

# ERSA Research Brief

April 2014

## **Lessons on governance for the move towards universal health coverage in South Africa<sup>1</sup>**

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Goudge's presentation emphasised that appropriate governance mechanisms are crucial for a successful transition to universal health coverage. She provided guidelines for using some of South Africa's existing health system capacity to improve governance.

This brief sums up the main points of her presentation, focusing on themes and insights that are most relevant to South African health policy. The objective is to encourage public discussion amongst practitioners, policy makers, academics and NGOs on the broad process of health system reform in South Africa.

### **1. The NHI reforms are about ensuring sufficient healthcare funding through a pre-payment mechanism and not about membership of an insurance scheme determining access to care**

It has been suggested that NHI is the South African version of UHC, but there is a difference between these two terms, and it is important to recognise that this difference matters. There are two broad pathways for rolling out UHC:

- a. Increasing coverage of membership-based insurance schemes (e.g. Nigeria and Kenya).
- b. Improving access to, and the quality of, publicly provided care, free at the point of use (e.g. Uganda).

The fact that the current reforms are called 'National Health Insurance' does not mean that South Africa has chosen pathway a). All current reform efforts in South Africa are focused on strengthening the provision of healthcare. Access to healthcare services will not be determined by insurance membership but rather, more fundamentally, by citizenship. 'Insurance', in the South African context, is currently being used to mean collective rather than individual pre-payment and citizenship rather than membership of an insurance scheme.

### **2. Sophisticated governance is required to achieve UHC**

UHC for South Africa is a long-term goal which is challenged by the fact that it is always a moving target. This is a result of, among other things:

- the complex and evolving nature of South Africa's 'quadruple burden of disease',
- the complex array of actors operating in different incentive environments, and
- the choices that have to be made between various costly, and constantly changing, interventions, technology and policy options.

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<sup>1</sup>On 6 February 2014 ERSA hosted a symposium in Stellenbosch on Critical Choices Regarding Universal Health Coverage. The symposium included a presentation by Jane Goudge from the Centre for Health Policy at the University of the Witwatersrand's School of Public Health on 'Governance for achieving universal health coverage in South Africa'. The full presentation may be found at: [www.econrsa.org/system/files/workshops/presentations/2014/governance\\_for\\_uhc\\_jane\\_goudge.pdf](http://www.econrsa.org/system/files/workshops/presentations/2014/governance_for_uhc_jane_goudge.pdf)

Because the health system requires constant evaluation and adjustment, it also needs sophisticated governance capacity. The various functions required for the initial establishment and longer-term development of governance capacity have been well-defined by the World Health Organization (WHO, 2014), as shown in the box below.

#### **UHC governance functions**

According to the WHO (2014), governance in the health sector refers to a wide range of steering and rule-making functions. These functions must be performed by governments and decision makers as they seek to achieve national health policy objectives conducive to UHC. Governance is a political process that involves balancing competing influences and demands, including the following:

- Intelligence and oversight: ‘ensuring the generation, analysis and use of intelligent health system performance’.
- System design: ‘ensuring a fit between strategy and structure’.
- Policy guidance: ‘defining goals, formulating sector strategies and technical policies’.
- Collaboration and coalition building: ‘influencing action on social determinants of health and ensuring joined up government’.
- Regulation: ‘designing regulation and incentives, and ensuring they are fairly enforced’.
- Accountability.

However, the move towards NHI in South Africa has thus far focused more on making changes to the health delivery system and less on evaluating these changes and the overall capacity to steer the system.

### **3. South Africa can build the required governance capacity by working with existing institutions but will also have to develop new institutions**

Established and new institutions in South Africa’s healthcare system could play important roles in the management and stewardship of UHC. Functions for optimal UHC must be delivered on three levels:

- data generation,
- knowledge management, and
- decision making.

The Office of Health Standards Compliance was established in 2014 as part of the initial NHI implementation, in a move to ensure the delivery of healthcare services that meet well-defined quality standards. The Office’s role will be to assess the quality of care and clinical governance (knowledge management level). Because it has access to information about the quality of services delivered and the need for quality improvement, it will set priorities and allocate resources (decision-making level). The Council for Medical Schemes has experience in regulating healthcare financing in South Africa and could continue to play a role in regulating various UHC actors (decision-making level). The proposed NHI purchasing fund will ultimately have to assess the cost effectiveness and feasibility of various health interventions and technologies and manage their provision (knowledge management) and also manage the accreditation and performance of providers (decision-making level).

South Africa has the institutions mentioned above that could perform important functions in delivering UHC. But some functions that are essential to delivering UHC are not yet actively addressed by the existing or planned institutional configuration. Examples of such functions are:

- On the data generation level: collecting and analysing survey data and performing vital registration and surveillance of diseases.
- On the knowledge management level: systematically assessing health system outcomes and relating these outcomes back to inputs.
- On the decision-making level: actively managing public opinion and engaging the public in the UHC process.

Tough decisions will have to be made about prioritising certain functions for effective implementation of UHC. Careful thought must be given to which institutional configurations best balance the benefits of institutional autonomy with closeness to government decision making. Strategies need to be considered to facilitate cross-institutional collaboration and to optimise the centralisation vs. decentralisation balance.

#### **4. Good governance through institution building was key to Thailand's success with UHC**

The table below illustrates how, as a result of good governance, Thailand has been able to achieve UHC at a considerably lower cost than South Africa's current spending on healthcare.

	Thailand	South Africa
<b>Per capita GDP</b>	9,280 USD	11,000 USD
<b>Total expenditure on health as % of GDP</b>	4%	8.5%
<b>Per capita expenditure on health</b>	152 USD	450 USD

Source: WHO statistics; all amounts in USD purchasing power parity (PPP)

The key to Thailand's success was building and developing its institutional capacity. It did this by establishing institutions that function as knowledge brokers and are therefore able to perform the necessary governance functions at the data-generation, knowledge-management and decision-making levels required by a UHC system. Examples of these institutions are:

- The Thai Health Promotion Foundation, financed through a 2% alcohol and tobacco tax.
- The Health Systems Research Institute (HSRI) established through a 1992 act. This is an autonomous agency at arm's length from the ministry. It is tasked with generating evidence in support of policy decisions.
- The 1998 International Health Policy Programme (IHPP), established to undertake policy research.
- The Health Insurance System Research Office (HISRO), established to monitor and evaluate the effects of reforms.
- The 2007 Health Intervention and Technology Adjustment Programme (HITAP), a publically funded non-profit organisation to assess interventions and new technologies.

Thailand's experience shows that evidence-based platforms matter and that, over the longer term, capacity to generate evidence and translate it into policy must be institutionalised. The South African system does not yet have this capacity to the degree required for effective UHC.

Besides ensuring that there are sufficient and relevant institutions to perform governance functions at every level of UHC, further steps must be taken to build a capable civil service. The National Planning Commission's 2011 report on a National Development Plan for South Africa makes some suggestions as to what these steps could be. One step, for example, could be to make the civil service a career of choice by developing and formalising graduate recruitment programmes and requiring that new appointees have sufficient and relevant experience for their positions, especially for senior positions. Another could be to develop technical and specialist professional skills through better planning and the provision of training programmes.

#### **5. Improving relationships between the three spheres of government – of particular importance for UHC governance in South Africa**

Health insurance reform is not just a technical process – it is also a political one. In a decentralised health system such as South Africa's, good central-local relations are essential. In South Africa the provinces are currently responsible for procuring and purchasing health inputs. It is planned that the NHI fund will take the form of a national purchasing agency. The key questions, then, are how the

provinces can best contribute to health service delivery and how constructive intergovernmental relationships can be created. The National Planning Commission argues for a more focused role for the provinces in the delivery areas of health, education and economic development, and support for weak local municipalities. How the NHI fund is ultimately configured and communicated will be crucial for managing these intergovernmental relations.

## **Conclusion**

The South African NHI / UHC fund will function as a 'pre-payment' system rather than insurance as a 'national scheme with members'. To effectively govern and steer the new health system, it will be necessary to build an institutional platform to generate evidence and translate that evidence into policy decisions. Central-local relations will be crucial in a decentralised health system and the current reforms are in the process of re-configuring these relations.

## **Selected references**

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