Health Policy Institutes: Landscaping and Learning from Experience

The case of the Health Economics Unit in South Africa

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Acknowledgements

I am grateful to all the people who agreed to be interviewed for this study at short notice. Thanks must go, in particular, to Di McIntyre, founder of the Health Economics Unit, for setting up the interviews that I requested in Cape Town and providing me with financial and other documentation on the Unit.

This case study was funded by the World Health Organisation’s Alliance for Health Policy and Systems Research as part of a larger project entitled Health Policy Analysis Institutes: Landscaping and Learning from Experience. The principal investigator for the overall project is the Alliance’s Sara Bennett who developed the research protocol and the semi-structured interview guide for the case studies.
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### ACRONYMS

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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>ANC</td>
<td>African National Congress</td>
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<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>DFID</td>
<td>UK Department for International Development</td>
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<tr>
<td>EQUINET</td>
<td>Regional Network on Equity in Health in Eastern and Southern Africa</td>
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<tr>
<td>HEI</td>
<td>Higher Education Institution</td>
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<td>HEU</td>
<td>Health Economics Unit</td>
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<td>HR</td>
<td>Human resources</td>
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<td>IDRC</td>
<td>International Development Research Centre</td>
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<td>MESH</td>
<td>Management, Economic, Social and Health Infrastructure</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NHA</td>
<td>National Health Accounts</td>
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<td>NHI</td>
<td>National Health Insurance</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>NRF</td>
<td>National Research Foundation</td>
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<td>PPI</td>
<td>Public-Private Initiatives</td>
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<tr>
<td>SHI</td>
<td>Social Health Insurance</td>
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<tr>
<td>SIDA</td>
<td>Swedish International Development Cooperation Agency</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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EXECUTIVE SUMMARY: LESSONS FOR THE INTERNATIONAL COMMUNITY

Introduction

This report forms part of a research project entitled Health Policy Analysis Institutes: Landscaping and Learning from Experience. The project was coordinated by the Alliance for Health Policy and Systems Research, a unit based at the World Health Organisation and funded by the Rockefeller Foundation. The Foundation had expressed an interest in supporting the development of health policy analysis institutes in low- and middle-income countries. This case study was conducted, along with eight others across Africa and Asia, to inform Rockefeller Foundation strategy in this area.

Aim of the study

The aim of the case study is to derive lessons about the organizational features and other factors that contribute to the effectiveness and sustainability of a policy institute, the Health Economics Unit, which is based at the University of Cape Town in South Africa.

The body of this report assesses the effectiveness and sustainability of the Health Economics Unit; recommendations on how to improve the effectiveness and sustainability of the Unit are presented in the conclusions and are not repeated here. Instead, this Executive Summary extracts lessons from the Unit’s experience that are relevant to members of the international community (specifically universities, governments and donors) that are interested in initiating or strengthening similar units in low- and middle-income countries.

Methodology

Data were collected through semi-structured interviews with 15 key informants from the Health Economics Unit itself, university management, international institutions collaborating with the Unit, government and the non-governmental sector. Interviews were tape-recorded (after receiving informed consent), transcribed and analysed according to the major themes that had been identified in the research protocol. Supplementary data were gathered by analysing publications lists and financial statements (from January 2004 to June 2009), reports produced by the Unit and information on the Unit’s website. Senior Unit staff provided feedback on the draft report.

Background to the Health Economics Unit

The Health Economics Unit is well-established and enjoys a high profile, especially in the National Department of Health. It has provided high quality research, policy advice and training for almost twenty years.

The Unit currently has a staff of fourteen, ten of whom are researchers. One of these posts is funded by the university while another is funded by the National Research Foundation; otherwise, the Unit relies on raising funds through project grants, mainly from international donors and agencies.
The Unit has a relatively high staff turnover and has been unable to increase its complement of senior staff over the last decade. However, the Unit’s founder still works at the Unit in a senior position, while two other senior staff have worked there for at least eight years.

Over time, the Unit has built up relationships with a diverse set of research partners. Increasingly it is a member of large multi-partner research projects, often involving international partners, particularly from elsewhere in Africa. It also participates actively in a number of networks, especially in the region.

Unit members have always provided policy advice to government. In recent times, the Unit has become particularly prominent through its engagement in the policy dialogue around National Health Insurance, medicines’ pricing and the funding of anti-retroviral therapy.

The Health Economics Unit is very active in post-graduate training in health economics and is the only unit in Anglophone Sub-Saharan Africa providing a Master’s in Health Economics. The teaching function has proved to be very important, given the dearth of health economics capacity, not only in South Africa but in Sub-Saharan Africa as a whole.

Lessons for establishing policy units, especially in the area of health economics

The points below identify organisational features of the Health Economics Unit that have contributed to its sustainability. Several of these features may be transferrable to other settings, depending on contextual factors.

1. Sustained leadership, in the form of a committed, long-term leader, was critical to the development and success of the Unit.
2. This person was supported by a core of hard-working, like-minded researchers who provided continuity for the Unit, even when there was a turnover of other staff.
3. The Unit was fortunate in being located within a supportive institution that had relatively efficient managerial and administrative processes. Recently, formal recognition of ‘social responsiveness’ (including the provision of policy advice) has helped promote staff whose contributions in this area had previously been overlooked.
4. The Unit built its credibility on the back of objective, high-quality, policy-relevant research and training. It demonstrated foresight in undertaking forward-thinking research that government had not always identified as a priority, and sourcing funding from donors for self-initiated projects; this enabled it to engage in innovative, long-term research and present timely data to government.
5. The case of the Health Economics Unit demonstrates the considerable advantages of a university base in terms of preserving the quality and objectivity of research, especially when the government environment is not enabling (see Box A). Because of the personalities of Unit staff, and their manner of engaging with government, their location in a university did not impinge on the policy relevance of their work.
6. Participating in a variety of research, teaching and networking spheres, and creating partnerships with a range of different players, including research collaborators, has been important for the Unit’s sustainability: the diverse portfolio and contact with international researchers, especially in the region, has created a stimulating working environment, deepened the Unit’s knowledge, generated new research ideas, extended the network of individuals
influenced by the unit’s perspective (especially in Africa), strengthened the legitimacy and confidence of the unit, attracted funding and introduced new ideas about dissemination.

7. The Unit invests heavily in developing the skills of its staff members: this includes paying course fees for postgraduate study, allocating time for staff to engage in study, allocating time for staff to write journal articles, providing supervision and providing sabbaticals. This level of commitment to capacity-building is unusual for a soft-funded unit.

8. The vulnerability of the Unit lies in the fact that it finds it very difficult to attract senior staff: this is because the salaries it is allowed by the university to pay are low, and because it does not have core funding to offer secure contracts. This means that existing senior staff are overburdened and are not able to respond to all of government’s needs. A major challenge for the Unit is to improve salaries for senior staff. In the meantime, the Unit’s supportive, stimulating and collegial environment is a major factor in the retention of existing staff.

Box A: The benefits of being a policy unit based at a university

1. **Confers an aura of respectability.** This is based on an understanding of the role of the academic as someone who does objective, good quality research in the interests of the country. This helps stakeholders (such as policy-makers and the media) trust advice. It also makes it easier for the unit to access donor funding and to set up partnerships with other academics around the world.

2. **Sustains research when government is not receptive.** This is because research can continue through other funding sources when government is not interested in a particular topic (especially when it addresses longer-term needs) or is resistant to certain analyses and policy options (as was the case in South Africa with HIV/AIDS). This enables the unit to be policy-responsive even when not supported by government.

3. **Provides an opportunity to engage with policy-makers and senior managers through teaching.** This is an important mechanism for researchers to understand the objectives and needs of government and to feed back the findings of their research. It can create an extended network of influence through former students.

4. **Provides collegial interaction and support.** This is important for enhancing the quality of research, providing new ideas for research and supporting personal development. It enables the unit to tap into the skills (and ideals) of a far larger set of individuals than simply those within the unit itself.

5. **Provides organisational support.** Although there can be some frustrations with administrative issues and the difficulty the university has in helping to fund activities in a unit, the unit is able to benefit from sound accounting, human resource and legal systems. Importantly, it can have access to publications and electronic journals through the university library.

6. **Attracts good quality researchers.** Even though salary levels are low, the academic environment allows people who are interested in research to flourish. All the features above contribute to this, as does the freedom to choose work that is personally interesting and the opportunity to engage with people and projects at the national and international level. There is a clear career path (even though it takes time to progress along it).

Lessons for impacting on policy

The Unit has been relatively successful in impacting on policy. The features that contributed to this are listed below. Some of these could be replicated elsewhere, depending on the context.

1. **Relevance of research to the social objectives of government.** The work of the unit is closely identified with the pursuit of equity and the development of the district health system which are key objectives of government. Research is focused on supporting the achievement of these objectives: it is applied research and it is generated on the basis of a clear understanding of
research priorities through sustained personal engagement with policy-makers and senior managers. Several projects have been commissioned directly by government.

2. **A long track record.** The unit has been around for 20 years. During this time it has deepened its understanding of the issues facing the country and of research methods to investigate these issues. It has built up extensive networks with local, regional and international researchers and policy-makers. Most importantly, it has built up a strong reputation for good quality, relevant research. This has given it a high profile as a source of policy advice.

3. **Maintenance of a relationship with government.** The unit has been able to retain government’s trust even in the face of ideological differences (e.g. around HIV/AIDS). The unit has been able to sustain its position as a ‘critical ally’ because it has been consistent and objective in its policy advice, and has focused on offering constructive support to government. It is seen as ‘one of us’ by government rather than as a stakeholder lobbying for a particular set of vested interests. This perception is bolstered by the fact that the unit does not do work for the for-profit private sector.

4. **Direct engagement with government.** While the unit also produces reports, journal articles, book chapters, conference presentations and some newspaper articles, a key mechanism for disseminating policy information is through personal engagement with policy-makers and senior managers. This is through project-related processes (meetings, workshops etc.) as well as direct involvement in policy-making committees and through the teaching of courses. It is this personal contact that is particularly important in influencing decision-makers (through transferring ideas, keeping an ‘ear to the ground’ and maintaining a high profile).

5. **Personal characteristics of researchers.** While the unit as a whole has a modus operandi that is trusted by government and others (such as activists, the media and donors), the characteristics of individual researchers are also very important. These characteristics include a high level of technical skill, commitment to equity, trust-worthiness, hard work and willingness to assist government. Inter-personal relationships are also important: some researchers have built these up more successfully than others.

6. **The provision of courses.** Teaching has become an integral part of the Unit and has proved a crucial mechanism for identifying priority areas for policy research, disseminating research and influencing policy-makers. One research collaborator felt that ‘the international world does not adequately acknowledge [the importance of teaching in achieving policy impact] ... It’s about shaping minds but not through the publication of information, by directly engaging with people and learning and growing through that experience. I mean, all of the international debates about how you influence policy don’t think about that as an important function.’

**Supporting the development of units such as the Health Economics Unit**

Soft-funded research units at universities live a precarious existence in the face of persistent demands for increased policy relevance and impact. While there may be small ways in which the Health Economics Unit could immediately increase its impact (see main report), it is essentially hamstrung by its inability to attract additional senior staff. Its inability to pay competitive salaries is one of the main reasons while lack of core funding is another. The future of the Unit would be in jeopardy if the current complement of senior staff, who have already been at the Unit for a long time, were to decide to make a career move.
Universities, governments and donors need to find ways to support policy units in a similar position, if they want to preserve a precious national resource. Some suggestions that emerged in this case study are listed below.

**Universities** could:

- recognise policy advice and health systems development as criteria contributing to the promotion of unit staff (and not just research, teaching and university management);
- allow units that develop scarce skills to pay higher salaries (i.e. a ‘scarce skills allowance’);
- assist units in securing more permanent posts; and
- ensure that course fees are used to reimburse units fully for teaching (this is currently not the case at the Health Economics Unit, for example).

**Government** could:

- profile the formal courses offered by such units (e.g. health economics) as an area for skills development in government and support bursaries for government staff to attend these courses;
- allocate adequate funds to support policy advice and ad hoc training offered by units; and
- allocate adequate funds for formal research internship training programmes provided by the units for government staff.

**Donors** could:

- first and foremost, provide opportunities for long-term, core funding (ideally this would fund a set of core staff and activities; another option would be to endow a Chair similar to the one the National Research Foundation funds at the Health Economics Unit);
- top up research staff salaries in line with a scarce skills allowance;
- increase funding opportunities (and the level of funding) for research dissemination, not only within specific projects but also for broader dissemination activities (e.g. for national seminars that encourage dialogue around key themes);
- provide research grants that stretch over more than one year (e.g. three years);
- provide funding opportunities for research that does not involve primary data collection (e.g. analysis of pre-existing data, synthesis of the literature) so that existing data and information can be mined in more detail;
- fund activities that are otherwise hard to fund and that help to develop staff (e.g. conferences, sabbaticals);
- fund visits and support by senior international experts to bolster senior capacity and provide more opportunities for capacity-building (there should be trust and a pre-existing relationship between the unit and such an expert, however, for such support to be successful);
- fund bursaries for local students to attend courses (some of these could be provided through the Ministry of Health so that students could be bonded to work for the Ministry);
- fund a research intern programme that is linked to the Ministry of Health and includes funding for regular meetings, salaries and associated costs for the research interns, the development and delivery of training courses, and the salaries of supervisors/mentors; and
• fund some teaching activities (e.g. development of new materials, training of trainers etc.).
1 INTRODUCTION

This report is a South African case study which forms part of a larger research project entitled *Health Policy Analysis Institutes: Landscaping and Learning from Experience*. This larger project was coordinated by the Alliance for Health Policy and Systems Research, a unit based at the World Health Organisation (WHO) in Geneva and funded by the Rockefeller Foundation. The Foundation had expressed an interest in supporting the development of health policy analysis institutes in low- and middle-income countries. This case study was conducted, along with eight others across Africa and Asia, to inform Rockefeller Foundation strategy in this area.

The aim of the case study is to derive lessons about the organizational features and other factors that contribute to the effectiveness and sustainability of a policy institute, the Health Economics Unit (HEU), which is based at the University of Cape Town in South Africa.

2 METHODOLOGY

A research protocol and semi-structured interview guide for the overall project were developed by the Principal Investigator, Sara Bennett, and submitted to WHO’s Ethics Review Committee for approval. The project is a comparison of case studies that draw primarily on qualitative research but also use some quantitative data.

In South Africa, data were collected through semi-structured interviews with 15 key informants: six are from the Health Economics Unit itself; one is a senior manager at the university; four are international collaborators who work closely with the Unit (one is based permanently at the Unit); and three are policy-makers and implementers from government and the non-governmental sector (see Table 1 for an analysis of the key informants by institution and Appendix A for a list of key informants by name).

<table>
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<th>Table 1: Analysis of key informants</th>
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<tr>
<td>CATEGORY</td>
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<tr>
<td><strong>HEU STAFF</strong></td>
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<tr>
<td>Director</td>
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<tr>
<td>Senior-level researchers (including founder and former Director)</td>
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<tr>
<td>Mid-level researcher and human resource manager</td>
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<tr>
<td>Financial officer</td>
</tr>
<tr>
<td>Communications officer</td>
</tr>
<tr>
<td><strong>FACULTY MANAGEMENT</strong></td>
</tr>
<tr>
<td>Head of School</td>
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<tr>
<td><strong>EXTERNAL COLLABORATORS</strong></td>
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<tr>
<td>Professors from overseas universities (one of whom also has a senior position in the Faculty)</td>
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<tr>
<td>Head of regional research and advocacy organisation</td>
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<tr>
<td>Donor</td>
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<tr>
<td><strong>POLICY-MAKERS/IMPLEMENTERS</strong></td>
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<td>National DOH</td>
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<td>Provincial DOH</td>
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<td>NGO</td>
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The generic interview guide was adapted for local circumstances by the South African researcher. Most interviews were conducted face-to-face but two had to be conducted telephonically. Because of logistical problems another two had to be conducted through written answers to e-mailed questions. Interviews were tape-recorded (after receiving informed consent), transcribed and analysed according to the major themes that had been identified in the research protocol.

Supplementary data were gathered by analysing publications lists and financial statements (from January 2004 to June 2009), reports produced by the Unit and information on the Unit’s website (www.heu.uct.ac.za).

In writing up the report, every effort was made to preserve the anonymity of opinions expressed by key informants. In the draft report, interviews were referenced by interview code (01, 02, 03 etc.) to allow the Principal Investigator to assess the ‘chain of evidence.’ However, this made it possible to work out the identity of some of the key informants. Accordingly, interviews in this final version of the report are grouped into three broad categories, namely university staff (A), international collaborators (B) and policy-makers and implementers (C) (see Table 1). Where a code appears more than once as a reference (e.g. A, A, A), this means that several sources from the same category support the information.

The research was conducted and written up in a short period (15 days) and suffers from the limitations associated with time constraints. The researcher tried to avoid inaccuracies in the text by ensuring that a sufficiently wide range of key informants had been consulted, and by discussing the draft report in detail with two senior HEU staff.

It should be noted that the researcher had worked at a sister research unit (the Centre for Health Policy) which has had a long-standing working relationship with HEU. The advantage of this is that she already had a working knowledge of the output of the Unit and its organisational features, especially as she had been involved in previous evaluations of the work of the Unit. This contributed to establishing trust between the interviewer and the key informant during interviews. The disadvantage is that she is somewhat of an ‘insider’ who has a similar perspective to that of HEU staff.

3 THE HISTORY, MISSION AND KEY FEATURES OF THE HEALTH ECONOMICS UNIT

3.1 The founding of the Unit
HEU was established in 1990 within the School of Public Health and Family Medicine at the University of Cape Town, South Africa. The founder was Di McIntyre, an economist who had graduated with a Master’s degree from the Department of Economics at the same university.

In the late 1980s, Di chose to establish a separate Unit in order to give the body of work it produced a discrete identity and to enhance the group’s profile. This strategy proved to be ‘incredibly helpful in terms of seeking external funding’ (A).

The Unit was located in the School of Public Health and Family Medicine because a non-clinical post had been freed up by the departure of the previous incumbent. The School’s Head at the time
happened to have worked in the British National Health Service and had a keen interest in the resource allocation processes that had been applied there: these circumstances were ‘really a good coincidence of fortune’ (A). In addition, the School did not have the enormous undergraduate teaching load that is typical of the Department of Economics and which can be ‘soul-destroying’ (A). In any case, internationally it is common for health economists to work closely with public health specialists (A). As one staff member reflected, ‘I think at that stage it was very, very important to ... be located in the Health Sciences Faculty, because there was complete lack of awareness of what health economists were about. There was a great deal of suspicion amongst the clinicians, about “Who [are these economists] who know not the first thing about health?” and it was just fortunate that ... there started to be budget cuts and the scarcity of resources clarified the mind about how useful an economist could be’ (A). An external observer noted that the fact that the unit calls itself ‘The Health Economics Unit’ is important because ‘there’s something about health economics and health economics principles ... being valued’ (B).

HEU is now well-established in the university. It is almost twenty years old and has grown to a size of 14 staff which still includes its founder. The Unit’s buildings have been upgraded recently and are now very attractive creating a pleasant environment for staff and visitors, including a large meeting room.

3.2 The mission and core activities of the Unit

HEU’s mission is ‘to improve the performance of health systems through informing health policy and enhancing technical and managerial capacity in Sub-Saharan Africa. Its foundation is academic excellence in health economics and management’ (HEU website, www.heu.uct.ac.za, accessed on 28 June 2009). The key values and beliefs that drive staff are identified on the Unit’s website and are presented in Box 1. All research staff interviewed were very clear about the organizational direction of the Unit and the words ‘equity’ and ‘social justice’ featured prominently in their responses to questions about what HEU stands for (A, A, A, A).

**Box 1: Principles underpinning the work of HEU**

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<th>HEU is committed to:</th>
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<tr>
<td>• excellence and independence</td>
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<td>• fairness, social responsiveness and accountability in health systems</td>
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<tr>
<td>• respect for its collaborators and stakeholders</td>
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<td>• innovative thinking, to ensure its work remains ground-breaking</td>
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The HEU website describes the key activities of the Unit as:

• ‘Research in health economics and management with an emphasis on equity in health, health sector reform, health care financing and expenditure, pharmaceutical policy and regulation and the economic evaluation of key health care programmes;
• Training at the post-graduate level and through client-specific short courses to improve technical research and management capacity;
Consultancy to facilitate the translation of health policies into practical programmes’ (HEU website, www.heu.uct.ac.za, accessed on 28 June 2009).

Interviews indicated that applied research is the predominant activity of the Unit and that research is aimed primarily at influencing domestic policy: however, there is considerable engagement with international policy debates, particularly in the region.

Capacity-building – within the Unit, in South Africa and elsewhere in Anglophone Sub-Saharan Africa - is also an important activity of the Unit (see later) and senior researchers spend between 30 and 40 percent of their time on post-graduate course administration, teaching and supervision (A). The expansion of capacity-building activities is the major change that the Unit has seen since its inception as it was initially established solely for research purposes. This change was in recognition of the dearth of health economics capacity in South Africa and Africa as a whole (A): this reflects capacity constraints in Africa itself but also the fact that Health Economics is still a young, ‘Cinderella’ discipline (B).

3.3 The Unit’s audience and partners

The Unit’s main target audiences are senior policy-makers and managers within the South African government (at national, provincial and local level). Other audiences are: South African parliamentarians; NGOs and activists in South Africa and the region; the academic community in South Africa and abroad, especially research partners; donors (especially DFID, IDRC, EU, SIDA) and international agencies (especially WHO); the South African media; and to a lesser extent, the for-profit private sector in South Africa (A, A, A, A, A, A, B).

Over time, HEU has built up relationships with a diverse set of research partners. Increasingly it is a member of large multi-partner research projects, often involving international partners, particularly from elsewhere in Africa (see Table 2 for a list of current partners). The Unit’s offices are a hive of activity what with the presence, over and above regular staff, of visiting research partners, research fellows and Master’s and PhD students.¹

HEU also participates actively in a number of networks, especially EQUINET (a network concerned with health systems equity in eastern and southern Africa) and HEPNet, an African health economics and policy network of which HEU was a co-founder (HEU co-ordinates the network).

¹ When the author visited HEU to conduct interviews, 2 principal investigators from northern partners were visiting for project workshops, a senior professor from Australia was visiting for 3 months for capacity-building purposes, 1 research fellow from Kenya had just arrived and there were 3-4 PhD students, most of whom were collaborating on a large, multi-partner project led by HEU.
Table 2: HEU’s current research partners

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<tbody>
<tr>
<td>Cost-effectiveness of public, private and public-private partnerships in the delivery of antiretroviral treatment to HIV-infected adults in South Africa</td>
<td>Division of Clinical Pharmacology, Department of Medicine, University of Cape Town (UCT), South Africa; Aid for AIDS; Broadreach</td>
</tr>
<tr>
<td>Cost-effectiveness of doctor versus nurse-based delivery of antiretroviral treatment to HIV-infected adults in South Africa</td>
<td>Desmond Tutu HIV Centre, UCT; AURUM Health Research</td>
</tr>
<tr>
<td>ALPS - Affordability Ladder Programme – Household level perspectives on equitable health systems</td>
<td>CHP; Liverpool University; National Institute for Medical Research, Tanzania; Institute of Public Health, Makerere University, Uganda</td>
</tr>
<tr>
<td>ALPS training – Developing training materials relating to the development of equitable health policies</td>
<td>CHP; Liverpool University; Health Economics Unit, University of the West Indies</td>
</tr>
<tr>
<td>SHIELD - Strategies for health insurance mechanisms to address health system inequities in Ghana, South Africa and Tanzania</td>
<td>CHP; Health Research Unit, Ghana Health Service; Ifakara Health Research and Development Centre, Tanzania; Health Economics &amp; Financing Programme, London School of Hygiene and Tropical Medicine (LSHTM); Medical Management Centre, Karolinska Institute, Sweden; Royal Tropical Institute, Netherlands</td>
</tr>
<tr>
<td>CREHS - Consortium for Research on Equitable Health Systems</td>
<td>CHP; Indian Institute of Technology, India; Health Economics &amp; Financing Programme, LSHTM; Health Policy Research Group, College of Medicine, University of Nigeria, Nigeria; Ifakara Health Research and Development Centre, Tanzania; International Health Policy Programme – Thai Ministry of Public Health and Health Systems Research Institute, Thailand; Centre for Geographic Medicine Research, Kenya Medical Research Institute, Kenya</td>
</tr>
<tr>
<td>Economics of malaria treatment</td>
<td>Division of Clinical Pharmacology, Department of Medicine, UCT</td>
</tr>
<tr>
<td>Fiscal Federalism, Equity and Governance in the Financing of Primary Health Care in South Africa</td>
<td>Health Economics and Financing Directorate, National Department of Health</td>
</tr>
<tr>
<td>Cost-effectiveness of introducing an HPV vaccine to cervical cancer prevention programmes</td>
<td>Women’s Health Research Unit, UCT; Engender Health, United States of America</td>
</tr>
<tr>
<td>REACH – Researching Equity in Access to Health Care</td>
<td>CHP; McMaster University, Canada</td>
</tr>
</tbody>
</table>

Source:  [www.heu.uct.ac.za](http://www.heu.uct.ac.za), accessed on 28 June 2009.

3.4 The advantages of being located at a university

For the university, HEU has been very successful in promoting its profile in Africa, especially through the delivery of a Masters programme (A). As HEU has been active in the policy arena, this has boosted the ‘social responsiveness’ of the university (A). HEU has found the School very supportive of the work of the Unit which, it acknowledges, would not be the case at all universities: ‘I know that a lot of ... research groups find academic politics really problematic and turf battles and all sorts
of battles over resources and those sorts of things. We haven’t really, we’ve been extremely fortunate. I think that we’re located in a very supportive department, a very supportive Faculty, and I think it does make a … big difference’ (A). A recent innovation of the university’s, namely, the valuing of social responsiveness (along with teaching and learning, research, leadership and administration) in decisions regarding promotion, has been to HEU’s benefit (A, University of Cape Town 2008). Many of HEU’s activities fall under the definition of social responsiveness (especially ‘Policy Input’ and ‘Health Systems Development’ (see Appendix E for the criteria and scores used by the University)) and had not been formally valued in the past.

From the Unit’s perspective, all the senior research staff interviewed indicated that, within the South African situation, being placed in a university environment is preferable to being positioned in government or being an independent NGO (A, A, A, A). One respondent said it was ‘critical’ to work within a university environment and another reflected that, given the controversy surrounding the attitudes of one of the recent Health Ministers (see Section 7), if the Unit had been positioned in government ‘we would not have survived. The Unit would have fallen apart, just like the Department of Health fell apart … It might change but there’s been so much upheaval and it hasn’t been stable, ever … So I don’t think that would have been an investment at all’ (A). Unit staff have good working relationships with many people in government, and clearly recognise the advantages that would be afforded a policy unit that is located within government, so these comments reflect not so much their experience of working with individual officials but their overall experience of political upheavals at the level of senior leadership which mean that ‘decisions are often based on politics not science’ (A) (see Section 7).

Foremost amongst the advantages of working at a university that key informants identified was therefore the protection afforded by academic freedom, especially when being critical of government (A, A). At the university, ‘there isn’t really any pressure to apply any particular ideology or politics, as long as we follow scientific principles’ (A). This was particularly important under apartheid but remains true today (A).

Thus, one staff member concluded, ‘I would trade it [i.e. direct influence with government] off for independent work and that collegial help you can get from the setting at the university’ (A). Another staff member commented, ‘I think it [i.e. the university] does provide an enormous amount of protection to speak one’s mind and I think you are a lot more vulnerable if you’re an NGO-type’ where access to funding can be cut off (A). Large donors and international agencies also tend to prefer funding university institutions (or government) rather than NGOs because of what they perceive as a financial risk (A). One respondent added that, ‘I think that the academic environment provides some of that aura of respectability, but to some extent it is whether you have proven in the past that you actually do rigorous [work], and you might have opinions or whatever but actually you know you back it up with evidence and create a line of argument’ (A).

Another important advantage of the university environment is that it allows the teaching of accredited courses. One interviewee felt that this is the main feature keeping the Unit within its current location (A). Teaching is not lucrative but it allows the Unit to fulfil its capacity-building mission: as one respondent said, ‘teaching and reproduction of knowledge is key because if you were just a policy unit and you weren’t training people or giving them degrees, you’re not creating … new human resources’ (A). The academic environment also provides valuable opportunities to
engage with colleagues who are working in similar areas: this helps to generate new research ideas and interpretations and also helps to build capacity (A, A).

Being part of the university also provides access to some resources (A, A): in the case of HEU, the Director’s post is funded by the university; the Unit also benefits from the university’s administrative systems even though these are somewhat bureaucratic; and the university has a ‘phenomenal range of electronic resources which we wouldn’t have access to otherwise, so it’s dead easy for us to get any journal article we want’ (A). Interaction with colleagues at the School and in other departments was also highly valued (A, A).

Apart from these resources, however, the Unit is entirely soft-funded, having to raise funding for salaries and other costs from outside sources on a continual basis: the university does not provide core funding or even reimburse the Unit adequately for the extensive teaching and supervision it provides (A, A). This is one of the disadvantages of working in this particular university environment, although the university is otherwise supportive (for example, if the Unit comes up with innovative ideas for fund-raising) (A). A bigger disadvantage of working in the university environment is the low salaries, especially for senior staff, as recruitment and retention of staff is the major problem facing the Unit (see later discussion).

When asked whether staff working in the Unit would not have had more impact working within the National Department of Health, one respondent reflected: ‘There definitely has crossed my mind that you can’t actually expect things to happen the way you want them to happen unless you’re prepared to actually go and get your hands dirty there ... But I just enjoy teaching and that sort of stuff too much: I’m too much of an academic and it would kill me to sit in meetings all the time and to be at the beck and call of the Minister and basically have to follow orders... And that academic freedom, that if you fundamentally disagree with something you are instructed to actually implement it - what do you do?’ (A). Another felt that ‘the culture of government is overwhelming ... So many ... people I know who go work for government, within two or three years they bureaucratise ... and don’t think in a critical way ... Fighting fires is one thing. I think it’s also their understanding of their role and also the culture’ (A).

Yet another noted that proximity to government is not always important for certain types of policy work, such as ‘work that’s more at a conceptual level and seeking to encourage different ways of thinking’ (B) (this would apply to the project summarised in Box 2 for example). Such work, which is wanting ‘to change people’s understanding of the world’ over the long term does not necessarily need direct feed-in to government processes: what matters is ‘to support those working in government to see their own world differently so they can act differently in it. And you do that partly because you’re not in government, you do that because you can bring theory to bear on the practical issues. You do that because you can bring other experiences to bear. And you as an academic have that luxury of not having to respond to today’s crisis so you can actually think about the future. And I don’t think you can ... do that in government ...[or] not that easily and there’s an important and legitimate role to be doing those things outside government’ (B). Overall, then, the sense was that the academic environment is important, especially when the political environment is not enabling (see Box 2, for example).

When user’s of the Unit’s work were asked whether they thought that HEU undermined government’s capacity by keeping scarce skills within the university environment, these respondents
did not see this as a problem, provided that HEU continues to do policy-relevant work and remains responsive to government’s needs (C, C). Furthermore, HEU has contributed to building government capacity over the years by training junior researchers who eventually find employment in government (Doherty 2005).

### Box 2: Policy units located within government – the example of the International Health Policy Programme in Thailand

‘If one thinks about the IHPP in Thailand, their position which is part of - but slightly independent of - government, gives them entry points which HEU or any such group does not have. They are engaging with policy-makers on a more regular basis to identify issues, being commissioned or responding to needs. And they have therefore been able, for example, to engage with the central stats office to improve the collection of information that’s relevant to health financing and expenditure issues. So they clearly have entry and engagement in a more operational way ... and that’s been facilitated by a broader political environment that’s enabled them. However, if that political environment isn’t supportive of types of analyses, or analysts being engaged, if it’s chaotic which now it is in Thailand, then those linkages are less possible anyway.’ (B)

### 3.5 The Unit’s local and international reputation

An external observer noted that HEU ‘does some very good research. I’m impressed by both the quantity and quality of the research that they do. Some of it is of a very high academic standard. Quite a lot of it is also highly policy-relevant’ (B). This same observer noted that HEU’s links to policy-making are very strong - more than many other similar units in the international environment - and characterised the Unit as ‘a highly successful unit.’ A senior university manager said, ‘I’m a great fan of their’s’ and noted that ‘that sort of policy work is highly regarded and acknowledged within the university’ (A). To substantiate these opinions, one observer raised the example of the project called SHIELD (see Table 2), saying that it ‘is clearly one of the few of its kind internationally, looking at insurance developments in different countries and seeking to do comparable work, ... and it’s recognised to be unusual and peculiar, you know, a leader in its field for Africa’(B).

Both Di McIntyre, the founder of the Unit, and the current Director, Sue Cleary, were spoken highly of by respondents (A, B, C). Di has developed an international reputation as a health economist working in less developed countries and, in 2008, she was awarded a National Research Foundation (NRF) Research Chair in Health and Wealth for the period 2008-2011. The Chair is funded by the South African Department of Science and Technology and acknowledges her stature within the South African research community. As discussed in more detail later, senior staff have been involved in a number of high-level government committees, provided technical support to government on numerous occasions and conducted research commissioned by government. The Unit is well-networked with prominent international research and advocacy groups and has a particularly close relationship with two internationally renowned health economists, Prof. Lucy Gilson (who has a joint appointment with the UCT School of Public Health and Family Medicine and the London School of Hygiene and Tropical Medicine) and the retired Prof. Gavin Mooney (formerly a professor at Curtin University and currently an honorary professor at Sydney University, both in Australia).

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2 The objectives of the NRF’s Research Chairs appear in Appendix B.
The Unit aims to provide policy guidance that is evidence-based and objective (A, A) but takes the view that, with respect to the health sector, there is a strong role for government (as evidenced by the Unit’s research output). With the ruling party, it shares a strong concern for equity but remains constructively critical of many of its approaches and policies. The unit is ‘becoming very prominent’ and has many allies amongst members of its target audience (A), not to mention the large African network of former students it has trained over the years (B).³

When asked who the Unit’s greatest critics are, respondents felt that the private sector, which is often critiqued by the Unit, seems to accept that, as an academic institution, the Unit will be critical and support the role of the public sector (A, A). Some criticism has been levelled on occasion by advocacy groups, especially those working in the area of AIDS activism. These groups sometimes feel that the Unit should be more critical of government and use more aggressive tactics to influence policy: the Unit, on the other hand, has chosen to keep channels of communication with government open in the hopes of being able to influence policy in the longer term (A). In the past, a bone of contention within the university has been the ‘disciplinarity debate’ for which the Unit has been a ‘lightening rod’ (A): this debate centres around who is entitled to teach a discipline with some arguing that the Unit should fall under the Department of Economics (A, A). However, with strong support from the School, this argument has been resolved (A, A).

4 ORGANISATIONAL STRUCTURE AND SYSTEMS

4.1 Organisational form and autonomy
As an academic institution, HEU falls under the jurisdiction of a special Act of Parliament. It is a single institution with its own discrete identity but, as evidenced by Table 2, undertakes joint projects with a wide variety of other organisations. For example, it is currently a member of an 8-partner research consortium called CREHS (Consortium for Research on Health Systems) which involves partners from Africa, India, Thailand and the United Kingdom.

4.2 Governance, leadership and strategy

4.2.1 The relationship between the Unit and the School
HEU is located within the School of Public Health and Family Medicine and its Director is answerable to the Head of the School. Within the past decade, a more participative approach to School leadership has been established, with the HEU Director forming part of an Executive Committee along with the other sub-sections of the School (A).

In practice, the Unit has always had almost complete autonomy in terms of its research and teaching agenda, providing that it meets the objectives of the School which are very broadly defined, such as ‘social responsiveness, the kind of research, you know, that is in effect applied, in the public domain and very robust and engaged with people who matter, whether it’s policy-makers or the community. And I think that within that, you know, we’ve created that sort of culture and I think that is what people do. So all of their work is within that sort of framework’ (A). HEU staff members say that the Unit has not experienced pressure to undertake certain kinds of work (A, A) although there is

³ Around 100 students have been trained on the Master’s in Health Economics and 180 on the Oliver Tambo Fellowship Programme with which HEU is closely associated (B).
sometimes an expectation from Faculty management that the Unit provide research and guidance with respect to negotiating for budgets and posts from the provincial Department of Health (A). The fact that the Unit is funded from sources outside the university has contributed towards the Unit’s autonomy in deciding its own research direction (A).

As an NRF Chair, Di is answerable to much more senior management but, unlike some other NRF Chairs, has chosen to still report to the Head of School which makes ‘for a very functional relationship’ (A). Unlike some other research Units in the university which are so autonomous that they are practically ‘off-shore ... HEU’s very integrated academically’ (A): this is not only due to the easy relationships between managers but also because the co-ordinators of the School’s Master’s in Public Health (which focuses on epidemiology and practice) and the Master’s in Public Health (which focuses on health economics) work collaboratively (A).

These arrangements reflect a high degree of trust between the Unit leadership and the leadership of the School which has evolved over 20 years of engagement (A, A). This is reinforced by regular interaction between HEU and the rest of the School, for example, through participating in research presentations which contributes to the collegial atmosphere of the School and promotes collaborating on projects in an ‘organic’ sort of way (A, A). There are probably more opportunities for achieving synergies than are currently exploited due to enormous time pressures on staff (A).

4.2.2 The management of the Unit
Within the Unit, the current practice is for the directorship of the Unit to rotate between senior members so, apart from Di who was director for many years, there have been three other directors. The current director is Sue Cleary, a senior researcher who holds a PhD and who has been very influential in government with respect to HIV/AIDS.

The Director is responsible for day-to-day decision-making. Regular administrative and research meetings involve the whole staff: these happen twice a month and allow collegial participation in decisions that affect the direction of the unit.

It was not possible to get a strategic plan for the Unit although there are annual strategic planning meetings which set the direction for the subsequent years.

4.3 Human resources

4.3.1 The staff complement
HEU currently has 14 staff, 10 of whom are research staff and 4 of whom are administrators (working on finance, communications, general administration - including the coordination of data collection - and administration of a teaching programme, the Oliver Tambo Fellowship Programme) (see Table 3). Two more staff at the senior end of the researcher level will be starting in the next couple of months (A).

Four of the 10 research staff are senior staff (two of whom are Professors, Di McIntyre and Lucy Gilson): they account for all four PhDs in the Unit. Strictly speaking, Lucy Gilson is not formally an HEU member: she is an internationally renowned researcher who recently joined the university as Professor of Health Systems and Policy in the School and convenes the Oliver Tambo Fellowship Programme. However, Lucy and the administrator of the Programme are located in the HEU building. Lucy holds a joint position with the Health Economics and Financing Programme of the
London School of Hygiene and Tropical Medicine and, in that capacity, has been part of a capacity-building initiative by the London School that has supported research and training at HEU (and at sister Unit, the Centre for Health Policy, where Lucy worked for many years) since 1999. An evaluation of this initiative identified Lucy as key to the success of the initiative: as one HEU staff member commented during this evaluation, ‘if one takes into account all of the things that Lucy has contributed, it’s phenomenal. I would have gone absolutely demented [because of the shortage of senior colleagues] if Lucy hadn’t come to work in South Africa’ (Doherty 2005: p45).

Table 3: Analysis of HEU staff over the past 5 years

<table>
<thead>
<tr>
<th>HIGHEST DEGREE</th>
<th>POSITION</th>
<th>CURRENT STAFF</th>
<th>ADDITIONAL STAFF OVER THE PAST 5 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhD</td>
<td>Prof.</td>
<td>2*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Senior researcher</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Masters</td>
<td>Researcher</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Junior researcher</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Technical support staff</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Bachelors</td>
<td>Junior researcher</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(studying towards masters)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>Administrative staff</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>14</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

*One of these is Lucy Gilson who is not strictly an HEU member (see text above).

Lucy still carries out this capacity-building role, is active in the CREHS consortium that developed out of the earlier capacity-building initiative and holds an honorary position. She is also involved in joint research projects between HEU and the Centre for Health Policy that developed during her time at the Centre for Health Policy. Lastly, the Oliver Tambo Fellowship Programme, which Lucy coordinates, is in any case closely associated with HEU as it grew out of a post-graduate diploma in management that had originally been convened by HEU and HEU still participates in teaching on this programme (most recently in a seminar for very senior government managers on NHI). All in all, then, Lucy is closely associated with the identity of HEU and contributes integrally to the work of HEU. This was evidenced by interviews with external observers who tended to assume that Lucy was part of HEU (B, C, C).

Prof. Gavin Mooney has visited the Unit for three months out of 2008 and 2009. Gavin is an internationally renowned health economist who has collaborated with the Unit on research in the past and has now been funded by the Melon Foundation to build capacity at the HEU, especially with respect to the writing and publication of journal articles. He received an Honorary Doctorate in 2009 from the University of Cape Town.

Over the last 5 years there have been an additional 7 staff – including two former Directors - that have since left (see Table 3). This is quite a high turnover and means that HEU have had to advertise for new staff every year (A). It is particularly difficult for the Unit to lose Directors as this level is extremely hard to replace. The same applies to staff who leave soon after having got their PhDs whilst working at the Unit (there have been 3 such cases) (A). On the other hand, mid-level and
senior staff tend to stay for at least 5 years, which is long enough to make a substantial contribution to the Unit, and the current complement of senior staff has been at the Unit for 8 years or more.

In the main, HEU conducts its own field work, often in partnership with research groups that have formed a partnership for the purposes of a research grant (A). It also employs short-term fieldworkers and occasionally contracts out field work to larger agencies (for example, in the case of a recent national household survey) (A).

HEU has a clear human resources policy with respect to hiring, firing and managing staff performance: this is based on university guidelines which ensures that human resource management falls within accepted standards and can draw on the skills of the university (such as the legal department). However, it is the Unit’s own management that makes decisions on when new staff are needed, arranges the advertising and selection processes and makes decisions on whom to employ. HEU follows an open and competitive recruitment process by advertising widely in the local and international media. The Unit ensures that these adverts are circulated internally within the university and also through networks to which it belongs (e.g. the International Health Economics Association). Because of the dearth of skills in health economics, especially in Africa, these networks are an important means for finding staff. As mentioned previously, a negative consequence of having to comply with university procedures is that salaries are low, especially for senior researchers.

There is a clear process of evaluation: annual evaluations are part of the UCT process but interim support and guidance is provided by line managers throughout the year. One staff member noted that mentoring by senior staff had worked well in the past but that not as much attention is being paid to it now because of high workloads currently confronting senior staff (A): Gavin’s presence in the Unit at present might mitigate this to some extent.

4.3.2 Reasons why staff want to work at HEU

One staff member commented that HEU’s commitment to the concept of equity infuses the way the Unit functions internally: ‘we try to be fair, to give opportunities to grow’ (A). Several staff members characterised the Unit as a very pleasant environment in which there is a lot of support for development (see, for example, Box 3). An external observer commented that, ‘you’re incredibly fortunate with the personalities of the senior staff here’ (B).

Box 3: Characterisation of the HEU’s working culture by a staff member

‘I think it’s the work culture. It’s a very supportive environment ... From what I understand from talking to other people, the Unit is, they have more of a collegial atmosphere here, they support each other which has been good, so unlike other institutions where sometimes there is a bit of competition ... so they can get projects and so on. But here, because we’re soft funded, we need to pool resources together.’ (A)

‘Most of us are very motivated, particularly the leadership of the management which makes it such a lovely institution to be part of in terms of giving researchers enough freedom to choose areas of research they would like to work in but at the same time giving us support and guidance into what is really is necessary, relevant and important in South Africa.’ (A)

4 The Mail and Guardian and Sunday Times which are both weekly newspapers.
The specific reasons why staff enjoy working at HEU are as follows:

- they are interested in working on equity issues in the field of health economics and for many years this was the only health economics Unit in Africa: it is still the only one in Anglophone Africa that offers a Master’s in Health Economics (which junior staff are encouraged to enrol in) (A), and it is seen to work on priority issues for South Africa and the region (A);
- the unit attracts funding because there is a lot of demand for health economics work (A,A);
- there is good infrastructure (A);
- they feel pride in working for an internationally well-known research Unit (A);
- it is a pleasant working environment (A);
- they receive a lot of training and guidance from senior people (A,A);
- there is freedom to work on issues of personal interest (A,A);
- they learn a lot about the South African health system and engage a lot with government (A);
- they have a lot of exposure to international issues through working with international partners and attending international conferences (A);
- they are encouraged to publish and authorship is sorted out fairly on the basis of people’s actual contribution to the work (A); and
- they get to travel (A).

Those staff who end up making a long-term career at HEU are people who are passionate about having an academic career (A,A).

4.3.3 Problems with recruiting and retaining research staff

Recruiting and retaining staff, especially at the senior level, was identified by key informants as the major challenge facing HEU. As one staff member noted, HEU has not been able to recruit a single person with a PhD in the last seven years (A). There are two main reasons for this problem.

First, the salaries offered by the university are low, especially with respect to senior staff: this is the most common reason given by staff for leaving during exit interviews (Cleary and McIntyre 2009). Much higher salaries are available in the private sector and within government, not to mention overseas, and there is a big demand for health economists. HEU did a market analysis and found that the university scale is very flat across different levels of researcher as they have tried to reduce the differential between the different ranks. As a consequence, more junior staff earn very much what they would get on the open market (their salaries being around 85-90 per cent of the market value) but senior researchers earn far less (with salaries 40 per cent less than the market value)(A, Cleary and McIntyre 2009).5 In addition, in government people can get a Director's post without even a Master’s and earn as much as an Associate Professor, whereas at the university people need a PhD just to get a senior lecturer position (A). Staff are therefore either not attracted to work at the Unit (especially if it involves relocating to a job which is not permanent) or leave after they have gained enough experience for better-paying jobs elsewhere (A). Thus, six staff who passed through HEU’s research intern programme left shortly after completing the programme, and three staff who

5 To create competitive salaries for lecturers, senior lecturers, associate professors and full professors (i.e. to compete against salaries offered by government, regulatory bodies, research institutions and the private sector), HEU estimates that it would have to increase salaries by at least 11%, 41%, 46% and 45% respectively (Cleary and McIntyre 2009).
completed their PhD while at HEU left soon after graduating (Cleary and McIntyre 2009). The two new researchers that joined HEU shortly after the completion of this project both took a year to recruit (A).

There are other reasons for leaving, though: these tend to be personal rather than having to do with dissatisfaction with the Unit itself (A). For example, some do not want to make a career in academia as, ‘it was very clear that they wanted to be at the coal face [of government]’ (A) or ‘want to use the skills that they’ve learned and apply them somewhere else,’ be it in government, NGOs or the for-profit private sector (A). In addition, ‘a lot of our staff are just not willing to invest the 20 years you need to invest to get to the top of the academic pile’ (A). A previous study that examined problems which the Health Economics Unit and Centre for Health Policy had in retaining health economists they had trained noted that losing well-trained research interns to government should not be seen as a failing as it is part of the role of HEU to build capacity in government (Doherty 2005). Others, especially those with a family, choose to return home to their country of origin after spending five years or so at the Unit (A,A,B).

A second major reason for difficulties in recruiting staff is that there is a dearth of health economists globally, especially those working on the problems facing low- and middle-income countries (especially from a perspective of equity) (A, B): this is because health economics is a relatively young discipline. HEU estimate that in South Africa there are only twelve individuals with a PhD in health economics, only seven of whom are South African (Cleary and McIntyre 2009). A contributing problem in South Africa is that only a tiny percentage of students on HEU’s Master’s in Health Economics are South African. The reason for this, in turn, is that the government does not provide bursaries to South Africans to attend the course (and the bursaries that are provided by the course itself are only for people from elsewhere in Africa as the funder, SIDA, wants to target low-income countries). As the Master’s is the only one in the country, attending the course means re-locating to Cape Town which is expensive, especially for married people with children.

As a consequence of the dearth of local health economists, the Unit often has to recruit foreigners, especially if it wants experienced staff (A). Often these are former students who are mid-level researchers (A). Thus, usually more than half of HEU research staff are foreign at any one time: as one staff member said, ‘we don’t actually attract South Africans’ (A). For foreigners, on the other hand, the Unit is an attractive place to work (especially for those who are still early on in their career): this is because the Unit has good infrastructure, provides existing funding and provides experience working on low- and middle-income issues that is essential for future career mobility (A,A).

Furthermore, the burden on senior staff is heavy. An external observer commented that ‘they just work and work and work, and one wonders if that is sustainable’ (B). The same observer suspected a history of ‘burn-out’ for some of the senior researchers who had left in the past and noted that if this were to result in any of the current senior staff leaving the Unit, especially Di, ‘the implications for this Unit would be enormous’ (B) and ‘it would be quite hard’ (A). In addition, the current Director who is highly respected by the key informants, is still in her early 30s and is, to some extent, sacrificing her academic career (that is, losing opportunities to publish) in order to lead the Unit (B).

It is clear that at least one additional senior researcher is needed for HEU but the chances of recruiting a suitable person are small at present (A, B).
4.3.4 Recent strategies to improve recruitment and retention of staff

Strategies to recruit and retain senior staff have exercised the minds of HEU’s senior management for many years. The Unit has been unable to get another core post funded by the university (apart from the one to which Di was appointed when she first set up the Unit and which is now used for the Director). Acquiring the NRF Chair for Di was therefore a major triumph, not only for Di but for the Unit as a whole.

For the past two years HEU has been trying to convince the university to allow it to pay salaries ‘above-rate-for-job’ for senior lecturers and professors (as noted earlier, salaries for other categories are relatively good compared to those offered by other institutions). ‘Above-rate-for-job’ is a university policy that allows higher salaries to be paid to people who have ‘scarce skills.’ Scarcity is identified by meeting one of four criteria, three of which HEU already fulfils: these are evidence of market competition, a limited pool of expertise and ‘actual difficulty in attracting applicants of quality or retaining those appointed’ (Cleary and McIntyre 2009). As one key informant commented, health economists are far more scarce than some of the other disciplines at the university that are currently benefiting from this new dispensation (A). In addition, HEU argues that it is able, as a soft-funded unit, to take on responsibility for paying the extra ‘scarce skills’ allowance (Cleary and McIntyre 2009). However, a response from the university has not yet been received to HEU’s proposal that, out of the funds it raises, it be allowed to pay senior lecturers, associate professors and full professors up to an additional 30 percent of their current remuneration.

Clearly, there are some people who are willing to accept lower salaries because they enjoy working in the academic environment and HEU is improving its skills in identifying these people during recruitment processes: ‘so I think, we’re trying to learn the trick of how to identify people who really are passionate about academia so that there can be a mix so there can be some turnover but at least we get to retain some’ (A). Part of retaining staff is working on maintaining a nice working environment as well as assisting staff to publish so that they can be fast-tracked for promotion (A).

4.4 Funding and sustainability

4.4.1 The sources of funding for the Unit

As indicated earlier, the Unit is soft-funded and does not have core funding apart from one university post and one NRF chair. As one staff member pointed out, the university is ‘very happy and quick to paint the Health Economics Unit as a glowing example of, you know, how we can actually generate funding and do all these activities and train all these students and that, but [they’re] not desperately forthcoming with money’ (A).

On average, the Unit receives R6 million per annum (see Table 4), almost 80 percent of this from international agencies and donors. The primary source of funding (45%) is a grant from SIDA to run the Masters in Health Economics, including the provision of bursaries to students. A third of the grant is for bursaries so this component does not benefit HEU financially (except that HEU receives that portion of the fees that represents the difference in the amount charged to local versus international students as the university has agreed that this portion can be used to supplement the salary costs of training) (A).

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6 The fourth criterion, which is not relevant to HEU, is ‘mobility within certain disciplines.’
The next most important funders are IDRC (14%), EU (10%) and DFID (7%), with the latter mainly being channelled through HEU’s partnership with the London School of Hygiene and Tropical Medicine.

HEU does not receive many funds from consulting: the bulk of the technical assistance provided to government is for free. Sometimes government does offer payment but the bureaucratic hurdles HEU has to undergo to sign contracts through the university does not make this worthwhile for small amounts of money. Thus, only 6 percent of funds are received from government (mainly for conducting commissioned research). One external observer felt ‘very surprised’ that, given all the policy support government benefits from, they do not provide a lump sum to help sustain the Unit: ‘that would be the more normal way that things would happen’ (B).

Table 4: Funding sources, January 2004-June 2009

<table>
<thead>
<tr>
<th>CATEGORY OF FUNDER</th>
<th>PERCENTAGE OF TOTAL FUNDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multilateral agencies (EU, WHO)</td>
<td>12.3</td>
</tr>
<tr>
<td>Bilateral agencies (SIDA, IDRC, DFID)</td>
<td>66.6</td>
</tr>
<tr>
<td>Private foundations (Rockefeller Foundation)</td>
<td>0.4</td>
</tr>
<tr>
<td>Government (national and provincial)</td>
<td>5.7</td>
</tr>
<tr>
<td>NGO (local and international)</td>
<td>6.9</td>
</tr>
<tr>
<td>Academic/research organisations</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Source: analysis of financial statements

4.4.2 Changes in the funding profile over time

There has been a shift over time to larger projects, often in collaboration with several partners: ‘when we started off, a lot of our research grants were kind of small, short-term projects, like a year or whatever. Really, quite small amounts of money to just cover the salary and to just do a bit of field work and that sort of thing ... Over time, although we still have quite a lot of smallish projects, we always make sure that we’ve got some really big projects that provide us with some security’ (A). These big projects act as a kind of core funding but only with respect to paying for research; they also lessen the need for senior staff – who carry the responsibility for fund-raising, including for the salaries of junior staff - to have to write proposals all the time (A).

4.4.3 Financial vulnerability of the Unit

With respect to research, the Unit has several funders and is able to access funding relatively easily, especially through partnering with other institutions in the North and the South. With respect to teaching, however, the Unit is heavily dependent on SIDA to mount the Masters in Health Economics. This is a problem as this money will cease in 2011. One staff member reflected that ‘for a soft-funded unit to do the amount of teaching that we do is actually a huge risk to the sustainability of the unit itself. Because when it comes to us no longer having the money to cover our teaching costs, UCT does not actually cover our teaching costs. They pay us some money but it’s not a cost-recovery rate. Which means we’re going to be in a very difficult position of wondering whether we should run the risk of continuing given the potential for quality reduction, the potential for burn-out, the need to cross-subsidise teaching from research funds which is not ethical anyway, or whether we should say, “Okay, we’re just going to be a research unit.” We’re trying to make this known in the Faculty but I’ve got no idea of whether they will take it seriously’ (A). Another strategy will be to find ways of attracting students without being able to offer bursaries directly: this will mean actively encouraging prospective students to seek bursaries elsewhere (A).
Funding salaries for teaching is generally a problem as the fees raised by the university for Master’s and PhD students are not passed on to the Unit (apart from the SIDA component described earlier). In fact, HEU has estimated that it is subsidising the university to the tune of R2 million per annum: although this was made clear to the university in a report submitted in 2006, this has not resulted in additional funding being channelled from the university to HEU (A).

A concession was won from the university in view of the Unit’s heavy commitment to PhD supervision (at present HEU staff supervise or co-supervise 6 PhDs). At one stage this was performed without reimbursement but now the Unit receives reimbursement for this activity. Unfortunately this reimbursement is at a very low rate, well below cost (A). The reason is that the rate has been designed for conventional academic departments who have permanent salaried staff funded through government teaching subsidies. In addition, these departments often have young staff with PhDs who are willing to supervise PhD students at lower rates as part of their work experience. A further problem is that university policy reimburses undergraduate teaching at a higher rate than postgraduate teaching (which is the domain of HEU), a policy that seems counter to the university’s drive to enrol more postgraduates (A).

So, in a larger sense, HEU remains vulnerable with respect to funding, despite the important injection of resources that was signified by the awarding of the NRF Chair (B). ‘They survive but they spend a lot of time chasing money’ said one external observer, at some personal, academic and policy cost: ‘it’s just silly that a Unit as successful as this has to spend so much time looking for a bit of money here and a bit of money there’ (B). Financial constraints become a problem whenever something out of the ordinary has to be planned for or there is a downturn, for example, when a number of large projects come to an end or the sabbatical of a staff member has to be funded. HEU is also in the strange position of having to cross-subsidise teaching costs out of research funds: this is not fair on funders who pay the research costs and takes a personal toll on staff who have to produce both the expected research outputs and train (often by working after hours). As one external observer commented, ‘they’re victims of their own success’ because staff generate so much work that they’ve tend to ‘create a treadmill’ (A).

Lack of financial support from the university is a problem experienced by the School as a whole: the School is atypical as it does very little undergraduate teaching and includes a number of Units such as HEU. Thus, only one new post has been secured for the School in five years or more. In reflecting on why this should have been so, one key informant felt that ‘there’s a cost containment model that dominates everything … I just think it is the culture of the institution. It is so conservative in that way. They definitely don’t want to take risks and, you know, creating posts is seen as risks, even for something like HEU … So there are some policy mismatches, so if you put a policy Unit like HEU into the university where, you know, there are all kinds of different forces and traditions and cultures and conflicting policies, they can’t kind of flourish inevitably, it’s a fight to get them to flourish’ (A). These comments were made with respect to financial support: as mentioned earlier, the university is seen as very supportive of the actual work of HEU in other ways. In addition, it provides bridging funding to projects if work has to continue before funders have deposited amounts owing (A).

4.4.4 Overheads charged by the Unit
HEU is required by the School to charge funders a departmental administrative contribution of 5 percent of the overall costs or a bit less, depending on the contract (A). The average over time has
been 3.4 percent (analysis of financial statements). A university levy also has to be charged: this is 15 percent of total costs or sometimes a bit less. Some of this money is fed back into Unit (e.g. for the recent refurbishment of buildings) (A, A). Funders do not generally allow HEU to charge School and university administrative fees directly so they have to be included in other items (general expenses, stationery, refreshments, venue hire etc.) which in total amounts to almost 17 percent (analysis of financial statements). By way of contrast, the biggest line item cost is salaries (at 48 percent) followed by the provision of bursaries (18 percent).

4.4.5 Publication of Unit accounts
HEU does not have its own ‘business unit’ which is responsible for fund-raising: this is the responsibility of individual senior researchers. There is a financial administrator, however, and the Unit uses the university accounting system and is able to track income and expenditure on a daily basis (although invoices take a week to be paid, and it takes a week to identify new funding that has been received) (A). Accounts are not published (for example, in annual reports) but are open to scrutiny within the university and do undergo internal and external auditing. Contracts underpinning research projects have to first pass through the university’s legal department and ethics process before being signed (A).

5 THE FUNCTIONS OF THE UNIT

5.1 Scope
As indicated in the mission, HEU focuses on research relating to the health system (defined in its broadest sense). Within the health sector, the Unit focuses on three main research areas: health systems and health equity research; health care financing and health economic analyses of priority disease areas. The Unit is also committed to capacity-building, both of its own staff but also of economists and senior managers more widely.

5.2 Services provided

5.2.1 Research-related services
Table 5 lists HEU’s research functions. The thrust of the work is policy-relevant research and technical support and policy advice. Several HEU staff noted that the Unit is in a busy period: there is a high demand for its policy advice and the Unit is engaged in a lot of large projects (A).

HEU mainly produces research reports and journal articles (as well as book chapters, the occasional book and tools for planning, such as tools for assessing deprivation and capacity at the district and sub-district level, and for conducting health expenditure and financing reviews) (see Appendix C). HEU do not tend to produce monitoring reports although the Unit has contributed to methodology behind the District Barometer, a publication produce by a South African research NGO, the Health Systems Trust. HEU do not produce many materials specifically designed for advocacy (although their research is often used for advocacy purposes by other NGOs) but HEU does engage with the media to some extent (see later).
Table 5: The research and technical support functions of HEU

<table>
<thead>
<tr>
<th>FUNCTIONS</th>
<th>EXTENT TO WHICH HEU ENGAGES IN THIS FUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct policy-relevant research</td>
<td>This is the bulk of the Unit’s work.</td>
</tr>
<tr>
<td>Identify and synthesize policy relevant research</td>
<td>Most of the Unit’s research work is original research but most projects are underpinned by literature reviews, while some pieces of work are stand-alone reviews.</td>
</tr>
<tr>
<td>Conduct evaluations</td>
<td>These are performed, especially with respect to specific disease-related work.</td>
</tr>
<tr>
<td>Conduct systematic reviews</td>
<td>These are performed occasionally.</td>
</tr>
<tr>
<td>Commission systematic reviews</td>
<td>This is generally not done.</td>
</tr>
<tr>
<td>Commission independent research</td>
<td>This is generally not done.</td>
</tr>
<tr>
<td>Convene expert meetings</td>
<td>This is sometimes done, a recent example being a meeting of senior policy-makers and managers under the auspices of the Oliver Tambo Fellowship Programme to discuss NHI.</td>
</tr>
<tr>
<td>Organize conferences, seminars to stimulate debate</td>
<td>This is seldom done.</td>
</tr>
<tr>
<td>Provide policy advice (eg. Direct one-on-one discussions with policy makers, drafting of policy briefs)</td>
<td>This is a core activity of HEU and is presently quite intense with respect to NHI.</td>
</tr>
<tr>
<td>Data archiving and analysis</td>
<td>This is generally not done.</td>
</tr>
<tr>
<td>Advocacy</td>
<td>This is done through the distribution of reports, presentation of findings at conferences and engagement with the media.</td>
</tr>
</tbody>
</table>

HEU’s average output of written products per year is 24 (assuming output during 2009 continues at the same pace) (see Table 6). There was a marked increase in the number of journal publications from 2008, but most especially in 2009, partly linked to the advent of Gavin Mooney and Lucy Gilson and the outputs of multi-partner projects, but also to maturing of HEU staff.

Table 6: Formal written outputs of HEU (2004-mid2009)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>JOURNAL PUBLICATIONS (refereed)</th>
<th>BOOK CHAPTERS</th>
<th>BOOKS</th>
<th>REPORTS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>7</td>
<td>3</td>
<td></td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>2005</td>
<td>6</td>
<td>2</td>
<td></td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>2006</td>
<td>12</td>
<td></td>
<td></td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>2007</td>
<td>9 (including 1 letter)</td>
<td>13#</td>
<td></td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>2008</td>
<td>19 (including 1 editorial and 1 commentary)</td>
<td>3</td>
<td>1**</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>2009 (until end June)</td>
<td>17* (including 1 book review &amp; 1 editorial)</td>
<td>4</td>
<td>1**</td>
<td>1</td>
<td>23    (until end June)</td>
</tr>
</tbody>
</table>

Source: See Appendix C.

Note: Most, but not all, of these outputs relate to South African research. All outputs published while the staff member was at HEU are counted, even if based on work done before joining HEU.

#Some of these are chapters in the book.

*6 of these are still in press.

**These are first-authored by Lucy Gilson and Gavin Mooney respectively.
The formats of reports for policy makers or other decision-maker audiences are typically full reports preaced by an executive summary. Policy briefs or summaries of take-home messages have not been common but there is an intention to use these more widely, with the recent appointment of a communications officer. Where policy briefs have been produced there is a sense that they have been useful: ‘they [i.e. people in government] will skim them, but the people who ... give a damn, who’re movers and shakers anyway ... It was interesting, within 15 minutes of ... sending [a recent policy brief] off to key people, [a senior manager] was on the [e-mail] , and he sort of said, “I need to understand why it is that the high-income ... groups are the ones who are getting such good access to the central hospitals. How do we actually change the situation?”’ (A).

The Unit has participated fairly consistently in conferences, especially international ones (see Table 7). Activity seems to have increased in 2009 quite markedly while over the last couple of years more invitations have been issued to HEU. This reflects, in particular, the growing reputation of Di McIntyre and Sue Cleary, the advent of Lucy Gilson and the relevance of HEU’s work to currently hotly-debated issues (especially around HIV/AIDS care). Unit staff have also chaired sessions at international conferences and participated in scientific committees, testifying to the Unit’s international reputation.

Table 7: HEU participation in conferences (2004-mid2009)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>INTERNATIONAL CONFERENCES</th>
<th>LOCAL CONFERENCES</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>8 (1 was a plenary paper; 1 was an invited paper)</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>2005</td>
<td>15 (1 was to participate as member of Scientific Committee; 1 was a plenary paper; 1 was to chair sessions; 1 was a poster)</td>
<td>1 (this was an invited presentation)</td>
<td>16</td>
</tr>
<tr>
<td>2006</td>
<td>5 (1 was an invited paper; 1 was to act as a discussant)</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2007</td>
<td>12 (1 was an invited paper; 1 was to co-organise a day-long workshop; 1 was to chair a session)</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>2008</td>
<td>14 (1 was to chair a Scientific Committee; 1 was to participate as member of Scientific Committee; 3 were invited papers; 2 were to act as session chair; 1 was a poster)</td>
<td>2 (both of these were invited)</td>
<td>16</td>
</tr>
<tr>
<td>2009 (until end June)</td>
<td>10 (1 was an invited paper; 1 was a poster)</td>
<td>2 (both of these were invited; 1 was a plenary presentation)</td>
<td>12 (until end June)</td>
</tr>
</tbody>
</table>

Source: Appendix C

5.2.2 Teaching-related services

Teaching is a big component of HEU activities, taking up around 30 to 40 percent of senior researchers’ time (A). Teaching is not lucrative but staff see teaching as essential to their mission of building capacity in the field, especially in Africa (A, A): ‘It’s not lucrative, I mean, as I mentioned, we’ve been heavily cross-subsidising the teaching through our research grants, in the sense that people work on a particular project and they’re expected to produce what’s required for that project, but we ask them just along the way to actually teach and supervise dissertations, and the
dissertations are not [even] linked to that research project, we give a lot of flexibility to our students’ (A).

Box 4: Main teaching activities undertaken by HEU

| Post Graduate diploma in Health Economics (this is the first such diploma to be offered on-line from an African university) |
| Masters in Public Health (specialising in Health Economics) |
| Masters in Health Economics (which is offered through the School of Economics) |
| PhD programme by dissertation |
| Supervision of research projects undertaken by Master’s students |
| Specifically designed short courses |
| Participation in Oliver Tambo Fellowship Programme |
| Internal capacity-building (see later discussion) |
| Founding member and co-ordinator of the Africa Health Economics and Policy Network |

Box 4 lists the main teaching activities. Different courses have different target audiences (A, A):

- the post-graduate diploma is mainly for people (often from the private sector) who want to get some background to health economics and apply this knowledge to their work environment, but do not have an interest in an academic career: around 98 percent of students are South Africans who are working in other jobs;
- the Master’s in Public Health is for people who have trained in the social or health sciences and are wanting to gain competency to work in health services, especially in the public sector: most are doing the Master’s on a part-time basis, are working in jobs and are taking leave to attend the course modules;
- the Masters for Health Economics is more for people who are seeking a career in this field: 98% are from other countries in Africa because of bursary opportunities and because students tend to be mature students who have family commitments;
- the PhD programme is also for people seeking a career in health economics and also tends to involve people from other African countries;
- specifically-designed short courses and the Oliver Tambo Fellowship programme tend to be for mid-level and very senior managers respectively.

HEU administers six bursaries for the Masters in Health Economics which is funded by SIDA: these are very good bursaries that cover all the costs of students, including relocation costs, but are only applicable to other African countries. Bursaries for South African students studying health economics are generally not readily available, partly because government has not identified this sort of skill as a priority scarce skill (B). However, the unit has recently accessed some bursaries for South African students from the NRF and will shortly have additional bursaries funded by WHO.

HEU has graduated around 100 Master’s students and seven PhD students over the years (A,B,HEU website) and HEU staff identified increasing demands for supervision (of both PhD and Master’s students) as being one of the factors that has led to an increased workload for senior staff (A).

Importantly, HEU staff identified teaching activities as being a key mechanism for identifying priority areas for policy research, disseminating research and influencing policy-makers: teaching is ‘facilitation of discussion and you learn so much about the health systems of other African countries’.
which kind of sparks idea. “Aha, that’s interesting, and I must actually try and find out more about that!” And also, certainly some of the ... really good, strong research collaborations [especially in Africa] have developed between us and former students’ (A). On reflection, one staff member recalled that many of the HEU’s former students are ‘people [who] have gone into very ... important, high-profile positions [in government and the private sector]. It provides entry points’ (A).

HEU’s participation in the African Health Economics and Policy Network (HEPNet) has a capacity-building component but also improves HEU’s awareness of regional policy issues.

5.2.3 Maintaining quality in teaching and research
With respect to teaching, there are periodic reviews of teaching programmes while external examiners are involved in every formal course. As one key informant noted, the former head of the School is in charge of postgraduate programmes and ‘holds quite a hand on the tiller to make sure people comply’ (A). Engagement with international collaborators (such as the Karolinska Institute and the London School of Hygiene and Tropical Medicine) has been very useful. In particular, the PhD programme has become more formalised (A). One external observer observed that HEU is ‘very strong on teaching and in an African context, particularly in a Southern African context, extremely valuable at that level’ (B).

With respect to research, quality is mainly maintained through an internal peer review process (A). Senior staff are very important in this regard, including those from international and local research partners but there is also regular discussion and critique of project outputs by all HEU staff members (A). Peer review is also provided through the process of applying for promotion, participating in international conferences and getting publications accepted in international journals (A).

5.3 Influencing domestic policy
5.3.1 Ensuring policy relevance
HEU ensures the policy relevance of its work by engaging closely with policy-makers, managers, other academics and NGOs working on key national issues. The HEU constantly re-evaluates its programme of work in an attempt to conduct research that will act as ‘a crystal ball’ for government (A). An example of this is the SHIELD project (see Table 2) which had raised money in 2006 to conduct a benefit and incidence study, the results of which were fortuitously available for the ANC’s NHI Task Team once it began its work in 2008 (A).

One researcher felt confident that the Unit is working on priority research issues for South Africa but noted that the Unit also needs to find a balance with responding to international calls for proposals and creating space for individuals to work on issues of interest to them and their careers (A) (see Box 5).

Box 5: Balancing policy relevance with financial sustainability

“Well, we try to find a balance there. We are soft-funded so we depend on research grants from outside, and most of them call for research in certain areas and you have to align your research to those areas. So we try to strike a balance between what we think is a major priority in terms of South Africa or the African region, and what those calls are asking for. Because we engage frequently with the Department of Health, the provincial government and so on, we know what the priorities are ... so we try to respond to the needs of the country and the region but at the same time there is a constraint ... But I think we’ve been largely successful” (A).
Another constraint is that, once a large project has been set in motion, there is not always scope to take on new pieces of work that take a different direction: ‘the projects are so big and so lumpy and so overlapping that there never is an opportunity to sit down with a clean slate and say, what is the research agenda. So it tends to be continuations of similar kinds of work ... It’s very difficult to change from one area of work to another. You invest so much in learning about how to do one particular set of analyses, or one set of literature etc’ (A).

5.3.2 Involvement of policy makers in the work of the institute

Sometimes working with government involves simply taking self-initiated projects to government and trying to get them interested in the findings (i.e. the need is identified by the research Units which endeavour to ensure the findings are as relevant to government as possible). Sometimes government is more involved, helping to guide the project, but is not involved in the actual data collection (especially when projects involve some evaluation of government itself and therefore should not include them as research partners (A)). Sometimes government staff are involved in the development of tools (e.g. for the MESH project, see Table 2) and the collection of data (such as the National Health Accounts project).

Working with government can be a very positive experience. For example, one HEU staff member recalled a recent project which ‘was really good because they continually gave us feedback as to what was expected, what their needs were’ (A): this was a project where communication in some form or another – by e-mail or telephone, or through meetings – occurred almost every week.

Box 6 provides a case study of how the Health Financing and Economics Directorate in the National Department of Health was involved very fruitfully in the work of the Unit in the late 1990s and early 2000s. This involvement was through the joint identification of research priorities and the funding of a research intern programme at HEU and its sister organisation, the Centre for Health Policy. Involvement was more intense when the internal capacity of the Directorate was limited: as internal capacity increased there was a greater sense that work should be done ‘in-house’ (A). Engagement with the Units was also dependent on a special grant from the EU and long-standing linkages between the Directorate leadership and the research Units.

In reflecting on this arrangement, an HEU staff member said that ‘there were times when it worked very well for them: I remember when we actually sat down ... and talked about the department, or that Directorate’s work plan, and they’d already thought through their work plan ... [T]hey wanted us to agree to do certain specific pieces of work but they didn’t do it in a kind of, you know, [they asked], “So where do you think your expertise lies? Where could you actually help us?”... I remember in that period, we did a couple of pieces of work which I think were kind of helpful like the social health insurance stakeholder analysis and analysis of utilisation and what were the implications from a social health insurance perspective ... there were all sorts of small things ... so there were periods where ... there was a coincidence of areas of interest’ (A).

5.3.3 Mechanisms for influencing policy

Influencing policy is a complex process and is not limited only to engagement with government: there are ‘other kinds of influences on how society is governed’ (A). Engaging with civil society actors (especially NGOs, donors, trade unions and other applied researchers) are important
alternative avenues, especially when government is hostile to evidence on a certain topic (as was the case with HIV/AIDS until recently, as discussed earlier). This section concentrates on influencing government decision-makers, however, as this is the area where HEU has worked particularly hard. A number of mechanisms were identified by key informants.

**Box 6: Case study of 10 years of engagement between HEU, CHP and the National Department of Health’s Directorate of Health Financing and Economics (1995-2004)**

Members of both CHP and HEU were active in the progressive health movement prior to 1994 and consequently were linked with activists who eventually took up government positions ... [K]ey members of both SA Units co-ordinated high-profile government committees ... These roles, as well as the other activities of the research Units, gave the Units both academic and political credibility with government, especially at the national level.

... Importantly, at the time when these contacts began to wane as government staff moved on to new positions, the Directorate provided both research Units with a capacity-building grant (funded by the EU). This funded two senior and two junior researchers in each institution. The idea for the grant had been initiated at a priority-setting meeting held by the Department of Health, to which the two SA Units ... had been invited. It represented a huge injection of resources for both institutions ...

The capacity-building grant led to an initial period of close engagement with government particularly as, according to one government respondent, ‘the department went through a serious dip in terms of internal capacity, not just to do work but to comprehend certain situations.’ In this context it needed assistance from universities ‘to get a couple of basic pieces of work done to help the Directorate move forward.’ It also led to quarterly meetings between the Units and the Directorate, which gave them ready access to government, opportunity to share results and an improved understanding of their priorities and needs. This process was not without its tensions, as the research Units had different ideas from government with respect to which were priority research questions and which were of interest to themselves.

In more recent years, the Directorate became less dependent on the SA Units. The capacity of the Directorate expanded considerably, which led to its doing much more in-house work. Some of its work was no longer relevant to the research portfolio of the Units. One government respondent expressed it as ‘a lot of menial stuff that it is difficult to contract out to universities’ (for example, detailed costing of hospitals). Another had a slightly more negative view, stating that the Units were somewhat reluctant to do ‘the nuts and bolts’ work which government required at the time to support policy development.

In the meantime, the research Units themselves were struggling with capacity constraints, given both the high load of large projects and the loss of some staff. They were trying to finalise large projects which meant that they were not able to engage totally in the Directorate’s agenda of work. However, one government official stated that ‘we always had access to some of the senior people at both universities in terms of saying I need to brainstorm something with you ... or here’s something I’m working on can you have a look at it and comment on it and give us some guidance on how to do it. So the relationship evolved from actually assisting us with doing work to helping us fine-tuning work.’

With the current tranche of EU funding having come to an end recently, and the shrinking of the Directorate due to a sudden exodus of staff, the close linkages have been lost. One government respondent felt that the Units could play an important role in building up the Directorate again. Both felt that it is likely that the EU funding would be renewed as the Directorate had had a good reputation with the EU: ‘the main reason was because it achieved results, not just because the programme achieved results, it was because the capacity-building programme within that achieved results ... and the work that we had done during that period of time had made its way right to the top.’
5.3.3.1 Engaging directly with policy-makers and senior managers
Engaging directly with policy-makers through face-to-face meetings or presentations to senior management committees was identified as a key way to influence policy (A): ‘it’s been sitting at the table, developing policy and strategy X, and putting information on the table that’s directly relevant to that need’ that has been important (B). HEU has had good access to these committees because of the relevance of their work (A). Engaging with policy-makers is also important for understanding properly what their policy objectives are (A).

5.3.3.2 Participating in national policy-making committees
Both Di McIntyre and Sue Cleary have participated in policy-making committees, Di over the whole lifespan of the Unit. This is a very effective way to feed evidence into policy formulation, and raises the profile of HEU, but it is associated with a number of challenges on a personal level. This form of engagement is very time-consuming (e.g. one day a week) and detracts from time to do research (A, A). Having to fly up to Pretoria weekly on early-morning flights and catch up other work on weekends also takes its toll (A, A). What is more, this kind of work is seldom paid. Lastly, there is the problem of having to wear ‘two hats:’ policy processes are often loaded with ideological meaning and often proceed behind closed doors, while academics are interested in providing independent, so-called ‘objective’ perspectives with an emphasis on trying to ‘shift the boundaries a bit’ (A). It is nonetheless important to be part of these policy processes because ‘a lot of the entrenched mindset has already happened through this [committee] process’ (A).

5.3.3.3 Undertaking commissioned research work
This is effective because the close involvement of government in the project is ensured. In these instances, government is usually involved in identifying research questions and developing methodology, as well as commenting on findings. Less frequently, government is involved in the actual data collection (such as in the National Health Accounts Project). This can have disadvantages when projects involve evaluation of government’s performance. As an external observer commented, ‘where there’s criticism to be made, [it’s] important [to be able to have space to be able to do that]. Molefe Sefularo [the current Deputy Minister of Health] spoke here [and] … was all for speaking truth to power … I think that’s the tension for us of engaging with government. If you get too close to government, it gets hard to speak that truth’ (A).

5.3.3.4 Training research interns for government
This has been dealt with already under 5.3.2

5.3.3.5 Training policy-makers and senior managers
This happens in a less structured way but was identified by HEU staff as an extremely important way of linking to policy-makers, as discussed earlier. The Oliver Tambo Fellowship Programme has proved particularly useful in this regard. Engaging in this way creates a forum where the focus is on scrutinising the evidence (rather than trying to develop policy), taking the time to reflect on international debates (a luxury which decision-makers do not always have) and creating a shared understanding of issues (A).
5.3.3.6 Producing publications
It is harder to demonstrate a link between publications and policy change although the potential impact of policy briefs has already been discussed. Another effective mode of reaching policymakers and managers has been writing chapters on health financing issues in the annual South African Review of the Health Systems Trust on which the NDOH has often drawn heavily (A).

5.3.3.7 Participating in international networks, particularly in the region
As with training, participating in international networks enhances the Unit’s knowledge of health systems issues and debates and stimulates ideas for new research in South Africa. It also provides opportunities to present policy advice to influential fora, such as the Southern African Development Community (SADC), of which South Africa is a member (A, A). The extent of HEU’s regional influence is considerable, partly because of the dearth of health economists in the region (A).

5.3.4 Measuring impacts on policy
HEU does not generally evaluate its impact on policy formally although researchers do strive to ensure that their findings impact on policy and informally review progress on certain projects in this regard. This is more so for some projects than others (A, A). However, HEU has been involved as a partner in two initiatives that did reflect on the policy impact of non-government analysts, including those from HEU.

The first initiative was a multi-partner research project that analysed progress in health financing reform in South Africa during the new government’s first term of office (1994-1999). One of the findings with respect to abortive discussions around Social Health Insurance (SHI) was that ‘analysts assisting government in developing SHI proposals failed to establish broad agreement on policy objectives even with the policy-makers who had commissioned them. There was a consequent lack of ownership of SHI proposals by health policy-makers. As a result, the special committees that were set up to drive SHI policy development became the site of disagreement between analysts and policy-makers rather than fora for constructive policy dialogue.’ A key informant from HEU commented that it can be extremely difficult ascertaining the real policy objectives of policy-makers as they can evolve over time and sometimes also shift as a result of needing to manage the expectations and interests of different stakeholders (A).

In the second initiative, HEU participated as a member of ‘the SAZA project’ team in reflecting formally on how the project had impacted on policy (Doherty, Gilson and McIntyre 2002). These thoughts are summarised in Box 7 but, in essence, the project had the following impacts:

- it produced the first comprehensive analysis of financing reform, producing a framework for thinking about future reforms and helping to identify priority areas of concern;
- it highlighted that the actual or potential impacts of the reforms went contrary to stated government policy;
- it contributed to growing appreciation by government of the need to prepare strategically for reform processes; and
- it impacted on the way project members supported future policy processes, given its critique of previous modes of engagement.

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7 So-called because it evaluated financing reform in South Africa and Zambia.
Box 7: Analysis of SAZA’s more conceptual impact on policy

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<tr>
<td>As a whole, the project produced the first comprehensive analysis of financing reform. Apart from critiquing the content and impact of reforms, it demonstrated the key role played by contexts, actors and processes in shaping the particularities of health financing reform in South Africa. These features helped to capture the history of reform efforts, creating a rare form of ‘institutional memory’ in an environment where the mobility of skilled staff, both between sectors and within government, means that the lessons of the past are often forgotten. These features also provided frameworks for thinking about future reforms. If the SAZA Project had never happened, it is conceivable that the priority areas and mechanisms for intervention in health financing matters may have been far more difficult to identify.</td>
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<td>In more specific terms, the project highlighted the fact that the actual or likely impact of certain reforms went contrary to stated government policy. Neither the resource allocation formula used by National Treasury to divide the government budget between provinces, nor the first official policy proposal on social health insurance (produced in 1997), did much for the reduction of inequity. In fact, the formula aggravated differences in government health care expenditure per capita between some groups. This information was presented directly to the Director General (Permanent Secretary) of the national Department of Health (DOH) and to his management team, clearly causing considerable concern and strengthening their resolve to review these areas of reform. The research team also made a submission on social health insurance to a commission of enquiry investigating issues related to social security. Indeed, the DOH has subsequently revised an aspect of the resource allocation mechanism (specifically the conditional grants that are top-sliced from the government budget before the application of the formula, which formerly led to the over-compensation of better-off provinces for their provision of highly specialised services and training). The social health insurance policy proposal has also emerged from the commission of enquiry in a different format. This may reflect some consideration of the critique developed by the SAZA Project, although certain important aspects of the critique have not been taken into account.</td>
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<td>The SAZA Project also seems to have contributed to a growing appreciation by government of the need to prepare strategically for reform processes. This is reflected particularly in the current process to develop a comprehensive approach to interactions between the public and private sectors. The SAZA Project had identified the lack of a comprehensive policy on the private sector as a significant problem. It had also emphasised the need to prepare clear objectives for any reform process, to involve key stakeholders and to take a fairly long-term approach where large-scale reform is involved. These principles are certainly being applied in the case of the aforementioned process, and may also have influenced another current process reviewing the configuration and financing of highly specialised services. The commissioning of three stakeholder analyses relating to social health insurance and the re-regulation of the private health insurance industry is another example of how government has become more sensitive to the management of interest groups during the reform process.</td>
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<tr>
<td>Equally importantly, the lessons of the SAZA Project have had an enormous impact on the way members of the research team support current policy processes (such as the aforementioned policy framework guiding public-private interactions, which has seen direct involvement by SAZA researchers). Some of these researchers had been involved in past policy processes that were the subject of the SAZA critique. The project showed that the poor strategic and tactical skills of analysts working both inside and outside government had contributed to their inability to ensure that sophisticated technical analyses influenced policy makers.</td>
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5.3.5 Positive examples of policy impact

Table 7 lists the main HEU projects which have had a positive impact on policy over the past twenty years and tries to identify what this impact has been. It is evident that HEU has had considerable impact, both through generating research and providing technical advice: one commentator felt that HEU’s footprint on policy in South Africa is seen as ‘pretty big’ and that they have more ‘in’ to government processes than many policy Units (A). When asked to give examples of HEU’s impact on policy, one government official said, ‘Oh, there are several … I don’t know where to start. The work that they’ve done around the user fees in the public facilities, the work around medicine pricing, the work around costing of tertiary services, perceptions of the public around the public health system. I mean there’s a whole host of research work that they’ve done that’s actually influenced policy’ (C).

Because of her long association with HEU, Di has probably had the most individual impact. At the time of being interviewed, one key informant noted that, because Di is involved in high-level meetings on National Health Insurance, including briefings to the Minister of Health, she ‘is in a very strong position to influence what is going on, as far as anybody can … The policy inroads that Di can make are very considerable, really because of her long history and association with the ANC and her ability, and also because of the links that she has. I think this means that she is very readily listened to.’ Another key informant felt that ‘ the State … values her opinion and role so they get her there [on national committees]’ (A). Apart from being a member of the ANC’s Task Team on NHI (after participating on other government committees on national health insurance in the early 1990s), Di has chaired (and continues to be a member of) the Medicines Pricing Committee: ‘that really is very substantial work in terms of the impact on policy’ (B). Sue Cleary has also done significant work as an individual with respect to HIV/AIDS (A) but within a difficult political context (see later) (B).

The ability of HEU to influence government is partly linked to the character of the individuals involved (both the researchers and their partners in government) and partly to the level of trust they have built up between each other: influence varies depending on variations in inter-personal and inter-institutional relationships over time (A). When people leave the Unit some of the momentum for engagement can be lost (A, C). Government also sometimes cannot make headway in moving policy forward or waters down policy recommendations (A). Most importantly, research has to be timely and meet government objectives (A), and the researchers who perform the research have to be skilled (A). Outputs need to be seen to be useful; they need ‘to speak to policy-makers and resonate with their experience’ (A).

When asked whether HEU’s location in a university has hampered the relevance of its work to policy, one government official replied, ‘No, I don’t think HEU suffers from that problem. I think they’re very much out there, they have their ears to the ground and they know what are the challenges and try to pursue those kinds of areas … [T]heir overall objectives and goals are to influence policy and the best way to influence policy is to actually understand what policy-makers are looking at and what are their challenges. And they interact with us on a fairly regular basis. They sit on committees that we’re involved with. They aren’t at a distance so they’re in the mix of decision-making as such. So they’re aware of what are the areas of research, the gaps in our knowledge, in order to implement a particular policy … [In different government programmes,] somebody from HEU’s usually involved in some or other way … So they haven’t behaved like what I would call a stakeholder, you know, which has an external plan and is coming to discuss it with us, they’re very much in the mix … We don’t feel
lobbied by them because we kind of see them as part of us’ (C). This perception of HEU seems to result from the quality of their work, their way of engaging with government and their decision not to conduct research for the private sector (thereby avoiding a conflict of interests) (C).
Table 7: Direct and indirect impact of main areas of research and technical support (1990-2009)

<table>
<thead>
<tr>
<th>AREA OF RESEARCH/TECHNICAL SUPPORT</th>
<th>DIRECT/INDIRECT IMPACT</th>
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<tbody>
<tr>
<td><strong>HEALTH SYSTEMS AND HEALTH EQUITY RESEARCH</strong></td>
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<tr>
<td><strong>Public/private health sector mix</strong></td>
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<tr>
<td>Evaluations of the cost and quality of primary care services (in general and for specific programmes, such as TB), by comparing direct public sector provision and contracting with private providers</td>
<td>Results were used in the government NHI policy process in the mid-1990s and are being fed into current NHI discussions because of the renewed interest in contracting private providers; results were also used in the costing of the National Primary Health Care Package (see later)</td>
</tr>
<tr>
<td>Chairing of NDOH’s Public-Private Interactions Task Team which resulted from a National Health Summit</td>
<td>Developed a national policy framework on Public-Private Interactions that was agreed to by all major stakeholders</td>
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<tr>
<td>Chairing of, and technical support to, the NDOH’s Medicines Pricing Committee (ongoing)</td>
<td>Advised NDOH on new drug pricing regulations that were subsequently implemented and led to a reduction in drug prices for end-users</td>
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<tr>
<td><strong>Human resources</strong></td>
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<tr>
<td>Evaluation of community health worker programmes</td>
<td>Results were drawn on when government began to expand community health worker programmes</td>
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<tr>
<td>Analyses of health worker motivation issues</td>
<td>Interest in these results is growing in relation to finding ways to turn the public sector around and improve staff morale, in the light of recent NHI proposals</td>
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<tr>
<td><strong>Health equity</strong></td>
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<td>Development of approaches to the equitable allocation of limited public sector health care resources:</td>
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<td>• alternative needs-based resource allocation formulae within the health sector</td>
<td>Created increased awareness of the need for needs-based allocation processes, which contributed to implementation of needs-based formulae for the distribution of the health budget in the mid-1990s</td>
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<tr>
<td>• analysing the distribution of material and social deprivation in South Africa and exploring how this could be incorporated into Treasury’s inter-provincial allocations</td>
<td>Subsequently, convinced Treasury to introduce a measure of poverty in its formula for allocating the national budget between provinces in order to account for backlogs in previously disadvantaged provinces</td>
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<td>Deprivation indices that were developed are used in the District Health Barometer, a regular publication of an NGO (the Health Systems Trust) which is used widely by government officials, especially district managers, to identify poverty-stricken areas at the sub-district level (A, A)</td>
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<tr>
<td>Analysis of whether user fee exemptions are being applied in practice to those who are eligible</td>
<td>Feeding into current national debates on whether user fees should be removed for all people ensured under social health insurance</td>
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<tr>
<td>Analysis of the supply- and demand-side factors that influence access to health services, using tracer conditions of obstetric care, TB care and anti-retroviral therapy.</td>
<td>This project is working very closely with provincial and district health managers and there is already an early uptake of findings (e.g. with respect to the fact that pregnant women are paying fees despite a free care policy)</td>
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<tr>
<td>Analysis of how fiscal federalism impacts on equity and governance in the financing of primary health care in South Africa</td>
<td>NDOH was closely involved in the design and implementation of this project but not clear yet whether it has had a direct impact yet. One of the main findings was that advocacy around equity has made an impact on government’s responsiveness to equity issues, including advocacy role played by HEU (particularly through repeatedly raising equity as an issue in repeated meeting with government) (A). Also highlighted the fact that there are many different players involved in the resource allocation for PHC (A) and that the ability to engage with Treasuries as the provincial level is important (A).</td>
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<tr>
<td>Primary Health Care and the District Health System</td>
<td><strong>Development of a methodology and tool for district health expenditure reviews</strong></td>
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<td><strong>Costing of a National Primary Health Care Package</strong></td>
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<td></td>
<td><strong>Development of a tool to assess the Management, Economic, Social and Health (MESH) infrastructure of districts.</strong></td>
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<tr>
<td><strong>HEALTH CARE FINANCING</strong></td>
<td><strong>A national health expenditure review immediately preceding the election of the first democratic government</strong></td>
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<td><strong>Subsequently, the development and implementation of a National Health Accounts (NHA) methodology which provided detailed analyses of public and private health sector financing and expenditure</strong></td>
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<td><strong>Analysis of user fees in the early 1990s</strong></td>
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<td></td>
<td><strong>Analysis of financing reform over the first period of office of the new government, including the design of reforms as well as processes of policy development and</strong></td>
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### Implementation

**Analysis of strategies for health insurance in support of equity:**
- Analysis of financing incidence (i.e. tax, medical aid and out-of-pocket payments by socioeconomic group) and benefit incidence (i.e. benefit received compared to need).
- Modelling of how financing and benefit incidence would change over next 10-15 years for different scenarios for social/national health insurance versus maintaining the status quo (not yet completed)
- A national household survey

The information is being fed into the current NHI debate, mainly through the ANC Health Task Team process but also through the media and in engagement with private sector groupings. In showing that the most progressive component source of health financing is medical aid contributions, and that the wealthiest are carrying a heavy burden, may offset opposition to NHI from the wealthy. The fact that the wealthy are benefiting disproportionately from both public and private services has strengthened advocacy for NHI and strengthened government understanding of the need for equity-promoting financing reform. All stakeholders in the NHI debate are waiting anxiously for this work to be completed in order to inform the debate. There is a high demand for this work.

This was commissioned by the NDOH which was involved closely in the questionnaire design. It has provided the most accurate data to date on levels of utilisation, relative utilisation (and for what services) between the public and private sectors and level of care. Included users’ views of the public and private sectors, revealing dissatisfaction amongst medical aid members, which has been very useful to the NHI debate. Views on solidarity revealed by the survey have been useful in informing advocacy strategies for those who want to promote NHI.

**Membership of key national policy committees including**
- the 1994 Health Care Financing Committee, the 1995 Committee of Inquiry into a National Health Insurance System and the International Review Panel of the South African Risk Equalisation Fund for Social Health Insurance; current membership of the ANC Task Team on NHI

**Provision of technical support, including injection of findings from above projects into the policy process**

### Health Economic Analyses of Priority Disease Areas

#### HIV/AIDS

**The cost-effectiveness of providing antiretroviral treatment to HIV-infected adults in South Africa (a range of projects)**

Information from early work was used in advocacy for the introduction of universal anti-retroviral treatment. Some subsequent work has not been fed into policy, partly because it showed that, if universal access is the primary goal, second-line treatment cannot be introduced because of affordability problems, but this finding emerged after second-line treatment had already been commenced.

**Analysis of the health system burden of HIV and AIDS in the Western Cape**

Used in advocacy by civil society to motivate to Treasury that funds should be injected into the health system because of the enormous health care costs associated with the HIV/AIDS epidemic

**Co-chairing of sub-group costing the recent comprehensive National Strategic Plan for HIV/AIDS**

Ongoing work on costing and the scaling up of ARVs fed directly into this process resulting in the cost data and approach that was used in the Plan.
<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
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<tr>
<td><strong>The cost-effectiveness of doctor versus nurse-based delivery of antiretroviral treatment to HIV-infected adults in South Africa</strong></td>
<td>This work is still ongoing but will be important for reducing the cost of delivery of anti-retroviral treatment.</td>
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<tr>
<td><strong>Cost-effectiveness of the introduction of ARVs at higher CD4 counts</strong></td>
<td>This will also have direct input into policy.</td>
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<td><strong>Malaria</strong></td>
<td>Most of this work served more as a vindication of existing South African policy (with respect to the re-introduction of indoor residual spraying and the introduction of combination therapy); this then had a profound impact on malaria prevention and treatment programmes in the region.</td>
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<td><strong>Tuberculosis</strong></td>
<td>Led directly to a national policy to pay community-based workers for DOTS</td>
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<td><strong>Women’s health</strong></td>
<td>This work is still ongoing but is likely to have a clear impact as South Africa is considering introducing the vaccine. The work shows that there is a threshold price below which it is cost-effective to introduce the vaccine which strengthens the government’s arm in negotiating with pharmaceutical companies.</td>
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This table only details the main areas of research and does not deal with all projects.

Sources: interviews, Health Economics Unit (2007)
5.3.6 Limitations of policy impact

Table 7 identifies some instances when HEU’s research has failed to have a policy impact. The reasons for this failure are being unable to follow up research with appropriate dissemination (especially workshops) due to time pressures, generating controversial findings to which government is ideologically opposed, producing research that is not aligned to government’s priorities and generating results too late to inform government policy (A). As researchers become more experienced, and they build up trust with government counterparts, they find mechanisms to improve the impact of research although the need to move on to the next research project always constrains opportunities for dissemination.

5.3.7 Dissemination of products

HEU disseminates its products mainly through e-mailing reports and posting reports onto its website (A, A). HEU members regularly attend international conference to reach an international audience. The CREHS consortium to which HEU belongs is also engaged in disseminating work generated by its members, including through a website and through the distribution of CDs and newsletters (A). A university member felt that HEU could, like most research groups, do more dissemination but that there are many demands on the Unit: given their circumstances, they are getting the balance between different activities more or less right (A).

5.3.8 Outreach and communication

To date, individual researchers have been responsible for undertaking research and policy outreach. Within the last two months, however, a Communications Officer with a Master’s has been appointed for the first time. The role of this new staff member will be to market HEU, advertise its courses and promote the materials produced by HEU. This will be done in harmony with CREHS which already has its own communications officer who produces materials in various forms.

One of the main functions of the new communications officer will to redesign research reports so that HEU can get user-friendly information more quickly onto its website. As one staff member said, ‘in my view, if you don’t have someone in that role[of communications officer] it becomes neglected and researchers do not have the time or capacity to sit looking at a website or, you know, thinking about designing a page or a poster. They just don’t have the time, so it doesn’t get done and a lot of the information is never seen by anybody else and people don’t know what you’re doing’ (A).

5.3.9 Relationship with the media

Table 8 lists the number of newspaper and on-line articles HEU produced between January 2004 and June 2009. It shows that HEU used the media to some, but not an extensive, extent. There was a sharp increase in media articles in 2009, partly because of the leaking of a confidential report by the ANC’s Task Team on NHI. This sparked an intense media debate which was ‘chaotic and disorganised’ (A): HEU tried to clarify issues by contributing newspaper articles.

One senior researcher commented that, ‘I think that we’ve been quite bad about engaging with the media ... We haven’t been very proactive in a lot of our stuff except, you know, on certain occasions. But now we have been very, very active. So it’s been very reactive, you know, when the media contact us’ (A). An organisation devoted to health reporting, Health-e, is instrumental in HEU’s attempts to
structure engagement with the media more proactively. *Health-e* provides on-line news but also places pieces in the press, radio and TV. As health reporters they tend to have more in-depth knowledge of health system issues. A recent intervention that has proved useful is for HEU staff to sit with a range of journalists from different organisations and provide detailed background on key debates so that journalists develop a greater understanding of these complex issues: ‘So not to kind of push a particular line but to try to help people understand how health services are financed, what some of the problems are ... how it could change, you know, and those sorts of things, and to look at all the options and to try to get them to understand some of the concepts so that they can be more informed’ (A).

**Table 8:** Engaging with the media

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<tr>
<th>YEAR</th>
<th>NEWSPAPER AND ON-LINE NEWS ARTICLES</th>
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<td>2004</td>
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<td>2005</td>
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<td>2007</td>
<td>3</td>
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<tr>
<td>2008</td>
<td>8</td>
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<tr>
<td>2009 (to end June)</td>
<td>15 (to end June)</td>
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</table>

Source: Appendix D

Now that a communications officer has been appointed, the intention is to plan media briefings when the results of important projects need to be communicated widely (A). One informant noted that the level of engagement with the media has already climbed steeply: this is because the new communications officer is networked with the university’s media department (A).

**6 CAPACITY DEVELOPMENT AND EXTERNAL SUPPORT**

HEU is strongly committed to developing the capacity of its staff and has ‘invested enormously’ in this activity (A). Several staff commented on this characteristic of the Unit (see, for example, Box 8).

**Box 8:** Dimensions of capacity-building of staff members at HEU

‘HEU has been a very good place for capacity-development ... Health economics is not offered at the undergrad level, it’s at a post-grad level ... You spend about a year or two being introduced to health economics. It’s quite interesting and if you were to continue working within the area, the Health Economics Unit is one of the best places in Africa to start your career in. It builds you and exposes you to different issues ... It develops your capacity in research and writing articles, and it gives you opportunities to engage with other health economists in Africa and other parts of the world. It gives you lots of opportunities for exposure.’ (A)

Capacity-building occurs partly ‘on-the-job’ as inexperienced staff (i.e. recent graduates) are employed as junior researchers and learn under the guidance of senior staff whilst working on projects. New staff also benefit from occasional seminars and are strongly encouraged to enrol in a Master’s programme part-time. The Unit pays their fees if they are enrolled at the University of Cape Town and allows them
to spend half their time on meeting course requirements (i.e. attending seminars, writing assignments and completing a dissertation). These opportunities were extended to the approximately five research interns that have been funded over time by the National Department of Health (A); funding for this initiative is no longer forthcoming from the Department because of funding shortages.

Staff who already have a Master’s are encouraged to enrol for a PhD. They are given assistance in writing their thesis proposal and have their course fees paid if they are registered at the University of Cape Town. As such staff often use their regular research project towards their degree, in effect HEU allows staff to achieve a PhD whilst being paid a full salary.

Furthermore, all research staff are entitled to a sabbatical amounting to one month per year of employment. A new arrangement is that, in addition, all research staff are encouraged to spend one day a week on writing, either for their thesis or in order to generate articles.

All in all, then, the level of investment in internal capacity-building is exceptionally high at HEU, a situation that is not common in many institutions, especially in soft-funded units.

A lot of senior expertise for capacity-building exists within the Unit itself. The Unit has also sought support from international experts:

- As described earlier, Lucy Gilson is part of a capacity-building initiative of the Health Financing and Economics Programme of the London School of Hygiene and Tropical Medicine. Both Lucy herself, and the partnership as a whole, were described by an evaluation of the partnership as highly effective: it is ‘a star partnership ... it’s a symbiotic relationship’ (Doherty 2005: p54; see also Mayhew, Doherty and Pitayarangsarit 2008). The original partnership with the London School has now evolved into the much bigger consortium CREHS which, amongst other things, includes capacity-building of HEU (but also contributions by HEU to the capacity-building of other partners).
- HEU has also had long-term, close ties with the Karolinska Institute in Sweden: for a while, one of the Institute’s staff members was seconded to work at HEU and helped in the development of the Master’s in Health Economics.
- The advent of Gavin Mooney, who’s specific remit is to support staff in getting journal articles ready for submission, has meant that staff are assisted in identifying parts of their work that are worthy of publication, identifying suitable journals, thinking through the ‘angle’ the article could take and editing the text, including in response to reviewers’ comments. This is intended to redress a persistent problem in finding time to publish, given researchers’ heavy project load (see later). Gavin also involves staff in reviewing articles that he is requested to review: in this way they are able to pick up additional skills and get a sense of the international context (A). He also identifies possibilities for collaboration on articles between himself and HEU staff. This strategy seems to be fairly successful and productive (B) and ‘so I think we’ve branched out in terms of our capacity development and I think that’s been really positive,’ said one staff member (A). Gavin has ‘got to know the staff well ... their strengths and ... some of the points where there’s need for development. So ... the continuing involvement ... is ... not only productive but
also rather pleasant’ allowing Gavin to ‘know the people as people and not just as health economists’ (B).

- There is fairly extensive engagement with a range of other international academics, mostly through joint projects, including ones where the principal investigator is foreign, but also through some specific training initiatives. These relationships have a strong capacity-building component but also provide collegial learning that benefits foreign partners, too; ‘so there’s a number of international people that the Unit is able to call on’ and HEU uses them very well (B).
- As mentioned previously, HEU is also involved in a number of international networks (most notably HEPNet and EQUINet) from which it learns but to which it also contributes integrally in terms of building institutional capacity (B).

All in all, capacity-building within HEU has been very successful and has benefited individual staff enormously. Although many of these staff have been lost to other sectors, HEU remains with a core staff made up of highly trained individuals who in turn are able to provide support to other people within the Unit and in the region. There are not quite sufficient senior staff, however, which is the Unit’s core problem, not only in respect of capacity-building but also in terms of leadership for projects and training.

Another – and linked problem – is that staff do not have sufficient time for publishing their work as a result of the way the Unit is funded: ‘It’s so obvious if one is here for more than five minutes that there is an issue is here’ (B). All work has to be performed at the project level (rather than through a core budget) which limits activities outside of the narrow requirements of the project itself. Being able to publish is critical for the Unit in order to raise its profile nationally and internationally: one commentator noted that the Unit’s profile is not as high as justified by its level of expertise and output (B). Furthermore, publishing allows people to develop an academic career: ‘If they don’t get the opportunity to publish, they’ll go elsewhere. It’s a very real problem. Trying to retain staff here is very difficult, people are under quite a lot of pressure because of the sheer volume of work that there is here, the volume of teaching and so on, which gets back to the financing issue again. It is difficult to hold onto staff’ (B).

7 RELEVANT FEATURES OF THE SOUTH AFRICAN CONTEXT

7.1 The openness of the political system within which the Unit functions

The Unit was established four years before South Africa’s first democratic elections in 1994. During these early years, there was widespread violence in the country and ongoing intimidation of individuals and institutions aligned with the progressive health movement, of which the Unit was part. However, there was an emerging climate of openness and the Unit was able to present its critiques of the apartheid health system. The 1994 and subsequent national elections were declared free and fair and the Unit has been able to conduct research and publish findings without political constraints.

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8 A key informant identified approximately nine such people who have been involved in HEU activities in recent months (A). This number excludes partners in the CRESH and SHIELD collaborative projects.
However, there has not always been a trusting relationship between the Minister of Health and senior bureaucrats in the National Department of Health and one key informant noted ‘a very big disjuncture between the Ministry and the department’ at the present time (A). This has contributed to what seems to be an attitude amongst some government bureaucrats of “We don’t trust the outsiders, we’ve got to have absolute control over the process” (A): now, as in the past, this sometimes makes it difficult for researchers to inject evidence into policy processes, although some officials, especially those with an academic background, remain receptive (A, A,) (Doherty et al. 2000).

In addition, one key informant said that, ‘one of the things that is not unimportant, particularly in relation to work on the private sector and PPI and all that sort of thing is the fact that how many very high profile ANC dudes have their fingers very heavily in the private sector health care pot, I mean they have investments’ (A). This has created resistance to efforts to regulate the private sector and make it more accountable.

7.2 Pressures on the government to use evidence in policy

The formation of the ANC’s Health Plan in 1993 was founded, amongst other things, on the work of progressive academics. This was particularly true of health financing policy. There has thus been a culture within government from the start of making use of evidence to inform policy. Since 1994, HEU has been commissioned periodically to do work for government and has been able to present research findings regularly to senior managers and policy-makers. Senior managers have attended courses over the years which have been informed by the research of HEU. Furthermore, HEU continues to train health economists funded through money allocated by government.

Government key informants noted that there is increasing pressure to make use of evidence in policy and planning (C,C). The pressures that contribute to government’s interest in evidence include:

- a tradition of using evidence to inform reforms as a strategy to counteract ideologically-driven policies during the apartheid era;
- a concern to achieve the main policy goal of equity, which requires measurement of equity in financing and access (C);
- increasing economic pressures that require improvements in efficiency (C); and
- using evidence as a mechanism to convince stakeholders – such as tertiary hospitals and the private sector - to support policy change (C, Doherty et al. 2000).

Acknowledgement of the importance of evidence, and the use of evidence to inform policy, was dealt a blow during the late 1990s by the reluctance of President Mbeki and his Health Minister Mantu Tshabalala-Msimang to acknowledge the link between HIV and AIDS and adopt antiretroviral therapy. Thus, with respect to the topic of HIV/AIDS, it was extremely difficult during these years to influence change on the basis of evidence. This did not stop HEU working in this area but meant that, until very recently, much of the work had to be used for advocacy rather than direct policy influence. With upheavals in government during late 2008 and early 2009, which displaced the aforementioned individuals, the climate for HIV/AIDS research and policy formulation improved.
7.3 The state of development of civil society
Civil society flourished during the late 1980s and early 1990s in opposition to apartheid. Many of the leading members of these organizations were absorbed into the new government during 1994, however, which saw a decline in civil society activity. Today, many NGOs are concerned with service delivery (such as home-based care) rather than with influencing high-level policy (C). An exception is the Treatment and Action Campaign which campaigns vigorously for rights and care around HIV/AIDS and has been influential in withstanding the HIV/AIDS position of government and the former President since the late 1990s (C).

7.4 The influence of donors
South Africa is not a large aid recipient: the country funds the vast majority of its activities from internal sources. Donors have provided some technical advice to government (in the form of foreign advisers seconded to work in government) and are important sources of funding for large research projects. There is not a big market for technical services directly to donors in the country, although there are some consultancy groups performing this sort of service. Aid agencies typically get their advice from people working within government and some consultation with academics and NGOs.

7.5 The external environment
South Africa’s economy has performed well since 1994 and is fairly mature. Government budgets are generally stable and predictable while the country is physically secure. The external government since 1994 has been fairly predictable and friendly to South Africa, partly because of global economic growth and goodwill expressed towards South Africa since the ending of apartheid. Political directions have been quite clear due to the clear mandate given to the ANC in 1994. Over the past year, however, the country has been affected by the global economic crisis, although not as severely as many other countries due to strict financial regulations and a conservative banking sector, amongst other things. In addition, infighting within the ANC due to the succession struggle following the withdrawal of President Mbeki from office by the ANC in late 2008, has led to a period of increased political uncertainty. This has abated somewhat with recent elections in April 2009 although there is still considerable uncertainty around possible changes in the senior management of the National Department of Health as well as in national policy.

7.6 Vulnerability of the Unit to changes in the external environment and the departure of aid agencies
The financial situation of the Unit does not seem to be more precarious than during other periods in its past which it survived (for example, immediately after the first democratic elections many donors re-channeled funds through government which had previously been provided to anti-apartheid NGOs). It is well networked and is part of several large donor-funded projects. If anything, recent political changes and uncertainty seem to have provided renewed opportunities for influencing national policy debates (especially around HIV/AIDS care and NHI).
8 CONCLUSIONS

The Health Economics Unit has continued to provide high quality research, policy advice and training over 20 years. It is well respected and enjoys a high profile. This has been achieved within a context of funding constraints and varying receptiveness to advice on the part of government. That HEU is currently in a strong position is testimony to the hard work and commitment of its staff, as well as innovative responses to the changing political and funding environment. Although it does not have long-term financial security, HEU has become ‘part of the furniture’ at the University of Cape Town and has therefore achieved a form of permanence (B).

HEU remains relatively small in size, however, and has been unable to increase its complement of senior staff: this is its major vulnerability and a source of frustration for government which would like to be able to draw on the Unit more (C, C). As one research collaborator put it, ‘So how would you have more impact? By having more of you and by being around longer and there being a sort of career profile for you that isn’t only about moving into government, because that’s not the answer to having analytical work that supports government’ (B).

In planning for the next few years, it seems that priorities for improving the sustainability of HEU are to:

1. **Pursue mechanisms to attract senior staff.** This is the most critical challenge facing HEU and includes offering higher salaries and longer contracts and, where a candidate does not have a PhD, valuing a good track record in social responsiveness and publication of journal articles. Raising the profile of up-and-coming staff (by finding opportunities for them to engage more closely with government, especially at the national level) would ensure that HEU is not identified solely with Di, Sue and Lucy.

2. **Seek opportunities for core funding.** This is in order to provide security to senior staff and relieve their workload. Motivating for another core post from the university is one option. Another is, in project grant proposals, to include amounts that are intended to promote the sustainability of the Unit (for example, by including personnel costs relating to senior oversight and management of the unit as well as the provision of benefits such as sabbatical, or by including the costs of extensive dissemination activities). This can be difficult, given that donors often do not offer sufficient funding for this or are not amenable to including certain types of cost. Leveraging different sources of funding is one strategy to get around this problem, as is finding ways to present costs in ways that are acceptable to donors (B).

3. **Build on recent internal capacity-building initiatives** (such as the appointment of Gavin Mooney). This is to ensure that capacity-building continues into the future, especially if problems with recruiting senior staff persist.

4. **Seek to fund formal teaching activities fully.** It is not normal practise for a teaching institution to subsidise the costs of courses out of other funds. Options for rectifying this problem include motivating that the university pass course fees on to the Unit, finding additional sources of bursaries for students (for both the Master’s and the diploma) and raising supplementary funds for course development e.g. development of materials and training-of-trainers.
It would make strategic sense for both the University of Cape Town and the National Department of Health to assist HEU in these efforts, given the enormous benefit they derive from the Unit’s activities. In the short term, the university should reimburse the Unit fully for teaching costs and allow the Unit to pay ‘above-rate-for-job’ for senior staff while, in the longer term, it should consider the allocation of another post to the Unit. This seems reasonable given that HEU estimates that the current net gain to the university of HEU’s activities is close to R2 million rand per year (Health Economics Unit 2007).

The National Department of Health should consider profiling health economics as an area for skills development in the department and support bursaries for South Africans to attend the Master’s in Health Economics (this could apply to several sections of the Department, not just the Health Planning and Health Economics Cluster). Allocating funds to support policy advice or research internship training provided by the Unit would be another avenue for strengthening the Unit as a national resource (C). This is important given that health economics is such a rare skill in South Africa.

Because HEU is experiencing a period of stability and has been joined recently by a Communications Officer and two fairly senior people working at the researcher level, it is well-positioned to re-evaluate current strategies for disseminating research findings in order to heighten its impact on policy (as one person put it, making 'more use of the work that is actually done, that makes it more available and more engaging' (B)). While HEU has had considerable success in this area thus far, a number of additional strategies emerged from the interviews with key informants (many of these strategies would have a dual impact on policy transfer and capacity-building):

1. **Disseminate more user-friendly written or web-based publications.** This could include policy briefs and stand-alone executive summaries that have a content and format that distinguishes between the needs of politicians and senior bureaucrats. Part of this is having easily downloadable versions on a website that advertises recent research more clearly. This is already under way with the appointment of a Communications Officer and the re-designing of the website.

2. **Increase engagement with the media.** This could be through newspaper articles, interviews, media briefings and seminars to discuss key policy issues. One government key informant saw engaging with the media as an indicator of policy relevance and a willingness to engage in, and inform, policy debates (C). Developing a strategy for dealing with the media is already under way.

3. **Convene national seminars.** There do not seem to be many opportunities for researchers from different institutions, government, NGOs and the media to get together to debate current issues and themes. A national seminar could create such a forum, help disseminate HEU’s work and raise HEU’s profile.

4. **Find more opportunities to engage with the Health Planning and Health Economics Cluster of the National Department of Health.** This could go beyond involvement in specific projects and committees to include regular meetings (say, three times a year). As the geographic separation between the Unit (which is in Cape Town) and the Cluster (which is in Pretoria, some 1600km distant) was identified by key informants as an obstacle to more frequent face-to-face contact.
(A, C), teleconferencing might be a more viable alternative. Suggestions for items for discussion are (C):

- the work the Unit is engaged in (so the Cluster could benefit from more than just the work it commissions itself);
- upcoming research needs of the Cluster and possibilities for structuring research around these issues; and
- current debates in the literature in to order to help the Cluster keep up-to-date with international developments (possibly supported by brief summaries of key literature).

5. **Provide training to Cluster employees.** A series of short courses was identified by a government respondent as the main need so that Cluster staff are not removed from their workplace for long periods (sending newly recruited staff on the residential Master’s programme was seen more as a long-term option) (C). Providing supervision and mentorship to Cluster staff working on small research projects is another priority so that the Cluster’s in-house research capacity can be improved (C). The possibility of bringing HEU staff up to Pretoria for training was also suggested, given the cost and logistics of sending several students down to Cape Town.

While there are several parts of government that can benefit from closer engagement with HEU (for example, those working on the District Health System and HIV/AIDS), the Health Planning and Health Economics Cluster is a natural choice for the development of a ‘special relationship.’ As described earlier, such a relationship did pertain in the past but, for a number of reasons, shifted and weakened over time. There appears to be a renewed interest on the part of the Cluster in revitalising this relationship, an opening that it might be useful for HEU to take up (see **Box 9**).

**Box 9: Finding a mode of engagement with government**

“We in South Africa haven’t got a very good way of doing that [i.e. setting a research agenda] in a mutual way ... The two communities [researchers and government] don’t get together to engage with each other at all ever, so a practical mechanism is to start talking. I think it’s tricky if government starts saying, “We’ll set the agenda!” ... because some of the broader, blue-sky sort of thinking ... for health systems and policy work isn’t allowed, but yet that is what can help you see your reality differently. So I think there’s a need for a forum which perhaps isn’t a priority-setting forum but where ideas can bubble up. And there’s a need for government to say “These are the things we need done” and there’s a need for researchers to say, “These are some of the things that we need to get done” and for there to be funding for both to get done - and not just funding, bodies, too.’ (B)
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Cleary S, McIntyre D. 2009. *Motivation for paying above Rate for Job for reasons of scarcity*. A proposal by HEU to the senior management of the University of Cape Town.


Health Economics Unit. 2007. *Application by the Health Economics Unit for URC accreditation as a UCT research unit*. Cape Town: Health Economics Unit, University of Cape Town.


University of Cape Town. 2009. *Guidelines for Promotion in the Faculty of Health Sciences*. Cape Town: University of Cape Town.
APPENDIX A:  LIST OF INTERVIEWEES IN ALPHABETICAL ORDER

Judy Boyes  Financial Officer: HEU
James Claasen  Sub-District Manager, provincial Department of Health (Western Cape)
Susan Cleary  Director: HEU
Lucy Gilson  Professor of Health Policy and Systems, University of Cape Town and at Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine)
Ria Grant  Director: TB Care Association
Rene Loewenson  Director: EQUINET (Regional Network for Equity in Health in Eastern and Southern Africa)
Leslie London  Head: School of Public Health and Family Medicine, University of Cape Town
Sharmila Mhatre  Senior Programme Specialist: Governance, Equity and Health, Programme and Partnership Branch, International Development Research Centre, Canada
Di McIntyre  Founder and former director of HEU and currently Chair of Health and Wealth
Gavin Mooney  Retired Professor from Curtin University in Australia (and currently Honorary Professor at Sydney University and the University of Cape Town)
Okore Okorafor  Researcher and Human Resources Manager: HEU
Anban Pillay  Chief Director, Health Planning and Health Economics: National Department of Health
Yogan Pillay  Deputy Director General of Strategic Health Programmes: National Department of Health
Edina Sinanovic  Senior Researcher: HEU
Allison Stevens  Communications Officer: HEU
APPENDIX B: SOUTH AFRICAN RESEARCH CHAIRS INITIATIVE

The South African Research Chairs Initiative is a strategically focused knowledge and human resource intervention that has five interrelated objectives:

1. To increase the number of world class researchers in South Africa

2. To retain and/or attract back qualified research scientists to the Higher Education sector and thereby:
   a. help reverse the systemic decline in research outputs, focus and capacity at publicly funded higher education institutions (HEIs), Science Councils and other research institutions; and
   b. strengthen and improve the capacity of HEIs, Science Councils, Musea and other research institutions (e.g. University linked Teaching Hospitals) to generate and apply new knowledge.

3. To stimulate strategic research across the knowledge spectrum and thereby increase the level of excellence in research areas of national and international importance

4. To create research career pathways for highly skilled, high quality young and mid-career researchers that effectively addresses historical racial, gender and age imbalances

5. To improve and accelerate the training of highly qualified personnel through research.

The aim of the Initiative is to make South Africa competitive in the international knowledge economy based on its existing and potential strengths.

Source: www.nrf.ac.za/sarchi/index.stm (accessed 7 July 2009)
APPENDIX C: FORMAL RESEARCH OUTPUTS OF HEU (2004-June2009)
Journal articles, book chapters, books, research reports, conference presentations

JOURNAL ARTICLES

2009, and forthcoming

2008


2007


2006


**2005**


**2004**


**BOOKS AND CHAPTERS IN BOOKS**

2009, and in press


2008


2007


2006

(none)

2005


2004


REPORTS AND WORKING PAPERS

2009

2008


McIntyre, D., O. Okorafor, et al. (2008). Health care access and utilisation, the burden of out-of-pocket payments and perceptions of the health system: Findings of a national household survey, A collaborative project between: Health Economics Unit, University of Cape Town; Centre for Health Policy, University of the Witwatersrand; Department of Health, South Africa; London School of Hygiene and Tropical Medicine.


2007


McIntyre, D., M. Thiede, et al. (2007). A critical analysis of the current South African health system, Health Economics Unit, University of Cape Town and Centre for Health Policy, University of the Witwatersrand.


2006

54

2005

2004


**CONFERENCES PRESENTATIONS**

**International**


*Presented at the 15th International AIDS Conference.* Bangkok.


McIntyre, D. (2005). Member of the International Scientific Committee (reviewing submitted abstracts) and chairing organized sessions. *International Health Economics Association 5th World Congress.* Barcelona.


Local


APPENDIX D: NEWSPAPER AND ONLINE NEWS ARTICLES

2009

OTF graduation dinner, 6 July 2009
A number of activities organised by the university’s Oliver Tambo Fellowship Programme (OTFP) included a graduation dinner attended by Dali Tambo. A seminar on national health insurance was held on 10 June for 26 senior public health managers...... UCT DAILY NEWS

Health system must first regain our trust, 22 June 2009
There is a crisis of trust in our health care system. Every day yet another group laments their lack of trust in “the system”, be they patients, doctors, nurses, wage negotiators or commentators. ......CAPE TIMES

A chance to provide proper health care for all, 18 June 2009
The South African health system is in deep crisis. We need a major transformation of our health system and we need it now. ......CAPE TIMES

Honorary doctorates for two, 15 June 2009
UCT conferred two honorary doctorates at its mid-year graduation ceremonies. .....UCT MONDAY PAPER

Equal access to ALL hospitals, 14 June 2009
South Africa’s private hospitals are to be thrown open to the poor — and the country’s wealthier people will have to pay more for a service that will include state hospitals......SUNDAY TIMES

NHI will be good for the poor, 13 June 2009
Professor Di McIntyre, said: “The poorest are sitting with the major burden of ill health — many don’t even go for treatment because of the cost of transport or the risk of losing income — and yet they get the least care..... THE TIMES

Too soon to panic over demise of your medical scheme cover, 13 June 2009
Proposals for a fairly radical overhaul of the country’s healthcare system - including the seemingly inevitable demise of medical schemes - are likely to make all private healthcare users fearful about the future of their cover............PERSONAL FINANCE

Contrasts in health care are stark and evil, 8 June 2009
I am a health economist visiting South Africa from Australia. With respect to South African society, as a foreigner the thing that strikes me more than anything is the continuing poverty amidst such incredible affluence....... CAPE TIMES

'Rich-country' solutions, 2 June 2009
An ANC task team headed by former director general of health Olive Shisana is trying to convince the ANC and government to implement a national health insurance (NHI) swiftly, but many believe this could be the kiss of death for an already buckling public health system. ....... MAIL & GUARDIAN

The health system of powerlessness, 2 June 2009
There is often a "vicious cycle" of power and distrust between patients and health care providers in Africa, often fed by another problematic cycle between employers and providers. ....... UCT DAILY NEWS

Flood or trickle? 21 May 2009
Archbishop Njongonkulu Ndungane in my view is rightly critical of Dr Dambisa Moyo’s book, Dead Aid (May 19). The book has unfortunately won much publicity and praise in the west where so many look for reasons to cut off aid to Africa – and lo! – a black African woman is providing “evidence” to support such a move. .... CAPE TIMES

**South Africa faces treatment funding shortfall, 23 April 2009**

South Africa will face tough choices in the years ahead as its government strives to extend treatment to all who need it through the public health system, a leading health economist told the Fourth South African AIDS Conference earlier this month. .... AIDSMAP.COM

**An outsider feels obliged to ask, why are South Africans taking this lying down?, 9 April 2009**

Robert Burns, the Scottish bard, wrote of the need to ‘see ourselves as others see us’. As a visiting Australian academic to UCT, I thought that for South Africans to see themselves as this ‘other’ sees you might be useful at this sad time in your country’s history. .... CAPE TIMES

**A more unified South African AIDS conference, 8 April 2009**

For the most part, there seemed to be a rather harmonious tone set last week between the South African Government, civil society, scientists and health professionals at the Fourth South African AIDS Conference held in Durban. This in itself is remarkable. A barometer for whatever is going on in the fight against HIV in the country, the conference has always been marked by controversy. .... AIDSMap

**National health unsureness, 7 April 2009**

To many, it’s the only answer to the enormous inequalities in South Africa’s healthcare system. Others fear it may limit the variety of health services available in the country. And some warn that it will mean the end of private practice and medical aid schemes. .... HEALTH24

**2008**

**Towards affordable healthcare in Ghana, SA and Tanzania, 3 November 2008**

In the latest edition of the *World Health Organisation Bulletin* health economists explore the extent of fragmentation within the health systems of three African countries. .... HEALTH-E

**Welcome to tobacco country, 15 August 2008**

We might think we’re big in mining, synthetic fuels, cellphones or banking, but our biggest listed company on the JSE soon will be in tobacco. British American Tobacco (BAT) will dwarf all other South African behemoths by market capitalisation when it sets up a secondary listing on the JSE later in the year....MAIL & GUARDIAN

**Professor Di McIntyre: inaugural lecture, 4 August 2008**

In her inaugural lecture on 30 July Professor Di McIntyre took a critical look at the current health system and the challenges facing it. .... UCT MONDAY PAPER

**Private healthcare sector’s big three give upward kick to prices, says economist, 28 July, 2008**

Too much power concentrated within the country's three largest hospital groups was pushing up prices in the private healthcare sector, Di McIntyre, a health economist from the University of Cape Town, said yesterday. .... BUSINESS REPORT

**Africa: Meeting The Abuja Promise Goes Beyond The 15 Percent Target, 11 July 2008**

When the African Union (AU) Heads of State committed to allocating at least 15% of annual government budgets to their health sectors In Abuja, Nigeria in 2001, they also called on high income countries to fulfil their own commitment to devote at least 0.7% of their GNP as ODA to developing countries and to cancel Africa's external debt in favour of increased investment in the social sector. .... ALLAFRICA.COM

**Health minister to assume more powers if new bills are passed, 17 June 2008**
Two bills recently tabled in Parliament are set to shake up the private hospital industry and centralise decision-making over hospital tariffs as well as the regulation of new medicines and scientific trials within the health minister’s office. .... HEALTH-E

Cabinet to breathe life into health insurance, 15 July 2008
Fourteen years after it was first mooted, the national health insurance scheme appears to be moving towards implementation. Some of the policy documents formulated over the past decade will be tabled before the cabinet tomorrow. .... BUSINESS REPORT

Smoking claims over 40 000 annually, 6 May 2008
More than 42 000 annual deaths in SA are attributed to tobacco use, the Cancer Association of SA (Cansa) said at the Health Portfolio Committee's public hearing in Cape Town on Tuesday......IOL

2007

Medical doctoral candidates honoured, 12 December 2007
The Faculty of Health Sciences honoured their senior doctoral and doctoral graduates at a function at the MAC Club last night, hosted by the deputy dean (postgraduate affairs), Prof Kit Vaughan. .... UCT DAILY NEWS

Up the rungs, 12 Nov 2007
Forty-one academic staff and seven scientific and technical officers received ad hominem promotions. They were congratulated by Vice-Chancellor and Principal Professor Njabulo S Ndebele at a function in the Senate Room last week. .... UCT MONDAY PAPER

Compulsory health insurance 'critical', 9 December 2007
Compulsory health insurance could be an effective way of dealing with problems in the private sector and addressing disparities between public and private health sectors. .... CAPE ARGUS

2006

Determining a viable dispensing fee, 6 December 2006
Professor Di McIntyre, chair of government's Pricing Committee, tasked with determining a viable dispensing fee for pharmacists, spoke exclusively to Health-e. .... HEALTH-E

2005

Medical aid cover to benefit low earners, 8 October, 2005
The National Treasury is proposing to change the way your employer's subsidy to your medical aid is taxed. The proposal would result in more low-income earners joining medical schemes. .... PERSONAL FINANCE

2004

Supreme court of appeal throws out medicine price regulations, 24 December 2004
This week's unanimous decision by a full bench of the supreme court of appeal (SCA) to overturn medicine pricing regulations does not signal the end of the battle between pharmacists and the department of health. .... FINANCIAL MAIL

Department 'has no say' on VAT on medicines, 14 October 2004
Officials in the department of health are optimistic that the money accumulated from VAT on medicines will be poured back into the health sector, it emerged yesterday. .... BUSINESS REPORT

Medical advisers wanted VAT scrapped, 5 October 2004
The statutory body whose proposals form the basis of the disputed medicine pricing regulations also recommended that VAT be scrapped on medicines, it emerged yesterday. .... BUSINESS REPORT
Pharmacists may be breaking the law, 5 October, 2004
Pharmacists charging administration fees, over and above the dispensing fee set down, are
contravening the law. .... CAPE ARGUS

Medicine pricing regulations are unenforceable, New Clicks tells court, 18 June 2004
The government’s new medicine pricing regulations were incoherent and so vague as to be
unenforceable, a full bench of the Cape high court was told yesterday. .... BUSINESS REPORT

How to save money on medicines, April 24 2004
Health Minister Manto Tshabalala-Msimang revealed details on Friday of the government's final
version of new regulations that could eventually slash the cost of pharmaceuticals to consumers
by up to 50 percent. .... PRETORIA NEWS
APPENDIX E: UCT’S CRITERIA FOR VALUING SOCIAL RESPONSIVENESS WHEN CONSIDERING INDIVIDUALS FOR PROMOTION

Social responsiveness

This includes **professional & extension services** such as Clinical Service; Community Outreach; And Policy Input and Health Systems Development

**Note:** This category has opportunities for staff to make contributions in three different but related areas: clinical service; community outreach; and policy input. It is not expected that staff will have made a contribution in more than one area.

**Score**

0  Has no clinical involvement; community outreach, policy input or health systems development.

1/2  **Clinical Service: Trainee.** A clinical trainee performing adequate clinical duties for the level of skill expected the post.

**Community Outreach: Limited Contributions:** Few and/or sporadic contributions to the health sector and other sectors and wider society. These interactions and consultancies make little contribution to scholarship at UCT, attract few students and hardly contribute at all the University’s stature in the community. Makes very little contribution to professional leadership outside the University.

**Policy Input: Limited Contributions:** Occasional involvement in policy related research; little or no evidence of impact.

**Health Systems Development:** sporadic consultations with health service or other public sector managers; occasional technical support for health systems interventions; aware of policy implications for development of health services.

3/4  **Clinical Service: Team Player.** Usually a junior specialist or principal medical officer who provides routine clinical services commensurate with the level of skills demanded of the position.

**Community Outreach:** Limited Contributions to UCT Scholarship Occasional interactions with the health sector and other sectors and wider society. These interactions make limited contributions to scholarship at UCT, have limited health advocacy value, and in a limited way contribute to the stature of the University in the community. Makes limited contribution to professional leadership outside the University.
Policy Input: Team Player. Involved in some policy research as member of a team but not involved in its dissemination and application; little evidence of impact.

Health Systems Development: Contributes to developing preventive, promotive, curative or rehabilitative services within a team, applies public health skills to solving health systems problems; participates as part of a team with local communities to determine needs for the development of health services. Interacts within the local community about clinical service development needs.

Clinical Service: Leader. Holds a leadership position in a clinical facility at primary, secondary or tertiary level. Has recognised clinical expertise and is consulted locally. May make an important contribution to a clinical unit in a facility that is nationally recognised as a centre of excellence. May have planned, developed or implemented new clinical programmes significantly benefiting the community all the clinical service at primary, secondary or tertiary level. May provide clinical leadership at a provincial, but not national level.

Community Outreach: Advocacy/interaction: Has developed some worthwhile interactions with the health sector, other sectors, and wider community (NGOs, civil society, etc.) that have also contributed to scholarship at the University. Has played some advocacy role in promoting the health of the public and marginal groups. Has contributed to partnerships between UCT and communities. Makes some contribution to leadership and administration in his/her discipline outside the University.

Policy Input: Advocacy/policy contribution: Participates in policy making or conducts relevant policy research on health system issues and communicates results and contributes expertise to relevant policy makers in different spheres of government; some evidence of impact.

Health Systems Development: Regularly asked for technical support by health service or other public sector managers and planners; provides consultant expertise not available within the health system to expedite public health functions; responsible for support to key health systems, improving their effectiveness; advocates for and actively participates in health service planning and development; actively engages with new structures and opportunities for clinical service development in professional area.

Clinical Service: National and International Recognition. Has nationally recognised clinical expertise. Is consulted nationally and may have patients referred for consultation and treatment from other provinces. May be the head of a clinical unit in a facility that is nationally recognised as a unique resource leading to international recognition with invitations to address international clinical meetings within the discipline. Referees reports support clinical ability well above the norm. Contributes to the development of the clinical discipline with innovative projects and may contribute to the development of new services. May act as a coordinating clinician. Is extensively involved in hospital administration and sits on hospital management committees. Contributes substantially to professional development outside UCT.
Community Outreach: Broad Recognition & Prominent Advocacy  Strong interactions with the wider community, the health sector and other sectors and is regularly consulted by civil society, private or governmental organisations. Regularly plays an advocacy role in promoting the health of the public and marginal groups. Has taken a lead in promoting partnerships between UCT and communities or in implementing research findings with local benefit. Actively promotes the cause of health equity in scholarship, drawing degree students, and conducting research.

Policy Input: Expert. Is involved in national level policy processes and committees to develop and evaluate policy. Is consulted regularly by national policy makers and invited to provide inputs and presentations. Inputs play major role in influencing policy developments such as related to professional service delivery and health system interventions.

Health Systems Development: Depended upon for ongoing technical support by health service or other public sector managers and planners, both local and national; provides unique consultant expertise for public health functions; participation in provincial and national processes results in changes to service delivery and health programmes; responsible at a high level for the development, monitoring and oversight of key health systems functions, improving their effectiveness; or for independently initiating and participating in new initiatives to develop services within and across professional disciplines; disseminates knowledge and experience locally and nationally on the development of health services and/or health systems programmes.

9/10  Clinical Service: International Stature. Usually the head of a clinical unit in a facility that is internationally recognised for clinical excellence. Is regarded by peers as an exceptional clinician and enjoys an international reputation as a leading authority within the discipline. May be invited to contribute editorial opinions in reputable channels on the basis of well-recognised clinical expertise. Has provided leadership in the development of clinically important new or innovative services that have been recognised internationally. Referees reports attest to clinical excellence. Provides senior leadership to the hospital and is a member of high-level hospital and/or provincial administrative structures.

Community Outreach: International Stature Very strong interactions with wider society, the health sector and other sectors in promoting health equity and making an impact on the health of needy populations. Has made a substantial, internationally recognised, contribution to promoting health across all sectors. Is a leader in promoting the health of the public and marginal groups at national and international level through scholarship, educating graduate students, and in conducting research addressing common health issues. Contributes to professional societies at a national level in executive and administrative roles. Serves on national committees and councils and contributes to local and national government policy development. Very likely has an international involvement in professional and scientific societies.
Policy Input: International Expert Chairs or coordinates national level policy processes on behalf of government. Is invited to participate in policy development and implementation of international bodies. Prominent member of committee of international funder or technical assistance body. Inputs have demonstrable impact on policy development such as related to professional service delivery and health system interventions.

Health Systems Development: Regularly sought for technical expertise by national and international health service or other public sector managers and planners; innovator of major public health intervention/s or interdisciplinary services recognized nationally and internationally, brings unique consultant expertise to the health system and actively builds sustainable capacity in this area amongst a dedicated team; regarded as a prominent and respected leader in professional community nationally and internationally for participating in development of professional service delivery in the interests of health equity; disseminates knowledge and experience locally, nationally and internationally of best practice in the development of health services and/or health systems programmes.

Source: University of Cape Town (2008: p7-9)