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SOME REFLECTIONS ON THE CHANGING ROLE OF PROGRESSIVE POLICY GROUPS IN SOUTH AFRICA: EXPERIENCES FROM THE CENTRE FOR HEALTH POLICY¹

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Introduction

This paper documents some personal observations of the changing role and relations of a policy research unit from the late-1980s to mid-1995. From personal knowledge of other broadly anti-apartheid policy units, I believe that our experience is not unique, though of course, I do not claim it is representative.

It has been enormously rewarding, professionally, to be working for the first time with a government that shares our understanding of the health problems of the country, and has a similar view of the solutions. Yet paradoxically, in our new post-apartheid roles and relations, progressive policy groups may be more constrained than we were in the apartheid period. For the changed environment has altered not only the relationship with policy makers from antagonists to allies, but perhaps more importantly has changed the types of knowledge we need to generate, the use of that knowledge, the audiences we address, the time constraints within which we conduct research, the sources of funding, and closely linked to funding, the power relationships between policy makers and researchers.

At a more general level, this is a case study illustrating how the relationship with 'policy makers' affects the behaviour of academics whose work relates to public policy. The paper suggests ways in which policy-oriented intellectuals and institutions will need to adapt to the new context of legitimate government, but will also need to challenge the state's inclination to monopolise the policy studies arena.

Role and Relations with Government before 1990

The Centre for Health Policy (CHP) at the University of the Witwatersrand was established in 1987 by a group of health activists with professional interests in the political economy of health. Explicit amongst its objectives was that of quantifying and publicising the impact of apartheid policy on the health of the population, and of mobilising health workers and communities against apartheid,

using health issues as a focus. The funding was entirely from overseas donors, usually European anti-apartheid organisations. During the apartheid era our role was clearly defined. Our relationship with government officials was similarly well-defined and simple. We were almost universally critical of government policy. And where we found the policies to be reasonable, their motivation was challenged as part of a 'winning hearts and minds' strategy to hold onto power. Since we were not dependent on government funding, we had complete autonomy over our research agenda and little concern about publicity that would antagonise government officials or politicians. In turn, these officials had no interest in hearing anything we had to say, and we were never consulted on any policy development. The Centre's target audience was usually trade unions, civic organisations, progressive health worker organisations and the public through the mass media.

Our accountability (besides through reports to funders) was through a steering committee selected by ourselves but approved by the University Council and representing half academics and half non-university based health activists. There was also a formal and routine process of consultation with health worker organisations and their policy arms.

It may be worth explaining why, with such an activist agenda, we chose to be an academic unit rather than another sort of NGO. Firstly, the individuals concerned saw themselves as intellectuals who wanted to involve themselves primarily in research activities. The university environment provides a space which legitimates such pursuits and offers some protection from the demands of daily, immediate political activities. Secondly, the university provides a community of peers which facilitates such activity and it provides much of the necessary infrastructure. It also provides opportunities through teaching to disseminate ideas to a wider professional community. And thirdly, in a politically polarised climate where analysis and even statistics were highly ideologised and generally suspect, we believed the academic base increased our public credibility and the way our work would be perceived. This was not simply a facade. Standards were maintained by a commitment to publish in peer-reviewed publications and through a triennial university academic review process.

Transition: 1990-94

Around 1989/90 the dominant style of our work changed from critical to constructive; the focus shifted from analysing past policies to developing concrete proposals for the transition and post-apartheid era. Our target audiences remained largely extra-parliamentary - support for liberation and opposition groups in developing their health policies. For example, members of the Centre worked closely with the ANC on its health plan. However, for the first time

government bureaucrats (local, regional, homeland and national) started consulting us, inviting us to comment on policy drafts, and even commissioning the Centre to undertake policy research and planning. At one level this reflected differing ideological positions within state structures. For example, the Ka-Ngwane homeland already had a pro-ANC, relatively progressive government in the late-1980s and had approached CHP in 1989 to evaluate rural health services and suggest plans for integration with non-homeland areas. At another level, it reflected a real dearth of resources for policy analysis and planning within state structures, particularly as it became clear that something radically different from the old-style planning was required. In some quarters there was a new and profound understanding of the need to plan with a community, not just for them, and establishment planners neither knew how to go about this nor had the credibility to engage with communities. So they turned to groups like CHP to do this on their behalf. Finally it is likely that, especially at senior levels, bureaucrats were seeing the writing on the wall regarding the inevitability of majority rule and the implications for restructuring the civil service. They needed to show a new government that they could change with the times, that they understood the concerns and goals of the democratic movement, and that they identified with them. Collaborating with progressive research units could achieve all these goals.

During this period, funding continued to come from overseas donors committed to supporting the democratic transformation, but in addition project specific funding was available from government 'clients' for the consultancy work they wanted done.

CHP generally responded positively to the government's overtures - our goal was, and is, primarily to promote better health rather than to manipulate party politics - and the more stakeholders that could be persuaded to support our policy proposals the greater the likelihood of their acceptance and implementation. However, recognising that interventions in the competition for the policy high ground would inevitably impact on the broader party political struggle, we engaged government and contributed to its policies only with written agreement to certain conditions. These included the right to publish and publicise our findings and recommendations, and the right to involve any stakeholders we thought appropriate in the policy research process (which, of course, included the liberation movements). A similar approach was adopted with regard to the progressive health organisations. However, we found that while the government was effective in making their policy needs known and in requesting support, progressive organisations including liberation movements were often more passive, and we had to take the initiative in approaching them with suggestions of policy areas requiring development in order that our research resources would

not be skewed towards the government's agenda.

During this period we were committed to a research process which was highly participatory. One reason for this, already mentioned, was to ensure access by non-government and anti-apartheid organisations to the policy work being done at the request of the government. A more profound reason was that in the absence of legitimate government, the terrain of policy development was highly contested. Intellectuals had unusual authority and power in this arena by virtue of their access to and control of information. Yet as a self-selected group acting on behalf of the disenfranchised, they had no mandate to make those political decisions, and the lay public had no institutionalised way of expressing their preferences for one or other policy option. Therefore intellectuals involved in policy research and development had to consult widely to ensure greater accountability of policy to popular sentiment, and to redress some of the imbalance of power between intellectuals and lay community members.

The Era of Democratic Government

In a sense April 1994 was the moment we had worked for all our lives - not only in the obvious sense as political activists, but professionally this was supposed to be the era of our making a difference, of being able to see our policy proposals adopted by government and implemented. But in addition to making a far greater impact through the substance of our work, we also anticipated a form of professional liberation. No longer on the fringe to be ignored or grudgingly acknowledged at the whim of those in power, we would now be driving the policy research process and be involved in policy making at every stage. As an institution we anticipated more secure financial support from the government and an eagerness to strengthen independent policy think tanks which shared the new government's broad values. We took for granted that, in the new democratic environment, the entrenchment of academic freedom would ensure greater freedom to determine our research agenda and to publicise our results than had been the case under the repressive apartheid regime.

Hence the irony of the many constraints, some self-imposed and some externally imposed, which resulted directly from that very transformation in our role and relations with government that we thought would liberate us.

Funding Sources and Control of the Research Agenda

The first notable change is in our funding sources. The anti-apartheid donors are gone, and the foreign government and international development donors that have taken their place generally want to function through the new democratic government. Consequently only projects that have government (in this case Ministry of Health) approval will be funded. To a large extent, this means that

our financial autonomy has suddenly and dramatically decreased, and control over the health policy research agenda has shifted towards a handful of Ministry of Health individuals who determine national policy research priorities and/or coordinate donor funding.

Consultancy versus Research

The fundamental proportions of the social transformation that the government envisages would normally merit extensive analysis, in-depth research and careful deliberation. Yet the political moment demands a far more rapid transformation, which in turn requires hastily developed policy solutions. As a result we are being asked and expected to function as consultants rather than as researchers. This is also a further consequence of the change in control of the purse-strings since the government, as the principal funder and client, is in a position to dictate the terms of a policy development project.

Consultancy and research modes of operation are fundamentally different. As researchers the standards of our work are set by an international community of colleagues, and a project will continue until we are satisfied that we have reached that standard. Just as one cannot undertake to develop a new cure within a predetermined time frame, much good public health research cannot be confined *a priori* to a fixed period and even less to a very short period, such as 'in time for the next budget vote three months away'.

This is not to say that government planners are wrong to set such time frames, or to set a very clear policy analysis brief. But the kind of work that this requires is consultancy not academic research. As consultants we will deliver a report on time. And the standard will be whatever is do-able in that time. Frequently it will not merit publication as such, and the extra time required to take a technical report to journal publication stage - drawing far more extensively on literature reviews, comparative analyses, identifying something really new in the work - none of which is needed by the client - is not funded and therefore much harder to do.

Since there are quite limited 'open research' funds for which one may apply, and there is usually no core funding from the university or statutory research bodies for policy studies, the freedom to determine research programmes and especially to undertake long term, generally high risk, more analytic research less applied to solving an immediate problem, is far more limited.

Participatory Research

One of the most unexpected developments has been the shift away from diligently consultative and participatory research processes that were a hallmark of the transition period from 1990 to 1994. There may be a number of reasons

for this. Firstly, many of the progressive organisations with which we interacted during the apartheid era have actually disappeared or are unrepresentative and don't warrant the substantial costs of consultation. The progressive health organisations in particular have suffered this fate, largely because of the overlapping membership of and commitment to the ANC. As a result the locus of health policy discussion moved out of organisations such as NAMDA, SAHSSO, PPHCN and into the ANC health department.²

Organisations that remain strong and representative, such as the unions and the civic organisations, have lost much of their technically specialised leadership to the new parliaments and their bureaucracies. As a result they are too weak in the area of health policy to be able to participate usefully in a policy process.

But aside from the problem of finding institutions and organisations with whom to consult, there are other pressures from government not to consult widely or make a process too participatory. One of these stems from the same time pressures identified above. Participatory research is far more time-consuming than research conducted by a tight team of consultants or academics. And a serious commitment to participatory processes is incompatible with rigid deadlines.

Another argument offered by politicians against consultation by researchers is that the elected officials now represent the collective will of the people, and that intellectuals involved in policy development no longer have to seek a mandate directly from communities. They argue that consultation by academics is likely to be less democratic because it is difficult to ensure representativeness in participatory research. Moreover, since consultation inevitably also becomes persuasion, lobbying, negotiation and compromise, they claim it as the proper job of government and not of 'technical researchers'.

Secrecy and Advocacy Roles

As a policy unit we have always viewed our work as two thirds research and one third advocacy. We exist to influence the world. By the end of a project, we generally believe one policy option is better than others and want to persuade as many people as possible of this. Most of our output has multiple formats ranging from newspaper articles to briefing documents for decision makers, conferences aimed at different types of audience, face to face meetings with key individuals, etc. At times we have even retained a public relations firm when we felt we were not being adequately heard.

Even if an issue was not requiring of advocacy, as academic researchers we would never allow our work to be kept secret; all work would ultimately be published and in the public domain. During the transition period this commitment to disclosure was strengthened by our concerns about working with an

illegitimate government. Yet now under more normal circumstances clients, including the new government, often want privileged access to the information and policy proposals. The minister may demand confidentiality until he/she sees fit to release a report, and may also claim the right not to release it at all.

On the one hand we recognise the right of a minister to obtain a confidential policy assessment and would like to participate in providing that kind of input to the policy process. On the other hand our belief in the importance of placing our work in the public domain and our commitment to an advocacy role means that, if the government pays us to investigate something and then ignores our recommendations, we should leak our report to the press, join battle in public, and use all possible means in the struggle against the government for public opinion.

It was easy, morally, to combine the roles of intellectual and activist when there was no legitimate institution to adjudicate policy decisions. The question now is whether these roles ought still to be combined in the presence of a democratic government? We could become a purely technical research unit, providing a range of options with pros and cons and exposing the underlying value systems inherent in each, but then tossing this analysis into a market place of ideas and leaving it to the politicians to make the decisions, since they are the only ones with a political mandate. Or we could use our privileged positions of power through research to criticise government choices from both ethical and technical perspectives.

Competition from Private Consultants

Compounding all these other environmental changes (the change in funding sources, in the kinds of knowledge needed, the time frames, a legitimate government's concerns with secrecy and advocacy) is a change in the market in which we are now competing both for funding and for influence. The client for policy studies is usually the government. On the supply side, the market is increasingly dominated by private consultancy firms who can tailor a job to the time and resources available and have few aspirations to standards set by academic peer review. They have no qualms about providing confidential reports to their clients, and would never get involved in independent advocacy of their positions. They see their role exclusively as one which promotes the client's interest, not the public interest. By contrast, we, as an academic policy research group, are committed to exposing the points at which government and public interests diverge. The loyalty, discretion and client orientation of private consultancy firms may come to look very attractive, even at a price. And in turn our financial dependence on particular bureaucrats generates disincentives to alienate them through public criticism.

Strategies for a New Environment

The Centre for Health Policy is still grappling with how we should function in this new environment. Before reviewing some of our strategies, it is pertinent here to make explicit CHP's own values that will guide these strategies.

First, we believe that ideas matter, and we are therefore committed to the pursuit of knowledge and to better understanding how our natural and social worlds function. Valuing knowledge carries with it an obligation to uphold certain methodological standards and to peer evaluation of our work. Second, we believe in the value of knowledge for social change. Moreover we are committed to a particular variant of social change, namely the redistribution of social resources and power. Third, we believe in the relevance of intellectuals in shaping public discourse, debate and policy.

Basic Structural Dilemma of a Policy Analysis Unit

One of the possible solutions to the tensions identified above, given that the government and the CHP share broad ideological goals, is to become a government planning unit in the ministry of health rather than an independent academic unit. This is an option we have discussed extensively but decided against for some of the same reasons that were originally given for becoming an academic unit rather than an activist NGO. Many individuals want to do research rather than planning and management. The university offers a better environment for this. Furthermore we recognise the government will struggle to meet its goals and will probably be forced to compromise on its ideals, and we believe an independent unit may be more effective in monitoring this and maintaining pressure on government than one operating from within the bureaucracy. However, individual researchers are leaving the CHP to work in the government, or to work part time in government committees or departments because they feel the goals of reforming the health sector can at this point be best served by strengthening the bureaucracy with skilled progressive leadership.

Specialisation within the Organisation

In response to the need for a different sort of knowledge at this point in the process of social and political transformation, the loss of funding for more academic type research and the constraints on the time allowed by consultancies to develop research to our satisfaction, we are developing a two-tier modus operandi within CHP. Some projects will be defined as consultancies and managed in a consultancy mode. Although the same individuals will undertake both consultancy projects and academic research, these will be done within different time, financial and research management systems. At commercial consultancy rate, these projects will be used to cross fund the academic research

projects that the Centre undertakes. We will also attempt to undertake joint ventures with pure consulting firms to strengthen our consulting expertise and to offer a wider range of skills to the clients. Although motivated in part by funding requirements, any consultancy work will still have to be consistent with CHP's basic set of values and promote our specific objectives. We therefore anticipate that such projects will usually be for public sector clients.

Diversify Funding Sources and Clients

As a way of countering the concentration of power over research funding and agendas, we are developing links with the new provincial health planning teams and local authorities, in the hope that there will be other potential clients outside of the central ministry with independent interests and funds and who may also influence the central decision makers.

A different strategy for placing some distance between funders and researchers is exemplified by the Health Systems Trust (HST). HST, established in 1992, receives large grants from government and overseas donors. Government and local health leaders are represented on its board of trustees who ultimately decide what research to fund. The pooling of funds in a kind of consortium of donors which acts as intermediary between funders and researchers, the use of independent trustees, and a secretariat which makes independent assessments of policy research priorities and the quality of proposals, protects the independence of research groups from the direct patronage and control of funders. This strategy is also effective in moderating the influence of international donors on local research and policy. Moreover HST not only issues requests for proposals based on its own assessment of priorities, but also entertains researcher-initiated proposals, and is willing to fund slightly longer term (two to three year) projects allowing space for more in-depth policy research.

Establish and Campaign for a Clear Standard of Academic Freedom

On the issue of secrecy, we have continued to insist that any work we do will be published, though we will allow a three month moratorium after presenting the reports to the client and would give equal prominence to any comments clients might wish to have published alongside our report. With respect to our advocacy role, we expect to remain as active as we were before with the main difference being that far more attention will be paid to government officials and politicians than under previous regimes. Regular 'leadership seminars' with senior officials from the provincial and central ministries will focus on different policy issues in a way that attempts to build understanding of each other's views, sometimes behind closed doors. In addition, recognising the susceptibility of elected officials to public opinion, we will continue to devote substantial resour-

ces to engaging with the public during the research process and to popularising policy debates and proposals.

Change Attitudes of Government Clients and Society

We have to get involved in changing attitudes amongst senior government officials and politicians regarding the value of independent policy analysis done by units outside of their official structures. We need to persuade them that the only way of ensuring the quality of the work done for them is by exposing it to public and peer scrutiny, and that this necessitates publicising the research results as soon as possible after completion. We need to demonstrate the added value of participatory research, even if this costs more. We also need to persuade the institutions funding research of the value of independent, long-term, unpredictable outcome research in policy studies and to get government to increase funding to policy studies units, and in our case to community health departments or schools of public health, in the same way that it provides core funding for other academic research departments.

One might anticipate a learning curve for the new government and its officials on how to relate to, and make optimum use of, independent academic policy units. Our experience suggests that in the year since the elections (and only a few months for most of the new civil servants) the officials and politicians are rapidly ascending that curve. We have to facilitate that, and protect the gains through educating society to recognise the longer-term importance of independent analysis to promote the public interest.

Conclusion

In reviewing the Centre for Health Policy's changing experience of, and relation to, 'power' over the last eight years, what started off as the paradox of increasing constraints just at the point we had anticipated professional liberation, in fact turns out to be the paradox of unusual and anomalous independence and freedom during the periods of repression and transition. For the environment we have encountered since the elections is in fact the normal environment in which academic policy units operate in most countries most of the time. Governments control most resources for policy work and largely determine agendas, time frames, and priorities; academic units compete with consultants for work and routinely confront the trade offs between academic and consultancy-type work. Academic freedom and client privilege are issues such units deal with on a daily basis. What was surprising and anomalous was the way progressive policy units functioned before.

The objective of this paper has been to draw attention to some of the unexpected difficulties that the new political context may present to progressive policy

researchers, and to open a discussion about how to respond. In addressing this objective it was not appropriate to elaborate the many positive and more predictable changes in our relations that have followed in democracy's wake. But lest this paper create the impression that we long for an earlier golden era, it must also testify that the overriding emotion in the Centre for Health Policy this last year has been one of exhilaration at being in a political environment and in a professional role where one feels one can make a difference.

Yet we need to recognise the rarity of this space - perhaps a few years during which there is sufficient openness in government to new ideas and a political imperative for change. Powerful vested interests are not yet firmly entrenched in the new political system, and there is the political will to try something really different. Our task is to avoid being seduced by the immediate rewards of becoming government think tanks and consultants, and to secure a long-term relationship with government and the society which will promote critical policy analysis into the future.

Acknowledgments

Many of the insights presented in this paper are born of numerous in-house discussions with colleagues at CHP to whom I am deeply indebted. Thanks also to Michael Reich for detailed comments on an earlier draft. This paper was written while I was a visiting Takemi Fellow in International Health at the Harvard School of Public Health, funded in part by the Carnegie Corporation of New York, the Centre for Science and Development and the South African Medical Research Council, and the University of the Witwatersrand. The Centre for Health Policy is supported by research grants from the Health Systems Trust, South Africa.

Notes

- 1 Based on paper presented to 'Conference on Population and Health in South Africa', University of Michigan, Ann Arbor, February 1995.
- 2 NAMDA, the National Medical and Dental Association, merged in 1992 with the South African Health Workers Organisation (SAHWCO) and the Organisation for Appropriate Social Services in South Africa (OASSSA) to form the South African Health and Social Services Organisation (SAHSSO). PPHCN is the Progressive Primary Health Care Network.