



*Designing and Implementing  
Health Financing Reform*

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## Introduction

### Issues in the Process of Health Financing Reform

To confront scarcity of resources and inefficiency in resource use, major changes have been introduced into public health systems across sub-Saharan Africa over the past 20 years. Important changes in health care financing mechanisms have included resource mobilization measures, such as the introduction or increase of user fees, and resource allocation mechanisms. Few countries have evaluated the consequences of such changes on health system performance. Despite the fact that reforms sometimes have led to negative equity impacts, there is only limited understanding of what factors influence the final impacts of such reforms. This paper summarizes the findings of a two-country study that analyzed the factors facilitating or constraining the contributions of financing policy change to the broad performance goals of equity and health system sustainability. The study was undertaken in South Africa and Zambia and focused on experience after the countries' political transitions in the early 1990s. In Zambia, political change involved the return to multi-party politics, and in South Africa, the removal of the apartheid regime through democratic elections.

The study's analysis was path-breaking in its focus. It considered not only what health care financing changes were introduced in these countries, but **why** and **how** such changes were developed and implemented and how these processes of policy change interacted with and shaped the impacts achieved, and vice versa. It provided detailed analysis of experiences in two countries that

have been held up in international health policy debates as reform leaders. In particular, it considered:

- ▲ who was involved in the process of reform
- ▲ how contextual factors shaped the interests of these actors as well as the design of particular policies
- ▲ how policy design affected actors' roles in policy change
- ▲ what were the strengths and the weaknesses of the processes used to initiate, develop and implement reforms.

Based on such analysis, the study's conclusions and recommendations offer important lessons for other low- and middle-income countries seeking to strengthen their approaches to implementing health care financing change.

This briefing paper is aimed at policymakers and analysts who would like a flavor of the study findings. It reflects the key findings of two years of in-country study, including extensive interviews with key players, document review, and media analysis. The paper first provides a brief review of the specific financing reforms assessed and their impact on equity and sustainability. It then outlines in more detail the factors explaining the patterns of policy change and their impacts, which leads to conclusions about how to strengthen processes of policy change. The bibliography provides a complete list of the series of reports upon which this paper is based.

### Overview of Financing Reforms and Their Impacts

In both South Africa and Zambia, health care financing changes occurred within the broader programs of health system reform that were introduced during the 1990s to improve the equity and efficiency of health care delivery. Table 1 outlines the health care financing reforms that were considered in each country as well as the parallel, institutional reforms that were implemented.

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*In the past 20 years, many countries have implemented health financing reform, but few have evaluated the consequences of change on health system performance.*

Table 1: Reforms of Focus

Type of reform	Specific Reforms	
	Zambia (1991-1999)	South Africa (1994-1999)
<b>Resource Mobilization</b>	Introduction/expansion of user fees	Removal of user fees for pregnant and nursing women and children under six and for primary care
	Development of exemption policy	Restructuring of public hospital fees
	Introduction of prepayment scheme	Development of proposals for social health insurance
<b>Resource Allocation</b>	Development and implementation of interdistrict resource reallocation formulae	Development and implementation of inter-provincial resource reallocation formulae
	Budgetary decentralization to district and hospital boards	Budget reform to reallocate resources between levels of care
	Budget reform throughout government leading to global budgets for provinces	
<b>Parallel, Institutional Reforms</b>	Creation of the Central Board of Health (CBOH) as implementation arm of the Ministry of Health	Creation of provinces within a semi-federal state
	Increased autonomy to public referral hospitals and the establishment of hospital boards	Proposals to strengthen public hospital management
	Strengthening of the district health system with formal autonomous boards	Development of district health system

The broad success of the South African health care financing reforms of 1994-99 was in the reformers' ability to make strong and early moves towards reorienting service provision from the needs of more affluent groups towards those of the population at large. This was achieved mainly through the provision of free primary health care services, which promoted increased utilization, particularly of curative services. In addition, the early moves to reallocate the public budget towards previously under-resourced provinces reflected the clear policy intent to promote geographical equity. The free care policies also generated substantial public support for the new government because they were seen as signaling its commitment to the previously disadvantaged population.

However, these considerable achievements went hand in hand with increased instability in certain aspects of the health system. The free care policies had negative impacts both on provider morale and perceived quality of care. Efforts to reallocate resources towards under-resourced areas and

the primary health care level were accompanied by a perceived deterioration in the quality of public hospital care. These by-products of reform have made the task of further reducing inequities more difficult. In addition, the initial resource reallocation within the health sector to semiautonomous provincial governments occurred so quickly that provinces were not able to effectively absorb budget losses or gains. As a result, the real resource reallocations across provinces promoted by the policy were less than the budgetary reallocations. More importantly, initial moves towards the equitable allocation of budgets by the Department of Health were jeopardized by a government-wide shift towards allocating global budgets to provinces under a system of fiscal federalism in 1996. There are clear signs that budget allocations to the health sector in some relatively under-resourced areas have since been cut back, while allocations to some of the more wealthy provinces have increased.

While policies on the development of a social health insurance scheme were the subject of intense debate

in South Africa, by 1999 there had been no progress on implementing such a scheme.

Like South Africa, the notable successes of health care financing policies in Zambia included both equity and efficiency gains. The use of a resource allocation formula providing budgets to district health management bodies and the deliberate shifting of resources from the tertiary level to the more cost-effective primary health care level resulted in these gains. In addition, by introducing user charges and promoting a culture of paying for services, cost sharing encouraged a strong concern for the quality of health care among the population, which may provide a foundation for demanding greater accountability from the health system. The broader program of

decentralization, moreover, strengthened financial management and planning capacity at the district level.

In contrast, however, a wide range of studies suggest that the introduction of cost sharing in Zambia resulted in equity losses by reducing access to health care services, as reflected in declining utilization levels (although some data suggest that utilization rates may have stabilized over time in some places). The exemption policy, which exempted specific categories of patients and waived fees for certain priority services, seems to have been more successful in promoting demographic equity than in protecting access to health care for the poor.

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## *Explaining the Patterns of Policy Change and Impacts*

### *Context and Policy Change*

Contextual factors can directly influence the scope and design of policies as well as actors' interests and roles within policy decision-making processes. Political factors, in particular, can affect the timing and pace of policy implementation, providing windows of opportunity to move policy change forward but also making successful implementation more difficult. In both South Africa, where there was a dramatic shift from apartheid to democratic rule, and Zambia, where one-party rule for two decades was replaced by a multiparty democracy, political transitions were key. Such transition brought support for speedy health policy change in recognition of the significance of health problems and the important, and very visible, role of health care in people's lives. Political change provided the opportunity for radical health policy change, such as the rapid devolution of authority over health sector issues to the district level or the South African removal of primary care user fees. Yet, as one Zambian health official noted, *"the political momentum often outstripped the technocratic."* In other words, political transition created a demand for speedy change and an environment in which it was difficult to implement coherent and careful policy action.

The broader organizational and economic changes of government reform programs can exercise significant

influence over health system reforms. For example, in South Africa, the authority of the Department of Health to increase equity in health budget allocations was undermined by broader administrative decentralization and the introduction of global budgets to the provinces. In Zambia, the limited availability of government resources placed a tight constraint on health system development, and growing levels of impoverishment contributed to reductions in utilization following the implementation of user fees. In South Africa, health care financing was shaped by a macroeconomic policy framework containing public spending and taxation levels, thereby placing further budgetary constraints on the health sector.

### *The Central Influence of Actors*

The role of specific actors during the health sector reform process was definitive in the sweeping health financing policy changes of cost sharing in Zambia and the provision of subsidized primary health care services in South Africa. In both countries, ministers of health were key players, but a range of other actors played varying roles.

*Ministers of health* are inevitably powerful within policymaking by virtue of their formal positions. This power is, however, strengthened when charismatic and tactical personalities fill the post, during

times of political transition when other actors have relatively weak positions, and when there is broad political support for the policies they promote. In each country, the ministers of health played critical, often dominant, roles across all areas of health care financing policy development. In South Africa, Dr. Zuma, the National Minister of Health throughout the first term of government, was instrumental in ensuring that free care policies were implemented, and she was very supportive of the health resource allocation formula. At the same time, her broad opposition to other proposals was a critical factor in preventing their implementation. In Zambia, meanwhile, Dr. Kalumba, the Deputy Minister then Minister of Health, was widely accredited as the architect of the overall health reform program and was supportive of both resource reallocation and cost sharing.

However, as noted in Zambia, “*the effectiveness with which [the Minister of Health] could sell a policy was influenced by the political strength [he or she] held*” (interview data). The effectiveness of ministers of health in garnering support for their respective policies was linked to the political (and sometimes personal) support of key political leaders, as well as personal characteristics. Dr. Kalumba was seen as a visionary and charismatic leader, and Dr. Zuma was said to command respect among her colleagues. In each country, moreover, health reforms were seen as spearheading broader governmental reforms efforts in a new political era.

**Economic policymakers** directly influenced health ministry policies, and tended to support changes that were congruent with their own interests. In Zambia, the Ministry of Finance and Economic Development enabled financing policy changes, though its involvement was limited by its own capacity. In contrast, the South African Department of Finance successfully opposed several reform proposals on the grounds that they would undermine efforts to promote fiscal prudence. Its influence stemmed partly from its relatively greater technical capacity in the financing area compared to that available within the Department of Health.

**Health managers and technicians** played a role in health financing policy development in both countries, though they perhaps wielded more influence in Zambia. Officials from the Zambian Ministry of Health (MOH) Planning Unit were consistently involved in policy debates. In both South Africa and Zambia



however, health sector technicians have been partly constrained by their small numbers and limited expertise in health economics. This weakness in technical capacity further contributed to ministerial influence.

**Health economists** from outside of government were drawn into the policymaking process because of limited internal technical capacity. In Zambia, expatriate economists and economists from the University of Zambia provided technical assistance while in South Africa, technicians from national research groups and one or two expatriate analysts played such a role. In neither case, however, did this group appear to have much immediate influence over policy development.

**Nongovernmental actors** exerting significant influence upon policy development included trade unions and the private insurance industry in South Africa, and churches and international donors in Zambia. In South Africa, trade unions expressed caution about the details of specific social health insurance proposals. Meanwhile, the private insurance industry pursued its commercial interests on the social health insurance agenda using a dual strategy of direct participation and informal lobbying throughout the

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policy process. In Zambia, it was the Church Medical Association of Zambia, an umbrella body acting on behalf of church health institutions, that was directly involved in policy development. At the same time, international financial institutions through advocating certain macro-economic policies provided support for specific health care financing policies, such as user fees, and had significant influence on policy debates.

### Engaging Actors in Developing Policy Options

The influence of various actors over policy debates may be shaped by the way in which they are brought into policy development. Although in both countries some attention was given to the need for alliances in support of change, reformers did not fully think through how interest groups should be involved in the process, which interest groups would support reforms, which would oppose, and how best to co-opt support or offset opposition.

In South Africa, for example, three different committees were established over time to address health financing policy. Despite the minister's publicly stated concerns about the private sector, the private insurance industry representative body was deliberately invited to participate in two of the groups. In contrast, the trade union movement and the Department of Finance only participated directly in one. Perhaps the most critical factor shaping the effectiveness of all committees was the lack of interaction with the minister. Although senior advisers reported the committees' deliberations to the

minister, these special committees were divorced from routine decision-making processes. The minister never met with the committees themselves despite their requests for such interaction. This lack of interaction undermined the functioning of all committees and, in the end, only those aspects of the committees' recommendations that fitted the minister's own policy preferences – specifically, free primary care – were taken forward into policy action.

In Zambia, the Health Care Financing Working Group was established to draw external analysts into the process of policy development. During the period 1994-96, the effectiveness of the group in influencing policy was sorely limited by its distance from the minister of the time. After Dr. Kalumba was appointed minister in 1997, the working group was reconstituted and reactivated to oversee the process of developing the official health financing policy. Although at this point it received strong political support, it still faced operational problems. A core problem throughout its life was that its role was not clearly identified, and more recently its relationship to the MOH and CBOH has been unclear. The fact that it did not have a specific role within the newly defined organizational structures meant that it was easier for policymakers to bypass the group, if they chose to do so, even though it was consistently the main repository of health economists and financing skills in the country. In addition, by the late 1990s there were several other groups working on specific aspects of health financing policy development whose relationship to the working group was not clearly defined.

The weakness of efforts to engage all stakeholders in the South African policy debate was exacerbated by the failure to develop an adequately strong alliance of reformers with political influence in support of reform proposals. For example, although most reform proposals reflected the consideration of political acceptability, there was little systematic analysis of stakeholder views as an input into social health insurance policy development. This shortcoming can be perceived as a failure of senior policymakers to provide adequate guidance, and also points to a critical weakness on the part of analysts, who “*concentrated on policy and forgot the power and the politics*” (policy analyst).

In Zambia, such matters of strategy concerning actors were less clearly identified as an important feature of resource mobilization policy development. A key

reason seems likely to have been the general support among a range of actors, including the Ministry of Finance, for the main thrust of the Zambian health reforms. Political support for the chosen policy options was already in place.

However, reformers failed to identify interest groups that would likely oppose, block, or delay reforms. One key group who were potential losers from Zambia's financing reforms were hospital consultants and managers. Reformers did little to appease this group and probably exacerbated tensions and opposition by endowing the younger, reform implementation team with visible perks and rewards while the older and more established hospital consultants received no improvement in their terms and conditions of service. While the influence of the hospital group waxed and waned with ministerial changes, they were able to help delay and obstruct certain specific policy elements.

In both countries, resource allocation policies were developed and implemented through the structures routinely involved in budgeting processes. However, neither country had an internal government structure through which new ideas on resource mobilization policy could be developed easily, and the internal government capacity to undertake such analysis was limited.

## Strategies of Policy Implementation

A number of different themes concerning the policy implementation process emerged from the study:

### *Overarching Policy Development*

A critical element of the Zambian health reform experience was the establishment of a vision, captured in key policy documents issued during the early years of the new government. These documents provided a guide to action and a source of inspiration to many of those involved in the reforms. Although the vision was strong initially, the Zambian reformers encountered problems over time in translating the vision into reality – particularly in relation to health care financing. As implementation progressed, so did the number of policy agendas that needed to be debated and agreed. Frequently, there were not enough knowledgeable people to carry forward all the policy agendas at any one time. Policies that gained precedence were not necessarily those that addressed areas commonly seen to be the highest

priority. Rather, choosing policies was probably influenced by donor support and financing, as well as the presence of individuals with both the technical skills and the interest to take policy development forward.

In South Africa, by contrast, the overall vision guiding reforms was less clear – and the development of an official health policy document was a slow process. This may have encouraged a rather piecemeal approach to policy implementation.

### *Central Capacity and Leadership*

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

### *Consultation and Communication*

In Zambia the health sector decision-making process in the 1990s was consultative, with input solicited from the central level, districts, provinces, hospitals, and other interest groups. Although the extent of consultation was generally quite wide, in some cases (such as the introduction of hospital prepayment) the intended processes of consultation were overridden by ministerial action. In South Africa there was much less consultation. As a result, health workers expressed great discontent with the free care policies, which they perceived had been implemented without consultation or preparation and which, ultimately, contributed to an overall problem of poor morale.

But perhaps the greater barrier to the effective implementation of reforms in both countries was the process of communication. For example, the lack of effective communication with health care workers and the general public regarding the reform program in general and financing policies in particular was perceived by many to be a problem in Zambia. There was no overarching communication strategy, and the

MOH and CBOH used ad hoc approaches to inform health staff about policy changes. Consequently it appeared that many of the public identified user fees as the key component of health sector reform and were unaware of the many important organizational changes undertaken by the MOH.

### *Preparing for Policy Implementation*

In general those reforms that were a more integral part of the routine policy process were better prepared for, and consequently better implemented. Reform of resource allocation formulae was better integrated into routine government budgeting procedures than resource mobilization reforms, which tended to be the result of unique actions unlikely to be repeated. User fee policy in Zambia was promulgated through a series of circulars without there being a clear overarching policy in place. There was inadequate preparation for management of cost-sharing revenues and for exemptions based upon income level. In contrast, the implementation of new resource allocation formulae followed a rational sequence of events that facilitated implementation.

The experience in South Africa was broadly similar in the sense that changes in resource allocation policies were effected through routine policymaking channels whereas policy on resource mobilization resulted from separate parallel processes. However, there was clearly inadequate preparation for implementing both types of policy. For example, no proper analysis of the risks involved in the free care policies was undertaken, nor was there any assessment of the adequacy of available capacity to provide services, nor were implementation guidelines provided.

### *Monitoring and Evaluation*

Financing reforms in Zambia appear to have been subjected to greater evaluation than the reforms in South Africa. In both countries, however, evaluations were constrained by inadequate data. In Zambia there was initially no proper system of monitoring of the new resource allocation mechanism but from 1995 there were substantial efforts to correct this omission. The monitoring systems put into place,

however, were hampered by the politically sensitive nature of the information.

In both countries evaluation reports have frequently been ignored or not fully considered by policymakers. The policy impact of evaluations is clearly linked to the timing of the evaluation and whether or not recommendations are in line with policymakers' interests.

### *The Broad Influence of Policy Design*

The design details of the respective financing policies of both countries directly influenced the level and pattern of their impacts.

Similar patterns emerge across countries around the certainties and confusions over the policy objectives of different types of reforms. Both in Zambia and South Africa, health sector resource allocation mechanisms were clearly implemented to promote equity, in terms of the geographical distribution of resources, with some concern for allocative efficiency. In contrast, the objectives of the different resource mobilization policies of the two countries were much less clear and, at times, appeared contradictory. For example, potential objectives for cost-sharing policy identified at a Zambian working group meeting in mid-1994 included raising revenue, promoting efficiency, fostering equity, and creating partnership. This lack of consensus on the objective contributed to lack of clarity in policy implementation.

Similarly, a diverse range of objectives was associated with the various South African social health insurance proposals developed over the 1994-99 period. Although concern for equity appears frequently in documentation, the exact nature of the equity goal was seldom defined, and the beneficiaries of improved services often remained unclear. Over time, sustainability, in the form of revenue generation, appears to have become a more fundamental objective underlying the proposals. By not initially formulating clear objectives, it became impossible to systematically assess whether the changing design proposals could still achieve stated policy goals.

Policy objectives and policy design also influence whether or not actors will support or oppose proposed policy changes. The changing nature of the South African social health insurance policy

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*Promoting equity and sustainability of health system is not only a function of better policies but of better policymaking.*

objectives reflected the way policy design evolved to tackle the Department of Finance's concerns; however, the adaptations made to policy design to address department concerns meant that the concerns of other actors were ignored or exacerbated.

In each country the impacts of policy change were influenced by the extent to which financing reforms were linked to one another, or seen as a combined package and linked with other policies necessary to support their implementation. For example in Zambia, there were weak links between individual resource mobilization policies: cost-sharing policies were implemented without establishing an effective exemption mechanism for the indigent, and a mismatch between prepayment premium levels and existing fee levels created perverse incentives for bypassing primary care facilities. In South Africa the benefits of free care policies on utilization and equity were compromised by slow-moving implementation of policies supporting primary health care. Geographic barriers, for example, continued to limit the improvements in access resulting from the removal of financial barriers.

Organizational reforms play a critical role in strengthening capacity to implement financing policy changes and vice versa. In Zambia, the 1994 decision to allocate government funds directly to districts was an essential component of the decentralization strategy, backing the intention to decentralize roles and responsibilities with resources. At the same time, the program of decentralization led to significant strengthening of district-level capacity to manage the newly available resources. In South Africa, too, the allocation of resources to provinces was a critical element of the decentralization of implementation authority and responsibility to this tier of government. However, the delay in developing approaches to protect equity in health resource allocations between provinces in the new fiscal federal context helps to explain the reversal of some of the initial equity gains since 1996. In this instance organizational reform was not matched by the necessary development of health care financing policies, specifically the development of norms and standards to influence provincial budget allocations between sectors.

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## *Strengthening Health Care Financing Policy Change*

The experiences presented above suggest that promoting the equity and sustainability of health systems is not simply a function of better policies, but rather requires better policymaking. Below are 10 principles intended to strengthen the process of health care financing policy change by encouraging new financing policies to be translated into service delivery improvements.

### *1. Make Financing Policy Change Integral to Health System Development*

Broad packages of health sector reform are now being promoted internationally. Such packages recognize that wide-ranging change is required to tackle deep-rooted, systemic problems. Such change can, in turn, only be implemented through a coherent policy package that is rooted in clearly articulated policy goals and that builds links between individual financing reforms and organizational change. Financing reforms are of particular importance

within such a package because financing mechanisms create incentives that have a wide-ranging influence over the provision of health care. They specifically influence the degree of effective decentralization, health provider behavior, and the level and pattern of demand for different types of health care.

Equally important is the fact that financing reforms, particularly resource mobilization policy changes, are often the public face of any health sector reform program and, therefore, impact on popular perceptions of that program. Giving attention to the wide-ranging influence of financing flows and financial incentives does not mean, however, that they should be the only focus of efforts to improve health system performance. Rather, this allows consideration of how to support broader systemic change through financing change and how to ensure that financial flows and incentives encourage desirable directions in health care provision.



## 2. Pay Attention to the “Art” of Politics

Health care financing reform has often been seen as the preserve of the few with relevant technical knowledge. As a result, it has frequently floundered because too little attention has been paid to the political, personality, and strategic factors that always shape policy change. In both South Africa and Zambia, technicians generally had less influence than politicians over policy design and implementation practice. The strategies of policy development and implementation also shaped the details of policy design as well as which policies were implemented and which were not, and the impacts of policies on equity and sustainability.

Therefore, to achieve their objectives, technicians and analysts often have to do more than just technical analysis to make an effective contribution to the policy process. In paying attention to the “art” of politics, various issues are important to consider, including the value of strategy and tactics in promoting policy change (see principle 5). The first step in considering how to influence policy development is for those seeking policy change to understand the relative power and values of the major groups interested in change. The next step is to develop strategies that recognize the power and values. For example, where

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

Reformers must also pay attention to the way in which they communicate policy goals and design matters, especially in relation to complex policies such as prepayment or social health insurance (see also principle 7). A policy that cannot be expressed simply and clearly will be difficult to sell. Presenting policies simply and clearly is also important in promoting public debate about societal goals and their pursuit through health care systems. As reforms evolve, they also have to respond to different sets of concerns: first focusing on the major thrust of policies to justify them in terms of meeting health sector needs and matching the political agenda, next judging the feasibility of policies against technical criteria and actor concerns, and finally, presenting and debating the details of policy and appropriate methods of implementation. Thinking through what information to present and when is an important strategy in developing reform (see also principle 9).

## 3. Use a Balanced Mix of Open and Closed Policy Processes

In both countries, financing reforms were largely developed either by politicians acting behind closed doors or by technicians sitting behind closed doors. Although there was interaction with some interest groups in some of the processes (particularly in Zambia), wider, public debate – in the media, or with a broad range of interest groups, such as front-line health care workers and the public – was

Table 2: **Ten Principles of Health Financing Policy Reform**

Principle	Description
<b>1. Make financing policy change an integral part of health system development</b>	Financing reforms should be part of a coherent policy package rooted in clearly articulated policy goals and linked to organizational change. They should also support broad systemic change and ensure that financial flows and incentives encourage desirable directions in health care provision.
<b>2. Pay attention to the “art” of politics (rather than just the “science” of technical analysis)</b>	In addition to providing technical analysis, reformers should consider: ways to communicate policy goals and proposals simply and clearly, the political agenda, strategies and tactics, the power and values of interested parties, and responses to the concerns of interested parties.
<b>3. Use a balanced mix of open and closed policy processes</b>	Open processes allow focused public debate about fundamental issues such as underlying values of policies, balancing trade-offs and societal goals. Closed processes can identify policy options based on publicly debated goals, and can also offset the power of vested interests.
<b>4. Develop wide-ranging strategies of information gathering</b>	Policymakers should consider the experiences of their own and other countries, new ideas being debated, and ideas from people other than analysts. Possible information sources include department inquiries, think tank reports, judicial reviews, legislative reports, commissioned research, informal discussions or advice from advisors or experts.
<b>5. Apply strategy and tactics</b>	Once the position, concerns and political power of potential allies and opponents are identified, strategies and tactics can build support, respond to concerns, or offset influences. Though structures may be in place to include government actors, special committees can engage nongovernment actors to expand the range of options and increase buy-in.
<b>6. Balance strong political leadership with effective technical capacity</b>	Though good leadership can help garner support for policy action, it should be balanced with technical inputs. Structures should be established to feed economic analysis into the policymaking process and long-term strategies of capacity development can help ensure the optimal participation of health economists.
<b>7. Establish clear roles for all technicians and analysts</b>	The role of technicians inside government is relatively clear: to inform and guide policy development in pursuit of government objectives. The role of technicians outside of government, however, may be different, as they may have more time to review, analyze, and categorize information, and have a longer-term view of needs. Whether they should be deeply involved in or disengaged from the policy process should be determined at the outset.
<b>8. Take account of implementation needs in policy development</b>	Implementation requires the involvement of committed and skillful implementers, clear and consistent objectives, a clear understanding of how policy will create change, and the adequate support of interest groups and government. In particular, structures to motivate effective implementation (e.g., guidelines, etc.) should be identified.
<b>9. Enable further change through the approach to implementation</b>	Implementation strategies should enable continued change rather than generate obstacles. Some strategies include prioritizing policy actions, working towards complex reforms in stages, clearly defining responsibilities of government institutions, developing communication process supporting implementation, applying flexible approaches, and developing capacity.
<b>10. Put monitoring and evaluation at the center of implementation</b>	Well-functioning monitoring and evaluation systems are essential, providing data that allow policies to be improved over time. They should support implementation and allow both the assessment of progress towards objectives and factors influencing progress achieved.

very limited. While speedy changes were seen as necessary, they also produced some unexpected, and perhaps unwanted results. This was true in the cases of the initial free care and resource allocation policies in South Africa and the hospital prepayment scheme in Zambia. In general, a combination of open and closed processes is likely to be important in generating sound and acceptable proposals for policy change. Open processes can have a particular role in allowing focused debate about fundamental issues, such as incorporating the values and goals that underlie health policy into system design, balancing trade-offs in policy design to pursue values like equity, or determining how health care systems can allow both personal and societal goals to be achieved.

Closed processes, in contrast, may be useful in identifying policy options on the basis of publicly debated goals, as an input into further public debate, or in developing detailed design proposals in relation to specified options. Closed processes may also have value as part of a strategy to offset the power of specific vested interests. In developing any policy there will always be a point at which debate must turn into action if change is to be implemented. In pursuing its

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*"Particularly in the absence of strong technical inputs, ministers had significant direct influence over policy development."*



broad mandate, a government must ultimately take responsibility for ensuring implementation of its preferred policy proposals (or for allowing and accepting no action). At this point, a government will need to strategize around how to include different actors, and such strategy should be developed with awareness of the interests each actor is likely to pursue and his or her potential support or opposition for specific lines of policy or proposals (see also principle 5).

#### 4. Develop Wide-ranging Strategies of Information Gathering

Although policymaking is ultimately a political act, policy development can be informed, shaped, and strengthened by information. Yet both countries had only limited data available with which to shape decisions and made limited attempts to generate relevant information.

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

For policy development, governments can draw on various governmental and external and formal and informal sources of information. These include department inquiries, think tank reports, judicial reviews, legislative report, commissioned research, informal discussions, or advice and consultation for advisors and experts.

#### 5. Apply Strategy and Tactics

Whether and how actors are involved in health financing reform is almost always a critical determinant of the outcome of any reform. The strategies used in South Africa to engage the national Department of Finance, trade unions, and the private insurance industry failed to build adequate support for the further development of social health insurance

proposals. Similarly, the Zambian reformers failed to offset the concerns of hospital professionals, allowing them to become the natural opponents of many changes.

Thinking through the strategy and tactics to be applied in implementing policy change is a critical step in recognizing the art of politics (principle 2). When and which particular strategies of engagement should be used will depend on different actors' potential to influence policy development and the sources of this influence, the character of policy supporters and opponents, the broader ethos of policymaking, and the stage of policy development.

Knowing who has what level of influence helps to prioritize which actors should be considered most carefully in the process of policy development. Understanding their sources of influence may prove useful in shaping strategies to offset their influence or gain their support. Such analysis might, for example, have pointed to the need for a consistent process of active engagement with the South African Department of Finance across all health care financing areas or with the Zambian hospital professionals. Understanding each actor's position and concerns about the reform is a further important input into strategy development, allowing identification of potential allies as well as opponents

Appropriate strategies will, however, differ between actors within and outside government. For example, routine structures usually exist to bring together governmental actors in the budgeting process, whereas structures have to be developed to engage nongovernment actors.

Which actors should be engaged and how may also depend on the configuration of power available to the reformer. Recognizing their lack of technical capacity, the Zambian Ministry of Finance and Economic Development allowed the MOH to move ahead in its reforms. It perceived the health sector's vision of its reform program to be strong enough to support effective implementation. In contrast, the South African Department of Finance not only perceived itself to have greater technical capacity than the Department of Health, but had a clear sense of its goals. It, therefore, was able to block social health insurance policy development. The technicians of both countries were also particularly unsuccessful at creating a pro-reform alliance to offset their own lack of power, except where ministerial

influence led or supported their actions. To engage effectively with other actors, therefore, reformers need to be very aware of their own level and sources of power, and must seek to bring in other actors who can complement them in these respects.

Special processes, such as committees of inquiry, can play important roles in policy development but must be considered carefully as their lack of connection to routine policymaking can be problematic. They can, however, be useful in specific circumstances, such as when the reform is outside government's routine administrative tasks or beyond government's own technical capacity. Other appropriate tasks for such committees are to expand the range of options, increase interest group representation and buy-in, or demonstrate government consultation. When groups are powerful and oppose the basic rationale of the reforms, their presence on special policy processes or on high-level decision-making fora may be counterproductive because it gives them too much power to shape or even block reform implementation.

## 6. Balance Strong Political Leadership with Effective Technical Capacity

Strong political leadership was important in initiating wide-ranging policy change in both South Africa and Zambia during the 1990s. In addition, the personal influence of the two countries' various ministers of health sometimes ensured action that was sensitive to the political needs of the moment. However, the limited use of information and technical analysis for policy development undermined priority setting and design development in relation to health care financing policy, and this was sometimes exacerbated by the personalized approach of decision making.

Information and analysis are particularly important, as societal objectives like equity and sustainability may be undermined by policies that are politically attractive but have some undesirable effects. Both the South African free care policies and the Zambian hospital prepayment scheme, for example, had some negative impacts on sustainability. There needs to be closer coordination between policymakers and those groups inside or outside government that can provide necessary analyses.

To provide relevant technical analysis, however, it is necessary to have technical capacity; yet in the

countries examined, capacity, especially in health economics within government, was limited. The capacity problem was not simply a shortage of people with technical skills. Also important was the broader failure to incorporate health economics analysis into policy development, leading to the suboptimal use of the available health economists. This may, in turn, have stemmed from policymakers' limited familiarity with the importance and use of health economics in reform processes.

Although there are no quick or easy solutions to these problems, it is clear that coordinated action must be taken to stimulate both a pull and a push for health economics expertise. Demand might be stimulated by establishing structures that allow economic analysis to be fed routinely to policymakers and into policymaking processes at appropriate times, rather than on the more ad hoc basis seen in each country. At the same time the supply of economists to government and other groups must be supported through formal and in-service training, as well as by drawing economists outside government into providing policy advice through structures like the *Zambian Health Care Financing Working Group* (see principle 7). Balancing political leadership with effective technical capacity inevitably requires long-term and sustained strategies of capacity development.

## 7. Establish Clear Roles for All Technicians and Analysts

One strategy for strengthening health economics capacity used in both countries was to create links between the health economists working inside government and those supportive of government but based outside it. In both South Africa and Zambia, however, the structures created to draw these groups together were undermined by problems, including the varying support of policymakers for their work and the operational functioning of the bodies.

The role of technicians working inside government is relatively clear: They are the government's primary advisors on health care financing issues, seeking to inform and give inputs to relevant policy

development in pursuit of government objectives. These technicians are "inside" both the formal and informal processes of decision making.

The role of analysts outside government is, however, less clear. The differing experiences suggest that the role of the external analysts was determined in a rather ad hoc way with little clarity about the role they were expected to play relative to technicians working within government.

The first step towards resolving this is to clarify the objectives of the external analysts' involvement. Based on the established objectives, the relevant role of these analysts might then be incorporated into terms of reference for contracted or commissioned research, leaving them to decide whether or not to become involved. The objectives and the related roles also might result from a process of dialogue with the analysts. Analysts based outside the government may have the advantage of having more time to review, analyze, and categorize information in ways that are useful for policymakers. Such analysts may also be able to take a longer-term view of needs rather than having to respond to the pressures of daily events and political cycles.

For their part, external analysts need to think through the terms on which they are prepared to be closely involved in policy processes, and the circumstances under which they might prefer to remain outside or disengaged from them. The potential alignment or conflict between their opinions and those of the policymakers is likely to be important in this decision, as well as the need for independent groups to retain their perceived objectivity. To be effective in their role, however, those from outside government cannot maintain too great a distance from the policymaking action. They must engage in current policy problems and issues and understand the operations of, and constraints on, government. Yet they must also learn how to balance the provision of support to government with constructive criticism provided at an appropriate time and in an appropriate manner.

## 8. Take Account of Implementation Needs in Policy Development

Implementation is often seen as a separate step of the overall policy process and one that somehow automatically follows policy formulation. Resource mobilization policies in both countries provide

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*The design of new policies affected the overall level of support for those policies from actors.*

examples of the assumption that implementation is simply a matter of policy proclamation. Even a well-designed policy may not be effectively implemented because guidelines are not concurrently developed to support implementation (as with cost sharing in Zambia). Implementation may also be limited by an initial failure to develop adequate support for it among those responsible for its implementation (as with free care in South Africa).

Any policy process must, therefore, include implementation issues as part of its focus, rather than targeting only the development of a policy. Issues include a clear understanding of how the policy will create change; clear and consistent objectives to evaluate policy change; identification of structures to motivate effective implementation; involvement of committed and skillful implementers; support of interest groups, government, and members of legislatures; and assessment of socioeconomic conditions to avoid unexpected changes.

A critical element of leadership for implementation is, therefore, facilitation. The importance of this leadership style is emphasized within the context of decentralized structures, such as those that exist in South Africa and Zambia, in which implementation is a joint responsibility at national and subnational levels. Leadership for implementation must also specifically enable the involvement of implementers in the design of policies. Again this may be especially important in politically decentralized systems in which implementers have to reconcile national policy decisions with local imperatives. It is also important to acknowledge that health care managers and providers, who are the implementers, have interests and concerns just like other actors and these may differ from those of policymakers and policy designers.

## 9. Enable Further Change through the Approach to Implementation

In South Africa and Zambia, wide-ranging health reforms were initiated in response to a “window of opportunity” for change resulting from political transition. Using such opportunities to further policy change is one element of the leadership required to support implementation. The pace and wide-ranging nature of change during a “window of opportunity” may, however, as it did in South Africa, force mistakes in implementation. Short deadlines tailored



to meet the demands of political cycles may be particularly counterproductive in developing complex reforms that involve the creation of new institutions or new ways of performing tasks, as with social health insurance. They may also encourage policy changes to be implemented without any clear plan for implementation, including developing the necessary capacity, or monitoring, as was the case with cost sharing in Zambia. In both countries, speedy action also prevented adequate consultation and communication with key actors, particularly implementers and the broader population. Although taking advantage of windows of opportunity for change may prevent opposition to reform from gradually becoming entrenched over time, these experiences indicate that taking too much, or too careless, advantage of such windows can bring its own problems. At such moments, it is important to consider the features of an implementation strategy that allow that strategy to enable further change rather than generate obstacles to such change. Such strategies include the following:

- ▲ *Prioritizing policy actions on the basis of clear analysis and understanding* of key health problems, how reforms might address these problems, and what level of political support can be built for a broader reform agenda.
- ▲ *Working towards complex reforms in stages* through the sequencing of individual actions.
- ▲ *Planning for implementation* even while taking advantage of opportunities for initiating change.



- ▲ *Creating a clear division of responsibilities between government institutions.*
- ▲ *Developing a communication process that supports implementation* by informing implementers and the public about the proposed changes and enabling them to feed back into the process of adapting and strengthening reforms.
- ▲ *Applying flexible and gradual implementation approaches* that allow policies to be adapted and strengthened in response to experience.
- ▲ *Developing capacity* through a gradual implementation process that allows the necessary skills and systems to be developed during implementation.

## 10. Put Monitoring and Evaluation at the Center of Implementation

Well-functioning monitoring and evaluation systems are essential for any health financing reform, providing data that allow policies to be improved over time and thereby strengthening their potential to meet their goals. The absence of monitoring and evaluation, and limited use of available evaluation data, was highlighted as a barrier to past implementation of health financing reforms in both South Africa and Zambia.

Monitoring and evaluation systems intended to support policy implementation, particularly the implementation of complex system-wide change, must allow assessment both of the progress towards objectives achieved by any policy change and of the factors influencing the progress achieved. This type of evaluation could, for example, clarify the skills, systems, and procedures required to support implementation, as well as to inform the development of information, communication, or tactical strategies. A critical element of further evaluation in support of equity-promoting policies is to develop a better understanding of the public's views on reforms through surveys or participatory monitoring exercises (see also principle 3).

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

## Concluding Remarks

Sweeping political changes can provide a unique opportunity for changes in health sector financing and service delivery, but along with economic and organizational changes, they can also lead to detrimental impacts. Understanding the relationship among these various influences is crucial to a successful reform effort.

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