Achieving good governance and management in the South African health system

A consensus report

Academy of Science of South Africa (ASSAf)

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SAMRC UHC / NHI webinar

science & innovation
Department:
Science and Innovation
REPUBLIC OF SOUTH AFRICA

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Context

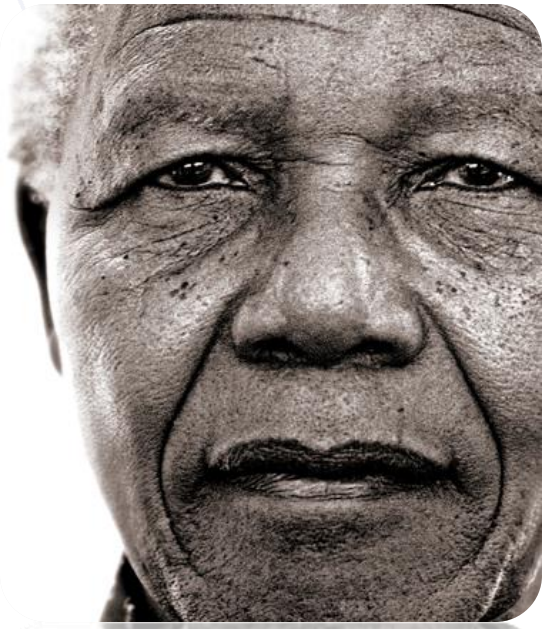
- Access to (quality) health care enshrined as a right in the SA Constitution

- 30 years post democracy - has there been a progressive realization of this right?
  - High burden of disease
  - Access to care
  - Quality of care
  - Equity
  - Health outcomes – worse than other equivalent MIC's

- How has governance and leadership of the health system contributed?

ASSAf: the official national Academy of Science of South Africa

- **Core Mandate** : To offer evidence-based science advice to government and other stakeholders
- Inaugurated in **May 1996** with Nelson Mandela as the patron of the launch
- Formed in response to the need for **congruency of democracy** in South Africa
- **Academy of Science Act** (*Act No. 67 of 2001*) came into operation in **May 2002**



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ASSAf brief

- Determine and describe the magnitude, the spread, and the effects of the governance challenges in the health system;
- Identify effective strategies or best practices that can be adapted or leveraged to address these governance challenges; and
- Make implementable recommendations on how to improve governance, management, and decision-making in the overall health system for better performance and sustainability.

Methods and approach

ASSAf appointed a **seven-member, multidisciplinary panel** of health system experts who volunteered to undertake the study, comprising:

- **Literature review** - historical context, theoretical frameworks and evidence on governance interventions in health systems
- **Consultative meetings** with expert key informants representing State, Service Providers and Citizens/Clients
- Review of grey and peer reviewed literature and **deliberations to reach consensus on key challenges and recommendations**
- **Review of strategic purchasing** as a lever to improve governance and is part of the NHI reforms
- **Peer review**

Governance definition

- '.. policy guidance to the whole health system; coordination between actors; regulation of different functions, levels, and actors in the system; and optimal allocation of resources and accountability to all stakeholders.'

- 'The mortar holding all the health system building blocks together'.

(Von Olmen, 2012)

- Governance 'of' versus governance 'for' health

Governance frameworks

WHO Building Blocks (Mikkelson-Lopez 2011)

Five key principles of governance:

- Strategic vision and policy design
- Participation and consensus orientation
- Accountability
- Transparency
- Addressing corruption

People-centred Framework (Bigdeli 2020)

- Roles and relationships between various important players

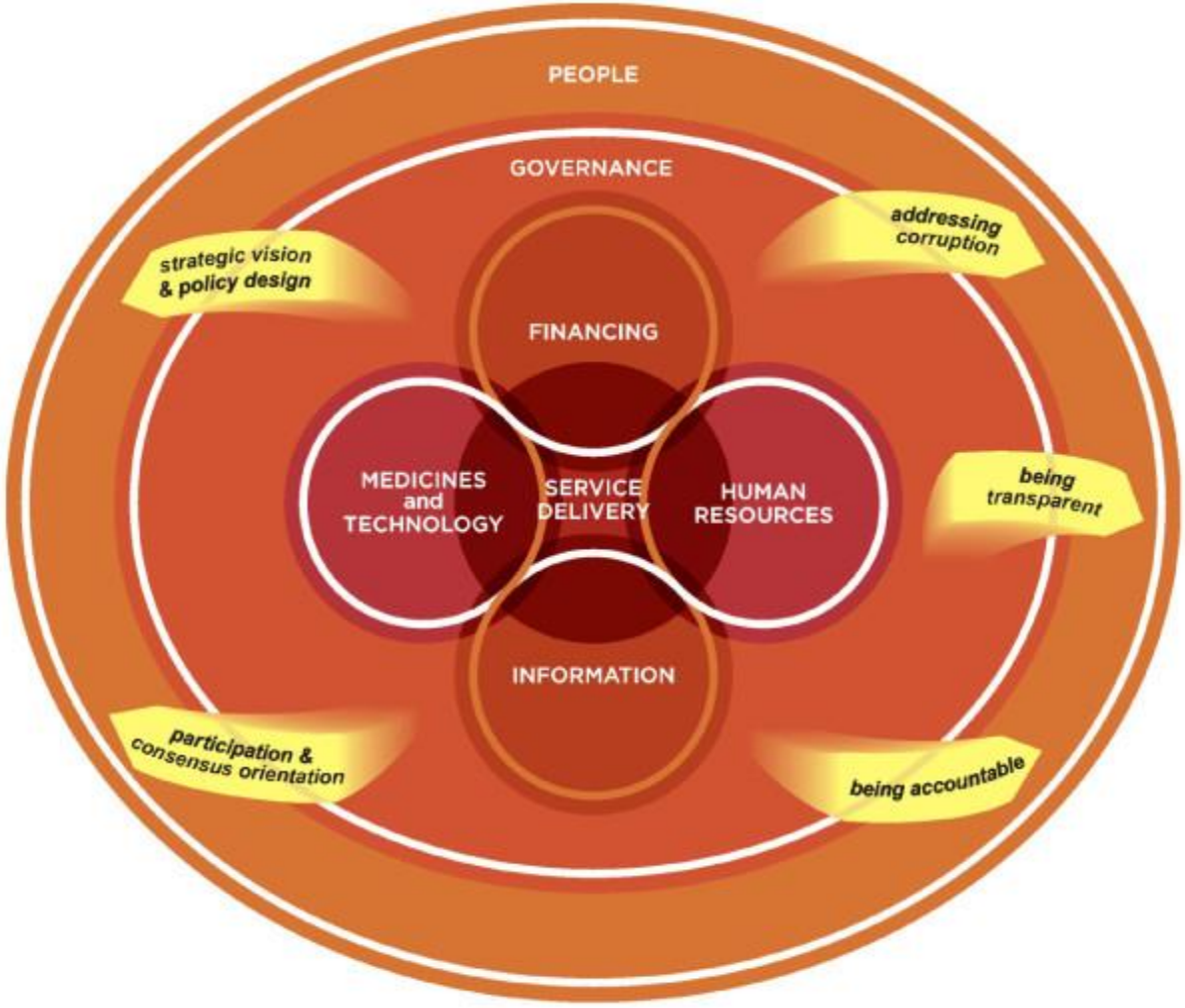

Figure 1: Mikkelson–Lopez framework for assessing health systems governance

History of health systems governance in South Africa

The organisation and governance of the health system has been deeply rooted in the country's political history.

Trekking back to 1652

- Healing practice of indigenous people
- Hospital care by Dutch East India Company 17th & 18th Century
- Public Health Amendment Act 57 of 1935

An early experiment in comprehensive primary health care

- 1942, National Health Services Commission (NHSC) & Gluckman report
- Commitment to unitary health system and democratic control of health services

The apartheid era

- Racial segregation, discrimination & Group Areas Act of 1950
- Homelands & fragmentation of health governance
- Public Health Act of 1977
- Two tier health system

The "rainbow" health system

- 1994, new democratic South Africa
- National Health Act 61 of 2003
- Governance policies, programmes to transform the health system

Progress towards Universal Health Coverage

- Universal Health Coverage & Health equity
- National Health Insurance Bill/Act (2023)

Literature on governance and leadership

- 'Everyday governance' is weak
- Weakness in leadership and management
- Conflicting legislation e.g. PFMA and PSA
- Poor governance of support systems
- Oversight structures not fit for purpose e.g. statutory bodies, hospital boards
- Inadequate community voice in governance
- Fraud and corruption not adequately addressed
- NDoH stewardship of the private sector is weak
- Examples of innovation and good practice at local levels
- International evidence of effective governance interventions

Interviews: Complexity – political, organisational, structural

"he is the Minister of health, not health care, not private health, not public health, but all of it."

- Public sector four levels – national, provincial, district and local/ municipal
- Varied political principals at each level and disjuncture between the levels
- Structural complexity: Concurrent responsibility and role confusion
- Community participation desired at each level
- Parallel private and public sectors pose a stewardship challenge
- Organisational complexity: institutions, disciplines, referral networks, public -private
- Financial complexity:
  - disjuncture national policy ←→ resource allocation;
  - austerity despite increasing burden of disease
- Social determinants of health and intersectoral action important for achieving health goals – realising 'health in all' policies.

STRATEGIC VISION AND POLICY DESIGN

Structures are not insulated from manipulation by vested interests
Software is undervalued – recognising relationship, teamwork and people is key
Appointments not always based on capabilities leading to juniorisation of management
Rigid recruitment process constrain getting best people for job
Oversight bodies lack teeth/independence
Fragmentation versus coherence
Devolution of authority, decision-making absent/poorly planned
Top-down implementation of key policies
NHI focus coming at cost of other health priorities
Health service not conceived of as a learning organisation
Lack of focus on competencies and mentorship in Human Resource planning and management
HMI recommendations never implemented and no accounting.
Weaknesses in organisations supporting the health system (Councils and Regulatory authorities)

PARTICIPATION AND CONSENSUS ORIENTATION

No meaningful roles for structures for community participation under NHA (and NHI)
Lack of independence from political parties
Weak integration across sectors
Relationships between formal system and range of community actors not enabled
Engagement processes not generally designed to align to principles of respect, equality of voice
Lack of capacity to use data for advocacy

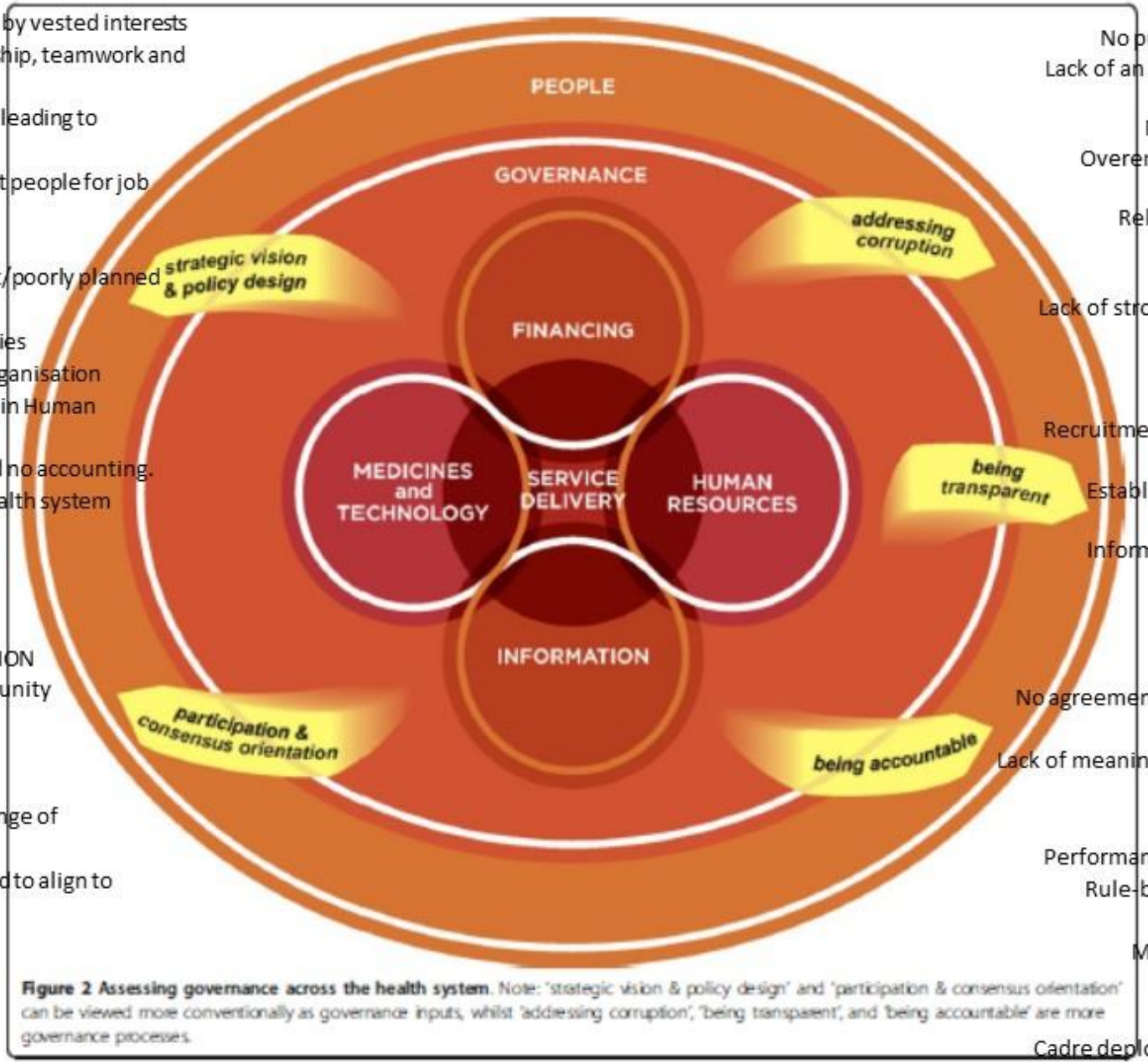

Figure 2 Assessing governance across the health system. Note: 'strategic vision & policy design' and 'participation & consensus orientation' can be viewed more conventionally as governance inputs, whilst 'addressing corruption', 'being transparent', and 'being accountable' are more governance processes.

CORRUPTION

No public value mission shared by staff and leaders
Lack of an array of arrangements to keep focus on public value mission
Mismatch managerial skills with tasks required
Overemphasis on compliance culture and rules stifles genuine responsiveness and innovation..
Reliance on rules at expense of ethical leadership
Lack of consequence for dishonesty
Transformative leadership lacking
Lack of strong and reliable protections for whistleblowing

TRANSPARENCY

Recruitment of Health Managers is not consistently done openly
Establishment of Boards and Clinic Committees lacks transparent procedures
Information flow is upward and does not translate in downward direction nor in use for action
Transformative leadership lacking

ACCOUNTABILITY

No agreement on powers of community structures to hold providers to account
Lack of meaningful accountability of boards and committees to communities
Systems not designed for accountability
Performance and budget not linked to health outcomes
Rule-bound controls hinder willingness to entertain innovation
Mismatch managerial skills with tasks required
Need to manage 'legitimate error' and negligence/dishonesty differently
Cadre deployment creates conflicts in accountability and political interference

1. Strategic vision and policy design

"What is the vision of the National DoH ? Everybody [in the system needs to] share the vision and currently that vision is unclear."

- A coherent public value mission not shared.
- Intended decentralisation but limited delegated authority.
- Top-down decision-making + rule-bound systems hinder innovation, integration at lower levels.
- Problem in structures (PSA gives politicians executive authority) and institutional culture (software often neglected).
- Focusing on what people do, rather than what to achieve.
- Support systems design not fit for purpose e.g. HR, procurement, health information systems.
- Regulatory bodies' weaknesses and perceived lack of independence from Executive.
- Successful examples occur when responsive to local context, senior managers invest time, space created for mid and frontline managers to innovate.

2. Participation and consensus orientation

We need leadership *"...that is uncompromising, ethical, and conducive to change, innovative, able to attract new skills and bring new ideas to the institution"*

- Instability of leadership – turnover at the top affects whole system
- Pushing back against political interference comes at a cost
- Appointment into positions "*for which they lack the technical or managerial capacity*"
- Team leadership enables shared visioning: "*value-driven approach,*" transparency, role-clarification, and learning

- Many policies for community participation not realised in practice, and are inconsistent across provinces and levels
- Missed opportunities for "*dialogue, in spaces that do not infantilise or undermine agency of communities, but which are built on mutual respect*"; overlook "*communities as unique holders of knowledge …*"
- Weaknesses of participation under National Health Act likely to be carried into the NHI
- Learn from some successes (e.g. Ritshidze): "*It is at the community and local levels where the policy will be tested on its functionality. This is where we are aiming to improve so as to provide a better service to the people.*"

3. Accountability

4 Pillars to accountability

- Explicit performance objectives
- Transparency in delivery
- Supervisory structure monitors performance to objectives
- Sanctions/rewards

- Intended for constructive system change, but undermined if systems is 'gamed'.
- Our systems generally fail to hold people within the health system accountable.
- Not just financial accountability (corruption) but failure in delivering on the public service mission.
- Lack of competent appointees linked to political interference
- Vulnerability to vested interests (political, professional, stakeholder).
- Weakness in Parliamentary system (illustrated in Digital Vibes).
- A range of accountability structures and mechanisms needed
- Extensive investments in identifying problems but..:
  - Health Market Inquiry recommendations not implemented
  - Ministerial advisory committee for the prevention and control of cancer 'toothless'

4. Transparency

- Appointment processes insufficiently transparent – victim of cadre deployment, patronage networks
- Consequence if health system is not equipped with the right people in the right place to deal with complex and wicked challenges
- No transparent use of health outcomes data for performance or contracting

One of the key things we have seen go wrong in institutions is the political interference at different levels political interference in appointments, there is a conflict of interest

5. Corruption

There must be a consequence for incompetence and dishonesty; when people are incompetent, they are merely moved around departments; which does not address the fundamental issue."

- Weakness of relying on whistleblowing (Babita Deokaran)
- System not designed to support taking a stand: "*I've had many experiences of people telling me that I moved from one institution to another because I refused to sign off a purchase*"
- Cadre deployment increases risk of capture
- Measures to address corruption are blunt and may be conversely negative ("… *we are so hedged with regulations, rules, and provisos… [I]t is more important to follow rules than it is to deliver services…")*
- A compliance culture rather than measured on outcome
- Genuine mistakes can be used positively in a learning organisation; it is corrupt behaviour that should not be tolerated
- We must create an environment that makes it difficult for corruption to thrive
- Effective prevention and mitigation needed

Important strategies

- Overall, as per Mikkelson-Lopez et al , all these factors are interlinked.
- System design and a clear public value mission are required and underpin accountability and transparency, which dove-tail and both improve health systems performance and outcomes as well as addressing corruption.
- Having the right people well trained and in place, with a commitment to the public-value mission, ethical leadership, and a participatory approach to how they work are therefore interlinked elements which can improve governance.
- Consultations generated three strategies:

Get the systems right, get the right people in the right places, and empower managers and teams.

- These steps would require the NDoH to focus on governance structures and what the health systems should achieve, leaving the implementing agencies (now peopled with the right people) to work out how to do that, with essential elements being oversight bodies and systems that include service users.

Governance issues for NHI : Strategic purchasing

Strategic purchasing

"the active use of purchasing functions, tools and levers by a health financing agency to achieve the strategic objectives set for the health purchaser(s) to contribute the wider health system objectives".

WHO

- Introducing **purchaser–provider split** in the national health system.
- Setting up a national purchasing authority (**NHI Fund**).
- **Changes governance powers and functions across spheres** and for district health authorities. Provincial health departments to play a service-delivery role in contractual arrangements.
- Progressively **greater autonomy for larger hospitals** with NHI contracting directly with institutions that provide services.
- **Developing new provider payment models**, case-based payments through diagnosis-related groups (DRGs) for hospitals; and value-based payments and contracts which link funding to population need, workload, and performance, rather than the incremental budget allocations
- Adopting a **mixed provision model**, NHI Fund purchasing from public and private should allow for greater competition on the basis of quality, outcomes or value.

Governance reforms required for strategic purchasing

- **Stronger, semi-autonomous provider institutions**: new legal status for hospital and new powers and responsibilities for its CEO, managers, and hospital board. New forms of governance could be developed.
- **Contracts**: The objectives and performance targets of the institution will have to be defined clearly in the form of legal contracts between the NHI Fund and provider institution.
- **Linking funding and performance through reimbursement reform**: linked to its performance and thus the system of accountability will need to change. This will require substantial re-organisation on the provision side as reimbursement forms change to become more output and outcome linked.
- **Information systems**: To demonstrate an institution's performance and allow for reimbursement and the operation of contractual terms, information systems will have to measure quality, value, or achieving specific targets.
- **Capacity**: Whether the strategic purchasing agency is the NHI Fund or the province, capacity needs to be developed in strategic purchasing; benefit, contract, and reimbursement design; incentive systems; information systems; governance of contracts; and payment systems.

Governance issues to be resolved for NHI

- **Independence**: Unless NHI Fund has sufficient independence from provision side, there is risk that strategic purchasing will not work well.
- **Governance of NHI Fund**: Composition of the NHI Board and powers of the Minister of Health will influence powers of the purchaser. NDoH has not accumulated much strategic purchasing experience to transfer into Fund. Transparency and accountability mechanisms will be NB. There is insufficient attention to community or user voice in the management of the NHI fund.
- **Powers of spheres**: Risks in service provision will arise unless powers of the spheres are clearly delineated and shifts in health function across spheres carefully managed.
- **Autonomy**: Unless institutions such as hospitals are provided with some degree of autonomy, they will not be able to contract directly with the NHI.
- **Procurement**: If strategic purchasing is not established as something different to current government procurement, risk that all the pitfalls of current government procurement will complicate the provision of services, including public sector health services.

In summary

- **Strategic Vision and Policy Design**: The absence of a unified public value mission and inadequate delegation of authority impede effective governance.
- **Transparency and Accountabilit**y: Political interference and lack of transparent processes undermine accountability and trust in the health system.
- **Participation and Consensus Orientation**: Limited community involvement and top-down management approaches restrict stakeholder engagement and decision-making.
- **Combating Corruption**: Corruption remains a significant issue, exacerbated by insufficient protective measures for whistle-blowers and lack of decisive action against corrupt practices.

In summary

- Complex but foundations for good governance
- Some gains but many failures of health systems governance and leadership at multiple levels
- Stakeholders expressed need for urgency in addressing these failures
- NHI presents new governance risks as well as governance opportunities
- Innovative and inclusive approaches to governance which are better designed for the current context and challenges needed

Recommendations – underpinnings

- Universal health coverage and access to quality care is a constitutional imperative.
- Doing nothing costs and restoring trust is essential
- The current policy shifts present a window of opportunity to 'reset' the governance system and establish improved governance processes to 'future proof' the health system
- Honest, committed, and consistent effort is required

Recommendations

Develop a common vision

Engage all sectors, partners, and stakeholders and work towards a common vision

Update legislation and governance structures - insulate them from vested interests and give them executive rather than merely advisory functions

Delegate authority appropriately to each level and within levels of the health system

Get ethical people with appropriate competencies into leadership and management in the health system

Surround managers with functional fit-for purpose systems (including HR, procurement, health information systems)

Build teams and attend to the relationships that make complex systems work

Remove command and control approach

Authentically engage community participation to ensure appropriate, respectful and responsive health services and to monitor health service outcomes and processes

Act on dereliction of duty and acts of corruption and protect whistle-blowers

Implementation

- This is not simple to implement but failure to grasp these opportunities will render UHC even more unlikely and can lead to the situation where quality health care is available to only a minority of South Africans

- Slow and steady wins the race

- There are many skilled people currently in the health systems willing to work hard and ethically

- *"Each person must ask themselves "If not me then who? And if not now, then when?" These investigations have shown that many in the South African health system, in its broadest definition, will stand up and say, "Me. And now.""*

Acknowledgments

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