Appendices
Health Policy and Policy Analysis Training Module

A facilitator's guide based on a short course taught at the School of Public Health, University of the Witwatersrand

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Appendix 1

Course overview and session overview pages.

Course overview

Health Policy and Policy Analysis

Learning outcomes

By the end of the course participants should be able to:

1. Demonstrate understanding of the varied and iterative nature of policy change processes;
2. Recognise that implementation is part of the overall policy change process;
3. Identify key components and factors facilitating and constraining policy and implementation processes;
4. Conduct comprehensive analyses of policy and implementation processes;
5. Apply theoretical frameworks and approaches in understanding policy and implementation processes and use specific policy analysis tools;
6. Use policy analysis for strategic planning;
7. Work in teams to achieve specific goals.

Broad outline of course

This course will:

1. Provide an outline of key issues in policy analysis;
2. Introduce and use theoretical frameworks and approaches;
3. Encourage application of theoretical frameworks to routine work experiences;
4. Introduce some key health policy debates;
5. Ensure an integrated assessment approach that links class-based work to assignments and any examinations;
6. Allow opportunities for developing teamwork skills.

Assessment practice

Assignment

- the individual assignment will be based on the policy scenario group work undertaken during the course, to provide a coherent learning opportunity that joins class-based work with the assignment
- the mark for the assignment will be split between the group work and the individual written assignment as follows:
  - 20% for group work presentation (Session 12)
  - 80% for individual written assignment
- a detailed outline of the marking schedules for each component of the assignment will be provided to all students, to clarify expectations for these pieces of work.

Readings

Key readings and references will be made available for each session. Participants are, however, strongly encouraged to read widely around the topics introduced within the course. The following is a recommended text for the course:

Buse, K., Mays, N. and Walt, G. (2005) *Making Health Policy*: Maidenhead. Open University Press.

Session overview

Session 2 What is policy? What is policy analysis?

Learning outcomes

By the end of the session participants should be able to:

- identify different uses of the term policy
- distinguish between policy as intent and policy as understanding and practice
- describe different forms of policy analysis.

Key points

- The term policy has a very wide range of different meanings.
- Governments, organisations and even households have policies.
- Public policy is government policy.
- Policy can be formal and informal, and can include non-decisions.
- Policy arises from a process and policy problems are often generated by that process.
- Policy analysis can be applied to understand or to intervene in policy processes.

Reading

*Buse, K., Mays, N. and Walt, G. (2005) *Making Health Policy*. Maidenhead: Open University Press, Chapter 1

For the really interested

Fischer, F. (2003) *Reframing public policy.* Oxford: Oxford University Press, Chapter 1

Other references

Hogwood, B.W. and Gunn, L.A. (1984) *Policy Analysis for the Real World*. Oxford: Oxford University Press Chapter 2

Individual reflection – consolidating your learning during the course

During this course, you may find it useful to follow a process of personal reflection as a form of self-assessment and as an opportunity to explore the relevance of policy analysis to your own work. Some questions to consider are given below. You could record your ideas on a mind-map after each session.

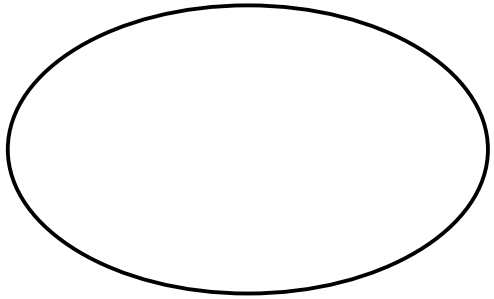
This process may also help to identify issues or concepts that you would like the facilitator to clarify during the course. It is one way to prepare yourself for the assignments through which your learning will be formally assessed.

How relevant is policy analysis to your own work? Suggested questions to consider

- Where would you place yourself in the policy process/es?
- Which part of the policy process affects you most? (policy development or implementation)
- What opportunities do you have to influence policy?
- What are some of the barriers/limits to your participation in policy development?

Reflecting on 'policy' in your own experience

1. Identify a policy within your work or home environment with which you are familiar.
2. Write its name or brief description in the central shape on this page.
3. During the course, create your own mind-map as you reflect on your own role in the policy process. Add something to your mind-map at the end of each session. For example, at the end of the first session you may consider the question: 'In which ways does this policy affect me?'



Session overview

Session 3 Analysing policy processes

Learning outcomes

By the end of the session participants should be able to:

- understand the focus and nature of policy analysis applied to processes
- recognise the complexity of the overall policy process
- understand the inter-linkage of policy development and implementation processes
- identify the key elements interacting within these processes.

Key points

- Policy analysis is interpretive and different theoretical frameworks emphasise different ways of understanding experiences.
- The policy process is rarely rational and linear, but always evolutionary and, often, conflictual.
- Policy analysis is concerned not only with agenda setting (the development of policies to tackle identified solutions) but also with implementation of new policies and routine service delivery.
- The policy process always combines, and is influenced by, four key factors: content, context, actors and processes.

Reading

Walt, G. (1996) Policy analysis: An approach. In Janovsky K (ed) *Health Policy and System Development*. Geneva: World Health Organisation, Chapter 14

For the really interested

John, P. (1998) *Analysing public policy.* London: Continuum, Chapter 1

Other references

Buse, K., Mays, N. and Walt, G. (2005) *Making Health Policy*. Maidenhead: Open University Press, Chapters 4 and 7

Walt, G. (1994) *Health Policy: An Introduction to Process and Power*. Johannesburg: Witwatersrand University Press/London: Zed Press Chapters 3, 4 and 8

Walt, G. and Gilson, L. (1994) Reforming the health sector: the central role of policy analysis. *Health Policy and Planning*, **9**(4): 353-370

Session overview

Session 5 The Central Role of Actors

Learning outcomes

By the end of the session participants should be able to:

- identify key categories of actors in the policy process
- explain how actors may influence the policy process
- recognise actors' practices and sources of power
- identify the factors influencing actors' behaviours and roles in the policy process.

Key points

- Actors can drive or support policy change, prevent new ideas even getting on the policy agenda, influence which policies are taken forward and how they are designed, support or resist implementation of new policies.
- Actors can exercise power to shape or resist policy-making, or to influence others in the process.
- Actors' power within policy-making is influenced by personality, process, content and context.
- Actor understandings of, positions on and responses to policies are partly shaped by their beliefs and contexts (as well as their interests and how these might be affected by policy content).

Reading

Buse, K., Mays, N. and Walt, G. (2005) *Making Health Policy*. Maidenhead: Open University Press, Chapter 2

Hill, M. (1997) *The Policy Process in the Modern State*. Third Edition. London: Prentice Hall. Chapters 4 and 9

For the really interested

Hudson, J. and Lowe, S. (2004) *Understanding the policy process.* Bristol: The Policy Press, Chapter 11

Other references

Green, A. (2000) Reforming the health sector in Thailand: The role of policy actors on the policy stage. *International Journal of Health Planning and Management* **15**: 39-59

Kaler, A. and Cotts Watkins, S. (2001) Disobedient Distributors: Street level bureaucrats and would-be patrons in community-based family planning programmes in rural Kenya. *Studies in Family Planning* **32**(3): 254-269

Walt, G. (1994) *Health Policy: An Introduction to Process and Power*. Johannesburg: Witwatersrand University Press/London: Zed Press Chapters 5-7

Session overview

Sessions 6 and 9 Stakeholder Analysis

Learning outcomes

By the end of the session participants should be able to:

- understand the purpose and approach of stakeholder analysis
- apply frameworks for conducting stakeholder analysis
- assess the strengths and weaknesses of stakeholder analysis as a management tool.

Key points

Conducting a stakeholder analysis:

- allows identification of key potential allies and opponents
- allows clarification of the resources and power of key actors
- provides the basis for developing strategies for managing actors.

Reading

Varavasovszky, A. and Brugha, R. 2000b. How to do (or not to do)… A stakeholder analysis. *Health Policy and Planning* **15**(3): 338-345

Other references

Buse K., Mays, N. and Walt, G. (2005) *Making Health Policy*. Maidenhead: Open University Press, Chapter 10

Session overview

Session 7 Considering Context

Learning outcomes

By the end of the session participants should be able to:

- categorise the main contextual features influencing policy change
- discuss how contextual factors influence policy actors, content and processes
- recognise the particular roles of institutions and broader political systems in shaping actors' power.

Key points

- There are different ways of thinking about context and categorising it.
- Context exists at a macro and micro level, and is relevant to all stages of the policy process.
- The interrelationships between contextual factors and other elements of the policy analysis triangle are often complex.
- Context changes: context may influence other factors, but other factors can also influence context
- It is not sufficient to merely identify different contextual factors. The relevance and importance of a particular factor will depend on how it relates to other factors (other contextual factors as well as other elements in the policy analysis triangle).

Readings

Collins, C., Green, A. and Hunter, D. (1999) Health sector reform and the interpretation of policy context. *Health Policy*, **47**, 69-83

Aitken, J.-M. (1994) Voices from the inside: managing district health services in Nepal. *International Journal of Health Planning and Management*, **9**, 309-340

Other references

Grindle, M.S. and Thomas, J.W. (1991) *Public choices and policy change: the political economy of reform in developing countries*. Baltimore and London: The Johns Hopkins University Press, Chapter 2

Atkinson, S. (2002) Political cultures, health systems and health policy. *Social Science & Medicine*, **55**, 113-124

Hofstede, G. (1997). *Cultures and Organizations: Software of the mind*. New York: McGraw-Hill

Session overview

Session 8 Considering Content

Learning outcomes

By the end of this session participants should be able to:

- recognise different forms of policy content and their varying influence over the policy process
- apply policy characteristics analysis to assess how policy design influences actors
- recognise different forms of policy instruments and determine the degree to which policy complexity and/or simplicity impacts on implementation.

Key points

- It is important to consider policy content because it can have a major influence over the course of the policy process.
- Different concepts can be used in the analysis of policy content.
- Thinking clearly about the nature of a policy (e.g. what it says, how it is saying it, and who it is appealing to) can help actors to devise strategies for successful implementation or to critique an available policy option.

Readings

Grindle, M.S. and Thomas, J.W. (1991) *Public choices and policy change: the political economy of reform in developing countries*. Baltimore and London: The Johns Hopkins University Press, Chapter 6

Beard, A. (2000) *The Language of Politics*. London: Routledge, Unit 2

Other references

Hastings, A. (1998) Connecting Linguistics Structures and Social Practices: A Discursive Approach to Social Policy Analysis. *Journal of Social Policy*, **27**(2), 191-211

Gustaffson, D. and Ingle, M. (1992). Policy Characteristics Analysis in *Technical Notes*, August 1992, USAID's Implementing Policy Change Project, No. 3.

Schön, D.A. (1979) Generative Metaphor: A Perspective on Problem-Setting in Social Policy. In A. Ortony (ed.), *Metaphor and Thought*. Cambridge: Cambridge University Press

Session overview

Session 10 Developing strategies to support policy change

Learning outcomes

By the end of the session participants should be able to:

- recognise the importance of strategy to policy change
- apply frameworks in identifying actor management strategies
- identify other types and forms of strategies
- recognise key factors influencing the processes used in policy development and implementation
- understand the relevance of policy analysis to managerial action and strategic planning.

Key points

- Processes can be understood at a macro level (agenda setting, formulation, implementation) and at a micro level (strategies).
- An actor aiming to influence the policy process needs to strategise around how to take advantage of factors supporting change, and how to overcome factors inhibiting change.
- Managing other actors requires consideration of which actors to work with and which to oppose, as well as assessment of actors' beliefs, interests and resources.
- Strategies need to take account of how different dimensions of context and content may influence policy change.
- The strategies available to an actor are influenced by the actor's own position inside or outside the political and bureaucratic system.
- A strategy must include identification of: information needs and how to fill them; allies and mechanisms for working with them; key messages and communication mechanisms; timing of actions.
- Strategies should be constantly evaluated and changed as necessary.

Reading

Klugman B and Hlatshwayo Z. (2001). Strategy and action for abortion access: a comparative analysis, in Klugman B and Budlender D (eds) *Advocating for abortion access: eleven country studies*. The Johannesburg Initiative, Women's Health Project, School of Public Health, pp.7-40

Thomas S and Gilson L. Actor dynamics in financing reform: The contested process of health insurance policy development in South Africa, 1994-99. *Health Policy and Planning* **19**(5): 279-291

Other references

Gilson, L. (2001) *Designing and implementing health financing reforms*. PHR Executive Summary Series. Bethesda: Abt Associates www.phrplus.org

Glassman, A. *et al*. (1999) Political analysis of the health reform in the Dominican Republic. *Health Policy and Planning* **14**(2): 115-126

Varavasovszky, A. and Brugha, R. 2000b. How to do (or not to do)… A stakeholder analysis. *Health Policy and Planning* **15**(3): 338-345

Session overview

Session 11 Thinking in an integrated way

Learning outcomes

By the end of the session participants should be able to:

- recognise the ways in which elements of the policy analysis triangle combine to influence policy processes
- recognise that understanding the policy process requires an integrated and synthesized analysis of problems and experiences.

Key points

- The elements of the policy analysis triangle always interact in influencing any policy change experience.
- Understanding the policy process requires interpretation and will be contested.
- Theoretical frameworks give insights into the ways in which the elements interact and provide different ways of understanding the same experiences.

Reading

Buse, K. Mays, N. and Walt, G. (2005) *Making Health Policy*. Maidenhead: Open University Press, Chapters 4 and 7

Other references

Hill, M. (1997) *The Policy Process in the Modern State*. London: Prentice Hall, Chapters 5 and 6

Walt, G. (1994) *Health Policy: An Introduction to Process and Power*. Johannesburg: Witwatersrand University Press/London: Zed Press, Chapters 4 and 8

Appendix 2

Handouts for distribution during the sessions.

Handout 1 *(1 of 6 pages)*

Separating drug prescribing and dispensing in South Korea[1]

Policy issue

In all countries, expenditure on pharmaceuticals (drugs) impacts on the total cost of providing health care. A high and increasing cost of drugs puts pressure on national health budgets and often makes health care unaffordable for poorer groups.

Pharmaceutical expenditure levels are driven by:

- drug prices (which include the cost of drug production and the pharmaceutical companies' profits); and
- drug prescription practice – particularly whether generic or brand name drugs are prescribed. Generic drugs and brand name drugs are equally effective, yet generic drugs are cheaper.

In South Korea as early as the 1980s[2], drug prescription practice was identified as the key factor influencing what was considered to be an unsustainably high level of pharmaceutical expenditure. It was also noted that South Koreans consumed more drugs than people in other high-income countries, particularly injectable drugs[3]. This over-consumption resulted in an increased level of resistance to antibiotics.

These drug prescription problems were linked to the activities of two groups of actors:

1. physicians and pharmacists[4], who prescribed *and* dispensed drugs (which was traditional practice in oriental medicine); and
2. pharmaceutical companies, who attempted to influence which drugs were prescribed and dispensed.

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[1] Source: Kwon S (2003) Pharmaceutical reform and physician strikes in Korea: separation of drug prescribing and dispensing. *Social Science and Medicine* 57: 529-538

[2] By the 1990s Korea spent 31% on pharmaceuticals (rising to over 40% when physician fees for prescribing and dispensing were included) compared to the average of below 20% in other high income countries.

[3] In 1997, 62% of consultations in physician clinics included injections, for example, compared to only 8% of outpatient visits.

[4] Pharmacists have traditionally played the role primary health care providers in Korea, given past shortages of physicians.

The majority of health care providers (pharmacists, physicians and hospitals) work in the private sector. They provide care on a 'for-profit' basis. Within the South Korean national health insurance system, all health care providers are paid on a 'fee for service' basis. The fees are paid after the service has been provided and the rates for the fees are tightly regulated. Before 2000, the government set the rates at which it reimburses health care providers for drug provision, on the basis of information provided by pharmaceutical manufacturers and wholesalers.

To encourage providers to prescribe 'their' drugs, pharmaceutical companies sold drugs to providers at prices that were less than government reimbursement levels. (In this way they increased sales.) Therefore, drug providers could generate a maximum profit by prescribing the drugs that cost them least to buy (relative to the government-set reimbursement level) and by prescribing more drugs than were necessary.

As a result of this financial incentive, pharmaceutical companies and drug providers would often work together in illegal and unfair ways to sustain their own profit levels.

In practice, therefore, drug prescription practice was based on which drugs gave providers higher profits, rather than on which drugs were the best quality or most cost-effective for the condition being treated. Nonetheless, government bureaucrats turned a blind eye to such practice for a decade or so. Even though the existing policy only allowed physicians to claim a maximum level of profit for drugs (24% of cost), this was not enforced.

The patients' lack of knowledge was also seen as a factor affecting drug prescription practice. Lack of knowledge limited patients' ability to challenge provider practices. In addition, patients' preference for some form of medication, reflecting oriental medicine practice, encouraged providers to over-prescribe drugs.

Policy change

On July 1st 2000 the Korean government introduced a new health policy to prevent physicians and pharmacists from both prescribing *and* dispensing drugs. Under the new policy (in relation to those drugs categorised as prescription drugs) physicians would only be able to prescribe, and pharmacists to dispense.

The reform aimed to reduce the overuse and misuse of drugs, and enhance the patient's right to know about their medication. Under the new policy, physicians could prescribe either brand name or generic drugs. When dispensing, pharmacists could substitute a generic for a brand name drug *if* an equally effective generic drug (as verified by a bioequivalence test) was available.

Chronology and experience of implementing pharmaceutical reform

Government actions to introduce reform

Since 1963 attempts to amend the law in order to separate drug prescribing and dispensing had been made. However, these had been unsuccessful due to opposition from physicians and pharmacists, whose strong professional associations actively lobbied against the proposed changes.

However, the 1994 amendment to the Pharmacy Law specified that the separation of prescribing and dispensing would occur by 1999.

In 1997 the national committee on health care reform proposed a model for separation, including a gradual implementation process between 1999 and 2005.

A new president came to power in 1998, after the demise of the previous authoritarian regime, determined to implement this reform as it had been one of the key elements of his presidential election campaign.

In May 1998 the Ministry of Health and Welfare established a steering committee to prepare for the separation. To facilitate implementation, the

committee made a revised proposal for the reform and classified drugs as either prescription or non-prescription. The civil servants made no special efforts to negotiate these proposals with the affected stakeholders. Apparently they believed that they could implement policy by instruction, as under earlier authoritarian regimes.

Reaction from civil society

The democratisation of South Korean society provided more opportunities for interest groups to shape policy processes, and increased their bargaining power relative to the state.

In November and December 1998, the *medical and pharmaceutical associations* appealed to Congress to defer the reform. They also appealed to the public for support by emphasising that:

- the new system would make it very inconvenient for consumers to obtain drugs; and
- it would not lead to reduced costs or other benefits.

Their activities were opposed by civic groups, mainly *progressive academics and political activists*, who had previously opposed military rule and who were aligned with the new President. These groups made pharmaceutical reform a major social issue, and deliberately revealed the huge hidden profits made by physicians. This information initially caught public attention and mobilised support. It led Congress to reject the medical and pharmaceutical associations' appeal.

However, neither the civic groups nor the government put much effort into persuading consumers to support the reform. Little publicity was given to the reason for the reform, and its potential benefits to consumers; and little effort was made to address the providers' claim that it would make consumer access to drugs more difficult. The civic groups also apparently did not take account of the possibility that revealing physician profit levels to the public would strengthen the physicians' resistance to the new policy.

Negotiations

Although the medical and pharmaceutical associations' appeal was rejected, their resistance and obvious power led the ruling party to enter into negotiations with them. As a result of which, the government accepted the professional associations' request to defer final implementation until 2000. This was on the basis of:

- an agreement made in March 1999 by the Korean Medical Association on behalf of physicians that they would work with civic groups to develop a final proposal for the reform;
- the medical and pharmaceutical associations' acceptance, in May 1999, of the civic groups' proposals, which had been discussed in five public hearings.

In December 1999 Congress passed the revised Pharmacy Law that provided the legal basis for the reform.

Implementation of a 'no margin' policy

In November 1999, the government implemented the 'no margin' policy. This policy cut the drug reimbursement fee that government paid drug providers close to the price that providers actually paid to the pharmaceutical companies. This strategy was intended to remove the physician's financial incentive to dispense drugs and so encourage their compliance with the separation reform. It was put through with little consultation or negotiation.

The 'no margin' policy showed the physicians how great an impact the separation policy would have on their profit margins (as the effects of the two policies were the same). They decided to go back on the attack.

In February 2000 about 40,000 physicians demonstrated against the reform. They were led by a splinter group of physicians that rejected the authority of the Korean Medical Association. This was followed by a series of other strikes (on April 4-6, June 20-26 and August 11-17). In the second strike more than 90% of general practitioner-type physicians went on strike. In addition, strikes by resident doctors in teaching hospitals (the vast majority of doctors in those hospitals) began in July and lasted for three months.

The Korean health system is extremely vulnerable to strikes by private sector physicians. It is heavily dependent on general and teaching hospitals for both inpatient and outpatient care. Only 7% of acute hospital beds are owned by the government. Therefore, the government not only agreed to raise the physicians' general reimbursement rates by up to 44%, but also to exempt many injectable drugs from the mandatory separation (although the latter was ostensibly to avoid patient inconvenience). At the same time, in order to offset the threat of further strikes, they increased dispensing rates for pharmacists.

The policy of separating drug prescribing and dispensing was, nonetheless, eventually implemented in July 2001.

Considering policy impacts

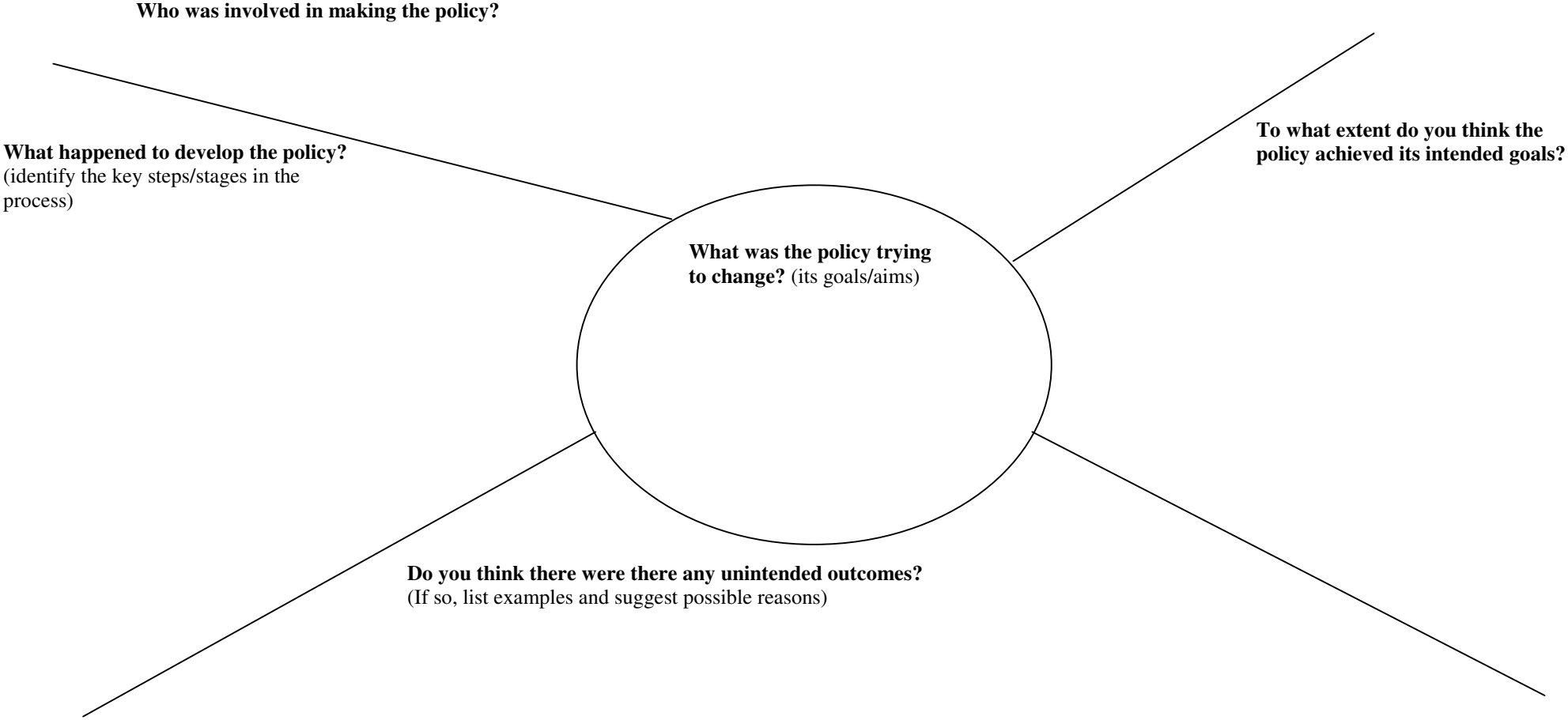
It is still too early to assess the impacts of the policy. However, three points can be noted:

1. the increases in reimbursement rates won by health care providers will limit the impact of the policy on total health expenditure levels, and may raise total costs for consumers;
2. consumers will also have to bear the impact of reduced access, and this has already led to consumer complaints about the policy;
3. physicians (in particular) have clearly demonstrated their power to influence the Korean health policy process – suggesting that the battle to contain the costs resulting from their practices is not yet over.

Handout 2

Tasks:
1. Read the case study.
2. Write down one or two things that you remember in answer to each of the questions on this sheet.
3. Use the sheet to record any other ideas during the next activity.

Separating drug prescription and dispensing in South Korea



Handout 3

Separating drug prescription and dispensing in South Korea: Looking deeper

1. In your groups, consider the way in which the South Korean policy developed. Discuss the following question:
   - Do you consider the experience to have been a success or a failure? Give reasons for your judgement.

   Keep notes of your discussion for use later in the week.

2. Identify five main issues, or factors, that influenced the policy development process. Summarise each issue on a separate piece of paper (they will be displayed on the wall).

3. In plenary, give a report back on the issues you identified.

Handout 4 *(1 of 2 pages)*

Key points that can be drawn from the South Korean case study

Category of issue	***Issues raised***	***Issue links to/ influences over other issues***
Context	Cost escalation due to pharmaceutical expenditure a policy problem identified in 1980s (partly past policy)	Underpins drive for policy change
	Health care providers paid on fee for service basis (past policy)	Provides incentive to over-prescribe drugs, underpinning policy problem
	1998 new President came to power with mandate to implement policy	Election gave power to implement new policies
	1998 move from authoritarian to democratic regime opened space for actors outside government to influence policy processes	Created space for civic groups supporting policy, but for those opposing, also allowed opportunities to influence policy; Bureaucrats could not adjust to transition, and continued to work in authoritarian and controlling way
	Government owns only 7% of acute hospital beds and does not employ general physicians (past policy)	Gave physicians considerable power in post 1998 processes
Actors & interests	Physicians, pharmacists and pharmaceutical companies – who work on for profit basis	Have interests in maintaining profit levels – underpins policy problem & their opposition to new policy
	Pharmaceutical companies offer drugs to physicians at lower rates than those paid by government to encourage sales of their drugs	Underpins policy problem, by giving physicians financial incentive to prescribe company-provided drugs
	Patients generally lack knowledge about drugs and had preference for anti-biotics	Underpins policy problem
	Government bureaucrats ignored past collusion between physicians & pharmaceutical companies in price setting, and used to operating in very controlling way	Past lack of action underpins policy problem and makes future action more difficult; controlling approach causes problems for policy change
	Physicians and pharmacists have strong professional associations, and sometimes worked in alliance	Enhances power in lobbying
	Post 1998 President and civic groups become key actors – with concern for public interest	Have interests in addressing cost escalation and promoting fairness in system, are key supporters of reform

Content	Pharmacy Act 1999 (implemented 2000) sought to separate roles of prescribing and dispensing between physicians and pharmacists, to encourage use of generics over brand name drugs and to educate patients	Remove incentives to physicians to over-prescribe Encourage use of cheaper but effective drugs Reduce irrational drug demands of patients
	'No margin' reimbursement policy implemented Nov 1999 to reduce reimbursement rates to physicians	Reduce profit margins of physicians Both policies undermine interests of physicians and pharmaceutical companies, and (partially) pharmacists – generating opposition and oppositional alliances
Processes of policy change	1997 National Committee on health care reform proposed model for policy change timeline May 1998 steering committee to prepare for separation, made revised proposal for reform	Committees composed of bureaucrats developed policy without consultation and with assumption that could control top down process of change, despite changing political context – but caused backlash
	Dec 1998 Professional associations appealed to Congress to delay reform and appealed to public to oppose reform because would reduce their access to drugs	Actors seeking power in policy process by lobbying other actors, and for public, using messages that would capture their attention
	Civic groups also lobbied in support of policy change, revealing huge profits made by physicians in order to gather public support – but only generated more resistance among physicians by threatening their self-esteem	As above, with some unexpected consequences – but Congress did reject physicians appeals
	1998-99 Given physician power, government negotiated with physicians and reached agreement (March 1999) that physicians would accept policy but final policy implementation would be delayed until 2000	Negotiations among actors affect overall plans regarding timing of reform implementation
	May 1999 professional associations accept civic groups reform proposals, discussed in five public hearings, and passed into law in December as Pharmacy Act 1999	Negotiations among actors lead to apparently acceptable proposals which reach legislation
	November 1999, government implemented parallel policy (no margin policy) – cutting drug reimbursement price close to levels physicians actually paid	Policy again developed without consultation or careful thought, and again resulted in backlash
	Feb 2000 physicians go on strike in protest at 'agreed' policy change, crippling health system – and leading government to raise reimbursement rates	Clear exercise of power with impact that reduced effect of Pharmacy Act on overall cost escalation, and re-affirmed influence of physicians in health policy arena

Handout 5 *(1 of 6 pages)*

Group Policy Analysis

Introduction to the Group Work Sessions

Your group's tasks:

1. To read, discuss and analyse the policy scenario (using the questions provided as a guide)
2. To make an overall judgement about the success or failure of the experience of policy change described in your scenario
3. To prepare a presentation that outlines your overall judgement on the success or failure of this policy change and explains this judgment by reference to the main strengths and weaknesses of the policy process described in the scenario.

Time allocated for the analysis and preparation of presentation: three sessions of 2.5 hours each, plus evening work as needed.

Time allocated for the presentation: 15 minutes (Session 12)

Assessment of your group's presentation will form **20% of your overall mark for your individual assignment**. It is therefore important that you read the assessment criteria so you know what you need to show evidence of in your group's presentation.

Key points to remember when preparing your presentation:

- task 3 outlines the issues on which you should focus in the presentation
- be guided by the presentation assessment criteria
- draw on your work from all the group work sessions but only present what you consider to be the most important issues
- the term 'policy process' covers both the various stages in the development and implementation of a policy and the micro-processes, mechanisms or strategies through which actors engage in these stages.

Homework after Session 4, in preparation for the Group Work Session 1

1. Read your group's scenario.
2. Complete Form 1: a timeline for the policy process described in your scenario.
3. Consider this question: Does the scenario report a success or a failure in policy change? Record your ideas.

This individual work will be useful throughout the process of the group work, so bring any notes you make to the discussions!

Guidelines for Group Work Sessions

Beware!

- Some of the guiding questions may not be relevant to your group's scenario
- To answer some questions you may need more information than presented in the scenario outline: if so, identify the gaps and decide whether they are important to raise in your presentation on Friday
- Always look for evidence and examples to explain or justify your responses to the questions AND the conclusions you make in your presentation
- You will need a system to help you keep track of ideas and group similar ideas together (use diagrams, charts, coloured crayons ….)
- Time is limited – avoid spending too long discussing irrelevant or relatively minor issues.

Group work skills

Everyone in your group has a contribution to make to the analysis and the presentation. Develop some 'ground rules' so you can all work effectively together (for example, listening, allowing each person an equal time to speak, sharing roles to allow different people to record, chair or keep time)

Group Work Session 1

Introductory discussion *– using the completed homework, briefly consider:*

- What was the policy of focus?
- What and when were the key events in the policy process?
- Do you judge the policy experience to have been a success or failure? (you will keep reviewing this point so you don't need to come to a final conclusion yet!)

Understanding actors:

- Who were the key actors involved in:
  (a) the policy development process/es?
  (b) the policy implementation process/es?
  (Were there any alliances or networks among the actors?)

- Which actors had most influence over the policy process as a whole or particular elements within it? In what way/s did they influence the process? How and why were they able to exert that influence?

- Which actors were not involved that could have been involved?

- How did actors' decisions and actions (or lack of decisions/actions) influence the success or failure of the policy experience (according your judgement)?

Planning your presentation

- Which of the issues that you have discussed today would be useful to include in your final presentation?

Group Work Session 2

Identifying key contextual features:

- what are the contextual factors that led to the initiation and development of this policy, and how did they influence the success or failure of policy development?
- what contextual factors were important in the implementation phase? How did they influence the success or failure of policy implementation? (remember to consider, in particular, how context influenced actors).

Considering policy content:

- were there any important differences between key actors in how they understood the policy?
- how did the key policy characteristics influence the experience of policy implementation and your judgement of it as a success or failure? (remember to consider how the policy content influenced actors' responses to it).

Stakeholder analysis:

- Complete the attached stakeholder analysis tables (forms 2 and 3).

Planning your presentation

- Which of the issues that you have discussed today would be useful to include in your final presentation?

Group Work Session 3

Remember you also have to develop your plan for your presentation in this session!

Analysing strategies *(micro-processes)*

- What were the key strategies used in this policy experience to a) manage actors, b) enable policy development (e.g. structures, committees) and c) support implementation (e.g. communication, phasing, capacity development etc)?
- In terms of the overall success or failure of the policy experience, which strategies had most influence and why? How, if at all, did features of the policy content or context impact shape the relative influence of these key strategies?

Planning your presentation

- Which of the issues that you have discussed today would be useful to include in your final presentation?

Form 1: Timeline

Year/Date	
Important/ Key event	

Form 2: Stakeholder characteristics **complete table only for the most important actors**

Actor (identify each actor)	**Interests**	**Impact of policy on actor's interests** (large/little; positive/negative) *Why do you think this?*	**Given the actors' interests and likely impact of the policy, how concerned is the actor likely to be about the policy?** (level of concern very high to very low)	**Actor's influence over policy process** (very high to very low) *Why do you think this?*

Form 3: Forcefield analysis

MAKE YOUR OWN EXTRA SHEETS AS NECESSARY!

Instruction: Name specific relevant actors within each group and locate them on this map of support and opposition

	Proponents				**Opponents**
	high support	<< <<	not mobilised	>> >>	high opposition
political sector					
government sector					
business sector					
social sector (civil society)					
donors					

Handout 6 *(1 of 2 pages)*

Assessment criteria
Group Policy Analysis Presentation

One final mark will be allocated for the group work presentation and the individual assignment. It will be based on the following split: 20% for the group work presentation and 80% for the individual assignment. *Each of these elements will be marked according to the marking schedules provided, so please read and think about these schedules carefully in your preparation.*

Group Work Presentation

Your presentation will need to:

(a) outline your group's overall judgement on the success or failure of this policy change; *and*
(b) explain your judgement by reference to the main strengths and weaknesses of the policy process described in the scenario.

Assessment criteria

In marking the presentations we will be looking for evidence of your understanding and abilities in relation to two broad areas:

1. Content i.e. knowledge and understanding of the material covered in the course;
2. Form, i.e. ability to present a clear and logical argument using this knowledge.

In addition, we will be considering some basic issues about the presentation and group work experience.

The specific criteria we will use are outlined in the table below. Each presentation will be marked by two people using these guidelines and the final mark will represent the combination of their marks. Each group will also conduct its own assessment of its own group work functioning, to be drawn into this evaluation.

Group work: marking criteria and mark allocation across criteria	
Criteria	**Allocation of mark** (out of a total of 100)
Set (1) Knowledge of subject area (policy analysis) Shows understanding of the key approaches of policy analysis • appropriately includes issues from all group work sessions • demonstrated understanding of terms and concepts introduced in the course sessions • identifies how interactions between elements of the policy triangle influence the experiences considered • appropriately and correctly uses information from the scenario	30
Set (2) Structure and argument ▪ answers the question posed and presents a clear and logically ordered argument ▪ provides adequate justification for argument through the appropriate selection and use of evidence ▪ evidence of originality in argument, extra work and initiative	50, of which: 20 20 10
Set (3) Verbal presentation ▪ keeps to time ▪ legible overheads ▪ enough information on overheads	10
Set (4) Group work ▪ demonstrated involvement of all group members in group work activities considering participation of all group members throughout week (does not require everyone in group to speak during presentation!)	10

Handout 7 *(1 of 2 pages)*

Session 5: The central role of actors *Activity 5.1*

What drives you?
Recognising belief systems in policy decisions

1. Read the scenario below and discuss the questions.

2. Consider which of the deep core values and beliefs given overleaf, most closely match your own.

A government has recently introduced a special health insurance programme for government employees. Within this programme:
(a) employees on higher incomes will make higher contributions than those on lower incomes;
(b) employees on higher incomes will be entitled to receive a wider range of services than those on lower incomes.

- Is this fair?
- Why?
- What values and beliefs drive your thinking?

Deep core	**Core policy positions**	**Secondary, administrative aspects**
Fundamental orientations that affect all policy issues Reflect strong personal beliefs	The policy positions taken reflect core values in particular policy areas. They influence questions such as: Who pays for health care? Which groups should participate in decision-making?	The administrative decisions and activities necessary to implement the core policy positions For example, the administrative rules needed, the budgetary allocations
Difficult to change	Difficult but can be changed through experience	Moderately easy to change

Deep core	Core policy positions	Secondary, administrative aspects
Examples		
All people are of equal value	The health system should treat all people fairly, and actively deter discrimination of any kind	Includes: Same criteria for all in deciding who gets care, and who gets care first Training approaches for staff Strategies for reaching socially marginalised communities, etc.
People are of different value	The health system should provide better care to those of greater value	Includes: Rationing procedures that prioritise those of greater value to ensure quick access and better care; Quicker and higher quality services available to some
People are fundamentally selfish (and so try to cheat the health system through their actions)	The health system should be organised, structured and managed to limit cheating	Includes: tight monitoring and strong disciplinary procedures for staff; user fees and other mechanisms to prevent over-use of services by patients
That poor people tend to get sick more than richer people is a result of their own actions	A basic minimum level of care should be available to everyone, but if you can afford to pay you should be able to get more and better services	For example through: a public sector providing basic care for everyone, but mostly used by the poor; and a private sector offering better services for those who can afford them
Poor people tend to get sick more than richer people due to factors beyond their control	Health systems should be structured and funded to ensure that the rich pay more than the poor, but that care is available to all in reflection of their needs; and special interventions should assist the poor to protect and promote their health	For example through: tax funded or social health insurance systems
Freedom of choice is the essential human value and economic opportunity is vital in promoting human health and welfare	Macro-economic policy should favour economic growth over redistributive policies (such as state funded health care)	The different labour market, trade, agriculture etc strategies that could be adopted to promote economic growth

Handout 8 *(1 of 3 pages)*

Session 5: The central role of actors *Activity 5.2*

A Policy Story: Getting to know the actors

1. Make a list of the key actors in the policy experience (story given on page 2).

2. Choose **two** of these actors: one a **policy formulator** and a **policy implementor**.

3. For each of your chosen actors, consider the questions below. To some extent you will need to use your own judgement about the actors' interests and belief systems and how they are likely to react/behave in relation to the policy experience. You could make notes of your ideas in a table like the one below.

   (a) How did each actor *understand* (interpret) the policy? (For example, what did they expect to gain/lose from the policy?
   (b) How did each actor *influence* the policy experience?
   (c) How much *power* did each actor have, and what were the main *types* and *sources* of this power?
   (d) What were the *limits* on each actor's power?
   (e) What key *differences* are there between the two actors in relation to these issues?

Factors to consider	*Actor 1*	*Actor 2*
Actor's understanding of policy		
Specific influences over process		
Strength and main types/sources of power		
Limits to their power		

Scenario

Elections have just returned a new government to office in country X. A central element of the new government's election platform was a promise to improve public sector efficiency.

The new *Minster of Finance* has linked this to the decision to introduce a set of reforms to public sector budgeting procedures. These include:

- developing a three-year medium term financial plan;
- implementing a process of activity-based budgeting; and
- introducing cost centres down to the level of clinics and hospital wards.

To support the implementation of this system, new posts have already been established to increase the number of *clerks, book-keepers, accountants* and *financial managers* working in the health sector. Steps are also underway to introduce a new computerised *financial management information system* that will allow managers easy access to expenditure data. A national contract to equip and re-equip all health facilities with a computer has also just been awarded.

Initial funding for some of these activities, and for a set of key *technical advisers* (1-2 per ministry), has been provided by a range of *international donors*. These donors are impressed with the new government's initiative and speedy action and are keen to support it.

Political and legislative authority in country X rests at the national level. The President, elected for a five-year term of office, is always the leader of the victorious political party in national elections. The new *president* is a technocrat, with US degrees and experience in business management. The Minister of Finance is a close colleague of the President, and the two studied together in earlier days. In contrast, the *Minister of Health*, a doctor and a woman, is seen by observers as someone with only limited political influence. She is, however, known to be loyal to the President.

The national *Ministry of Health* is ultimately responsible for health policy development and implementation, as well as ensuring good health system performance throughout the country. However, a little managerial authority is decentralised to *district* and *hospital management teams*, generally led by *medical doctors*. For example, they can hire and fire certain categories of

personnel (junior staff) and have been responsible for managing their non-personnel and non-drug budgets for some time. They have also been required to develop annual plans for their areas/facilities, identifying the priority activities for the year ahead. Budgeting has, however, been undertaken on an historical basis, meaning that the annual budget increases awarded to districts and hospitals have simply been calculated as a percentage of the previous year's total budget without reference to activities planned or implemented. The new budgeting procedures will require a much more active process of budget development in which future budgets take account of planned activities, and requiring the involvement of staff working at cost centre level.

The appointment of new financial management staff at district and hospital level is intended to support the implementation process. However, even in these early days of implementation some tensions have arisen between the new staff and the existing health managers. The health managers are concerned that the new financial people do not understand the specific needs and problems of health care provision; the financial managers are concerned that the health people do not have the necessary skills and inclination to be effective resource managers.

Within hospitals and clinics, doctors and nurses are complaining that their time for patient care is being squeezed by the requirement to attend a set of workshops to introduce the new approaches and develop relevant skills. However, after the initial set of workshops, a few health managers and staff expressed excitement at the opportunity for pro-active planning. In one workshop, an initial set of plans to introduce a new outreach service to a remote community was developed for inclusion in the new budget. The financial manager facilitating the workshop warned that wish lists of activities would not be accepted and that, ultimately, local budget levels would be dependent on nationally-set budget limits. However, he also indicated that the Minster of Finance has already hinted that, if the initial experience of implementing the reforms is successful, additional financial management authority may be handed over to managers at district and hospital levels, over time. This would give managers greater flexibility in resource use, within established budget limits.

Handout 9 *(1 of 3 pages)*

Issues raised in and by the policy story

Actor	*Understanding of policy*	*Main role and influences in the policy process*	*Strength and main types/sources of power*	*Power limits*
Minister of Finance	Approach to raise efficiency of health services Strategy to implement new government's mandate Strategy to secure donor support for new government	Primary policy formulator Broadly pushed for policy and secured implementation support May have played key roles in putting together policy package and securing donor support?	High (but with limits) *Explicit:* Contextual power from political moment (election) Positional/political power as Minister of Finance ?Political power from backing from President (key figure in government) & support of donors (with international influence and whose funding may be necessary) *Implicit:* Technical/knowledge power relevant to field as degrees and experience in business management	Does not do final implementation ?Organisational culture of maintaining status quo so difficult to implement new policies ?Extent of ability to persuade others of value of policy, as imposed policy may generate resistance (personality)
Minister of Health	Unclear Perhaps seen as an instruction from senior political figures?	Unclear Perhaps to back up implementation?	Low *Explicit:* Positional/political power as Minister of Health, so nominally need her support/approval (though how important?)	Limited political influence Loyalty to President (so maybe not take own positions)? Gender Limited technical expertise in financial/economic issues Extent of ability to persuade others of her views (personality) Does not do final implementation

Actor	*Understanding of policy*	*Main role and influences in the policy process*	*Strength and main types/sources of power*	*Power limits*
Donors	Approach to raise efficiency of health services Strategy for meeting organisational mandates Strategy for pursuing ideological goals?	Providing funding for technical advisors and elements of new financial management systems and staffing Enables implementation Supporting technical advisers may allow more detailed influence over implementation May have pushed for policy in first place?	Medium – High (in implementation) *Explicit:* Financial/economic power (from funding role) ?Political power from potential influence over how new government seen internationally *Implicit*: Knowledge power from provision of technical experts to positions in government ?Influence through training in US over President and Min of Finance	Extent of country dependence on external funding Nature of personal relations with key figures in new government (personality) Influence over expat technical staff (who may be able to influence implementation process)
District/hospital managers (doctors)	Varied: For some a distraction from clinical and other managerial priorities, perhaps threatening power and position within system; also perhaps an unnecessary imposition from above? For others an opportunity to improve services, and to secure additional managerial authority – to strengthen power	Implementors of new planning and budgeting procedures Potential to enable or resist policy implementation through way engage with new procedures	Medium-High (in implementation) *Explicit:* Positional power as implementers of new procedures (to enable ore resist) *Implicit:* Professional power as doctors within health system	Lack of relevant technical knowledge Limited managerial authority and, perhaps, organisational culture of accepting instructions from bosses in hierarchy Extent of tensions with new financial management staff Extent of alliances and networking with others in similar positions Ability to manage tensions with new financial management staff and to influence other implementers to resist or engage with new procedures (personality)

Actor	*Understanding of policy*	*Main role and influences in the policy process*	*Strength and main types/sources of power*	*Power limits*
New local level financial management staff	Unclear Perhaps approach to raise efficiency of health services opportunity to improve status within system just part of job tasks?	Implementors of new planning and budgeting procedures Potential to enable implementation by doing own jobs well, and by training others in new procedures Potential to generate resistance to new policy from other actors through way implement new procedures	Medium - High *Explicit:* Positional role as tasked with implementing new procedures Technical/knowledge power relevant to policy Political power as roles backed up by Minister of Finance *Implicit:* Potential to influence others through training	Extent of authority to enforce new procedures Extent of ability to work with others and manage tensions with other implementers (personality) Not medical professionals

Handout 10 *(1 of 11 pages)*

Session 6: Stakeholder analysis *Activity 6.1*

Stakeholder Analysis

***Your task**:* To do a stakeholder analysis in order to make a judgement about different actors' level of support/opposition to the 1997 social health insurance proposals (within the South African health system).

In Session 6

1. In preparation for Session 9, please read the case study material provided. It consists of:
   (a) background information about the South African context and the policy processes relating to social health insurance;
   (b) details about the 1997 social health insurance proposals in particular (Table 1); and
   (c) a summary of the main interests and power of the actors involved in the policy development process at that time (Table 2).

2. You may find it useful to use Form 1 to record the key factors influencing the two actors that you have been allocated.

In Session 9

1. In your groups, complete Form 2 as far as you can (make educated guesses when necessary!)
2. Locate your groups' actors on the forcefield analysis (Form 3) i.e. simply write actor names in relevant cells, considering:
   - Who was likely to be more or less supportive of initiating social health insurance discussions?
   - Who was likely to be cautious and maybe even oppose such discussions?
   - Highlight if either of your actors was likely to have had high power to influence the policy process

3. Be prepared to discuss your ideas with the wider group.

A policy experience from South Africa:

Towards a social health insurance system?

This case study has been derived from Gilson *et al.* 1999[5]

Objectives of case study

To use the South African experience of Social Health Insurance development in the 1990s to:

- undertake a stakeholder analysis
- consider the influence of actors over policy change
- consider how stakeholder analysis can be used in developing strategic action to support policy change.

Background information

Demographic and socio-economic context[6]

Population

- total population of 40.6 million (1996)
- 54% lived in urban areas (1996)
- 13.7 million economically active people (1996)
- 34% of economically active unemployed (1996)
- 36% of economically were employed in the formal business sector (1998)

Income inequality:

- middle income country: per capita income of US$3160 (1995)
- Gini coeffficient of nearly 0.6 (mid 1990s)
- the poorest 40% of households account for only 11% of total income but the richest 10% of households capture 40% of total income (mid-1990s)

The South African health system: the apartheid legacy[7,8]

- The health system is costly, fragmented, inefficient and inequitable
- Relative to other countries, SA spends a large amount on health care (about 8% of GDP) but has poor average health status indicators e.g. infant mortality rate estimated as 54/1000 live births in 1990/91 (revised to 45 per 1000 by the 1998 Demographic and Health Status Survey)[9]

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[5] Gilson L., Doherty J., McIntyre D., Thomas S., Brijlal V., Bowa C. and Mbatsha S. (1999) The Dynamics of Policy Change: Health Care Financing n South Africa, 1994-99. Monograph No. 66, Johannesburg: Centre for Health Policy, University of Witwatersrand/ Cape Town: Health Economics Unit, University of Cape Town.

[6] Statistics South Africa (2000). Statistics in brief 2000. Pretoria: Statistics South Africa; May J (ed) (1998) Poverty and Inequality in South Africa. Report prepared for Office of the Executive Deputy President and Inter-Ministerial Committee for Poverty and Inequality. Durban: Praxis Publishing

[7] McIntyre D, Bloom G, Doherty J, Brijlal P (1995). Health expenditure and finance in South Africa. Durban: Health Systems Trust and World Bank.

[8] van den Heever A (1997) Regulating the funding of private health care: the south African experience. Chapter 10 in Bennett S., McPake B and Mills A (eds) Private health providers in developing countries: Serving the public interest? London: Zed Press

[9] Zimbabwe, in contrast, had an infant mortality rate of 48/1000 in 1990/91 but had an income level around a quarter of that of South Africa (US$650) and spent only around 3% of GDP on health care.

- SA has large inequalities in health: for example a five to six fold difference in infant mortality rates between the African and white populations and a three-fold difference between the highest and lowest income households

The South African health system is divided between
- the public sector, serving the majority of the population, the lower income groups, and
- the private sector primarily serving the middle and high-income groups that represent the minority of the population

In 1992/93 the private sector:
- routinely served only 23% of all South Africans
- accounted for 58% of total health care expenditure
- captured the majority of all types of health personnel (except nurses)

The public sector = services provided directly by government and funded from conventional tax revenue

The private sector = several different sub-sectors funded through various combinations of insurance premiums, employer contributions and out of pocket payments.

Although the institutionalised racism of the apartheid era reserved the private sector for the white population, the powerful trade union movement began to demand access to it for its lower income, African and Indian members over the 1980s. This led to the provision of some employer-based medical benefits for people who had previously relied exclusively on the public sector. But as these were still largely funded separately from the traditional medical aid schemes, funding from higher income groups was hardly used to fund the health care of lower income groups using the private sector. Nonetheless, this development did increase demand for privately-funded medical benefits from lower income groups – particularly in the face of a perceived decline in the quality of public services.

The evolution of social health insurance proposals

Anticipating a new government, towards the end of the 1980s the health policy community inside South Africa began debating policy matters. A key issue within these debates was how the health system should be funded and organised, and what role the private sector should play within that system. Some favoured a tax-funded national health system along the UK lines. Others suggested that some form of insurance-based system would be more technically and politically feasible as an immediate goal. The second group's views won the day. They began to develop initial ideas around the design of an insurance-based system and the African National Congress's Health Plan, published in 1994, recommended that a commission be established to investigate the appropriateness and feasibility of an insurance-based option, through consultation with interested parties.

This proposal was then fed into a series of ad hoc committees established after 1994 to advise government on these issues. The three main committees that, between 1994 and 1999, considered the form an insurance-related mechanism should take were:

The Health Care Finance Committee (HCFC) of 1994

- established by the new national Minister of Health as a body to advise her on a range of financing issues
- comprised 17 members drawn from the South African academic community, government structures and private sector (1 member from the medical aid scheme environment), with three international advisors
- worked over a 6 month period, behind closed doors
- proposed three insurance options in a confidential report to the Minister: one of these came to be known as 'the Deeble option', after the international adviser who proposed it, and following a leak to the press became the subject of much media debate;
- proposals largely ignored by Minister and policy-makers.

The Committee of Inquiry into a National Health Insurance System of 1995

- established by the national Minister of Health to provide advice on how to fund the provision of primary care access to all South Africans (either through an insurance-based system or through a tax-funded alternative)
- a key starting point of its deliberations was the government's intention to remove all public primary care fees (finally announced in 1996)
- in practice its deliberations included a broader investigation of insurance options and of how to regulate the private insurance industry
- comprised 13 members, drawn from the South African academic and government community, with 2 private sector analysts, 2 Department of Finance representatives and 3 international advisers
- worked over only a four month period, and involved both detailed face to face discussions with key stakeholders such as the medical aid schemes as well as public consultations around the country
- published a draft report for public comment in mid-1995 and a final report in 1996
- proposals on social health insurance (SHI) largely ignored by Minister but those on regulation of private insurance industry fed forward into development of 1998 Medical Schemes Act.

The SHI Working Group of 1997

- established by the Department of Health's Deputy Director General (equivalent to deputy principal/permanent secretary)
- comprised only 6 members drawn from the academic community and national Department of Health
- specifically tasked with developing detailed proposals for an SHI scheme for low income groups that would support public hospital use
- met periodically throughout 1997
- proposals were submitted to and approved by the structure ten national and provincial ministers of health

- proposals apparently overlooked after 1997 decision of the African National Congress to look at health insurance in context of a broader review of social security undertaken in 2000-01.

However, none of these committees was able to develop a set of policy proposals that had enough political support to be accepted as starting point for implementation. Therefore, despite the work of these three committees, SHI had not moved into an implementation phase by 1999, the end of the first government's term of office.

The design of different SHI proposals, and the key actors involved in SHI debates
Social health insurance schemes always combine a range of features linked to who pays insurance contributions and their basis, what benefits are received and who benefits, who provides health care and how providers are paid.

Table 1 outlines the key design details of the 1997 SHI proposals, and Table 2 then identifies the range of relevant actors in these debates, their interests and the levels and sources of power they brought to the debates.

TABLE 1: THE 1997 SHI PROPOSALS		
ELEMENTS	MAIN FEATURES OF 1997 PROPOSALS	KEY CHANGES FROM EARLIER PROPOSALS
Main objectives of proposals	1. Generate revenue for the public sector 2. Expand coverage and some increased cross-subsidisation between people served by the public sector 3. Improve efficiency of service provision	Focus on those served by public sector only Emphasis on generating revenue for public sector
Beneficiary group	Formal sector employees, particularly targeting the lower income (although above the tax threshold) and currently uninsured	Focus on lower income employed and uninsured workers only (as opposed to wider population)
Contributors	Only those formally employed (above the tax threshold) and currently uninsured	Focus on lower income employed and uninsured workers only (as opposed to all formally employed)
Basis of membership	Compulsory for target group and voluntary for informally employed	
Benefit package	Defined public hospital package (possibly including better amenities than usually provided in public hospitals)	Public hospital provision only (as opposed to including primary care and allowing private sector provision)
Benefit provider	Primarily public hospitals (top-up cover from private sector allowed)	
Benefit funding mechanism(s)	Shared employer/employee contributions	
Provider payment mechanism	Some form of re-imbursement	
Regulation	To define core benefit package and ensure target group take out public hospital insurance	
Administrative body	Statutory SHI authority located outside civil service to manage scheme (plus small administrative role for medical aid schemes)	Creation of new administrative body

TABLE 2: ACTORS AND SHI DEBATES WITHIN SOUTH AFRICA 1994-99		
ACTOR	**PRIMARY INTERESTS**	**POTENTIAL SOURCE AND LEVEL OF POWER/INFLUENCE**
The public	The uninsured: • To improve security of access and sense of social protection The insured: • To maintain and improve existing benefits (of access to private care) at reduced or lower cost	The uninsured: • Some broad political power through the democratic process and through membership in trade unions but no direct influence over SHI debates which largely occurred 'behind the closed doors' of government and committees. The insured: • Some broad political power through the democratic process but no direct influence over SHI debates.
Private providers	• To secure or improve incomes and working conditions by obtaining access to a large pool of private patients • To increase access to new technologies in order to improve quality of care	• Potential economic power partially contained by fragmentation and competition within sector • Limited political power in the post 1994-era • Organised medical profession weak because main organisation discredited by history and considerable fragmentation among alternative organisations • Roles within SHI discussions limited to making submissions to some committees • Technical knowledge of own operations.
Employers	• To limit costs by keeping premiums low • To secure benefits for workers • To improve labour relations	• Economic power, harnessed through various organisational structures • Limited political power • No formal role in SHI discussions but regular meetings with government and trade unions on broader macroeconomic and labour issues • Technical knowledge of its own operations
Trade Unions	• To expand and improve health care coverage for poorer groups within society • To consolidate or expand the current benefits available to their own members (which, for many, means free public primary care and cheap public hospital care; but some TU members are seeking access to private primary care)	• Strong political power through formal alliance with the African National Congress and role in anti-apartheid struggle • Potential economic influence constrained by political alliance and allegiances (limiting strike action, for example) • No formal role in SHI discussions • Limited technical capacity to support direct engagement in these discussions.
Medical schemes	• To maintain market share and revenue levels, and if possible expand it • To counter proposals hostile to its interests • To support the new government in expanding access	• Considerable economic power initially harnessed through a single structure (the Representative Association of Medical Schemes: RAMS) but later undermined by fragmentation within industry • Limited political power after 1994 but considerable tactical awareness, and some strategic action • Given formal place in SHI committees of 1994 and 1995 • Technical knowledge of its own operations

TABLE 2: ACTORS AND SHI DEBATES WITHIN SOUTH AFRICA 1994-99

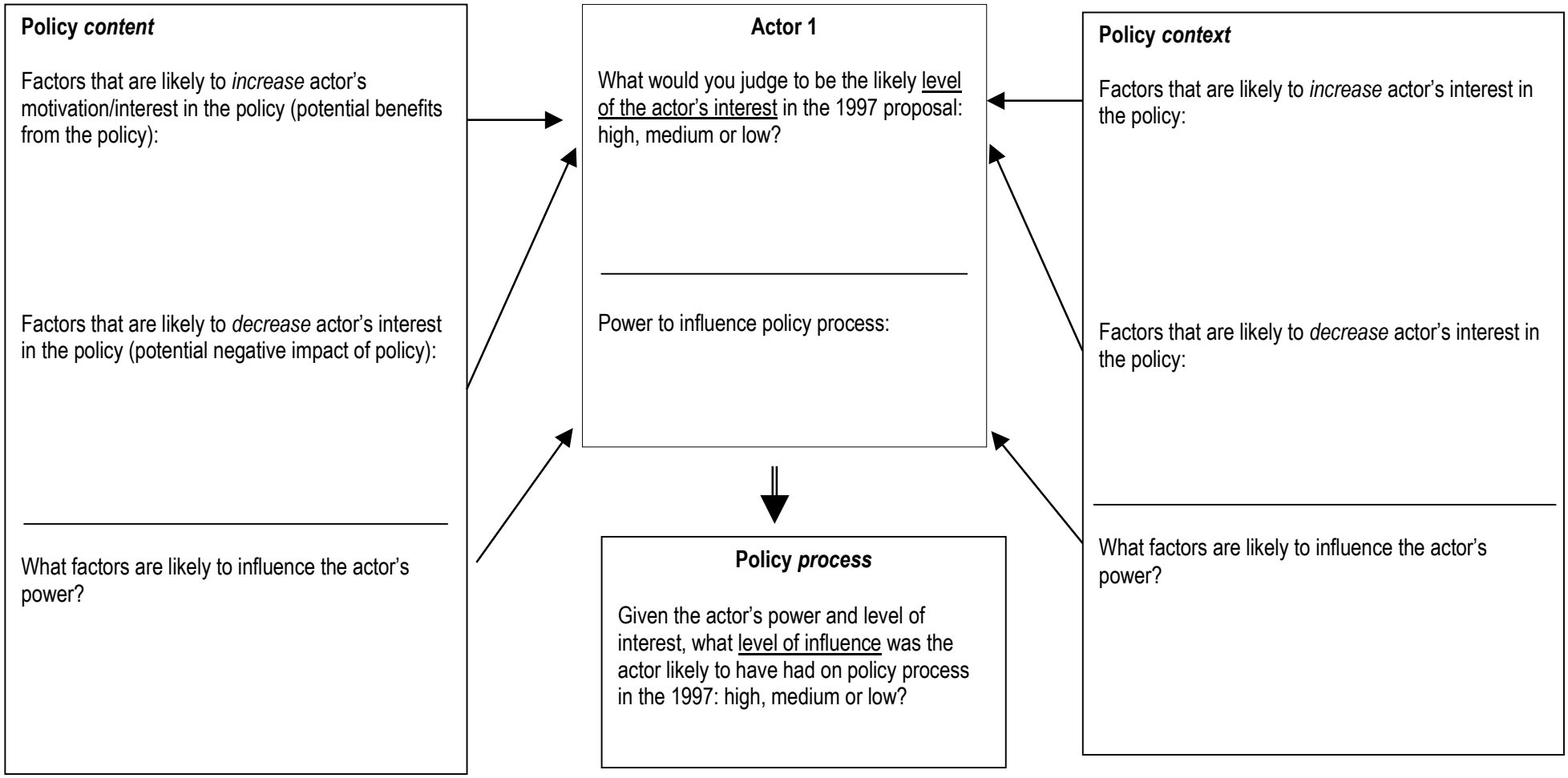
ACTOR	PRIMARY INTERESTS	POTENTIAL SOURCE AND LEVEL OF POWER/INFLUENCE
Government: Department of Finance	Overall objectives rooted in the relatively conservative post-1996 macro-economic framework which aimed to promote economic growth by encouraging private international and national investment. They include: • To improve efficiency in government expenditure • To contain public expenditure levels and reduce the government deficit • To contain the tax: GDP ratio • To protect the 'already highly taxed' middle income from further taxation • To ensure accountability for government expenditure Given these objectives, the Department of Finance's interests in SHI included ensuring that overall public expenditure limits would be maintained; the overall tax: GDP ratio would not be increased by an 'earmarked tax'; that all decisions about health spending levels would be made through Cabinet; that the middle income were protected from increased health taxation; and that improved efficiency of spending remained a key priority of the health sector.	• Strong political and economic power as the central economic ministry within the newly-elected government, charged with ensuring implementation of the politically high profile and well-accepted macro-economic policy (particularly after 1996) • Strong role in all policy processes concerning government policy on financing and expenditure issues, although varying formal role within SHI discussions • Strong technical capacity only enhanced other forms of power
Government: Department of Health	Objectives not clear but broadly a combination of: • Improving equity through strengthening cross-subsidisation mechanisms (between sectors of the system and between population groups) • Revenue generation for public sector Apparently changing over time from stronger emphasis on cross-subsidisation towards stronger emphasis on revenue generation	• Some political power from leading role given to the health sector in formal ANC policy documents, and from personal standing of Minister in government; but contained by position as spending ministry subject to overall government economic policy • Technical and managerial capacity undermined by broader evolution of governmental structures, appointment of new government personnel, limited technical knowledge and understanding of new personnel of health financing issues

TABLE 2: ACTORS AND SHI DEBATES WITHIN SOUTH AFRICA 1994-99

ACTOR	PRIMARY INTERESTS	POTENTIAL SOURCE AND LEVEL OF POWER/INFLUENCE
Minister of Health	• To improve access to health care particularly for the poor and rural populations, preferably through government controlled funding arrangements • To maintain a public health system with the same access and quality levels for all (and cautious about profit-motivated private health sector)	• Strong political power from being in health sector base , itself seen by the ANC as a sector where speedy change to redress the apartheid legacy could be implemented, and from personal standing within ANC (personal backing of President and Deputy President) • Strong formal role in health and wider policy processes, as national Minister of Health and cabinet member • Additional influence from clear values and stated goals, and from decisive management style
Health economists advising government	• To develop a technically and politically feasible insurance-based funding mechanism with which to support overall health system development	• No economic or political power • Strong formal role in SHI committee processes constrained by the way in which the committees functioned (e.g. limited time, too many issues, little interaction with senior policy-makers) • Technical capacity constrained by limited understanding of their role among DOH officials and by their own weak strategy

Form 1 (copy form for Actor 2)

1. Read the background information.
2. For your two allocated actors, record the key influences that you think would affect their interest in, and influence on, the policy process.



Form 2 Stakeholder characteristics

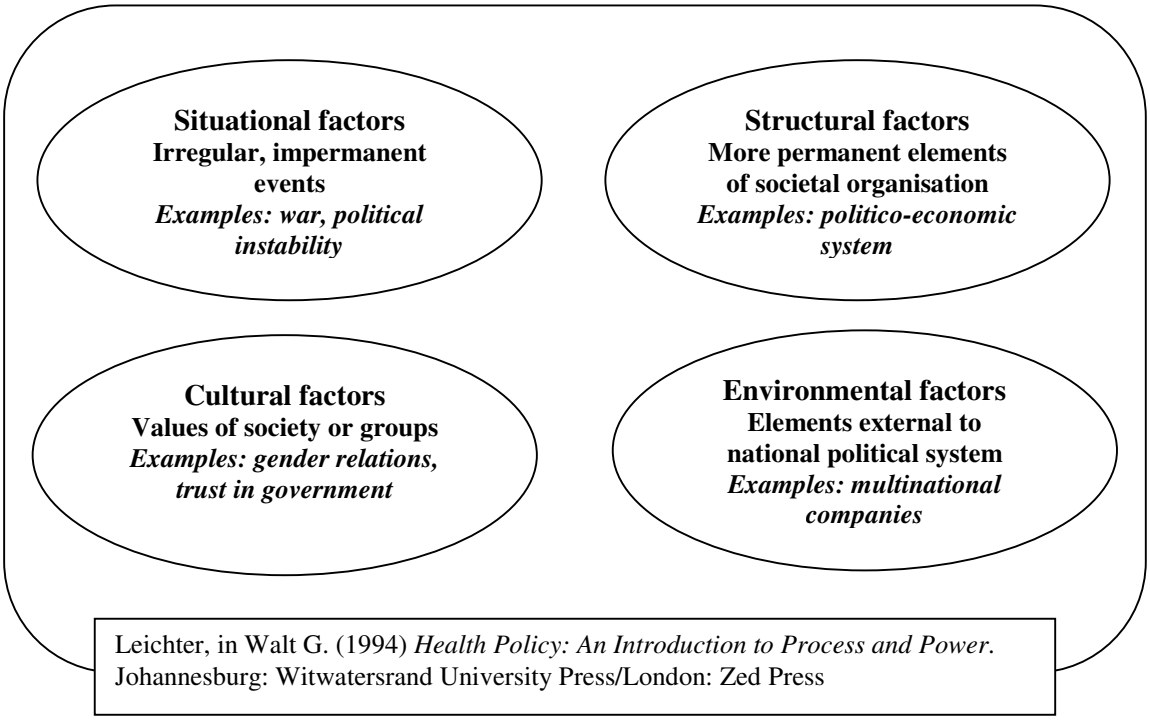
Actor (name each actor)	Given the actor's interests (Table 2), *what level of impact were 1997 proposals likely to have had on actor?* (high, medium, low)	Given the actor's interests (Table 2) *and* the likely impact of 1997 proposals on the actor, *what level of concern was the actor likely to have in 1997 proposals?* (high, medium, low)	Given the actor's source and level of power (Table 2), *what level of influence was the actor likely to have had on SHI policy process in 1997?* (high, medium, low)

Form 3 Stakeholder analysis

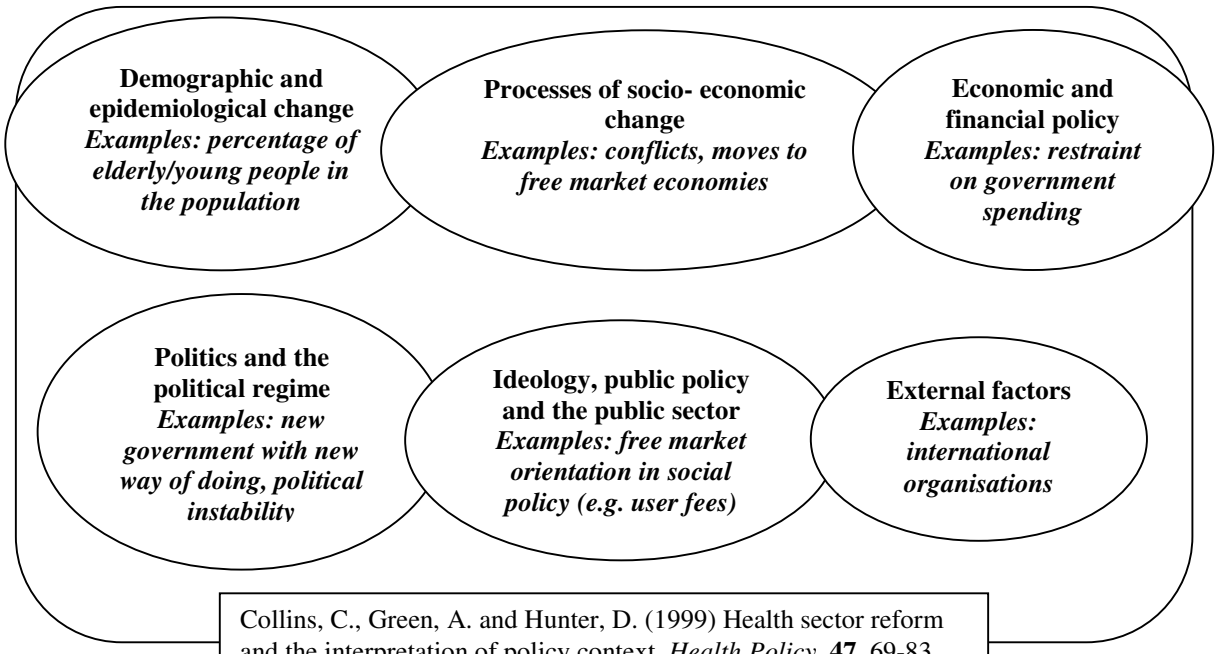
Actor	**Proponents**			**Opponents**	
	high support	**<< <<**	**not mobilised**	**>> >>**	**high opposition**

Handout 11

Different ways to categorise contextual factors



Leichter, in Walt G. (1994) *Health Policy: An Introduction to Process and Power.* Johannesburg: Witwatersrand University Press/London: Zed Press



Collins, C., Green, A. and Hunter, D. (1999) Health sector reform and the interpretation of policy context. *Health Policy*, **47**, 69-83.

Handout 12

Session 8: Considering content *Activity 8.2*

Policy characteristics analysis

South Korean case study

Cost and benefits	
Administrative / technical content	
Extent of participation	
Resources	

Handout 13

Session 8: Considering content *Activity 8.2*

Policy characteristics analysis

South Korean case study: *Some key points*

Cost and benefits	▪ These policies intended that physicians, pharmaceutical companies and pharmacists would incur significant financial costs in terms of reduced profit margins. It also envisioned certain benefits to patients, including lower costs and enhancing their right to know about their medication. The medical and pharmaceutical associations argued that patients would also bear the cost of greater inconvenience in obtaining drugs. ▪ The experience suggests that the patients are in fact shouldering the burden of reduced access, but that the policy might end up increasing their financial costs and increasing the financial benefits received by the providers, given the increases in reimbursement rates won by the health care providers
Administrative / technical content	▪ From an administrative and technical point of view, the policies seem quite complex. On the one hand, they entail significant changes in the health care delivery and payment system as a whole. On the other hand, they involve information about prices, profit margins, etc. which can be very complicated and contested.
Extent of participation	▪ These policies required the involvement of many actors to be successful. It not only asked thousands of physicians and pharmacists to do things differently, but also affected the beliefs and behaviours of consumers and patients. ▪ This was complicated further by the fact that the significant costs were so clearly concentrated on a particular, mobilised group of people, while neither civic groups nor the government put much effort into persuading consumers (the many who stood to benefit) to support the reform.
Resources	▪ The election of the new president seemed to bring some fresh political resources, which enabled the reforms to be taken forward. ▪ The health care providers were very successful in using a massive resource at their disposal (their dominant position in the health system) to extract concessions and compromises from the government during the policy change process.

Handout 14

Language analysis

Identify the metaphors present in each of the following statements:

1. The Ministry of Health has taken flack from Aids activists

2. The gloves have come off in the run up to the elections

3. The new permanent secretary promises to hit the ground running

4. Africa's economies are overheating

5. A tidal wave of change is about to hit the health sector

Handout 15

Session 9: Stakeholder analysis *Activity 9.1*

A forcefield analysis of the 1997 SHI proposals

(Gilson *et al*., 1999, see Handout 10)

Actor categories	*Proponents*			*Opponents*	
	high support	***<<< <<<***	***non mobilised***	***>>> >>>***	***high opposition***
political sector	MINMEC		political parties other than ANC		**Minister of Health ANC**
government sector	DOH DDG DHFE		DOH DG		**DOF**
business sector	RAMS		employers; private providers		[COMS]
analysts	some analysts		some analysts		Dr. Deeble
social sector			other groups	**COSATU**	

Notes:

- actors highlighted played most critical role
- not mobilised = did not play identified role in debates, but this allows for an actor to have played a 'behind the scenes' role
- COMS = Concerned Medical Schemes group; COSATU = Congress of South African Trade Unions; DG = Director General; DDG = Deputy Director General; DHFE = Directorate of Health Financing and Economics; RAMS = Representative Association of Medical Schemes;

Handout 16 *(1 of 2 pages)*

Session 10: Developing strategies to support policy change *Activity 10.1*

Actor management 1: Strategies with a focus on interests

1. Remind yourselves of the two actors you considered in the stakeholder analysis exercise.
2. For each actor, identify whether you should involve, collaborate with, defend against or monitor them. Use the Table below to record your ideas.
3. For each actor, identify a strategy for managing them (perhaps drawn from those listed on the next page). Give reasons for your choice, and one or two examples of how you would implement the strategy.

Place your actors in the relevant column below

Individuals/groups to **involve**	Individuals/groups to **collaborate** with	Individuals/groups to **defend** against	Individuals/groups to **monitor**

	Actor 1: ……..	**Actor 2: ……..**
What strategy?		
Reasons		
Ideas for implementation (tactics)		

Strategy examples

1. Redefine the way people understand the proposed policy action so that they are more likely to support it.

2. Mobilise an existing actor to support the policy action.

3. Enhance the power of an existing actor in support of the policy action, for example provide information or build alliances with others.

4. Strengthen alliances among actors in support of the policy action.

5. Directly block the power of actors opposed to the policy action.

Strategies and Tactics

Example

Strategy 1: Redefine the way people understand the proposed policy action so that they are more likely to support it.

Strategic goal: to influence public opinion
Tactics (practical action taken in order to achieve the goal):
- develop relationship with specific journalists and provide them with information
- hold events to capture media attention, such as demonstrations outside hospitals

Strategic goal: to build support of politicians
Tactics (practical action taken in order to achieve the goal):
- write short policy briefs that contain relevant information from research, distribute the briefs to politicians
- run workshops for politicians who are likely to be open to the ideas in the policy

Handout 17

Session 10 Developing strategies to support policy change *Activity 10.2*

Actor management 2: Designing a communication strategy

1. Choose one of the actors you considered in the previous activity
2. Develop an appropriate communication strategy for this actor, making brief notes in table below to show the judgements on which your strategy is based and drawing on the overheads from the theoretical input.

Actor: …….

Psychograph (what are the actor's aspirations, hopes, beliefs, values)	*Key message* about the policy that is most likely to reach actor's hearts (affect them on a personal/emotional level)	*Sociograph* (what does the actor do , with whom, where; considering work and social life)	*Channels of communication* most likely to reach actor	*Materials needed*

Examples of *channels* of communication

Public statements
Media briefings
Inputs at parliamentary committees
Community group meetings and activities
Mass meetings, marches
Petitions
Public hearings
High profile events
Routine committees
Training activities
Others?

Examples of communication *materials*

Press releases
Briefing notes
Posters, T-shirts
Training curriculae documents/resources
Memos, Speeches
Videos, Others?

Handout 18

Session 11: Thinking in an integrated way *Activity 11.1*

What would have happened if …?

Start thinking individually and then work in groups

1. Remind yourselves of the South Korean drug prescribing and dispensing policy change scenario and the key issues you identified as influencing the experience (using your notes from Session 3).

2. For a minimum of 2-3 of the changes listed below:
   - categorise each change using one or more of the policy analysis triangle elements (actors, content, context and process)
   - consider how this change would have affected the overall policy experience: what, if anything, would be different? What, if anything, would have stayed the same? What categories of issues (according to the policy analysis triangle) are affected/not affected?

Changes to the South Korean policy experience

What would have happened if …

(a) Korean society had not been opening up as a result of democratisation?

(b) A new President had not just been elected?

(c) The private health sector had played a weaker role in the overall health system?

(d) Civil society organisations had conducted a stronger public awareness campaign focussing more on the policy's benefits to the public and less on the profit-motive of the physicians?

(e) The government had delayed implementation of the 'no margin' policy?

(f) The pro-reform lobby had been able to exploit divisions within the professional grouping?

Handout 19

Group Work Presentations

Peer Review Form

Group being assessed:	
	Views and ideas
Clarity of content, e.g: Is enough information given to allow you to understand the argument? Is too much or unnecessary information given? Do you understand the judgements made? Why/why not?	**Overall judgement**: good/OK/inadequate? **Comments**:
Presentation format, e.g: Is the presentation clearly structured? Did it keep to time? Are the overheads legible? Is there too much/too little information on the overheads?	**Overall judgement**: good/OK/inadequate? **Comments**:

Handout 20

Self-assessment of your own group's functioning

Group name (or policy scenario):

Think about the way you have worked as a group during the Group Work Sessions.

1. Take 2-3 minutes initially to reflect individually on your group functioning, considering questions like:
   - Has everyone participated in some way?
   - Was anyone too dominant or too quiet?
   - Has there been openness and courtesy to all?
   - Did you share tasks appropriately?
   - Have you learnt from others in the group through the discussions?
   - Were you able to manage the time available effectively?
   - Did you manage the process of preparing the presentation as effectively as possible within the time available?
   - Did you enjoy the group work?

2. Take 5-10 minutes to share your views with each other.

3. As a group, make a final overall judgement about your group functioning (circle one):

   Bad

   Poor

   Fair

   Good

   Excellent

Please think about the lessons you can draw for yourself from this experience, to take forward into group situations in the future.

Finally, please return one form per group to the course organisers.

Appendix 3

Examples of: a course evaluation form, marking criteria for the individual assignment, a policy scenario.

Example of an evaluation form, for the end of each day's sessions

EVALUATION QUESTIONNAIRE

1. Rate today's sessions under the headings given on a scale of 1 (lowest) to 5 (highest) :

	Relevance to me	Knowledge gained	Presentation and facilitation
What is policy and policy analysis?			
A framework for analysing policy processes			

2. In these sessions, I really enjoyed :

_____

_____

_____

3. In these sessions, it would have been better if :

_____

_____

_____

4. Any other comments or suggestions :

_____

_____

_____

MARKING CRITERIA

INDIVIDUAL ASSIGNMENT

Overall marking practice: group work and individual assignment
One final mark will be allocated for the group work presentation and the individual assignment. It will be based on the following split: 20% group work presentation and 80% individual assignment. Each of these elements will be marked according to the marking schedules provided to you.

INDIVIDUAL ASSIGNMENT: TASKS

Prepare an individual report of between 5000 and 6000 words that provides:

Part 1: An analysis of the strengths and weaknesses of the policy change experience presented in your scenario, that

(a) provides an initial brief and basic description of the experience
(b) presents a reasoned and justified argument about whether it was a success or failure (or had elements of both), explaining this judgement through a careful assessment of the strengths and weaknesses of the experience
(c) uses a policy analysis approach to describe and explain this experience in an integrated way.

Part 2: A set of relevant and justified proposals about
EITHER (a) How 'you' would have strengthened policy development and implementation over the period considered in the scenario;
OR (b) How 'you' would strengthen policy development and implementation from the time at which the scenario ends.

NB For Part 2, always make clear whose perspective you are adopting in presenting your response i.e. spell out who 'you' are; and think carefully which option is most relevant to your scenario.

Important notes about assignment topic:

- Your response to part 1 should be different from your group work presentation, although it may build on it.
- Your response to part 1 requires an analysis that recognises the inter-linkages between the four elements of the policy triangle as influences over the policy process, and might be undertaken by applying particular concepts and/or a specific conceptual framework.
- Only answer **one** part of (a) or (b) for section 2.

Instructions for formatting and submission

Instructions for assignment layout

1. On the front page of the report please clearly identify:
   - your name;
   - the scenario considered
   - the total word length of the report (excluding references).

2. Type using a font size greater than 10 point and with 1.5 spacing;

3. Indicate clearly which option of part 2 of the assignment you are addressing;

4. References should be marked in the text using the author's name and date of publication e.g. (Bloggs 1989)

5. The list of references used in the report should be listed in alphabetical order at the end of the report in the following format:
   Walt G. (1994) Health Policy: An Introduction to Process and Power. Johannesburg: Witwatersrand University Press/London: Zed Press
   Walt G and Gilson L (1994) Reforming the health sector: the central role of policy analysis Health Policy and Planning 9(4): 353-370

Submission instructions

Your report must be handed to [person] by [time and date].
Late submission will incur the usual penalty.

Marking criteria and approach

Assignments will be awarded a final percentage mark that can be broadly categorised as below.

Fail	Pass level	Fair Pass	Good Pass	Distinction
49% and less	50-55%	55-64%	65-74%	75% and above

Using the detailed criteria outlined below, the award of a:

- fail mark will reflect consistently poor levels of performance;
- pass mark will reflect more adequate than poor performance levels;
- fair pass mark will reflect generally adequate performance levels;
- good pass mark will reflect some adequate and some good performance levels;
- distinction mark will reflect generally good performance levels.

Assessment criteria

In marking the assignments we will be looking for evidence of your understanding and abilities in relation to two broad areas:
1. Content i.e. knowledge and understanding of the material covered in the module;
2. Form i.e. ability to present a clear and logical argument using this knowledge.

In addition, we will be considering some basic issues about how you addressed the question.

Given the assignment tasks we will assess these areas of understanding and ability using the following criteria sets (together accounting for around 75 out of 100 marks with items 2, 3 and 4 counting most).

Assignment task Part 1

a) *Provides an initial brief and basic description of policy experience of focus*

Poor answer	*Adequate answer*	*Good answer*
• Poorly structured: no sense of chronology, repetition, some points not necessary, contradictions • No sense of context of experience • Too long in relation to rest of assignment	• Offers generally clear structure and chronology of events, using enough and appropriate information, little or no unnecessary information • Contextualises problem and experience • Appropriate length relative to rest of assignment	Moves beyond adequate answer by e.g. • Offering better structured presentation of greater clarity, whist being succinct • Using policy analysis ideas and approaches appropriately in way structures and presents description

b) Presents a reasoned and justified argument about whether it was a success or failure (or had elements of both), explaining this judgement through a careful assessment of the strengths and weaknesses of the experience

Poor answer	*Adequate answer*	*Good answer*
• Does not make clear judgement OR • Judgement not based on evidence or analysis of strengths and weaknesses as presented in assignment AND/OR • Judgement based on poor review of evidence available (ignoring some important elements of experience that contradict judgement)	Clear judgement made which is generally based on • evidence from experience • the analysis of strengths and weaknesses as presented in assignment • the range of evidence available	Moves beyond adequate answer by e.g. • more clear/stronger use of evidence • stronger link from judgement to analysis of strengths and weaknesses presented in assignment • including critical reflection on judgement and strength of evidence base used in making it (author provides own views on these issues, appropriately justified)

c) uses a policy analysis approach to describe and explain this experience in an integrated way.

Poor answer	*Adequate answer*	*Good answer*
• No analysis – only outlines features of experience in limited detail, without use of policy analysis concepts or frameworks OR • Only limited use of relevant analytic framework, e.g. only categorises issues using elements of the policy analysis triangle, does not consider interactions between elements, uses policy analysis concepts incorrectly and without explanation • Colloquialism: style of language and use of description couched in common sense evaluation (could have written without doing module)	• Mostly works coherently with the policy analysis triangle as an integrated analytic framework, e.g. appropriately categorises issues, analysis structured in way that draws out and discusses some of the interactions between issues in different categories • Uses policy analysis concepts appropriately and with adequate explanation	Moves beyond adequate answer by e.g. • offering more comprehensive use of policy analysis concepts and approaches, perhaps drawing on additional concepts or frameworks • critically reflecting on the policy analysis approach as applied in assignment, developing or adapting frameworks used in relation to the problem of focus or critiquing the approach (author provides own ideas or views, appropriately justified)

Assignment task Part 2

a) Perspective

Poor performance = actor perspective being adopted not made clear and/or does not make clear which option addressing in response and/or tries to address both options of Part 2.

Ad/Good performance = actor perspective and option addressing clearly stated and only one option considered.

b) Proposals

Poor answer	*Adequate answer*	*Good answer*
• inappropriate to stated perspective • based on everyday knowledge rather than conclusions or ideas that are drawn from the analysis presented in the assignment • addresses only small part of experience as presented in part 1 • focusses on a few individual problems as presented and so does not take comprehensive approach to addressing problems outlined	• appropriate to stated perspective • derived from analysis presented in essay • addresses main issues in experience raised in part 1 • attempts to address problems as a whole • demonstrates an awareness of range of strategic interventions	Moves beyond adequate answer by e.g. • using policy analysis ideas or concepts to generate ideas about strategic interventions • taking into account contextual opportunities & constraints for proposals • critically reflecting on interventions proposed (e.g. author presents own ideas that clarify the purpose of using them, the potential for unintended consequences, the need to link up strategies)

Both parts of assignment

a) Use of concepts

Poor	*Adequate*	*Good*
Little or not use of concepts OR largely confusing and inappropriate use of concepts	Largely tacit use of concepts, where concepts not spelt out, explained or critiqued, but underlie analysis and largely used appropriately	Moves beyond adequate answer by e.g. • Generally explaining concepts clearly when used, and uses them appropriately in analysing experience • Justifying and explaining meaning and/or concepts used in relation to experience of focus • Critically reflecting on or critiques concepts and their significance for the analysis (author provides own ideas or views, appropriately justified)

Given normal expectations of post-graduate work, we will also apply the following additional sets of criteria in assessing your essay (together accounting for around 25 out of 100 marks).

Evidence of reading and research around the problem

Poor	*Adequate*	*Good*
Course material not used OR little used	Course material used within analysis	Course material and perhaps other relevant texts used in assignment in ways that illuminate experience

Structure and argument

Poor: language and argument unclear: difficult for reader to grasp issues at stake; assignment consists of description and/or discrete points that are not linked to other points through logical connectors (e.g. I judge/think xx because yy)

Adequate: has a clear structure – introduction, body and conclusion with generally clear arguments within sections

Good: not only carefully structured but also clear and logical interconnections between points and sections

Academic literacy

Good/Adequate performance =
Appropriate spelling and grammar
Uses appropriate referencing conventions
Appropriate word length

Poor performance =
Poor spelling and grammar
Does not reference material correctly
Considerable over or under word limit

Penalties will be applied for

1) Late submission

2) Plagiarism

You are also reminded that:

- The assignments must be prepared by individuals working alone; students should not copy from each other in writing their assignments;
- You must reference all material you use taken from any source (published or unpublished);
- If you take word for word quotes from any reference to use in your report you must reference it indicating the page number from which the quote is taken.

Any evidence that these standard rules have been ignored will be **penalised** in marking.

Example of a policy scenario for Group Work Sessions

Scenario:
Implementing the Bamako Initiative in Kenya 1987-1995

Policy of focus
The policy considered in this scenario is the implementation of a community financing mechanism in Kenya, inspired by the Bamako Initiative programme of UNICEF/WHO. Community financing schemes generally involve communities both in paying for health care and in the related decision-making. Seeking to improve access for under-served communities, Kenyan BI activities were based within communities where no other form of formal health facility existed. Village pharmacies were established and community members were selected, at a community-wide meeting, either to work within the pharmacy or to work as community health workers (CHWs), offering services in the surrounding villages. These CHWs received three months basic training before starting work, and then offered first-aid type curative care, a range of maternal and child health services and health education on water and sanitation issues. An initial supply of simple drugs and of mosquito bednets was provided to each pharmacy by UNICEF and then sold to the community as needed. The funds generated through these sales were intended to allow the purchase of new supplies of drugs and bednets, for re-sale to the community. Finally, it was hoped that the pharmacies would become the basis of wider community-based health and development activities, such as income-generating activities for the local communities. The overall management of the local pharmacy, its activities and its funds was placed in the hands of a village health committee, which worked with both the local chief and the local District Health Management Team. This scenario considers the implementation of these activities between 1989 and 1995.

Issues of focus
This scenario allows consideration of *why* and *how* the implementation of BI activities in Kenya failed to achieve their promise of long-term and sustained equity gains within the communities within which they were located.

In this case *equity* is understood as the distribution between different groups of community members of the benefits, payment burdens and opportunities to be involved in decision-making of BI activities. Particular concern is paid to the distribution between the majority of community members and the poorest groups within the communities.

1. The emergence of the Kenyan Bamako Initiative programme

Experiences with primary health care

The Kenyan BI programme grew out of the country's long experience with primary health care activities. These activities were strongly shaped by the 1978 Alma Ata declaration on Primary Health Care (PHC) and sought to mobilize communities to take health-promoting actions. They were, therefore, implemented outside the existing network of health facilities. For example, from the late 1970s Community Health Workers (CHWs) had been trained to provide preventive and promotive health care, and even to manage basic diseases. In the early 1980s village health committees were also established in some areas to help manage community-based health activities.

In many cases CHWs were supported by their communities and the government undertook their training, technical support and supervision. This form of partnership between communities and government reflected the broader harambee movement of Kenya. Meaning 'pull together', the harambee movement was part of the national political philosophy and involved the mobilization of community resources (particularly labour and materials) in support of national development activities. It provided an important platform for the type of community-based health activities envisaged in the primary health care approach.

Non-governmental organizations also supported CHW programmes in some areas of the country and made important contributions to PHC development over the 1970s and 80s. For example, they experimented with the introduction of charges for CHW service and, and more controversially, with allowing CHWs to prescribe and dispense drugs. As a result, the 1986 government primary health care guidelines[10] recommended both that CHWs be able to dispense first aid and basic essential drugs, and that the supplies of these drugs be paid for by charging people for using the CHW services. These guidelines also re-emphasized the importance of community-based health care, as opposed to primary care services offered through clinics, and of community participation in implementing such activities. They even proposed the establishment of income generating activities and community health funds to support the development of a range of local health-promotion initiatives.

Health system development

Interestingly, although the PHC guidelines indicated government approval of charging for *community-based* health services, services provided through fixed health facilities (clinics and hospitals) remained free of charge until 1989. Until then, the government remained committed to its 1965 Independence pledge of free health care at the same time that experiments with charging were conducted within PHC programmes. This difference of policy on charging seemed to reflect the greater flexibility allowed to health care initiatives developed outside the existing health infrastructure and bureaucracy, as compared to policy developments inside it.

The development of community-based PHC activities did, however, go hand in hand with a deliberate expansion of the rural health care infrastructure. The number of health centers increased three and a half times between 1963 and 1993, and the percentage of total government spending on rural primary care increased by two and half times between 1984/5 and 1993/4. The development of an Essential Drugs

[10] Bennett FJ and Maneno J. (1986) National guidelines for the implementation of primary health care in Kenya. Ministry of Health/WHO/UNICEF, Nairobi.

Programme (EDP) with donor support also ensured the availability of drugs in rural areas.

Yet despite these deliberate efforts, access to health care services remained relatively poor. PHC projects were confined to specific areas rather than being extended nationally, and in 1986 only about 30% of the population lived within 2km of a health facility[11]. The majority of health care expenditure (two thirds or more) remained allocated towards curative care provided mostly through hospitals. By the late 1980s the limited availability of health facilities was seen as the key weakness of the health system. In 1991, a UNICEF reported noted that "the development of the rural health infrastructure has lagged behind plans although the Government's major health policy focuses on the increase of coverage and accessibility in rural areas"[12].

However, the late 1980s also saw rising concern about the quality of care provided from existing facilities. Problems with the functioning of the EDP led to drug shortages in rural facilities, there were also problems with the supply of basic equipment, and staff morale was poor. Drug supply problems often meant that people had to buy drugs from private pharmacies or kiosks even when they had attended a government facility.

The broader national and international context

The weaknesses of the Kenyan health system in the late 1980s must be seen in the broader economic context. Despite the government's commitment to health care as part of the national development, national economic problems after 1980 led to a fall in the total amount spent by the government on health care. National economic policies designed to control the level of government spending also made it difficult to re-allocate resources to improve rural health services because it would require overall reductions in hospital spending. At the same time, the rising price of drug supplies bought on the international market made it increasingly difficult to purchase an adequate volume of drugs. Over time national economic policy began to reflect the international policy ideas of organisations like the International Monetary Fund and so, amongst other things, began to emphasise the need for the population to take over some responsibility for funding health care. Health care charges were initially introduced in 1989. However, these charges were suspended nine months later because of massive media and public criticism of the policy change, and falling utilization levels. They were only re-introduced in April 1992.

By the late 1980s the trend in international health policy was also in favour of the implementation of user fees for health care. Despite the impressive improvements in primary health care coverage achieved in some countries in the 1960s and 70s, many countries still had access problems and most suffered during the world-wide economic recession of the 1980s. In many African countries, the existing primary health care infrastructure deteriorated so badly that people effectively stopped using it, particularly because of the lack of drugs. Existing community-based health care initiatives, such as community health worker programmes, also suffered. Increasingly, charging fees for health care (called cost sharing) came to be seen as a key response to many governments' difficulties in funding health care, as well as a means of strengthening the partnership between government and communities in

[11] Bennett and Maneno 1986, op cit.
[12] UNICEF (1991) Community financing of primary health care: The Bamako Initiative in Kenya. UNICEF, Nairobi, p.9.

health development. An influential 1987 World Bank document strongly encouraged user fees as a new financing approach for the sector.

In this context, the WHO and UNICEF called a high level meeting of African health ministers and their advisers, held in Bamako, Mali in 1987, to develop a strategy for tackling the problems of rural health services. Senior Kenyan government health officials attended. The resolution of the meeting called on UNICEF and WHO to help accelerate the implementation of primary health care at district level, giving priority to women and children, with the goal of achieving universal accessibility to these services[13]. This resolution also proposed that the central components of the Bamako Initiative activities would be: decentralized decision-making, including the involvement of community members in managing primary health care activities; user financing of health services under community control; and the provision of essential drugs within the framework of a national drugs policy[14]. In practice, and unlike in Kenya, most countries that developed BI activities applies these strategies to the task of strengthening health care provision from the existing, fixed primary level facilities.

2. National level activities supporting the development of BI activities

Initiation and expansion

In November 1988, following the Mali conference, the Kenyan Ministry of Health (MOH) established a Task Force to review available Kenyan experiences with community distribution of drugs, assess needs for essential drug programmes, assess the economic potential of cost recovery and potential community use of revenue, and to look at some sustainability issues. The Task Team concluded that the use of community-based pharmacies and of CHWs in managing selected drugs for treatment would improve access and save lives. Some also saw the drugs as an entry point for developing a broader PHC development strategy involving community mobilisation activities, and so contributing to community development. The Task Team, therefore, sought and secured funding from the UNICEF Kenyan Country Office (KCO) to support the development of BI activities in Kenya.

The UNICEF KCO and the government PHC unit became the driving force of BI activities in the country. Together they initiated the first pilot project in September 1989 in Sigoti Location, Kisumu District, and two others developed quickly in neighbouring districts. At this stage, however, the BI architects limited the further extension of activities: as one said, *"we deliberately let it float initially, then, based on experiences we developed systems and guidelines building on the common characteristics of experiences"*. In effect, the first districts chosen served as 'learning areas' for developing the total national programme[15].

However, over time the demand for BI activities from communities and members of parliament grew. Kenyan MPs came to see the popularity of the activities and sought to ensure that their constituencies benefited. From one site in 1989, the total number of sites increased to 3 in 1990, 84 in 1992 and 237 sites in 1994. Most of these were

[13] World Health Organisation (1998). Guidelines for implementing the Bamako Initative. Regional Committee for Africa, Thirty-Eighth session, Brazzaville, 7-14 September, AFR/RC38/18 Rev. 1

[14] WHO 1998 op cit; UNICEF (1990) The Bamako Initiative Planning Guide. BIMU, UNICEF, New York

[15] UNICEF (1992) Project: Strengthening Primary Health Care through community-based action. Kenya Country Office, Nairobi, p.7.

supported by the MOH and UNICEF, but in some places NGOs adopted the broad BI model in their own activities. A range of internal and external evaluations continued to support the development of BI policy and activities over this period, and in 1994 a set of national guidelines was published by the MOH/UNICEF to support the establishment of BI activities in new areas[16].

Programme objectives and activities

The objectives of the programme remained more or less the same over time, focussed on: supporting communities to improve their health through the development of a community pharmacy and network of CHWs; ensuring the availability of drugs at the community level; and empowering the communities to fund and implement local development activities. However, the range of activities integrated within the BI programme expanded quite considerably. In some ways it seemed as if UNCIEF and MOH staff saw BI sites as areas where they could experiment with new strategies and ideas. By 1995 BI activities included: income generating activities; community-based malaria control; nutrition and community-based growth monitoring and promotion; immunisation; safe motherhood; water and sanitation; control of diarrhoeal diseases; health education; STD/AIDs/HIV control; community-based health information system; and control of acute respiratory infections. The addition of the last activity also led to the inclusion of anti-biotics in the range of drugs provided to pharmacies. However, the other drugs provided to pharmacies remained relatively simple, first-aid type drugs.

Links with the health system

As the BI progamme evolved, however, only limited attention was paid to the integration of BI activities with the broader health system. Two different units within the MOH were, for example, responsible for the BI programme and for the parallel programme of introducing fees within static facilities (which was seen as a leading component of MOH efforts to improve the health system in the 1990s). The implementation of the two programmes at the same time but without coordination, generated a confusing situation for health care users. They were faced with the possibilities of free care but poor drug availability at clinics and reasonable drug availability at a price in pharmacies. Instead of visiting BI pharmacies first and then being referred, when necessary, to clinics, there was some evidence that they went first to the clinic to get a prescription and then took that to the pharmacy to buy the drugs. The lack of coordination over fee policies also indicated that BI activities were separated from mainstream policy development within the MOH. One possible cause was that different donors funded different activities within the MOH (e.g. UNICEF funded BI, and USAID funded the cost sharing policy) and this “tended to create kingdoms within the MOH establishment"[17], making co-ordination between programmes difficult. In addition, because UNICEF was not "an advocate for broader health reform", it is possible that the BI was just not given the attention it deserved in Kenya nor were efforts made to link it to wider activities. A critical failure was to ensure that drug supply to BI pharmacies was tied into the overall programme of supplying drugs to health facilities throughout the country.

[16] Liambila W., Maneno J. and Hill J. (eds) (1994) A practical guide to the planning and implementation of the Bamako Initiative in Kenya. Ministry of Health/UNICEF, Nairobi.

[17] Cohen S., Mwanzia J., Omeri I., Org'ayo S. Decentralisation and health Systems Change in Kenya. Revised case study, 1995 (mimeo) p. 31.

Driving partners
The Ministry of Health and the Kenya UNICEF country office remained the key partners supporting the BI programme in the 1990s. Within the MOH the main groups involved in the programme were a special BI sub-unit of the PHC unit and the District Health Management Teams (DHMTs) who responsible for ensuring implementation of all health activities in the districts where BI sites were located. A range of people were involved in the BI programme from within the UNICEF office. But a key player was someone who had been a senior MOH official, and had attended the 1987 Mali conference on behalf of government, and had moved to UNICEF in the early days of developing the Kenyan BI programme.

Within this partnership, UNICEF was the stronger partner. The influence of the MOH was undermined by personnel turnover at national level and by the failure of the government to allocate its own funding to BI activities. Even the special unit established to support BI activities was largely donor funded. In contrast, the UNICEF office was the major funder of all the costs associated with pharmacy-based activities, including the supervision and training activities conducted by DHMTs. It even funded the transport costs of the officials working within the central PHC unit. The UNICEF office also itself ensured distribution of drugs and bed nets to pharmacies and frequently brought new ideas into the development of the BI programme. For example, it was a UNICEF consultant who recommended the inclusion of bednet provision as one element of pharmacy-based activities. UNICEF officials were also responsible for refusing to allow the procurement and supply of drugs to pharmacies through the national EDP, preferring instead to experiment with community-based mechanisms for drug distribution. As a result, when UNICEF support to the BI programme was suspended in late 1995/early 1996 there was no system in place for the routine provision of drugs and bednets to pharmacies. The BI programme was seriously damaged at this time, as community members made clear:

"The quality of services is generally low, since external support stopped drugs are no longer available and CHWs are no longer working for the project"

"Accessibility had improved but now the BI is not as vigorous as at the start".

This scenario does not consider BI programme development after 1995.

3. Implementation of BI activities within communities

Selecting sites
Local areas selected for inclusion in the BI programme were initially chosen on the basis of high infant mortality rates and the existence of a good working relationship between UNICEF and the DHMT serving that area. A specific set of criteria was subsequently developed for DHMTs to use themselves in identifying which communities should be include within the programme. However, in practice DHMTs more often responded to community requests for support than initiated activities themselves. UNICEF officials also continued to play an important role in identifying communities where new BI pharmacies could be initiated. Nonetheless, in line with the programme goals, the majority of BI sites were located in geographical areas with poor health status indicators. A BI site was actually a group of villages all located within one administrative area managed by a chief- or sub-chief.

Selecting VHC members and CHWs

Once a site was identified or selected, the next step was to discuss the idea of initiating BI activities at a Baraza (Chief's gathering). Community members from *all* of the villages falling within that chief's area were then supposed to elect, at a Baraza, the Village Health Committee (VHC), of between six and 12 members. Policy guidelines stated that VHC members were required to be literate and have previous experience in health-related work. The VHC was also supposed to have equal representation of men and women. Subsequently VHC members were trained to take on specific roles in the daily running of the community pharmacy. These might include store-keeper or bookkeeper. CHWs were also selected by the community at a Baraza. Again policy guidelines stated that CHWs should be literate and respected members of the community; they also had to be available for a minimum of two days a week, live in the community, be able to work voluntarily, and, preferably, should be women.

These selection processes were inevitably less open than the policy guidelines envisaged. Sometimes particular groups within the community had a clear influence over the selection process. In some areas the CHWs selected VHC members without consulting with other community members. In other areas, only people from some of the villages within the site were involved in the processes. Other villages were, then, not represented on the VHC or among the CHW network. Inevitably, the chiefs were always in a position to influence the processes. Sometimes this happened indirectly: their presence at the baraza leading the community to select particular people to the VHC or as CHWs. In other areas they made the decisions about who would be on the VHC or work as CHWs without discussions at a Baraza. There were also cases where chiefs and sub-chiefs took over control over BI assets for their own benefit. So, for example, in one case, the chief took control of one of the dairy cattle owned by the BI for "safe keeping" and then declared the animal his, in spite of opposition from some of the members of the community.

As a result many members of communities with BI pharmacies were not aware that *they* "owned" the projects. Instead, there tended to be an assumption that the project belonged to someone else – such as the chief, or the VHC or the CHWs. As one group of community members said, "*We find ourselves at crossroads now because there is nothing we can ask the VHC about this project because we were not part and parcel of its inception"* and *"Rules and conditions governing the management of the project have never been made open to the community".* In one place the CHWs commented that they were *"just called by the VHC to sing while visitors are on call"*. Elsewhere, the BI pharmacy was identified as 'the UNICEF project' or, in one case, was named after the UNICEF officer responsible for the BI programme!

The group that was most excluded from these decision-maing processes were the poorest and more marginalized groups within communities. Although the majority of CHWs were women and women were well represented on VHCs, they were rarely selected to occupy leadership positions – such as chair, or secretary. In addition, as the poorest less frequently attended Barazas than other groups within communities and were generally illiterate they were simply not selected as CHWs or VHC members. Community members themselves noted that:

"They [the poorest] do not get the opportunity to be a CHW or join a VHC since they do not go to the places where such activities take place"
"The vulnerable members do not get an opportunity to be a CHW or join a VHC because that selection is only for the fittest members in society"

"The poorest people in the community do not take part in selecting CHWs or VHCs, normally they are neglected due to poverty".

Setting prices and planning revenue use

According to the policy guidelines the two most important management decisions for which VHCs were responsible were: (a) setting prices and (b) deciding how to use the revenue generated. However, on both issues VHCs had to work within national guidelines. Prices had to be set per item of each drug available within the pharmacy drug kit. VHCs were also encouraged to set prices at two to three times the cost of purchasing each drug, whilst keeping the price below the level charged in local shops or kiosks. CHWs were made responsible for deciding which people were too poor to pay, and were then supposed to provide services without charging them (perhaps referring them to VHCs for further assessment of their circumstances). Of the money generated through the fees, half was to be paid into the community account (to replenish drug and bednet supplies), one quarter into a VHC fund (to support wider activities, such as income generating activities) and one quarter was to be used to fund small payments to VHCs/CHWs for their services.

In practice the prices set for drugs more or less followed the guidelines, with VHCs considering both what people could afford and prices in the local market place. Nonetheless, price levels for the same drug varied quite a lot between sites and, more critically, very few people were ever treated free of charge in any site (see section 4). When questioned, community members generally agreed that price levels were affordable for most people within communities but often expressed concern that they did not know how prices were set and had not been consulted in the process. Some also indicated that they felt that the poorest could not afford the prices.

"Prices are set by the VHCs and the CHWs without consulting the community"
"Payment mechanisms do not take into account issues of poverty but prices are set on the basis of what the majority can afford"
"Payments for drugs and bednets do not take into account the issue of poverty. Drugs and bednets are not supplied free to the poor"

Decisions about revenue use were also often said to have been made without consultation – either with the general community or with the poorest.

"The poor do not know how the money generated from the project is used and therefore do not have a say in the use of the revenues generated"

In some places community members felt that VHC members were mis-using funds. *"The people who borrowed the money should return it"*. This concern might have arisen because VHCs were not open and transparent about how they decided how much to award themselves as payments for their time. In some sites quite large amounts were allocated as allowances to VHC members and CHWs.

Only a few communities used the revenue placed in the VHC fund to support community development activities. And even where they were used in this way, the activities were quite limited in scope. The types of activities supported included a women's cooperative shop selling foodstuffs to CHWs at reduced rates; a rice growing project to generate money to pay CHWs; the bulk purchase and re-sale within the community of sugar and milk; the purchase of maize at harvest time to be resold later when supplies were short. Again, moreover, community members sometimes expressed the concern that decision-making around income generating activities was

only in the hands of the VHC and/or the CHWs, not the whole community. One group said: *"We cannot comment on the IGAs because even at present none of us knows the number of bags of maize which were bought to be sold".*

But in practice, across sites the majority of the revenue raised remained in bank accounts, without being used. This was primarily because UNICEF continued to supply drugs and bednets free of charge to pharmacies and so VHCs did not need to use the funds to purchase new stocks of these items. Without guidance or support on how else to use their funds, VHCs simply banked the money after it had been collected.

Examination of the amount of money generated within sites, however, also suggested that not enough money was generated to cover the costs of purchasing new stocks of drugs and bednets. Only the wealthiest communities raised enough funds to be able routinely to buy adequate levels of new stocks. Price levels were not high enough to generate enough funds to re-stock the pharmacies on a monthly basis. Thus, when VHCs were forced to use their revenue after the withdrawal of UNICEF Kenyan Country Office for the BI programme (in 1995), they often found that they simply could not afford the prices at local pharmacies. They also found that they were sometimes sold expired drugs by these pharmacies. As a result, at this time community and VHC members commented:

"The services are poor and there are no drugs and whenever drugs are available, they are usually very expensive"

"BIs are selling us water"

Supervision and support

Experiences in the early days of the BI showed that good supervision was critical in the effective development of the community-level activities, and particularly in the first year. The 1994 national guidelines, therefore, proposed that the staff from the clinic nearest to the pharmacy would both undertake the initial training of VHCs and CHWs and provide the follow-up supervision, with back up from a nominated person on the DHMT. Supervision and monitoring were expected to focus on the use of funds, distribution of supplies, quality and extent of services provided, and level of malaria screening. UNICEF provided transport, and funding for fuel, for clinic staff and DHMTs. In practice, however, in most cases clinic staff had little contact with BI pharmacies adfter the initial training period. DHMTs were more likely to provide routine supervision to BI activities. Indeed, in some cases DHMT members were very involved in BI activities, even influencing who was selected as VHC members or CHWs and the price levels established. DHMT staff sometimes also helped VHCs to develop mechanisms that would allow free care to be offered to the poorest members of communities. These included establishing an approved list of those entitled to exemptions and a special bank account to cover the costs of care provided to the poorest. In practice, however, these types of mechanisms were not implemented.

Moreover, the role of DHMTs was itself generally undermined by the broader centralisation of decision-making both within the overall health system and within the BI programme itself. Although policy statements committed government to decentralise authority to the district level across all sectors, the national level retained control of decision-making. These trends were only repeated within the BI programme. UNICEF and central MOH officials retained responsibility for developing BI activities, leaving DHMTs to implement their decisions. Management capacity at the district level

was anyway quite weak and there were critical mis-matches between responsibility and authority. So, for example, DHMTs had only limited control over the hiring, firing and posting of staff and no role in determining district resource allocations. The resulting overall top-down implementation pattern of the BI programme was reflected in the VHCs' reluctance to take any initiatives with respect to revenue use. UNICEF's influence within the programme was also re-inforced by the fact they provided the financial support for the whole programme. When UNICEF withdrew its support DHMTs stopped supervising BI activities because they had no funding for this supervision.

4. The impacts of the BI activities on equity

There were two main equity gains from BI activities.

1. Most importantly, access improved for many within the communities served by the pharmacies. The pharmacies provided some types of care closer to the communities within which they were located than had previously been available. Community members frequently described BI activities as essentially being *"a community pharmacy which provides drugs cheaply and within easy reach"* commenting, for example, that because of the BI *"it is easy to get drugs at midnight and cheaply"*. In a household survey in seven BI sites 91% of respondents felt there had been improvements in access to health services since the introduction of the BI, pointing to the availability of drugs and bednets close to home as the most important improvements.

2. Revenue generated from the sale of drugs and nets was used to support the provision of services that benefited the whole community and not just those using curative care. This revenue provided some financial remuneration for the CHWs who provided preventive and promotive care and, in some places, was used to support broader development or income generating activities.

However, there were five main factors that limit the extent of equity gains - and may even have promoted inequity.

1. There are clear signs across communities that the poorest and most marginal groups within communities gained less than other community members from the improved services - be they curative, preventive or broader community development activities. Household surveys in seven sites indicated that the poorest group:

- used BI pharmacies less often than other groups;
- were less likely to have bednets than other groups;
- were less likely to perceive that the care available was good quality than other groups.

In addition, only around 15% of the poorest group reported having been given an exemption from payment.

Overall, therefore, it is likely that the BI activities did little or nothing to tackle the access barriers faced by the poorest groups in using health services.

2. Even the access gains achieved by the majority of community members were limited, because of the nature of the services provided. The provision of only a very basic package of first-aid type curative care meant that people still had to use, and pay for, other public or private services for more serious illnesses, such as severe

malaria. Household surveys showed that community members were particularly concerned about the limited range of drugs available in pharmacies and the level of training received by CHWs. *"CHWs are in possession of very few types of drugs and as such cannot treat many diseases"*. Few communities established broader health and development activities.

3. VHCs often did not consult with the broader community and rarely took account of the needs of the poorest groups. Given that, as already reported, the poorest were also less likely to be selected as CHWs or VHC members it is not surprising that they were less likely than other groups to feel that they belonged to the BI community. How could local decision makers therefore judge how to protect this group from the burden of payment, or how to ensure that they obtained benefits?

4. Any equity gains actually achieved in Kenya were compromised by the problems experienced by the BI pharmacies and CHW networks following the withdrawal of support from the UNICEF KCO.

"*Accessibility had improved, but now the BI is not as vigorous as at the start.*"
"*CHWs no longer visit the community or schools as they used to.*"

5. There was evidence of differences in activity and performance levels between communities, such as different price levels, different levels of revenue generation, and different CHW utilisation levels. To the extent that the better performing BI sites were more wealthy communities, then these differences were inequitable. For example, more wealthy communities were better able than others to generate revenue.

Additional references

1. Jarrett S, Ofosu-Amaah S. Strengthening health services for MCH in Africa: the first four years of the Bamako Initiative. Health Policy and Planning 1992; 7(2): 164-76
2. Gilson L, Kalyalya D, Kuchler F, Lake S, Oranga H and Ouendo M (2001) Strategies for promoting equity: experience with community financing in three African countries. Health Policy 58: 37-67.
3. Gilson L, Kalyalya D, Kuchler F, Lake S, Oranga H and Ouendo M (2000) The equity impacts of community financing activities in three African countries. International Journal of Health Planning and Management 15: 291-317