Potential constraints to equitable service delivery in Cape Town in 2003

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Executive summary

The research was located in Cape Town, South Africa where the need for equity policies to be implemented is great. However ongoing restructuring and change lead to fatigue in the management and staff of the primary health services. Their resistance could block the implementation of equitable staffing plans. It is necessary to understand the management and workplace factors leading to potential resistance of equitable staffing plans and thus these were explored.

A policy analysis approach using a case study analysis was sought to provide understandings, approaches and tools to illuminate the processes involved in health policy. This work was done under the Regional network for Equity in Health in east and southern Africa (EQUINET) co-ordinated by the Wits University, Centre for Health Policy South Africa. This study is part of a broader programme of work which looks at equity and human resource management. It builds on a prior, unpublished study conducted by our department in 2002 which described nurses' perception of a high clinical workload in facilities and the contributing factors. Another source of secondary data used in this study was a series of interactive workshops held from March 2002 to February 2003 with the heads of public primary health care services and their district managers to explore the feasibility of equitable staff planning. In this process the key managerial constraints to implementing equity-promoting staff allocation were illuminated. Individual interviews were also conducted with twelve managers and focus group discussions with six facilities that stood both to gain and loose from the equity promoting policy.

Both managers and frontline nurses are broadly supportive of the principle of equity in health care provision, based on an understanding of fairness. While managers and nurses broadly support equity goals, when implementation becomes a reality, resistance emerges in both groups. Resistance is seen not just in overt statements, but also in the attempts to justify the unwillingness to consider equity-promoting staffing as feasible. The barriers identified were: transport, language barriers, physical working conditions, nature of caseload, and health risk.

While managers are concerned with broader issues such as equity, staff are focused on the reality of service delivery on the ground and are less likely to value the broader issues as much. They work directly with clients, so their concern is the effect that staff reallocation will have on the quality of care of clients. Delivering quality care is considered their main purpose in their profession.

Managers speak of their difficulty in knowing how to manage nurse resistance whereas nurses speak of an expectation of being involved in decision-making and treated with respect. The findings suggest that a core issue in understanding the resistance of nurses to the proposed equity-promoting policy is an underlying lack of trust in the nurse-manager relationship.

In conclusion, we found that to implement an equity-promoting policy trust has to be restored between nurse and manager and actors in the policy process must be involved in the process.

1. Introduction

In 1994 the democratically-elected post-apartheid South African government inherited a highly fragmented health care service with inherent structural inequities along racial and geographical lines. The new government has expressed a commitment to equity. While much progress has been made in unifying the health services and introducing a district health system, significant inequities continue to exist in service delivery. In the Cape Metropole this is partly due to the location of primary care facilities and staffing based on service utilisation. It is thus a function of supply, rather than need. Historic budgeting processes by the two agencies providing primary care, the City Health Department and Community Health Service Organisation, perpetuate marked inequity. The crucial issue in Cape Town is how to manage implementation of the equity-orientated policy.

While the national and provincial tiers of government are able to address inequity by changes in financial allocation to the provinces and the regions, local health managers face a far more complex task. In health districts and sub-districts, significant changes in expenditure can only be achieved by reallocating staff posts, as staff make up 70% of the expenditure in the districts.

The need for equity policies to be implemented is great: Inequitable service delivery in the face of marked health inequities in Cape Town can no longer be tolerated. However ongoing restructuring and change lead to fatigue in the management and staff of the primary health services. Their resistance could block the implementation of equitable staffing plans. It is necessary to understand the management and workplace factors leading to potential resistance of equitable staffing plans.

This study set out to explore the factors influencing equity-orientated staff plans. It asked the following questions:

- What managerial factors experienced by agency and sub-district managers in Cape Town constrain or enhance the implementation of equity-orientated staff reallocation within a district?
- What workplace factors experienced by facility managers and nurses in Cape Town place constraints or enhance the implementation of equity-orientated staff reallocation within a district?

1.1. Conceptual framework and guiding hypothesis

The policy analysis triangle described by Walt and Gilson (1994) provides a framework for describing and analysing the influences of context, content, actors and processes on the policy process from agenda setting and policy formulation through to implementation and evaluation. The policy process is not linear but interactive. The implementation stage is as crucial to the success of a policy as the agenda setting and policy formulation stages. Indeed the policy can be redefined during implementation:

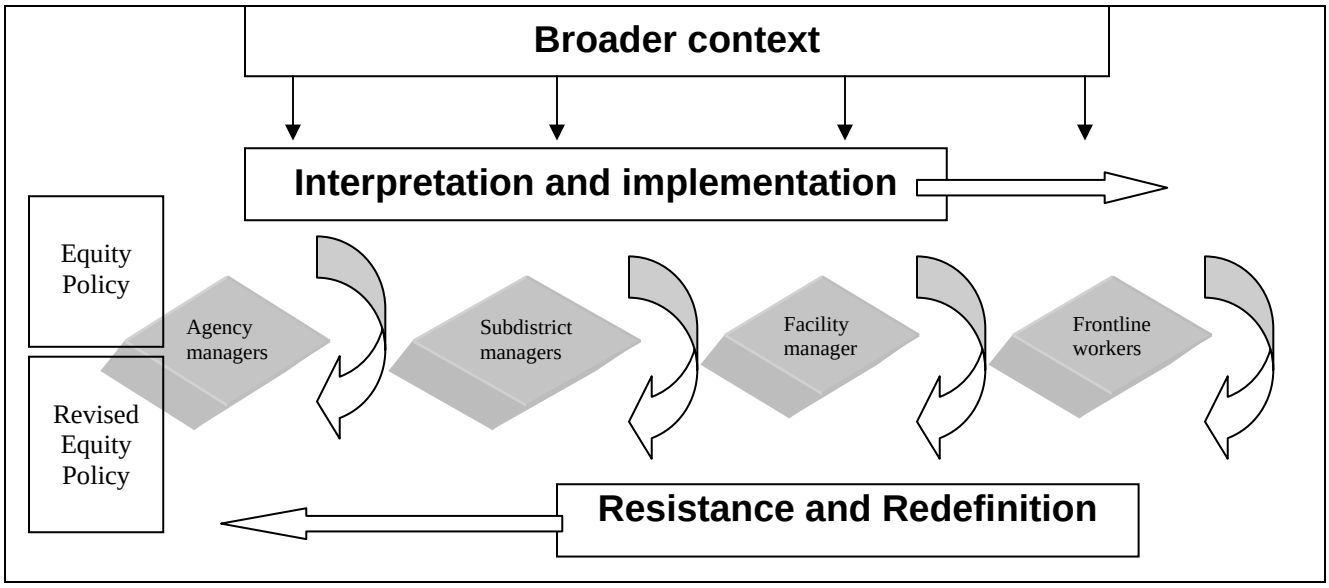
> *Thus implementers may change the way a policy is implemented, or even re-define the objectives of the policy because they are closer to the problem and the local situation. Rather than seeing implementation as a stage in the sequential transmission of policy from formulation to implementation, it should be seen as a much more interactive process, and just as policy formulation may be characterised by bargaining, so may implementation be characterised by negotiation and conflict* (Walt, 1994).

Involving the implementers in the earlier stages of policy formulation is key to ensuring that policy content and the policy implementation process is appropriate to the local situation so that the desired policy objectives are met. It is helpful to examine potential resistance to policy change by implementers to inform this. The contextual, content and process factors influencing the following actors (as implementers) are important:

- health management (agency managers and sub-district managers)
- frontline health workers (in particular nurses and facility managers).

As shown in *Figure 1*, implementation is not a linear management paradigm from agency managers to sub-district managers to facility managers to frontline workers. Policy interpretation and resistance to implementation occurring at each level finally impacts on the policy and redefines it within the system. The broader context also acts on each player to modify their interpretation of the equity policy. To formulate an implementable policy that will achieve our policy objective (equitable staffing between sub-districts) we must investigate the factors that influence the way a policy proposal is interpreted by each actor group, given their different roles, past experiences, values, motivations. This will enable us to identify factors which are possible constraints on managers and facility staff that need to be addressed if resistance is to be managed.

Figure 1: Implementation process of Equity Policy involving policy interpretation and redefinition



1.2. The study site

The research was located in Cape Town, South Africa. In South Africa there are 53 health districts of which six are Metropolitan Municipalities. The City of Cape Town is one of the six Metropolitan Municipalities and has 3.4 million inhabitants. In 2001-2004 when this research was undertaken, Cape Town Health District was divided into 11 health sub-districts, each with a population of between 380 000 and 480 000. Primary health care services are delivered by the organs of two tiers of government: local government (City Health Department) and province (Metro District Health Services). Both allocate resources centrally. City Health is mainly responsible for promotive, preventative and limited (to children under 6 years and tuberculosis) curative services

while the Metro District Health Services provides mainly curative and rehabilitative services. Each primary care provider continues to have its own director and sub-district managers responsible for parallel services in the same geographic area.

2. Methods

A policy analysis approach seeks to provide understandings, approaches and tools to illuminate the processes involved in health policy (Hogwood and Gunn, 1984). The framework guiding the analysis presented in this paper considers the influence of actors in the policy process, focusing on the implementation stage of the process. Building on the work of Sabatier (1993), we look at factors that influence actors in decision-making.

A case study approach was used to focus on the circumstances, dynamics and complexity of implementing a policy (Bowling, 1997). The approach allows for in-depth investigation providing rich descriptions of the factors influencing actors in the implementation process. Case studies are particularly useful when the surrounding conditions are central in understanding what happens (Yin, 1994) and why it happens. The case study approach relies on the use of multi-method data collection for evidence and triangulation (Yin, 1994; Bowling, 1997; Stake, 1995), as used in this study, consisting of a workshop process, in-depth interviews and focus group discussions.

This study is part of a broader programme of work which looks at equity and human resource management. This work was done under the Regional network for Equity in Health in east and southern Africa (EQUINET) co-ordinated by the Wits University, Centre for Health Policy South Africa. It builds on a prior, unpublished study conducted by our department in 2002 which described nurses' perception of a high clinical workload in facilities and the contributing factors. The report of this study (Matwa et al, 2003), was used as secondary data. The key findings of that study illustrated that nurses feel:

- they suffer from stress and burnout due to their perceived high workload;
- there is little middle- to top-management support for nurses;
- they are not involved or do not participate in decision-making processes; and
- there is no transparency concerning changes that directly affect them.

Another source of secondary data used in this study was a series of interactive workshops held from March 2002 to February 2003 with the heads of public primary health care services and their district managers to explore the feasibility of equitable staff planning. During this process the key managerial constraints to implementing equity-promoting staff allocation were illuminated.

From the managers' perspective it is necessary to balance equity goals with efficiency and workload and, so as to maintain a quality service, the speed of reallocation must be controlled to ensure that supervision and support is put in place. These workshops fed into the development of a managerial tool to factor in logistical concerns to make equity-orientated staff planning possible. Short notes from these workshops and a review of the managerial tool were used in validating the primary data collected through a process of triangulation. Primary data collection methods used in this study are outlined in *Table 1*.

Table 1: Primary data collection

Actor group	Primary source of data collection	Description of primary data collection method
Managers	In-depth interviews with twelve managers.	Semi-structured in-depth interviews with managers to explore contextual factors impacting on managers, as well as the effect of their motivational interests, roles and experiences on equity-orientated staff planning.
Facility staff	Six focus groups. Discussions with facility nursing staff (48 staff included in discussion groups).	Conducted in the form of workshops where a presentation was prepared with extracts of a model on equity-promoting staff planning. The nurses' views and opinions of the feasibility of an equitable reallocation policy were sought.

For the actor group "managers", purposive sampling was used to select the twelve key informants, most of who had participated in the workshops. Key informants were selected on the basis of them having a range of management responsibilities (head of public primary health care service management, district management, health information management, health policy and planning). In addition, equal numbers of managers from districts that stand to gain and to lose from the equity-promoting policy were selected.

For the actor group "nurses" we selected the same six facilities as those used in the secondary data source study (Matwa et al, 2003). In addition, they reflected both facilities in districts that stand to gain and to loose from the equity-promoting policy.

Individual interviews and focus group discussions were initially analysed to identify categories and themes. The analysed data from each interview and from the focus group discussions were then compared to establish common understandings and perceptions, and differences in opinions. This was followed by constant comparison between the two actor groups for emerging themes. A stakeholders' analysis adapting Crosby's (1997) approach was used to analyse the influence (past experiences and responsibilities), values and interests of both actor groups based on emerging themes. The full range of data was used for interpretative analysis but specific quotations were selected for use in this paper to illustrate particular issues, perceptions or views either in agreement or disagreement to reflect the emerging themes. The analytical process was conducted systematically and vigorously through constant comparisons and seeking emerging themes. Triangulation of data was conducted through the comparisons of both primary and secondary data.

3. Findings

3.1. Support for equity in principle

Both managers and frontline nurses are broadly supportive of the principle of equity in health care provision, based on an understanding of fairness. They accepted that gross inequities currently exist in financial allocation of resources to public primary health care between districts in Cape Town and agreed that this was inherently unfair. The technical measures of inequity between health districts, calculated by a team of external analysts

together with mid-level management, was in keeping with managers' and nurses' knowledge and experiences of current inequities in access, quality and staffing in clinics and community health centres.

Managers and nurses differed in their views on how to address the inequities in health service provision. Managers, tasked with providing services with increasing financial constraints, accepted that the resource envelope was limited and recognised that the only way to operationalise equity goals would be to reallocate existing resources between health districts, which translates into reallocating staff.

> *I think it (equitable reallocation of staff) is the most important (priority facing us). I'm saying so because within health, if you look at our budget, I think 67 to 70% of our budget is taken up by labour. And if you can get that right – allocate resources according to need – then I think we will make better impact on the communities that we service.* (Manager, 13 August 2003).

Nurses uniformly strongly resisted this proposal and instead called for increased funding and resources of the system to improve staffing in the under-resourced districts.

> *I think equity is a good thing but (do) not treat staff and resources at one phase and spoil them or very good a health system to help another area. There should be more money allocated to Khayelitsha. We all know they need more staff; they need more money, more resources. But why take (staff) from other areas because everybody is going to suffer then?* (Professional Nurse, 14 May 2004)

This difference in the perceived options for rectifying inequities reflects the difference in realities faced by managers and nurses, as discussed in *3.2* below.

3.2. Resistance to implementing equity-oriented measures

While managers and nurses broadly support equity goals, when implementation becomes a reality, resistance emerges in both groups. Resistance is seen not just in overt statements, but also in the attempts to justify the unwillingness to consider equity-promoting staffing as feasible.

Managers working at district level speak of competition for scarce resources, which tempers their support for equity. They say that they have a responsibility to secure optimal funding for their own district and so cannot voluntarily give up resources. Nurses are more overt in their resistance. They threaten to undermine any staff reallocation. A common sentiment was: "I will just leave the service." In defending their resistance, managers and nurses spoke about a range of reasons why equity-promoting staff reallocation was not feasible. As they were only raised on prompting within the interviews and focus groups, they did not carry as much weight in the analysis.

4. Understanding reasons for resistance

The emotive force behind the resistance to an equity-promoting staff allocation policy does not lie with the constraints summarised in *Figure 1*. In the interviews and focus group discussion it was the negative effect of past experience and the key concerns related to their formal roles that came to the fore in the analysis.

4.1. Effect of past experience

Both managers and nurses spoke of the negative past experiences of staff restructuring that makes them skeptical about the feasibility of implementing a new equity-promoting staff reallocation process. The significant restructuring of the health system under the new democratic government has had its greatest impact on the front-line workers, predominantly the nurses who are the backbone of the primary care service. The experience of many changes in quick succession has resulted in change fatigue. District managers speak of this change fatigue at both management and facility level.

Figure 2: Factors constraining the implementation of equity-promoting staff reallocation

Transport: while it is possible for staff to travel to work in different districts in an urban setting, this affects costs, travel time and can disrupt established routines related to parental responsibilities such as taking children to school.

Language barriers: clients in different districts speak different first languages; some nurses would either require interpreters or need to learn the required language

Physical working conditions: there are marked differences between facilities in different districts with some in a state of general bad repair and others are well-equipped, have comfortable tearooms and are situated in a pleasant environment.

Nature of caseload: the disease profile differs between districts with some experiencing more trauma and emergencies, which makes the work more stressful.

Health risk: there are concerns that staff will fall victim to the violence endemic in some communities in certain districts; there is also a high HIV prevalence in some districts and nurses speak of a higher risk of infection through needle stick injuries.

Change fatigue is especially felt where the prospect of change has been ongoing or not fully resolved, such as the introduction of the district health system. In Cape Town this is an example of poorly managed implementation, fraught with poor communication of goals, and poor timing and sequencing of change. Given the stress of uncertainty they have experienced, staff have become skeptical about the benefits of change and resistant to further proposed change. Managers speak of the need now for stability, not further change.

Based on past experience, most managers anticipate nurses' resistance in implementing staff reallocation. They have already experienced difficulties in attempting to reallocate staff to improve the imbalance in workloads across the city. In their experience, nurses resist reallocation strongly and are not always rational in their resistance. Managers have had to deal with perceptions of workload and stress among frontline staff which do not correspond to objective measures. In their experience the issue is strongly personalised by nurses, who feel victimised: "Why is it always the nurses who have to move?" Managers have been unable to address nurses basic concerns, related to how they feel they are being treated.

Ironically, even the nurses in districts who stand to gain staff from this policy are not supportive as they have been disappointed by past attempts to assist them: previously new staff brought in to assist under-resourced areas did not remain in the service. They regard the promise of new staff posts in under-resourced areas with suspicion, as their recent experience has been that even existing vacant posts could not be filled. Their past experience has undermined their trust in the change process and in their managers' ability to provide support when it is required.

4.2. Effect of formal responsibilities and concerns

Managers and nurses spoke of key concerns which influenced their support for equity-promoting staff reallocation. On reflection we have linked these concerns back to some of the formal responsibilities of the positions they hold, as a way of understanding some of the ambivalence and the differences of perspectives.

Table 2: Formal responsibilities and the effect on support for equity-promoting staff reallocation

Position	Formal responsibility	Concerns	Effect on support for equity-promoting staff reallocation
Health managers	Strategic management of health service (regional focus).	Improving equity	Creates support (+).
	Strategic management of health service (District focus).	Financial well-being of district	Dependent on financial position of district whether it stands to gain [support created (+)] or lose [resistance generated (- -)].
	Line management functions (staff focus).	Support staff	Diminishes support (-).
Nurses	Works directly with clients in providing health services (individual client focus)	Quality of client care	Creates resistance (- -).
Facility manager (as a subset of nurses)	Line management functions (staff focus)	Control workload	Diminishes Support (- -).

4.2.1. Managers' strategic responsibilities

A major constraint to introducing equitable resource allocation policies are the financial cut backs experienced in provincial and city health budgets since restructuring began in 1996. District managers have had to deal with increasing cuts to their budgets and staff losses. There was an extended embargo on filling vacant staff posts. Now, while staff recruitment is again permissible, funding is still limited and there are critical shortages with difficulties in attracting and retaining key staff, including nurses and medical officers. With hospital outpatients downscaling, the financial cut backs have coincided with a real increase in the scope of practice and client volume at primary care level. The perception

is “we are doing much more with less”. The resource scarce environment limits the managers “room-to-manoeuvre” as staff are already under pressure.

Another factor of increasing concern for health managers is the current migration of health care professionals and real shortage of nurses in the market place. Retention of nurses is becoming a challenge. There is a concern (backed by experience) that, if the conditions of service are not attractive, nurses will leave the service. In the current climate, managers are struggling to replace nurses who leave.

As a group, managers are motivated to promote equity because of their responsibility for strategic planning in the region as a whole. In this role, they look beyond the interests of their own district to effective management of the region. Equity is one stated strategic goal for health care delivery and this creates support. However, there is little experience in implementing equity-promoting resource changes as equity as an objective, measurable management performance area is a relatively new management concern.

Furthermore, support at the regional level is in tension with their role at a district level where a major concern is the financial viability of their own districts. They are not impartial in their assessment of differing health needs between the districts, and equitable financial allocation. Despite having been intimately involved in developing a needs-based formula for determining equitable resource allocation across the Cape Metropole, their perceptions are still skewed by a sense of loyalty to their own district. The objective assessment provided by financial management tools is coloured by whether their district stands to gain or loose. The financial position of their district is key in determining whether they support fair re-allocation.

> *It is amazing if you move a manager from a well resourced area to an under resourced area, how she changes overnight and all of a sudden sees the need; whilst he or she didn’t see the need while she was in a well-resourced area.* (District Manager, 14 August 2003)

4.2.2. Managers’ concerns about their ability to manage resistance

Managers’ line management responsibilities come into tension with their strategic management responsibilities when they have to respond to concerns about staff well being. Some speak of the difficulty they have on a personal level of dealing with staff complaints. They are particularly concerned about the nursing staff as they recognise that they bear most of the effects of restructuring, yet many managers feel inadequate in dealing with what some call “the emotional reaction of nurses”. Many have no basic management training, and some are still in acting positions as the district health system is not fully implemented. They too do not feel supported. This undermines their ability to manage effectively and has implications for the introduction of equity-promoting restructuring:

> *(We are) totally ill-equipped. There has been no Change Management. It never occurred in a conscious way that we have a Change Management Unit with people who are appropriately skilled to advise in how you manage change.* (District Manager, 22 August 2003).

There are examples of poor management practice with changes being forced upon unwilling staff, without prior communication and consultation. This is linked to weak organisational communication and supervisory systems, which isolates frontline staff from management. Some district managers find that strategic responsibilities get in the

way of their supervisory work; they realise this creates tension with staff who are disappointed and frustrated that managers are not supporting facilities as they ought to:

> *I'm very well aware of the fact that I should be (getting round to the clinics). I just can't get there. And then I set up meetings and then I have to cancel it. I'm just glad I'm not there when the message gets carried across that I have cancelled the meeting! …And supervision is literally non-existent.* (District Manager, 19 August 2003).

Managers feel that part of the resistance from facility staff in equity-promoting staff shifts is because they do not understand the importance of equity and so perceive it as a random and uncertain management process. Staff are suspicious of the tools used in the measurement process and, in retrospect, some of the managers realise this is, in part, because nurses weren't consulted in the development of the tools.

4.2.3. Nurses' concerns and responsibilities

While managers are concerned with broader issues such as equity, staff are focused on the reality of service delivery on the ground and are less likely to value the broader issues as much. They work directly with clients, so their concern is the effect that staff reallocation will have on the quality of care of clients. Delivering quality care is considered their main purpose in their profession. They perceive the managers' interest in patient workload to be in opposition to providing quality care and feel this is unprofessional. Some facility managers argue that it would be contrary to the mission and visions of the organisations that try to uphold quality.

> *We want to render quality but they don't want that. They want us to see (increased patient numbers to meet workload norm) and you are (like a) robot to do this and then go and that is not nursing. I didn't do nursing for this.* (Professional Nurse, 4 May 2004)

There is a grave concern among the frontline staff that, if an equity-driven staff allocation policy is implemented, the quality of service will go down. This is related to their concern that such a policy will increase workload. In particular the nurse-client relationship is considered to be at risk, as well as the safe-guarding of preventative services that can be overtaken by curative services if workload increases. Here we see evidence of a breakdown in communication between managers and nurses. From the managers' perspective, equitable staff reallocation is a measure to improve quality of care, but they have not been able to communicate this effectively to nurses who believe equity will increase workloads and cause deterioration in quality of care. Managers are characterised as being distant and with a different agenda to the nurses on the ground:

> *They (managers) are sitting up there. They do their own little thing according to this and the other (referring to work on equity) that's working for them. It's not working for us.* (Facility Manager, 11 March 2004)

4.2.4. Low morale

One of the consequences of change fatigue is low nurse morale. Nurses feel they are victims of change. They felt that an equity-promoting policy would not have any benefits for them and would instead lead to increased workloads, burnout of nurses, absenteeism and ultimately resignations. A symptom of low morale is the nurses' perception of high workload: they feel overwhelmed by client care and complain that their workload is too high, yet this is not borne out by objective measures. It seems that their experience of stress makes them perceive their workload to be high. This has become a point of

conflict between nurses and managers. Nurses feel that managers do not take their concerns seriously and that they are not supported by managers.

Nurses feel undervalued in their work. They work hard to provide a quality service and yet do not feel appreciated by management, nor given credit for their good work.

> *We get much more from the patient than from anybody else. We don't get that (appreciation) from managers.* (Professional Nurse, 4 May 2004)

The nurses reacted negatively to the fact that they had not been consulted in the process of developing an equity promoting policy. They had not been asked to provide input by their managers nor even informed about the process. They claimed that this is a common experience with other policies and procedures that come down from management. They also feel that this reveals a lack of transparency at management level in decision-making which they resent.

> *Same thing. The same way. No consultation beforehand. Training afterwards. It had to be implemented first and then you go for training. Not the other way around. No feedback how it is impacting on you. You will do it, that's it. No backchat.* (Facility Manager, 11 March 2004)

Not being involved in the decision-making process contributes to low morale as it makes the nurses feel powerless. They feel that managers will decide to go ahead with implementation without taking the nurses concerns into consideration. The fragile relationship between nurses and management is illustrated in the fact that, at a certain stage in the focus group discussions, nurses became very suspicious that the managers were using the researchers to introduce the policy and to inform them.

5. Discussion

This study demonstrates that, while the legitimacy of a policy goal may be accepted, resistance can be generated to the implementation of the policy. Our findings suggest that a core issue in understanding the resistance of nurses to the proposed equity-promoting policy is an underlying lack of trust in the nurse-manager relationship.

Gilson (2003: 1457) describes a knowledge-based form of trust to be "a judgment/ prediction that the other will act in your interest". The types of expected behaviours generally underlying inter-personal trust include technical competence, openness, concern and reliability (Coulson, 1998b in Gilson, 2003).

In this study, lack of trust was manifest in various ways:

- nurses feel victimised by managers (they are always the ones negatively affected by new policies);
- nurses feel that managers have not kept their promises in the past (for example, in increasing staffing in under-resourced facilities);
- there is unease in communication (the instance when a managers are too ashamed to directly tell staff that she had to cancel yet another supervisory meeting);
- both managers and nurses realise that consultation is poor (which contributes to a feeling of not being respected) and that nurses are not involved in decision-making;
- nurses don't believe managers consider their well-being (for example, in promoting equity when nurses are concerned about high workloads); and

- there is evidence of suspicion (the concern that managers might be using researchers to inform them about a new policy rather than dealing directly with them).

The central importance of trust (or lack of trust) in our analysis is supported by other studies in South Africa: Walker and Gilson (2002) conclude that demonstrated trust is necessary to strengthen the social resources of the health system to support policy implementation and Gilson et al (2004) suggest that workplace trust is an important factor in health worker performance.

The theoretical literature claims that trust is important in health systems. In order for a health system to function effectively, there needs to be cooperation among health system agents (Alford, 1993; Cahn, 1997 in Gilson, 2003). Gilson (2003) argues that this cooperation can be facilitated by trust. In contrast, as our findings show, a breakdown of trust means that the smooth-running process of interactions between different levels of health agents (managers and nurses) is disrupted: nurses resist a new policy because they do not trust mangers to be fair, supportive, inclusive in the decision-making process and to communicate openly.

In our study, managers speak of their difficulty in knowing how to manage nurse resistance whereas nurses speak of an expectation of being involved in decision-making and treated with respect. This is part of a broader health system problem in South Africa of lack of capacity in managing human resources. In our analysis we have focused on the nurse-district manager relationship, but there is suggestion in our findings that district managers too look up to their superiors and feel unsupported. This is supported by other studies (e.g. LGH, 2003).

6. Policy implications and conclusions

6.1. The importance of managing actors in the policy process

Our findings are supportive of the importance of the role of actors (including implementers) in the policy process. We have demonstrated the resistance of nurses to a proposed equity-promoting policy and how this threatens to derail the implementation of the policy. Unless nurses are actively involved in the decision-making process, any policy implementation will not be successful.

6.2. Trust must be restored to improve health sector functioning

Trust, an important part of social capital, has been eroded between managers and nurses in the health sector. In South Africa the predominant management culture has been one of top-down management (LGH, 2003). For top-down management to be effective, nurses must be prepared to accept the authority of managers as being legitimate. Our findings suggest that, when trust has been broken, the legitimacy of managers is questioned. In this context a top-down approach to management cannot work. Lack of trust undermines cooperation in implementation. There is a need manage nurses in an inclusive way that demonstrates respect and restores trust.

6.3. Implementing equity measures depends on a well-functioning broader health system

The important lesson here is that we cannot deal with implementing measures for equity as a stand alone measure. Dysfunction in health system management will undermine the introduction of any new policy: resistance is not necessary to the goal of equity itself, but to solutions to improve equity that results in a change in an environment, particularly where there is no trust. Because implementing measures to improve equity will always involve change, the system has to be able to cope with change. To achieve equity there is a need for a strengthening of the relationships currently governing the system.

6.4. Reflections on the use of policy analysis

The experience of adapting a health policy analytical approach was indeed valuable and contributed to the learning experience of the researchers. In our work as an Equity Gauge it brought new insight into the constraints faced in implementing equity policies and broadened the focus, which had initially been on technical aspects of policy, to include consideration of the actors and the processes of engaging actors in decision-making. This is an important shift. Our experience as external researchers has been that the first act of resistance to an equitable policy is for the health sector to challenge the technical aspects of a policy. While at times this may have merit, at other times it is a defense mechanism and deflects attention away from the actors who have particular concerns that need to be addressed if equity implementation is to be successful. We found that the policy analysis approach provided us with tools to examine the role of actors in resistance. It deepened our analysis of the resistance.

Our experience on this project has strengthened our belief that the policy analysis approach is a much neglected area and can make a significant contribution to health systems research. This EQUINET supported project has not only contributed to capacity building of the researchers but also our colleagues involved in the consultation and discussion process.

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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