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THIS EDITION

How strengthening governance can improve NHI

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People's health in South Africa is in the midst of a severe crisis, with a high burden of disease, and fragmented and dysfunctional health services. We are re-igniting our Critical Health Perspectives (CHP) series with a fresh face. Our first focus is on the health system transformation we would like to see with the implementation of National Health Insurance (NHI) currently under way. Our first issue gave a brief history and basic introduction to the NHI process. The second issue looked at financing of NHI and involvement of the private sector. This, the third NHI unpacks governance in relation to NHI and the policy process. First, it unpacks the meaning of governance and accountability, then unpacks current governance in the public health system, and finally explores the current governance in the current NHI Bill and how this relates to both participation and financing of NHI.

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Critical Health Perspectives (CHP), published by the People's Health Movement-South Africa (PHM-SA), are short editions critically analysing the health system of South Africa. They aim to take a deeper dive into some of the health problems we currently face, scrutinising their root causes and discussing potential solutions to these complex issues. Originally started in 2005, CHPs are written by activists, academics, and experts in their field to spark debate on the most pressing issues in health today. The views expressed here do not necessarily reflect the view of all those who have identified with PHM-SA.

Introduction

South Africa's public health system is in desperate need of reform. It is plagued by poor service delivery and the inability to meet the need for public sector health services.

The proposed National Health Insurance (NHI), laid out in the NHI Bill, is touted to resolve these problems by establishing an NHI Fund as the basis of a new public health care financing system. However, the current proposal overlooks lessons from the shortcomings of the present system, notably the critical importance of good governance and accountability to the efficiency and effectiveness of public health systems. It lacks effective measures to ensure transparency, accountability and meaningful community participation.

In this article, we outline governance and accountability and their importance in public health care delivery and the eventual goal of universal health care. We then describe how they go wrong in the current health system and the shortcomings in governance and accountability in the current NHI proposal. Finally, we make recommendations for how NHI can incorporate governance and accountability mechanisms and how to achieve true public health reform effectively.

What are governance and accountability, and why are they important?

***Governance* is a critical element in effective public health systems. It includes tangible and intangible factors such as regulatory and managerial systems, strategy and goal setting, and key values such as equity and transparency. Good governance is a constitutional imperative — it is required from all organs of state. Accountability facilitates good governance.** [1] ***Accountability* means holding public officials, individuals and organisations charged with a public mandate accountable to the public for their actions and decisions in their public roles.** [1] **Accountability requires performance criteria for public officials and "oversight mechanisms that ensure that standards are met".** [1]

Good governance systems and accountability mechanisms require implementation to be effective. The problems with the current health system show that this is easier said than done. However, there are some excellent examples of how good governance may be incorporated into a system and its benefits, particularly when seeking to provide universal health coverage. The proposed NHI should correct the failings and improve on the stronger elements of the current governance system, while adopting an overall reformative approach. However, the proposed NHI Bill adopts a "system reset" approach without recognising the importance of solid and clear provisions on governance. This does not bode well for the success of NHI.

Universal health coverage systems require principles of good governance, such as transparency and participation. Participation implies meaningful involvement in the law-making process. Participatory governance seeks to go beyond "information sharing" to "create relationships based as much or more on trust and reciprocity than advocacy, strategic behaviour, and deceit". [2, p.458] Participatory governance,, therefore, requires "the development of a wide and transparent exchange of knowledge and information, the establishment of collaborative partnerships, an emphasis on inter-institutional dialogue, and greater accountability". [2, p.458] Participatory governance requires the provision of the means

necessary to engage individuals and organisations outside government through political networks as well as institutional arrangements that facilitate supportive collaborative-based discursive relationships among public and private sectors. [2]Participatory governance is effective when it is legislated into universal health coverage provisions in addition to public participation in the law-making process. [2] Participatory governance is directly linked to successful health governance in health systems seeking to achieve universal health care. [6]Effective public participation increases the responsiveness of the system; this would contribute to building public trust in the NHI.

How is the governance in the public health system currently structured?

The current administration and governance structure of the public health system is decentralised. There are various built-in checks and balances where decision-making vests in diverse roles within the governance structure at a national, provincial and local level, and financing falls under the auspices of the national and provincial treasuries. The system is designed to encourage inter-governmental cooperation, and such cooperation is required to make a decentralised system work. However, the current approach has challenges and needs reform. The intergovernmental structure is overwhelmed by bureaucracy, and the overlap of political and administrative roles often blurs the lines between these two functions. Effective and efficient administration, operation and service delivery are the victims of these shortcomings.

The governance of the public health system is regulated by the National Health Act (NHA) and accompanying regulations. The public health system is divided into three levels – national, provincial and local. [3] Leadership at each level comprises political and administrative roles. Political appointments are made at the discretion of the President or the Premier at national or provincial levels respectively. [3] Appointees represent a party's political interests in the department and are not necessarily selected for their skill and health expertise. Administrative roles should be appointed based on merit and expertise and protected by labour laws. At the National Department of Health (NDOH), the Minister and Deputy Minister of Health are political appointments by the President. The Minister oversees the NDOH and has the constitutional responsibility for ensuring the provision of health care services. The Minister is responsible for strategy and goal setting for the country and determines the "what" and "why" of the country's health priorities. The Director General, on the other hand, fulfils an administrative and implementation role and determines how the strategy and goals will be achieved.

Confusion between political and administrative roles contributes significantly to systemic inefficiencies and critical failures in the public health care system. Although political and administrative roles have different functions, there is often overreach and overlap in their day-to-day activities. For example, in 2019, Limpopo Member of the Executive Council (MEC) Dr Phophi Ramathuba removed the entire hospital management at Tshilidzini hospital for "shocking mismanagement". [4] Similarly, former Gauteng MEC Qedani Mahlangu played an active role in implementing the decision to terminate the contract with Life Esidimeni which led to the loss of 144 lives.

Procurement, human resources and project implementation are the functions of the Head of the Health Department, not the MEC. Good governance requires that Premiers and MECs act within their mandates and be held accountable when they fail to do so. Political and administrative functions at each level of governance are laid out in legislation, and political and administrative leaders should familiarise themselves with their duties and make sincere efforts to fulfil them. However, prioritising political interests over good governance obligations allows this kind of overreach to persist, crippling the system.

Does the current NHI Bill guarantee good governance?

The NHI Bill is a critical part of the attainment of universal health coverage as it is the enabling legislation for the NHI in the same way the NHA is the enabling legislation for health in South Africa. Although government's attempt to achieve universal health coverage in South Africa is laudable, the provisions of the Bill raise serious concerns that must be addressed if NHI is to succeed.

Provisions in the NHI Bill relating to the governance structure of the NHI governing bodies do not reflect principles of good governance, specifically: independence, participation, transparency, universality, and a holistic approach to revolutionising an entire public health system. Generally, the main issues reflect in the centralised nature of the governance structure. The governance structure of the NHI will comprise the NHI Fund Board, Benefits Committee, Pricing Committee and the Stakeholder's Committee. The Minister will appoint the ad hoc committee that shortlists candidates for the Board, and then will appoint the Board members, the Board Chairperson, and the NHI Fund CEO, as well as the members of the advisory committees.

Essentially, the Minister is overly involved in and has massive decision-making power in the operations of the NHI Fund Board (the Board). Boards' serve a stewardship function where they oversee management and ensure an institution's affairs are conducted in a way that achieves the institution's objectives. [7] The Minister's power over the Board disrupts the Board's oversight and operational functions, and creates an imbalance in the Board as an accountability body.

These concerns may be remedied by adding measures to the NHI Bill to grant the Board independence from the Minister. The Bill only specifies the Minister's role in the appointments and removal of Board members and the CEO, and the committees. The current public health system shows the negative impacts of the overlap between administrative and political roles. The Board's independence is crucial to build public trust in the Board and the efficacy of the NHI. Specifying the principles for Board appointments and the composition of the ad hoc committee will contribute more transparency in the process for the appointments to the Board. Appointment of board members must be based on the principles of transparency and openness, public participation in the nomination process and publication of shortlisted candidates. The appointment criteria must specify that the Fund's Board has the right balance of knowledge, skills, and experience; and inculcate honesty, integrity and expertise as a requisite for the appointees.

Participation

For the NHI to successfully contribute to the effective provision of universal healthcare, it must allow for community and Civil Society Organisation (CSO) inclusion and participation. CSO participation is more than tick box representation exercise or participation in the legislative process. It requires a recognition of the value of the contributions from people that use the system to improve or maintain good governance. Participation is not just for the benefit of the participants, it benefits governance bodies and structures so that they are able to actually serve communities and meet their needs.

Currently, the NHA provides for community participation in the governance of primary care facilities through clinic committees. However, their regulation and functions depend on the MEC and therefore, clinic committees differ between provinces. "Only four provinces (Kwa-Zulu Natal, the Eastern Cape, the Western Cape and the Free State) have passed provincial legislation or have adopted policies on the regulation of these committees, but not all these documents deal with the powers and responsibilities of the structures." [5]

Consequently, clinic committees fail to fulfil their purpose and community issues in primary healthcare facilities are rarely addressed. Clinic committees show the impact of poor regulation for community participation in governance structures and the negative consequences. The NHI provides for the Stakeholders Advisory Committee, which is the only place for CSO and health service users, but it has no clear function and is not designated as an advisory committee of the Fund, in spite of its name. Real and meaningful participation of civil society and health service users is not, therefore, provided for, contrary to accepted practice around universal health coverage.

There is an opportunity to improve community participation under the NHI and adopt a participative governance approaches. Evidence shows that participatory governance has a positive impact on improving health systems working toward universal health coverage. [6] This form of participative governance allows for population participation in health policy-making and decision-making. [6, p.1] Thailand's National Health Assembly serves as a vehicle for participative governance. It brings together "government technocrats, policy-makers and politicians; civil society, communities, and the population; and academia, think tanks, and research institutions" on "critical policy issues to achieve progress and reform has benefited from incorporating stakeholders with various perspectives to foster mutual understanding among health stakeholders". [6, p.2]

The Stakeholder Advisory Committee provides an opportunity to improve and facilitate NHI's participatory governance. This committee has the potential to contribute invaluable evidence and expertise needed for the implementation of the NHI (including such evidence collected through the Ritshidze Project, described at the beginning of this submission, for example). [9, p.20]. In their submissions to Parliament on the NHI Bill, SECTION27 and TAC recommend that the Stakeholder Advisory Committee be recognized as an advisory committee to the fund and thus be able to advise the Benefits Advisory Committee on issues relating to availability and suitability of health care services; and the Health Care Benefits Pricing Committee on the affordability of health care services. [9, p.20]. The NHI Bill can strengthen the participatory governance by providing for community and civil society participation at the district level which is currently not provided for. But there are mechanisms provided for in the NHA which can be used to improve district level participatory governance in the era of the NHI. District Health Councils can be amended to require five health users as members.

How will funds be allocated under the NHI?

SA's current inequitable system epitomises the Inverse Care Law which states that "the availability of good medical care tends to vary inversely with the need for it in the population served". [10] The inverse care law is inappropriate for the South African context and is, together with financing the NHI, in greater detail in the second issue of Critical Health Perspectives. [11] This section outlines the movement of funds through the various government departments currently vs the NHI.

Most of the national health budget is distributed to provincial departments through transfers in the form of the provincial equitable share and conditional grants. Provincial departments are funded through transfers from National Treasury and each provinces' own revenue. The budget is allocated based on the size, needs and demographics of each province. Provinces then distribute the funding to the district level.

The management and allocation of these funds varies greatly. Provinces struggle with underspending their allocated budgets while failing to adequately meet service delivery needs. Underspending allocated budget spend leads to decreased budget allocation and contributes to a cycle of decreasing allocation for health funding. Persistent decreases in the budget allocation for health is worsened and perpetuated by National Treasury and government's austerity measures. Austerity measures cause reductions on social spending needed to fulfil socio-economic rights. [12] Therefore, sound financial management will be critical for successful implementation of NHI.

Under the NHI, the intention is that all health funding (including what is currently paid to medical schemes and as out of pocket expenditure) will be directed to the NHI Fund. In anticipation of NHI, some programmatic funding will be consolidated under NHI, as will some or all provincial equitable share funding. This consolidation has already begun. In the 2022 National Budget, mental health and oncology programmatic funding has been consolidated under the NHI. The transfer of the mental health services and oncology services component of the District Health Programmes Grant to the National Health Insurance Grant results in a R299 million increase in the NHI programme. The budget states that R2.1 billion of the direct NHI budget has been allocated to provinces for the combined contracting of primary healthcare doctors, mental health and oncology service providers. The budget review notes that mental health and oncology services "will not be standalone components, but will be part of the activities that are funded by the grant". [13]

However, this consolidation misses a step – government austerity and cuts in social protection. In 2022, cuts to health spending comprised the majority of 80% of budget cuts in the national budget. NHI funding will have to be part of a holistic solution toward financial reforms that move away from austerity. Government must recognise that social spending is an investment and budget for it accordingly. NHI funding will be more complicated than shifting spending from private to public healthcare, particularly considering new structures required for NHI, including over 300 Contracting Units for Primary Care and 52 District Health Management Offices. [9] Shifting insufficient health budget NHI will translate to insufficient funding and will require a review of government's current austerity approach. Experience shows that there is opportunity for looting and corruption within NHI, so the NHI Fun should incorporate transparency into its model and provide regular information on the fund to the public.

Conclusion

As a form of achieving universal health coverage through instituting a new public health funding model, NHI will not exist in a vacuum. The NHI will inherit a healthy system in need of reform and which provides lessons for strengthening NHI. The success of NHI will rely on strong good governance principles that provide for the independence of the Board, and health users, CSO and community participation. Systemic health reform is required for the NHI to be effective, particularly addressing and correcting issues with political and administrative overlap and addressing persistent budget cuts to health, that cannot easily be made up for. The NHI Bill must consider lessons from the current health system and good practice on universal health coverage. Addressing the shortcomings in the NHI Bill will directly affect heath care users and contribute to achieving equality in access to medical health care services.

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ABOUT THE PEOPLE'S HEALTH MOVEMENT

The People's Health Movement South Africa (PHM-SA) is the South African Chapter of the People's Health Movement, a global network of grassroots activists, civil society and academics, predominantly from low and middle income countries. PHM-SA was started in 2003 by a small group of health activists, and launched in 2007 with its Right to Health Campaign. The mission of PHM-SA is to improve the capacity of individuals and communities to realise their right to health and health care, and to advocate for a Primary Health Care (PHC) approach, as defined in the Declaration of Alma Ata. PHM uses the term PHC in its broad, developmental sense, affirming health as a social, economic and political issue and, above all, as a fundamental human right. Fulfilment of this right requires not only universal access to excellent, equitable health services, but also concerted intersectoral state action to address the social determinants of health.