

Actor management in the development of health financing reform: health insurance in South Africa, 1994–1999

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Health reform is inherently political. Sound technical analysis is never enough to guarantee the adoption of policy. Financing reforms aimed at promoting equity are especially likely to challenge vested interests and produce opposition. This article reviews the Health Insurance policy development in South Africa between 1994 and 1999. Despite more than 10 years of debate, analysis and design, no set of social health insurance (SHI) proposals had, by 1999, secured adequate support to become the basis for an implementation plan. In contrast, proposals to re-regulate the health insurance industry were speedily developed and implemented at the end of this period. The processes of actor engagement and management, set against policy goals and design details, were central to this experience.

Adopting a grounded approach to analysis of primary interview data and a range of documentary material, this paper explores the dynamics between reform drivers engaged in directing policy change and a range of other actors. It describes the processes by which actors were drawn into health insurance policy development, the details of their engagement with each other, and it identifies where deliberate strategies of actor management were attempted and the results for the reform process. The primary drivers of this process were the Minister of Health and the unit responsible for health financing and economics in the national Department of Health Directorate of Health Financing and Economics, with support from members of the South African academic community. These actors worked within and through a series of four *ad hoc* policy advisory committees which were the main fora for health insurance policy development and the regulation of private health insurance. The different experiences in each committee are reviewed and contrasted through the lens of actor management. Differences between these drivers and opposition from other actors ultimately derailed efforts to establish adequate support for any form of SHI, even as regulatory proposals received sufficient support to be enacted in legislation. Drawing on this South African experience together with a simple analytical framework, the authors highlight five potential strategies by which reform drivers of any policy process could create alliances of support sufficient to overcome potential opposition to proposed policy changes. As little is currently known on how to manage the process of engaging actors in reform processes, these findings provide a foundation for further analysis of this issue.

Key words: health policy, policy analysis, policy committees, equity, social health insurance, health financing, South Africa

Introduction and rationale

While problems in health care reform and the solutions proposed often relate to technical or economic issues, health reform must deal with broader concerns and interests (Walt and Gilson 1994; Barker 1996; Berman 1996; Reich 1996). Grindle and Thomas (1992, p. 2) note:

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

Indeed, Barker (1996) notes that the design and implementation of policies is all about allocating resources, distributing power and deciding whose needs come first. Health reform embraces wholesale change, reallocating resources amongst different actors and producing conflict (Grindle and Thomas 1992; Reich 1996). It is, therefore, inherently

political (Cassells 1995). Large-scale financing reforms, such as the development of social health insurance (SHI), are especially contentious because they directly influence who pays for, and who benefits from, the health care system.

Such factors are often ignored by proponents of reform working at an international level (Reich 1996). But it is these concerns that are often uppermost in the minds of national political leaders. They may want to know how reforms will affect different groups in society and may favour reforms that produce the least opposition or ‘the smallest amount of hissing’, to misapply Jean-Baptiste Colbert. Some reforms appear to be more politically contentious than others. Both Olson (1965) and Nelson (1989) note that it is redistribution to the poor that often meets with the most opposition. In many low- and middle-income countries (LMICs) the urban middle-class tends to be more organized, with a louder voice, than other groups. In contrast, rural populations are usually dispersed and without the economic means to influence policy. Consequently, the concerns of the rich and influential

are seldom ignored (Grindle and Thomas 1992). Further, in one of the few published studies of the politics of health financing reform, Glassman et al. (1999, p. 115) note the problems for government in dealing with powerful interest groups who stand to lose from change:

‘One of the most important and complex problems in the process of health reforms is the management of these short-term, concentrated costs, and of the powerful groups affected.’

Financing reform, and particularly that directed toward equity, has, in all settings, to be handled very carefully to contain the undermining potential of opposition (Oliver and Dowell 1994; Blas and Limbambala 2001; Swenson and Greer 2002). Recognizing the often determining influence of actors over policy development and implementation, some attention has recently been given to ‘stakeholder analysis’, which involves mapping out the power and interests of actors in the health sector (Crosby 1992; Reich and Cooper 1996; Brugha and Varavasovszky 2000; Varavasovszky and Brugha 2000). However, such analysis often stops short of the next steps – that is, proposing strategies for how to manage actors and evaluating how viable such strategies are in a particular context.

Yet, there is some evidence to suggest that the deliberate management of actors is a key factor in driving reforms (Glassman et al. 1999; Nandakumar et al. 2000), and may even facilitate the implementation of health financing reforms concerned with redistributing resources (Reich 1996; Bloom 2001). As Bloom (2001, p. 221) notes:

‘Governments . . . need to become managers of sectoral change. This involves . . . an ability to negotiate with stakeholders and regulate their performance.’

In this paper we investigate actor management, and its absence, by considering the contrasting experience of health insurance policy development in South Africa and private health insurance regulation over the period of the first term of democratic government, 1994–99. This occurred through, or around, a series of committees established by government, which were the main policy-making bodies for health insurance. The different experiences of the committees, both formal proceedings and informal interactions, are reviewed and contrasted.

The development of health insurance policy engaged a wide range of actors with quite diverse objectives and concerns around a large-scale health financing reform that, for many, was seen as central to redressing the health system inequities of South Africa’s apartheid inheritance. Yet despite 10 years of discussion before and during this period, no set of social health insurance proposals had, by 1999, secured adequate support to move towards implementation. In contrast, proposals for the re-regulation of the private insurance industry, which many considered to be an important foundation for SHI, were successfully implemented in the 1998 Medical Schemes Act.

The struggle among actors that was central to this experience offers relevant insights by providing examples of deliberate actor management and its absence. We explore how different health insurance proposals were developed, noting the ways in which actors engaged with each other, the extent to which reform drivers deliberately managed other actors in these processes and where they did not, and how these patterns of management influenced SHI policy development. The term ‘reform driver’ is used here to refer to any actor who takes responsibility for steering the process of policy change toward a desired end-point. In contrast, an actor is an individual or organization that has an interest in the reform and has some power to affect the policy’s progress (Crosby 1992; Walt 1994). Through this analysis of South African experience we seek to throw some light on the prospects for effectively managing actors in any process of large-scale health financing reform. To this end we consider, finally, the lessons that can be derived from applying an analytical framework for selecting strategies of actor management to the South African experience.

We do not, however, debate the technical merits of the various sets of SHI proposals (or the 1998 Medical Scheme Act) developed through the processes of focus.¹ The development of health insurance is, instead, seen here primarily as a context for the exploration of actor conflict, and management of this conflict, by those wishing to drive through a reform. One danger of this approach is that it risks proposing good strategies for passing inappropriate policies. As this is not our intent, we wish to emphasize two points at the outset. First, strategic management of actors is no substitute for sound technical analysis. On the contrary, the two should go hand in hand to allow the effective implementation of policies promoting health system goals; which brings us to the second point. To retreat to the purely technical is to risk having good policies that never get implemented. Reform leaders, public sector managers and researchers are all forced to deal, to varying degrees, with the politics of health financing reform. To be aware of how to interact with such processes may allow technical input into reform processes to count for more (Gilson et al. 2003).

Methodology

This paper utilizes South African data drawn from a larger project: ‘Analysing the Processes of Health Financing Reform in South Africa and Zambia’, or the SAZA project (Gilson et al. 2000, 2003). The study’s primary focus was the detailed investigation of factors that influenced the overall process of health-care financing policy formulation and implementation in each country, shaping the nature and extent of change achieved. The South African study specifically explored the re-allocation of government budgets between provinces, the removal of user fees for pregnant women and children under six, and comprehensive primary health care, plus the development of proposals for SHI. As noted, only the last reform experience is considered in this paper.

In addition to studying the design of these reforms, the way in which policies were developed and implemented was investigated, together with an assessment of the key actors,

conflicts and steps in the processes. Following the policy analysis approach of Walt and Gilson (1994), factors influencing the reform process were explored fully. The primary source of information was a set of 28 in-depth interviews with those either directly involved in these processes or involved in the broader processes of policy development occurring at the same time. In addition, a wide range of secondary literature (policy documents, minutes of meetings, newspapers and parliamentary speeches) was collected and analyzed.

The authors adopted a grounded approach to analysis (Glaser and Strauss 1967). The interpretation and analysis of actor dynamics emerge, therefore, from the data and not a preconceived conceptual framework. This sets the methodological approach in stark contrast to that used by Glassman et al. (1999), where researchers were actively involved in the development of political strategies for health reform and used a specific conceptual framework to assist in the choice of strategies by which actors should be managed and reform processes developed. Here, instead, the researchers use the experience of health insurance policy development as a natural experiment and case study (see Hearst and Blas 2001). The views and opinions of different actors were recorded as they relayed their experience of the processes, conflicts, engagements and actor management strategies encountered. This case study approach allows for rich detail, avoids influencing actors, allowing them to be placed within their natural environment, and may facilitate unforeseen avenues of analysis (Yin 1994). Indeed, it may reveal cases where actors were not managed as an important focus of inquiry.

Nevertheless, researchers using a grounded approach must be careful that their own prejudices do not impede analysis (Thomas 1998) and that interviewees do not reshape history with hindsight (Carroll and Johnson 1990). To counteract such potential problems, great care was undertaken when conducting the initial analyses to compare and contrast information from different sources in order to seek confirmation of views and opinions. In addition, the initial analyses were reviewed by a range of key informants (Gilson et al. 1999, 2003).

Finally, a deliberate policy was adopted not to mention actors by name, either in sourcing interviewees or referring to the actions of an individual in the description of events. There are a variety of reasons for this. First, where actors were interviewed it was judged that anonymity would allow a better flow of information and so richer analyses. Secondly, our focus is (on balance) more on the type of actor than on the individual. It is true that readers knowledgeable of the context will be able to identify certain prominent individuals, but we seek to present an analysis that goes beyond personalities.

South African context

The apartheid regime entrenched inequity into the provision and financing of health services. On the one hand, resources were allocated with disregard to basic needs, producing a lack of access to essential services for the majority of the population. The results were indicators of life expectancy and infant mortality to rival low-income countries (Gilson et al.

1999). On the other hand, a small minority had access to first-world health care provided by well-resourced tertiary services. Overall, the public health care system was inefficient and fragmented and the private sector soaked up health care resources, contributing little to the human development of the country (McIntyre et al. 1995). Redistribution and restructuring were clearly needed when the new government came to power.

The first democratic government in South Africa set out on this task, including developing policy on health care financing to improve equity.² The overall policy framework developed into the White Paper for the Transformation of the Health System in South Africa, published in 1997. Its vision embraces a unified health system where all actors (including the private sector) are coordinated in pursuit of the fundamental goal of equity (Republic of South Africa 1997; Gilson et al. 1999). Health care is to be provided in accordance with the Primary Health Care Approach, and the District Health System is to be the main service delivery vehicle.

The implementation of this vision has inevitably required substantial institutional reform as well as changes in financing patterns. While much has been achieved already, through free health care policies, decentralization and restructuring, many challenges remain to realize an equitable health care system (Thomas and Muirhead 2000). These include furthering geographical equity through the resource allocation process, promoting public-private partnerships and effective regulation, and protecting and increasing funding of Primary Health Care and the District Health System.

Health insurance was included in the African National Congress's (ANC) 1994 National Health Plan as an important financing reform and vehicle for health system equity in the new South Africa (African National Congress 1994). Although early debates had favoured a UK-style tax-funded National Health System, by the 1990s most analysts favoured a national health insurance system (covering the entire population, with mandatory income-related contributions into a fund that would purchase services from both the public and private sectors). In part, this view reflected a realization that the growing private sector should be brought into a system through contracting, where it could be regulated appropriately. However, there had been little discussion of design details – and once the ANC-led Government came to power the feasibility of a *national* health insurance (NHI) system came into question. Instead, proposals were developed for social health insurance (which would be voluntary and would cover and benefit only a part of the formally-employed population) alongside continuing discussion of the need for stronger regulation of the private sector.

Analyzing the process of health insurance development in South Africa, 1994–99

Overview

Altogether, three different but related sets of SHI proposals were developed between 1994 and 1999, through three ad hoc policy advisory committees. These were:

- (1) The 1994 Health Care Financing Committee (HCFC), one of a series of broad-membership policy advisory committees established by the new Minister of Health immediately after the 1994 elections;
- (2) The 1995 Committee of Inquiry (COI) into Social Health Insurance, again established by the Minister with a broad membership that included a few members of the HCFC;
- (3) The 1997 SHI Working Group, a much smaller task group comprised only of Department of Health (DOH) staff and South African academic analysts, and established by the DOH Director General (Principal Secretary).

The proposals of the first two of these committees also considered the role of the private insurance industry, but a fourth committee, the 1997 Medical Schemes Working Group, finally developed the regulatory proposals incorporated in the 1998 Medical Schemes Act.

The experience of these committees involved late nights and hard work, negotiations and technical analysis, informal interactions and careful strategy, successful out-manoeuvring of potential opponents and unexpected opposition. All this happened during a period of immense societal and health system transformation that both enabled and constrained policy change (Gilson et al. 1999, 2003). As a result, reform drivers were sometimes not entirely in charge of the processes they initiated, although, over time, there were clear signs of increasingly deliberate efforts to manage at least some aspects of the way actors worked within these processes.

Ultimately, the set of SHI proposals produced by the analysts engaged in the 1997 SHI committee was considerably different from the initial ideas outlined in the ANC Health Plan. Most starkly, the equity objective of insurance proposals appears to have been watered down (McIntyre et al. 2003). By 1997, the National Department of Health (NDoH) proposals covered hospital care *only* for those formal sector employees who did not already have private health insurance (medical aid coverage) *and* were above the income tax threshold. In addition, there was to be no risk equalization between the SHI fund and other private insurance schemes, further reducing the degree of cross-subsidy between different income groups. Whilst technically elegant, and developed in response to the specific concerns of the Treasury, these proposals were effectively blocked by the combined political power of the Minister and the Trade Unions (who were concerned about their limited re-distributive potential) and the national Treasury (who were concerned by any additional burden on the tax-payer and the earmarking of funds for the health sector which would be outside their control).

In contrast, the 1997 Working Group on Medical Schemes gained the support of the Minister, in the face of opposition from the national Treasury, in enacting the 1998 Medical Schemes Act. This Act met at least some of the objectives of the earlier SHI proposals in re-regulating the private insurance industry to the benefit of the insured population by promoting greater equity, efficiency and financial

sustainability in the industry. As mentioned earlier, some academics also saw this as a necessary precondition for an effective SHI policy.

The key reform drivers and actors

As a first step in understanding the factors underlying these contrasting experiences, it is useful to outline the key actors involved in these debates, and their broad concerns, recognizing that views and power-bases did change slightly over the period considered. The description makes clear that the identification of reform drivers is not always clear-cut. They may not always be pursuing a clear policy vision or even work from within the government. Their positions and preferences may also change over time. This listing, however, highlights the actors most clearly and consistently visible as health insurance reform drivers in the period of focus.

Health insurance reform drivers

- *National Minister of Health*: The Minister had a central role in all aspects of health policy development between 1994 and 1999. This was not only due to her formal position but also because she had strong backing from the President and Deputy President. She also had senior aides who were able to push her goals. Her primary concern appeared to be the promotion of equity in the health system rather than the promotion of a particular vision of health insurance. She was unconvinced of the benefits of SHI given that only a portion of the population would benefit, and opposed the suggestion that SHI beneficiaries would need a better level of hotel amenities. Nevertheless, she did identify an NHI approach, presented by an international analyst, as a potentially useful vehicle for achieving better equity, and took steps to promote its development. Indeed, the Minister kept returning to the idea of NHI over the course of the committees as a potential solution to her concerns about inequity, despite contrary technical advice from South African analysts. She can therefore be considered as a reform driver of NHI. Yet she appeared rarely to engage with the details of proposals. Her personal involvement in driving policies such as the removal of fees for primary health care or legislation to allow abortion can, thus, be contrasted with her sometimes distant engagement with the health insurance debates.
- *The Directorate of Health Financing and Economics (DHFE) in the National Department of Health*: Although the Directorate was involved in all stages of insurance proposal development, it only played a driving role toward the end of the period. Its influence over early debates was limited because it only became fully functional in 1996, after a process of Department-wide re-structuring. Even then its influence was initially restricted by a small personnel base and by the fact that other actors within the NDoH did not understand its potential or importance. Nevertheless, it played a critical role in developing the 1997 NDoH SHI proposals as well as the parallel Medical Schemes Act of 1998. It was assisted in pushing forward proposals in both these areas by some academic analysts. The Directorate was strongly in favour of SHI and the re-regulating of the private insurance sector, to promote equity.

- *South African Academic Analysts*: These technicians often had backgrounds in political activism and were mostly based in South African universities. They typically had close links with the NDoH and while not politically powerful after 1994, gained influence from their pre-1994 activism, their broad support of the overall redistributive intent of the government and their own technical expertise. They were key members of each of the four policy advisory committees that considered SHI and insurance re-regulation over the 1994–99 period, and substantively shaped each committee's products. They can, therefore, be considered both as a reform driver and actor. While not a homogenous group, they typically were in favour of reforms to promote equity, such as the re-regulation of the private insurance industry. Nevertheless, they saw an NHI scheme as being unfeasible within the South African context.

Actors

- *National Treasury* (previously the Department of Finance): This Ministry developed and guides the Government's current macro-economic policy, GEAR (Growth, Employment and Redistribution). Introduced in 1996, GEAR conforms to relatively orthodox liberal economic thinking and has won acclaim from key multilateral institutions and foreign investors. Key targets for the national Treasury relate to the tax to Gross Development Product (GDP) ratio, the reduction of government debt and the control and cost-effectiveness of public sector expenditure. Through its power to set the macro-economic agenda and control the government budget, the Treasury is probably the most powerful government Ministry. It objected to SHI on the basis that it was an earmarked tax that would affect the tax to GDP ratio and unfairly raise further the tax-burden on the middle class. It also objected to the proposals for re-regulation of the insurance industry because of the importance it placed on private sector growth.
- *Trade Unions*: The Congress of South African Trade Unions (COSATU) was, and is, a member of the political alliance headed by the ANC. It is also the largest grouping of trade unions in South Africa. It is concerned with general redistribution, as shown by its central role in drafting the Government's initial equity-oriented macro-economic framework, the Reconstruction and Development Programme. At the same time it is also interested in the impact of sectoral policies (such as health insurance) on its members (see also Wade et al. 2002).
- *Medical Scheme Administrators*: Medical schemes are the principal financial intermediaries in the private sector, and accounted for 40% of expenditure on health in South Africa in 1992/93, the majority of the 60% spent in total through private sources (McIntyre et al. 1995). They are non-profit, voluntary associations funded primarily out of contributions from employers and employees. Nevertheless, the large companies that administer them are profit making. Consequently, the administrators are concerned to protect their commercial interests and profit margins. Nevertheless, or because of this, they initially showed willingness to be involved in the transition and in policy dialogue about SHI.

Analyzing the committees and their processes

Table 1 outlines the basic features of the four committees.

A key feature of the 1994 HCFC was that, as with parallel policy committees, it was conducted behind closed doors. A senior aide of the Minister coordinated the selection of members, who were asked to be involved in their personal capacities and to rely on their own skills, judgement and knowledge, without outside consultation. While the HCFC was meant to be a purely technical committee, covering a wide range of financing issues, the private sector was effectively represented through the inclusion of one person associated with the medical scheme administrators (but the Trade Unions were overlooked). Some HCFC members suggested in interviews that the private sector lobbied the Minister for a place on the HCFC. Committee members also knew that committee discussions were relayed back to key decision-makers in the medical schemes. Although some of the policy options being considered were potentially damaging to the private insurance industry, the sector decided to stay at the table in order to show its willingness to be involved in a time of political transition, as well as to track government thinking.

Although the Minister never met with the Committee, members did not have free rein. One member of the HCFC noted that the Minister and a senior aide:

“... had a political objective, [they] wanted to see clever people deliver the mechanism, but at the end of the day they wanted to know that the political objective was achieved”.

The constraints on the HCFC's deliberations became tighter during the course of its work. Eventually the committee came under pressure from the senior Ministerial aide to adapt its conclusions towards the Minister's preferred insurance option, a National Health Insurance system that allowed universal access to primary health care. However, committee members drafting the report refused to change their findings.

The NHI option was initially generated mid-way through the HCFC's term by an international analyst on the committee. Most members rejected the model as unfeasible but it seems that the analyst then bypassed the HCFC and convinced the Minister of its viability. Indeed, the potential for redistribution offered by the NHI model appealed to the Minister's values. Perhaps as a result, the committee's final report, supporting SHI, was largely disregarded. Rumours abounded that the NHI option was to be taken forward and, perhaps to block the proposals, details of the option were leaked to the press, though the source of the leak is unknown.

The resulting furore in the media then affected the subsequent 1995 Committee of Inquiry (CoI). The initial terms of reference for the Committee suggest that it was initially intended by the Minister as a mechanism for taking forward NHI.³ However, as noted, there were widespread objections to NHI as an appropriate form of insurance from both from HCFC members and the Medical Schemes. Ultimately, the

Table 1. Details of health care financing policy advisory committees, 1994–99

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

Table 1. Continued

1994 Health Care Finance Committee (HCFC)	1995 Committee of Inquiry into a Social Health Insurance system (CoI)	1997 Social Health Insurance Working Group	1997 Medical Schemes Working Group
Report to Minister, December 1994 (aspects leaked to press)	Initial report to MINMEC & Cabinet; Draft report published mid 1995, finalised 1996	Report to MINMEC, released as NDoH policy document September 1997	Medical Schemes Act, 1998

Note: The 1997 Medical Schemes Working Group is included in the table, despite it not being directly charged with developing Social Health Insurance, for three reasons. First, and foremost, legislation around the private medical schemes is inextricably linked with SHI policy. Secondly, the processes of the working group were used to help develop SHI policy. Thirdly, it offers some interesting insights into managing key actors in the SHI debates.

Minister agreed to change the Committee's terms of reference, under pressure from the newly appointed committee Chair, a South African academic analyst, who threatened to resign. The new terms of reference directed the committee more broadly towards developing policy intended to ensure universal access to PHC, including consideration of different insurance options (Table 1).

Nevertheless, the Minister appointed her senior aide as a co-chair of the CoI, presumably to allow a more direct Ministerial influence over the committee. At the same time, the number of analysts invited to sit on the committee was reduced and some, labelled as troublemakers in the HCFC, were specifically excluded. In other ways membership on the CoI was more representative than the HCFC. The national Treasury (Department of Finance) and the private sector were, for example, granted two representatives each. However, the Trade Unions were not represented. Unlike the HCFC, the CoI was given a mandate by senior policy makers in the National Department of Health to consult broadly. The Committee initially invited submissions from the public and once it had reached some draft conclusions, it consulted key stakeholders, such as the Trade Unions, on their views. Again, however, there was little direct engagement between the committee and the Minister.

To a certain extent, after the change in its terms of reference, health insurance was a secondary concern of the CoI. Nevertheless, an informal grouping within the committee sought to make sure that the NHI proposal did not gain credence. The group exposed the proposal as infeasible by costing the extra resources needed to implement it. Further, the international analyst who had initially proposed NHI was consistently opposed in the committee meetings. At the same time, this informal group worked hard to develop a set of SHI proposals for the CoI. These proposals did not, however, get much publicity with the release of the final report, and were largely overlooked by the Minister. In addition, the Treasury members thought the SHI proposals represented an unwarranted increase in the national taxation burden.

In the next attempt to take forward SHI proposals, the Deputy Director General of the NDoH established a Social Health Insurance Working Group in 1997. This was a much more focused, deliberately small and low-profile body of technicians from inside and outside the NDoH, tasked with reconsidering SHI. Its terms of reference required it to develop a detailed design for SHI in public hospitals. However, under pressure from the Ministerial aide (then the NDoH Director General), it was again requested to reconsider some of the issues linked to NHI examined in previous committees. The Working Group ran in parallel to a second working group driving the development of the Medical Schemes Act and shared some common members. As a result, the open consultations conducted with stakeholders, particularly with the Treasury and Medical Scheme administrators, during the preparation of the Medical Schemes Act were also fed back into thinking on SHI (Gilson and Thomas 2003). In addition, mindful of the Treasury's earlier opposition to SHI, the Working Group attempted to address some

of its specific concerns in the design of its proposals, but in so doing effectively restricted their redistributive potential (see McIntyre et al. 2003).

Nonetheless, the proposals were again contested by the Treasury on the same grounds as those of the CoI, whilst also being unacceptable to the Minister because of their limited redistributive potential. Perhaps as a result, although they were approved by the health MINMEC (a committee of the national and all nine Ministers of Health), they were eventually put on hold at the 1997 Conference of the dominant political party, the ANC. The conference delegates approved a resolution calling for the development of a comprehensive Social Security policy that would include a health component, rather than agreeing to proceed with health insurance by itself.⁴ The Trade Unions were also in favour of this more comprehensive approach.

Actor management strategies

By 1999 no SHI proposal had gained sufficient support from enough actors to become the basis for more detailed implementation planning. Tension between key policy-makers and South African analysts, both within and outside government, persisted throughout the evolution of these proposals. Their views about what was desirable, and feasible, were never reconciled, nor was any process initiated to build consensus among them. Analysts paid too little attention to whether their recommendations were acceptable to policy makers. Although their goals were clear, the latter gave too little leadership about what forms of SHI design were politically acceptable and ultimately rejected the later proposals. Other actors were not well engaged in the processes. In contrast, the potentially very contentious insurance regulation proposals were speedily developed and implemented, ultimately with Ministerial support and in the face of Treasury opposition.

In this section, we explore the ways in which the two identified reform drivers, the Minister of Health and the DHFE, tried to engage with key actors around these policy development processes. The four main actors we consider are: National Treasury, Trade Unions, Medical Scheme Administrators and Academic Analysts.

Two issues are noteworthy in this analysis. First, we focus primarily on actor management strategies that appear to have been deliberately applied within the process of policy development. These strategies were identified from the careful analysis of interview data outlined in the methods section, including review by key informants. Such deliberate management emerged more clearly in later processes. We largely ignore, however, the more informal processes of engagement between actors that are always important components of policy processes, and may themselves enable or block these processes. Secondly, the distinction between reform drivers and actors is sometimes blurred: reform drivers were themselves sometimes managed as actors, and actors at times functioned as reform drivers.

Table 2. Engaging key actors in formal policy structures

Actor	Strategy of engagement by committee			Actor position of policy proposals
	1994 Health Care Finance Committee	1995 Committee of Inquiry	1997 SHI Working Group	
Trade unions	Not yet active	Representation Consultation	Consultation Marginal consultation	Opposed Generally unclear, but opposed 1997 proposals
Medical schemes administrators	None	Representation	Consultation only through medical schemes regulation process	Broadly supportive
Analysts	Personal involvement	Personal involvement	Personal involvement	Supported SHI, generally
			1997 Medical Schemes Working Group	
			Consultation None	
			Strategic consultation	
			Personal involvement	

Note: Personal involvement implies that the members were there in their own capacity and not as representatives of actor groupings.

Focusing on actors

- *National Treasury*: The two main reform drivers used different strategies of engagement with the Treasury over time, with varying degrees of success (see Table 2). The Treasury's power is hard to ignore given that it sets macro-economic policy and holds the public purse strings. To leave it out of any policy process is to risk it creating a block to the process at a later stage, while to include it risks losing control of policy direction. The Treasury was directly involved in the CoI, but the interview data makes clear that this led to major opposition within the Committee to the SHI proposals. Instead, therefore, the SHI Working Group deliberately adopted a different strategy: it consulted with the Treasury without giving it drafting rights on policy proposals and sought to develop proposals that would secure its support. However, the Treasury continued to oppose the Working Group's proposals and this played a key role in blocking their further development. In contrast, the Minister of Health's strong intervention within Cabinet in support of the legislative proposals on medical schemes in the face of Treasury opposition (see Table 1) was important in securing approval for the proposals and their subsequent implementation. Together these different experiences highlight that merely sidelining opposition is no guarantee of success, particularly where that opposition is powerful enough to help block the reform (e.g. the Treasury).
- *Trade Unions*: The drivers of SHI development largely ignored this group of actors. Trade Unions were not represented on any of the committees. This may have reflected their broad engagement with the ANC in other political fora, as well as a certain disinterest from the unions themselves, at least initially, in the SHI debates and their lack of capacity (Wadee et al. 2002). Although COSATU made a submission to the Committee of Inquiry and broadly endorsed its work, this support seemed to be more or less the routine support given to political allies rather than resulting from a carefully considered analysis of the proposals. Yet the failure of the DHFE and its analyst allies to engage properly with the Trade Unions in 1997 may help explain why the SHI proposals were effectively stalled at the 1997 ANC conference. The importance of adequately understanding the position of latently powerful actors on key issues is thus highlighted.
- *Medical Scheme Administrators*: The handling of the private insurance sector by reform drivers changed over time. It might be argued that too much power was given to the private sector by allowing a representative to sit on the HCFC. This seat may have not only given the sector informal drafting rights on the final document of the committee, but also, and more importantly, an advantage in subsequent policy development. Whilst it gained an inside view of the new Department of Health's plans, it was not required to reciprocate. However, having the private sector in the HCFC may have given the new government some political advantage by ensuring the committee had a balanced flavour. Thus, many groups within the private insurance sector acclaimed the consultative approach of the subsequent CoI as constructive and important.

But the most deliberate, and successful, process of managing the private sector occurred through the Medical Schemes Working Group, with the DHFE and academic analysts as the reform drivers. Here, the medical scheme administrators were consulted by the Group, but not represented on it. Mindful of an emerging split in the insurance industry (between the traditional medical schemes and the emerging life assurers), the Working Group deliberately pursued a divide and rule strategy by consulting with 'friends' in the industry and excluding 'enemies'. It also developed a set of tough proposals as an initial bargaining position that gave it room for compromise at a later stage. Finally, it sought to conduct its consultations privately and away from the glare and influence of the media. This experience suggests that the dealings of reform drivers with the private sector became more sophisticated over time, from the perhaps naïve approach encapsulated in the HCFC to the canny negotiations of the Medical Schemes Working Group.

- *Academic Analysts*: Although not a powerful actor grouping by virtue of political mandate or economic power, analysts were involved in all committees (Table 2) and, as discussed, some acted as reform drivers in unison with the DHFE. Experience shows that their technical skills also gave them a collective power to block proposals that they could demonstrate were technically unfeasible. This power became evident in the stalemate over SHI development: policy makers preferred one course of action, NHI, while analysts designed others. The resulting impasse may have been due to several factors. On the one hand, analysts were given limited guidance in early committees by the Minister and senior aides and few opportunities to meet with key policy makers. The Minister herself made little effort to provide a concrete vision that could shape detailed proposals. On the other hand, analysts never really made the case for SHI in terms of the achievement of the Minister's political objectives – and, indeed, designed proposals that appeared to have less and less redistributive potential. It appears that the focus on technical detail (in an attempt to offset Treasury opposition) resulted in too little attention being given both to the equity objectives and the need for Ministerial support. These experiences point to another important element of managing actors: carefully identifying the powerful allies with whom you want to work, and convincing them that their objectives will be achieved through reform.

Focusing on strategies

More specific proposals for how to manage actors can also be derived from considering the South African experience through the lens of a relevant conceptual framework. Figure 1 suggests that, in essence, a reform driver must be concerned to mobilize as much support from powerful actors as possible, or necessary, while also neutralizing powerful opposition.

The vertical axis of Figure 1 denotes *interest* in the policy issue, while the horizontal axis relates to *power*. Interest here relates to the extent to which an actor will perceive itself to be affected by a reform, whether positively or negatively.

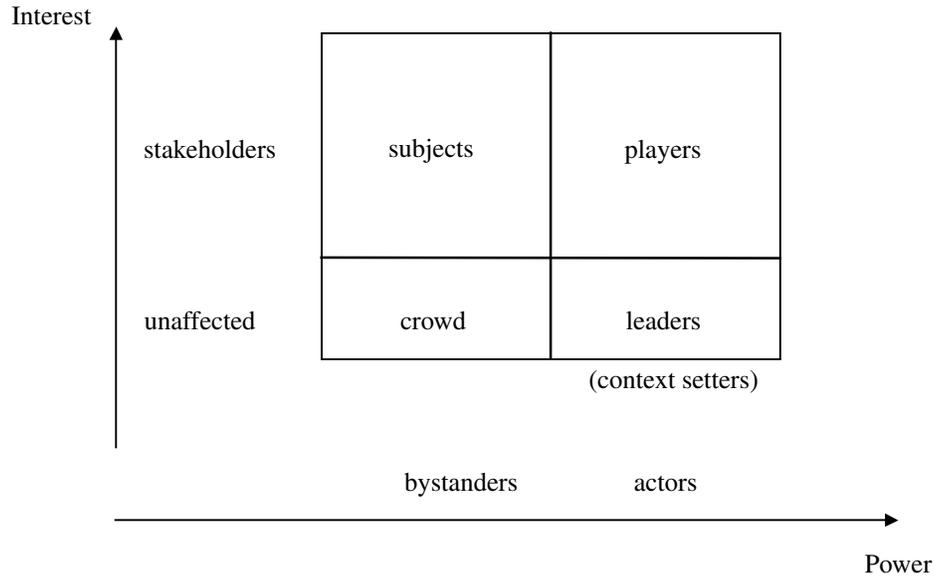


Figure 1. Categories of organizations or people in relation to stakeholder analysis and collaborative formation
 Source: Eden (1996).

Power relates to the degree to which the actor can block the reform or help push it through. Four groups of people or organizations are identified, categorized by whether they perceive their interests to be strongly or weakly affected and whether or not they are themselves powerful.

The first aim of any reform driver in developing a financing policy change is to get as many supporters as it can in the top right-hand quadrant where they are *players* who see the reform as promoting their interests and have power to support the reform. Three strategies might be used:

(1) Mobilize *leaders* by persuading them that the policy is of

interest to them and will produce important benefits. This turns *leaders* into *players* (strategy 1 in Figure 2); where *leaders* carry with them high prestige and influence, this strategy can be particularly useful. For example, the DHFE mobilized the Minister of Health in support of the Medical Schemes Act by meeting with her and convincing her of its merits. She then successfully defended it in Cabinet, in the face of opposition from the Treasury. In contrast, neither the Minister nor the Trade Unions were mobilized by the DHFE and academic analysts in support of SHI.

(2) Group together *subjects* (possibly also with *players*) through alliances among those who would not otherwise,

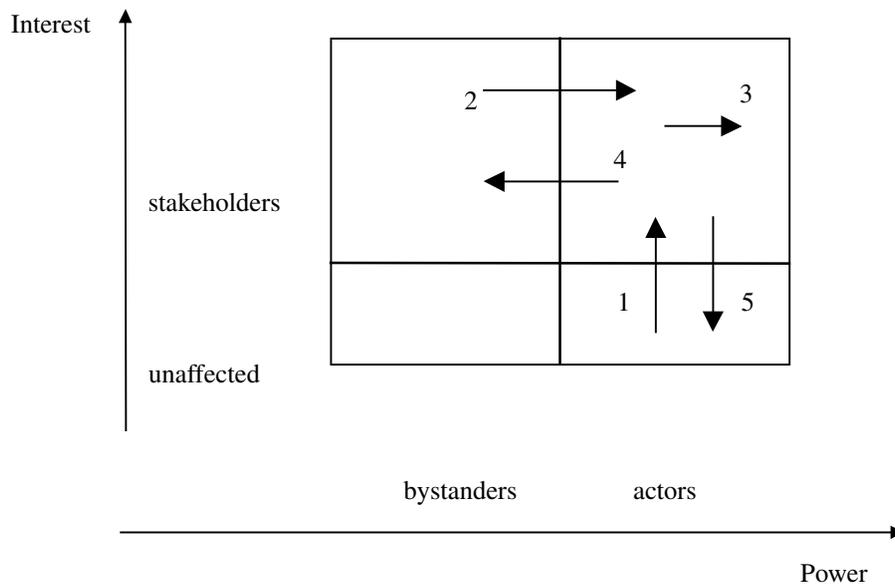


Figure 2. Strategies for creating a powerbase for health financing reform

by themselves, have sufficient power. This turns *subjects* into *players*, moving them into the top right-hand quadrant (strategy 2 in Figure 2). For example, the policy advisory committees may have fulfilled this role by grouping analysts together and so making them more powerful than they would have been individually. Yet the failure of academic analysts to create an alliance between themselves and the Trade Unions, or between themselves and the Minister, may also represent missed opportunities with regard to this strategy. Such alliances would have brought together political influence and technical power and could have been sufficient to offset the opposition of the national Treasury.

- (3) Coordinate interested *players* to take action to support the policy through developing a shared vision. Even where players are generally supportive of a policy, it may be important to unite them together for policy development to give them more collective power (strategy 3 in Figure 2). The consensus building across diverse stakeholders attempted through the 1995 Committee of Inquiry may have been, at least in part, an attempt to develop a common vision that could facilitate coordination among other players. However, the failure to develop a common vision between the Minister, Trade Unions and analysts only heightened the power of the national Treasury to oppose the SHI proposals.

Secondly, and conversely, reform drivers may also need to minimize opposition by turning *players* (from the top right-hand quadrant of Figure 1) into *leaders* or *subjects*. Two further strategies are useful in this regard:

- (4) Divide and rule. By splitting a *player* along a line of argument, for instance, an actor grouping is divided and may become disempowered, with the constituent parts moving into the *subject* area, the top left-hand quadrant in Figure 2 (strategy 4). This was clearly an effective strategy used in dealing with the private insurance industry around the development of the Medical Schemes Act.
- (5) Convince the *player* that its objections to the reform do not hold by presenting the proposal in their own language and relating it to their values and goals. This strategy turns *players* into *leaders* (strategy 5 in Figure 2). The failure to apply this strategy appears to explain the impasse between analysts and key health policy makers over SHI, since analysts and the DHFE never really convinced the Minister of Health of the benefits of SHI. At the same time, the apparent efforts by the DHFE and analysts to apply this strategy to the Treasury may have failed because of fundamental disagreements over the goals of SHI.

Conclusions

The South African experience contrasts the failure to develop a policy around national or social health insurance with the successful adoption of regulation of private health insurance. The former confirms the difficulty of pursuing large-scale, equity-based financing reforms. However, unlike other experiences of such reform, it appears that

disagreement about reform design, among the reform drivers and with other powerful actors, led to conflict, as much as the reform's impact on societal interest groups. In seeking to develop a feasible SHI option that would have adequate support to take it towards implementation, the design changed in ways that undermined the original equity goals, and so also undermined the support of powerful actors. More than 10 years after health insurance ideas were first proposed for South Africa, a common vision was still lacking. In contrast, the deliberate management of actors in pursuit of regulatory reform of the private insurance industry enabled a successful policy development process, where reform drivers mobilized powerful actors to support reform and blindsided the opposition. The development of health insurance proposals is never simply a matter of good technical design.

It is important for those driving reforms like SHI to have a clear vision of what is desirable, both in terms of objectives and design details. This may be an important precondition for managing actors effectively. Reform drivers must then try to create supporting players (those with power and interest) from leaders and subjects while disempowering opponents. In South Africa, it is clear that the reform drivers for SHI never managed to gain sufficient support from powerful actors, such as the Minister of Health or the Treasury, for their version of reform.

Policy advisory committees may represent useful actor management strategies. For example, they may empower analysts acting as reform drivers or may secure stakeholder support for specific proposals. The South African experience may suggest that smaller technical working groups may be useful in empowering analysts, while open and consultative leadership may be important in larger stakeholder committees. Nevertheless, these conclusions are tentative and further work is needed in this area.

Theoretical frameworks, such as those of Eden (1996), provide a useful starting point for considering which strategies may be most useful in particular contexts (see also Varvasovszky and Brugha 2000). Such frameworks, however, do not meet all the strategic needs of reform drivers. For example, how do reform drivers know when they have sufficient support (or enough actors in the top right-hand quadrant of Figure 1)? What processes can they use to manage the players (who remain in the top right-hand quadrant of Figure 1)? Further work is required to understand when and how to apply specific strategies of actor management.

Endnotes

¹ This paper complements a companion article by McIntyre et al. (2003) that provides a technical analysis of the various sets of SHI proposals developed in South Africa between 1994 and 1999. Together, the two papers provide a comprehensive analysis of SHI development in South Africa, from which wider lessons can be drawn about both the design of such policy and about managing actors in health care financing policy development.

² Following 1994, two key bodies have been at the pinnacle of government decision-making in health. Their composition reflects

the quasi-federal structure of government within South Africa. First, 'MINMEC' is a forum of all nine provincial MECs (Member of the Executive Council; a provincial 'minister') chaired by the national Minister of Health. Second is the PHRC (Provincial Health Restructuring Committee), which consists of the heads of the provincial departments of health under the chair of the national Director General of Health (who is equivalent to a Permanent Secretary). The PHRC will report to MINMEC and often civil servants will accompany their MECs or Ministers to the MINMEC meeting. The PHRC itself will sometimes establish smaller working groups which coordinate action on particular policy topics.

³ Committees can add legitimacy to reform objectives or designs (Challis et al. 1994).

⁴ Subsequently, a Committee of Inquiry into Social Security was established which published its report in 2002. It is not examined further in this paper.

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