted and had specific skills. Hence reform drivers varied the rules of engagement according to key characteristics of actors.

The backlash to the initial Terms of Reference on the Committee of Inquiry showed that rules can be affected by the action of other actors and are not the sole domain of powerful reform drivers. Still, because the rules were in some cases unclear or were contentious or even evolved as the reform proceeds there was conflict and uncertainty in this type of relationship especially where there was a lack of trust between parties. This certainly seemed to be the case on the early committees. Where trust is lacking, clear rules may be important.

Interestingly with respect to rules there seemed to be a significant difference between the resource allocation reforms and the resource generation reforms. While resource generation reform drivers established their own rules of engagement, the rules relating to the resource allocation processes were largely set by the formal budgeting processes in government and were not the domain of the reform driver. This lack of control over the rules of engagement for a health resource allocation reform may

weaken the hand of any prospective reform driver³. Nevertheless, as noted above, the presence of clear rules for engagement may reduce uncertainty and conflict over appropriate processes.

7.4.4 Incentives

The conceptual framework noted the importance of incentives to the behaviour of each actor. The conceptual framework suggests there will be different types of incentives, some will relate to material rewards from the outcome of the reform, some to the process of the reform and some to any direct payment for participating in the process. Insufficient incentives may well produce uncooperative behaviour that could, at worst, derail a reform. More formal and controlling processes will need more incentives to work effectively. In this section the focus is on two actor groups who were engaged in almost all the policy committees, analysts and medical scheme administrators, and who have very different forms of motivation. Analysts were involved in all the resource generation reform processes while the Medical Scheme Administrators were part of deliberations over the appropriate form of health insurance and the medical schemes' reregulation. There was less information on the motivating factors for actors in resource allocation reforms but we explore available data at the end of this section. The range of motivating factors for the actors is presented for each of the resource generation committees (Tables 7.10 and 7.11). It is interesting to see how these motivating factors changed across committees and evaluate what effects such changes had on the actions of each actor grouping and the policy development process. The categories presented in Tables 7.10 and 7.11 are grounded in the data according to the actors' statements about motivation, and relate to:

- Material rewards from the reform outcome – Actor gained materially from the end result of the reform process (or expected to);
- Ideology – Actor agreed with the values of the reform process;
- Process – Actor appreciated the way in which the reform process was conducted;
- Role – Actor gained value from being part of the policy process;

³ Nevertheless, the one reform driver that would have sufficient power to influence and even alter the rules is the NDoF.

- Payment for participation – The actor received direct material or financial reward for participation in the process.

Analysts had no material rewards from the outcome of reforms other than perhaps a rather indirect potential benefit from being associated with its overall technical success. (Note: that a distinction was drawn between the self-interest of an actor relating to the outcome and their ideological values.) The ideology of analysts tended to be largely in favour of the financing reforms, with the notable exception of NHI. This is interesting as the analysts came from different institutions, with different backgrounds and might, therefore, be expected to hold competing views. Nevertheless, the number of potential analysts with relevant expertise was quite small and the individuals may have been drawn from prior policy processes, guaranteeing a certain set of values.

From the data it also appeared that analysts were motivated by open processes in the committees. One analyst and committee member voiced a prevailing sentiment in the HCFC:

“And we said that we weren't willing to work that way, that firstly we weren't employed by the Government and we weren't civil servants in the way that she might expect an internal advice, and that we wanted to reserve the right if she did disagree or did choose a different policy to be able to debate that policy in public and didn't want to find that because we participated in a commission that we now could not take contrary views outside, because we would somehow be breaking the confidence of the committee.”

Where key policy makers tried to control the outcome (the HCFC and at the beginning of the CoI) or proved unavailable for comment and feedback (the SHI Working Group) there was some frustration with the processes of reform. In contrast, on the Medical Schemes working group, the DHFE technicians were able to access the Minister and get her support, allowing analysts to exert some indirect influence.

Table 7.10: Motivating factors for Analysts in various policy committees/initiatives

	HCFC	CoI	SHI WG	Medical Schemes WG	Health Task Team in Social Security Review
Reforms	Free Health Care NHI/SHI Equitable RA	Free Care SHI/NHI	SHI	Reregulation of Med Schemes	SHI
Engagement	On committee	On committee/ reform driver	On committee/ reform driver	On committee/ reform driver	Reform driver
<i>Motivating Factors</i>					
Material rewards from outcome	No direct interest apart from wanting to be associated with a success	No direct interest apart from wanting to be associated with a success	No direct interest apart from wanting to be associated with a success	No direct interest apart from wanting to be associated with a success	No direct interest apart from wanting to be associated with a success
Ideology	Support improved equity, through FHC and RA but not NHI	(largely) Support free PHC but opposed NHI	Support SHI	Support reregulation of Medical Schemes	Support SHI
Process	Dissatisfied – no consultation allowed and heavily controlled	Satisfied – after initial reworking of the ToR	Satisfied with technical workings but problem of access to power	Satisfied with technical workings.	Unknown
Role	Keen to play part in reforms	Keen to be part of reform process	Very keen to be part of reforms	Keen to be part of reforms	Unknown
Payment for participation	None	None	Employer partly paid	Employer partly paid	Paid on individual basis

Payment for participation appears to have become a factor only in the later committees. Even here it was relevant only as it alleviated a funding constraint. (Lack of funding was noted as a negative characteristic for analysts, see Table 7.5.) Indeed only on the Health Task Team for SHI were analysts individually paid for their time. Interestingly, on the SHI and Medical Schemes working groups the only two analysts participating had to stop working on these committees because of a lack of reimbursement of their employers for the heavy time commitment.

The committee that stood out as being the least attractive in terms of overall incentives for analysts was the HCFC. While motivation was gained from having a role in the process, the actual way in which the committee was managed demotivated many analysts. Further, no payment for participation was offered and all the South African analysts disagreed with the NHI being pushed by the reform drivers *and* were worried that their names would be associated with the NHI option. While analysts were keen to be part of the reform process, it is perhaps not surprising that there was a lack of cooperation on the committee, as noted earlier, when the analysts were “told” what the results had to look like. Even though the CoI also offered no payment for participation its more open processes proved to be far more acceptable with the analysts on the committee. Later committees were barred from open debate with policy makers but analysts were “compensated” with playing a role in the process, pushing something they valued ideologically, following open processes and, on the Health Task Team, being paid for their time.

Table 7.11: Motivating factors for Medical Scheme Administrators in relation to various policy committees

	HCFC	CoI	SHI WG	Medical Schemes WG	SHI in Social Security
Reforms	Free Health Care NHI/SHI Equitable RA	Free Care SHI/NHI	SHI	Reregulation of Med Schemes	SHI
Engagement	On committee	On committee	Consulted by committee (but not openly)	Consulted by committee	Consulted
<i>Motivating Factors</i>					
Material rewards from outcome	NHI would destroy MS administrators. SHI <i>could</i> be beneficial depending on design	NHI would destroy administrators SHI <i>could</i> be beneficial depending on design	SHI <i>could</i> be beneficial depending on design	Removal of risk rating split the industry (good for some and bad for others)	SHI <i>could</i> be beneficial depending on design
Ideology	Pro-market and private health care.	Pro-market and private health care	Pro-market and public/private collaboration on SHI	Pro-market but differing views on appropriate regulation	Pro-market and public/private collaboration on SHI
Process	Closed process generated suspicion.	More open process added credibility to the debate and reform drivers	Effectively excluded from process	Initial suspicion. Part of industry accepted the process and part fought through the courts.	Unknown
Role	Wanted to be part of transition and process	Wanted to be part of the process	Unaware of the process	Not part of the committee, but wanted to be	Unknown
Payment for participation	None	None	None	None	None

The Medical Scheme Administrators had a very real interest in the outcome of the policy committees as they related to NHI and SHI, see Table 7.11. In particular they had a very high stake in the design of the Medical Schemes reregulation. Their ideology favoured the private sector and private health care but the appropriate degree of regulation became a matter of some dissent and caused a rift in the industry in the debates around the Medical Schemes reregulation. Just as with the analysts, it appears that the Medical Schemes Administrators were affected by the process around each of the major committees. It may well be that their concern for open processes reflected their huge stake in the outcome of reform. A closed process limited their influence on the outcome. Yet there did also seem to be some motivation derived from open processes and the integrity of the workings of committees.

“And, he (co-chair of CoI) played a fantastic broking role in a sense and he was able to present the philosophy in a consultative manner and it won the hearts, as it were, of the constituency at the time.” (Private Sector Representative)

“...if you’ve tackled those parties openly and transparently and you’ve genuinely made them feel as though they have been part of the process. And the documentation revealed an appreciation of those issues. And even if the policy didn’t fall on the side of that, that cleverly it was debated in the policy document, and the merits were examined and the route towards reaching a decision was clear in that articulation, it added enormously to the credibility of the people that had complied that.” (Private Sector Representative)

The two most disliked committees for the Medical Schemes Administrators seemed to be the HCFC and the Medical Schemes Working Group. The closed process of the former with the drive toward NHI produced a hostile response from the industry. It was suggested by one source that the leak to the press and the associated media barrage was part of the industry’s strategic response, though this is not confirmed. The CoI was more open and consultative and, with less of a focus on NHI, was more acceptable.

The decision to move the industry to a consultation role on the subsequent working groups and committees, rather than as a member with drafting rights, was no doubt

due to the industry's likely opposition. Nevertheless, the SHI working group managed to earn the "confidence" of some Medical Scheme Administrators through displaying their knowledge and working together with the industry. The industry split on the proposals for the Medical Schemes reregulation. The more hostile grouping (COMS) attempted unsuccessfully to scupper the proposals, as described by one working group member:

"They were also getting shot in the foot by their own experts flown into SA at great expense. After COMS broke away they hired US consultants to make an assessment of our proposals, which concluded that in five years there would no longer be a medical aid industry. The work was very shoddy. So we did an evaluation of their work. (Analyst) showed that technically they were on a much weaker footing than the Department (of Health). COMS couldn't even defend their database at a NDoH meeting. They also took it to the NDoF. The NDoF were very weak so they thought it was OK. Then the NDoH showed them what was wrong which made COMS lose even more face." (Senior official, DHFE and policy committee member)

By pursuing an open process the working group was at least able to nullify any concerns of dishonest technical debate or closed discussions. Technical expertise backing up a consultative process may remove ammunition for complaint from an actor with opposing interests.

Motivating factors will differ from actor to actor. For analysts, ideology, technical debate and open processes were important as well as a role in the reform process and to some extent payment for participation⁴. For medical scheme administrators, material rewards from the outcome of the reforms was the dominant motivating factor, as it affected profits and sustainability. Processes were also important; consultation, quality technical debate and openness had value even where reform was not in their interest. The range of motivating factors was thus quite broad. Further the above analysis adds flesh to the dimensions specified in the conceptual framework. Interestingly payment for participation appeared to be relatively unimportant in motivating participants in reform.

⁴ Though the evidence suggests this was only a factor where analysts needed their institutions to be compensated for time spent in policy processes.

What evidence was there that insufficient incentives undermined the reform processes? As a result of the HCFC and the CoI the reform drivers failed to take forward the NHI option in the face of opposition from both analysts and the Medical Schemes industry. Had the HCFC been structured differently, with different incentives would the NHI reform have gone ahead? The answer is probably not. A more open process may have guaranteed more heated debate and perhaps a stalemate of positions. Flexibility on the NHI position may have encouraged the analysts and the Medical Schemes Administrators to participate but then the reform drivers would have lost their key goal. The lack of payment for participation to compensate the employers of the two analysts on the Medical Schemes Working Group eventually undermined their role and they had to stop work. Nevertheless, their agreement with the reform and satisfaction of being part of the process proved sufficient motivation earlier on. Perhaps then better incentives just encourage better participation, but this is not guaranteed to be a recipe for successful reform driving and depends on the values of the actors.

7.4.5 Formal Contracts

According to the conceptual framework formal contracts should be restricted to those relationships where characteristics are not complementary, with a lack of trust, poor reputations for cooperative behaviour and differing interests. The evidence available showed that the use of formal contracts within the policy reforms was fairly limited in terms of single strands of policy development. Only one reform relied entirely on this method, the Hospital Strategy Project (HSP). Yet rather than this being because of a lack of trust or need to control, the contracts were organised because of need to pay for outside expertise to conduct the intensive amount of work required (according to one HSP member and analyst). Perhaps also a more arms-length relationship was allowed because the financing of hospitals was a lower level of priority (two sources). There were insufficient data from the case study material to draw conclusions on this issue.

An interesting question is whether the committees themselves functioned as contracts with committee members. Under this line of argument the Terms of Reference for the committee, and associated negotiations, would form an implicit contract between the reform drivers and the policy committee members. Perhaps where more control is needed these arrangements would be more formal. Again, there was insufficient evidence to judge whether more formal contracts or committees were implemented where there is less trust. Certainly while there was a focus on policy development in formal committees there were quite a few instances of informal networking around these committees, for example among sub-groups within the committee and between reform drivers and analysts outside the committee (see below). It would be expected from the conceptual framework that these informal engagements would be more collaborative, less structured and based on trust and alignment of interests than on material outcomes and payment for participation.

There are problems testing this. The informal nature of such interactions and the limited number of participants meant that it was often difficult to get corroborated data on this type of engagement. Table 7.12 examines evidence of informal networking around the committees. Much of the evidence is unsubstantiated and must, therefore, be handled with care. Indeed, only one informal engagement was verified by several sources, i.e. the interaction between one external consultant and the Minister of Health.

What was the basis of this alignment between the Minister and the specific external analyst? First the Minister saw the external analyst's proposal for NHI "as the morally right thing to do", according to one interviewee. Several analysts confirmed that the Minister supported an NHI because it was pro-poor and appeared equitable. Further the Minister shared socialist values with the external analyst whereas she did not find the support she wanted from the South African analysts, who unanimously opposed NHI on the HCFC, CoI and SHI WG. To a certain extent such "personalised policy-making" may have undermined the process of committees to develop policies. Yet it may also reflect a failure on the part of the South African technicians to engage with the political concerns of the Minister.

Table 7.12: Evidence of Informal Engagement around Committees

Committee	Informal Engagement	Source
HCFC	External analyst having discussions with the Minister, (both support NHI) Private sector representative and senior NDoH policy maker (unspecified link) Private sector representative lobbied Minister to get on committee Private sector representative and senior health policy makers drafted alternative NHI policy	Analyst Analyst Analyst and HCFC member Analyst
CoI	External analyst and Minister plan CoI informally External analyst and Minister meet with two other external analysts to plan out CoI Analyst set up informal sub-committee to wipe out NHI option and counter senior policy makers and external analyst.	Analyst and CoI chair Analyst and CoI chair Analyst and member of informal sub-committee.
SHI WG	External analyst engages with Minister on NHI.	Government official; 2 SHI WG members and analysts; another analyst.

The Minister was not the only one to bypass formal policy processes. One member of the CoI commented:

“(External analyst) is a consummate sort of corridor politician... and he never gives up. If he loses in the Chamber then he goes outside, in the corridors behind the scenes. So that’s his style and he’s still doing that, to this day. He’s still waging the same battle, the same proposal.”(Analyst)

While part of the basis for the informal engagement was *alignment of interests* and previous *cooperative behaviour*, *personalities* also appeared to be an important influence.

7.4.6 Resource Allocation vs. Resource Generation

As noted in many ways participation in the resource allocation reforms was determined by official role in the budget process and representation of a key constituency. Securing effective participation did not seem to have been such a problem. Provincial representatives had to participate in reforms. Also the membership of key committees or groups tended to be restricted to government, where everyone's time is technically fully funded. People did have interests in the reforms, especially from particular provinces, but there seemed to be a general support of the first resource allocation formula and the second reform was effectively taken out of health's hands.

There was also a little information on informal activities around the resource allocation reforms. One middle manager in the National Department of Health noted that prior to PHRC and MINMEC meetings there were informal discussions to make sure that people were on board; people would phone up their friends to see how they would respond to key ideas. Likewise one provincial manager noted how much information sharing was down to a certain individual being able to talk with the National Department of Health and now that this person had left there was a communication gap. Again, it appears that personalities mattered to such informal interactions. Yet there is insufficient evidence to draw firm conclusions on the matter.

7.5 Interaction and Learning

The conceptual framework predicted that:

- Actors may actively:
 - Negotiate the form and rules of a relationship
 - Try and change the goals and tasks of the reform driver where they are strongly opposed to the reform.
- Learning occurs from past behaviour. More specifically;
 - Reform drivers and actors change their perceptions of characteristics and reputation in response to each other's actions
 - Reform drivers review engagement and incentives in response to the behaviour of actors

- Reform drivers and actors are less likely to collaborate where the other has a poor reputation for collaboration.

7.5.1 Strategic Actors

The conceptual framework noted that actors can make different responses to the proposed engagement. Actors may, for example, simply accept or reject the proposed engagement. They may also engage in more strategic behaviour if they disagree with the task set, the terms offered or the fundamental goals of the reform (driver). Below the evidence is reviewed both for more active and passive responses by actors. I explore cases where actors *negotiate* over engagement and where they try and change either the *goals* of reform and/or the *tasks* for policy development.

7.5.1.1 Negotiations

Case 1:

One instance where actors negotiated the TOR for a committee was around the HCFC. In response to the proposed closed process many analysts protested:

“And we said that we weren’t willing to work in that way, that firstly we weren’t employed by the Government and we weren’t civil servants in the way that she might expect internal advice, and we wanted the right if she did disagree to be able to debate that policy in public.”(Analyst)

A compromise was achieved in that members of the HCFC weren’t able to comment before they had submitted their final recommendations but that the document was to be made public within a fixed time.

Case 2:

Another interesting case of negotiation, where the DHFE and the NDoH were actors rather than reform drivers, was the development of SHI through the Social Security committees. The NDoH found itself without either a representative on the sub-committee for health or the main co-ordinating committee. This happened partly through chance in that key individuals who were government health officials moved

to different posts. It may also, however, have reflected the personalised nature of policy making. As one technical adviser to the DHFE noted:

“My personal view is (SHI has) always been driven by (analyst), (senior official, DHFE), (senior official, DHFE) and that little sort of clique. Well, at least in recent years it’s been driven by them. And it thus continues to be.” (External Adviser to the NDoH)

These individuals were the reform drivers for the SHI Working Group and the Medical Schemes Reregulation. Despite having different jobs the same individuals gained responsibility for health insurance development, (perhaps because of a lack of interest and expertise from other actors). This was of concern to the NDoH officials:

“Frankly, if I’m honest with you, our worry, or my worry, and others here, has always been that (analyst) will just be allowed to play with his toys, either leading to a sterile proposal which does not go anywhere, or to some sort of Frankenstein’s nightmare kind of thing (laughs), which will be the (analyst’s) plan for the health sector, rather than a more specific social health insurance. I think we still detect worrying signs of that...” (External Adviser to the NDoH)

“The weakness of the strategy that’s being pursued on the health side is that some people have a preconceived notion of how this social health insurance is gonna work....(and) the mandate of the committee is quite broad. It’s basically giving them license to restructure the entire health sector...rather you should see how you can fit that piece of the puzzle (SHI) into the picture, rather than build a picture around it.” (Senior official, NDoH)

The response of the NDoH was to enter into negotiations with the reform drivers in 2001 to allow representation of the NDoH. While this was initially resisted by the Social Security committee, the DHFE mobilised a senior policy maker in NDoH to support them and were subsequently allowed representation (3 sources). This was an interesting situation where an actor mobilises other actors, with power, to get on to the committee. It shows not only that actors can and will behave strategically in response to the efforts of reform drivers but that actors may combine together to be more

powerful than they would have been otherwise. In other words in their response to proposed engagement, or in this case disengagement, actors may also assess the characteristics that they need to change the reform driver's behaviour.

7.5.1.2 Tasks and Goals

While actors altered through negotiations the engagement and control strategies of reform drivers there was also evidence that they achieved more fundamental change to the *tasks* of policy development and even the *goals* themselves. The first example was the battle between reform drivers of NHI and SHI in and around the start of the CoI. Here the Minister and the Director General sought to engage a key analyst as an actor who himself wanted to drive the process in a different direction. At the start of the CoI, there was intensive debate over its objectives. The chair effectively altered the task of reform development to developing any financing mechanisms that would allow access to health care for all South Africans and not just the implementation of National Health Insurance (3 sources)

The second case involved the mobilisation of the media at the end of the HCFC and the start of the CoI. Here the NHI option was leaked to the press according to several committee members. While it is difficult to be sure one source suggested that this was done by the Medical Scheme industry in order to undermine the proposal and change the direction of the CoI. Here the media was most likely used by an actor as an important check to the policy processes of government. The media was probably mobilised to try and subvert the perceived tasks of developing an NHI.

The third case involves the blocking of the SHI proposal developed by the SHI Working Group. While reconstruction of exact events is difficult it appears that the Minister wanted to put the matter to the ANC conference. She was not convinced of its technical merits and thought that this would serve as a useful check with her political allies. There it was passed over, in particular by the trade unions, in favour of a more comprehensive social security package. Thus the Minister, as a powerful actor, was able to derail the task of SHI policy development and open up the possibility of different goals for reform.

7.5.1.3 Speed of change thwarting strategic actors

A key question is whether the strategic reactions of actors were thwarted by speedy reform design and implementation. Thus speedy implementation may undermine opposition because opposing actors do not have enough time to respond before the reform is in place. This issue is explored across different reforms. The fast implementation of the first free health care policy and, to a certain extent, the second, certainly limited the opportunity for opposition. Nevertheless, because there was little consultation before implementation service providers became demotivated and this may have produced more opposition to the reform than would have been present otherwise. This in turn may have affected the long-term viability of such reforms. With respect to the resource allocation reform following fiscal federalism, certainly the changes happened very quickly. This meant that there was no opportunity for any strategic reaction by health sector actors, such as the NDoH, who may not have liked the move to decentralised allocations of health resources. Nevertheless, even had the implementation of the reform been phased in it is not at all clear that the health sector actors had sufficient power to make any changes. The move towards NHI in the HCFC and the beginning of the CoI certainly happened quickly however the reaction produced to this attempted bulldozing of the issue was very strong and may well have contributed to the undermining of the push towards NHI. Interestingly the preparation of the Medical Schemes reregulation occurred behind the backs of the National Treasury and the Medical Schemes and it may be that this was a more important strategic move than speed of policy development.

It may be important to differentiate between speed of reform design and reform implementation. In the implementation stage speed may be useful in pushing forward change in the face of opposition but it may lead to poor implementation which in turn creates more opposition. Further, in the design phase speed is no guarantee of success in that it may risk technical rigour in policy design which may again produce more opposition. Slowness of policy design may not be a problem where opponents are not informed of the policy process and thus are not involved in galvanising opposition. Thus it is not clear from the evidence that speed of reform is a key determinant of managing opposition. Instead issues around actor relationships, information exchange, power and context may be more important.

7.5.2 Learning

Learning implies that reform drivers or actors will alter their strategies of reform development or blocking based on information about what has occurred in previous engagements or policy reform processes. The implication of the conceptual framework is that learning helps the reform driver manage the actors more appropriately.

There is mixed evidence from the South African experience that this occurred over the course of the development of the reforms. Examples for and against learning are highlighted:

7.5.2.1 For

- It is apparent that an external analyst gained a reputation for working behind the scenes with the Minister. Hence other actors and reform drivers learned about the values and strategic tendencies of the external analyst, in particular his non-cooperation, and adjusted their behaviour in response. For instance, three sources noted how one aim of the CoI was to “wipe out” the NHI option proposed by the external analyst. On the SHI WG there was evidence that the committee engaged with the external analyst to try and convince him that the working group’s recommendations were the most technically appropriate and to stop him pushing forward other plans with the Minister.
- Two committee members of the CoI noted that a senior official from the NDoH was appointed as co-chair probably in response to the original chair’s resistance to the initial TOR. As the Minister learnt of the values of the chair, and his opposition to a NHI scheme, there was a breakdown of trust between them. This led to the need to have more control in the process, which was the rationale for the co-chair appointment.
- There was an extensive filter applied to the selection of members from the HCFC onto the CoI. The decision to *stop engagement* was based on improved information about the characteristics of the actors and their reputation for a lack of cooperation. Originally none of the analysts on the HCFC were to be part of the

CoI. However, the chair intervened to include two analysts whose expertise was thought to be critical. Their lack of cooperation was overlooked because of the indispensability of their technical skills. This reinforces an earlier finding that there may be a conflict between managing actors who are “problematic” but have positive characteristics.

- The DHFE, and NDoH more generally, learnt to take care when engaging with the NDoF, since collaboration did not seem to have worked e.g. CoI and 4x4. The NDoF acquired a reputation for obstructing reform. One strategic response was that the DHFE only allowed minimal discussions with NDoF over the proposed Medical Schemes legislation. The Minister took this to Cabinet and was able to push through the legislation. On other occasions senior policy makers in NDoH did not engage with NDoF on technical issues outside of Cabinet meetings, seeking to gain broader approval for policies.

7.5.2.2 Against

- The stalemate between the Minister and analysts around the appropriate form of health insurance seems to be a case where neither side learned. According to several analysts and policy committee members the Minister kept rejecting the work of analysts and setting up new processes and committees, while the analysts kept presenting proposals that were unacceptable to the Minister.
- Senior health policy makers failed to learn from the hurried implementation of the first free health care policy with an equally rushed and unplanned implementation of free Primary Health Care (according to several sources).

What makes the difference between learning and not learning? The above examples do not really provide enough information to draw firm conclusions. Some individuals and groups appear to be better at learning than others. For instance the first Minister appears to have failed to learn from previous experience on two separate issues. Hence personalities may affect learning. Where learning does not occur it appears to have undermined the reform process, in terms of developing the reform or it achieving its aims. As such the preliminary data are consistent with the conceptual framework.

7.5.3 Resource Generation vs Resource Allocation

There are several problems looking at actor interventions and learning in the resource allocation material. First, the processes were less well documented from the interviews. Second, the reform drivers for each reform were different and so the concept of learning does not carry over from one reform to the next. Third the budget process was so tightly controlled by the National Department of Finance that there was little opposition with any power to effect change. The reform stream did not really provide us with a useful test for these components of the conceptual framework.

7.6 Reflections on the SAZA Case Study Evidence

The SAZA case study material provided some important insights into the process of managing actors in health financing reform. Many new factors were highlighted that were not in the conceptual framework. The evidence is summarised in Table 7.13.

7.6.1 Points of Agreement

The SAZA case study material provided evidence to confirm several elements of the conceptual framework. First, there were usually reform drivers for reforms who take responsibility for the overall direction of a process and this appeared to be particularly the case for the resource generation reforms. The picture is perhaps more complicated than the conceptual framework would suggest, with reform drivers often working in teams and in sequence, handing on the baton of reform management. For instance, government technicians and analysts often handled one part of the reform process only to see senior managers and politicians carry it forward for official approval. Nevertheless, the material suggested activity by reform drivers in managing the reforms which is consistent with the conceptual framework.

Further, there was some evidence to suggest a reasonable amount of self-awareness for reform drivers in resource generation reforms. Constraints to reform development were usually identified by reform drivers, though sometimes in a general rather than

reform-specific way. Further, there was evidence to suggest that reform drivers engaged to relieve their own identified constraints, especially for the resource generation reforms. Nevertheless, there were some mistakes here, such as analysts not engaging with the unions on SHI and thus failing to have sufficient power later in the process. Failure to engage appropriately with other actors undermined this version of SHI and this is consistent with the conceptual framework.

Additional points of confirmation were that opposition to the reforms and a reputation for non-cooperation were important factors in seeking how to deal with some actors, such as the NDoF, and gave rise to less collaborative relationships. Rules of resource generation reforms were influenced by the policy task and actor characteristics. Further, the use of control where it wasn't warranted backfired in the HCFC and this points to control only being justified where there is opposition and poor reputation for cooperation of an actor. There was also evidence to suggest that actors could act in a strategic way to try and alter the relationship with the reform driver and also the tasks and goals of reform.

7.6.2 Points of Disagreement

Reform drivers sometimes found themselves in competition with each other, developing different versions of the same reform. While reform drivers must manage their own process, they must also seek to destroy alternative models. This aspect of managing actors in reform development is not present in the conceptual framework.

Power was critically important to taking forward reform and needed to be accessed by those who did not have it. Policy makers often hold the key to successful approval of a reform and reform drivers must ensure that they have such people on board their version of reform. Relatedly, representation of constituencies and institutions may be important and this was particularly the case in the resource allocation reforms. In the latter power and representative were critical to reform development. Indeed, it may be here that power and issues around representation actually determine, and even dictate, engagement in formal reform processes and the type of relationships that must occur in reform.

Nevertheless, informal relationships may still be important to developing reforms around these formal processes and there may be some room for reform drivers without power to use them. This raises the important issue of personalities of reform drivers and other actors. Particular qualities of reform drivers may be important for getting things done. This is not really considered by the conceptual framework though it might possibly be seen as a resource of the reform driver, or a constraint where lacking.

While the conceptual framework recognised that the managing of actors must happen with a specific context it is important to reflect a little more on how important context actually is. While a facilitating context may allow a reform driver to pursue a fairly logical process, there are times when context impedes rational management of reform processes. Changes to the constitution and the transition to democracy were major contextual events that transformed the resource allocation processes. In such circumstances reform drivers must respond to events and try and deal with them as best they can.

Other issues that arose were:

- A lack of incentives for an actor, other than participating in the reform, did not appear on the basis of evidence available to be critical to reform development, though it did affect the actor's response and it did precipitate strategic behaviour.
- Contracting was not done for reasons of control but for remuneration
- The complementarity of characteristics did not appear to affect the form of engagement
- Strategies for control related to limited or non-engagement as well as, or even in place of, more formal relationships

7.6.3 Inconclusive Issues and a Lack of Data

While the case study material was very rich and brought out a number of factors that were not considered in the conceptual framework, there were gaps in the data. In several areas it was not really possible to test adequately the hypotheses of the conceptual framework. In particular, it was impossible to draw any conclusions on the importance of *trustworthiness* in determining the type of engagement with actors. There was some evidence that it was a factor in some interactions around resource generation but its precise role and importance proved difficult to disentangle from an analysis of the complementarity of interests of different actors and reform drivers, and the reputations of actors. There was evidence both for and against *learning* in the reform processes. Some reform drivers appeared less able to learn from past experiences than others. Yet, it was impossible to tell what factors caused this, whether it was due to personality traits or whether the prevailing context prohibited learning. In any case, learning on the basis of past behaviour may not always be relevant where the context changes the behaviour or characteristics of an actor.

7.6.4 Resource Generation vs Resource Allocation.

The conceptual framework would appear to be a far better fit for resource generation reforms than resource allocation according to the available material, and not withstanding the problems highlighted above. To what extent this reflects insufficient material in the interviews and to what extent it is due to the fact the resource allocation reforms and processes were tightly guided by the budget process is unclear. Certainly, context seemed to play a much larger role in the development of resource allocation reforms. To help answer such issues, the deductive approach used in Chapter 8 is aimed not only to test directly the implications of the conceptual framework but also to focus in on a resource allocation reform which was completed outside of the timelines of the SAZA project material. This should provide more information on the ability of the conceptual framework to provide insight into resource allocation reforms.

Table 7.13: Summary of findings from SAZA case studies

Elements of Conceptual Framework	Agreement	Disagreement	Inconclusive
<u>The Reform Drivers</u>			
There exist active reform drivers who take responsibility for taking forward reforms with reference to goals.	Evidence for active reform drivers who take responsibility for taking forward reforms. But often work in teams or sequence.	Not just a single reform driver. Reform drivers may be in competition over the same reform. They must seek not only to take forward their own tasks but sabotage the efforts of the other reform drivers. Context may impede the rational management of actors as some processes and relationships are given.	
They are aware of their own constraints to reform development	Reasonable amount of self-awareness – though mistakes were made with adverse consequences for the reform’s progress	Power not included as a characteristic but key to taking forward reform. Personalities of reform drivers are also important.	
<u>Seeking out Characteristics</u>			
Reform drivers will seek out characteristics from other actors depending on their own limitations and the task ahead	Opposition to reform and negative reputation affected engagement by reform driver	Both power and representation of a constituency were identified as characteristics additional to those in the Conceptual Framework.	
<u>Establishing the Relationship</u>			
The form and rules of relationships between the reform driver and other actors will be dependent	An actor’s opposition to reform and negative reputation led to less collaborative/more controlling engagement strategies.	“Control” may relate to limited engagement with, or avoidance of, other actors. Contracting was not done for control but	Difficult to say what role trust had in determining the type of relationship

<p>on key characteristics i.e. trust, reputation and interests</p> <p>Incentives will affect behaviour</p>	<p>Unwarranted control backfired on the reform driver.</p> <p>Overall motivation was important for affecting actors' behaviour (I need to check this)</p>	<p>to allow appropriate remuneration where needed.</p> <p>Complementarity of characteristics does not appear to have affected the form of the relationship.</p> <p>Payment for participation was typically not critical for developing reform – other factors usually more important</p>	
<p><u>Interactions and Learning</u></p> <p>Actors may actively try and change the reform tasks and goals.</p> <p>Learning occurs from past behaviour and may result in changing reputation, engagement and incentives.</p> <p>Evidence for actors behaving strategically to try and change the form and rules of engagement as well as the policy task or goal.</p> <p>Inconclusive evidence on whether reform drivers learned and changed their behaviour – some did and some did not. This points to the importance of personalities and context.</p>			

Chapter 8: Testing the Conceptual Framework against Reflections of key Reform Drivers

8.1 Introduction

This chapter examines the relevance of the conceptual framework to managing actors in the reform of Conditional Grants between 2000 and 2002. The development of the Conditional Grants reform occurred largely outside the time period of analysis of the SAZA project. Nevertheless, as noted in Chapters 6 and 7, some preliminary activities for the reform had been initiated within the National Department of Health by the time of the second round of SAZA interviews. Yet the difference between this and the preceding chapter is not just the time period of analysis but the methodological approach. This chapter focuses on the reflections of the Conditional Grant reform drivers in the Directorate of Health Financing and Economics (DHFE), National Department of Health. The key people interviewed were the Director of Health Financing and Economics and the Foreign Technical Adviser (FTA) to the DHFE. Both participated actively in the reform process and the quotations shown in this chapter relate to their views expressed in interview. The conceptual framework is tested against what they did and what they perceived to be important. Further, interview questions were drawn directly from the Conceptual Framework, and its working hypotheses, rather than using a more grounded approach to draw out data. See Annex 3 for a detailed list of questions. Hence, this material provides an additional test for the conceptual framework from that contained in Chapter 7. Nevertheless, findings are grouped under the same four headings: the reform drivers, seeking out characteristics from other actors, establishing the relationship and interactions and learning (see Box 7.1)

It is helpful to provide a brief overview of the reform, in the form of major events, actors and processes to set the scene. There were four stages in the process of the Conditional Grants reform (see Table 8.1). First, the PHRC and the Director General, National Department of Health, decided there should be a technical review of the Conditional Grants, honouring a commitment made at the introduction of the grants in

1997/98 to evaluate them after a suitable time. The conditional grants for hospitals were introduced to protect certain services and functions which were seen as national assets such as specialist hospital services, training and research (for further details see Chapter 6).

Table 8.1: Timelines of the Conditional Grants Reform

January – June 2000: Task initiation	July 2000 – January 2001: Agreement on approach and initial data collection	February – June 2001: Further data collection and reform design	July 2001 – January 2002: Final negotiation
<ul style="list-style-type: none"> • PHRC/DG approve task • DHFE work on options and methods 	<ul style="list-style-type: none"> • DHFE develop concept paper • DHFE present concept paper to NHCC, PHRC and MINMEC • DHFE conduct initial data collection 	<ul style="list-style-type: none"> • DHFE present initial results to PHRC • PHRC ask for more data • DHFE conduct additional data collection • DHFE present revised results to PHRC and Health MINMEC and get approval 	<ul style="list-style-type: none"> • Debate over phasing-in of reform between Health MINMEC and Budget Council (Treasury) • Eventual compromise reached – five years for phasing-in.

In January 2000 the review task was given to the DHFE in the National Department of Health with access to senior officials in NDoH for back-up. After some initial work on viable options the DHFE developed a concept paper, by mid 2000, outlining the key methods to be used in the evaluation of the reform. This was presented to the National Hospitals Coordinating Committee (NHCC). The NHCC is a technical body that debates issues around hospital management. It consists of representatives from each Provincial Department of Health plus line managers from the National Department of Health. The concept paper was subsequently presented to PHRC and the Health MINMEC for approval in early 2001. The DHFE then brought in to the team mid-level NDoH hospital management, who would subsequently oversee the

reform's implementation. Concurrently, the DHFE were collecting data in 17 hospitals to gain insights into the funding of Tertiary services, by liaising with facility managers and PDoHs. The data were to reveal the extent to which the existing Conditional Grants were actually funding national assets. The DHFE presented their findings to the PHRC, in February 2001, and met with some opposition from Western Cape and Gauteng PDoH officials, who feared they might lose out from any reform based on the initial results. Consequently, PHRC asked for a more comprehensive review of hospital data across provinces, to include information from another 40 hospitals. After a further round of data collection, the results were presented to, and approved by, PHRC and the Health MINMEC in mid 2001. The additional data actually highlighted even more the inequities of the Conditional Grant system, which had been overfunding services in Western Cape and Gauteng, and led to a more redistributive design for the reform. At this stage National Treasury¹ intervened to change the extent of redistribution through technical negotiations but the DHFE reform drivers gave little ground. From the approval of the Health MINMEC ratification was needed by the Budget Council. The proposal went backwards and forwards between the two fora in late 2001 and early 2002 because of a disagreement over the phasing of the reform. The Health MINMEC approved three years (although the Minister wanted immediate implementation) and the Budget Council proposed an eight year phasing-in. Eventually a compromise was reached to the effect of a five-year phasing-in process which began with the announcement of the 2002/03 Budget in February 2002.

8.2 The Reform Drivers

From the conceptual framework it is predicted that:

- Key reform drivers coordinate health care financing reform through policy development processes, or tasks, to achieve the desired outcome.
- Reform drivers are aware of their own resources and constraints in conducting tasks to develop financing reform.

¹ As noted previously, the National Department of Finance had changed its name to National Treasury by the time of the interview. The name change was purely cosmetic and involved no change in function or power.

8.2.1 Active Reform Drivers

The DHFE interviewees both confirmed that they were the drivers of the conditional grants reform.

“Well I think it is fair to say that we, as a directorate, were the driver and I suppose yes I probably was ...between us I did more of the kind of directing and doing of the work, I suppose. Although I think that we were both very much equally involved in the later stages of negotiation of it and everything. Weren't we? Yes but certainly this unit was undoubtedly the driving force.”

While the Director General, NDoH, and the PHRC were committed to the review: *“they never gave any clear indication of what they meant”*. This gave the DHFE considerable freedom to steer the reform:

“So the actual direction that it then took was really pushed substantively by us. The direction evolved from the work we were doing and we then pushed it forward.”

While this involved examining all the conditional grants, apart from primary school nutrition, shown in Box 6.1, the DHFE decided that the major focus of the exercise would be the revision of the Central Hospitals Specialist Services Grant, as it was 75% of total conditional grant resources allocated. The revision task involved initial work on assessing options and methodologies, collecting and analysing data, developing a cost model, presenting results to key decision-making bodies such as PHRC and negotiating over the design of the reform.

“...it was really the whole thing apart from making the final decision.”

8.2.2 Reflection on constraints and resources

In line with the conceptual framework, the DHFE consciously reviewed how the task should go ahead and considered their strengths and weaknesses in the development of the reform:

"I think we sat down and said: 'How can we approach this? What do we need to do?'"

"And we decided to...do a really good piece of research. And...once we had decided to move on that route we then had a real capacity problem."

"I think we were confident we had the skills to do the analysis, the planning and everything. The problem was the leg work."

The DHFE was quite short of staff and while the reform drivers considered they had the necessary technical skills to take forward the reform they were concerned about how they would collect all the appropriate data for the task. Consequently, the DHFE limited its involvement in other activities to try and preserve what little capacity it had and focus it on the task at hand. Interestingly, a decision was taken right at the start of the reform process that the DHFE would do much of the technical work itself:

"It was a conscious decision that we would do it internally, and we wouldn't do the usual desk job on it either."

Part of the reason for this was that the Director had just changed. The previous Director had been heavily involved in the reform of the Medical Schemes regulation and indeed had left to join a new regulatory body for the Medical Schemes. It was seen to be important for the new Director to reorientate the research of the unit on to public financing issues and to ensure that the DHFE conducted its own research to establish its credibility within the NDoH.

"I think it was a very important strategic move."

This issue of the DHFE's credibility in the eyes of NDoH actors became very important and was a key factor in decisions concerning engagement strategies. Nevertheless, the development of the credibility of the DHFE may have helped it secure access to powerful actors within NDoH, a typical problem it had experienced in previous reforms (see Chapter 7). These factors are explored more below.

8.3 Seeking out Characteristics

From the conceptual framework it is predicted that:

- Reform drivers engage with actors to alleviate their own constraints, by utilising the resources of those actors, and avoid other actors with risky negative characteristics.
- Different resources will be needed by different reform drivers, depending on their own constraints and the policy task.

8.3.1 Alleviating Constraints through engagement

In this section I explore the evidence both for and against the notion that reform drivers sought engagement to alleviate their identified constraints in the reform process. As discussed in the previous section, it is clear that the reform drivers thought they themselves had the technical skills to conduct the reform. It is, therefore, in line with the Conceptual Framework that there was little collaboration to gain extra technical skills and indeed this comes out clearly from the interview data:

"I think the short answer is, if we leave aside the provinces as sort of direct participants in the process...I think the answer is really "no" actually. It didn't involve a great deal of collaboration. I mean various other people asked us about it and we kept them vaguely informed, but we didn't really...we weren't heavily...we certainly didn't rely on anyone else."

While the DHFE were confident of their own skills they also were wary of other researchers and their "baggage" of ideas and agendas and that they wouldn't "come with an open mind".

“It takes a very extraordinary person to really step back from previous work and say let’s absolutely start again.”

Nevertheless, the DHFE did collaborate with other actors to get data and to gain access to power. As noted earlier, the decision to conduct all the research within the DHFE left it with a capacity problem and the need for “*extra pairs of hands*”:

“So effectively we had to go out and look for people who would do the menial tasks of actually doing some data collection”

New staff were trained on the job and retained in position, thus boosting the DHFE’s general capacity to take on work. Furthermore engagement with senior personnel in the NDoH afforded the reform drivers support and assistance at key times:

“We had the protection at PHRC, from someone like (senior policy maker) when things tended to drift on the border of stupidity. We had someone senior like (senior policy maker) who was saying this is it, this is how it’s going to go, type of thing.”

Nevertheless there are some additional factors in the engagement strategy of the DHFE that weren’t considered in the conceptual framework. First, rather than engaging with outside technicians to collect the data, the DHFE reform driver decided to hire personnel directly because it was more efficient:

“...generally when you contract out what you’re really paying for is a senior person and the brain power and we were fairly confident that we didn’t necessarily need rocket science, that we needed somebody to do a lot of legwork so we had really good data. It was also actually much more cost-effective for us to hire people rather than paying all the overheads, and the senior researchers as well, to be able to get an outside institution to put junior people on the ground to do the work. I think it was probably a lot more efficient for us to do it in-house.”

This is a gap in the conceptual framework, which focuses on temporary, task-specific collaborations rather than general contracting of new staff into an organisation.

Nevertheless, such a strategy was particularly helpful to boosting the capacity and the credibility of the DHFE. Indeed, a weakness of collaboration with other actors, and particularly those with similar characteristics may be that it reduces the credibility of the reform drivers in the eyes of other actors (see Box 8.1). In such circumstances the reform drivers may be seen to be weak in their own supposed area of specialisation or responsibility. This linkage between reputation and engagement strategy is not considered in the conceptual framework. Nevertheless, the evidence suggests that actors may have a core area of responsibility, indicating a formal role in a reform process.

Box 8.1: Technical Collaboration and Reduced Credibility

“...we could have done the contracting out of the research but it would not have done anything to improve our credibility, as a policy analysis unit of value.”

“So it was one opportunity to get people in the department to recognise, and especially the Director General, to recognise that we could still do certain things. We were still capable of doing a lot of thing.”

“Breaking the reliance on external people is a critical thing and this process has been very important for this directorate but for the Department (NDoH) more widely. I think it has changed the mindset of people like (senior policy maker) which I mean really a few years ago would have assumed that the people in this department would not be capable of exercising a big thing and only a few people in the research community, they would be the only people who could be trusted to come up with something sensible.”

“... it was very important to break the cycle of dependence of the department.”

Indeed, a theme that emerges from the DHFE reform drivers is that an actor's *role* or *position* is an important determinant of collaboration. Some actors were involved in the reform *not* primarily because of their skill or their power but rather because that it was part of their job (such as managers in the NDoH) or they represented an important constituency (such as provinces). This seems to echo findings from the SAZA case studies around resource allocation.

“...those people were directly and integrally involved ... But conditional grants were a key part of their job. That was the reason. It wasn't like we had to involve them

because of their influence. They were automatically an integral part of the process and really the same is true of the provincial NHCC people...you couldn't have done such a process without those people."

"They were people who structurally had to be involved either at National or Provincial level that you couldn't possibly have made it work without them, but their inclusion was not related to any of those criteria (from the Conceptual Framework). Although some of them, obviously, did have useful technical knowledge blah blah blah, that was incidental. They were involved because it was their job."

This reinforces the notion that was addressed in the previous chapter, that health reform development and managing actors must work with given processes and in a specific context. Further actors have responsibilities and roles and a reform driver must take these into account when planning a reform process. All of this may constrain and even dictate how a reform driver pushes forward reform development and the patterns of engagement made.

Another general weakness of collaboration not discussed in the conceptual framework is that it may reduce the detailed understanding of the reform driver. Where others have done the work there may be little opportunity for the reform drivers to understand the fine print of the reform design

"You tend to ignore those details when someone else has done the work for you."

This may lead to weaknesses in defending the reform when questioned on specific issues or methods. It may also undermine implementation because of a lack of awareness of the reform's minute workings.

8.3.2 Problematic Actors

Certain actors were seen to be problematic in that they were perceived to have fixed ideas about how the reform should be designed (academic analysts) or potentially competing agendas to those of the reform drivers (previously advantaged provinces and National Treasury).

“So we were quite concerned that the plausible researcher candidates we didn’t trust to come with an open enough mind to come up with a really new approach. Because the only people who really could have done it in the country certainly had axes to grind from earlier work...”

“It was a purely National Department of Health exercise. We were not being biased in any way by provincial input, by distortion, or by individuals who may have had provincial biases.”

Interestingly many individuals in National Treasury were thought to have affiliations with Gauteng and Western Cape, the provinces who stood to lose most from the reform, and would be unlikely to support the reform:

“There are key people, (a senior manager) and (another senior manager) and (the Minister) also who really deeply were opposed to taking money from the Western Cape, from those institutions.”

Of one key Treasury player it was noted that:

“He loves Gauteng and he loves Jo’burg general (hospital). Anything that takes money away from Jo’burg general is a bad thing.”

In a deliberate move, those perceived to be risky actors were kept at arms length. First, no academic analyst was engaged in the reform process, as has been noted earlier. Second, the Director HFE noted the very limited information that was

supplied to National Treasury throughout the development of the reforms. Indeed a National Treasury senior manager

“...was pushing, at the “four by four” meetings,... show us the numbers, give us the details, type of approach and he got very frustrated with us always showing him the conceptual framework (laughs). To the extent that the first time that Treasury actually saw what we were talking about was the Joint Health Finance MINMEC.”

In addition, the reform drivers kept provincial analysts largely out of the process of the reform development. One of the reform drivers explained:

“Part of the dynamic was that some of the analysis people (from Western Cape) started getting upset with us because they felt they had a right to be in the thick of this doing the sums with us and they got a bit upset when we weren't having that really.”

Further, the reform drivers were aware that there was a danger that the reform process itself could be easily upset by inappropriate engagement. The reform drivers thought that a high degree of flexibility was required to manage the process, which could only be guaranteed by doing the work internally to the DHFE. Thus contracting out to analysts was avoided essentially because of the associated transaction costs:

“It certainly was about managing elements of the risk more effectively by having it in-house. There's a sort of naïve assumption that outsourcing transfers risk to the contractor but actually if they don't produce what you want you still carry the can. So it's partly about that. But I think also... it was clear from the outset that this would be a rapidly evolving process that wouldn't lend itself to contractor goes away, does report, gives us report, we do some more work, contract something else, back and forward.”

“We felt we needed to be controlling a process internally so that we could learn and make decisions as we went along and we felt that contracting out a piece of work would be far too risky. It could only...you'd become completely reliant on having specified it correctly in the first place and I think we were very worried about whether you could do that in advance.”

“Once you’re outsourcing you eliminate all of your bodge factor flexibility. You just can’t do it anymore. You’ve got to wait.”

Consequently collaboration was limited. In the case of academic analysts it was avoided altogether while with provincial analysts from Western Cape and National Treasury the interaction was kept to a minimum, with little exchange of information. As a result of the perceived instability of the policy process the reform drivers were also unwilling to let the reform out of their control, concerned that the process of contracting out would be too inflexible. Interestingly the Conceptual Framework considers risk in relation to managing specific actors but does not deal with the risk associated with the overall process and which is dependent on the prevailing context.

8.4 Establishing the Relationship

In this section the relationships fostered by the reform drivers are explored with important actors before I examine whether the factors in the conceptual framework were critical in determining the nature of these relationships.

From the conceptual framework it is predicted that:

- The type and rules of a relationship offered by a reform driver to an actor are dependent on their combined characteristics and the policy task. The more complementary are the characteristics (resources, constraints, interest, reputation and trust) of the actor and the reform driver, the more likely is collaboration and partnership.
- Incentives will affect the behaviour of actors and insufficient incentives will lead to uncooperative behaviour

8.4.1 Developing Relationship with Key Actors

As noted earlier, the reform drivers did need to engage with some actors partly because of need for support of their work and partly because the prevailing context determined decision-making processes through specific committees. Engagement with senior management in the NDoH, the National Treasury and Provincial Department of Health representatives is analysed as these were the most important other actors that determined the shape of the reform.

With the Deputy Director General the reform drivers built an informal collaborative relationship. Initially the Director General directed the DHFE reform drivers to report to the Deputy Director General on their progress, even though they were not under her in the formal bureaucratic hierarchy. This provided an informal mechanism of liaison that allowed a regular and open exchange of ideas on the reform and other issues and brought active and knowledgeable support from the Deputy Director General.

While the reform drivers also tried to develop a similar informal relationship with the Director General, this was only partly successful, due to the heavy time commitments of the Director General. Nevertheless, both the reform drivers felt that formal lines of management could be bypassed in approaching the Director General and that direct phone access was not a problem. The basis for the improved relationship with the DG appears to be the DHFE's enhanced credibility from its good performance (see later):

"It's actually all about doing the work."

In contrast the relationship with National Treasury was more problematic. The reform drivers were at first keen to engage and share data with National Treasury in the interests of pursuing an open process. In contrast, senior management in the National Department of Health were concerned that this was not a good idea because of National Treasury's likely opposition:

"We were naïve."

“We were personally much more inclined to share more data with Treasury. For a long while we felt we were being pointlessly restricted by superior people here but I think it was both of our judgements ultimately that they (senior management in NDoH) were correct and that actually it’s very nice to talk about collaboration and everything but actually it’s giving people a chance to shaft you. You need to be very careful about not doing it for the sake of it.”

The strategy followed was to give as little information as possible to National Treasury in formal committees other than the overall conceptual framework for the reform. Once however data was in circulation the National Treasury desk office manager spent long hours in heated negotiation with them trying to “fix the numbers” and soften the impact of the reform on the Western Cape and Gauteng.

“We got annoyed and irritated at the time and then we realised that giving someone too much information worked against us in that particular instance.”

“With Treasury you need to give them just enough information to keep them in the game but no more.”

Nevertheless, perhaps because the principles of the reform had been agreed earlier, as part of a deliberate strategy to get buy-in from different actors, its conceptual design was not called into question.

With provincial representatives the engagement was fixed largely through the need to report to PHRC. Nevertheless, as noted earlier, closer collaboration was not pursued. This was partly because the DHFE thought it had sufficient technical skills and that provinces did not have much technical capacity (see later). Even where they did, or were thought to have, the reform drivers were concerned about provincial biases towards certain outcomes. Finally, the reputation of the DHFE could be compromised by engagement with provincial analysts.

8.4.2 Testing Key Factors from the Conceptual Framework.

8.4.2.1 Complementary Strengths

As already noted the reform drivers did not need to engage with other actors with similar technical skills. Instead there was a need to interact with power brokers such as the Director General and the Deputy Director General to get their support.

“Complementary strengths” indicated which actors *could* be engaged with but did not specify precisely who and how relationships should be structured. For instance both National Treasury and senior management in the NDoH were seen to be powerful. Yet, as discussed, different engagement strategies were pursued with each actor (see below for further analysis of this issue).

8.4.2.2 Common Interests

This proved vitally important in making a relationship more collaborative. Where interests were in conflict the engagement was limited (National Treasury, representatives of advantaged Provinces). Nevertheless, where interests of DHFE and other actors aligned, as in the Director General and the Deputy Director General, it provided a foundation for collaboration

8.4.2.3 Trust and Reputation

Both reform drivers highlighted the importance of trust as a basis for collaborative relationships. In particular, the reform drivers noted the significance of trust in relation to their interactions with senior management in the National Department of Health:

“It sort of opened up a different space of who and why they might listen to your opinions, relative to their normal modus operandi.”

“It builds an informal relationship which is very good and very constructive, because it takes us away from the bureaucratic style and nature of doing things.”

In contrast a lack of trust between actors and reform drivers, as with the external academic researchers, resulted in no engagement. This begs the questions of the precise meaning of trust in this context. Is it possible to separate trust from the discussion of common interests? In the interview trust is discussed in relation to being able to do a specific task and it thus also appears to be closely linked to reputation for capable work.

*"...we are **trusted** professionally because I think we are now seen to deliver good work which will more or less work and get the job done."*

*"...we were quite concerned that the plausible researcher candidates we didn't **trust** to come with an open enough mind to come up with a really new approach."*

*"...only a few people in the research community, they would be the only people who could be **trusted** to come up with something sensible."*

Indeed there was a sense in the interview that trust and reputation and common interests "*all run together*". Just as the reform drivers were trusted more after their successful delivery of the Conditional Grants reform, they also gained credibility and a good reputation for their work:

"The way in which the work on the conditional grants was put forward made it very clear that we did things the correct way... which gave us credibility."

"There's a degree of personal credibility I think for both of us with (senior policy maker) now."

Reputation and trust appear to be very closely linked and from the data available appear to be important in shaping the degree of collaboration in relationships. An alignment of interests between the reform drivers and other actors also appears to be an important factor in pursuing informal collaborative activities. However, it is impossible to assess from the interview the relative importance of the different factors in relation to each other.

8.4.3 Rules

To a large extent the reform drivers were limited in the extent to which they could determine the rules of engagement, especially with more powerful actors. In relation to the collaboration with the senior policy makers in NDoH, the rules of engagement were effectively determined for the reform drivers by the Director General. Even with National Treasury, senior NDoH officials effectively determined the rules of engagement. The context also determined, to a large extent, engagement with provincial actors through the routine budget allocation processes and internal government policy-making processes (such as PHRC). Thus the power of key actors in NDoH and existing government processes did much to determine specific rules of engagement.

It was perhaps only in relation to the data collection processes that the reform drivers were able to set rules in relation to the provision of data by hospital authorities and representatives of Provincial Departments of Health:

“At the hospital level there was a very clear sense from the manager and people dealing with the data that they must comply or get shafted...At a provincial level, all provinces at the outset wanted to be seen to be participating properly either because they felt there was something in it for them or for the Western Capes and Gautengs because the more awkward they were the more likely it was to cause trouble for them basically.” (FTA to DHFE)

The reform drivers' ability to set rules in this context was as a result of being given a mandate to conduct the review by higher powers in the NDoH. Thus while, as noted in Chapter 7, DHFE does not have that much power in general, it was given authority to perform the data collection and analysis which allowed it to set some of its own rules for this activity.

8.4.4 Motivating Factors and Incentives

In this section I explore the motivations of actors involved in the Conditional Grants reform process and consider the effect that these factors had on behaviour. Table 8.2 outlines these motivating factors for the main actors. While one of the reform drivers commented that there were “*powerful and very straightforward incentives to collaborate*” it seems that this did not apply to the National Treasury. The National Treasury opposed the Conditional Grants reform partly because of its prevailing ideology and also partly because many of the key individuals had personal links with the Western Cape and Gauteng (as discussed earlier). The importance of growth and employment creation may mean that National Treasury may well be reluctant to move resources and infrastructure away from urban areas, which are seen as the main engines of growth. This view was reflected by one Treasury official in the SAZA case studies. Yet it is difficult to make out the dividing line between individual interest in the material rewards of the reform outcome and institutional ideology, on the basis of the data available. Whatever the reason, there was little to motivate the National Treasury in the reform. It is also noticeable that this opposition became more active and pronounced once National Treasury realised the extent of the redistribution being proposed.

All the National Department of Health players were primarily motivated by a desire to improve the equity of resource allocation. The Conditional Grants reform may have been particularly appealing to senior health policy makers as there was a shortage of equity-based reforms at the time. Being part of the process also enabled the NDoH hospital desk officer to gain an in-depth understanding of the reform. This familiarity with its design and the input data from each province helped the desk officer in the management of the reform’s implementation.

Facility managers and provincial officials found themselves with a direct incentive to go along with the reform and provide data, even though some were going to lose out from the reform process:

“The more data you could come up with, the more money you were likely to get, literally, which is true actually given the structure of the thing. The more and the bigger the services you can prove the more money you are going to get.... if they were seen to be awkward it would only count against them.”

While many provinces were keen to collaborate as they thought they would gain materially from the outcome of the reform, the Western Cape and Gauteng found themselves in predicament. They were in danger of losing out in terms of the reform outcome but felt they couldn't be seen to be obstructive of the process. Indeed the DHFE communicated to facility managers and provinces that non-cooperation with the reform would be penalised, through the outcome of the reform process.

Interestingly, the importance of playing a role in the process and payment for participation were not relevant for any of the actors. Government actors regularly must serve on committees and reform processes; it is their job. In contrast non-government actors may derive more value from playing a role (see also Chapter 7). Second, funding constraints for participation are not a problem for government actors as it is one of their core functions.

Table 8.2: Motivating Factors for Key Actors in the Conditional Grants Reform

Actors	National Treasury	National Department of Health			Facility Managers	Provinces	
		Minister	Senior Managers	Mid-level Hospital Management		Western Cape and Gauteng	Others
Motivating Factors							
Material rewards from outcome	Opposed to taking money from Western Cape and Gauteng.				Direct Interest in outcome	Concerned they would lose out	Anticipated direct benefits
Ideology	Opposed to taking money from Western Cape and Gauteng.	Pro-equity	Pro-equity	Pro-equity			
Process				Being part of reform development helped understanding and subsequent management	Interest in collaborating to try and improve outcome	Couldn't be seen to oppose the process as may harm the outcomes	
Role	Not a factor	Not a factor	Not a factor	Not a factor	Not a factor	Not a factor	Not a factor
Payment for Participation	None	None	None	None	None	None	None

8.5 Interaction and Learning

The conceptual framework predicted that:

- Actors may actively:
 - Negotiate the form and rules of a relationship
 - Try and change the goals and tasks of the reform driver where they are strongly opposed to the reform.
- Learning occurs from past behaviour. More specifically;
 - Reform drivers and actors change their perceptions of characteristics and reputation in response to each other's actions
 - Reform drivers review engagement and incentives in response to the behaviour of actors

8.5.1 Strategic Actors

The conceptual framework suggests that actors will try and change the reform and its processes. I review the evidence for and against such intervention.

8.5.1.1 National Treasury

There are several incidents where National Treasury representatives acted dynamically in the process:

1. One senior manager consistently pushed to be more fully informed of the progress of the reform in the “four by four” committee.
2. Once the membership in the “four by four” committee changed to favour a more pro-equity lobby one senior manager in National Treasury suggested the committee be expanded to a ten by ten committee (to include representatives of National Treasury, National Department of Health and all Provincial Treasuries and Provincial Departments of Health). This was an attempt to shift the committee membership back to support a National Treasury line.

3. National Treasury hired a new desk officer to promote a better relationship with the National Department of Health and to help keep an eye on what was happening in the health sector.

"...part of it was they got (the new desk officer) in because they recognised that Department of Health now had an enhanced capability and they actually needed somebody on their side if we weren't going to run around them a little bit. So I think that's part of what they did. But part of it was that genuinely they wanted to have a better, closer interaction with us."

4. One official from the National Treasury got very involved in trying to alter the data to affect the design of the reform. This was resisted by the DHFE reform drivers but led to tensions on both sides.

"But he was the only one who really tried to change the outcome, not the general direction in which it was going, but the magnitude of change...Fixing the numbers. So that Western Cape didn't come out looking too bad and in the process Gauteng looked a bit better"

5. One official from the National Treasury tested the united stand of the DHFE reform drivers:

"And we got tested on that. Surprisingly enough ... we had situations where...(National Treasury official) would phone me up and ask me a question to see what answer I would give and then two minutes later would phone (External Adviser to the DHFE) and ask him exactly the same question just to see whether we deviated in our opinion. (laughter). It's what happens!"

6. National Treasury in the Budget Council meeting pushed for a much longer phasing in period for the reform to allow provinces time to adjust. They agreed on an eight-year transition in response to the three-year period discussed by the Health MINMEC.

Hence there is significant evidence to suggest that the National Treasury attempted to change the reform, particularly in the final stages of its development.

8.5.1.2 Advantaged provinces

There is also some evidence to suggest that the advantaged provinces, Western Cape and Gauteng, but particularly the former, tried at several stages to intervene in the process. Nevertheless, and interestingly, they never produced a viable alternative to that directed by the DHFE.

“We had a lot of bellyaching at all stages from the Western Cape but never really coming up with anything substantive. They were a bit half-hearted really. They would moan and groan but they never actually made a concerted effort to really try and torpedo it which I suspect if they had really tried they might have been able to, as is the nature of all of these sorts of things.”

“The Director General gave them an opportunity to come up with an alternative strategy and what they came up with was far below the level of what you would expect from the Western Cape. They really couldn't come up with anything. The same with Gauteng. Gauteng were basically saying that we'll moan and groan about the data but we really don't have anything else to put on the table.”

Nevertheless, Western Cape and Gauteng did make some important strategic interventions. They asked for a longer phasing in period in the final negotiations in the Budget Council forum. Further in the PHRC meeting of February 2001, they pushed for a more comprehensive data collection exercise to be done for the reform thinking this would help their cause:

“...Western Cape pushed it very hard, didn't they, even though it was ultimately to their detriment (laughter). It was quite interesting. They believed that they had lots of other Tertiary services that would bring money back to them whereas in fact it had quite the reverse effect.”

8.5.1.3 Senior Management, NDoH

There is also some evidence that suggests that senior management in the NDoH acted at key times to protect and support the reform. Senior management gave advice on engagement with Treasury and also helped give support in meetings, such as PHRC, as has been noted.

8.5.2 Learning

It is more difficult to test learning in the case of a single reform than over consecutive reform processes. The Conceptual Framework implies that learning will occur and will help modify strategy and engagement in future reforms. While it is easy to get reform drivers to say what they have learned from a process there is no guarantee that they have actually learned these lessons when they have to manage another reform. Nevertheless, it is interesting to see how the perceptions of the reform drivers changed towards specific actors and the whole process of reform management.

8.5.2.1 Concerning Actors

The reputation of National Treasury was altered by the interactions around the reform. The reform drivers realised that National Treasury was largely opposed to such a redistributive reform. Further individuals in National Treasury were seen to be aligned with specific interests in the outcome of the reform as they related to key provinces. As a result, the reform drivers noted the need to be more careful about their engagement with National Treasury in the future.

“...we must be more strategic in the way in which we approach certain people and certain things so that Treasury interactions around not always falling for their trap of pressure to disclose things I think was quite important. So it is necessary to hold on to what you've got for a little bit longer until you are ready to do certain things with it.”

The reputations of the provinces also changed from the viewpoint of the reform drivers. The technical capacity of the richest provinces was not nearly as good as expected. In Gauteng Provincial Department of Health there was “*no analytical capacity*”, whereas in the Western Cape there was “*a great deal of self-delusion on*

their analytical strengths”, with capacity being spread too thin. Both the Free State and the North West appeared to have the best functioning health systems which was a surprise to the reform drivers. In addition, the lack of understanding of the Conditional Grant (CG) reform in the Eastern Cape Provincial Department of Health was “*frightening*” particularly as the province was one of the main beneficiaries of the reform.

8.5.2.2 Concerning the Process

The reform drivers also cited several lessons learnt from the actual process of driving the reform which would be useful for the future. Thus there is not only learning about the reputation of others but reform drivers may learn from their mistakes and handle the general process better in the future. Two lessons which fit with the Conceptual Framework are that:

- reform drivers need to be careful not to over-extend themselves: “*don't bite off more than you can chew*”. Regular activities and other commitments of the DHFE tended to pull the reform drivers away from the reform, particularly the Director. Hence limiting the number of tasks taken on became important.
- there are advantages to collaboration to gain data and insights into how things work outside your field of speciality. The reform drivers maintained there were particular benefits from collaborating with the National Hospital Coordinating Committee and the Provincial Departments of Health.

Perhaps another lesson is that reform drivers need certain characteristics to be successful in reform development:

“...but I think a big lesson is really just about will-power and determination, actually. If you are determined enough that you are going to bludgeon this through you will. You will get there actually.”

8.5.2.3 Evidence of Other Actors Learning

There was also some evidence to support the notion that other actors learned from the process in so far as the DHFE's reputation was seen to have changed. The increased credibility of the DHFE with a senior policy maker was an important by-product of the successful CG reform. This allowed both closer access to that senior policy maker and extra personnel for the unfilled positions in the DHFE. Both examples indicated that the senior policy maker altered his behaviour in response to the DHFE's enhanced reputation. On a different note, a senior policy maker in NDoH was reported to have said that one National Treasury official would never be allowed to come back to his former position in the health sector after the games played in the negotiations over the CG reform. This is another example of behaviour change in response to altered reputation.

Overall there is some evidence to support learning but the single case approach of this chapter limits the degree to which this can be adequately tested.

8.6 Resource Generation vs Resource Allocation

One of the issues that arose from Chapter 7 was the differing relevance of the conceptual framework to resource generation and resource allocation reforms. While the main focus of this chapter has been about resource allocation the reform drivers were also asked to reflect on the differences between their approach to this reform and to Social Health Insurance, as an example of a resource generation reform. While not closely involved in the SHI developments in South Africa the reform drivers were able to comment on how they would approach the task if given it as they had previously devised a strategy in case they were given this responsibility.

'At one stage we had a fairly good plan, I thought, of how we would develop SHI policy.'

One key similarity in the approach taken by the reform drivers, both in the actual Conditional Grants reform and a hypothetical Social Health Insurance process, was to do as much work within the DHFE as possible.

“...we would have had similar type of exercise which was a more dedicated effort within the Unit to do certain things”.

“...Left to me I would have pursued a similar policy of avoiding out-sourcing.”

“I would not have contemplated drawing particularly academic institutions into the inner circle of developing the policy...We will come up with the proposal.”

Thus all the reasons for not collaborating with academic analysts on the Conditional Grant reform were also seen to hold for Social Health Insurance such as fixed agendas, lack of flexibility and reduced credibility for the DHFE. Nevertheless, one of the reform drivers admitted that the complexity of Social Health Insurance would have meant that some discrete pieces of research would have to be contracted out, but not the overall design.

Also because there were many more actors involved in the process the issue of managing actors would have been far more important.

“We were always confident with the grants that we would come up with something. I think if we had been given SHI to do I don't think that we would ever have been confident that we were going to get something through because of the dynamics of it and the contentiousness of it. That fact that you can't avoid a Medical Schemes interface in some form or other just means that the thing becomes a dreadful morass of negotiation again.”

Interestingly, this may highlight a critical set of differences between resource generation and resource allocation reforms. Resource generation reforms may involve more actors, both inside and outside government. This is clearly the case for SHI and may be the case for user fee policy, depending on whether the private sector are impacted and involved in the changes. Such reforms may be more contentious and broad-ranging in the issues debated. These things may make the process more difficult to manage but further research is needed in this area to clarify these issues.

“...whereas the distraction of always opening everything up wider and wider and wider, which is very frequent in SHI and the PPI (Public-Private Interactions) story and lots of these more or less financing types of things you always end up getting pulled wider and wider and therefore run out of momentum. Whereas with this we kept it in the tunnel and we pushed it all the way through out of the other end.”

“...Having a relatively constrained focus massively maximises the likelihood that you will actually get somewhere...”

8.7 Deliberate Management: Reality or Illusion

An important question for the conceptual framework is the extent to which the reform drivers actively managed the reform process. The conceptual framework implies there is conscious and deliberate management throughout the process, but is this realistic? Chapter 7 highlighted the importance of context to reform processes particularly for resource allocation reforms, indicating that there are other forces at work which may determine the path of a reform. I consider the evidence for and against the deliberate management of actors.

The first example of strategic actor management was the decision by the DHFE to keep the reform within the Directorate, at least at a technical level, as much as possible. Justifications for this approach have been explored earlier in this chapter, but range from building up the capacity and credibility of the DHFE to maintaining control over the technical work, to avoiding the ideological biases of other researchers and the risks associated with contracting out work

A second example of management of actors was the presentation of the conceptual options paper to the PHRC and the Health MINMEC in January 2001:

“... that was deliberate. I suppose that was a deliberate question of managing the process...”

The analysis focussed on the different ways of approaching the task seeking buy-in from key actors on how to do the analysis before proceeding with it. Quite purposefully it contained no numbers and no indication of the size of change that might be produced:

“...we were trying to get this idea that you have agreed a priori to a sort of a just mechanism so that therefore you’re actually backed into a corner a bit when we start giving you numbers and you get upset about it. You have actually agreed that this is a reasonable process.”

“And we used that as the basis for saying: ‘remember we brought you this which you approved.’”

Getting all the provincial players to agree to the reform in principle was a device to limit opposition later.

A third example of deliberate management was the interactions of the reform drivers with the National Treasury. Under guidance from senior policy makers in the NDoH the reform drivers limited information sharing with the Treasury on account of their likely opposition to the reform:

“There was a very strong feeling from a very early stage that we shouldn’t share as much information with Treasury as we would have liked to. And that kind of worked to our advantage.”

Limiting collaboration with National Treasury meant that the active opposition from this actor was delayed until late on in the process by which time the principles of the reform had been agreed.

A fourth example is less clear-cut and relates to the formulation of the options for the conceptual paper. The first option presented to PHRC was not to change the status quo. It suggested government should:

“...do nothing. You can actually sit and look at it and say I don't want to do anything about it and as stupid as it may seem people consciously took a decision that they can't do nothing about it. So they got a bit annoyed with us but it pushed them along to engaging with the process, which is now starting to realise that maybe it's a good strategy to use in certain circumstances.”

While this appears to be an instance of actor management at first reading it may rather be an example of the interviewee reflecting, with hindsight, on the beneficial effects of the decision to use a no-change option in this case. The interviewee appears to indicate that it was and could be a useful strategy and that it helped to move the process forward. Nevertheless, it does not appear to have been a deliberate strategy prepared in advance.

While there were three clear occasions where actors were managed by the reform drivers there were also several “lucky breaks” that helped the reform develop. First, the final negotiations over the approval and phasing of the reform happened very late in the Budget process and this may have helped limit opposition. There was virtually no time for a concerted attack on the reform.

“That's a very important point we basically got this whole thing through the backdoor of the budget process at the 11th hour and if this was first discussed in April of last year as opposed to the period between July-August last year (2001) we might have had a different outcome.”

However, there had not been any strategic planning on the issue by the reform drivers:

“That wasn't a deliberate ploy it just happened by coincidence.”

“...we were quite fortunate that it all happened at the end.”

A second factor that proved fortunate for the reform drivers related to the extra funds made available for the new Conditional Grants. As noted the reform drivers had focussed their reform efforts on the largest grant relating to the hospital specialised

services and were hoping that this would eat up all the money available. Instead, National Treasury made available extra funds for the training Conditional Grant:

“We were hoping that by default we could kill it (the training grant). We didn’t quite get away with that one. I think the way it turned out was actually quite good... the odd thing was Treasury coming up with extra money to put into that grant ...pragmatically it turned out very well.”

A third fortuitous event was the resignation of the chair of the “four by four” committee in the middle of the reform process. The chair of the committee was the head of Treasury from the Western Cape, a province which was set to lose from the reform. The switch of chair appears to have tipped the balance of membership in the committee away from a hostile approach to the Conditional Grants reform.

“Basically they wanted us to constantly brief them on progress that was being made and (there were) a lot of threats being put on us, how the funding would be withdrawn because we weren’t doing certain things. And suddenly the composition of the “four by four” changed slightly with the Head of Treasury from the Western Cape withdrawing from the “four by four” because he felt it wasn’t going anywhere and he was actually the chair.... He was replaced by Mpumalanga, Head of Treasury, so effectively when you looked at this... you could quite clearly see ... it was going to work”

Drawing together the interview data reveals both active strategic decision-making and several “lucky breaks”. Such findings reinforce the notion of the reform driver managing actors and processes within a context, which will by its nature change, and against the activities of actors who may be opposed to the reform. With the conditional grants reform we see a prevailing context which facilitated the reform process. Apart from the events discussed above the reform was conducted in an accommodating policy environment. There had been a general agreement that the Conditional Grants should be reviewed after a period of time. Further, policy makers in NDoH were keen for an equity-based reform as there few other such reforms on the horizon. While there was limited freedom for the reform drivers, given that the PHRC, the Health MINMEC and the Budget Council largely dictated the processes of

approval, the reform drivers had sufficient support and maintained flexibility to be able to push forward the reform and manage the opposition. Indeed, the reform drivers noted the importance of continued effort, involvement and determination in steering through a reform:

“I think we knew that we were going to have to be immersed in the process to actually be able to move it around the obstacles that did come along the way and all that...to get something out.”

“...Part of that is being a bit bloody-minded and not necessarily listening to everybody who says, oh but you're not considering the such-and-such. Yes, so what. I think that it is necessary to push some things through.”

8.8 Additional Issues

There were several issues related to the design of the reform that did not fit neatly into the conceptual framework, either to support or challenge particular features.

Nevertheless these factors appeared to be important in managing actors.

- Data as a foundation for the design of a reform

Both reform drivers noted the importance of basing their reform on original data rather than just ideology and abstract modelling. This gave the reform design more credibility and made it hard for opponents to challenge the reform without their own datasets.

“I think there is a sort of understanding now that you can't do real planning without the data.”

“I remember small meetings with some Treasury people, (a senior manager) in particular where we are talking about data issues and he was basically challenging the data and when the question was turned around, put what you've got on the table the whole argument changes.”

“...being able to face down people who disagree with your analysis because you can demonstrate that your data is better than theirs and I think that’s the fundamental lesson of all of this for me. If you actually work up some reasonable data you can do more or less anything.”

- Flexibility on less important design issues in negotiations

Another key issue concerning the design of the reform is knowing which areas you can be flexible in and give ground in negotiations and knowing which areas are at the core of the design and cannot be forfeited. Indeed the reform drivers were comfortable with negotiations around several aspects of the reform, such as the length of the phasing in process, particular pieces of data around provision of services in hospitals and on the lesser grants (training and research) in order that the main approach of the reform was accepted.

“But we said fine there are problems with the data, but we don’t think that the overall trend or picture will change. So we knew we could concede on data but we knew we couldn’t concede on methodology.”

“We were always very aware that Tertiary Services was over 75% of the amount of money, so we were quite happy therefore to compromise the 25% in order to get the main thrust through... what you need to do is push through a main thrust which is hard to argue with, but how you then fiddle around the margins is fine if that can quieten people down.”

- Presentation of the design to other actors

Before the results were presented to the relevant policy-making committees the reform drivers developed a conceptual paper for presentation. This enabled the reform drivers to get an in-theory agreement to the methodology of the reform design even before any results became known.

“...we were trying to get this idea that you have agreed a priori to a sort of a just mechanism so that therefore you’re actually backed into a corner a bit when we start giving you numbers and you get upset about it. You have actually agreed that this is a reasonable process.”

This division of the reform approval process into two parts may have been an important strategic move. First the reform drivers got policy makers to consider appropriate methods and the conceptual approach. Only later did the reform drivers present the results of their data collection and the extent of redistribution required. This may be a useful tactic where the approach is reasonable and “just” but the outcomes are not in the interests of some players.

Another issue that arose from the conceptual paper was which options should be chosen to present to PHRC and Health MINMEC. There was some debate in the NDoH on this issue. One manager in the NDoH believed that the options to choose from should consist of your preferred option plus others that were clearly unrealistic. This would force policy makers to choose your preferred option.

“There is culture within various people that you put up your options...basically what you want to do is put up two options: one which is what you want to do and another one which is some kind of ludicrous, utterly impossible, doomed to failure one, so that everyone goes oh OK. It’s not as easy as that. Particularly in the earlier stages there was no way you could have come up with an obvious winner.”

Nevertheless, the reform drivers developed sixteen different scenario approaches and preferred to rate the alternatives according to their perceived risks and benefits and present the highest scoring three in the conceptual paper. It is interesting to consider whether this approach and the data foundation of the reform gave the reform process more credibility and integrity, which subsequently meant that the reform process and other actors were easier to manage.

A final issue on presentation was that the reform drivers agreed that they needed to make it simple for policy-makers, so that it could be understood and agreed upon:

“The other thing which came out very clearly was keep it simple.... One of the lessons from the past is that previous bits of work were not so simple or easy to understand. Not to complicate things.”

8.9 Summary

The findings of the conditional grant case study, using the more deductive approach, are highlighted in Table 8.3 and discussed in the text.

8.9.1 Points of Agreement

In accordance with the Conceptual Framework there were reform drivers who attempted to direct the reform and drive the process through from the initial task specification and ideas to the approval of the reform. Further these drivers reviewed their own strengths and weaknesses at the start of the reform process to identify the useful next steps and engagement strategies. The reform drivers then engaged with actors on the basis of their own weaknesses, in this case concerning a lack of power and data. Further, the reform drivers managed risky actors, those with conflicting agendas, by seeking to limit collaboration with them. In contrast, common interests of other actors facilitated close collaboration, as with senior policy makers in NDoH. Trust and reputation also proved to be important as a foundation for informal collaboration. Indeed, the two factors were interwoven.

There was evidence to suggest that motivating factors, or their absence, proved important for determining the behaviour of other actors. It is important for reform drivers to understand such factors to anticipate opposition and plan strategically. A useful intervention may well have been when the reform driver threatened provinces and providers with a worse outcome from the reform process if they did not share their data.

In general there was evidence that actors behaved dynamically in that they tried to change the reform or the reform process to suit their interests. Nevertheless, the

degree to which this was done depended on the particular actor. Western Cape and Gauteng PDoHs despite facing the prospect of adverse outcomes did not propose any viable alternative to the reform. Nevertheless, they did intervene to prolong the phasing-in and the dataset upon which the reform was to be based.

8.9.2 Points of Disagreement

There were also many points where the Conceptual Framework proved to be either inaccurate or missing elements:

- The importance of power was again highlighted as a key characteristic and something that is needed for reform development.
- The credibility of the reform driver may improve prospects for collaboration including access to senior officials and their power.
- Among the characteristics a reform driver should possess is obstinacy and determination to see the reform through.
- The official roles and positions of players were important in determining who needed to be engaged with.
- The need for flexibility in reform processes may make engagement with actors in reform development unhelpful.
- While the complementarity of strengths between reform drivers and actors may indicate the type of actors that need to be engaged, they do not indicate how to structure a relationship.
- There appear to be linkages between different types of motivation and it is sometimes difficult to work out which is the most important factor.
- Payment for participation was not important at any stage.

Table 8.3: Summary of findings from Conditional Grant case study

Elements of Conceptual Framework	Agreement	Disagreement	Inconclusive
<i>The Reform Drivers</i>			
<p>There exist active reform drivers who take responsibility for taking forward reforms with reference to goals.</p> <p>They are aware of their own constraints to reform development</p>	<p>Evidence for reform drivers attempting to direct the reform and drive the process.</p> <p>Drivers reviewed their own strengths and weaknesses at the start of the reform process to identify the useful next steps and engagement strategies.</p>	<p>Reform drivers needed characteristics not identified in the conceptual framework such as obstinacy and determination to get the reform through.</p>	<p>There were instances of deliberate actor management but contextual events also intervened in the reform's progress.</p>
<i>Seeking out Characteristics</i>			
<p>Reform drivers will seek out characteristics from other actors depending on their own limitations and the task ahead</p>	<p>Reform drivers engaged with actors on the basis of their own weaknesses. Reform drivers managed risky actors, those with opposing agendas, by seeking to limit engagement.</p>	<p>Engagement with actors may reduce credibility and hiring of personnel may be a better option. Power was highlighted as a key characteristic and important determinant of engagement. Official roles and positions were important in determining who must</p>	

		<p>be engaged with.</p> <p>Risk is not only related to actor characteristics but also to context.</p> <p>Issues of technical design and its presentation are also important in determining support from other actors.</p>	
<i>Establishing the Relationship</i>			
<p>The form and rules of relationships between the reform driver and other actors will be dependent on their characteristics.</p> <p>Incentives will affect behaviour</p>	<p>Common interests facilitated close collaboration. Trust and reputation also proved important as a foundation for informal collaboration.</p> <p>Motivating factors, or their absence, proved important in determining the behaviour of actors</p>	<p>Complementarity of characteristics does not indicate how relationships should be structured.</p> <p>Contracting may reduce flexibility</p> <p>Different forms of motivation appear to be interlinked and may be difficult to disentangle. Nevertheless, payment for participation in processes was not important.</p>	<p>It proved impossible to disentangle the relative importance of common interests, trust and reputation in developing collaborative informal relationships</p>

Dynamic Interactions

Actors may actively try and change the reform tasks and goals.

Learning occurs from past behaviour and may result in changing reputation, engagement and incentives.

Actors behaved strategically to try and change the reform and its process to suit their interests, to varying degrees.

Using a single case reform makes it more difficult to test whether reform drivers and actors learned. Nevertheless, there was some evidence to support changes in how Reform Drivers perceived actors and this may lead to changes in action in future reforms.

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Interestingly, the data reveal problems with pursuing collaboration with respect to reduced credibility and inflexibility under certain conditions. Hiring of personnel was seen to be a safer and more efficient option than temporary task-specific collaborations, where fewer skills were needed.

Other additional factors that were not considered by the conceptual framework relate to the importance of design and its presentation to other actors. First, having data as a foundation for the reform provides it with added legitimacy and makes it harder to oppose. Second, flexibility over non-core issues in design may be important to get other actors on-board without losing the essence of the reform. Third the presentation of the reform needs to be kept simple so that it is understandable and therefore more attractive. In addition, reform drivers may undermine opposition to a reform by seeking first agreement to the conceptual approach before filling in the numbers in the reform design.

8.9.3 Inconclusive results

There were several areas where the data did not conclusively support or reject the Conceptual Framework. In some cases this was because of insufficient data. In other cases the data were contradictory. First, it proved impossible to disentangle the relative importance of common interests, trust and reputation in developing collaborative informal relationships. Second, it is more difficult to test whether reform drivers and actors have learned when using a single case reform and a relatively short process. Ideally the behaviour of a reform driver would be tracked over several years and across different reforms. Nevertheless, there is some evidence that there have been changes in the perceptions of reform drivers, which may lead to changes of behaviour in future reforms

Finally, while there were certainly instances of deliberate management there were just as many unforeseen events which affected the outcome of the reform. The context of the Conditional Grants reform proved to be quite accommodatory. This highlights the importance not just of active management of a reform but an understanding of how context and reform management interact. Reform drivers will not always have

freedom to choose how to deal with actors, where policy processes and the context is given. On a calm sea you can direct where you want to go. In stormy conditions you get buffeted all over the place.

8.9.4 Resource Generation vs Resource Allocation Reforms

The reform drivers indicated they would pursue broadly similar approaches to resource generation and resource allocation reforms, particularly in relation to trying to do as much work in the DHFE as possible. Nevertheless, there were some apparent differences which need to be examined further. It appeared that resource generation reforms:

- Involved more actors from both inside and outside of government
- Related to more contentious and broad-ranging issues
- Were as a result of the above more difficult to push through

Still, it did not appear from the views of the reform drivers that resource generation reforms were a better fit for the conceptual framework.

Chapter 9: Conclusions

9.1 Introduction

Health reforms redistribute resources, by deciding whose needs come first. They are inherently political and often cause significant opposition. Those reforms aimed at improving equity in health care financing may be especially prone to opposition and reform drivers might frequently find themselves pitted against vested interests. A growing body of literature has been documenting this opposition in both developed and developing countries, as noted in Chapters 1 and 2. Instances of derailed reform range from countries as diverse as USA, Sweden, Australia, India and Zambia. Thus, the process of reforming a health system cannot be properly understood without reference to the impact, actual or intended, of the reform on key actors and their likely response. It is crucial that those who are in charge of reform have an appropriate understanding of the reform processes to be able to offset opposition and push through valuable change.

A central aim of this thesis was to understand reform from the perspective of a reform driver wishing to pursue change in the face of potential opposition. In accordance with the specific objectives, highlighted in Chapter 1, the thesis:

- Explored the need to manage actors by reviewing the international literature (in Chapters 1 and 2) and noting the opposition to health financing reform in South Africa (Chapter 6).
- Explored the tools available to the reform driver to manage actors and the conditions under which they would work (Chapters 2, 4, 7 and 8)
- Developed a conceptual framework to highlight choices for a reform driver and guide best practice (Chapter 4)
- Derived a conceptual framework from relevant bodies of theory and a review of health care reform literature (Chapters 2, 3 and 4)
- Tested this framework against case studies of health financing reform in South Africa (Chapters 7 and 8)

This chapter completes the analysis presented in earlier chapters and indicates both the methodological and policy contributions of the thesis. It begins by comparing the key findings from Chapters 7 and 8, in relation to the testing of the conceptual framework, and explores the issues that emerge from the data on the practice of managing actors in health financing reform. I then reflect on the methods used in the thesis and explore the contribution of economics to the managing of actors in health reform. Finally I discuss the findings of the thesis in relation to lessons for reform drivers and actors in South Africa and other countries, and explore the contribution of the thesis to health reform and health policy literature.

9.2 Comparison of the findings

It is useful to compare the findings from Chapters 7 and 8 in order to test the utility of the conceptual framework and draw lessons for managing actors. While the two sets of results relate to different case studies they are also produced by different methodological approaches, as discussed in both Chapters 1 and 5. Yet both are tests of the conceptual framework and it is therefore valuable to explore and contrast their findings. The material from the SAZA case studies, in Chapter 7, represents a more grounded approach to testing the concepts and working hypotheses of the conceptual framework. In contrast, the material in Chapter 8 was produced by a more deductive approach: direct questioning of reform drivers on the elements of the conceptual framework. The results of this comparison are outlined in Table 9.1. It must be noted that Table 9.1 does not explicitly highlight where there is agreement with the conceptual framework (an analysis presented in Chapters 7 and 8). Instead it focuses on points of agreement and points of contradiction between the two approaches. This is important as it goes beyond the conceptual framework, with the evidence from the South African reforms, to draw out the key elements in driving reform.

A notable aspect of Table 9.1 is the widespread agreement of the two approaches on many issues across virtually all the elements of the conceptual framework. Indeed, there are only two points of direct contradiction, shown in the second column, where the two sets of findings explicitly disagree on key elements of the conceptual framework. Nevertheless, there are several “points of difference”, shown in the third

column. The latter refer to findings from one approach that were not discussed in the other. In effect, the points are neither confirmed nor refuted by the other set of findings.

A summary of the comparison is discussed below. Both sets of findings agree that reform drivers do take responsibility for reform processes. They do intervene sometimes to direct the course of events towards a certain goal. Nevertheless, reform processes are also hostage to the prevailing context and other processes that are already in existence. These may constrain or even impede the deliberate management of reform actors and processes. Hence the issue is more complicated than implied in the conceptual framework. A theme which emerged from the SAZA case studies (Chapter 7), but that was not confirmed by the Conditional Grant reform material (Chapter 8), is that there were often several reform drivers acting together or in sequence or sometimes in competition. Again, the reality of reform processes may be more convoluted than the conceptual framework implies.

A key factor where both datasets agreed was that the official roles of actors and/or their representation of institutions are important in reform processes, and this may force engagement between reform drivers and actors. Thus reform drivers may have less choice about whom they engage with in reform processes, than the conceptual framework implied. There is also contradictory evidence on the degree to which reform drivers seek out other actors to alleviate their own weaknesses. Analysis of the Conditional Grant reform implies that reform drivers reflect on their own weaknesses and then engage with others to offset these, as indicated in the conceptual framework. The experience of the SAZA case studies imply the issue is more complex. While reform drivers often do engage with others to offset their weaknesses, sometimes alliances are overlooked or avoided. Still, there was agreement that reform drivers would often avoid contact with actors, or at least limit engagement, where they knew that these actors were likely to oppose the reform process. Further, the Conditional Grant reform highlighted that engagement with others may reduce the reform driver's credibility.

Interestingly, the findings across the case studies were inconclusive on the issue of learning. It appears that some reform drivers just did not learn despite repeated

opportunities while others adapted their approaches, reviewing previous interactions. Again, the picture appears more complex than was set out in the conceptual framework pointing to the importance of personalities and context. Both sets of findings identified evidence which supported the idea that actors are often in competition with reform drivers and try to change reform processes or goals. There was agreement that it was important to consider the motivating factors of actors when considering the form and rules of engagement. Nevertheless, payment for participation proved less important for motivating actors than other types of motivation.

Power was highlighted by both sets of findings as an important characteristic for a reform driver to possess or pursue through engagement. Personality traits of being obstinate and determined were also identified as important for reform drivers across the case studies (see also section 9.5.3 for a fuller discussion). Both approaches found it difficult to disentangle the effect of trust from other factors such as a good reputation and aligned interests when considering the type of relationship to have between a reform driver and an actor. Nevertheless, the Conditional Grant reform noted the importance of trust and good reputation for securing collaborative activities.

Many of the points of difference highlight extra elements or factors that were not taken into account in the conceptual framework. They paint a more detailed and complex picture of the realities of the reform process: the content of reform and its presentation will affect the buy-in of other actors; different contexts will constrain or promote reform management; contracting may reduce flexibility in a changing and risky environment.

There is a disagreement between the results chapters on whether the conceptual framework is more appropriate to resource generation reforms than resource allocation reforms. The case studies from Chapter 7 highlighted that in that context the resource generation reform processes were a closer fit to the conceptual framework. The Chapter 8 results indicated, however, that reform drivers perceived no such difference between different types of reform. (See section 9.3 for a fuller discussion of this point.)

Overall the comparison of findings between Chapters 7 and 8 presents a more chaotic picture of reform development and management than set out in the conceptual framework. Where context and prevailing processes allowed, some of the basic tenets of the conceptual framework reflected actual practice in reform management.

However, the framework over-simplified the process of reform and its omission of power was a key weakness (see section 9.4.2 for a fuller discussion). Nevertheless, the convergence of the two methodological approaches on many common issues implies there is much that can be learned from it about managing actors in reform development. Hence in the next section I discuss the methodological contribution of the thesis.

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Table 9.1: Comparing the findings of the two methodological approaches

Points of agreement	Points of contradiction	Points of difference
<i>The Reform Drivers</i>		
<p>There are reform drivers who take responsibility for taking forward reform. While they may steer events from time to time, the prevailing context and given processes may be just as important in directing the reform and may impede the efforts of reform drivers.</p> <p>Reform drivers appear, in general, to be aware of their own constraints.</p> <p>Personalities of reform drivers are important to the success of their task</p>		<p>There may be more than one reform driver in any reform process (Chapter 7).</p> <p>Reform drivers, with different goals, may compete with each other (Chapter 7).</p>
<i>Seeking out Characteristics</i>		
<p>Power is a key characteristic for taking forward reforms and must be acquired if the reform driver doesn't have it.</p> <p>The prevailing context and processes may determine engagement patterns. Relatedly, official roles and representation of actors may also influence engagement between reform drivers and actors.</p>	<p>(Chapter 8) Reform drivers engage with other actors to alleviate their own constraints vs. (Chapter 7) only sometimes do reform drivers engage to alleviate their constraints – sometimes alliances avoided or overlooked.</p>	<p>Engagement with others may reduce credibility and hiring may be a better option (Chapter 8)</p> <p>Risk may not only relate to actors but to contexts (Chapter 8)</p> <p>Issues around the content and presentation of reform design are important in producing support from other actors (Chapter 8)</p>
<i>Establishing the Relationship</i>		
<p>For actors who opposed the reform, reform drivers often pursued limited engagement or avoidance rather than trying to control.</p> <p>Complementarity of characteristics not important in determining the type of relationship</p> <p>Difficult to isolate the role of trust from other characteristics (such as reputation and interests) in determining the type of relationship</p> <p>Payment for participation was not that</p>		<p>Contracting done to allow remuneration – not for control (Chapter 7).</p> <p>Contracting may reduce flexibility.(Chapter 8)</p> <p>Trust and good reputation were important foundations for informal collaborative activities</p>

important in driving behaviour in relation to other forms of motivation. Nevertheless, the latter were important as drivers of behaviour.		(Chapter 8)
<i>Interaction and Learning</i>		
Actors behaved strategically in trying to change the goals and processes of reform. Inconclusive evidence on learning. Some reform drivers appeared to learn, others not.		
<i>Application to Resource Allocation and Resource Generation reforms</i>		
	(Chapter 7) Resource generation reforms appeared a better fit for the conceptual framework vs. (Chapter 8) resource generation reforms appeared more complex but not necessarily a better fit for the conceptual framework	

9.3 The Contribution to Methodology

The thesis offers two potentially useful approaches to health policy analysis and the study of health reform. First, the conceptual framework was derived from both a comparison of relevant theories and health reform experience. The existing literature on health reform and health care financing reform was reviewed to establish what is currently known, and not known, about managing actors in health reform. Key gaps in knowledge were identified and additional bodies of theory were selected for review on the basis of several criteria. Specifically, the theories had to offer additional insight into relationships between reform drivers and actors. Four bodies of theory were chosen (three of which were from economics) on the basis that they provided insight into interests, incentives, constraints, uncertainty and different types of relationships. Each theory was explored and their insights compared and contrasted in relation to the gaps in understanding identified in the literature review. The findings were taken

forward into the development of the conceptual framework. The fact that the conceptual framework had input both from theory and international experience of health reform gave it a strong foundation and potential for testing in different settings and across different reforms.

Second, the conceptual framework was tested using quite different, but complementary, methodologies in one country, South Africa. One approach involved drawing out key themes about managing actors from actor interviews in the SAZA case studies of health financing reform. This grounded approach allowed ideas to emerge from the interviews. These ideas were then tested against the elements and working hypotheses of the conceptual framework. The strengths of this approach relate to the wealth of data produced and the understanding of the phenomenon within context. The potential risks relate to data overload. The sheer volume, and in some case length, of interviews presented a challenge of how to handle the data and it was important to use qualitative software to store the information and develop coding. The related risk of having so much data is the temptation for researchers, overwhelmed by information, to see only what they want to as a means of being able to cope with the data.

The other approach used the components and expected findings of the conceptual framework as a foundation for the interviews. Reform drivers were questioned on every element of the conceptual framework to see whether it provided an adequate description and understanding of how reform processes and actor management occurred. This deductive approach allowed for precise testing of the conceptual framework. Nevertheless, its reductionist approach ran the risk of understating, or even ignoring, the importance of factors outside the framework and thereby oversimplifying the situation.

However, these two very different approaches acted as a check against each other. Interestingly, the findings of the two approaches agreed on very many issues (as was shown in Table 9.1). Each may therefore have served to validate the other. While each approach also threw up issues considered neither by the conceptual framework nor by the other approach, there were only two points on which the approaches produced contradictory findings. Even here the differences between the methodological

approaches do much to explain the apparent contradictions, and thus are worth exploring. The two points of contradiction were related to the:

- **Engagement Strategy of Reform Drivers** - the grounded approach (Chapter 7) of analysis led to the conclusion that reform drivers sometimes engage to alleviate their constraints, but at other times avoid or overlook alliances. In contrast, a conclusion of the deductive approach (Chapter 8) was that reform drivers engaged with other actors to alleviate their own constraints. Here the wealth of the more grounded approach, with its understanding of context, and its coverage of more reform processes, may have allowed more sophisticated and balanced insight into reform processes. It would be interesting to investigate whether the deductive approach would have produced similar findings had it been used across several reform processes, and not just one. Nevertheless, it may also be that reform drivers directly questioned under the deductive approach may be tempted to avoid relating mistakes, such as “overlooking” a potentially useful engagement with a supportive actor.
- **Application of the conceptual framework to specific types of reform** - the grounded case study approach indicated that resource generation reforms appeared a better fit for the conceptual framework. In contrast from the deductive approach it appeared that while resource generation reforms were more complex they were not necessarily a better fit for the conceptual framework. The findings of the deductive approach may deserve less weight as the main focus of the interview was on resource allocation and the question on SHI was more reflective and hypothetical. In contrast the SAZA case studies offered a richer analysis of actual experience with both types of reform. Again, though, more case studies for the deductive approach, and specifically those around resource generation reforms, could have altered the findings and produced agreement.

It is nevertheless worth restating the fact that only in the above two instances was there contradiction in the findings of the two approaches (compared to thirteen points of agreement identified in Table 9.1). It is also interesting to note that the deductive approach did not come up with fewer unexpected findings (i.e. those that were not

related to components of the conceptual framework) than the more grounded SAZA case studies. As noted, a concern about deductive testing of the conceptual framework is that the concepts will direct the interview questions to the exclusion of other, potentially important issues. However, an open interviewing approach can ensure both that concepts are tested and additional insights gleaned. Thus unexpected insights emerged from the analysis in Chapter 8 about the importance of credibility and flexibility to reform drivers, as well as the presentation of reform design to opposing actors. This highlights the importance of making room, even in a deductive approach, for interviewers to follow up interesting lines of inquiry, to deviate from a set sequence of questions and allow interviewees chance to reflect on issues. This argues against a rigid deductive approach.

9.3.1 Summary

1. Comparing and contrasting relevant bodies of theoretical literature to fill gaps in existing knowledge may allow for the generation of more useful conceptual frameworks for understanding health reform and health policy processes. These can then be tested against actual practice, preferably across a variety of case studies and contexts. This testing will allow both a gain in empirical knowledge and a gain in understanding of how useful specific theories are in addressing issues of importance.
2. Ideally a conceptual framework should be tested using different methodologies. All methodological approaches have their biases, and hence weaknesses. Utilising more than one approach will allow crosschecking. Where time and resources do not permit this, then researchers need to be clear about the potential weaknesses in their methodology. Researchers using a more grounded approach must be careful not to see what they want to and let their own biases intimidate the data. In contrast, researchers using a more deductive approach must allow for reflection and new ideas to emerge.

9.4 The Contribution of Economics to the Analysis of Health Policy and Reform

As noted previously, steering reforms and engaging actors are political processes. It is helpful to consider how useful economics has been, and can be, in illuminating such activities for health policy analysis and health financing reform. Certainly, neoclassical economics and its derivative rational actor model of decision-making have very little to offer. Their assumptions about full information, plentiful resources and no constraints on government decision-makers choosing among different reforms are unconvincing as a portrayal of the practice of health reform. Nevertheless, as argued, New Institutional Economics and Game Theory have far more potential. They seek to relax many of the binding assumptions of neoclassical economics and focus on the interactions of institutions and individuals within institutions. They are concerned with information imbalances, uncertainty, strategic behaviour, constrained rationality and motivation. All these issues are pertinent to actor management. Indeed, while the economic theories have different concerns from each other they all offer insight into relationships and the determinants of behaviour which is at the core of the issue of actor management.

Nevertheless, it is important to investigate the relevance of economics theories in more detail, using the results of the thesis as a test for an economic approach to analysis of managing actors. In the following paragraphs I consider some of the main areas of insight of the economic theories chosen before reviewing areas of omission.

9.4.1 Insights

9.4.1.1 Motivation

A key feature of economics is that incentives drive the behaviour of individuals and institutions to maximise their own utility, or more broadly their goals. All the case studies suggested that motivating factors were important in determining actors' behaviour. Better incentives for actors appeared to impact on their participation in reform processes. The failure to provide adequate forms of motivation on the earliest

health financing committee may well have contributed to the lack of cooperation of committee members. Still, while motivation affected participation the evidence suggested that a lack of incentives was not critical in reform development, though it did precipitate strategic behaviour.

Interestingly, the case study material does highlight the importance of different *types* of incentives. Actors may collaborate with reform drivers to achieve certain ends that match their own interests, or to pursue their ideological visions, or because they want to be part of the process of reform and derive value from this alone. Further, there is evidence that actors may trade-off these different forms of motivation. For instance, on some committees analysts indicated they were willing to sacrifice their concerns for good process in the interests of pursuing a vision. While economics highlights issues around motivation as an important driver for behaviour, is it able to handle different objectives? The more sophisticated and recent agency theory allows for such a multiplicity of objectives and may be helpful in thinking about the different drivers of behaviour. Transaction Cost theory does not typically consider different forms of incentive apart from the strategic interests of each party, but the discussion of trust in this context at least hints at other forms of motivation. Game Theory is less helpful in this respect as it creates a composite single measure of utility or gain. It therefore loses the subtlety of trade-off between different forms of motivation.

Perhaps more damning for a simplistic agency approach is that payment for participation was relatively unimportant across the case studies. Traditional agency theory indicates that agents act only according to their payment from the principal for doing so. Yet payment for participation in reform processes appeared to be a relatively unimportant driver of behaviour. Self-interest derived from the material rewards of the reform's outcome, ideology or non-financial value from process and participation were more important forms of motivation. This view is consistent with a more sophisticated agency approach, which allows both for multiple objectives and for the objectives of principal and agent to overlap.

9.4.1.2 Information

Imbalances of information between actors, and their response, are an important area of focus of all the economic theories. All discuss how information affects action and how new information changes existing patterns of behaviour and relationships.

Uncertainty produces strategic behaviour both to close the information gap, from one side, and to exploit it, from the other. Acquiring information was a reason for reform drivers to engage and this was illustrated by the engagement with both medical schemes administrators and analysts. Further, information holding, or preserving an information imbalance, was pursued by the DHFE in its dealings with the National Department of Finance.

Nevertheless, the *ability to process* information is generally not explored in economics, which tends to assume that players will change their behaviour in accordance with available information. Indeed, learning from new information is an assumption in Game Theory and agency. Nevertheless, the evidence is mixed. Some reform drivers appeared to be better “learners” than others. Again, personalities may count for much. In addition a particular context may impact on the ability of reform drivers to learn. The importance of a vision to a reform driver or the need to get things done quickly may impact on the ability of reform drivers to learn from experiences. Of the economic theories explored only Evolutionary Game Theory, with its notion of prevailing conventions and individual idiosyncracies, is able to cope with these sophistications around the analysis of learning.

9.4.1.3 Strategic Behaviour

Economic theory implies deliberate and rational action to achieve desired ends.

Principal Agent theory, Transaction Costs literature and standard Game Theory all demand that their protagonists behaved in a logical way to achieve their goals.

Certainly, there is evidence to suggest that both reform drivers and actors behaved like this, part of the time. Nevertheless, it is also apparent that at times this was not done or was just irrelevant because of the prevailing context and processes. Again, only Evolutionary Game Theory comes close to capturing the complexity of irrationality and convention from an economic perspective.

9.4.2 Gaps

Perhaps one of the greatest strengths of economics is its ability to abstract and simplify. This allows a focus on the most important factors that determine behaviour, where correctly identified. Hicks (1981) notes of economics:

“Our theories...are rays of light, which illuminate a part of the target, leaving the rest in dark. As we use them we avert our eyes from things that may be relevant, in order that we should see more clearly what we do see.”

Yet this approach is not entirely adequate for understanding actor management, managing actors and understanding policy processes and reform development. It assumes simplicity and that the factors ignored are relatively unimportant. Certainly the economic approach has identified some key elements in relation to managing actors i.e. recognition of motivation, information constraints and imbalances, the potential for learning and deliberate and rational strategic behaviour. As such the economic theories contribute knowledge but at the same time the data from Chapters 7 and 8 highlight that there are missing elements to this type of approach, in particular power and context. A review of these factors is necessary to conduct a balanced appraisal of the contribution of economics to policy analysis, and specifically to the management of actors.

9.4.2.1 Power

In Chapter 3 I discussed whether or not the omission of the concept of power from the bodies of literature was a weakness of my approach. None of the economic theories brings the concept of power to the fore though all have it woven into their assumptions and framework to some extent, certainly in terms of their capacity to achieve intended results and also selectively in terms of dominance and authority. The issue of the importance of power was at that stage left open until after the analysis of data. Yet from the results set out in Chapters 7 and 8, power is unquestionably an important characteristic for taking forward reform. It must be acquired where the reform driver does not have it. Analysts, as reform drivers, are often particularly weak in terms of access to power, which can impede their effectiveness as reform drivers. The processes around SHI show clearly that the inability of analysts and the DHFE to access powerful actors, such as the Minister of Health, and get their support

was a key constraint and effectively undermined the reform. Sound technical design, while important, was no substitute for access to power. Further, reform drivers not only have to make sure of their own power base but be aware of the power of opposition groups and respond to this appropriately, as discussed.

From the results of the case studies it appears that power is often connected with official position. Certain roles and responsibilities carry authority to make decisions and endorse change, such as the Minister of Health. Yet power can also be associated with an institution's role. The National Department of Finance has key roles in terms of budgeting and resource allocation. Individuals from the National Department of Finance may not hold high rank but still exert power in relation to their representation of that institution. Indeed, the representation of certain groups on policy processes may be both important for credibility and obligatory in terms of their functions and responsibilities. Power may also be connected with key processes or committees, where actors work together. Again, the individuals in the processes may not have much power in themselves, but are granted power in relation to a specific task. Such findings confirm the existing literature on health reform and health policy which suggests that policy elites have the power to take forward reform but can also be influenced by broader society (Grindle and Thomas, 1992; Walt, 1994; Barker, 1996).

Powerful actors also have the ability to set up their own processes of reform, such as committees. This ability to affect the processes of reform development, as well as endorsing particular versions of reform, means that powerful actors are critical for reform development. Such concepts are missing from the primarily economic approach of the development of the conceptual framework. Nevertheless, they are essential to understanding the prospects for managing actors in reform processes.

9.4.2.2 Context

Both sets of results highlight the importance of the context of the reform process to the issue of managing actors. Often the prevailing context, and given processes, may be just as important in determining engagement between reform drivers and actors as the reform driver's own strategic choices. Indeed, the SAZA case studies highlight that, in relation to resource allocation reforms, context was far more important to reform development. Key contextual events, such as the new constitution and the

move to fiscal federalism, have been important in triggering reform processes, leaving little room for conscious planning. Even with the Conditional Grant reform the existing budget processes dictated to some extent the actors that the reform drivers had to engage with. Thus, existing processes may impede the efforts of reform drivers to seek out specific actors, or at least will force reform drivers to engage with other actors as well. It is apparent, then, that reform drivers must discern the prevailing context and try to work within it. There may be opportunities to behave strategically but the data suggest that there will also be unforeseen events that can aid or weaken a reform development process.

It may even be that context determines behaviour. Reform drivers may well get caught up in changes which affect their ability to drive reforms. The need to deliver reforms quickly may have pressurised early reform drivers in the SAZA case studies. Contextual issues also had an impact on learning. First, changing contexts may result in redeployment of personnel. This may undermine institutional memory and the ability of reform drivers and other actors to learn. Second, there may be pressure on reform drivers to ignore reality, and thus not learn from experience, when driven by a consuming ideological vision.

The handling of context varies across the economic theories examined, but it is largely notable by its absence. Standard Game Theory and Principal-Agent theory tend to focus on incentives, information and interactions of players. The Transaction Cost approach examines institutional form as a basis for more effective relationships but again there is no focus on the broader context. Only Evolutionary Game Theory explicitly locates the interactions of players, and different types of relationships, within a societal context with established conventions of behaviour. In effect the social context affects the beliefs of players, their goals and ability to learn. Conventions may also become established in which, as a result of the context and belief patterns, players always interact in a certain way and not necessarily that which is most logical.

9.4.3 Reflection

From the above analyses, it can be judged that economics can provide insights into actor management. To demonstrate the utility of economics in this field is important, as it is not a traditional domain of an economic approach. Indeed, there are relatively few applications of economic theories to policy analysis, reform and politics and these are mostly limited to agency and Game Theory. Yet actor management requires an understanding of information, strategic behaviour and motivation and an exploration of alternative courses of action. While this is necessary it is not sufficient. A solely economic approach will miss key forces and fail to understand policy processes in all their complexity. In particular issues of power and context are important determinants of behaviour and reform development.

9.4.4 Summary

1. The findings of the analysis suggest that an economic approach can provide insights into health policy analysis and health reform, and specifically issues around managing actors. To ignore this body of literature in these fields may be to risk downplaying, or lessening insight into, actor motivation, the importance of information and learning and the effects of strategic behaviour. Nevertheless, economics by itself is not enough to understand all the important elements of managing actors. An eclectic approach which combines economics with other disciplines such as politics and sociology, may better guarantee effective contribution, but not domination, of economic concepts and ideas.
2. The more recent and sophisticated versions of principal agency theory and the emergence of Evolutionary Game Theory appear to be the most useful individual economic theories for capturing the complexity of policy relationships. Explicit development and application of these theories in policy analysis would be interesting and may provide further insights. Following the lead taken by Newton and Sharpe (1977), when discussing policy research:

"Understanding can only be achieved if one breaks down the barriers between the disciplines." (p248)

9.5 Insights into Driving Health Financing Reforms

This section presents key insights into managing actors in health financing reform. It also explores how the thesis confirms and adds to the knowledge contained in the international literature on the practice of managing actors in health financing reform. A summary of the discussion is presented in Table 9.2.

The main focus of the thesis is to be able to further understanding of driving health reform and specifically health financing reforms. Nevertheless, as argued in Chapter 1, it is hoped that because of the derivation and testing of the conceptual framework (using different bodies of literature, international evidence and both deductive and inductive methods) the insights presented here will be generalisable to other instances and contexts of health reform. This needs to be tested against such experiences. It may also be that the findings are generalisable beyond the health sector as there is nothing in the following discussions which is unique to the health sector. Nevertheless, a thorough examination of these points, while important, is not within the scope of this thesis and must await further research.

9.5.1 The situation:

Chapter 2 highlighted that health care financing reform involves the pursuit of substantial change in the financing of, and allocation of resources to, health services to achieve improved performance. Certainly in South Africa substantial change was attempted in health financing and resource allocation and, in some cases, achieved. The international literature suggests that health reform is often complex, likely to produce opposition and there is consequently much uncertainty about its outcome. The evidence from this thesis suggests that resource generation reforms may be particularly complex to manage and design. SHI stands out as an especially difficult reform to develop, given its intricate design and impact on many and diverse actors. Certainly of all the reforms it experienced the most opposition and to date no design has generated sufficient support to get it endorsed. The evidence in this thesis also emphasises that reforms may not only generate opposition but that reform drivers may also have to deal with other reform drivers pushing different, potentially opposing,

visions of reform. This suggests a rather chaotic picture of reform development. Grindle and Thomas (1992) highlight the complexity and uncertainty of change. This thesis confirms and stresses the uncertainty faced by reform drivers in terms of the values and behaviour of other actors and the shifting sands of their environment. Given this it might be wondered whether reform management is possible at all. Yet, the results in Chapters 7 and 8 highlight that reform drivers did indeed take responsibility for reform, behave strategically at times and were sometimes successful in achieving their desired aims. Again, this confirms the international health reform literature that actors do attempt to drive change and can sometimes succeed (Reich, 1995; Grindle and Thomas, 1992; Bloom, 2001).

9.5.2 Context and the timing of reforms

In testing the conceptual framework it became evident that the context for the reform was extremely important for the reform's development. Reform drivers have got to be able to understand the environment within which they work and deal with changes in circumstances and unforeseen events, where possible. Contextual events may produce periods of upheaval, such as after the 1994 elections or after the shift to fiscal federalism where the previous rules and structures are totally altered. Such events may determine the path of reform and in the face of them reform drivers can do little. The resource allocation reforms in the SAZA case studies demonstrate this. Deliberate strategic engagement is just not a realistic option.

Nevertheless, there are contexts where reform management is possible. Indeed the honeymoon period for change after the democratic elections gave government an opportunity and responsibility for significant reform and the free health care policies were direct responses to this. Further the broad consultation on the ANC's National Health Plan and, to a certain extent, the CoI may indicate that even traditional opponents of government, such as the private sector, were willing to engage in reasonably constructive policy debate at such times. Nevertheless, financing reforms concerning the private sector did not occur until five years after 1994 with the reregulation of the medical schemes in 1999. This suggests that the accommodatory policy environment after 1994 was not in itself sufficient for change.

Reform drivers need to recognise when they have a window of opportunity and to be sufficiently determined to be able to push through the reform processes before there is further radical change. Such results confirm key findings in the health reform and policy literature (Kingdon, 1984, Reich, 1995), see Table 9.2. The art of the reform driver may well be to identify when, and in what context, strategic behaviour will work and to be sufficiently flexible to deal with unforeseen events, focussing on where they can be turned to some advantage. The latter may of course mean totally rethinking reform processes and actor management. There may also be times when change forces a reform driver to understand that reform is no longer possible and that any efforts in this respect will be futile.

It is apparent from the South African data that an important first step for a reform driver in a window of opportunity is to consider which reform, or reforms, to push forward. There is only a certain amount that a reform driver can do in addition to his or her regular responsibilities. Further, the pool of resources available from other actors, which may be mobilised for the policy task, may well be limited. To spread scarce resources thinly across many reforms may be to undermine all the processes. Hence prioritising among competing policy needs is essential and requires that the importance of each proposed reform is considered in relation to health system goals and the feasibility of implementing change. In deciding which reform to take forward, and how, it will be important for reform drivers to consider the nature of different types of reforms and the resources that can be brought to bear on their development. An example of such reasoning was displayed with the fast tracking of the policy of free health care for women and children in 1994. The policy was identified as being easy to implement just after the 1994 elections, when public pressure for delivery was very high, and with an important redistributive impact.

Relatedly, the South African data suggest that different types of reforms have different characteristics for actor management. Resource generation reforms involve more actors outside of government, may be more complicated but also may allow more freedom for a reform driver in choosing whom to engage with. Resource allocation reforms tend to involve actors within government, but at the same time, are more governed by existing processes.

Table 9.2: Contribution of the Thesis to the Existing Literature of Health Reform Management

Reform Themes	Existing Literature	Thesis Contribution
Timing of Reforms	There will be windows of opportunity where change is possible (Reich, 1995, Kingdon, 1984) or alternatively where policy makers have sufficient “policy space” to pursue change (Grindle and Thomas, 1992)	The results of the four case studies confirm that there are windows of opportunity for the pursuit of successful reforms, though they also caution against trying to do too much in these times because of limited resources for reform.
Who takes forward reforms?	It is Government’s responsibility to steer reform efforts (Bloom, 2001). Reform coordination will happen through policy elites (Grindle and Thomas, 1992) and policy entrepreneurs (Kingdon, 1984). Political leaders may set up change teams to steer reforms (Grindle, 2000).	The thesis partly confirms and partly adds to the existing literature. Many but not all reform drivers were in government in the four case studies. There were three different kinds of reform drivers; powerful policy makers, government analysts and academic analysts, each with different characteristics and needs. Also reform drivers often worked together or in sequence. The thesis also examines leadership qualities, which would ideally be possessed by reform drivers.
Importance of coalitions	Coalition building is a key strategy for effective change (Glassman et al, 1999, Bloom, 2001), especially where the poor can be allied with the powerful (Reich, 1995; Bloom, 2001). Teams of change managers are important for reform development (Grindle, 2000).	The thesis confirms the importance of coalitions of actors and teams of reform drivers to take forward reform
Building effective coalitions and teams	Importance of who is on the teams and how they are organised (Grindle, 2000). Importance of consensus, common values and compromise in change teams (Grindle, 2000). Importance of vision and coordination of alliances (Glassman <i>et al</i> ,	A key contribution of the thesis is in its exploration of team and coalition dynamics and composition. To achieve successful reform it is important for reform drivers to combine power, technical skills and specialist interest, along with other characteristics needed for the policy task.

Reform Themes	Existing Literature	Thesis Contribution
	1999).	It is also important for reform drivers to consider different forms of motivation of actors on the team, to guarantee their effective collaboration, whether relating to the outcome of the reform, the ideology of the reform or its process.
How to defeat the opposition (other than building coalitions)	<p>Different strategies are highlighted:</p> <ul style="list-style-type: none"> • Provide powerful groups with compensatory benefits (Reich, 1995). • Mobilise the media in favour of the reform (Glassman <i>et al</i>, 1999) • Identify opposition and involve them in the design of the reform (Glassman <i>et al</i>, 1999). • Do not involve or collaborate with non-supportive actors (Varvasovszky and Brugha, 2000). • Cloud reform issues by leaving them imprecise (Waterbury, 1989) • Choosing to fight opposition in public or bureaucratic arenas (Grindle and Thomas, 1992) 	<p>The thesis partly confirms and partly adds to the debate about managing opposition, noting several effective strategies within the South African context:</p> <ul style="list-style-type: none"> • avoidance or limited engagement (where avoidance is not possible); • debating the reform at the conceptual level to achieve buy-in from the opposition; • splitting opposition on key issues to weaken their power • choosing to fight in an arena where the opposition is weaker • undermining the technical foundation of opposing reform streams.
Analysis of actors and their effect on reform.	General review of reform experiences in several countries provide an understanding of who did what and what their interests were and how this affected the health reform (Grindle, 2001; Reich, 1995; Grindle and Thomas, 1992; Glassman <i>et al</i> , 1999).	<p>A key contribution of the thesis is its detailed exploration of the characteristics (such as resources, constraints, interests and reputation) of reform drivers and actors and the effect that these characteristics have on engagement strategies, the form and rules of relationships and strategic behaviour in developing reforms. Thus the thesis examines linkages between the characteristics of reform drivers and actors and their impact on the development and success of health financing reform.</p>

9.5.3 Reform Drivers

The importance of strategic leadership is highlighted by the international literature in taking forward health reforms (for example Bloom, 2001). Policy elites and entrepreneurs are important coordinators of reform processes (Kingdon, 1984 and Grindle and Thomas, 1992). The South African data confirmed this, though also noting that reform drivers can be from outside government. As well as government policy makers and analysts, academic analysts were important in driving reforms, and in particular SHI. Indeed, the variety of different reform drivers across the four South African case studies was notable. Further the data revealed how reform drivers not only worked together in teams, but also operated in sequence, as well as in opposition to reform processes.

The thesis suggests also that the key characteristics for effective leadership in managing actors in health financing reform development are:

- flexibility to deal with the shifting sands of events – the reform driver ideally should be aware of how the context is changing and how this might affect the reform development;
- honesty to admit own weaknesses – by overestimating his or her own abilities as reform driver is risking not engaging with the other actors and, therefore, not bringing sufficient resources to a policy task. This will undermine its chances of success;
- insight to be aware of the strengths and weaknesses of others – to alleviate the constraints faced by the reform driver it may be important to engage with others. Yet picking the right partners will require an understanding of what they can and will bring to the policy reform;
- obstinacy to have a vision of a reform goal and push it through – certainly determination to see a reform through was an important characteristic for successful reform drivers;
- aptitude for learning from past reform experiences – those reform drivers that could learn from previous interactions with other actors were able to direct subsequent reforms more successfully.

9.5.4 Importance of Teams and Coalitions

Building alliances and coalitions is important for taking forward reforms (Bloom, 2001; Glassman *et al*, 1999) especially in relation to pro-equity objectives which challenge vested interest groups. Grindle (2000) hones in on the importance of public sector “change teams” in the successful development of reforms in Latin America. Both the conceptual framework and the South African experience confirm such findings and highlight the importance of reform drivers engaging with other actors to acquire the necessary resources to push through the reform task.

9.5.5 Building effective teams and coalitions

The international health reform literature provides some insights on this issue. It stresses that a clear vision is important for managing coalitions, as is coordination (Reich, 1995). It is also suggested that the composition of change teams is important in that there should be common values among members (Grindle, 2000). The thesis explores in detail the composition and dynamics of such teams and coalitions in the South African context. It is here that it makes a substantial contribution to the existing literature. Reform drivers must build alliances by engaging with other actors. Reflection on the strengths and weaknesses of the reform driver will help indicate where engagement with other actors is necessary. For a coalition to pursue reform successfully it must collectively possess certain characteristics, from the reform driver and other actors, and these include power, information and technical skills. What is precisely required in addition to these characteristics is context dependent. For instance other positive characteristics that were valued in engagement were representation of an institution or office, good reputation and trustworthiness, and available funds.

Where such resources were not acquired problems occurred. Analyst reform drivers, from academic institutions and the DHFE, did not pay sufficient attention to getting the backing of powerful actors for SHI. Indeed, for analyst reform drivers, power will be an important characteristic to acquire through engagement, as in the successful Medical Schemes reregulation and the Conditional Grants reform. Such findings again confirm the importance of power in developing health financing reforms. The

Conditional Grant case study brings out an important point not previously addressed in Chapter 2 and that is that the credibility of a reform driver, especially an analyst reform driver, is critical in determining access to power through senior officials. Such credibility can be gained by reliable, timely quality work that meets the needs of policy makers. This credibility may well help build teams and, conversely, a lack of credibility on the part of the reform driver may impede team development.

For those actors with power, such as senior government officials or politicians, technical expertise, specialist knowledge and an understanding of the details of implementation will generally be an advisable necessary complement. The failure to develop National Health Insurance and the problems associated with the implementation of free health care may well reflect the dangers of power without expertise. Policy makers often lack a detailed picture of the required technical design of reform to meet their goals and will need technical expertise to make it a reality.

The reform driver should review existing actors to identify likely candidates for collaboration in teams. Such actors will need to have the required resources, whether power or technical expertise (depending on the strengths and weaknesses of the reform driver) and will need to be in agreement with the end goal of the reform. A reputation both for being collaborative and for good work with respect to previous policy tasks will also be valuable to the reform driver. The reform driver should then review existing processes to see whether these will help build such teams for taking forward reform, by allowing engagement with other actors with useful characteristics. Where existing processes will not suffice the reform driver might consider whether additional processes could be set up to develop the reform, whether formal or informal. Powerful reform drivers may have more options here as they can establish formal processes, such as committees, which can act as change management teams and such reform drivers may also be able to mobilise funds for such activities. Reform drivers with less power may have to rely on informal networking. Other options for acquiring appropriate resources for the policy task may be direct hiring of staff and the use of foreign technical assistants. In the Conditional Grant reform, direct hiring of staff proved viable where there were available funds, where more junior staff were needed and where it was important for the institution to develop own capacity and tightly control the policy process. Nevertheless, this strategy involved extra

supervisory support and guidance to such staff. While the hiring of foreign technical assistance is another option for skill acquisition the case studies do not provide much information on the strengths and weaknesses of this approach, though it is questionable to what extent it would increase the capacity of local institutions.

It is also important for reform drivers to consider the different types of motivation that will enhance performance on a team. Clearly the outcomes of the reform process and its ideology are important drivers of behaviour, but other factors may also motivate actors to collaborate fully on teams. In particular, powerful reform drivers establishing teams of analysts and experts should: (i) provide clear direction of what end points they want to achieve and engage with them on the feasibility of this, allowing them to play an active role in the process, and (ii) compensate them, or their employees, for time taken on policy processes.

There are circumstances where the precise characteristics of an actor are unclear. A reform driver may be faced with insufficient knowledge on current motivations to discern whether that actor should be brought into a change management team. Caution is advisable. The South African experience highlights that there were a number of Trojan Horses on committees, specifically in relation to the health insurance debates, whose hidden agenda was to influence reforms toward certain end-points and where that was not possible to prevent reforms from progressing. While representation of some actors may be important it is vital to reflect on their likely motivation, reputation and past performance in policy teams. Where the interests of an actor in relation to the reform task are not precisely known the South African data suggest that an actor's reputation for cooperation, previous actions and general trustworthiness will be a good guide to the viability of collaboration.

9.5.6 Dealing with Opposition

The extent of opposition to many health reforms, especially those pursuing equity, was highlighted in Chapters 1 and 2. Bloom (2001) emphasises the importance of government's role in managing change and negotiating with stakeholders to overcome this opposition. The international health reform literature highlights several strategies to negate the opposition to reforms. These involve such strategies as providing

powerful players with compensatory benefits or clouding the reforms by obscuring the extent of their likely impact (see Table 9.2). Interestingly, some of the strategies appear to conflict. Glassman *et al* (1999) suggest involving the opposition in the design of the reforms, while Varvasovszky and Brugha (2000) suggest that reform drivers should not involve opposing actors in reform design. This raises the important issue that some strategies will be context dependent.

The South African data confirmed some of these strategies and highlighted additional ones, adding to the debate about appropriate strategies for dealing with opposition. The case studies show that reform drivers need to consider which actors are opposing, or are likely to oppose, the reform process. In particular, it is important for a reform driver to be aware of other policy streams that may conflict with the reform task ahead. The reform driver needs to consider how to defeat these competing reforms. Just as a reform driver's team needs power and technical expertise and information, so any opposing team will need these characteristics. Thus in undermining opposing reforms it may be useful to examine issues of power and technical expertise. In relation to undermining the power of the opposition, two strategies emerge from the Medical Schemes reregulation. The first related to reform drivers deliberately exploiting a division in the Medical Schemes industry to weaken them, thus reducing their power. The second related to analyst reform drivers choosing not to engage with technicians in NDoF, but allowing their Minister to fight the battle in Cabinet. This strategy then relates to identifying in which arena the reform team and its supporters have more power than the opposition and making sure that the reform is fought there. In relation to technical expertise, reform drivers may wish to marshal arguments against any competing stream of reform. This may involve demonstrating that the opposing reform has dire consequences for health sector performance or that it simply is not viable. Such a strategy was pursued in relation to destroying the proposal for NHI around the Col.

A key strategy for reform drivers with less power than opposing actors was to avoid them wherever possible or at least limit engagement (confirming the strategy outlined by Varvasovszky and Brugha, 2000). Such reform drivers should try and get more powerful actors to fight their battles, as noted above. Where a reform driver is forced to deal with opposition, such as on a routine committee, the research highlights a

number of strategies. First, the reform driver should limit the amount of information given to the powerful opponent. The less information available the more difficult it is for the opponent to prepare a counter argument. In essence then the engagement is kept to a minimum. Second, the reform driver should try to get conceptual agreement to the principles of the reform from opposition before actually engaging over detail and numbers. Where there is likely opposition a discussion of the concepts and values of a reform may help buy in before the extent of the reform's actual impact is understood. This was an effective strategy on the Conditional Grants reform. Third, the reform should be based on solid data and good analysis. The objections of opponents should be anticipated and, where possible, refuted. Fourth, the reform driver should be clear on the core and peripheral areas of reform. The peripheral areas may be negotiated away to ensure that the core reform proceeds intact. Thus reform drivers appear to compromise their reform design to secure buy-in from the opposition, but in reality no such compromise occurs.

The evidence from the case studies in South Africa does not suggest that using committees to manage opposition is particularly effective, at least where that opposition is represented on the committee. The analysis of the dynamics around the HCFC and CoI shows that overt efforts by reform drivers to control other actors backfired. The results also suggest that reform drivers paid insufficient attention to the motivation of different actors. If the opposition forces itself on to a committee is it possible for a reform driver running the committee to pursue his or her vision? The South African evidence does not provide positive lessons either from the CoI or the HCFC. This situation would clearly require very careful handling. Theoretically, it may be possible to exercise control in the committee by carefully designing the Terms of Reference, selecting the chair and informal networking with other actors to neutralise the opposition.

9.5.7 Analysis of Behaviour and its Impact on Reform

There are several useful and important case studies of health reform in the literature which highlight the behaviour of actors and reform drivers and document the success or failure of reform (Grindle, 2001; Reich, 1995; Grindle and Thomas, 1992; Glassman *et al*, 1999). One of the key contributions of the thesis is its detailed

exploration of the characteristics of reform drivers and actors as a basis for, and explanation of, such behaviour. Characteristics include the *resources* that each actor brings to the reform, *constraints* which affect their participation in the reform process, their *interests* in the reform and their *reputation* for collaboration and general trustworthiness. The thesis explores the linkages between the characteristics of reform drivers and actors, their interrelationships and the success of health financing reform.

The conceptual framework highlights that the reform driver must understand the task ahead and be aware of his or her own constraints in relation to the resources needed to take the reform forward. Such understanding should ideally be updated periodically as individuals, institutions, processes and context change over time. Updating understanding will allow the reform driver to take and modify strategic action to drive forward reform and manage other actors. Learning about the characteristics of other actors is especially important. The South African data showed that where reform drivers learnt it was very helpful for the success of reforms. The increasing success of how DHFE and NDoH handled National Department of Finance demonstrates the power of learning from experience. Reform drivers are well served by actively reviewing their reform experiences and reconsidering the reputations of key actors before embarking on new reforms. This may allow for more appropriate engagement in future reforms. Still, learning may be undermined; where there is only a small elite driving reforms then staff turnover can effectively kill institutional memory and learning. This may require that a broader pool of staff be involved in debating such issues within an institution, or that potential reform drivers consult with other reform drivers with previous experiences. Still, as change occurs what is learnt from previous interactions may not always be relevant for today's reform. New staff may bring with them new ideas. Nevertheless, change may be more superficial in that new personnel may also adopt an institution's identity and culture. In this setting past experience may still be a reliable guide to future behaviour.

9.5.8 Interventions from Actors

While not a main strand of the thesis it is apparent that the research is able to offer some insights for those wishing to influence reform processes but who are not reform drivers. A key issue is to identify the reform driver, the reform area and the end goal. The actor must determine what impact to the reform he or she wishes to make, whether it is to the process, or the design or the goal. An actor may also identify existing processes which will allow engagement with the reform driver so that the potential collaboration can be assessed and possibly discussed. If no existing process is available the actor may consider creating new ones, even if only through informal contact. This initial engagement may allow an actor to advertise his or her positive, and preferably niche, characteristics to that reform driver such as power, technical skills and specific information. In this respect it will be useful if the actor has complementary characteristics i.e. if the reform driver is a policy maker then an actor with the right technical skills may be an effective complement. A good reputation for being both collaborative and for helping to achieve prior change is also extremely important in determining whether the reform driver will engage with the actor. In effect the actor must demonstrate his or her trustworthiness to the reform driver.

In relation to trying to undermine a reform, the data show that there was more than one instance where actors were able to get on key policy processes and then block some reform proposals as well as encouraging the consideration of others by their technical input or strategic behaviour, which included informal networking to undermine the reform and leaking plans to the media. Where such routes are not desirable or feasible, an actor may consider open opposition to try and block the reform, if sufficiently powerful, or build an alternative alliance which will stand in opposition to the reform. This may involve the actor becoming an alternative reform driver or just catalysing such a process. As noted previously such teams will need both power and technical expertise to create a viable alternative reform process.

9.5.9 Summary

1. Reform drivers wishing to take forward change must reflect on whether it is possible to drive a reform in the prevailing context. This will require examining existing processes and the landscape of other actors to see whether there is a window of opportunity that can be exploited.
2. When the context allows reform drivers must take care to plan their reform process. This involves reviewing the type of policy task ahead and what resources will be needed to get it through, the constraints of the reform driver and the existing pool of resources from other actors who could be mobilised to support the reform.
3. Faced with a window of opportunity and a range of potential changes, reform drivers must prioritise reforms and focus the available resources (from other actors and the reform driver) on these. Failure to do this may mean that resources are spread too thinly across many reform processes, and so are blocked or undermined.
4. It is helpful for reform drivers to build up teams for the specific reform task and engage with other actors on the basis of what they can bring to the policy task. At the very least such teams should consist of actors with power, technical expertise, specialist knowledge and an understanding of implementation concerns. The credibility of the reform driver in the eyes of other actors can be especially helpful in securing support and building teams.
5. When examining potential engagement with other actors the reform driver should focus on whether the actor:
 - a. Has characteristics to help offset the weaknesses of the reform driver and take forward the policy task
 - b. Agrees with the end goal of the reform and
 - c. Has a good reputation both for collaboration and past performance in policy tasks.

In securing the full participation of such actors it will be important for the reform driver to consider a range of motivating factors including allowing them to play a role in the reform development, paying for their participation and managing an open and fair process

6. Reform drivers will need to ascertain whether existing processes will allow the necessary engagement with other actors or whether other processes will need to be created. Options available include the development of committees or working groups, the hiring of staff or the employing of technical assistants. Where high-level skills are needed for a short period then committees or working groups may be more useful. Where lower level skills are required and it is important to strengthen capacity within institutions then it may be important to hire new staff.
7. The reform driver must consider how to undermine competing versions of reform. This can be done by weakening the power of those driving that reform stream and/or by undermining its technical worth. Strategies include:
 - a. trying to split the opposing team on contentious issues to reduce their power;
 - b. choosing to fight the opposition in an arena where the reform driver, or representative, has more power;
 - c. undermining the technical standing and desirability of the opposing reform by highlighting its weaknesses.
8. When faced with likely opposition from other actors a reform driver should avoid contact with them or at least limit engagement to a minimum. Where forced to deal with them other strategies are to:
 - a. limit the sharing of information;
 - b. try to get agreement on the concepts or values of reform before discussing detail;
 - c. make sure that the technical arguments for, and design of, the reform is sound;
 - d. be prepared to negotiate away peripheral areas of the reform to secure buy in.

9. The reform driver should periodically reflect on the progress of the reform process and see whether he or she can learn from the reform experience, whether about the characteristics of actors or a changing context, and reflect on whether the reform development strategy needs to change.

The studies that have previously explored similar issues to this thesis in relation to managing health reform and opposition have looked at a range of topics that includes the timing of reform, the responsibilities of government, the need for coalitions and strategies for undermining opposition to health reform. This thesis makes a significant contribution to this literature in two main areas:

- its analysis of reform teams and coalitions, specifically with respect to their composition and the different forms of motivation for team actors;
- its analysis of the characteristics of reform drivers and actors, and how they influence relationships and the success of health financing reform.

Overall, this thesis suggests that an awareness of actor characteristics can help a reform driver better manage reform development, through building teams, to achieve the desired change.

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Annex 1: SAZA Phase 2 questions of relevance

Managing Stakeholders by NDoH

- Outside of the NDoH, who do you involve in developing or implementing policy?
- How do you involve them? Committee, informal consultation, telephone conversation, presentation?
- What makes this joint work successful? What attributes do outsiders bring?
- Where are their problems? What problems do they bring?
- When developing or implementing policy how do you deal with other actors who do not share your vision or goals? (Such as: The private sector (including Medical Aid Schemes); Provider Groups; Trade Unions and Department of Finance)
- What type of collaboration is useful with these “problem” groups? What are the strengths and weaknesses of collaboration?
- When do things start to go wrong?
- In your view what strategies can be used to manage “problem” groups?
- Under what conditions is it important not to collaborate with “problem” groups? In your experience, what is the upshot of not collaborating with “problem” groups?

Provincial budget politics and processes – for health officials [*aim = details of the politics and strategies of budget negotiations*]

- Describe negotiation process around health budget, especially with provincial treasury and any interaction with other provincial departments [Who is main person/people within it that affect resource allocations? And that PDOH deals with in relation to resource allocations? Who is main people/person in PDOH that deals with Treasury over resource allocations?];
- What information is given out to key actors involved in the process at the different stages of the process – by whom and when? Is it adequate? In what way? Is it timely? Why not? (perhaps focus on last year of process).
- What are the expectations of key actors in this process? Are they met? How/why not?
- To what extent does provincial cabinet/EXCO impact on final allocations relative to provincial treasury;

- How characterise role of MEC finance, Treasury in relation to resource allocation issues in your province?
- What principles does Treasury explicitly/implicitly use in making resource allocations?
- How characterise PDOH relationship with Treasury? Has this changed over time? (why?)
- From your perspective, what are the strengths and weaknesses of Treasury?
- How closely can you work with them? Can you trust them? Why/Why not?
- How would you describe the strategies the PDOH applies in negotiating with Treasury over resource allocations? How well-thought through are they? Have they changed over time? (why?) etc etc
- Tactically what is the best way to get the budget that you need?
- What shouldn't you do in budget negotiations?
- Does the PDOH work with other departments in any way during the budget negotiations? Who? Why? Why not? How useful or not?

Provincial budget politics and processes – for treasury officials [*aim = details of the politics and strategies of budget negotiations*]

- Describe the negotiation process around health budget, especially concerning the treasury/PDOH interactions: Who is main person/people involved on all sides? What are their roles? What are the expectations of key actors in this process? Are they met? How/why not?
- What information is given out to key actors involved in the process at the different stages of the process – by whom and when? Is it adequate? In what way? Is it timely? Why not? (perhaps focus on last year of process)
- To what extent does provincial cabinet/EXCO impact on final allocations?
- How characterise role of MEC health, PDOH in relation to resource allocation issues in your province?
- How characterise Treasury relationship with PDOH? Has this changed over time? (why?)
- From your perspective, what are the strengths and weaknesses of PDOH?
- How closely can you work with them? Can you trust them? Why/Why not?
- How do they rate in comparison with other Departments?

- How do you manage competing claims from different Departments?
- How would you describe the strategies the Treasury applies in negotiating with sectors such as PDOH over resource allocations? How well-thought through are they? Have they changed over time? (why?) etc etc
- How does PDOH approach to process compare with that of other sectors? Has it changed over time? Why?

MTEF [*aim = clearer understanding of effects of MTEF on budgeting/planning*]

- Are there changes to the provincial/national health budget during the year & if so why?
- Are there major changes in MTEF provincial/national projections between years/ is the MTEF meeting the objective of creating a more stable medium-term planning and budgeting environment & explanation;
- Now that MTEF has been operating for a few years and initial difficulties being resolved, is the MTEF serving to improve the link between planning and budgeting? (why/why not?)

Internal PDOH budgeting capacity [*aim = clearer understanding of capacity constraints on turning financial into real resource allocations*] (note might be to able to specify further given information from Women's budget and NHA?)

- Describe the annual process of PDOH recurrent and capital budgeting, identifying who the key actors are, what they do and what the key timelines in the process are
- What are the expectations of key actors in this process? Are they met? How/why not?
- What role do programme managers, regional managers, district managers play? What are the key factors aiding/hindering their involvement?
- Do lower levels health managers get involved? Why and in what way? (why not?)
- What information is given out to key actors involved in the process at the different stages of the process – by whom and when? Is it adequate? In what way? Is it timely? Why not? (perhaps focus on last year of process)
- How does the PDOH budgeting process link to the provincial MTEF process?
- How do the recurrent and capital budgeting processes link to the process of planning activities within provinces?

- What are the difficulties of linking the budgeting and planning? How have then/can they be addressed?
- How will the Public Finance Management Act and Civil Service Act impact on provincial health departments? Will aid/hinder attempts to link plans and budgets?

4x4 functioning [*aim = clarification of role and functioning of 4x4 from technical and process perspectives*]

- what is its role and what issues does it focus on;
- how does it do its work?
- Is there generally co-operation or tension? Why?
- Who are the more/less dominant members and why?
- review most recent MTEF/budget process – what were the major issues considered by 4x4;
- in what way and how (through what mechanisms) does it impact on health sector budget allocations;
- what authority does it have? (give examples)
- to whom does it report? who acts on its decisions? what are the types of decisions it makes? Who takes forward those decisions? how are its decisions ‘enforced’?
- if focus of 4x4 given as largely efficiency (technical and allocative efficiency), explore if equity issues (inter- and intra-provincial) are ever raised (with details) and whether equity could/ should be one of its concerns.
- what information does it use?(who provides?) how useful is that information seen to be? why not use other available information?
- how does the health 4x4 compare in terms of impacts to other sectoral 4x4s?
- does the health 4x4 give any consideration to the DoF formula for the horizontal division of revenue (health component and overall formula)?
- what are the 4x4’s views on the latest FFC proposals for a costed norms approach to the horizontal division of revenue?

PHRC/MINMEC functioning [*aim = clarification of role and functioning of bodies from technical and process perspectives*]

(get examples from recent discussions/debates wherever possible)

- how frequently are health financing issues raised within it?

- what are the types of decisions it makes in relation to financing issues?
- what are the types of concerns raised in relation to financing issues?
- what's the relative weight of efficiency and equity concerns?
- who sets the agenda and who raises financing issues when they come up?
- what authority does it have? who acts on its decisions concerning financing matters? who takes forward those decisions? how are those decisions 'enforced'?
- what technical back-up does it receive from whom on financing matters?
- what information does it use for financing discussions?(who provides?) how useful is that information seen to be? why not use other available information?
- who are the more/less dominant members and why? are they also dominant on financing matters?
- what level of cooperation is generally shown through it? why is there cooperation? is there any difference in relation to financing matters? Why?
- is there generally tension within it? why? over what? is there any difference in relation to financing matters? Why?
- how efficient is it? what sorts of problems does it face in doing its work? how have they been addressed in the past/could then be addressed in the future?
- How has its role/functioning changed over time? Why? why did such changes come about?
- Has the appointment of the new Minister affected its functioning? How?
- Have such changes improved/weakened its ability to address financing issues? in what way?
- does the PHRC and/or Minmec give any consideration to the DoF formula for the horizontal division of revenue (health component and overall formula)? If yes, have they considered specific strategies for attempting to influence the formula?
- what are the PHRC's and/or Minmec's views on the latest FFC proposals for a costed norms approach to the horizontal division of revenue?

Factors affecting role and influence of health economics advice [*aim = explanations of continuing lowly influence*]

- What importance is given to what health financing issues by Minister, MECs, NDOH DG, CDs in NDOH, PDOH DGs? What influences how important financing issues are seen to be by these various actors?

