

# Achieving Good Governance and Management in the South African Health System



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The Academy of Science of South Africa (ASSAf) was inaugurated in May 1996. It was formed in response to the need for an Academy of Science consonant with the dawn of democracy in South Africa: activist in its mission of using science and scholarship for the benefit of society, with a mandate encompassing all scholarly disciplines that use an openminded and evidence-based approach to build knowledge. ASSAf thus adopted in its name the term 'science' in the singular as reflecting a common way of enquiring rather than an aggregation of different disciplines. Its Members are elected on the basis of a combination of two principal criteria, academic excellence and significant February contributions to society. The Parliament of South Africa passed the Academy of Science of South Africa Act (No 67 of 2001), which came into force on 15 May 2002. This made ASSAf the only academy of science in South Africa officially recognised by government and representing the country in the international community of science academies and elsewhere.

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TABLE OF CONTENT  
.....



<b>List of Figures</b> .....	<b>ii</b>
<b>List of Tables</b> .....	<b>ii</b>
<b>List of Appendices</b> .....	<b>ii</b>
<b>List of Acronyms</b> .....	<b>iii</b>
<b>Foreword</b> .....	<b>3</b>
<b>Acknowledgements</b> .....	<b>5</b>
<b>Executive Summary</b> .....	<b>7</b>
<b>Chapter 1: Introduction</b> .....	<b>13</b>
<b>ASSAf commissioning brief</b> .....	<b>13</b>
<b>The consensus study</b> .....	<b>13</b>
<b>Governance taxonomies and definitions</b> .....	<b>14</b>
<b>Study framework</b> .....	<b>15</b>
<b>Study approach and rationale</b> .....	<b>17</b>
<b>Organisation of the report</b> .....	<b>17</b>
<b>Chapter 2: Methods, Approach, and Frameworks</b> .....	<b>19</b>
<b>Panel</b> .....	<b>19</b>
<b>Panel meetings</b> .....	<b>20</b>
<b>Literature review</b> .....	<b>20</b>
<b>Consultative meetings with experts/key informants</b> .....	<b>21</b>
<b>Strategic purchasing and health sector governance reform</b> .....	<b>22</b>
<b>Analysis</b> .....	<b>22</b>
<b>Recommendations</b> .....	<b>23</b>
<b>Peer review</b> .....	<b>23</b>
<b>Dissemination</b> .....	<b>23</b>

<b>Chapter 3: Health Systems Governance in South Africa</b> .....	<b>27</b>
<b>Historical developments</b> .....	<b>27</b>
Trekking back to 1652.....	27
An early experiment in comprehensive primary health care .....	27
The apartheid era .....	28
The “rainbow” health system.....	29
Progress towards a National Health Insurance.....	34
<b>South African evidence on health systems governance</b> .....	<b>35</b>
South African Health Reforms 2015–2020 .....	35
South African Lancet Commission on a High-Quality Health System .....	36
Other relevant governance studies.....	36
Governance of the private healthcare sector .....	38
<b>Global evidence on health systems governance</b> .....	<b>40</b>
<b>Conclusion</b> .....	<b>42</b>
<b>Chapter 4: Governance Issues for National Health Insurance</b> .....	<b>43</b>
<b>Introduction</b> .....	<b>43</b>
Proposed reforms.....	43
<b>Strategic purchasing</b> .....	<b>45</b>
Global experience .....	45
Purchasing tools.....	46
Building purchasing systems .....	47
Progress and perspectives from Africa .....	48
<b>A potential lever for governance reform</b> .....	<b>50</b>
Private sector provision and regulation .....	52
Early examples of strategic purchasing.....	52
Factors underlying slow progress.....	52
Governance reforms required for strategic purchasing.....	54
<b>Governance of the NHI Fund</b> .....	<b>57</b>
Office of Health Standards Compliance .....	57
Governance issues to be resolved for NHI .....	57
<b>Conclusion</b> .....	<b>58</b>
<b>Chapter 5: Consultative Meetings</b> .....	<b>61</b>
<b>Introduction</b> .....	<b>61</b>
<b>Context</b> .....	<b>62</b>
Complexity and the South African health system.....	62
Public and private sectors .....	62
Intersectoral determinants of health .....	62
Concurrent responsibility and confusion of roles .....	63

<b>Strategic vision and policy design .....</b>	<b>64</b>
A coherent vision.....	64
A delegated, decentralised system .....	66
Support systems design .....	67
Regulatory and oversight bodies.....	67
<b>Participation and consensus orientation .....</b>	<b>69</b>
Public sector managers .....	69
Managerial skills .....	70
How managers manage.....	70
Engaging communities .....	73
<b>Accountability .....</b>	<b>74</b>
System level .....	74
National and provincial level.....	76
<b>Transparency .....</b>	<b>78</b>
<b>Addressing corruption.....</b>	<b>79</b>
<b>Conclusion .....</b>	<b>81</b>
<b>Chapter 6: Discussion .....</b>	<b>83</b>
<b>Strategic vision, policy and systems design.....</b>	<b>83</b>
Strategic vision.....	84
Policy and systems design .....	84
Decentralisation.....	85
Health information .....	85
Financing, strategic purchasing, and procurement .....	86
Organisational “software” .....	86
<b>Participation and consensus orientation .....</b>	<b>87</b>
Health leadership and management.....	87
Community voice .....	88
<b>Being accountable .....</b>	<b>89</b>
<b>Being transparent .....</b>	<b>90</b>
<b>Addressing corruption.....</b>	<b>91</b>
<b>Limitations.....</b>	<b>92</b>
<b>Chapter 7: Recommendations .....</b>	<b>93</b>
<b>Implementation .....</b>	<b>98</b>
<b>References .....</b>	<b>99</b>

## List of Figures

Figure 1: Mikkelson–Lopez framework for assessing health systems governance.....	15
Figure 2: Health Governance Framework adapted from World Bank .....	16
Figure 3: Public Health Sector governance arrangements in South Africa. ....	31
Figure 4: Health system design and governance of the private health sector .....	32
Figure 5: Proposed reimbursement structure for a NHI GP contracting model.....	51
Figure 6: HMI recommendations for supply and demand side regulation.....	53
Figure 7: Information from consultations, placed within a diagrammatic representation of the Mikkelson-Lopez, et al framework. ....	61

## List of Tables

Table 1: Members of the Consensus Study Panel and ASSAf Secretariate.....	19
Table 2: Overview of Consensus Study Methods and Activities .....	24
Table 3: Profiles of key Informants/experts who participated in consultative meetings .....	24
Table 4: Profile of key informants/experts invited to consultative meetings who did not respond.....	25
Table 5: Key governance policies, programmes and investigations between 1994 and 2020 which sought to transform the health system.....	29
Table 6: Summary of strategic purchasing status in Africa .....	48

## List of Appendices

Appendix 1: Biographies of Panel Members.....	109
Appendix 2: Schedule of Panel Meetings.....	112

## List of Acronyms

AG	Auditor-General
APC	Academic Programme Committee
APL	Approved Post List Budget Tool
ANC	African National Congress
ASSAf	Academy of Science for South Africa
AUGE	Acceso Universal con Garantías Explícitas
ARVs	Antiretrovirals
BHMS	Behaviour and Health Management Sciences
BMI	Budget Management Instrument
CARTA	Consortium for Advanced Research Training in Africa
CCMDD	Centralised Chronic Medicine Dispensing and Distribution system
CEO	Chief Executive Officer
CHW's	Community Health Workers
CMS	Council for Medical Schemes
CMSA	Colleges of Medicine South Africa
COPC	Community Oriented Primary Care
COVID-19	Coronavirus disease
CTOP	Choice on Termination of Pregnancy
CUP	Contracting Units for Primary Care
DBSA	Development Bank of South Africa
DHMOs	District Health Management Offices
DHS	District Health System
DPSA	Department of Public Service and Administration
DRC	Democratic Republic of Congo
DRG	Diagnosis-Related Groups
EHIF	Estonia's Health Insurance Fund
EMS	Emergency Medical Services
ESL	Essential Supply List
EVDS	Electronic Vaccination Data System
FCPHM	Fellowship of the College of Public Health Medicine
FMHS	Faculty of Medicine and Health Sciences
GDP	Gross Domestic Product
GEAR	Growth, Employment, and Redistribution
GPs	General Practitioners
HIV	Human Immunodeficiency Virus
HMI	Health Market Inquiry
HPCSA	Health Professions Council of South Africa
HR	Human Resources
HRH	Human Resources for Health
HSACF	Health Sector Anti-Corruption Forum
HST	Health Systems Trust
ICN	International Council of Nursing
ICT	Information and Communications Technology
LMICs	Low- and Middle-Income Countries
LSE	London School of Economics
LSHTM	London School of Hygiene and Tropical Medicine



MCOs	Managed Care Organisations
MECs	Members of the Executive Committees
MENA	Middle East and North Africa
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
NCOP	National Council for Provinces
NDoH	National Department of Health
NDP	National Development Plan
NEA	Nursing Education Association
NHA	National Health Act
NHI	National Health Insurance
NHISSA	National Health Information System of South Africa
NHLS	National Health Laboratory Services
NHS	National Health Service
NHSC	National Health Services Commission
NSDA	Negotiated Service Delivery Agreement
OHSC	Office of Health Standards Compliance
OOP	Out-Of-Pocket
OSD	Occupational Specific Dispensation
PFMA	Public Finance Management Act
PHC	Primary Health Care
PMBs	Prescribed Minimum Benefits
PSA	Public Service Act
RUNURSA	Rural Nursing South Africa
RWOPS	Remunerative Work Outside of the Public Service
SA	South Africa
SACMC	South African Cuban Medical Collaboration
SAHPRA	South African Health Products Regulatory Authority
SANAC	South African National AIDS Council
SANC	South African Nursing Council
SDG	Sustainable Development Goals
SHSPH	School of Health Systems and Public Health
SIU	Special Investigating Unit
SPARC	Strategic Purchasing Africa Resource Centre
STTI	Sigma Teta Tua International Honor Nursing Society
SU	Stellenbosch University
TAC	Treatment Action Campaign
TB	Tuberculosis
UC	Universal Coverage
UCT	University of Cape Town
UHC	Universal Health Coverage
UK	United Kingdom
UMIC	Upper Middle-Income Countries
WBOTS	Ward Based Outreach Teams
WCDoH	Western Cape Department of Health
WHO	World Health Organisation
WOSA	Whole of Society Approach

## Foreword

ASSAf recognises the societal mandate to contribute evidence-based solutions to national and global priority challenges. Through rigorous consensus studies, we strive to achieve science-to-policy advice to government, to support decision making in the formulation and implementation of policies.

In September 2020, ASSAf appointed a voluntary seven-member consensus study panel, comprising expert practitioners from various disciplines within South African public health and health systems, to comprehensively examine the pillars which support Achieving Good Governance and Management in the South African Health System.

This report encapsulates the culmination of the panel's work, offering a detailed study of governance challenges within the South African health system. The examined parameters ranged from strategic vision, policy design, transparency, inclusive participation, accountability, to combating corruption; the findings underscore the multifaceted nature of governance deficiencies and their profound implications.

While acknowledging some positive examples of effective governance, the study emphasises widespread systemic issues, including leadership instability, inadequate delegation of authority, and deficiencies in accountability mechanisms. It also highlights the critical need for transparency, ethical leadership, and systemic reforms to address these challenges effectively.

The panel's recommendations provide a roadmap for transformative change. From defining clear public value mandates, to strengthening participatory governance mechanisms, the recommendations are designed to address the root causes of governance failures and to pave the way for a more equitable and efficient health system.

Implementing these recommendations will undoubtedly be challenging, but the critical importance of taking action cannot be overstated. The cost of inaction would be far greater, jeopardising the realisation of universal health coverage and the constitutional commitment to health care access and equality for all South Africans – the overall requirements to advance progress on Sustainable Development Goals 3 and 10 (Good health and well-being, Reduced Inequalities).

As we navigate the journey to strengthen governance and leadership within the health system, it is imperative that all stakeholders recognise their critical role in driving positive change. Together, we can realise the vision of health for all, and ensure that quality universal health coverage becomes a reality for every citizen of our country.

I extend my appreciation to each panel member who contributed to this study, and I commend their dedication to advancing the health and well-being of our nation.

**Professor Stephanie Burton**

**Acting President: Academy of Science of South Africa**



## Acknowledgements

This consensus study report is the result of the collaborative work of several people who are acknowledged as follows:

The members of the panel: Emeritus A/Professor Lilian Dudley, panel chairperson, Stellenbosch University (SU); Professor Flavia Senkubuge, University of Pretoria (UP); Professor Sharon Fonn, University of the Witwatersrand (Wits); Professor Leslie London, University of Cape Town (UCT); Dr Mark Blecher, National Treasury; Dr Guinevere Lourens, Stellenbosch University (SU); A/ Professor Catherine Mathews, South African Medical Research Council (SAMRC). These members volunteered their time and expertise for this study and are acknowledged.

The panel would also like to thank Professor Marina Clarke for her contributions to the analysis of the interview data that formed the foundation of the study report.

As part of the information-gathering process, consultative meetings/interviews were held with various stakeholders. All interviewees are acknowledged.

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**Professor Lilian Dudley**  
**Panel Chairperson**



## Executive Summary

The Academy of Science for South Africa (ASSAf) commissioned a consensus study on achieving good governance and management in the South African health system. ASSAf holds a mandate within South Africa to generate evidence-based solutions to national and global challenges and consensus studies provide evidence-based advice to government and other stakeholders to support policy development and practice. A seven-member consensus Panel was drawn from a multidisciplinary group of South African public health and health systems researchers, academics and practitioners. The Panel contributed their time and expertise on a voluntary basis over a three-year period, from September 2020, with the overall brief to:

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

The Panel explored relevant conceptual frameworks to guide the investigation, identified experts to serve as key informants, and invited them to individual consultative meetings. The key informants were chosen purposively from across different sectors including the State, Service Providers, and Citizens/Clients. Key informants included senior health managers who had extensive experience in public sector governance at national and provincial levels, academics, and key actors representing civil society, health worker unions, non-governmental organisations, and patient advocate groups. Information was supplemented by a review of relevant peer-reviewed literature on governance in South Africa and globally.

The Panel was guided by the five key principles of governance identified in the conceptual framework by Mikkelson-Lopez et al (1): strategic vision and policy design; transparency; participation and consensus orientation; accountability; and addressing corruption. The National Health Insurance (NHI) Bill was under debate during the review period and passing through various parliamentary processes. Underpinning the formulation of the NHI is the concept of strategic purchasing, and, for that reason, the Panel took special interest in this area.

This report describes the historical context of health governance in South Africa and provides a summary of the international and local literature (Chapter 3); a detailed reflection on strategic purchasing and financing in the context of the NHI (Chapter 4); and current experience of health governance in South Africa mapped to the Mikkelson-Lopez et al framework (Chapter 5); as key inputs to a discussion to define the issues and what should be done to enhance good governance in the South African health system (Chapter 6). The report closes with a set of recommendations that the Panel believe to be both implementable and essential if South Africa is to realise the Constitutional promise of the right to access health care and equality (Chapter 7). Several points and arguments recur in different chapters for the benefit of readers who want to focus on individual chapters or specific aspects of the Report.

Despite some important positive examples of good health system governance in South Africa, the Panel's analysis of the overall picture suggests widespread problems in governance arrangements. Multiple indicators of dysfunction – including the many managers in acting positions, frequent changes in senior leadership (for example, the Gauteng DOH has had ten accounting officers in a decade), worse health outcomes than similarly resourced countries, and overall deterioration of morale and trust in the public health system – confirm that much needs to be done to improve governance of the South African health system.

We acknowledge that across the health system there are examples of good service and health workers committed to their jobs and to providing good, even excellent care. These 'pockets of excellence' can be found across the country and at all levels in the health system. Nonetheless, there are also system-wide failures. It is because of the evidence of pockets of excellence that we are able to make recommendations about how to improve the South African health system.

Nonetheless, the findings underline that poor governance results from many factors interrelating within a complex health system still influenced by its historical context.

**Strategic vision:** A clear vision and mission which focuses on public value is essential for good governance. The Panel found that the National Department of Health (NDoH) and provincial departments of health did not share a guiding vision or common understanding of a public value mandate, nor did they build commitment or inspire people to deliver on such a vision.

**Policy design:** The design of the system – particularly the inadequate delegation of authority to district, sub-district, and hospital levels – means that governance is not a distributed function. Managers at these levels either lack the authority to act or do not exercise the authority they have. The NDoH has neither assumed its role of stewarding the entire system, both public and private, nor created the necessary environment and systems to ensure good governance. Oversight bodies have not been designed to insulate them from vested interests, particularly political influence. Many of the existing systems in the public sector are no longer fit for purpose. Aspects of current procurement, financial, and information systems in the public sector inhibit modern management and require reform. Merit is often not the primary guiding principle for managerial appointments. In many cases, the criteria and process of appointments are not transparent and open to public scrutiny. Political interference is described as a major challenge. Together, these issues contribute to incompetence of and instability in leadership at the higher levels which impacts every level in the health service and undermines its public value mandate.

**Participation and consensus orientation:** Top-down management and a “command and control” approach to leadership are described as widely prevalent. This limits the ability of managers at many levels to participate in decision making or engage with communities and other stakeholders. Current policy and guidelines on operationalising community participation are inadequate, with inconsistencies in the arrangements to facilitate community voice in the health system. The ability and capacity of structures such as clinic committees and hospital boards to influence decisions is extremely limited and they are seldom involved in holding health services accountable on public service goals.

**Being accountable:** Structures to ensure accountability exist within the health system but their functioning is sub-optimal because they are not designed to be insulated from political and other vested interests. For example, parliamentary portfolio committees should oversee the executive but are dominated by the political party that appoints them and the executive, and thus are unlikely to make findings that are contrary to the interests of their political party. Findings of the Auditor General and the Office of Health Standards Compliance are not used sufficiently to improve accountability and performance. Health information systems do not produce data to enable the measurement of health outcomes and system function and, as a result, people in the health service are not held accountable to those outcomes.

**Being transparent:** The general lack of transparency in the appointment process of civil servants and political interference and/or cadre deployment have harmful consequences to the ability of the health system to meet citizens' needs. Limited transparency of health data makes it impossible to contract service providers based on good health outcomes.

**Addressing corruption:** Informants perceived that corrupt people may be given positions where they can redirect or manipulate procurement for private or third-party benefit, at the expense of the health services' mandate to provide care for patients and populations. This can be the result of cadre deployment or infiltration by corrupt elements. There is an absence of clear, visible, and swift action to charge and penalise corruption when detected, and inadequate protection for whistle-blowers.

The Panel's recommendations summarised below (and described in detail in chapter 7) address the key governance elements of strategic vision and policy design, participation and consensus, accountability, transparency and protection against corruption. These interrelated recommendations are, in the Panel's view, implementable and achievable with commitment of policy actors.

**Define and communicate a clear public value vision and mission with the mandate for each level of the health service and governance actor.**

To fulfil its stewardship role, the NDoH needs to engage all actors in the public value vision and mission of the health system, communicate the goals of improving health outcomes throughout the health system including both the public and private sectors, and ensure that statutory and regulatory bodies are aligned to support the public value mission.

**Update legislation and governance structures to insulate them from vested interests and confer executive rather than advisory functions.**

It is essential to ensure that governance structures and oversight bodies are insulated from political and other vested interests. Measures to achieve this include amending conflicting legislation; ensuring an array of accountability arrangements; providing oversight structures with effective decision-making powers; and restructuring the nomination, appointment, and removal of members of oversight structures to reduce opportunities for capture of such structures.



**Delegate authority appropriately to each level and within levels.**

Actors at each level must have the necessary authority to carry out and take responsibility for their work in meeting the public value mission of universal health coverage and improving health outcomes. Properly resourced oversight bodies, insulated from vested interests, need to provide measures of performance for delegated functions.

**Get the right people – ethical individuals with appropriate competencies – into the various leadership and management positions of the health service.**

To professionalise the civil service, appointment criteria and processes must be transparent, open to public scrutiny, merit based, demonstrating competencies appropriate to the post. Where job incumbents are wrongly placed, posts should be restructured within the prescripts of existing labour laws and staff invited to upskill and /or reapply for their positions.

**Surround managers and leaders with functional fit-for-purpose systems (such as human resources, procurement, health information) so that they can do their work.**

Strategic purchasing should be introduced incrementally and immediately, with health technology assessments to guide decisions about purchasing health interventions. Facility managers need greater delegated powers to order supplies off transversal tenders. An integrated electronic national health information system needs to be established so that patient-linked data is available to provide measures of service quality, including patient outcomes, and to support decisions at each level, whilst maintaining protection of the privacy of patient information.

**Support managers at every level so that they have the resources, understanding and ability to build teams and attend to the relationships that make complex systems work, focusing on both the people within the health system (providers) as well those whom the health system serves.**

More attention needs to be paid to the 'software' (relationships, social networks, and collaborations) of the health system. Health system managers need to implement and monitor interventions to build teams and strengthen relationships and trust with and between staff. They should build learning organisations which allow for innovation, reflection and creative problem solving with co-creation of workable solutions.

**Harness the potential of community participation in an authentic manner to ensure health services are appropriate, respectful and responsive and use the capacity of communities to monitor health service outcomes and processes.**

Governance arrangements need to accommodate spaces for organised civil society to contribute to policy, decision making, and performance monitoring. This requires the review and revision of policy and legislative frameworks to ensure meaningful participation of civil society in a uniform approach across the country and within all levels of the health system. Participation by and accountability to the community is a fundamental tenet of the Constitution for which the health system needs to make adequate provision.

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

A package of interventions needs to be implemented to prevent fraud and corruption, and to rapidly detect and decisively deal with them when they occur, along with adequate protection and legal support for whistle-blowers. Action against corruption requires not only intervention

within the health system but also improved functioning of South Africa's investigative and related authorities.

### Implementing these recommendations

The Panel sees these recommendations as reflecting our commitment to strengthening governance and leadership of the current health system in order to restore the vision of health for all as a common goal for the health sector to move closer toward achieving quality Universal Health Coverage (UHC). The passage in 2023 of the NHI Bill through the National Council of Provinces underlines the significant risks of implementing a system of National Health Insurance (NHI) within the current context of weak governance of both the private and public sectors.

The Panel acknowledges that these recommendations will require concerted action by key stakeholders, but we emphasise the high cost of not addressing them. Failure to implement these recommendations will render UHC even more unlikely, with quality health care becoming available to only a minority of South Africans. Many of these recommendations are interrelated; action in one area will reinforce changes in other areas.

The art is to skilfully find the right balance in governance between an enabling central system and strengthened, decentralised health structures, configured to use NHI funds (well managed and independent of vested political or other interests) to achieve quality UHC.

These outcomes require greater recognition of the essential value of health districts and health facilities and of their critical role in a distributed governance model. Accordingly, they should be given appropriate status and authority. Bottom-up participatory approaches to governance need to be strengthened to balance and complement the current authoritarian top-down model of governance and to improve transparency and accountability at all levels.

Proposals to further centralise governance as part of the NHI hold considerable risk given the major shifts being proposed across the spheres of government, capacity limitations and the difficulties of establishing multiple semi-independent districts and institutions. Shifting many health service functions to the national level in order to establish the NHI fund could be problematic. This shift will need careful attention and may need to be reviewed over time, particularly with proposed decentralised reforms not being appropriately implemented leaving provinces with responsibilities for delivery whilst budget is held centrally. Although it is envisaged that some of these will be delegated back, history suggests that once functions are centrally assigned, they are not easily relinquished. Lack of trust in the management of the NHI fund can be rectified by establishing it as an independent entity with appropriate oversight bodies constituted to insulate it from vested interests. The NHI needs to review and clarify roles and responsibilities of various players with respect to the NHI funds.

Creating a system that understands governance as a distributed function will make implementing change easier. There exist in the health system skilled people who are able and willing to work hard and ethically. They need to be given the space to do so, so that existing successful examples of distributed governance can be reinforced and replicated across the system.

As governance is a task that demands personal responsibility, each person has to ask themselves, "If not me, then who? And if not now, then when?" The research behind this report has shown that there are people in the South African health system, in its broadest definition, who will stand up and say, "Me, and now!"



## Chapter 1: Introduction

### ASSAf commissioning brief

The Academy of Science of South Africa (ASSAf) commissioned a consensus study on achieving good governance and management in the South African health system. ASSAf holds a mandate within South Africa to generate evidence-based solutions to national and global challenges. ASSAf uses consensus studies to provide evidence-based advice to government on a range of topics to support policy development.

In the commissioning brief for the consensus study, ASSAf noted that South Africa has technically sound health policies and relatively high per capita health expenditure compared to other low- and middle-income countries (LMICs), and yet exhibits poor implementation, poor health service provision, and, in general, poor outcomes (2,3). This compromises the country's attempts to reach the Sustainable Development Goals, particularly Goal 3, Good Health and Well-being, by 2030.

The ASSAf commissioning brief identified the current challenges in South Africa as a failure of leadership and governance of the health system (4), corruption, lack of accountability, discordance between central and provincial government, mismanagement and poor management, and poor planning and decision-making especially on resource allocation.

The commissioning brief noted the urgent need to review the challenges of governance and leadership in the health system, delineate shortcomings, and ascertain how these can be addressed by identifying best practices in South Africa and other countries, particularly those with recently established national health insurance systems. South Africa's transition to a National Health Insurance (NHI) system provides an opportune moment to consider governance options for improved accountability. In the brief, ASSAf spotlighted the inadequate understanding of good governance, leadership, and management within the health system, particularly with multiple levels involved in decisions on policy and resource allocation. The limited information regarding the contribution of governance or lack thereof to the substantial health system challenges in South Africa, forms the basis for the need of this initiative.

The Academy therefore requested the Panel to:

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

### The consensus study

A consensus study request can be initiated by various entities such as a Standing Committee, the ASSAf Council, an ASSAf Member, a Programme Officer (PO), the Executive Officer, or an external funder/external partner. Once the need is identified, the initiator prepares a proposal and submits it to ASSAf. The proposal should include essential elements, such as a succinct description of the proposed study topic, the rationale for addressing it, and why the Academy is best suited for the task rather than another organisation. Additionally, the proposal should outline significant background factors, highlight previous efforts and their outcomes, present international comparisons and studies conducted outside South Africa, and articulate the anticipated outputs, outcomes, and impacts of the proposed study. Information about existing resources or those accessible to the Academy should also be included.

The proposal needs to list authoritative scholars and experts in the study topic (including but not limited to ASSAf members) who could contribute as panellists or peer reviewers. The ASSAf Council reviews the biographies of proposed panellists as the basis for approval. To ensure a diverse perspective, Panel experts should be representative in terms of gender, race, and geographic location.

This comprehensive approach ensures that the consensus study proposal is well-founded, supported by relevant expertise, and aligned with the Academy's mission and capabilities.

ASSAf commissioned this consensus study in order to contribute to planning and decision making to improve governance of the health system in South Africa. The Academy appointed a seven-member consensus Panel drawn from a multidisciplinary group of South African public health and health systems researchers, academics, and practitioners who contributed their time and expertise on a voluntary basis over a three-year period. The report was generated by the Panel through active engagement with key stakeholders and decision makers throughout the health system; through reviewing the available evidence on governance of the health system in South Africa and elsewhere; and through deliberations among Panel members. The Panel aimed to be independent, to reach unbiased conclusions, and to achieve consensus on recommendations through deliberation.

## Governance taxonomies and definitions

While governance is a concept that almost all actors in the health system recognise as important, it is not always a concept for which people necessarily share a common understanding. We start by exploring what is understood by governance in order to reach a common framing to serve this study.

The term "governance" originates from the Greek word "kubernaein" and the Latin verb "gubernare" which both mean "to steer". It is this role of 'steering' that the panel felt was central to all definitions of governance. While the study of governance has long been central to the disciplines of political science and development studies, it has only recently emerged as a focus on health systems governance, along with a range of definitions. The concept of health governance was introduced by the World Health Organization (WHO) in 2000 as "stewardship", focusing largely on the vertical leadership and oversight of the health system by the state to provide "effective trusteeship of national health" to achieve the goals of improving population health, responsiveness, and financial risk protection (5). WHO broadly describes good leadership and governance as including elements of accountability, effective oversight, appropriate regulation, and policy frameworks (6).

The concept of governance has evolved since 2000 to respond to more complex and increasingly decentralised health systems with multiple actors and levels of authority and accountability (7). Herrera and colleagues have provided a valuable inventory of the range of definitions of governance and stewardship and how these two concepts have been distinguished (8). Van Olmen described governance as 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 (9). Van Olmen further defines governance of the health system as the mortar holding all the health system building blocks together (9) and it is this definition of governance that was adopted for the consensus study.

To shift from a top down to inclusive policy, planning, and implementation processes, increasingly adopting a "people centred approach" requires governance arrangements which rely more on inclusion, participation, and co-production (10). The outcomes of good governance are the achievement of health systems goals of effectiveness, efficiency, equity, responsiveness, and fairness, ensuring better health outcomes and social protection for individuals and populations (9,11).

In clarifying the scope of governance, "governance **of** health" generally refers to formal health care delivery systems as opposed to "governance **for** health" which takes a whole-systems approach

including governance of intersectoral components that address the social determinants of health and usually involve policy actors outside the health sector. The ASSAf brief focused on “governance of health”, but also recognised the importance of governance of the whole system. This report, focused on governance **of** health but including health system actor responsibilities for engaging actors responsible for population health (i.e. the stewardship / steering function), is regarded as a vital first step towards improved governance for health. As per the brief, the report focussed largely on governance, but also explored the role of leadership and management as they relate to governance.

## Study framework

Aware of the extensive literature on approaches to governance, leadership and management, the Panel reviewed frameworks of relevance to the ASSAf brief and the South African context that would assist in organising and translating the evidence into practicable recommendations. Of the frameworks they reviewed on the governance of health systems (1,10,12,13), the Panel chose the Mikkelson–Lopez 2011 framework to guide their work (1). The authors of the Mikkelson-Lopez (1) framework describe it as “a practical approach which we believe will facilitate a more comprehensive assessment of governance in health systems leading to the development of governance interventions to strengthen system performance and improve health as a basic human right.” This fitted well with the aim of ASSAf in commissioning this consensus study, which was to suggest how any challenges with governance may be addressed.

What is particularly useful about the Mikkelson-Lopez framework is that it locates governance as a meta layer above the WHO building blocks (financing, human resources (HR), information, medicines and technology, service delivery) and underlines the necessity for governance of all the WHO building blocks. (See Figure 1). The framework further breaks governance into various components called elements, which reflect key principles of governance.

Five key principles of governance can be assessed across the WHO health systems building blocks and at different levels of the health system (community, facility, district, national):

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

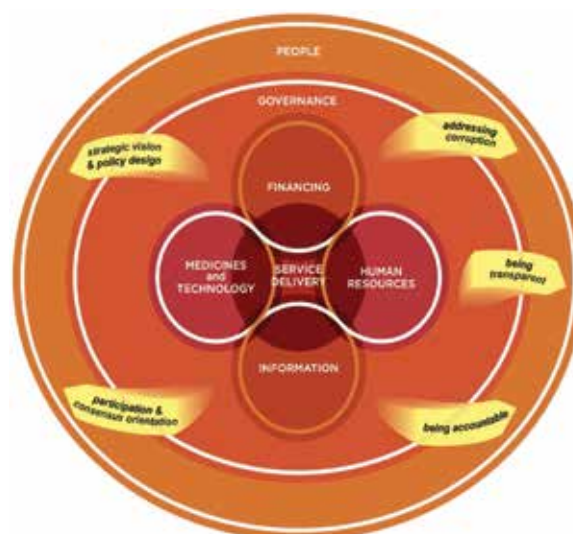


Figure 1: Mikkelson–Lopez framework for assessing health systems governance (reproduced from source) (1).

The Panel takes the view, as did Mikkelson-Lopez et al, (1) that “Governance also incorporates management which is concerned with implementing policies and decisions”. The Van Olmen (9) definition of governance, adopted for this consensus study, also aligned well to the Mikkelson-Lopez et al. framework.

The panel also used the people-centred framework proposed by Brinkerhoff and Bossert, involving the “principal-agent” theory of health systems governance, 2014 (13), to provide a complementary understanding of the relationships between various important players in health systems governance. This framework draws on earlier World Bank frameworks for service delivery and focuses on the roles and relationships between three main groups of governance actors, the state, service providers and clients/citizens (Figure 2) (13). This approach shifted the focus from WHO's earlier emphasis on governance functions to the importance of the exercise of power between actors as a key component of governance. Bigdeli (2020) (10) expanded on this governance triangle framework by emphasising the nature of relationships within each of the three groups of actors and the stewardship of these, for example, within the ‘providers’ group, the roles and relationships between formal service providers in the public and private sectors, health profession organisations, health worker unions, and training institutions for health professionals (10). This framework has been applied at different levels in several countries, including in explorations of local governance of primary health care (PHC) services in South Africa (14–16).

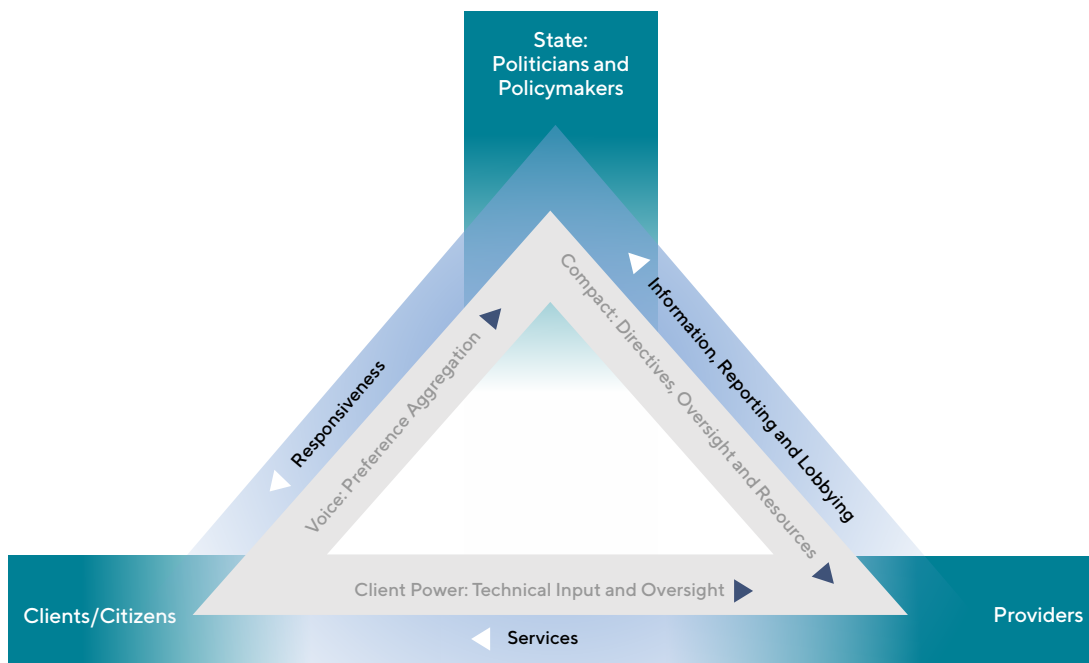


Figure 2: Health Governance Framework (13) adapted from World Bank (reproduced from source) (17,18)).

## Study approach and rationale

These two frameworks, one focusing on the key principles of governance and the other on the actors and their roles and relationships, have guided the approach as the Panel sought to unravel the complexity of governance of the South African health system and identify the key challenges and potential solutions.

This consensus document does not seek to contribute to theoretical academic discussion, and therefore does not offer a comparative analysis of either definitions or frameworks. Rather, the Panel have applied definitions and frameworks which aligned with and could inform the review of health systems governance within the South African context.

## Organisation of the report

This chapter sets out the context, the commissioning brief, the conceptual framework and key definitions. Thereafter, Chapter 2 explains the overall approach, sketching broadly what categories the informants were drawn from and what literature was consulted. Chapter 3 gives a short overview of the historical antecedents in policy and practice that have brought the South African health system to its current challenges. Chapter 3 additionally examines international literature on health systems governance. Then, given the enormously important changes facing the South African health system with the introduction of National Health Insurance (NHI), Chapter 4 examines the governance system needed for strategic purchasing in the health system. This is likely to be a critical vulnerability under a future NHI if not carefully addressed in the planning and implementation phases. Chapter 5 presents and analyses the results of consultations with key governance "actors" from a variety of backgrounds and perspectives, including senior management both within and outside the health services, civil society, labour, and academia. The report pins their views and understandings of what ails South Africa's health governance to the framework proposed by Mikkelsen-Lopez et al (1), so as to identify implementable responses to address these shortcomings. Chapter 6 presents a critical overview of the key challenges and the strategy options available to redress, remedy, or avoid pitfalls. Chapter 7 highlights the critical importance of addressing the governance issues identified in this report by making a set of recommendations that the panel believe are feasible and achievable to start a path towards improved governance in the health sector.





## Chapter 2: Methods, Approach, and Frameworks

### Panel

A Panel of experts, guided by a chairperson, undertook this consensus study. The ASSAf Council approved the study proposal on 12 February 2019. Once constituted, the Panel held its first meeting on 3 September 2020. The Panel was supported by the ASSAf secretariat.

Table 1 lists the members of the Panel and the ASSAf secretariat, together with information about Panel members' key areas of expertise related to the study topic. Panel members' biographies are included in Appendix 1.

**Table 1:** Members of the Consensus Study Panel and ASSAf Secretariat

Name	Gender Key Area of Expertise	Affiliation
<b>Panel Members</b>		
Emeritus Assoc Professor Lilian Dudley (Panel chair)	Female Health systems research, health systems strengthening, leadership and management, communicable disease control.	Department of Global Health, Stellenbosch University
Professor Flavia Senkubuge	Female Acting Deputy Vice Chancellor Student Life and Deputy Dean Stakeholder Relations; Expertise in health policy and management, tobacco control, global health, health systems and leadership in health	Faculty of Health Sciences, University of Pretoria
Professor Sharon Fonn	Female Policy development and implementation; health systems research; gender and rights; women's health; research methods training; research capacity development, curriculum development, national and international multi-country studies	University of the Witwatersrand, Johannesburg University of Gothenburg, Sweden
Professor Leslie London	Male Chair of Public Health Medicine; Expertise in public health policy, human rights in health systems, public participation	University of Cape Town
Dr Mark Blecher	Male Chief Director Health and Social Development Expertise in health financing	National Treasury
Dr Guinevere Lourens	Female National Nursing Manager Expertise in public and private healthcare and quality management	Evergreen Health Ukwanda Centre for Rural Health, University of Stellenbosch
Dr Catherine Mathews	Female Chief Specialist Scientist, Health Systems Research Unit Expertise in health systems for sexual and reproductive health	South African Medical Research Council

Name	Gender Key Area of Expertise	Affiliation
<b>ASSAf Secretariat</b>		
Dr Khutso Phalane-Legoale	Female Programme Officer: Health and Related Sciences	Academy of Science of South Africa
Professor Himla Soodyall	Female Executive Officer	Academy of Science of South Africa
Dr Melusi Thwala	Male Manager: Science Advisory and Strategic Partnerships	Academy of Science of South Africa

The Panel reviewed existing evidence and conducted key/expert informant consultative meetings with a range of governance actors. An overview of methods and activities and their purpose, location, and duration are presented below and in Table 2.

### Panel meetings

The Panel convened regular meetings to deliberate on and define the study parameters, approach, methods, findings, and conclusions, and to propose implementable recommendations. Appendix 2 outlines the schedule of Panel meetings.

### Literature review

Panel members, guided by the ASSAf questions for the consensus study, conducted reviews of the literature to clarify the terminology, to explore relevant conceptual frameworks to guide the investigation, to describe the state of governance in the South African health system, and to review evidence of the effects of strategies, interventions, and practices to improve health systems governance and management.

Panel members reviewed definitions and terminology used for governance and stewardship in key sources (7,8). They searched for literature describing the theoretical frameworks used to conceptualise governance in health systems, to guide the selection of relevant conceptual frameworks for this study. Chapter 1 describes the definitions and frameworks the Panel selected.

In order to meet the objectives of the consensus study, panel members reviewed both published and grey literature. Identification of published and unpublished reports and documents was accomplished through Panel members sharing their own sources, searching PubMed and other scientific search engines, asking key informants to identify key published and unpublished works, reviewing websites, and hand-searching appropriate selected references listed in various source documents.

## Consultative meetings with experts/key informants

The Panel identified key informants/experts, each to be invited to an individual consultative meeting. Guided by the principal-agent theoretical framework of governance (13), the key informants were chosen from different sectors, being the State, Service Providers and "Citizens/Clients". The Panel sought to include senior health managers who had experience in public sector governance at national and provincial levels (including several provinces), academics from different sectors, and key actors representing civil society, health worker unions, non-governmental organisations, and patient advocate groups. They included expert informants from outside the health sector, including from Treasury and the public service, as relevant to the governance of the NHI. Table 3 lists key informants who accepted invitations to consultations, while Table 4 lists those who were invited, but did not respond.

The purpose of the meetings were, drawing on their diverse experience; to obtain the experts' views on the key challenges of good governance in the health system; to identify evidence of best practices and effective strategies; and to gain expert input on the following five key governance principles according to the Mikkelson-Lopez conceptual framework: strategic vision and policy design; transparency; participation and consensus orientation; accountability; and addressing corruption. Broad topics for the meetings were decided in advance. A Panel member made the initial contact with the key informant to obtain their agreement to participate in a consultative meeting. Subsequently, the ASSAf secretariat followed up and sent an email invitation which included the purpose of the ASSAf consensus study and the questions the Panel would like the key informant to focus on. If the key informant did not initially respond to the invitation, at least three follow-up attempts were made.

Given that the consultative study took place during the COVID-19 pandemic, the Panel did not conduct face-to-face meetings but, rather, used the Zoom video conference platform. Scheduled for one hour, each meeting began with one or two broad, open-ended questions tailored to the informant's area of expertise. The Panel asked follow-up questions, which varied by respondent and by their responses to the opening questions. Where relevant, the Panel sent further questions by email. All consultative meetings were audio-recorded with the permission of the key informant and transcribed by the ASSAf secretariat. The transcriptions were sent to the informant for checking before they were finalised.

The expert key informants had all worked either in (insiders) or with (outsiders) the South African health services. All have been committed to developing a health service to meet South Africa's health care needs and a working environment that promotes quality care and commitment from staff. The expert key informants were willing to participate, gave hours of their time, and demonstrated openness and self-awareness (with some degree of self-reflection) in their responses. In one instance, the Panel was unable to meet with a selected informant, a health NGO, but referred to a recent, relevant report they had written. The consultative meetings did not include people at more decentralised levels within the public service. Instead, the Panel relied on recently published articles that conveyed relevant perspectives and integrated those findings into Chapter 3.

## Strategic purchasing and health sector governance reform

As the NHI Bill was under debate during the review period, many key informants referred to it. Some pointed to the NHI Fund – which, if implemented, will purchase health services – as a major intervention and policy lever. Underpinning the formulation of the NHI is “strategic purchasing”, the idea that incentives in the health system can influence the behaviour of providers, the cost of services, and ultimately access to care.

Corruption is an important factor plaguing the South African health care system in both public and the private sector, as confirmed by informant interviews, literature reviewed by the Panel, the Auditor General's reports over several years, the findings of a 2010 report for the then Minister of Health Barbara Hogan (19). The extent of corruption reported in South Africa in general and in the health service in particular looms large in the public eye and in policy considerations. Stark instances include the murder of Babita Deokaran, the chief director of financial accounting in the Gauteng Department of Health, and the related investigations into the Tembisa Hospital corruption scheme through which close to R1 billion was fraudulently paid by officials to companies. Procurement is one of the primary mechanisms through which corruption is enacted (others include nepotism in appointments, bribery, and ghost salaries) and thus strategic purchasing, as one of a number of strategies to address corruption, was of particular interest to the panel. Furthermore, strategic purchasing can address one of the key challenges identified by ASSAf in their commissioning brief: poor planning and decision-making in resource allocation.

For these reasons, the Panel included a particular focus on governance aspects of the NHI with a particular focus on the role and potential of strategic purchasing. To this end, one Panel member assembled a group qualified to offer background on strategic purchasing and to deliberate on its possible place in a future South African health system. Chapter 4 of this report, authored by Dr Mark Blecher with colleagues S. Kaye, C. Atim, C. Cashin, and J. Davin, presents the work on this topic which served as a base and was reviewed and amended by the panel

## Analysis

Transcripts of the consultative meetings provided the narrative dataset for qualitative content analysis. A deductive qualitative approach was used to analyse the information in order to understand the challenges of good governance and management in the South African health system and to identify best practices and strategies to address these challenges. This dataset consisted of 12 transcripts from 13 individuals (one consultation included two people). The transcripts were line numbered, double spaced and printed and then were read and re-read independently and annotated by two external researchers to immerse themselves in the data. To enhance reliability, the researchers then re-read the transcripts together and marked segments of the transcripts into themes aligned to the governance elements presented in Mikkelson-Lopez (1). These findings were tested against other research that exists in the public domain to assess the degree of agreement between the expert informants and other research findings as contemporary evidence. In this way, the Panel employed “methods triangulation”, relying on more than one method of data collection about the phenomenon of health systems governance (20).

After reflecting on the various approaches to governance and stewardship as presented in Chapter 1, the Panel chose the Mikkelson-Lopez framework (1) to guide the organisation of findings because of its simplicity. However, there was too much narrative information to capture in one table (as presented by Mikkelson-Lopez, who analysed only one issue). Therefore, a matrix was designed using Microsoft Excel spreadsheets to distil data as themes and sub-themes (Figure 4). Information was then aligned to the governance processes and elements used by Mikkelson-Lopez. As the data analysis crystallised, the Panel inserted subsections within the framework for ease of understanding.

Two researchers carried out the analysis using “investigator triangulation” to ensure agreement and credibility of results (20). All members of the Panel attended consultative meetings or read the transcripts. Three Panel members immersed themselves in the data and worked with the two additional researchers to refine the findings. Chapter 5 was reviewed by all Panel members who concurred that relevant information was presented and reflected the information gleaned.

As far as possible and feasible, Chapter 5 presents the “voice” of study participants to maximise authenticity and do justice to passionate calls to be heard by those in a position to reform the current struggling health system. (21). All informants were anonymised to focus on what was said rather than who said it. The number after a quote refers to the particular expert informant whose verbatim expression is quoted.

## Recommendations

The Panel deliberated over the literature and interviews, identifying areas where there was consensus between findings of the literature review and the key informant interview content, and consensus among Panel members. In this way, the Panel reached consensus on the key challenges as well as the most important recommendations to address them. The goal is to improve governance, management, and decision-making in the South African health care system through the implementation of these recommendations.

## Peer review

The completed draft consensus study report was submitted for peer-review to one national expert, one regional expert, and one international expert, following the guidelines that ASSAf provides for all its consensus studies. Potential reviewers were recommended to the ASSAf Council who then approved the final reviewers. Reviewers responded to five questions:

1. Does the report respond to the study aims?
2. Does the report remain within the scope of the study objectives?
3. Are there any areas of evidence missing in the report?
4. Do the conclusions follow logically from the evidence presented? and,
5. Do the recommendations follow logically from the conclusions?

Peer-reviewers' comments were then addressed, and consensus was obtained from the committee before final submission to and approval from ASSAf.

## Dissemination

This consensus study report is aimed at key stakeholders in health system governance, particularly the South African Department of Health (all levels); Portfolio Committee on Health; Department of Planning, Monitoring and Evaluation; National Treasury; World Health Organisation; Academia (especially governance and leadership institutes); Statutory Bodies; non-governmental organisations; civil society groups and community governance structures; and funders. Launched at a public event, the report will be available to the public and to relevant stakeholders for the consideration and implementation of recommendations.

**Table 2:** Overview of Consensus Study Methods and Activities

Method	Activities	Purpose	Time and place
Panel meetings	Regular meetings and two writing retreats.	Deliberate on study objectives, approach, methods, findings, and conclusions; propose implementable recommendations on improving governance, management, and decision-making in the health system; and produce the final report.	29 meetings were held between 3 September 2020 and December 2023. (For details see Appendix 2) A writing retreat was held on 16 March 2022 (Retreat Centre, Cape Town) A writing retreat was held on 25 November 2022 (University of Pretoria, Future Africa Campus)
Key informant/expert consultative meetings	Panel members invited selected experts for meetings, conducted virtually using Zoom	Describe the key challenges of good governance in the health system; identify evidence of best practices and effective strategies	18 August 2021 (first consultative meeting) 21 September 2022 (last consultative meeting)
Reviews of evidence	Panel members reviewed literature on evidence related to effective governance strategies	Identify effective strategies or best practices/interventions that can be adapted and/or leveraged to address governance challenges	Ongoing, starting 3 September 2020
Peer review	ASSAf invited three peer reviewers who reviewed the report	Assess the quality of the report and the Panel's work, to enable the Panel to improve the report.	

**Table 3:** Profiles of key Informants/experts who participated in consultative meetings

Key informant Gender	Main Affiliations (past and present)	Expertise
Senior Manager Male	National Treasury	Public entities (finance, procurement funding, budgets), stakeholder involvement
Senior Manager and former academic Male	Provincial Health Departments (Free State and Western Cape) and academia	Health department management, leadership, government policies

Key informant Gender	Main Affiliations (past and present)	Expertise
Academic and former Public Sector Official Male	Academia and national government	Social security systems, health economics and public finance administration, management studies
Academic and Senior Manager Male	Academic and provincial government (joint post; Western Cape)	Public health, human rights, public health ethics
Senior Manager Male	National Health Department	Hospital policy formulation, workforce development and planning
Senior Manager Male	National Health Department	Health programmes, strategic planning, health systems
Academic Female	Academia	Public health, health systems, policy research
Civil Society Activist Male	NGO and social movements	Public health, rural health, health systems
Academic Female	Academia	Public health, health systems, policy research
Senior Manager Female	Provincial Health Departments (Free State and Western Cape)	Public health, health systems, policy research
Civil Society Activist Male	Community governance structure (Eastern Cape)	Public health, rural health, community service, advocacy
Civil Society Activist Female	National NGO	Advocacy, community voice
Trade Unionist Male	Health sector national trade union (Union A)	Public health, health systems, health worker interests

**Table 4:** Profile of key informants/experts invited to consultative meetings who did not respond

Key informant	Main Affiliations (past and present)	Expertise
Trade Unionist Male	Health sector trade union (Union B)	Public health, health systems, health worker interests
Senior Provincial Manager Female	Provincial health department (Eastern Cape)	Senior provincial manager
Senior Manager Female	Disease-specific, patient advocacy non-governmental organisation	Advocacy, community voice, patient rights
Young Public Health Practitioner Female	Public health system	Public health, health policy and systems





## Chapter 3: Health Systems Governance in South Africa

This chapter provides an overview of key historical developments in health systems governance in South Africa, a review of research and reports on health governance in South Africa, and lessons on health governance from global evidence.

### Historical developments

#### Trekking back to 1652

Across the last four centuries – from the first Dutch settlements in the late 1600s, followed by British occupation in 1806, through the Union of South Africa established in 1910, to the ascendancy of the apartheid government in 1948 – the organisation and governance of the health system has been deeply rooted in the country's political history. The effects of colonisation, violent displacement and dispossession of indigenous populations and legislated racial segregation and discrimination against the majority of South Africans, impacted extensively on health and health care (22).

Early Dutch settlers made use of the traditional healing practices followed by indigenous people. However, by the 17th and 18th centuries, the Dutch East India Company provided hospital care to settlers under the leadership of the colonial government. Indigenous people mostly still relied on medicinal herbs and traditional healers but there was some cross-use of missionary hospitals. Although there were initially relatively few hospitals and trained doctors and nurses, the influence of the colonial powers saw the gradual ascendancy of biomedicine in the country (23,24).

The first health legislation was adopted in 1807 and a Supreme Medical Committee established to oversee all health matters (22). In 1830, all medical procedures in the Cape Colony became subject to regulation and later, in response to the smallpox pandemics of the 19<sup>th</sup> century, the Public Health Act of 1883, amended in 1897, made vaccinations mandatory and laid out separate provisions for preventative and curative care (22).

With the discovery of lucrative minerals in the early 1900s, mining operations expanded rapidly in the northern parts of the country, resulting in intense labour migration and a massive influx of people from rural to urban areas between 1910 and 1948 (22). The urban living conditions of mine workers were deplorable, with overcrowding leading to diseases such as tuberculosis, malaria, and syphilis along with high maternal mortality. Mine workers were at risk for a range of lung diseases because of exposure to hazardous dust in closed working conditions and also at high risk of injury and death due to mine accidents and disasters (22).

Due to the demand for health services around this period, the government began building hospitals in both the rural and urban areas (22). The Public Health Amendment Act 57 of 1935 intended the expansion of health services to “native areas” and, in 1936, a “native medical service” was planned, along with expanded training for “native medical aides,” in accordance with the government's segregation policy (25).

#### An early experiment in comprehensive primary health care

In 1942 the National Health Services Commission (NHSC), established to review the state of health and poverty in South Africa and chaired by Henry Gluckman, unequivocally condemned unacceptable levels of disease amongst black South Africans particularly and advocated for a National Health Service for all citizens (25,26). The Gluckman Report recommended that all health-care services be provided for free, including all necessary personal and preventive services and province-run hospitals (25,26). It advocated for a model of Community Oriented Primary Care (COPC) based on a network of

community health centres staffed by a local medical team supported by community health workers, to provide curative, preventive, and promotive health care (25). The outstanding innovative feature was the commitment to a unitary health system and democratic control of health services (26). With shifts in political power in the late 1940s, however, the recommendations of the Gluckman Report were largely abandoned.

## The apartheid era

The National Party, elected to power from 1948 through to 1994, substantially reinforced racial segregation and discrimination under apartheid (25). The Group Areas Act of 1950 forced physical separation between “races” in South Africa and, in 1951, the Bantu Authorities Act established the “homelands” or reserves as a base for the government of black South Africans. All political rights of black South Africans, including voting, were confined to the designated homelands, thereby denying them their South African citizenship. In the 1950s, infant mortality was less than 15 deaths per 1,000 live births among “White” South Africans, but 110–115 deaths per 1,000 live births among “Black” South Africans (25,27). Life expectancy among the “White” population was nearly twice that of the “Black” population.

From 1976 to 1981, the apartheid government made four of these homelands “independent” (Transkei, Bophuthatswana, Venda, and Ciskei), with access to all social services (including health) removed from the territory defined as “South Africa” and transferred to the so-called “independent” homelands or Bantustans. More than nine million South Africans were denationalised in this way (25). However, without viable economies or the resources to run services, the homelands were totally dependent on the apartheid government. Lack of resources resulted in compromised health care delivered in poorly equipped, understaffed, and severely overcrowded hospitals that were, moreover, usually inaccessible (25). In the early 1970s, the doctor-to-population ratio in the Bantustans was estimated to be 1:15,000, compared to 1:1,700 in the rest of the country (22). In many cases, faith-based organisations substituted for state services in health. The proliferation of departments of health in each of the “homelands” meant that governance of health in South Africa was highly fragmented in addition to being highly inequitable.

The Public Health Act of 1977 assigned curative care delivered mainly by hospitals to the provincial government, consolidating the hospicentric approach to health care. Preventative services delivered through clinics and public health officers were allocated to local government municipalities, thereby further fragmenting health care. The government exercised centralised control of the health system with little input from health professionals and communities.

The apartheid government supported entrepreneurs to expand private health care to service the increasingly affluent white population through encouragement of medical insurance. This created a two-tier health system with a well-resourced private sector for the wealthier enfranchised white population and an under-resourced and highly fragmented public health system for the rest of the population. Public–private inequalities exacerbated inequalities by race<sup>1</sup> – for example, in 1980, 40% of doctors were employed in the private sector, rising to more than 60% by 1990.

By the end of apartheid, the country had two parallel sectors, public and private. Private health care accounted for 58% of total health expenditure serving 23% of the population. The public sector was characterised by chaotic governance with a highly fragmented system of 14 operating authorities which included the “homelands”, highly unequal provision, and a skewed distribution of human resources. In the expensive and inefficient health sector of that time, 44% of total public health-care expenditure was directed at tertiary care and only 11% at primary care.

1 The apartheid system coined the categories of “White”, “Black”, “Indian” and “Coloured” to achieve racial stratification needed to effect discriminatory practice. The use of these terms here does not legitimise their validity or biological plausibility but is rather intended to foreground the way discrimination was deployed by previous governments to determine health opportunities for all South Africa – on a discriminatory basis.

## The “rainbow” health system

In 1994, the new democratic South Africa inherited an extensively fragmented health system characterised by central, autocratic, and patriarchal control, a hospicentric focus, exclusion, and inequity in health status and access to care across the population and between the public and private sectors. An intense process reviewed and revised national health policy and legislation and established the framework for broader health system transformation (28), informed by the Constitution of 1996 and expressed in the 1997 White Paper for the Transformation of the Health System. The Constitution created one democratic state; separated the powers of the legislature, executive, and judiciary; and established a system of co-operative governance across national, provincial, and local spheres of government. The ANC Health Plan and the White Paper – subsequently formalised as the National Health Act 61 of 2003 – described the government’s comprehensive health policy and plans and the organisation of the district health system across these three spheres of government. The White Paper also called for strong health governance as part of the post-1994 health agenda (29).

Priorities were the decentralisation of health care services, promotion of a district-based health system, redress of past racial inequalities, and building an equitable health care delivery system based on health as a fundamental human right (30). Clear goals and strong leadership contributed to several significant achievements. The numerous administrative departments were amalgamated into one national and nine provincial authorities. The gender, racial, and professional profile of health administration was transformed. Access was expanded through an ambitious clinic building programme and providing free health care at primary level. Some health outcomes improved significantly. For example, maternal mortality decreased following the Choice on Termination of Pregnancy (CTOP) Act, while life expectancy increased overall (31). Table 5 summarises the key governance policies, programmes, and investigations between 1994 and 2020 that sought to transform the health system.

**Table 5:** Key governance policies, programmes and investigations between 1994 and 2020 which sought to transform the health system

Year	Policies, programmes, or investigations	Governance relevance
1994	Free health services for pregnant women and children under the age of six years.	First major health policy introduced under the Mandela government to expand access to health care for women and children
1996	Primary Health Care Standard Treatment Guidelines and Essential Drugs List 1996. South Africa: The National Department of Health.	Adoption and updating of medicines recommended for treatment for specific conditions; intended to reduce costs through rational drug use
1997	Medical, Dental and Supplementary Health Services Professions Amendment Act of 1997.	Creation of the Health Professions Council of South Africa (HPCSA) to replace the old South African Medical and Dental Council with a wider range of health professions and inclusive of community representatives in order to increase accountability and transparency
1997	White Paper for the Transformation of the Health System in South Africa	Established the framework for a unified health system based on primary health care and the district health system model
1998	Medical Schemes Act	Established the Council for Medical Schemes, a statutory body to provide regulatory supervision of private health financing through medical schemes
1998	Compulsory community service for health professionals	Policy intended to improve the supply of professional health personnel in underserved areas, thereby improving health service provision to all South Africans
2000	National Health Laboratory Services (NHLS) Act	Established the NHLS in order to consolidate all public sector laboratory services as a single national public entity
2002 – current	Hospital revitalisation programme	Government initiative intended to plan, manage, modernise, rationalise, and transform health infrastructure, health technology, and monitoring and evaluation of health facilities in the country

Year	Policies, programmes, or investigations	Governance relevance
2003	National Health Act	Provided a legislative framework for a structured uniform health system, taking into account the obligations imposed by the Constitution and other laws on the national, provincial, and local governments with regard to health services.
2007	Traditional Health Practitioners Act 22 of 2007	Established the Interim Traditional Health Practitioners Council of South Africa and provides a regulatory framework to ensure the efficacy, safety, and quality of traditional health care services. However, while the Traditional Health Practitioners Council came into being in 2013 and some of its power came into effect in 2014, it has still not established a credible licensing procedure.
2007	Occupational Specific Dispensation	Intended as a financial incentive strategy to attract, motivate, and retain health professionals in the public sector; placed immense financial burdens on recurrent budgets; implementation gaps
2007	Nursing Amendment Act 19 of 2007	Provides for the restructuring of the South African Nursing Council; consolidates the merger of different homeland councils previously regulated as an Interim Council
2008	Development Bank of South Africa (DBSA)-led Investigation of the management capacity in South Africa's hospitals	Chief Executive Officer (CEO) assessments were to inform capacity strengthening within the Department of Health to address human resource issues highlighted by the assessment
2011	National Health Insurance Green Paper	First of three policy papers setting out the contours of the National Health Insurance
2013	Establishment of the Office of Health Standards Compliance	Independent agency to monitor and enforce health care safety and quality standards in health establishments; independent ombud service.
2015	National Health Insurance White Paper	Second policy document on the NHI
2017	National Health Insurance Policy. Towards Universal Health Coverage. White Paper	Third policy document on the NHI
2017	A Comprehensive Policy Guideline on Remunerative Work Outside of the Public Service (RWOPS) for Medical Practitioners and Dentists	Attempts to regulate the conduct of limited private practice by state-employed health professionals in line with the Department of Public Service and Administration (DPSA) 2016 Directive on remunerative work outside public service employment
2018	Establishment of the South African Health Products Regulatory Authority (SAHPRA)	Creation of a SAHPRA to ensure the safety, quality, and efficacy of medical and other health products
2018	Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams	Consolidated the NDoH strategy on three streams of primary healthcare re-engineering intended to improve access to healthcare for vulnerable communities, strengthen the DHS, and expand the human resources available in under-served areas
2019	The Health Market Inquiry (HMI)	Found that the South African private healthcare market is characterised by high and rising costs of healthcare and medical scheme cover, significant overutilisation, and an absence of demonstrable associated improvements in health outcomes. Identified multiple features that prevent, restrict, or distort competition, along with the failure of the Department of Health to fulfil its stewardship role, leaving the private sector neither efficient nor competitive.
2019	National Health Insurance Bill	Final Bill under consultation process
2020	National Public Health Institute of South Africa Act	Established a Public Health institute to coordinate public health functions in the four main areas of Burden of Disease, but the Act remains to be promulgated

As part of the transformation of the national health system, new or reorganised structures were established to support governance across and within levels of the health system. Figure 3 seeks to illustrate formal structural arrangements for governance within the public health sector. Political oversight bodies included the Health Portfolio Committee of the National Assembly which has oversight of the Executive Authority at national level (MoH and NDoH) as well as health bodies such as the OHSC, SAHPRA, HPCSA, SANC and SAPC. The National Council of Provinces (NCOP) Select Committee on Health ensures Provincial input to national legislative processes and has oversight of the executive within its role as the representative of the provinces. Provincial Standing Committees on Health and Municipal structures such as mayoral committees play a similar role at their respective levels.

The Auditor-General South Africa (AGSA) provides oversight of the use of public funds in the health sector through regular audits of national and provincial government departments, identified public entities, municipalities and municipal entities. The National and Provincial treasury departments allocate public finances to and demand accountability for the use of public finances from different levels of government and public entities. Both the AGSA and the Treasury are powerful actors in the governance and management of public finances within the health sector.

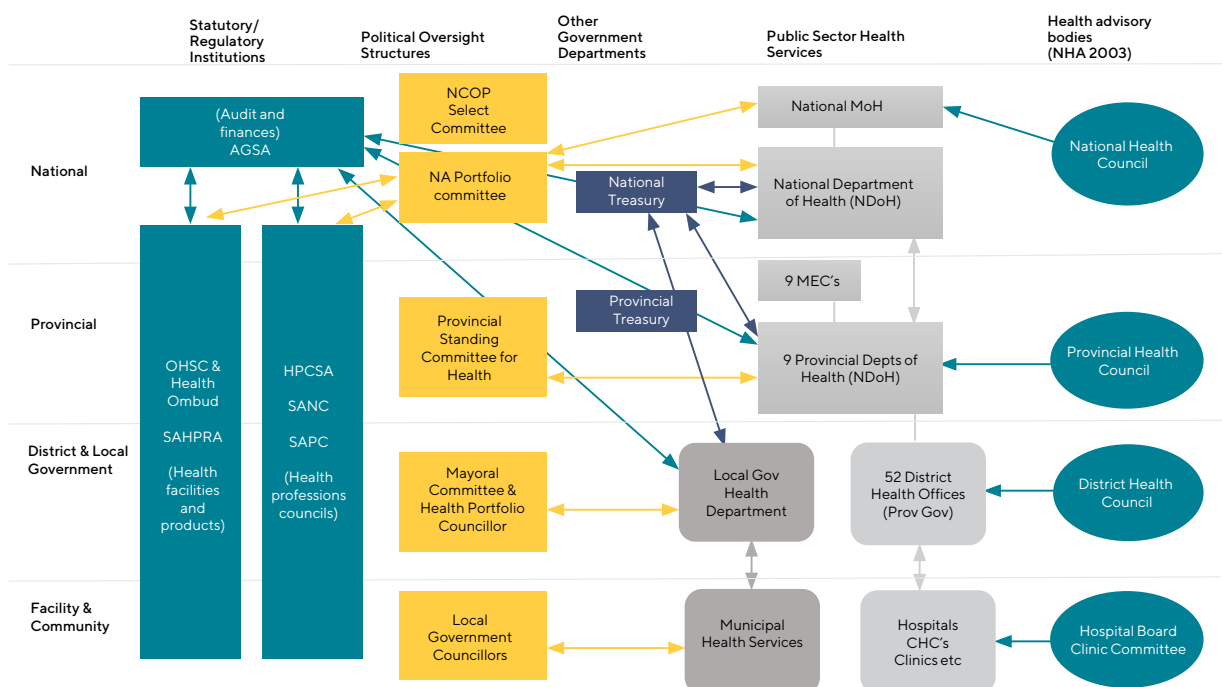


Figure 3: Public Health Sector governance arrangements in South Africa.

The NHA 2003 also made provision for Health advisory structures across the levels of the health system including National, Provincial and District Health Councils, as well as hospital boards and clinic committees (Figure 3). The limitations of the governance role of these advisory structures is discussed further in this and subsequent chapters.

Governance structures for health professionals were strengthened through the creation in 1997 of the Health Professions Council of South Africa (HPCSA) to replace the old South African Medical and Dental Council, and the restructuring of the South African Nursing Council (SANC) in 2007. "Independent" statutory bodies such as the Office of Health Standards Compliance (OHSC), the South African Health Products Regulatory Authority (SAHPRA) were established to provide oversight and quality assurance of important areas of the public health sector. The Council for Medical Schemes (CMS) was established to provide oversight of private health financing, but no governance structures were established for oversight of delivery of private health care. The HPCSA, SANC and other regulators of health professionals do have oversight of the licensing to practise of individual practitioners, but not of healthcare groups

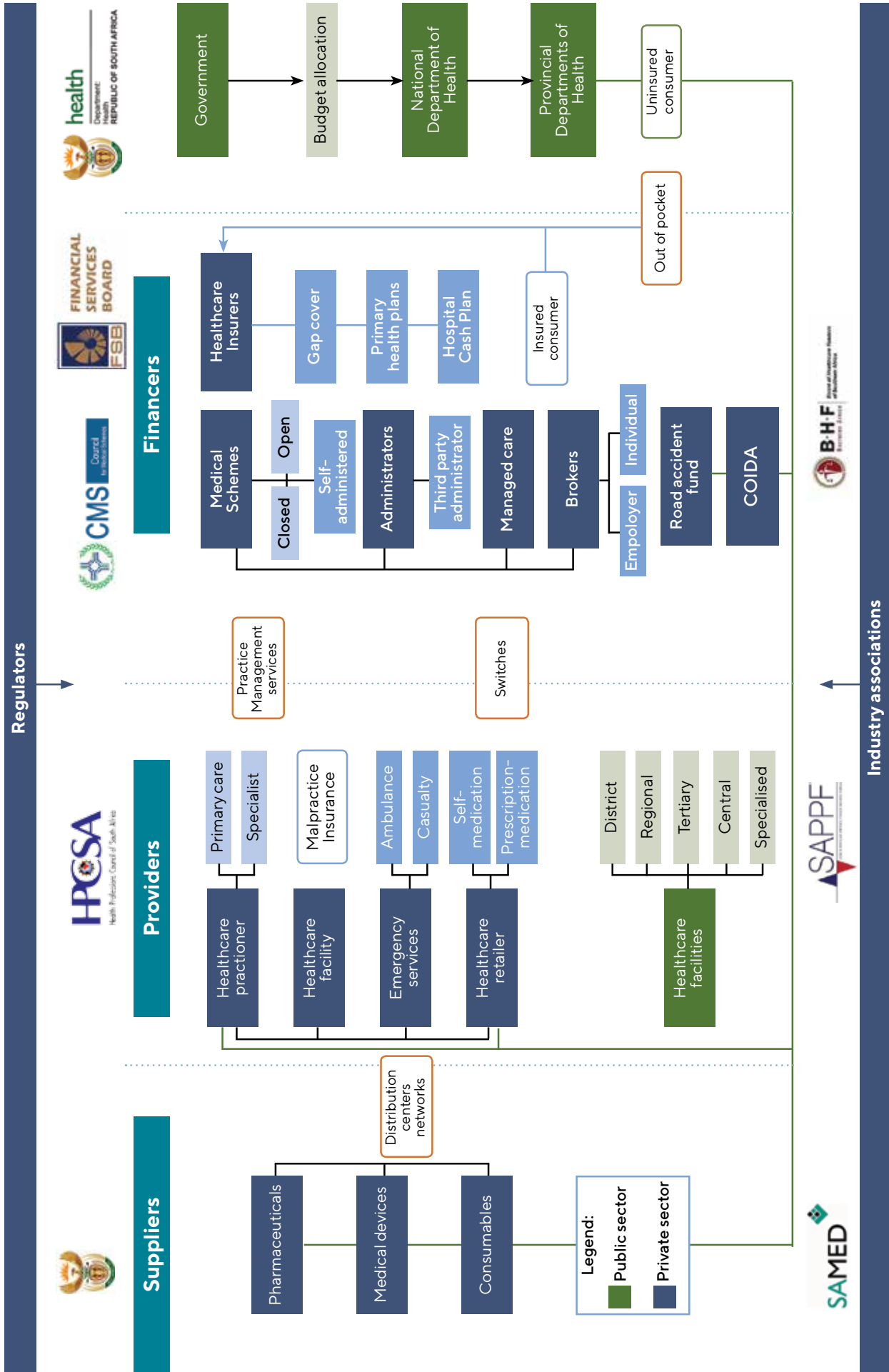


Figure 4: Health system design and governance of the private health sector (source HMI report).

or organisations in the private sector. And although the mandate of the OHSC extends to the private sector, the office has had insufficient capacity to undertake inspections of private sector facilities until very recently (Figure 4).

While the public health system was transformed at face value into an integrated comprehensive national service, fundamental disjunctures remain in its design, while some core legal provisions of governance might be interpreted as contradictory. For example, the Public Finance Management Act (PFMA) under the Treasury gives power to accounting officers or heads of department, who are responsible for financial management, service delivery, and human resource management. Simultaneously, the Public Service Act (PSA) designates Ministers and Members of the Executive Committees (MECs) in the provinces as executive authorities and gives them substantial powers (for example, the right to make appointments, S9) which may lead to cadre deployment or political interference. This political-administrative interface has been one of the trickiest areas of public governance.

The South African Constitution (S41) makes provision for co-operative governance, with health as a concurrent responsibility of national and provincial governments. As the National Health Act of 2003 is not entirely clear on the precise functions of the spheres of government, constitutional and legal provisions introduce both complexities and difficulties. For example, several National Ministers of Health have cited lack of powers to intervene in provincial service delivery problems. For example, responding to the terrible tragedy in which at least 144 long term psychiatric patients died following enforced discharge by provincial authorities from a long-term facility as part of cost-cutting, the minister noted that the issue "never came to the National Health Council to be dealt with" and so he was unaware (32).

Although the 2003 Act established health districts, their status and powers under the act was unclear. The district model which was (and still is) the acknowledged cornerstone of the health system has thus not been fully implemented, with delays in finalising district borders and delegation of powers to districts, and weaknesses in the local sphere of government (33). Another core problem in the existing legal framework for health is that institutions such as large hospitals have few original powers but limited delegated responsibilities with considerable reliance on provincial head offices. This reduces flexibility, accountability, and the ability to procure strategically.

Thus, despite the reorganisation of the health system into nine provinces, power and control remained centralised in provincial head offices, with relatively little authority or decision-making and spending power given to institutions and health districts. The failure to rapidly institutionalise the District Health System (DHS) and a host of related managerial and governance systems led to a loss of an institutional and organisational focus in the health system (34). This lack of decentralisation has inhibited the ability of local services to respond flexibly and to strengthen primary health care (PHC). Piecemeal attempts through strategies to strengthen PHC such as the 'Re-engineering of PHC' from 2011 have not adequately addressed the core governance problems (35).

One important development outside of the Department of Health which had significant ramifications for health was the introduction in 2007 of the occupation-specific dispensation (OSD) by the Department of Public Service and Administration. This aimed to attract, motivate, and retain health professionals in the public sector and make working in remote areas more attractive. While the policy seemed adequate, implementation was complicated by poor data to understand who should receive such benefits and a lack of administrative capacity and high cost of the reform.

The post-1994 period was impacted by the HIV/AIDS epidemic and a human resource crisis in the health sector exacerbated by the implementation of the Growth, Employment, and Redistribution (GEAR) five-year plan. From 1999 to 2009, South Africa's health system had to cope with rising HIV infections, initially under a cloud of denialism encouraged by the President and Minister of Health (36).



The Minister of Health was eventually forced to provide Antiretroviral (ARV) drugs to pregnant women to prevent mother-to-child transmission of HIV in 2002 when the Treatment Action Campaign (TAC) won a ground-breaking court case. The rollout of ARVs to others with HIV infection followed rapidly as the government shifted direction and began to respond to the epidemic. A key lesson was the importance of civil society's role in health policy, in holding government to account. South Africa's HIV programme at the time attracted substantial donor funding, reinforcing a strongly vertical and medicalised programme as opposed to strengthening comprehensive PHC within the DHS and has taken the subsequent decades to reintegrate (37,38).

The human resource crisis came about not only because of health professionals leaving, but also because the HIV/AIDS epidemic increased needs. At the same time, GEAR's aim of reducing government spending on human resources meant a decrease in the supply of health professionals: the number of people employed in the health system stagnated and decreased on a per capita basis. Training institutions, in particular nursing colleges, were closed down and insufficient nurses were produced to replace those leaving and retiring. Fundamentally, GEAR reduced spending precisely when additional resources were needed for transformation of the health system. Further, it entrenched a conservative managerial culture that is preoccupied with staying within budget rather than with delivery-oriented goals (39).

Political interference in health governance also began to emerge as a concern. Cadre deployment would later see the politicisation of government administrations and lead to depleted resources and bureaucratic capacity(22,25). Failures of leadership and stewardship, as well as poor management, resulted in insufficient implementation of (often good) policies, poor service delivery, and wastage of resources, and – overall – undermined the quality of care. Corruption – defined as the abuse of resources, power, and connections for private gain – has become a serious problem in the South African health system as reported by the Attorney General of South Africa (AGSA), the Public Service Commission, and the Health Market Inquiry (HMI) (4,40).

Examples of implementable measures to address fraud and corruption exist, such as the NDoH Litigation strategy, the medico legal project in partnership with the South African Law Reform Commission and a Health Sector Anti-Corruption Forum (HSACF). Launched in 2019 following the signing of the Presidential Health Compact, the HSACF mandates government and social partners to work together to reform the healthcare system. Convened by the Special Investigating Unit (SIU), the HSACF successfully dealt with serious maladministration, fraud, and corruption in 2020, providing an effective model of a multisectoral collaboration (41).

Despite these initiatives, progress by agencies external to the NDoH has been slow in acting on corruption cases in the health sector. Delays in investigations and convictions – for example, in corruption at Tembisa hospital, the 2021 assassination of whistle-blower Ms Babita Deokaran, and the involvement of the national department in the Digital Vibes scandal – contribute to public perception of an absence of the ability or will to act.

## Progress towards a National Health Insurance

Almost three decades after it was first proposed, a National Health Insurance (NHI) is being planned. It aims to provide universal health coverage to all South Africans and address the massive inequity between the public and private health care sectors which has persisted since democracy (42,43).

As envisaged in the National Health Insurance Bill (2019), the NHI has huge implications for health sector governance.

- Introduction of a single national purchaser, the NHI Fund, which would ultimately hold a substantial portion of the health budget

- Amendment of the powers of the different spheres of government in order to centralise funding with delegations back to districts, provinces and institutions for service delivery, potentially in a way which might substantially change the powers and functions of these spheres.
- Introduction of strategic purchasing (see Chapter 4) which would substantially change incentives in the system and see the introduction of contracts between purchasers and providers to cover the mechanisms of reimbursement.
- Contracting by the NHI Fund, or initially by provinces, directly with health districts and institutions such as hospitals could substantially change the institutional framework and semi-autonomous powers and governance arrangements of these bodies.

If passed, the National Health Insurance Bill of 2023 will thus substantially alter and/or shift functions between spheres.

## South African evidence on health systems governance

In addition to theoretical frameworks and principles of health governance (as described in Chapters 1 and 2), the Panel explored recent reviews of the evidence on governance interventions in health systems, as well as studies from South Africa and other low- and middle-income countries (LMICs) on issues such as the relationships between governance and leadership, community voice, and the 'practice of governance' within PHC and hospital settings. National reports – such as the Health Market Inquiry (HMI), the South African Lancet Commission on a High Quality Health System in the SDG era, and South African Health Reforms 2015–2020 – provide important findings on health governance and leadership in South Africa (4,44,45). Findings from the unpublished 2021/2022 OHSC Annual Inspection Report on governance are also referenced.

### South African Health Reforms 2015–2020

Reviewing the current state of public health sector governance and leadership in a chapter of *The South African Health Reforms 2015–2020*, Engelbrecht and Gilson conclude that the structural and legislative foundations of governance of the health system are well established, but that the everyday practice of governance is weak (34). Drawing on Amimbola's theory of governance as the relationships between actors, they discuss health systems governance at national, provincial, and district level, and the relationships between these levels and other key governance actors including "oversight" bodies such as the Auditor General's office (AG) and the Office of Health Standards Compliance (OHSC). Their view is that governance is regarded largely as an internal function of government and the public health system in South Africa, with very little independent oversight from "social actors".

The review emphasises both the importance of the everyday practice of governance within health districts and the finding that "governance challenges at the district level often stem from higher levels". Nonetheless, the authors identify some successes in district governance that focus on collaboration and relationship building, such as a district governance model which included a monitoring and evaluation unit to improve governance of Maternal Neonatal and Child Health (MNCH) in Limpopo and Mpumalanga) (46); Operation Sukhume Sakhe in KwaZulu Natal using a multi-level governance approach which included addressing "governance for health", and the Western Cape's "Whole of Society" governance model (47–49).

At provincial level, a "structural design flaw" in governance is the disjuncture between the exercise of powers that the PFMA and PSA allocate to the Member of the Executive Council (MEC) and the Head of Department. Good relationships between the province and the Auditor General (AG) and Treasury are seen as key to supporting governance at a district level.

At national level, the National Health Council chaired by the Minister of Health, provides for cooperation among political heads across the provinces. Figure 3. Despite some good practices at this level, the national-provincial relationship has not functioned effectively, largely as a result of NDoH capacity weaknesses and inadequate engagement between national policy decisions and implementers at provincial and district levels.

The chapter acknowledges current reforms such as the draft National Implementation Framework towards the Professionalisation of the Public Service (50) as important initiatives to insulate the public service from politics and political parties but also calls for several internal health systems “governance resets”. These include placing communities and the DHS at the heart of the health system and strengthening frontline governance; adopting a new mindset of stewardship for health to support intersectoral collaboration and deepened engagement with social sectors at all levels; and deepening health systems leadership skill sets including those of ethical practice at all levels. The authors highlight the current misalignment between the need to strengthen frontline governance and the NHI Bill’s proposed centralisation of decision-making, noting concerns about the excessive influence of the Minister of Health over the NHI governance structures.

### South African Lancet Commission on a High-Quality Health System

In 2019, the Consensus Report of the South African Lancet National Commission on a High Quality Health System in the SDG era was published, based on a country-specific analyses on quality of care by a 13 member Commission (4).

A key finding of this report was that gaps in ethical leadership, management, and governance contributed to poor quality of care in South Africa, with corruption and fraud seen as major threats to equitable access to quality health care (4). The report pointed to governance weaknesses in the regulators of most health care professionals.

This finding echoes earlier investigations of statutory councils in South Africa. The 2015 Ministerial Task Team on the HPCSA found poor governance and extensive mismanagement, and a review of nursing in South Africa highlighted serious failures of the South African Nursing Council (SANC) to provide governance of nursing education and practice (51,52). The NDoH was noted to have provided inadequate stewardship of the governance of these and other statutory regulatory bodies.

The Lancet report also highlighted barriers to community participation in policy and decision-making and a lack of accountability of health services to communities, with very few functional health committees or hospital boards. The most important recommendation was to enhance governance and leadership, including the prevention of fraud and corruption, strengthened community governance structures, and improved governance of the various health professions councils (4).

### Other relevant governance studies

A 2020 review of the governance of human resources for health (HRH) attributed many of the ongoing health workforce challenges in South Africa to the lack of effective HRH governance and poor high-level stewardship of the implementation of HRH plans over the past 30 years (54). Although comprehensive national HRH policies and plans were developed, there was insufficient capacity for national level HRH stewardship of implementation within the health sector and across sectors. This was compounded by poor governance within and across the health professions regulatory bodies and limited “system intelligence” in the form of either reliable routine information on HRH or external evaluations of implementation of HRH plans and interventions. Recommendations included improving the capacity of the HRH unit at NDoH to perform its governance functions and addressing the “software” (values,

relationships, social networks, and collaborations) required to establish a shared HRH vision and manage actors effectively, including obtaining explicit political support for implementation of HRH plans (54).

A recent evaluation of Return-of-Service bursaries at provincial level supports these findings, concluding that such initiatives were bedevilled by loopholes in contract design, the absence of effective information systems for monitoring and decision-making, and poor coordination between departments (55). As a result, the potential of such efforts to overcome health professional shortages in underserved provinces and underserved areas was not realised to the full, with up to 30% of recipients defaulting on their bursary commitment.

Other South African studies of health systems governance largely focused on operational aspects, exploring the practice of governance by health managers in a range of PHC and hospital settings. Important themes emerge from these studies. The approach to governance in South Africa is found to focus on the structures and rules, leans towards a hierarchical and authoritarian mode, and provides little space for innovation, flexibility, and participation at operational levels (15,56). This is reflected in the organisational culture, styles of leadership, information systems, and accountability mechanisms at multiple levels (14,15,57–59). Despite resulting constraints on decision-making space for managers within health districts and at facilities, local managers have found ways to adopt more “participatory” approaches using “co-production” modes of governance to engage peers, communities, and other stakeholders in decision making and problem solving (15,56,58). Context-specific leadership development programmes strengthened leadership skills by building relationships, practising self-awareness, and developing multidisciplinary teams, with positive impacts on quality improvement processes (60). These “bottom up” approaches to governance were seen as complementary to the “top down” rules and audits; more of this is needed to support organisational learning, leadership development, and quality of care at all levels of the health system.

South Africa's policy framework sets out a commitment in principle to community participation in health governance, but the legislative framework is weakened by separating hospital boards from other community health governance structures and by leaving the definition of the roles of community governance structures to provinces. As a result, there is wide discrepancy between the policies adopted across different provinces in terms of the roles expected of health committees – for example in terms of governance, oversight, networking, fundraising, advocacy, complaints management – and in terms of composition, how they are assembled, how support is provided, the duration of appointments, and linkages with other structures (61).

National and local surveys found that less than two thirds of clinics reported having a clinic committee and that their functioning was adversely impacted by lack of political commitment, a lack of guidance on how committees should be comprised and constituted, limited resources, limited capacity and skills, attitudes of health workers, lack of clarity of the role and mandate of committees, limited co-operation from health services, and lack of support to health committees (61,62). Studies of hospital boards found similar challenges and highlighted weak representation by the community that they serve, resulting in limited commitment, inability to function well, and the absence of feedback to the community and health users (63,64). Underlying these challenges is the question of how power is expressed, with community representatives having insufficient countervailing power when holding the state accountable, which undermines effective and meaningful participation (65).

Commenting on the health sector, the National Development Plan\_(NDP) in 2012 lamented the fact that “the fundamental importance of full community participation ... has been underplayed and the focus on ‘people first – Batho Pele’ has diminished (66). The culture of valuing and respecting the expressed needs of communities has faded, replaced by a top-down approach.” It argues for community participation “through structures that are integrated into the wider health system”.

Yet, importantly, the NHI Bill is completely silent on how participation structures will be operationalised under an NHI when purchasing of services is separated from delivery and when private providers, who have thus far had no obligation to institutionalise community participation structures, will be integrated into service delivery to poor communities (67).

The adoption of community-oriented primary care (COPC) as a model for ward-based outreach teams (WBOTs) has raised new governance concerns. The role and integration in the public sector of the 54,000 community health workers (CHWs), representing 22% of the total and 47% of the PHC workforce in 2019, is being formalised through national health policy and agreements between the Public Health and Social Development Sector Bargaining Council, the NDoH, and unions (68,69). The 2018 policy framework for WBOTs stipulates that accountability is to the formal health sector with CHWs reporting to health facility management and not to community structures (69).

The evidence on the effectiveness of COPC in South Africa and the region identifies obstacles including a lack of ongoing political commitment, poor cooperation between levels of government, poor intersectoral collaboration, sub-optimal managers' understanding and ownership of COPC, and a centralised leadership style (70). Thus, with respect to emerging frameworks of public-health governance, concerns emerge about the limitations on the accountability of CHWs and COPC to communities (71,72).

The 2021/2022 Annual Inspection Report of the OHSC found that Governance and Human Resources was the domain which health establishments performed least well on, with a national average of 41% of clinics, 51% of CHC's, and 43% of district hospitals meeting the requirements. Only 5% of the clinics and 18% of the CHC's inspected in the year had functional governance structures (53).

## Governance of the private healthcare sector

At the end of November 2013, the Competition Commission instituted a market inquiry into the state of competition in the private healthcare sector under the provision of the Competition Act, 98 of 1998 (44). The Health Market Inquiry (HMI) conducted an extensive review of the private health market and focused on competition in the sector. The HMI noted that the Minister of Health is assigned extensive powers to make regulations across a range of areas "We are concerned that although the National Health Act was enacted 16 years ago, its key provisions, in particular those relating to the licensing of facilities, reference lists, the creation and publication of a national database on financing and pricing of healthcare goods and services, have not yet been implemented." (HMI Final report page 49.)

Overall, the HMI found that the NDoH had reneged on its responsibility to steward the private health sector. "There has been inadequate stewardship of the private sector with failures that include the Department of Health not using existing legislated powers to manage the private healthcare market, failing to ensure regular reviews as required by law, and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive."

"A more competitive private healthcare market will translate into lower costs and prices, more value-for-money for consumers and should promote innovation in the delivery and funding of healthcare. As the state becomes a purchaser of services (from the private sector as indicated by the NHI Bill), it will be able to enter a market where interventions like the establishment of a supply side regulator, a standardised single obligatory benefit package, risk adjustment mechanism, and a system to increase transparency on health outcomes have already led to greater competition and efficiency. Competition [between providers] should occur on price, cost and quality, not on risk avoidance. The risk adjustment mechanism is a regulatory component designed to eliminate fragmented risk pools but, more importantly, it is an essential market mechanism to ensure that purchasing in the market becomes more effective, by forcing funders to compete on value and, therefore, stimulate competition between and the efficiency of providers. The resultant competitive environment will benefit the NHI." (44).

It can be argued that good governance would have ensured a complete policy framework. The HMI proposed that a risk equalisation mechanism would make private funds individually sustainable as risks – such as more elderly people in one fund – would be cross-subsided by funds where, for example, the average age was younger. Without this mechanism, medical aid schemes competed for young and healthy members rather than focusing on developing value-based contracts with suppliers. Not putting pressure on providers to innovate or compete sufficiently meant that the private sector became extremely lucrative, particularly for medical specialists. This, in turn, meant that pull factors of a good income in the private sector, accompanied by push factors from a poorly managed public sector, drove the majority of specialists into the private sector.

Section 30 of the PSA allows for remuneration of work outside of the public sector (RWOPS) under strict conditions. Some specialists stayed in the public sector but flouted the rules on, for example, the number of hours of private practice permitted or barely attended their public sector jobs; but they have yet to be sanctioned. This practice was however outlawed in KwaZulu Natal (KZN) and is reported to be well managed in the Western Cape, although the full extent of RWOPS was unknown. The examples from KZN and the Western Cape illustrate that governing at least some aspects of the private sector is not impossible.

Government at provincial level has the opportunity to use hospital licensing as a mechanism to control the private sector. During the public hearings of the HMI, most provincial authorities were hostile to the idea of changing licensing requirements to ensure reporting that would make the private sector more transparent and competitive. For example, reporting regularly on bed types and occupancy rates, quality measures, and hours and times of work of specialists with RWOPS could ensure better regulation of the sector and might stem the tide of specialists leaving or abusing the public sector. South Africa would have been better prepared for the COVID-19 pandemic when information on number of beds, bed types and occupancy rates were urgently needed. Instead, the country risks continued reliance on quickly assembled data in the face of disaster.

Resistance to such interventions was articulated at the provincial level in the form of reasons related to staff being too busy and overworked to take on additional functions. Some said that they were employed to serve the public, not the private sector. This strongly suggests that the overall stewardship role of the health ministry is not understood at either national or provincial level.

Those stewarding the health sector seemed not to understand the impact of rapid and under-regulated private sector growth on access to care in both sectors: high and rising costs for private-sector users and inadequate human resources in the public sector. The HMI demonstrated that supply-induced demand driven by access to beds and specialists in the private sector consumed resources unrelated to health needs. Lucrative work attracts specialists to the private sector, undermining the ability of the public sector to capitalise on its investments in training specialists and denying public-sector patients highly qualified staff. Overall, the NDoH seemed not to take into account the interrelationship between the private and public sectors or the impact on access to affordable quality care for everyone. The delay in acknowledging and addressing this impact has resulted in trends that are difficult to reverse.

Cognisant of both the current reality and the desire to implement a NHI fund, the HMI made recommendations that would rein in the private sector and set in place various institutions to be partially funded by the private sector. These steps, if implemented, would test redistribution of health spend, initially within the private sector alone, through a risk equalisation mechanism. These measures would also build skills and trust in a centralised management capacity.

Health outcomes data are essential for any strategic purchasing. The HMI recommended drawing co-investment from private-sector funds to build capacity to monitor health outcomes. This system, according to the HMI, could and should be uniform across the public and private sector.

The HMI also suggested a series of measures to make contracts transparent (those between purchasers and suppliers of hospital beds and, separately, with clinicians of various types) and subject to review so that vested interests and corruption can be curtailed. In addition, the HMI proposed a mechanism to ensure that regulatory bodies and oversight boards are in place and protected from vested interests. The HMI identified necessary changes to HPCSA rules, in particular allowing for fully integrated care offered through multi-disciplinary practices as both a way to contain costs as well as representing best clinical practice. The NDoH has the authority to ensure that the HPCSA acts on the HMI report but has not done so.

Its refusal or reluctance to engage with the contents of the HMI report demonstrates that the NDoH does not fully understand its governance role: making sure that the right incentives and regulatory bodies and systems are in place for the entire health system, not the public system alone. The NDoH has argued that, once the NHI is in place, the private sector will *de facto* be managed. Nonetheless, implementing the HMI recommendations would have allowed for a number of systems to be tested and developed, building both trust and experience in managing big funds. Many of the checks and balances suggested by the HMI are needed across the health system. Most importantly, the private sector could have been engaged early on, easing integration into the NHI at a later stage.

## Global evidence on health systems governance

The Panel searched the literature for systematic reviews or overviews of systematic reviews of governance arrangements for health systems and found three relevant studies.

Firstly, a 2017 overview of systematic reviews (8) defined governance arrangements as including “changes in rules or processes that determine authority and accountability for health policies, organisations, commercial products, and health professionals, as well as the involvement of stakeholders in decision-making”. Such arrangements can affect health and health-related goals through changes in authority, accountability, openness, participation, and coherence and can have effects on patient outcomes, the quality or utilisation of health services, resource use, or social outcomes such as poverty or employment (8).

The overview included 19 reviews and found that, in all the main categories of the taxonomy of governance arrangements for health systems, there were important evidence gaps where primary studies and/or rigorous reviews were needed (8). Of the included studies, 18 were judged to have only minor limitations and thus to be reliable (8). The overview found that there was moderate- or high-certainty evidence of desirable effects and no moderate- or high-certainty evidence of undesirable effects for the following interventions on at least one outcome.

1. **Interventions focusing on decision-making about what is covered by health insurance:** The overview found that “placing restrictions on the medicines reimbursed by health insurance systems probably decreases the use of and spending on these medicines” (8).
2. **Interventions focussing on stakeholder participation in policy and organisational decisions:** The overview found that “participatory learning and action groups for women probably improve new-born survival” and “may slightly reduce still births”; and “consumer involvement in preparing patient information probably improves the quality of the information and patient knowledge” (8).
3. **Disclosing performance information to patients and the public:** The evidence in this area is relevant to South African initiatives such as the Office of Health Standards Compliance and the Ideal Clinic. The overview found that “public disclosure of performance data on hospital quality may lead to little or no difference in patient selection of hospitals” but “probably stimulates hospitals to undertake quality improvement activities (moderate-certainty evidence) and may lead to slight improvements in hospital clinical outcomes (low-certainty evidence)” (8)..

The overview found insufficient evidence to assess the effects of the following interventions and therefore further studies evaluating these interventions are needed:

1. **The effects of inspections:** This point is relevant to the role of bodies such as the Office of Health Standards Compliance. The overview found that it is “uncertain whether external inspection of adherence to standards improves adherence and quality of care or decreases health-acquired infection rates in hospitals (very low-certainty evidence)” (8).
2. **The effects of stakeholder participation in public policy and organisational decisions:** The overview found it was uncertain whether telephone discussions change consumer priorities for community health goals compared with face-to-face meetings (8).
3. **The effects of fraud prevention interventions:** The overview found that it is “uncertain if prevention, detection, or response interventions reduce healthcare fraud and abuse and related expenditures (very low-certainty evidence)” (8).
4. **District manager training programmes:** The overview found weak evidence in relation to managers' knowledge of planning processes and monitoring and evaluation skills. This point is relevant for the future human resource capacity needs for universal health coverage (UHC) in South Africa under an NHI.

Secondly, a 2016 Cochrane systematic review of interventions to reduce corruption in the health sector noted a paucity of evidence about how to best reduce corruption but identified promising interventions (73).

1. **An independent agency at national level to investigate and punish corruption** in the health sector, as part of a package of interventions, secured many convictions, recovered large amounts of money, and led to savings. Other components of the package of interventions included obtaining more sophisticated computer analytic capacity to review payment trends and spot improper billing, stricter healthcare fraud and abuse control laws, prepayment claim checking, manual reviews, educating providers (for example, with guidelines on ethical practices), provider enrolment screening, and restructuring programmes. The reviewers noted that a functional judicial system and continued political support would be required to obtain the benefits of this intervention (73).
2. **Guidelines to prohibit doctors from accepting benefits from the pharmaceutical industry** may reduce corruption and change doctor's perceptions of the influence of the pharmaceutical industry on their prescribing behaviour. However, this was an effect of low certainty.
3. **Increasing transparency and accountability for co-payments**, together with reducing incentives for demanding informal payments, might reduce informal payments.

Lastly, a 2016 Cochrane review of public stewardship interventions for for-profit healthcare services in low- and middle-income countries included 11 studies. It reviewed interventions made by governments to ensure private healthcare providers met certain quality standards. The review found two promising interventions (74).

1. **Training on prescribing and dispensing drugs** offered by the ministries of health to private drug sellers probably improves the quality of healthcare services.
2. **Training and regulation of private pharmacies**, comprising educational visits and visits by inspectors to enforce regulations, probably improves the quality of care.



These systematic reviews do not, unfortunately, provide comprehensive evidence of interventions that might address the many governance challenges which the South African health system faces. However, the findings do support the use of particular interventions to address provider practices and public participation and to control corruption.

## Conclusion

Although the post-apartheid government attempted many key changes, the health system is still facing numerous governance challenges. The struggle to redress structural inequalities and to provide quality universal health coverage remains pressing. Other challenges compounding weak governance include a quadruple burden of disease, limited resources, an ongoing leadership and human resource crisis, poor quality health care, and high levels of poverty, exacerbated over the past few years by the impact of the COVID-19 epidemic and control measures.

The literature reaffirms many of the elements that were identified in Chapter 2 in terms of the roles and interactions of actors in governance and the key elements for health governance. It identifies several promising governance and leadership practices locally and some evidence of effective interventions elsewhere.

## Chapter 4: Governance Issues for National Health Insurance

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### Introduction

Health care provision in South Africa lacks consistent comparable measures of quality and health outcomes and, by extension, the ability to purchase strategically, to purchase on the basis of value. This is true for both the public and private sector. Of the multiple ways to achieve strategic purchasing, South Africa's chosen option is a National Health Insurance (NHI) system centred around a single national purchaser, the NHI Fund, which will purchase services from both public and private healthcare providers. The NHI Bill, which aims to establish the NHI Fund, has recently been considered by Parliament and is awaiting promulgation by the President. Some details regarding how the fund will work are not fully articulated in the Bill and will need to be spelled out in revisions to the NHI Bill or later regulations. Whatever the ultimate formulation, strategic purchasing will almost certainly be central to any future NHI system and so it is important to address governance issues ahead of implementation and think through how strategic purchasing can operate as a lever to improve governance of the South African health care system.

The progressive introduction of NHI, in whatever form, will require huge changes to the governance of the health sector in South Africa and holds potential opportunities for governance reform. Strategic purchasing in particular could be a key lever for governance reforms, improving accountability and performance but will also require capacity and changes in governance arrangements.

In the conceptualisation of health financing reforms globally, strategic purchasing is typically envisaged to be a key element. The World Health Organisation (WHO) identifies the pillars of health financing to be revenue raising, pooling, purchasing, and benefit design (75). Purchasing is the transfer of pooled funds to the providers of health services, and includes such functions as benefit specification, contracting, provider payment, and performance monitoring, all to be carried out with strategic intent. Governance arrangements greatly influence the success of strategic purchasing.

In South Africa, NHI is one of the most important medium- to long-term sectoral reforms proposed for the health sector, with strategic purchasing defined as a key element (76). The ability of NHI to achieve health sector improvement is significantly dependent on its ability to do active and strategic as opposed to passive purchasing and to put in place the systems of governance within the NHI to link spending to performance and value.

### Proposed reforms

As currently proposed, South Africa's NHI is likely to encompass a number of reforms related to strategic purchasing.

- Introducing a purchaser–provider split in the national health system.
- Setting up a national purchasing authority (the NHI Fund), with the possibility of regionalised branches (as in Thailand) at a later point.
- Reforming provincial health departments to play a service-delivery role in contractual arrangements with the Fund. As some functions of the health sector are shifted from provinces to the NDoH and then decentralised to district or local level – as indicated in Annexures to the draft NHI Bill – provincial departments are likely to have reduced powers.
- Increasing the governance power of district health authorities, envisaged as stand-alone government components under the NDoH. (Each government component produces its own financial statements.) The NHI Fund would contract directly with the government component,

not via the province. Greater clarity is required on the relationship between the district and the proposed contracting units for primary care (CUPs).

- Progressively greater autonomy for larger hospitals (as per the hospital trust model in the UK), in line with the NHI principle of contracting directly with institutions that provide services. This will require stronger governance of such institutions. The Academic Complex Act has never been implemented in South Africa, but under the NHI the potential exists to set up specific hospital complexes as government components or other institutional forms such as public entities.
- Developing new provider payment models, moving away from line input budgeting to output-oriented or needs-based payment systems such as capitation for PHC; 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 that currently obtain in the public sector.
- Adopting a mixed provision model, with NHI Fund purchasing from public and private organisations, which will allow for greater competition on the basis of quality and outcomes or value.

Central to these reforms is the establishment of some form of strategic purchasing arrangement between the NHI Fund and the providers of health services. Strategic purchasing in this context refers predominantly to purchasing health services through a purchaser-provider split and not the procurement of inputs. The South African model also allows for a mix of public and private sector participation on the provision side, which, in countries such as Australia or Germany, encompasses extensive purchasing of private services by public purchasers.

To be effective – to achieve quality, economies of scale, and efficiency and equity –strategic purchasing needs to be active rather than passive and to be well governed. It therefore has potential to change the governance landscape.

## Strategic purchasing

### Box 1. What is strategic purchasing?

Purchasing in the context of health financing systems is the process of transferring pooled funds to healthcare providers. This can be done in a passive or active, strategic manner.

*Strategic purchasing* has been defined by WHO to mean “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”. The different activities within purchasing can all be done passively or strategically:

*Benefit specification* is considered strategic when the benefits package is well and transparently defined and reflects health priorities.

*Contracting* is strategic when it is in the shape of formal agreements specifying the obligations of both purchaser and provider and when these agreements reflect explicit health system objectives.

*Provider payment* is strategic when payment mechanisms and payment rates are linked to the benefit package, incentivise efficiency and performance, and promote effective and equitable allocation of resources.

*Performance monitoring* is strategic when appropriate information is routinely collected, is used for monitoring by both purchaser and provider, and informs purchasing policy.

Purchasing is not strategic if a purchaser just pays providers for every item through line-item budgets or multiple fee-for-service payments without links to specified health system objectives such as coverage, outcomes, and accountability.

### Global experience

Strategic purchasing is not a new idea. It can be traced at least as far back as reform efforts in the UK's National Health Service (NHS) in the 1980s that aimed to improve efficiency by introducing a “purchaser–provider split” and an “internal market” (77,78). Somewhat controversial at that time, the idea of strategic purchasing has evolved; these days, it is viewed less as an ideological position touting the primacy of market forces, and more as a general set of approaches to improve the effectiveness of government health spending by better linking budgets to performance and more explicitly determining the services, outputs, and quality that government wishes to purchase (79,80).

Although the promise of strategic purchasing is intuitively powerful, there is a lack of robust evidence of large-scale implementation of the full range of approaches with clearly traceable impacts on service delivery and health outcomes (78,79). Despite some weaknesses in empirical evidence of strategic purchasing reforms (8), however, many countries and international organisations see strategic purchasing as a set of reforms with the potential to improve health systems performance and achieve value for money (81,82). WHO has published guidance (83) on the governance of strategic purchasing along with related country case studies, for example for Egypt (84) and Kyrgyzstan (85).

Health insurance has grown globally as a means of achieving universal health coverage. At the same time, countries have moved to establish purchasing authorities and to separate purchasers from providers. With the shift from passive to active purchasing comes a range of tools to govern the relations between purchasers and providers. Even in countries such as the UK or Spain with relatively integrated National Health Services, systems of strategic purchasing have emerged, over decades, in which different levels or actors in the system allocate funds to providers based on particular outcome

objectives. In a review of purchasing arrangements in Europe, Figueras describes how countries that are constantly striving to improve the performance of their health systems want to see what they are buying, what value they are getting for their money, rather than simply reimbursing. He talks of strong stewardship purchasing, translating policy intentions into spending decisions, in many cases backed up by contractual arrangements (82). Strategic purchasing reforms are underway in various countries in Africa, as discussed below.

## Purchasing tools

The core set of purchasing tools include benefits specification, contracting, provider payment, and performance monitoring (86). Any and all can be applied either passively or strategically to direct funding and provider behaviour toward health system objectives. Benefits specification includes selecting the services and interventions to be included in the benefit package, the service delivery standards, where and how the services can be accessed (including gatekeeping policies), how much of the cost of services will be covered by the purchaser (and accompanying cost-sharing policies), and which medicines and medical devices will be covered. Benefits specification is strategic when a package is well defined and periodically revised through a transparent process, reflects health priorities, and is an entitlement to the covered population (87,88). For example, in Chile's national health insurance system, which includes both public and private purchasers, the benefits package takes the form of explicit and enforceable service guarantees for a list of conditions. The list of conditions, known as Acceso Universal con Garantías Explícitas (AUGE), is reviewed every three years by an advisory committee. Care for these conditions is guaranteed within a defined waiting time and must be provided according to national service delivery standards (89,90).

Once the service package is defined, the purchaser contracts with providers to deliver the services to the covered population. Contracting can take many forms, from the highly structured and competitive to the more implicit and relational, and the most appropriate approach is likely to be context specific (84). Contracting is considered to be strategic when formal agreements between the purchaser and the public and private providers specify obligations on both sides. The purchaser can use contracts to achieve explicit objectives (such as improved prescribing of medicines or better data reporting), and contracts selectively with public and private providers based on uniformly applied quality standards. In the U.S. Medicaid program (government-financed coverage for low-income and vulnerable populations), states increasingly use strategic purchasing arrangements with managed care organisations (MCOs) to provide efficient and equitable coverage for Medicaid-eligible populations. These managed care contracts spell out service delivery priorities and performance expectations, as well as the terms of payment. State contracts also identify population health improvement priorities, areas for specific investment, and desired innovations in care and payment reform (91).

The purchaser pays contracted providers to deliver the services in the benefit package through a set of provider payment systems. Provider payment is strategic when payment incentives and rate-setting are used to achieve health system objectives – that is, when payment is linked to services in the package and specific service delivery objectives, creates incentives for efficient and high-quality service delivery, promotes effective allocation of resources across levels of care, and enables stronger management of the purchaser's budget (86, 92–94). Provider payment policy in Estonia's Health Insurance Fund (EHIF) provides an example of payment methods evolving to become more sophisticated as capacity grows and new priorities emerge. Early in the reform process when EHIF was established in the mid-1990s, hospitals were paid according to fixed price-volume contracts based on diagnosis-related groups (DRGs), and primary health care (PHC) providers were paid through a blended system, with 70% of revenue paid through capitation and the remainder through fee-for-service and fixed allowances (95). Over time, the payment systems have evolved, with, for example, a performance-based component added to PHC payment (96) and a pilot of disease-specific bundled payments across levels of care to promote better care integration (97).

Performance monitoring includes systems and processes for assessing provider performance, providing feedback for improvement, and carrying out system-level analysis of utilisation, quality, and so forth, to inform purchasing decisions. Performance monitoring is strategic when information is generated routinely through integrated health information systems and used for monitoring at both the provider level and the system level to inform purchasing policies (77,86,91,98). In the Philippines, for example, the national health insurance agency (PhilHealth) introduced case-based payment for inpatient services in 2011. The automated monitoring system showed that 60% of patients admitted for moderate-risk pneumonia were discharged earlier than treatment guidelines suggested. Based on this finding, PhilHealth instituted new payment conditions and denied claims for cases not treated according to the treatment guidelines (96) to balance the efficiency incentives in the case-based payment with quality incentives.

Countries that have made strategic purchasing a central focus of the governance of health financing have been able to achieve improved health system outcomes within the limits of their fiscal constraints. In Thailand's Universal Coverage (UC) Scheme, for example, strategic purchasing has been crucial to achieving improved access to services and reduced catastrophic spending for households, while keeping the costs of the system under control (99,100). The UC Scheme's purchasing agency uses a range of strategic purchasing levers to prioritise covered services, direct service utilisation toward the appropriate level of care, create provider incentives for high-quality and efficient service delivery, negotiate pharmaceutical prices, and cap total expenditure in the system. This has made it possible for the UC Scheme to offer comprehensive benefits with high financial protection at relatively low cost per person.

### Building purchasing systems

Strategic purchasing requires a set of institutional functions and capacities in the health system, and an effective governance structure to set objectives, priorities, and rules while ensuring accountability. More mature strategic purchasing systems are made up of "task networks" of agencies and actors that are responsible for coordinating, carrying out, and overseeing purchasing functions (101). The main purchasing agencies that transfer funds to providers, whether an insurance agency or other public institution, require institutional authority to make purchasing decisions and enter into contracts with providers, flexibility to allocate funds to pay for outputs and outcomes, and well-functioning information systems to design and implement purchasing mechanisms (102,103). Effective health purchasing also requires purchasing power: a large purchaser or multiple purchasers operating under a unified set of rules and regulations can exert influence over how health care resources are used and how providers deliver services.

In practice, health financing systems are often characterised by multiple funding flows, each of which may be responsible for its own population group, service package, provider payment mechanisms, and reporting requirements. This creates a fragmented set of signals and incentives for providers, which weakens the power of any one purchaser to drive provider behaviour to achieve system objectives (99). Governance of purchasing arrangements should provide stewardship of the system to manage and overcome this sort of fragmentation. Governance should also provide strategic direction and ensure coherence, oversight of the various actors, definition of their roles and responsibilities, and ways to hold them accountable for carrying out their responsibilities. Transparency is essential to ensure that decisions are rational, and evidence based, and purchasing agencies have to be insulated from vested interests.

Governance arrangements should also clearly specify the mandate of the purchasing agencies and hold them accountable for achieving health system objectives, not only financial objectives. In the U.S. Medicaid managed care experience, for example, although some positive impacts have been observed on service delivery and client satisfaction, negative impacts on health outcomes have

also occurred, particularly for more vulnerable populations, when MCOs are dominated by for-profit players and purchasing incentives over-emphasise cost containment (104). Failure to create a clear legal mandate and accountability for the purchaser to meet specific health objectives has, similarly, limited the effectiveness of strategic purchasing in health insurance systems in other countries such as Indonesia and Vietnam (105,106).

### Progress and perspectives from Africa

Africa faces multiple problems: a high disease burden, a growing population in many countries, and tight resource constraints. The promise of achieving more with limited resources is tied to the efficiency with which the limited resources can be applied to obtain optimal results. Strategic purchasing, among other potential benefits, can help countries do just that.

Atim, Arthur and Achala (107) conducted a study on recent history of health financing reforms in Africa with special focus on strategic purchasing and priority setting. They categorised strategic purchasing functions into different dimensions or core functions: the existence of a defined benefit package of services; provider payment mechanism; provider autonomy; accountability and monitoring mechanisms; contracting arrangements; and pooling mechanisms and the level at which they occur. Resource-constrained countries, especially African countries, stand to capitalise on the efficiency, equity, and quality principles and rewards of strategic purchasing as a tool for accelerating progress to their UHC targets. However, reviewing documents on strategic purchasing in over 20 countries across the five regions of Africa, the authors concluded that African countries are not maximising the benefits of strategic purchasing because they are only making limited use of the approach (108–116). Their findings are summarised across the dimensions of strategic purchasing functions in Table 6.

**Table 6:** Summary of strategic purchasing in African countries

Countries	Defined benefit package	Provider payment mechanisms	Provider autonomy/ accountability & contracting	Pooling mechanisms & levels at which pooling occurs
Algeria, Botswana, Burkina Faso, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo, Egypt, Ghana, Kenya, Lesotho, Morocco, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Tunisia, Uganda, Zambia and Zimbabwe	Virtually all countries have defined benefit packages, but the packages are often fragmented along the lines of the fragmented financing schemes	Payments in most countries have no link to output and do not incentivise quality services – fee-for-service is the dominant provider payment mechanism Government budget funding of health services mostly by rigid budget line items payment with no explicit link to provider performance A few countries (including Kenya, Ghana, Nigeria and South Africa) use mixed provider payment (capitation, per diem, case-based payment, Diagnosis Related Group (DRG))	Generally, provider autonomy is limited in all countries Monitoring and accountability mechanisms are weak and contracting of providers, especially public sector providers, is limited Private sector providers have far more autonomy than public sector providers	Pooling schemes exist in most countries, at least at the level of general government budget funding Pervasive fragmentation in financing schemes means that pools are not large enough to effectively spread risk or take advantage of purchasing power The population is often segregated for the purpose of providing different financing schemes for different segments (such as formal versus informal workers)

**Source:** Adapted from Atim, Arthur & Achala, (2022), (107)

Findings by Atim, Arthur and Achala (107) are reinforced by Gatome-Munyua, Sieleunou, Barasa, et al (117) who used data collected on the core functions of strategic purchasing between 2019 and 2021, and applied the Strategic Health Purchasing Progress Tracking Framework developed by the Strategic Purchasing Africa Resource Centre (SPARC). They conducted a comprehensive analysis of strategic purchasing progress in nine African countries, representing the continent's regional diversity and a mix of income levels. They concluded that, in most of the nine countries, strategic purchasing has been limited. Their key findings suggest that the pervasive out-of-pocket (OOP) payments and the high degree of fragmentation in financing schemes and purchasers are major constraints to strategic purchasing. These constraints – together with others such as limited contracting of providers, especially public health care providers, weak monitoring and accountability mechanisms, and limited harmonisation of benefit packages – limit the use of purchasing power to allocate resources strategically, to incentivise providers' performance, and to improve care quality. Similarly, a study of micro health insurance in Kenya (118) revealed weaknesses in the regulatory and legal framework that does not support the practice of strategic purchasing in the financing schemes studied.

Gatome-Munyua et al (117) summarised their findings according to dimensions of the strategic purchasing function (benefit package specification, mechanism for contracting, provider payment mechanism, and performance monitoring). Findings from their study suggest that:

- Countries have made progress in establishing defined benefit packages, but multiple packages of services are observed across the multiple financing schemes.
- Countries have established mechanisms for contracting private sector providers, but very few contracting arrangements are applied to public sector providers.
- Countries are beginning to link strategic purchasing and provider payment mechanisms to health system objectives.
- Most countries have some basic routine monitoring mechanisms for providers that produce analysable data especially for health service delivery indicators.

This is however not enough to reap the full benefits of strategic purchasing. Besides some work to define a benefit package, few countries have gone on to define a transparent process for reviewing the benefit package, defining quality standards and linking quality to the contracting process, or a process and criteria for determining provider payment rates, or to use data to provide feedback for provider incentives (117). The least progress has been made on:

- Using the benefit package to define what services to buy and from whom, and linking benefits to provider payment mechanisms,
- Monitoring provider performance and linking contracting to provider performance,
- Harmonising multiple fragmented provider payment mechanisms and financing schemes,
- Streamlining and integrating monitoring processes and systems to facilitate evidence-based decisions for strategic purchasing.

The study therefore concludes that progress on strategic purchasing has been limited in most of the countries studied, and that this, together with pervasive and high OOPs, limit any large-scale health system improvements. South Africa's OOPs are relatively low in comparison to international levels and extremely low compared to most other African countries, so the potential power of purchasing reforms may be stronger in South Africa.

A comprehensive analysis of strategic purchasing in the Middle East and North Africa (MENA) region identified gaps in the use of strategic purchasing in all four North African countries (Algeria, Morocco, Tunisia and Libya). The gaps include lack of contracting arrangements, provider autonomy, accountability, and performance monitoring. While several countries define a service package, the



link to population health needs is often in doubt, with no formal or deliberate attempt to use data to inform purchasing decisions. These findings again present a picture of limited application of strategic purchasing in African countries. Witter et al (119) arrived at similar conclusions in comparison of strategic purchasing status and progress in three African countries (Democratic Republic of Congo (DRC), Uganda, and Zimbabwe). They identified fragmentation of financing schemes as a major challenge to strategic purchasing. Studies conducted by the Strategic Purchasing African Resource Centre (SPARC) of individual countries exploring strategic purchasing find similar limitations, noting as key challenges the lack of formal contracting arrangements especially among public sector providers, inadequate performance monitoring, and fragmentation of financing schemes and its effect on the purchasing power of the purchasers (110,113–116).

These studies underline the need for reforms to address these bottlenecks. In southern Africa, fragmentation of financing schemes continues to limit funding pools from growing large enough for requisite purchasing power. As different schemes have different purchasers, there is no single, large pool to purchase services strategically (120–122). Medical Aid Schemes comprise a significant share of private financing in Botswana, South Africa, and Namibia, but the HMI found that, without risk equalisation mechanisms, schemes focus on attracting lower risk members rather than negotiating with suppliers for value-based care.

## **A potential lever for governance reform**

Extensive evidence demonstrates relatively poor value for money from the South African health system. While spending over 8% of GDP on health care (of which around 4% is in the public sector), sectoral outcomes for life expectancy, child mortality, and many other key indicators are substantially below that of many other upper middle-income countries (UMIC) (123). This is despite health sector funding in South Africa comparing favourably with peers; public sector funding is around the median, but outcomes towards the bottom of UMIC countries (3). Although this is due in part to a high burden of disease, particularly the high prevalence of HIV/AIDS, there are also widespread shortfalls in governance, management, and accountability in the public sector and huge inequities between public and private sectors, with poor sharing of resources and collaboration. The two sectors function largely in parallel, with inequitable and inefficient utilisation of often scarce national resources such as medical specialists, obstetric units, and MRI machines. Evidence shows excess utilisation in the private sector, often fuelled by supplier-induced demand, whereas many parts of the public sector are plagued by resource scarcity and underutilisation.

Weaknesses in accountability in the public health sector are due in part to problems in design of incentive arrangements and the lack of a relationship between funding and performance. In many cases, it is near impossible to meaningfully reward good as opposed to poor performers, discipline poorly performing health managers, or enforce accountability. Existing public service performance agreements with managers and bonus systems in line with DPSA rules focus on individuals rather than institutions and appear to have become an exercise in compliance (124,125) as opposed to a strong mechanism to differentiate good from poorly performing managers and a way to turn around public sector performance. There are also weaknesses in accountability in the private sector, where uniform measurements of quality are lacking, making it difficult to enforce consequences for poor quality of care or reward good performance.

Two important factors limiting traction of strategic purchasing in Africa as a whole – high out-of-pocket payments (OOPs) and fragmentation of financing schemes – may be less significant in South Africa. The country has relatively low out-of-pocket expenditure, around 8% of total health spending. While there is fragmentation in the private sector, the public sector is predominantly funded by tax revenue raised nationally and the NHI reform will further consolidate the nine existing pools under provincial governments into a national pool under the NHI Fund. Thus, strategic purchasing represents a potentially

powerful lever for UHC progress and governance reform in the country. There has, however, been very little progress with strategic purchasing in South Africa to date. The public sector has neither introduced a purchaser–provider split nor embarked on purchasing from private providers to any significant degree.

The introduction of strategic purchasing in South Africa is relevant to governance for several key reasons.

- Strategic purchasing potentially changes the incentive arrangements in the health sector, by linking reimbursement to performance. This is intended to incentivise particular outputs or outcomes, and may have positive or unintended negative effects, depending on how the system is designed and implemented. For example, in recommendations for a capitation model for reimbursing general practitioners (GPs) contracted by the NHI, Ranchod proposes a set of tools, including add-on incentives for payment for performance or additional payments to incentivise particular quality or outcome measures (126). (See Figure 5) The primary care reimbursement model is based on a capitation model adjusted depending on the population served and how sick or well they are, with age and sex often providing useful proxies. Add-on incentives allow the doctor or practice to be paid more if they reach predefined performance levels such as a given level of child immunisation or keeping people with hypertension or diabetes out of hospital.

**The proposed reimbursement structure is illustrated below:**



Figure 5: Proposed reimbursement structure for a NHI GP contracting model.

Source: Ranchod / National Treasury (126) \*pppy = per person per year; FFS = Fee for Service.

- Strategic purchasing changes the accountability arrangements within the sector, to include formal contracting and systems of performance measurement for both public and private providers. This will require substantial reorganisation on the provision side, such as giving hospitals greater autonomy, establishing new structures such as District Health Management Offices (DHMOs), or contracting CUPs.
- Introducing a purchaser–provider split may change the power relations between the parties at both central and institutional levels. For example, the NHI Fund may contract directly with a hospital, district or clinic. This may require giving greater autonomy to institutions such as hospitals and changing their governance structure so that they have the power to contract with the Fund and to make decisions in a decentralised, flexible, and accountable way. This may substantially change the role of provincial health departments, for example, and the location of powers and controls.
- Shifting from passive to active purchasing changes the nature of the governance arrangements and will require substantial additional and different types of capacity in both the purchasing agency and the providers from which it will purchase services.

To explore one aspect in more detail: introducing strategic purchasing potentially redesigns incentive and accountability arrangements in the health system. Previously, a hospital, for example, was funded on the basis of line-item input budgets from a provincial health department; with strategic purchasing, the hospital would be reimbursed in line with its performance, workloads, and quality of care. In the existing situation, annual funding would likely not change in response to poor performance or might even increase; with strategic purchasing, the funding of the institution would be based on how well it does its work. Previously, there was little way for the public sector to engage with private providers; the

new model would enable the public sector to purchase from a range of providers, public and private, depending on value for money and quality of care. A citizen/patient could register with a public clinic/ community health centre or with a private general practitioner capitated via the district, CUP, or NHI.

### Private sector provision and regulation

The HMI (44), finalised in 2019 by the Competition Commission, included several findings and recommendations relevant for purchasing and related governance. One of the overall findings was that South African private healthcare (the focus of the HMI) is characterised by high and rising costs and significant overutilisation. This is partly due to inadequate stewardship of the private sector by the NDoH, and results in the private sector being neither efficient nor competitive. The HMI found that excessive utilisation is, at least in part, supplier-induced, incentivised in turn by reliance on fee-for-service. The prescribed minimum benefits (PMBs), while positive in guaranteeing a minimum coverage for medical scheme members, do not cover for primary health care. This has promoted hospicentric care and contributed to high healthcare costs.

One key recommendation from the HMI is to strengthen regulatory oversight of the private sector by establishing a supply-side regulator (see Figure 6), responsible for a range of interrelated activities, including licensing, which would be linked to quality. The regulator would provide essential information to support value-based purchasing as well as reviewing contracts to ensure the use of value-based metrics in contracting and thus promote transparency. The proposed regulator would interact with existing regulatory bodies and could over time oversee both the private and public system. Further, the HMI report recommends that the public sector use strategic purchasing from private providers to augment capacity where the public sector capacity is limited, noting that this does not need to wait until NHI is rolled out. To be implemented at scale, unified output and outcomes measurements are essential, as well as interoperable information systems.

### Early examples of strategic purchasing

Two recent examples have demonstrated the potential of strategic purchasing in South Africa.

- Under the COVID-19 vaccination programme, persons registered on the Electronic Vaccine Data System (EVDS) were directed initially to public or private vaccination sites depending on whether they were members of medical schemes or not. Many had to travel long distances and uptake was low. Later, administrative arrangements were made (and reimbursements made behind the scenes) to enable citizens to use either a public or private site regardless of insurance coverage.
- Under the centralised chronic medicine dispensing and distribution system (CCMDD), public patients can collect medicines at a range of public and private sites. This has increased convenience and improved access to chronic disease treatment.

### Factors underlying slow progress

For South Africans who have grown used to the public sector over many decades, the concept of strategic purchasing requires a major mind-shift, even among supporters of NHI, similar perhaps to the idea of shifting, after decades of government support for Eskom as a single power monopoly, to the idea of a public electricity distributor buying from a mix of power producers both public and private.

Although strategic purchasing in the health sector is widespread in many countries with UHC systems and has been NHI policy for several years in South Africa (Green and White Papers and NHI Bill), very little has been developed by way of contractual and purchasing arrangements, either within the public sector or between public purchasers and private providers. This suggests how entrenched existing thinking is in South Africa, and how difficult change management will be (127).

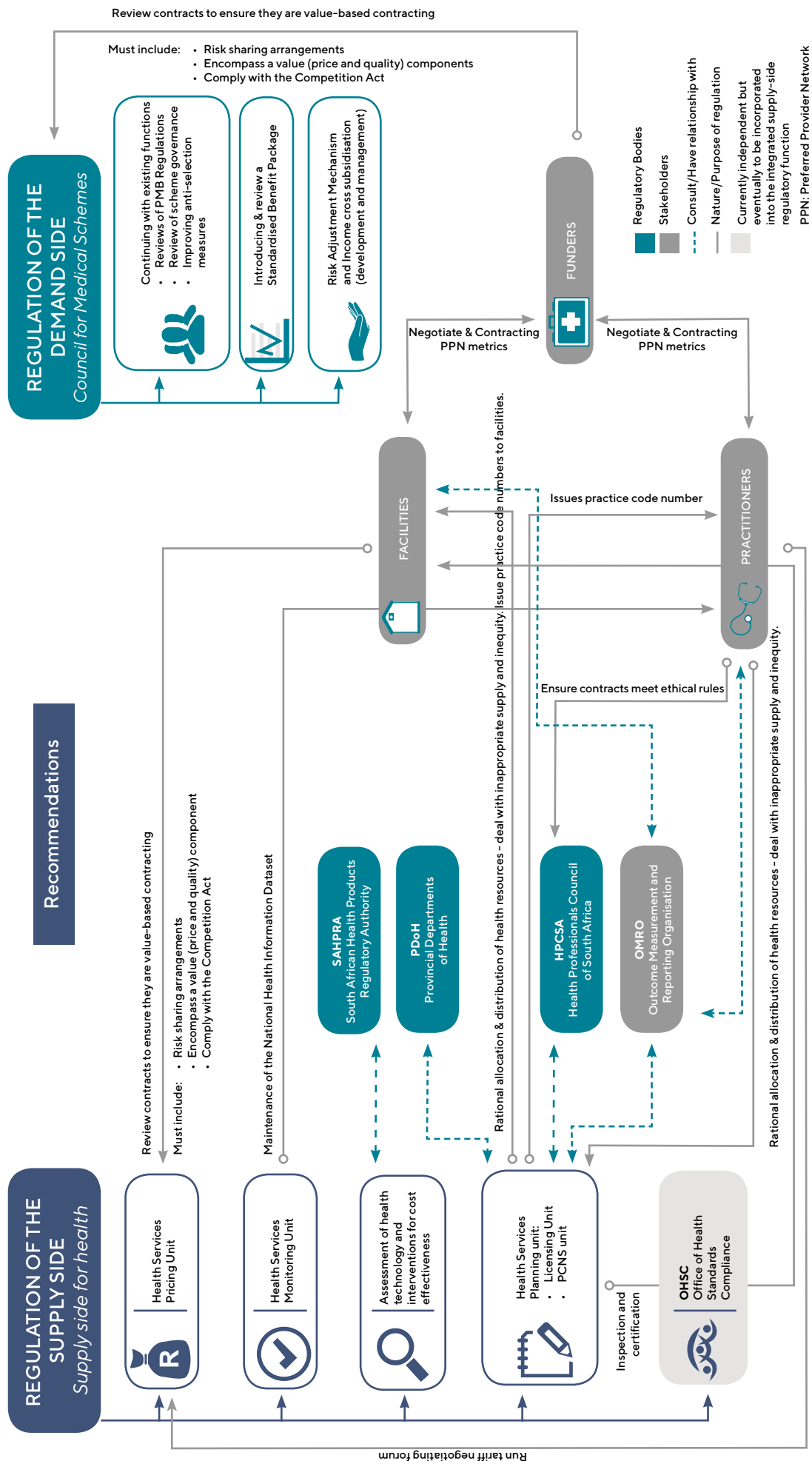


Figure 6: HMI recommendations for supply and demand side regulation.

Over the past 20 years, many supply side reforms have been attempted in the health sector to improve service provision, including staffing, pharmaceuticals, and infrastructure. Yet, repeated health sector audits for example from the Office of Health Standards Compliance show that many if not most facilities are not up to standard. In contrast, there have been almost no reforms on the demand side, in other words, financing reforms that follow where patients choose to go and incentivise performance. In 2012, an NHI indirect conditional grant was established and for the following five years a set of “NHI pilots” were set up with a budget exceeding R2 billion per annum. Once again, the reforms focussed on health service strengthening, tested virtually no strategic purchasing reforms, and produced little in the way of lasting benefit.

Many reasons explain why strategic purchasing, although a key NHI pillar, has been so slow to evolve in the public sector in South Africa. These include:

- Lack of know-how and innovative thinking around incentive and reimbursement redesign and lack of capacity at both the provincial and national level to design and implement contractual arrangements and a purchaser–provider split.
- Perceived fears that contracting private providers might take funds away from public ones. High costs in the private sector (44,128) are sometimes seen as prohibitive to purchasing by government.
- A desire to retain direct control at provincial head offices.
- The demands of a data-driven model including challenges with ICT infrastructure and connectivity in many public health establishments and a lack of integration of health information systems with the private sector (128,130), although some NHI information systems are being developed.
- Lack of accountability on the part of facility managers, and fear that poor performance will be exposed. Linked to this is a culture of defensiveness rather than learning.

Exposure to other UMICs that have introduced such systems to good effect, such as Thailand, Turkey and South Korea, does help to create a vision for what might be possible in South Africa.

## Governance reforms required for strategic purchasing

Strategic purchasing as envisaged in the South African NHI will require radical changes in health sector governance. Poorly developed purchasing arrangements may not achieve the intended benefits.

1. **Stronger, semi-autonomous provider institutions:** The NHI Fund (or in a simpler interim arrangement, the provincial government) will contract with an institution such as a hospital. This requires a new legal status for the hospital and therefore new powers and responsibilities for its CEO, managers, and hospital board. New forms of governance could be developed. Hospital boards for example could gain executive as opposed to advisory powers. In academic hospitals, universities could potentially become key partners on hospital boards and in management.
2. **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 (or provincial departments under current arrangements) and the provider institution.
3. **Linking funding and performance and reimbursement reform:** Funding and reimbursement of the institution will be linked to its performance and thus the system of accountability will need to change. This will require substantial reorganisation on the provision side. As reimbursement forms change to become more output and outcome linked, more attention can be focussed

on these areas rather than on line-item input controls and historical budgeting. This could mean greater flexibility for hospital managers.

4. **Information systems:** To be able to collect the information and indicators to demonstrate an institution's performance and allow for reimbursement and the operation of contractual terms, information systems will have to change. Depending on the nature of the reimbursement reform, the institution might get specific or additional funding for quality, value, or achieving specific targets.
5. **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.

These are key governance reforms as they change the nature of accountability, the basis for funding, and the incentive system. The distribution of power in the system also changes significantly with the institution (as opposed to head office) holding and controlling a greater share of their funds and having greater flexibility to change internal arrangements to meet contracted targets.

Such arrangements exist in many countries and work well or poorly depending on various factors. For example, a real and meaningful link between performance and funding is likely to improve performance. On the other hand, if certain indicators are selected above others, those deselected may receive inadequate attention. If the accountability arrangements are not enforced – and South Africa has difficulty with corruption, procurement, and enforcing contracts – then strategic purchasing may not achieve its full intended benefits.

## Box 2. Western Cape provincial perspective on strategic purchasing

With a population of approximately 7 million people, the Western Cape is the third most populated province in South Africa and comprises 6 districts, with 24 local municipalities. The Western Cape Department of Health (WCDoH) receives funding from nationally raised revenue via the provincial equitable share and conditional grants and through the generation of its own revenue. The department provides preventive, promotive, curative, rehabilitative, and palliative care services across 586 service points, consisting of 462 primary health care service points, 52 hospitals and 48 Emergency Medical Services (EMS) stations. There are 33 district, 5 regional, 2 central, 1 tertiary, and 11 specialised hospitals.

The WCDoH's budget allocations to facilities and districts have primarily been based on historical costs, plus an inflator. Historical cost budgeting does not necessarily allocate budgets to the most cost-effective interventions which have the greatest impact on health outcomes, nor does it provide incentives to improve performance or efficiency, nor does it support equitable resource allocation. To change course, the WCDoH has embarked on an initiative to shift from passive allocation of budgets towards strategic purchasing, from both its own facilities and private providers, by linking the allocation of funds in a more purposeful manner to meet the health needs of the population and health system performance from an equity, efficiency, effectiveness, quality point of view as well as managing the expenditure growth.

- **PHC:** This initiative aims to allocate funds to the primary health platform on a geographical basis, applying a risk-adjusted capitation index and output data.
- **Hospitals:** Allocations will be based on a risk-adjusted capitation index, as well as using Diagnostic Related Groups (DRGs) to improve allocative efficiencies for reimbursing the hospitals for their clinical activities.

To support this process, the WCDoH is building internal capacity and developing mechanisms for efficient strategic and technical collaboration without becoming cumbersome.

A core element of the Western Cape department's policy reset is the governance and culture journey, with "governance" understood to be a system and process to direct and control an organisation, establishing how objectives are set, risks managed, and performance optimised. The governance reforms are intended to make the paradigm shift from a disproportionate reliance on command and control to a more inclusive, participatory, and consensus building leadership. Recognising that governance and culture (the collective behaviours of the individuals who constitute the organisation) are intrinsically linked, the WCDoH is committed to building a trusted health system with reliable and legitimate organisational and managerial practices, values, and norms.

Facilities with greater authority will benefit from the approved post list budget tool (APL) that assists facilities to calculate which posts it can afford to retain and which vacancies can be filled. Facility managers have access to the essential supply list (ESL) which contains approximately 16,000 health care related products and services which the strategic sourcing supply management team have contracted through provincial rate-based transversal contracts. Each entity has a separate budget management instrument (BMI) to reflect actual costs against budget and project future expenditure. District management teams will have managerial oversight and remain accountable for the financial performance of their geographical area.

Performance will be measured against collected data, initially output driven, and indicators such as vaccination rates, antenatal visits, TB treatment success rates, HIV viral suppression rates, and readmission rates.

Interconnected governance systems, processes, and capacities will be built on the basis of geographical area. The performance measures that impact health and well-being are partly determined outside of clinical care and include the health behaviour of the citizen and the physical, social, and economic environment. Improved population health outcomes will be measured through changes in premature mortality and the deprivation index, amongst other indicators.

Besides the "softer issues", the Department will identify any legal impediments, for example around the existing procurement framework which might make value-based contracting difficult.

Strategic purchasing of health care services is widely recommended as a policy instrument but can be difficult to implement. The Department must build on existing foundations. The Western Cape is fortunate to have a strong technical foundation but acknowledges the need to do better at community engagement and listening. "Thus, the need exists for us to learn collaboratively and from each other and iteratively implement what works."

"As a province we realise that the way we have allocated funding is not equitable and thus we are unable to measure financial performance from an equality perspective. Managers who overspend tell us that they are underfunded and managers who save get to retain that budget for the following cycle. Therefore, we are going down the road of capitation at PHC and a hybrid global fee model at the hospital level to at least create an equitably level playing field. Underpinning this from a provider perspective is the clinical service delivery model which we are progressively trying to improve."

## Governance of the NHI Fund

Because the NHI Fund will provide a governing structure and control large amounts of centralised funds, its own structure and governance are critical. The NHI Fund needs to be built with sufficient technical expertise and adequate information systems to manage strategic purchasing wisely, whether through central or regional offices. The Board of the NHI Fund needs to be highly skilled and diverse in order to lead and govern the Fund. There is a risk that the current version of the Bill vests excessive power in the Minister, (129) unlike for example the Board of the Thai UC Fund which, through a diverse set of stakeholders, provides a balance of key voices. If the NHI Fund is not well and cleanly governed, the advantages of the single payer system will be derailed. Single-payer NHI systems have some advantages (such as bulk purchasing) and are not uncommon internationally, although many countries (Germany for example) have competitive multi-payer NHI systems instead. It is noted that South Africa has historically encountered problems with the governance of monopolistic entities (Road Accident Fund and Eskom for example).

## Office of Health Standards Compliance

Established as an independent public entity in 2013, the Office of Health Standards Compliance (OHSC) may play an important role under NHI as an independent arbiter of the quality of care delivered by health institutions. Quality of care needs to be part of the contracted deliverables of institutions, can be linked to reimbursement incentives, and might also become a basis for accreditation. Currently in year 9 of operations, the OHSC inspected 387 health establishments in 2020/21 and needs to be further capacitated to expand its coverage. The independence and power of the authority may also need attention as it must be able to report publicly and transparently without fear or prejudice and have "teeth" where necessary to enforce compliance with critical standards. The scope of OHSC's assessments may need to expand to cover quality of care as measured by outcomes, and not only compliance with facility standards.

## Governance issues to be resolved for NHI

Although NHI offers huge opportunities, it may not prove effective unless a range of governance issues are appropriately addressed. Comments on the NHI Bill identified many weaknesses around governance issues, which may or may not be addressed in regulations to be promulgated; these will require attention (129).

- Unless the NHI Fund enjoys sufficient independence from the provision side, there is a risk that strategic purchasing will not work properly, leaving the introduction of a purchaser-provider split to be an expensive experiment and without exercising the true potential of strategic purchasing.



- The composition of the NHI Board and powers of the Minister of Health are factors that will influence the powers of the purchaser. The NDoH has not accumulated strategic purchasing experience to transfer into the NHI Fund. Transparency and accountability are not discussed nor guaranteed by the current structure of the NHI Bill and there is no indication of how the Board and purchasing decisions will be insulated from vested interests. There is as yet insufficient attention to community or user voice in the management of the NHI fund. By comparison, the Thai UC includes a range of stakeholders on the Board, which makes it substantially independent.
- Significant risks in service provision will arise unless the powers of the spheres are clearly delineated and any shifts in health function across the spheres are carefully managed. Uncertainties exist as to the location of powers and functions and mismatches in location of funds and functions. For example, the NHI Bill suggests that 53 new independent government components under the national Department be established to manage primary care services, but it is unlikely that this will be affordable for some years, given the fiscal problems facing the government. If primary care services are centralised under the national department, there is little to indicate that their governance from a distance will be an improvement on more decentralised arrangements through provinces. In a delegated arrangement Provinces potentially face risk in retaining staff and facilities, while funds are centralised into the NHI Fund.
- Unless institutions such as hospitals are provided with some degree of autonomy (as discussed above), they will not be able to contract directly with the NHI. There needs for example to be a clear process to set up large academic hospitals as semi-autonomous providers that can contract with the Fund.
- If strategic purchasing is not established as something different to current government procurement, there is a risk that all the pitfalls of current government procurement will further complicate the provision of services, including public sector health services. It is a good thing that the NHI Act will override certain procurement legislation and this needs to be made clear from the outset.
- A mixed public and private provision platform is one of the main potential strengths of NHI, but if this is not well governed there exists a range of potential pitfalls including corruption, lack of buy-in and trust from users, and failure to achieve both quality and economies of scale.

## Conclusion

National Health Insurance and strategic purchasing may not prove effective if relevant governance challenges are not appropriately addressed in South Africa's health system, nor will NHI on its own address inefficiencies and other problems facing the sector. NHI and strategic purchasing operate within a system and require other elements to be present, such as good stewardship, accountability, and strong information systems. Strategic purchasing is nonetheless an important tool, anchored in the core tenets of UHC: equity, quality, and efficiency in the use of scarce resources. Many countries have made important strides in making purchasing more strategic, which has contributed significantly to their UHC progress. However, evidence suggests that Africa is losing out on these benefits by making limited use of such purchasing. Key bottlenecks affecting the full application of strategic purchasing include fragmentation of financing schemes and high reliance on OOPs (not so relevant to South Africa); limited provider autonomy; passive purchasing with no link to provider performance (rather than active purchasing, linking purchasing decisions to provider performance); lack of adequate provider performance monitoring and accountability; and limited contracting arrangements especially among public sector providers.

Adopting strategic purchasing in the context of the introduction of NHI in South Africa will have massive implications for governance reform; undertaking this wisely will be key to the success of the reforms. An NHI Fund needs to be built with the requisite skills and governing body. The allocation of public sector health functions needs to be changed and new forms of semi-autonomous institutions (such as large hospitals or hospital groups) created to allow for meaningful contracting with the Fund. These need sufficient managerial autonomy to respond to incentives created by strategic purchasing mechanisms. The toolbox of the new governance arrangements, including new forms of reimbursement and contracting, needs to be developed and progressively refined. Shifting health functions between the spheres holds substantial risk and unless very carefully and wisely managed holds risks of governance and service failures.

If well governed, all of this has the potential to significantly improve the linkage between spending and performance, achieve greater efficiencies, build a mixed public and private provider platform with greater attention to quality, and provide an improved basis for accountability.

Conversely, the NHI will not achieve its lofty goals if careful attention is not given to active as opposed to passive purchasing, incentive arrangements not redesigned, contracts not developed and reinforced, reimbursement systems not appropriately reformed, outcomes not linked to funding, an appropriate mix of public and private providers not established, and these and other governance arrangements are not smart and clean.

Attention to governance of the Fund itself is essential. The components of good governance as outlined in this report have not yet been sufficiently identified. Strategic vision and some policy design exist, but many questions about the NHI Bill have not been answered. Attempts were made at participation and consensus orientation during the formulation of the Bill, but it includes insufficient detail on how the Fund itself will be managed to ensure the participation of relevant stakeholders and build consensus (129). Accountability requires the correct oversight structures; however, control is currently vested in the Minister of Health, who is also responsible for service delivery, which does not allow for sufficient independence. A massive venture such as an NHI Fund, which will take years to develop fully, should be insulated from changes in government. Locating the Fund within a government department makes it vulnerable to changes in Ministers and governments and could render it unstable. Locating the Fund outside of government with a board carefully insulated from vested interests and reporting to a range of regulatory institutions to ensure transparency may serve the South African population better. Lastly, the country has yet to see success in addressing corruption in the health sector; given problems in several other monopolies within government, there is insufficient assurance that this will be avoided. At least part of managing corruption is making sure that the design and governance of the Fund are thought through with sufficient care.



## Chapter 5: Consultative Meetings

This chapter addresses in particular the first of ASSAf's three requests: Determine and describe the magnitude, spread, and effects of the challenge of good governance in the health system.

### Introduction

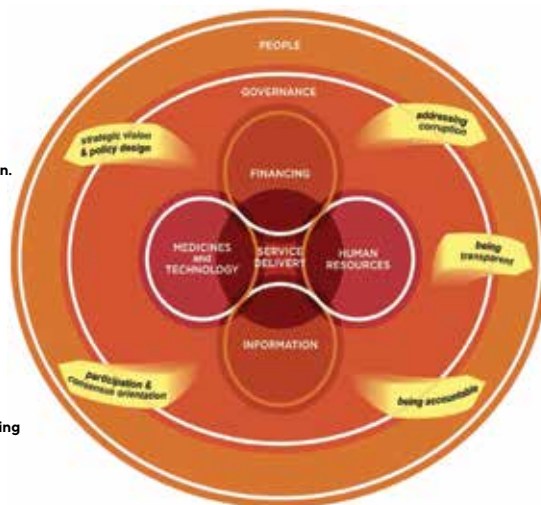
Consultative meetings for this report focused on interviewees' experience of and opinions about governance of the health system in South Africa, exploring examples of good and bad governance and identifying likely contributing factors. This chapter addresses ASSAf's request to the Panel "to determine and describe the magnitude, the spread, and the effects of the challenge of good governance in the health system".

The Panel chose to learn from those who have played key governance roles in the recent past and those who have interacted with such people. Their assessments, based on those consulted, were tested against and supplemented by research findings and reports in the public domain. This enabled the Panel to assess the degree of agreement between the two sets of findings and to consider ideas beyond those voiced during the consultations.

To organise and present the rich data, simplify a complex set of interrelated issues, and address governance from a health system perspective, the Panel used the Mikkelson-Lopez (1) framework.

**STRATEGIC VISION AND POLICY DESIGN**  
 Structures are not insulated from manipulation by vested interests  
 Absent or insufficient attention to "software" of the system  
 No system to institutionalise recruitment of best person into decision-making posts  
 Oversight bodies lack teeth and independence  
 Fragmentation versus coherence  
 Authority not delegated; small decision space  
 Top-down policies  
 Focus on what people should do (rules) rather than what they should achieve (outcomes)  
 Health service not conceived of as a learning organisation.  
 Weakness in councils and regulatory bodies supporting the health system  
 Absence of a clear public value mission  
 HMI recommendations never implemented

**PARTICIPATION AND CONSENSUS ORIENTATION**  
 Managers lack skills and capacities to lead consensus orientation - juniorisation  
 Inability to prioritise within budget constraints  
 Underinvestment in leadership teams  
 Excessive management turnover  
 Top down approaches undermine consensus building  
 Lack of focus on competencies in human resource planning and management  
 Failure to professionalise the public service  
 Lack of clarity on roles for structures for community participation  
 Relationships between formal system and range of community actors not enabled  
 Engagement processes not generally aligned to principles of respect, equality of voice  
 No agreement on powers of community structures to hold providers to account  
 Failure to appreciate exact contribution community participation can make



**CORRUPTION**  
 Lack of effective whistleblower protections  
 Mismatch managerial skills with tasks required; wrong person appointed for the job  
 Systems unable to discipline incompetent or corrupt officials  
 Overemphasis on compliance culture and rules stifles genuine responsiveness and innovation.  
 Reliance on rules at expense of ethical leadership  
 Lack of consequences for dishonesty  
 Public value mission not shared by staff and leaders  
 No system to keep focus on public value mission

**ACCOUNTABILITY**  
 Political control undermines autonomy of oversight  
 Interference  
 Insulation from vested interests and political interference  
 Lack of powers to community governance, and so does not improve accountability  
 Accountability systems not linked to health outcomes  
 Community excluded from holding services accountable  
 Failure to use data for decision-making  
 Need to manage 'legitimate error' and negligence /dishonesty differently  
 HMI recommendations never implemented

Figure 7: Information from consultations, placed within a diagrammatic representation of the Mikkelson-Lopez, et al (1) framework.

This chapter places the South African health system in context and discusses the complexity of the health system as described during the interviews. What emerged from both the consultative meetings and the literature is organised under each of the headings from Mikkelson-Lopez et al. (1): strategic vision and policy design, participation and consensus orientation, being accountable, being transparent, and addressing corruption. Literature is referenced through numbered endnotes while quotes from consultations appear in italics with the number in {braces} indicating which key informant contributed what information. Where the material is paraphrased, the Panel have simply added the key informant

number but not quoted directly nor used italics. Figure 7 presents a summary of the main results in this chapter, allocating findings to each domain within the framework.

## Context

However, to make sense of the narrative that emerges from the consultative meetings it is important first to review how the health system interlinks with the external environment as well as the interlinkages within health and health care.

### Complexity and the South African health system

Health systems are complex systems (131), an inescapable fact when examining good governance in the sector and one that emerged clearly from the Panel's consultations. Various informants' comments about the South African health system illustrated what Khan and colleagues describe as the "wider system of interdependencies that enforce or constrain how the organisation operates", the "multiple interdependencies with other organisations to secure operational necessities (such as resources) and deliver services in a network of patient care", and the fact that "this network of organisations exists in a broader system that sets priorities and policies, and allocates resources that dictate how patient health is managed within these multiple systems" (131).

Interviewees noted that the legislated structure and related policy environment of the South African health system that was "*put in place in 1994 is very complex; a proportional representative system, a party system.*" {1}, and that the "*health system is inevitably a political terrain*" {9}.

South Africa's public sector is organised at four levels – national, provincial, district and local/ municipal – with community participation desired at each level. The political principals at each level may not be from the same political party. Many interviewees noted disjuncture between the national and provincial departments of health. As South Africa is a quasi-federal state, the Constitution makes provision for cooperative governance, and health is a concurrent responsibility of national and provincial government with some limited functions (primary preventive, non-personal functions) devolved to local government. The constitutional provisions introduce both complexity and difficulties for governance in the health system.

The complexity of the South Africa health system is amplified by parallel private and public sectors, which pose a stewardship challenge. As noted in one consultation, "*he is the Minister of health, not health care, not private health not public health but all of it.*" {13}.

### Public and private sectors

The National Health Act governs the work of the National Department of Health. Section 2(a)(i) makes clear that this means both the public and private sector. The Panel did not seek new information about the private sector, given that an extensive review of the private sector, the Health Market Inquiry (HMI), was recently undertaken, albeit from a competition perspective. This review generated an extensive set of information on the private sector, available in the public domain on the Competition Commission website (<https://www.compcom.co.za/healthcare-inquiry>), including two detailed reports (40,44). Information from these reports supplements the interviews in this chapter.

### Intersectoral determinants of health

The need for intersectoral action – realising health in all policies – adds to the complexity of stewardship in health. For other ministries, it is not always necessary to work across government departments in an intersectoral manner and with communities in order to meet the primary aim of their own department or ministry.

However, “health is a multi-sectoral entity” [involving several government departments, e.g., Education, Welfare, Sport etc.]. “A whole-government approach is required to address, for example non-communicable diseases.” {11}. “Health cannot do it without education, without municipalities and without safety and security.” {9}. “Intersectoral collaboration is also about relationships between the formal system and a range of community actors working together in a way to support and promote health.” {9}.

This affects the way that the South African health system is financed. The NDoH makes policy for provinces to implement, but funding from the tax base goes directly to provinces to allocate across sectors – health, education, housing and so on. In other words, there is a disjuncture between national policy and planning and resource allocation. Provinces may allocate resources in line with national policy, but they may decide on different priorities. In theory, this allows provinces to tailor implementation plans as relevant. While this can be frustrating for the national ministry, the larger issue is the absolute limit of funding available: “...SA is experiencing 40% unemployment, a high disease burden, a declining tax base and a significantly unequal society [complicating the provision of] effective and efficient health services to our citizens.” {1}. There is widespread perception of resource constraints: “In the last 10 years managers have struggled much more because of budget cuts; also, the ability to implement a new strategy is hampered because there are just not enough resources available at various levels e.g., human resources, expertise, finances [and] infrastructure.” {5}. “Another challenge is that the budget for the Department of Health has been reduced over the years, we want to do more with very little ... if you have an increasing burden of disease, an increasing demand, and an increasing population the budget should be increasing, however on an annual basis the opposite is happening.” {13}.

A useful example of the impact of financial decisions from the national level on provinces is the implementation of the Occupational Specific Dispensation (OSD) promulgated in 2007 for the occupations of professional nurse, staff nurse, and nursing assistant in the public service (132). This is described in detail in the government’s Consolidated Report of the Integrated Support Team Review of health overspending and macro-assessment of the public health system in South Africa 2009 (133). This agreement between the national government and public-sector worker unions resulted in a situation in which “All but one province ...went into debt and they have never recovered” {7}. This illustrates what can occur when initiatives are developed in a top-down way but without the budget required to implement them. For a decision made in 2007 to still reverberate through the system in 2022 is profound and suggests that either the decision was so momentous or that capacity at the provincial level was so poor that there is still inadequate recovery from that shock. This happens in smaller ways too. As one example, the national policy on breast cancer screening is not implemented as there is no budget allocation for it. Thus, while there is an understandable focus on corruption and misuse of funds in the health sector, this is not the only problem. It is important to underline that focusing on corruption or cadre deployment alone will not necessarily improve health-system governance.

### Concurrent responsibility and confusion of roles

Interviewees noted that in this complex system the “The National Health Act gives a lot of power to the National [Health] Minister, much more than they are willing to acknowledge...” “The power of the National [Health] Minister to create the rules of the game for the whole country is immense: (s)he has the ability to design governance frameworks.” {3}. This degree of power creates huge expectations of the ministry. However, some felt that “power must be in the provinces” {9}. There is an expectation that the NDoH should create the rules of the game but also delegate and leave room for bottom-up innovation. The NDoH is seen as being inadequately aware of its primary role: that of setting up strong and incorruptible governance structures and creating incentives in the system to ensure that its policies are realised, while also supporting the implementation of programmes by other levels and agencies (provincial government, hospitals, local government, and so on). In addition, some funding, through conditional grants such as for HIV, is allocated to provinces directly from treasury and bypasses the provincial budget votes, while reporting bypasses district managers.

The NHI Fund is one mechanism that aims to change funding and, importantly, incentives in the health system across both the public and private sector in order to achieve better population health outcomes. Its champions are clear that this is the best guiding framework for health care in South Africa and there is general willingness to see it as such. Interviewees noted the importance of a whole-system approach, integrating public and private and across sectors, and believe that this could be precipitated by introduction of the NHI.

*"We have not as yet developed a system where we can talk of integrated health. A system where equitable Universal Health Coverage is agreed upon by all players; [public and private sectors for all diseases]. We are hopeful that the proposed NHI will address some of these issues." {11}.*

However, the Panel also noted a perception that attention to system design and governance challenges have been neglected because there is only capacity or perhaps political will to focus on the NHI Fund. One respondent noted that: *"The NHI debates have not helped in setting up a vision for the country" because "... the NHI is only an insurance system. There could be other solutions to achieve UHC [Universal Health Coverage]." {9}.* Other respondents warned that *"Discussion around the service delivery platform is required as much as on financing the NHI" {6}* but that planning was not focused on strengthening the health sector: *"Raw strategic direction is required and if I were asked if there is a national plan for health for the country, the answer is no, there is not. There was an ANC plan in 1994, which was a good plan; yes, it had its flaws. Things have changed and there is still no plan." {9}.* Another informant echoed this concern: *"What we need is a national programme, to rebuild the health sector and the context needs to be whatever shape the NHI system would take." {6}.*

Key informants were clear that *"for the national DoH to take on the kind of responsibilities required by the NHI bill, the capacity of the Department of Health will have to be significantly upgraded both in terms of human resources and skills." {6}.*

In summary, there is support for the concept of UHC and some confidence that the NHI fund will achieve this. Whether the National Department of Health has the capacity to manage it is contested. Some foresee that the NHI Fund will increase role confusion as the NHI Bill is unclear on the role of various key players, for example, district managers. Some argued that as the NHI Bill currently stands it will only cause further confusion.

## 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." {9}.*

In spite of its efforts, the NDoH was not seen by interviewees to communicate a clear strategic vision, build commitment, or inspire people to deliver. After a number of consultations, it became clear that the NDoH is seen as focusing on what people should do rather than what they should achieve. *"There is too much micro-managing [from national level], and then the emergence of these vertical conditional grants, programmes and initiatives that seek to manage what is happening at the coalface." {7}.* Given that provincial departments have been placed under administration at times, it may be understandable that the national department feels the need to micromanage.

## A coherent vision

A chasm was noted between national department aspirations, policy plans and directives, and the finances to achieve these goals. Key informants expressed a common concern about the lack of a unified guiding aim and noted that too many uncoordinated piecemeal initiatives competed for priority. The leadership at national level was said to suffer from a short attention span, lacking the insight or patience to allow enough time for initiatives to take hold, mature, and be evaluated. As a result,

the opportunity for deep learning is missed (34). Neither national nor provincial leadership explain how the system is to be incrementally developed in a logical sequence or to what end. Multiple national health plans exist, they do not cohere into a national vision for health that all levels and stakeholders understand, buy into, and work towards. It may be, as noted by some, that initiatives are siloed. Often, nationally driven programmes are administered through conditional grants and so bypass the district structure that is meant to be the core building block of the health system. A "strategic vision" needs to be communicated as a foundation of governance. The link between a strategic vision and day-to-day activity is currently not clear.

The same point could be made about provincial leadership, and they too have been described as not delegating authority to hospitals or districts. *"In some provinces [inadequate or lack of] authority to purchase, procure, and appoint has led to inefficiencies and an inability of managers to determine what they have and can spend. It has also removed the ability of hospital managers, CEOs to appoint key people in key positions. For [the] short-term, centralisation [may] make sense but in the long term one must promote managerial autonomy within a system of checks and balances."* {2}.

The lack of any clear, coherent vision to bring people together (both providers and community) was noted in many consultations. Some identified fragmentation as a factor that leads to a lack of coherence. *"Within the NDoH, there are at least three to four divisions that deal with cancer. There is no coordinating mechanism between all these sections, and there are three different streams of funding for cancer."* {11}. *"We are not in favour of the silo approach."* {11}. One seasoned manager who has worked at many levels within the health system noted that *"In fact, the fragmentation within government in general and within health specifically is unbelievable. This fragmentation is mostly due to the lack of leadership at the top."* {5}.

Informants appealed for data-based decision making and a more bottom-up approach. *"We have to start with a better understanding of what the information systems are telling us. Incentivise greater investments in the areas where we are achieving the lowest, find ways of creating better mechanisms of accountability at the local level, and then cascade them up. But just developing grand designs at the top level is not going to help."* {8}.

Having a clear vision and mission, particularly ones that emphasise public values, was also seen as essential for good governance. *"Public sector organisations need to achieve a public value goal or mission and this public value mission is largely determined by politics and essentially politics is how society prioritises what it wants and needs."* {3}. *"Goals have to be institutionalised into the way in which [the health system] is governed. If you do not, then it will drift from its goals."* {3}. *"What you want is to have an array of arrangements that exist and keep an organisation focused on its public value mission."* {3}.

One option put forward to keep an organisation focused on its public value mission is to ensure that "the right people are in place", a solution that was seen as structural, the need to *"design an institutional structure that quite literally institutionalises the promotion of the best people into the senior decision-making positions."* {3}. Others, however, thought that structural interventions would not provide a solution, but that it was, rather, to do with the culture of the health system and that addressing how managers manage (to, for example, ensure accountability) would be a solution.

In summary, a consistent vision is not articulated; there is no rousing tune to dance to. National and provincial departments are seen to function by taking a command-and-control approach which stifles creativity and innovation and can instil fear. Documented instances confirm the impact: for example, an evaluation of the First Thousand Days programme in the Western Cape using a Whole of Society Approach (48) found that success was related to both its place-based context (i.e., responding to local needs) and to the *"substantive investments of time by skilled and highly committed senior managers"* to



generate localised deep impacts. This signals the importance of senior leadership creating the space for mid and frontline managers to innovate and lead, an example of how one key informant described good leadership: indicating what managers should achieve, rather than what managers should do.

### A delegated, decentralised system

The South African health system is intended to be a delegated system. While many people appear to support this intent, a frequent refrain in consultations, corroborated by research findings, is that, in practice, authority is not delegated, and decision space is small.

Key informants confirmed the value of decentralisation for effective and equitable health systems. For example, having *“a decentralised [system] means allowing managers where they are, to be able to make the choices about how resources are allocated and how to [deliver] the expected services.”* {1}. *“The way in which we improve performance is to create frameworks that delegate powers to people lower down in the system to make these decisions properly”* {3}: *“[within] a system of checks and balances.”* {2}.

At the same time, some key informants cautioned about the complexity of successfully decentralising decision-making. *“But it is not a simple process. There are conditions that need to be considered, an environment that needs to be created.”* {5}. *“It is never going to work if you concentrate those powers in a single office.”* {3}.

Interestingly, staff at national level held the view that, *“We decentralised a bit too quickly, without the necessary skills and systems in place both at the centre, and in the periphery. ... In moving forward, we have to have a better idea of skills and systems and how to build those over a period of time and what to delegate, to whom and what to keep centralised.”* {6}.

This is at odds with reporting from others who note too little delegation of authority. The top-down view is that it was done too quickly and perhaps there is frustration with lower levels for not taking action. The bottom-up view, in contrast, is that authority is not delegated and there is a culture of fear.

Research findings support the idea of little or no delegation of authority and a cramped or absent space for decision-making in the South African health system. Schneider et al (134) note from work done in Mpumalanga, Limpopo, and Eastern Cape that the “[m]eso-level decision-space – the product of delegated decision-making, sub-district and district capacity and accountabilities – is in effect very narrow. Not only are ‘district level managers ... not about to implement any initiative without the approval of the provincial managers’, fear of breaking the rules discourages them from taking such initiative, and inadequate leadership and management capacity prevents them from claiming the spaces they do have available to them. Caught in a rule-bound and centralised command and control system, with upward flows of reporting and little reciprocal downward responsiveness, it is not surprising that the meso-level is often perceived as a passive player.” (134). As one key informant noted, lacking agency and working in fear of making a mistake meant *“there is no way you can be innovative and creative.”* {9}.

Problematic top-down decision making was attributed to the national level being out of touch with what was going on at the provincial level, while provincial staff were too distant from district and sub district levels. Those who had to integrate parallel and sometimes competing initiatives were the clinicians, almost always nurses, who had to integrate all the various programmes at the point of care.

An important design contradiction mentioned by some interviewees is the non-alignment of the Public Service Act (PSA) and the Public Finance Management Act (PFMA). The PSA makes the politicians the “executing authority”, thus creating the opportunity for political appointments (or removal) and

cadre deployment, as well as the management instability seen in many provinces. In contrast, the PFMA makes the Head of Department (HOD) or the Director-general (DG) the accounting authority, responsible for financial management (budgets, procurement, etc), human resource management, and service delivery. However, these executive managers (HODs or national DG) operate at the behest of politicians, who need to delegate the function of staff appointments to them (according to the PSA). In some instances, the politicians do not even delegate the appointments of cleaners or clerks to HODs. Hence, these HODs are unable to delegate to lower levels of the health system, even if they want to. Some senior managers saw this as the central limitation but others recognised and worked around the possible conflict. Either way, design that can preclude delegation in a decentralised system is problematic at best and an error at worst.

## Support systems design

In addition to the lack of delegated authority and a culture that rewards inaction, some systems are seen as dysfunctional or not fit for purpose. Informants described procurement systems as unwieldy and sometimes contradictory. One noted that, *"When one deals with public funds and the complexity of arrangements including very rigid procurement rules, we tend to introduce more rules which don't necessarily work."* {1} Another informant noted a long-standing lack of transparency and, as a result, a lack of monitoring of procurement processes, which undermined any recognition of procurement as a public value function *"within government that enables the delivery of services to citizens."* {3}.

Health information system data are usually collected at the local level but are not adequately used there. Frequently, multiple reporting systems operate at the same time within a single health care facility – a separate entry system for each disease. In some parallel reporting systems, a programme manager may report to a provincial or national programme manager rather than the responsible district manager (135,136). Informants noted that much effort is invested in collecting information, frequently without anything being done to act on the information. For example, one informant noted that the District Health Information System (DHIS) *"clearly shows under-performing districts in South Africa but nothing is done."* {3} Another informant commented that *"The closing of the loop is a big problem. So, there's a lot of data collected, but whether that changes practice is another question. Another issue is that of the many fragmented initiatives."* {7}

Another indication of problems with support systems design emerged from research conducted with hospital CEOs. Most of the CEOs reported that they were unable to manage their institutions effectively and noted that systems that support management (human resources, finance, procurement) were inadequate or inappropriate (137). With weak systems, it was felt that even good managers would struggle.

## Regulatory and oversight bodies

Regulatory and oversight bodies, such as those described in Chapter 3, are essential for the health system and operate across both the public and private sector. They include: the Health Professionals Council of South Africa (HPCSA) which covers a wide range of health care providers from medical doctors, physiotherapists and more; the Pharmacy Council; the South African Nursing Council (SANC); the Council for Medical Schemes (CMS); and the South African Health Products Regulatory Authority. The Office of Health Standards Compliance (OHSC) has an oversight function which is aimed at improving quality of care with an initial, but not exclusive, focus on the physical integrity of healthcare facilities. The OHSC's mandated functions cover both the public and private sector but to date there has been limited activity in the private sector because of capacity and resource constraints.

These regulatory institutions are established by national legislation and the boards are appointed by and accountable to the National Minister of Health {1, 4}. Several consultations revealed that there is weak governance of these institutions which reflects a failure of both the functioning of the boards and poor oversight by the National Minister {1,4}.

In response to widespread complaints, a 2015 Ministerial Task Team chaired by Professor Mayosi reported on the functioning of the HPCSA. The team found that the organisation was bedevilled by administrative irregularities, mismanagement, and poor governance, including tender irregularities. In terms of the Council's mandate to the public, the report noted that the inefficiency and ineffectiveness of the HPCSA was undermining its core functions with respect to the registration of health professionals, examination and recognition of foreign qualifications of practitioners, professional conduct enquiries, approval of programmes in training schools and continued professional development. Some eight years after that investigation (51), the HPCSA was still reported to be "failing victims of medical malpractice" and "protecting their own", with its "legal services in disarray" (138).

The failure of the SANC to approve various nurse training programme curricula meant that, at a time of human-resource crisis, no nurses were being trained. Informants perceived this as institutions such as SANC not being aligned with the national agenda {3,5}. How this came about was unclear; some blamed the SANC, while others noted that training institutions did not submit their curriculum for review. Either way, it was seen as a moment when ministerial intervention and leadership were required, but not evident.

Oversight bodies such as the OHSC were described as being out of touch with conditions on the ground and were reported to make punitive and incorrect findings {9}. It may be that those identified as being in breach of meeting standards are being defensive, but they claim that the OHSC was too technical and did not interpret data correctly or reached sweeping conclusions which did not apply across the entire province. Some felt persecuted by OHSC findings, while others noted that OHSC recommendations were not acted upon, and that targets meant nothing as there were no consequences for not meeting them {6}. This was true for Auditor General reports as well, where "*the data produced was not used for system improvement and often had no impact or consequence*" {5}. It was also noted that regulatory bodies – in this case the OHSC – "*were insufficiently resourced to achieve their mandate and were subject to political interference*" {6}.

With regard to the private sector, the HMI (44), after extensive investigation and consultation, found similarly that the HPCSA and CMS would have benefitted from better stewardship as "practitioners are subject to little regulation and [there are] failures of accountability at many levels" and that health care "facilities are not regulated beyond the requirement of a licence to operate and practitioners are licensed to practise by the HPCSA but little more" (44).

Many key informants noted that various structures in the health system (boards, advisory groups, regulators etc.) are not functional and must be changed to improve governance and to ensure that they are immune to manipulation by vested interests. One informant pointed out that system design is key to accountability. Accountability is explored in more detail later in this chapter, along the structural changes needed in relation to the Mikkelson-Lopez element of accountability. Informants' suggestions for structural changes generally aimed at ensuring accountability as an aspect of good governance.

Other key informants felt that there has been an over-emphasis on getting the structures right and thought that, rather, attention should be paid to the software of the system, how people interacted, and processes that can be used to promote system development, quality care, and commitment from staff. "*We just have not paid enough attention to the things that make a system complex, which are relationships, people, individuals, and values; instead of redesigning health care, or redesigning structures.*" {9}. Behind this approach is an appreciation that governance (like leadership) is a distributed function.

Another common view held that what is required is a managerial response from "*skilled, strategic public interest players with a vision. If you have a critical mass of this kind of person, they start to shape the system*" {3}.

Despite different views about the root of the problem, there was consensus that many regulatory and oversight bodies, which are critical for a strong health system, are not working optimally.

Many of the informants who suggested managerial solutions included, as elements of good management, factors such as building relationships, teamwork, and allowing for mistakes for the purpose of learning. This Report discusses teamwork below, under the Mikkelson- Lopez et al. (1) element of participation and consensus orientation.

## Participation and consensus orientation

This section discusses, firstly, participation and consensus orientation between different actors within the health system, using Brinkerhoff and Bossert's "principal-agent" model for governance of health systems (13). Because several key informants focused on how managers manage, emphasising that a participatory orientation is required, this report covers management under the heading of participation and consensus orientation. The section deals with public sector managers and the managerial skills they need; how managers manage, including the need to take seriously the "software" of the health system, such as relationships and teamwork; and consensus orientation towards actors outside of the health system, with a focus on community participation.

### Public sector managers

In comments about managers and management two themes emerged: having the right people in place and those people doing the right things. Informants noted that management in the health sector is not simply a general management function. Generic managers cannot easily be parachuted into a health setting.

*"The function of a ...senior manager in the health sector is not a generic issue, in other words it cannot be that any generic manager can manage anything. In the health sector there needs to be background and insight into the area in which you are managing." {2}.*

However, respondents argued that in some places (too many), it is the weakest people who are in positions of leadership. The Human Resources for Health Report 2012/13-2016/2017 noted that "The Minister of Health commissioned the DBSA to review the management of hospitals, health care facilities and health districts. The outcome of the review was that the management cadre of the health sector, managers responsible for facilities and districts at all levels, were of varying competence and varying backgrounds." (139). The Panel's consultations indicated that many were inadequate to the task. "A public health system has vastly more complex problems than virtually any private sector organisation has to deal with in South Africa. What clearly needs to happen is to 'Put the right people in the right positions, with the right capacity to do what needs to be done.'" {2}.

The public sector requires strong leadership. This was framed in the consultations as leadership "... that is uncompromising, ethical, and conducive to change, innovative, able to attract new skills and bring new ideas to the institution" {1}; those who "remain true to their core ethical values; the 'right' decision is often not the most popular" {2}; who demonstrate "objectivity, integrity, independence and accountability" since these "... are critical concepts when implementing government strategies and changes" {1}; and people who are "decisive and ethical" {2}.

During this consultation, informants emphasised the importance of resisting political pressure. For example, when a politician wishes "to do something unethical or inappropriate, one, as a senior public servant, has to stand your ground. Some individuals have had their lives and careers destroyed in taking the ethical pathway and others have become party to fraud, corruption, and inappropriate activities." {2}. This is what is known as "a wicked problem" and places the manager/leader in an extremely difficult, conflicted situation.

## Managerial skills

An often-repeated point was the necessity of managerial skills to allocate resources and manage budgets and expenditure.

*“There is a budgeting and financing element to all of this, in addition to the failure [to achieve] ... good governance.” {7}. To illustrate this point, it is worth noting that a district hospital budget can be in the ballpark of R200 million annually and that of a regional hospital R750 million; these are large amounts of money to manage and require significant skills and support systems. As noted above under “design”, support systems (for instance those for human resources, finance, and information) are not easy to use and may have design flaws.*

One key informant stated the belief that *“Failure to be able to pay service providers [is] a result of a burgeoning cost of government employment without consideration for the balance of the budget.” {2}. Other sources, however, show that public sector budgets, in particular health and education, have been static for years or fallen in real terms (140). Increased demands for services driven by the increase in the population (as one important driver) means that it is unrealistic to expect health services to come in on budget without a real increase in that budget.*

The lack of a clear vision within the Department of Health is perhaps also a symptom of the lack of a common understanding or commitment to a clear development plan for South Africa. *“Cabinet has been deciding to increase pay while adopting budgets that effectively invalidate its own decisions.” (140). This Report by Sachs et al acknowledges that real expenditure in South Africa as a whole is stagnant or, in some cases, has reduced in absolute terms; accepts the logic behind fiscal consolidation; but does point out that this comes at the expense of “state capabilities, especially in the provision of core services” (140) of which health is one. The ineffective strategic vision and policy design of the Ministry of Health must be seen within the context of a lack of effective national political leadership. This environment makes it particularly complex to manage resources and resource allocation for health services and underlines how essential it is to have managers in posts who can prioritise within budget constraints. Some good guidance exists on how to prioritise and rationalise spending, with the Essential Drug List as one example, but the lack of a functional Health Technology Assessment capacity makes it difficult to make rational decisions (141,142). This is exacerbated by the absence of a nationally shared vision about how to build the health system incrementally and how to prioritise among the many national programmes.*

## How managers manage

Some informants emphasised “good” managers (civil servants): *“[m]ost of all, find strong and capable leadership.” {1}. As one informant put it: seek “individuals that can be trusted to perform in a given context, once sufficient competence has been demonstrated; [individuals] who have the ability to exercise and execute these tasks. Use the current available leadership in the country, both public and private, academic, and civil service, as well as international, [to form] a group of experts with knowledge and expertise that are available and able to provide on the job support for managers.” {5}.*

Informants and the relevant literature emphasised that the capacity to work as a team is an essential attribute of a good manager. One source noted *“pockets of effectiveness where there are positive experiences, not just of individual leaders but of team leadership of districts and hospitals, etc. where individual leadership spreads a culture that enables.” {9}.*

As an example of good management, one key informant described a District Director who *“brought managers, clinicians, healthcare workers, information, and programme managers together around the table and worked strongly on getting the link between primary health care and hospitals and all*

*the interfaces [including Emergency Medical Services (EMS)] to function cooperatively. The principle was that he was not going to bring any extra money to that district, just himself. So, he used his authority and personality; he got people to work together and built relationships. So, that is what you need to do in governance. He got everyone to start collaborating and to focus on a few outcomes." {7}. As well as good management, this example demonstrates working on the software of the system.*

Another key informant noted that excellence is not simply a matter of qualifications. *"[i]n some institutions the [Chief Financial Officer] has a [Grade 12] or diploma qualification and manages to obtain unqualified audits and then there are some institutions with highly qualified people with poor ethics and leadership skills that perform poorly." {1}.*

The Panel noted an obvious overlap between those advocating for better managers and management and those who consider the software of systems to be paramount. Key informants commented on the need for *"professionalisation of management. ... You have to create an environment where there is stability in the public sector at a management level, where there is respect for senior bureaucrats and an ethical framework within which senior bureaucrats function; a professional relationship where colleagues are held accountable." {2}.*

*"If there is a commitment to teamwork, to trust, to openness and integrity and to all values and there is clarity about the behaviours that are aligned to those values, it speaks to the culture that you are trying to create." {9}. Intersectoral action to address COVID 19 in the Western Cape, for example, demonstrated that a "value-driven approach" of openness, transparency, role-clarification, and learning contributed to success by enabling shared visioning across departments (49).*

A key informant who focused on the managerial response held that *"Once there is a strong provincial structure of health governance and a strong structure at district level, all the other structures at community/ grass root level will function effectively." {10}. Conversely, success can be leveraged in the process of replication, starting small and local and expanding gradually.*

While pockets of excellence exist, political interference and cadre deployment (discussed later under transparency), have an impact on the calibre of the people employed in the public sector. *"The quality of leadership and management in the country has decreased significantly". {5}. Many people were said to be appointed into positions "for which they lack the technical or managerial capacity" {2} or "for which they are not ready", described as a "juniorisation" of management {6}. This was seen to present "a central paradox; at the coalface of the system and frontline level, you have very skilled people doing great things but the higher you go in the system the less skilled it is." {7}.*

The risks from frequent changes in leadership were highlighted by several key informants, noting both the change of people in positions of authority and the number of people who are in acting positions. One key informant noted that a section in the national department *"has had so many Deputy Director Generals, it is unreal" {11}. The Western Cape was different, being historically "better resourced with no homeland burden (meaning the province did not have to integrate two administrations as did most of the other provinces)" with the benefit "of an organisational culture with less political interference. [As a result, they have had] stability of leadership for the last twenty odd years, [especially in the ranks of] senior managers in the health department [who] knew exactly what to do and how to do it." {5}. "The stability of leadership is an important element." {5}.*

The impact of absent, acting, unskilled, and constantly changing management is confirmed in research involving managers and providers working within the public health system on improving maternal and neonatal health in Mpumalanga, Limpopo, and Eastern Cape provinces under the Mphatlalatsane initiative(143). Forty interviews conducted between February 2020 and August 2021 with participants at various levels of management found that:

1. Instability of leadership at the top levels hampers service delivery and is echoed at every level in the health service. "In just about every place there have been a number of managers over the time and people keep coming and going and every time you have to start afresh .... particularly at the management level."
2. This lack of able and stable management means that bottom-up innovation is not recognised, not replicated and over time, stifled: "you can get enthusiastic people on the ground, and they can improve the situation in their hospital, and they can have good ideas ... but to take it beyond that is almost impossible because of the lack of capacity and stability in the middle management."
3. The lack of management capacity is common throughout the health system where managers are appointed without training and "these include 'simple things' like running an effective meeting".

Changes in management cause disruption and paralysis. "Every time when there's a new political leader there are new ideas, whatever happened previously is thrown out and there is no initiative taken until the [new] political leadership gives the go ahead." {5}.

While some felt strong leadership and good teamwork could set the tone and change the quality of public service management and delivery, there was also a focus on good training for managers. Others said that strategic partnerships, for example with universities, could also improve health systems.

"[T]here is no need for any new policies. ... Rather, to move from policy to practice, it is important to focus on the question of competencies, rather than the knowledge", along with "ongoing on the job mentorship by experienced managers." {5}. Some provincial Departments of Health had reached out to academic institutions in Gauteng and Western- and Eastern Cape to create management development programmes. What was needed was to move beyond "ad hoc workshops" to dedicated and consistent "systems for leadership development." {9}.

Currently, there is a "lack of focus on quality-of-service delivery and a lack of focus on improving health outcomes." {5}. As one respondent {2} framed it, senior managers should tell their subordinate managers what they must achieve, not what they must do.

Experience from the Whole of Society Approach (WOSA) project in the West Coast (48) found that engagement processes designed to align to principles of respect, equality of voice (between departments, between levels of government), distributed leadership, and co-creation were key to effecting successful change.

A key informant explained that: "For governance from the bottom up" {9} to be effective, "all the interfaces, [i.e. "the everyday relationships amongst people"], need to work well: from the national department, from the provincial level, from the district level, from the local level, from the municipal interfaces and from the community interface" {5}.

Schneider et al (49), writing about the success of intersectoral action to address COVID 19 in the Western Cape, concluded that "District health (and other provincial sectoral) managers should be given the authority to liaise directly with their counterparts in local government or other provincial departments on transversal matters ..." such as direct engagement at the Deputy Director level. This speaks to the related issue of devolving authority and decision-making instead of being restricted to routing engagement with peers through superiors.

By contrast with a top-down, command-and-control approach, participation and consensus building are methods of forging a common vision, allow for teamwork, and indicate an openness to those using the health system.

## Engaging communities

In the South African health care system, structures have been “created to provide an avenue for communities to give input into the planning, delivery, organisation and evaluation of health services, as well as to play an oversight role in the development of health policies and provision of equitable health services.” {10}. Patient-oriented care and the Batho Pele principles (putting People First, a person-oriented civil service) (144) have been popularised since the late 1990's, but there is little evidence that they have influenced the norms in the South African public sector, and respondents identified many weaknesses in governance related to participation and consensus.

One measure of the lack of participation and consensus building is the number of times that the NDoH has gone to court to resolve issues, indicating in turn insufficient attention to consultation. “The implications of not engaging are seen through the number of court cases and judgements forcing departments/entities to implement things in a certain way.” {1}. (Delaying tactics by organised interests, such as medical doctors or pharmacists, are another reason for resorting to the courts.) Overall, in the opinion of numerous informants, consultation and community oversight should be improved.

One respondent noted that, after 1994, “during the first five years the relationship between National Health and civil society organisations was strong. However, this has weakened significantly since then” {6} and was at its lowest ebb in the 1990s over the provision of antiretroviral treatment. Huge additional inconsistencies stymie arrangements intended to facilitate community voice, such as health committees and hospital boards mandated by the National Health Act (NHA). Currently, “[c]linic committees and hospital boards [are] nearly toothless.” {6}.

In 1997, the White Paper for the Transformation of the Health Services (1997) gave community structures strong governance roles. The NHA, intended to give meaning to the White Paper, “provides for formally constituted, community-based governance structures such as hospital boards, clinic and community health center committees within the health care delivery system.” {10}. However, “unlike the White Paper, the NHA was rather insipid on matters to do with community participation. This Act provided no detailed guidance on the roles of health committees. The NHI also created a separate provision for Hospital Boards, distinct from health committees.” {4}. “Importantly, the NHI is completely silent on how [community] participation structures will be operationalised; ostensibly, the Office of Health Standards Compliance has introduced into its accreditation standards for private hospitals and clinics, indicators for community participation. {6}.”

As a result, while “the National Health Insurance (NHI) White Paper repeats the mantra that PHC will be the heartbeat of the NHI, ... there is a serious gap in the institutionalisation and effective implementation of community governance structures.” {6}.

The respondent noted that “there is also wide discrepancy between the policies adopted across different provinces for governance structures in terms of what roles are expected of health committees” {6}.” and went on to lament “[t]he number of provinces that have Provincial Health Acts that have been revised and kept up to date to current circumstances, is also almost zero.” {6}.

A respondent from the community sector noted, “We do find difficulty and I must say with the provincial governments based on their differences we notice that it depends on the executive authority of that particular government in that particular province. Some of them have got an open-door policy – we engage them, they do not have a problem, they solve issues. Some of them are very arrogant, and just refuse to engage you, until you find that there is a serious problem.” {13}.

Responses from the health system to community engagement were variable and sometimes seen as inadequate. “In some instances, ministers and departments are open to community engagement and



in others not {1}. It would appear that “Valuing and respecting the expressed needs of communities has faded, replaced by a top-down approach.” {6}.

The respondent noted that “[i]t is not in the interest of a bureaucrat to be told by a community what it wants. We need to think about changing the Act in order to give communities a greater voice and increased participation and governance decision making, particularly at the lower levels. The key question would be how to keep the improvements happening while discussions on the NHI are ongoing.” {6}.

“[M]ultiple benefits to the health system” are lost by failing to incorporate community participation: loss of “any meaningful opportunities for community participation to help to address the burden of disease faced by health services”; loss of responsiveness to users and to communities through trust built on “opportunities for dialogue, in spaces that do not infantilise or undermine agency of communities, but which are built on mutual respect”; and overlooking “communities as unique holders of knowledge and experience which the health services need in order to function better”. By contrast, determining need would be strengthened through “a deliberative process in which communities and health professionals learn to listen and engage respectfully in creating new understanding of how to promote health and manage illness.” {4}.

This frustration was echoed by others, who noted clear examples of the failure of system openness to participation and consensus orientation. For example, “[t]he Ministerial Advisory Committee for the prevention and control of cancer ... has been there for nearly ten years and is absolutely toothless. Nothing has happened under the leadership of the committee.” {11}.

## Accountability

Often interpreted as holding an individual accountable, this is clearly central to any organisation and is evidently lacking or poorly practised in the South African health system and in South Africa more generally. As an example, the Auditor General's findings do not result in constructive system change. Systems that were designed to foster accountability may instead promote risk-averse behaviour and/or encourage “gaming” of the system. Accountability mechanisms are intended to insulate institutions from vested interests but should also achieve broader functions and ought to be designed to “incentivise continuous and improving performance.” {3}.

## System level

System design, as one respondent noted, is key to accountability. The Panel acknowledges that accountability structures do exist, with for example the parliamentary portfolio committee on health exercising oversight on behalf of the public. In consultations, the Panel asked whether these were functioning effectively, and if not, why not, and what needs to be done to make them more effective.

The proportional representation party system, described as one of the complexities of South Africa {1}, was described by another key informant {3} as a factor explaining why parliamentary portfolio committees do not function as representatives of the South Africa population. The example, see Box 3, which is drawn in large part from the consultation with a key informant.

### Box 3: The role of parliamentary portfolio committees – the example of Digital Vibes

Between January 2020 and February 2021, the NDoH awarded a company called Digital Vibes R150 million for public communications, initially intended for the National Health Insurance (NHI) campaign but then redirected to essential public Covid-19 prevention. The deal was exposed by investigative journalists in February 2021 and as a result the Special Investigation Unit (SIU) launched an inquiry. In June 2021, the SIU report suggested that the contract was irregular and that some of these funds may have been used fraudulently and may have benefited family members and associates. The SIU also found that the tender was awarded improperly. The public outcry prompted the resignation of the then Minister of Health, Dr. Zweli Mkhize, in August 2021. Seven government officials were suspended during an investigation into possible misconduct.

Parliamentary portfolio committees have a range of powers. They can and should investigate matters such as corruption and governance failures, as seemed evident in “the Digital Vibes case”. During this period, many people expected the parliamentary portfolio committee on health to investigate and hold the executive to account but this did not appear to happen, despite likely public support after the groundswell of outrage about the misuse of money intended to address the COVID-19 pandemic. Instead, the portfolio committee accepted a briefing on the matter from the Director General, which did not appear to lead to any further action by the committee nor to censure of any member of the cabinet involved.

#### An interpretation

Parliamentary portfolio committees derive from the original Westminster system of government and have two roles; firstly, to supervise and oversee the executive, and secondly to oversee and lead the legislative process. In both roles, parliamentary portfolio committee members are meant to be independent of the executive. In the Westminster system, members of parliament are voted in by a (geographic) constituency and, while portfolio committee members do have to follow the party line, they can still act with some degree of independence from their political party.

However, in South Africa, one's place in parliament is determined by party lists. An individual who disagrees with the party may be at risk of losing their place on the list. If they are removed from the party, they might go to court to challenge the removal as has occurred in the past. However, one cannot switch to becoming an independent to stay in parliament as happens, for instance, in the United Kingdom. The power that political parties hold over members of parliament can limit the potential action of a portfolio committee member, particularly if it contradicts the wishes of party leaders.

In addition, members of the executive are also appointed by the party. Moreover, cadre deployment in practice means that those employed in the administration of government are actually appointed by the party as well. Thus, any separation of powers is hard to exercise and may be lost entirely, since everyone – parliamentarian, minister, or public official – is ultimately beholden to the political party. This is true in South Africa no matter which party is in power. The members of a political party within a portfolio committee and within parliament are essentially part of the executive and part of the political party itself.

As a result, the oversight role that a parliamentary portfolio should perform is nullified. Holding the executive to account will be the exception rather than the rule in such circumstances. If a parliamentarian is primarily interested in keeping their party happy, they are likely to have less time or interest in doing their oversight job. The scrutiny of legislation is compromised.

Insulating institutions and systems from vested interests is essential in any society to protect citizens' rights. Checks and balances have to be real and effective. This is the case no matter which party is in power as long as South Africa has a party (list structure) rather than a constituency system.

One solution offered was that there have to be a range of accountability structures which can be independent from vested interests. This, it was argued, can be achieved if attention is paid to how oversight bodies are constituted. A system for ensuring that structures are not diverted from their real purpose is described in Box 4, based on an argument put forward by the same interviewee {3}.

#### Box 4: Accountability for the South African Health System

An accountability regime should be based on four pillars, all of which should be operative:

- Explicit and agreed performance requirements/objectives
- Transparency around the delivery of those objectives
- A supervisory structure that ensures that the organisation performs against those objectives
- Application of sanctions/rewards for performance

Essential steps in creating an effective accountability structure:

1. Institutionalise a public-value mission in the goals of the organisation
2. Establish an array of arrangements to keep the organisation focused on its public-value mission (such as an external regulator, ombud, independent board)
3. Create more than one entity to supervise what is going on in an environment
4. Proscribe capture from above (by politicians or senior managers) and from below (by stakeholders' groups, professional groups, trade unions)
5. Manage stakeholder groups in advisory committees rather than decision-making committees
6. Insist that boards demonstrate that:
  - a. who can nominate and who can appoint are different entities
  - b. who appoints and who removes are different entities
  - c. removal requires the involvement of more than one party to be involved
7. Establish that, in order to govern, boards have more than a merely advisory role

Changing structures alone cannot achieve what is required but this is seen, at least by some key informants, as a good starting point.

### National and provincial level

Oversight bodies such as the Auditor General's report and the Office of Health Standards Compliance (OHSC) provide information about where rules or standards have not been met. From an outside point of view, there is a sense that these reports are ignored and do not improve accountability.

Importantly, informants noted that accountability is not simply about financial probity. *"A corrupt organisation has no interest in performance in relation to its public value mission. [but] [y]ou can also have an organisation that is not corrupt but is also failing to perform its mission and you want to deal with both in your institutional design."* {3}.

Accountability on service delivery and meeting goals requires the use of data for decisions about service outcomes rather than focusing exclusively on input and process measures. There are currently, however, few or no outcomes measures in the health system; the system is seldom seen to be correcting itself based on either service or process measures. *"If there is lower than average performance, it should be a red flag and the constraints, and the contributing factors investigated. But we do not see anything in the system responding to that."* {8}.

A system that lacks a sufficient participatory and consensus orientation limits the potential for community organisations to hold health services accountable. *“Client satisfaction reviews and quality complaints and compliment systems [are undertaken] and a lot of data is collected, but whether that changes practice is another question.”* {7}.

However, some informants had positive expectations and experiences of citizen monitoring. *“[W]e have projects such as the Ritshidze Project, it is a citizen, community-led monitoring system that is run by the HIV organisations such as TAC (Treatment Action Campaign).”* {7}. *“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.”* {10}.

The literature identifies responsiveness at a system level as essential, meaning not just the dimension of answerability but also the requirement to see action in response at both individual and collective levels, either pro-active and preventative, or remedial, for redress (145). Two clear examples of failure of system responsiveness were noted. One was the ministerial advisory committee for the prevention and control of cancer, described above as *“toothless”*. The other was the failure of the NDoH to implement the recommendations of the Health Market Inquiry: *“The NHI project has consumed the department as the NHI carried political weight and was seen as the only thing that had to be done. As a result, nothing will happen with the recommendations of the Health Market Inquiry.”* {6}.

To succeed in getting a health challenge prioritised was not perceived to be always evidence based, it *“is mainly about personal relationships, if there is a good personal relationship at national level then support will be given to those specific organisations. Is it about who you know or what you know? Who you know plays a major role when trying to engage with government.”* {11}. This reinforces the argument that if there is no guiding plan it is possible to go off course.

A further threat to accountability was the *“vested interests within the system”* such as *“the apex professionals [such as medical specialists who] hold a lot of power and are not accountable in the hospital system at all”* {8}. More worryingly, for *“a lot of health leaders, especially at the senior level, political interference is a reality and not all of them feel protected [and are afraid] to speak truth to power.”* {9}.

Important steps would include information systems to produce data to measure things that matter (such as health outcomes) and, in turn, enable holding people to account against those outcomes. This may not replace holding people to account for other matters such as performance, absenteeism, honesty, managing budgets well, or facility readiness, but would allow for assessment of health department staff against tangible measures that can be checked and verified. From here, it would be possible to judge who is doing a good job and thus who should be promoted or replaced. This is relevant as it links to the most common issue raised across all the Panel's consultations, especially from those within the public sector: the importance of having people in the job who were competent.

The lack of competent appointments was linked to political interference. Political interference can take various forms, such as appointing someone who is not appropriate for the task or a political head not supporting a senior civil servant in their decisions (such as holding people accountable for fraud) because that would have uncomfortable political connotations.

*“The managerial politician is the one who wants to take over the role of the Head of Department and manage the department; the other type of cadre manager is purely political but does not provide the political support for accounting officers to do their work. It is important to understand the politician you are working with and understand the nature of the political interface.”* {2}.

## Transparency

Transparency may apply to many aspects within a health service. Most consultations raised the lack of transparency in the appointment process for civil servants in the public sector. Integral to achieving good governance is that merit, capacity, and capability form the basis of all appointments; this was “a golden thread” throughout all the consultations. The most common and consistent comment, confirmed in various analyses of the quality of the South African health system, is the need to “[f]ind the right people to deliver” {1}. Here, many key informants referred to political interference, a problem exacerbated when both appointees and managers were “not always clear about their roles.” {1}.

*“The biggest problem is in the appointment of people. The procurement of goods and services is key but the most crucial is people, the Human Resource planning and appointment systems and how those have evolved because they are driven by political imperatives. The appointment system allows replacing professionals with general workers.” {7}.*

Cadre deployment was commonly raised as a key concern. *“The people appointed into the administrations of government are actually appointed by the governing political party through the cadre deployment process.” {3}.* *“When cadre deployment [is] a primary objective, there is no dedication to the skilled people in the system.” {2}.* *“Cadre deployment [into managerial positions] results in interference at different levels” {1} and has caused “the blurring of the political and administrative functions, [as well as] the blurring of decision making” {7} and accountability. {2}.*

Informants noted that political interference was not restricted to staff appointments but was seen across all health system functions and undermined the integrity of the health system. *“One of the key things we have seen go wrong in institutions is the political interference at different levels.” {1}.* *“[T] here is political interference in appointments, there is a conflict of interest that destroys integrity.” {3}.* *“At provincial level, the ability of senior managers and career managers to implement whatever is necessary is hampered significantly by the political leadership; what people are capable and able to do, is largely influenced by the party-political leadership”. {5}.*

*“[T]here [are] a lot of patronage networks in government systems, patronage networks which at some points do not respond to the needs of the population. So, you find that people who are not meeting the minimum requirements are in positions, when I say minimum requirements, I include qualifications and experience. A person who is not experienced and does not even know how to respond to a crisis, or what to do to get things done, struggles because they are just not capable at that particular time. I must say that we find this problem very transversal (you find it in most provinces), we also find those who do not meet the minimum requirements, or you would think this is a patronage confirmation, but they are able to deliver. So, I don't know how to draw a distinction, but the majority would be hired through patronage networks and because when you raise an issue of patronage, you get victimised.” {13}.*

One solution suggested as a starting point was to ensure “a system of open appointments of district managers that is a public process.” {7}. This is clearly only part of the solution as competency is also required, not merely popularity, and the notion of “a public process” needs to be defined. The Panel argues that it should be public enough for disinterested parties to learn and judge the clear reasoning for appointments. Transparency in the appointment process seems to be one of the ways that the harmful effects of so-called cadre deployment can be limited.

The discussion about accountability is relevant here too. If clear expectations are set (for example meeting positive health outcomes), then having data against which people are measured in the public domain will mean that it should be more difficult to retain or promote people when they do not achieve. Transparency of health data is also required, such as in the OHSC reports and the annual HST District Health Barometer (which is in the public domain). The HMI made a number of recommendations

about health outcomes data and how this can be used to contract with providers based on good health outcomes. While the HMI made recommendations only for the private sector, they are relevant to the public sector as well. The HMI also proposed a system to ensure that contracts between suppliers and payers (again in the private sector, but relevant in the public sector) could be reviewed to make sure they are serving to ensure that the purchaser is engaged in a relationship with the provider in such a way that better and more rational use is made of the health spend.

Transparency in all of these areas can improve health governance and avoid the political interference referred to so often.

## Addressing corruption

The murder of Babita Deokaran on 23 August 2021 (146) illustrates the danger, difficulty, and remarkable courage required to address corruption at the individual level. Deokaran was a long-serving civil servant in the Department of Health in Gauteng who found and reported corruption and worked with state authorities to hold people accountable. She exemplified the principle of holding true to a department value mission. She was assassinated by persons still to be brought to justice, for being a public servant in the truest sense of the word.

To address corruption, both prevention and mitigation strategies are needed. As strategies to create an environment that makes it difficult for corruption to thrive, Rispel and colleagues highlight the political will to run corruption-free health services, effectively enforce anti-corruption laws, and appoint and train public servants with the right skills, competencies, ethics, and value systems. They point to the role of citizen voice, through civil society organisations, hospital boards and clinic committees, in holding public officials accountable (147).

As the murder of Babita Deokaran emphasises, protection for whistleblowers is critical, along with legal protection, professional peer support, and education to raise awareness. Such protection needs to be effective and reliable if individuals are to stand up and resist pressure (148). If people in power (senior staff or politicians) are themselves corrupt or incompetent, they will not offer such protection or, worse, will victimise a public servant who refuses to tolerate corrupt practices.

One interviewee noted, *"This staff is afraid to raise such issues.... [P]eople who say they don't want to sign off the RLS01 forms for purchases of wrong things, or inflation of prices and if they refuse, they get punished by being suspended/ precautionary redeployed. 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 because I saw the price and I know the normal price."* {13}.

Relying on whistleblowers would not be a solution on its own. Overall, key informants stressed system-level processes to prevent corruption such as the well-functioning oversight bodies to prevent corruption described above.

Another contribution to a solution lies in the strategy repeated throughout this Report: putting the right people in the job and preventing cadre deployment. As noted in one consultative meeting during a discussion on the management of finances, *"[W]here there is cadre deployment, the normal accountability structures are nullified, and it is called top-down capture."* {3}, *"essentially the capturing of governance, leadership, and stewardship for narrow material interests; many of them for corrupt ends/ for private gains. This is a key problem."* {7}.

Fundamental to addressing corruption would be *"a consequence for incompetence and dishonesty; when people are incompetent, they are merely moved around departments; which does not address the fundamental issue."* {2}.

A distinction here is drawn between incompetence and dishonesty. Lacking competence means you cannot and do not identify corruption taking place or about to take place, or, if you do, you don't know how to deal with it. This may result from cadre deployment but could also result from appointing someone who does not have the capacity required for the job. Dishonest individuals may also take advantage of incompetent employees who do not recognise corruption or do not challenge it.

Incompetence differs from putting dishonest people into positions where they can purposely redirect or manipulate procurement for private or third-party benefits, at the expense of the health services' mandate to provide care for patients and populations. This can be the result of cadre deployment or infiltration by criminal elements in what is increasingly being described as "a gangster state". Dishonest people in position, together with a failure to hold people accountable quickly enough, has led to brazen actions such as the murder of Babita Deokaran.

Both these deficiencies, incompetence and dishonesty, are destructive for the health system but require different solutions.

It is essential to enable and insist on clear, visible, and swift action to charge and penalise corruption when it is found. Changing governance structures may assist in better detection of corruption. Improved management as described above and having the right people in place as well as finding mechanisms to prevent cadre deployment (as discussed under "transparency") are necessary. However, not all of this is within the scope of the Department of Health.

A paradoxical feature of the impact of corruption on the health sector surfaced in the Panel's consultations. Because corruption was neither prevented nor adequately mitigated, blunt measures were often put in place in the health sector to control corruption. While well intended, these measures sometimes hampered problem solving and innovation.

*"[C]orruption has become a central theme and because of that, there has been an intensification of an audit and compliance orientation." {7}. As a result, "the rules that we put in place to protect the system against things like fraud, like the Public Finance Management Act (PFMA), actually land up disabling us from being able to do anything because we are so hedged with regulations, rules, and provisos... [I]t is more important to follow rules than it is to deliver services." {9}.*

*This has meant that "people are fearful of making mistakes. The Auditor General is flushed down your throat all the time and there is such a punitive culture, even the wording that the Auditor General would use in their reports is extremely punitive. The OHSC, despite them verbalising that they are not, they are massively punitive, and they actually mislead in their reports." {9}. "A qualified audit becomes a mechanism for punishment within organisations e.g., forms of malicious compliance where reward and sanctions are used by people at the top to control people at the bottom of the system. So, you have a climate of fear and a climate of reluctant compliance which is entirely orientated towards upward accountability. It is looking outwards and upwards and a complete failure of downwards responsiveness and accountability to service delivery and the coalface." {7}.*

*As noted before, "if you work in the fear culture, there is no way you can be innovative and creative." {9}.*

*Corruption and the response to corruption have spawned a compliance ethos. "Due to fraud and corruption, we have developed a compliance framework that is very strict and to a certain extent, limiting. If we had more ethical leadership, compliance would require less regulatory frameworks." {2}. Another interviewee confirmed: "What is important is a principled approach to deal with these matters, as this does not require legislation and can be implemented through conduct, behaviour, and leadership. When one deals with public funds and the complexity of arrangements including very*

*rigid procurement rules, we tend to introduce more rules which do not necessarily work... [M]ore rules do not [necessarily] mean compliance."* {1}.

The Panel's consultations highlighted the fine line between managing corruption from a regulatory and rule-based point of view and allowing understandable mistakes which create opportunities for learning. *"On the issue of mistakes, if there is negligence or a criminal act, that cannot be allowed, but if a person made a legitimate error, an error of judgement and there is a good reason for that, then that should be a learning experience."* {9}. *"So, allow people, trust them, give them space, and make sure leadership is visible and present in the front line. Rather learn from the front line. [Fear causes] people to sit in the corner and not do anything even if they see things are wrong because they are fearful about losing their jobs."* {9}.

As informants pointed out, a learning organisation can only exist with leadership that is present, competent, focused on a commonly agreed public-service mission, and ethical themselves, bringing the discussion back to having the right people in the right places. That, combined with transparency and accountability, may create an environment where trust can be rebuilt. As noted by one key informant, fixing the health system is *"a marathon not a sprint"* {2}.

Some key informants saw oversight and review bodies as out of touch with conditions on the ground, misrepresenting reality, and overreaching. For example, in the view of one provincial official, the OHSC was interpreting data incorrectly, so the official feared that they would be criticised in AG reports. This sentiment co-exists with the contrary view that review bodies actually have little impact as no remedial action is taken consequent on a bad finding. One interviewee noted that *"Targets mean nothing because there are no consequences if we do not meet them."* {8}.

Due to ongoing and pervasive accounting problems, *"a clean audit is seen as the gold standard [in government departments]. However, there needs to be a marriage between good performance and compliance. Compliance and accountability should not just be box ticking."* {2}. *"You can have a department that is not functioning well but is found to be compliant in terms of pure rigid regulatory framework."* {2}.

## Conclusion

Overall, as per Mikkelsen-Lopez et al (1), all these factors are interlinked. System design and a clear vision based on a public value mission are required and underpin accountability and transparency, which are elements that dovetail, and which 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.

When pushed on where to start, the consultations generated three strategies: get the systems right, get the right people in the right places, and empower 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.





## Chapter 6: Discussion

This chapter synthesises and discusses the key findings on governance challenges and opportunities emerging from Chapters 3 to 5 in response to the ASSAf brief described in the Introduction. The discussion is organised around the five elements of the Mikkelson-Lopez framework: i) strategic vision and policy design, ii) participation and consensus, iii) accountability, iv) transparency, and v) addressing corruption. The framework assisted in ordering the issues but does not reflect the order of importance or priority (1). Here, the Panel continued to apply Van Olmen's definition of governance, emphasising that governance is the glue which holds the health system together and is thus a crucial leverage point for wider systems strengthening (9).

The chapter presents strategies that emerged from various sources – consultations and literature – and from the Panel's deliberations. Given the complexity of the health system and its governance, it is important to stress that the findings and strategies are interrelated and impact each other.

Governance of the health system continues to be shaped by South Africa's long and traumatic history of colonialism and apartheid, reflected in ongoing inequity in health status and access to quality health care, despite attempts at transformation since 1994 (22,25). It has been further negatively impacted by the broader socio-political and governance context during the era of "State Capture" (149). Despite this troubled context and the extensive ongoing challenges to health governance, the Panel contends that much can be achieved by addressing internal health systems governance and leadership factors (7,34). A system of good governance and leadership should clarify the strategic goals of the health system, define "rules" for engagement (including roles and relationships of the various actors), and coordinate the multiple actors across the health system through participatory and transparent processes which promote accountability to achieve a clearly articulated public value mission.

This review identified numerous laws, policies, and structures which provide a foundation for governance and leadership of the South African health system. The Panel reported a number of gains and examples of good governance over the past three decades. However, important aspects of the governance system are not being fulfilled as intended or are no longer fit for purpose. Current systems and processes appear incapable of ensuring good governance in a health system which has evolved, which is facing immense challenges, and to which further substantive changes are envisaged in order to pursue universal health care (UHC) through a national health insurance (NHI).

The Report identifies failures of governance at multiple levels within the South African health system. These shortcomings contribute to inefficiency, wastage and poor quality of care; constrain the ability of the health system to respond to needs; and undermine the collective efforts of health workers and communities to achieve better health for all.

Stakeholders expressed the need for urgency in addressing failures of governance and leadership in South Africa's health system. While it is important to build on the foundations and gains of the past, the urgent need is to find innovative and inclusive approaches to governance that are better designed for the current context and challenges.

### Strategic vision, policy and systems design

Morale and confidence in the public sector in South Africa have been substantially eroded. Levels of commitment to a shared public value mission vary widely among health workers and managers and this is compounded by distrust from communities. Failure to steward a complex system that integrates public and private providers across levels of care allows fragmentation to undermine a common vision for population health.

## Strategic vision

Despite numerous annual national strategic and performance plans and budgets on paper, in practice coherence and prioritisation are lacking. The absence of a clearly communicated and jointly shared strategic vision for the health system was identified as a serious governance constraint by several sources. A common thread was an absence or weak commitment to a public value mandate in the health system.

The White Paper on the Transformation of the Health System and the South African Constitution established an initial vision for the health system in the 1990s, with a strong emphasis on public value (29,150). However, this was not translated into practice and, after the initial period of restructuring of the health system to establish comprehensive primary health care (PHC) within a district health system (DHS), the national response to the HIV/AIDS pandemic contributed to a shift back to a largely vertical health programme approach (36). The focus on the core strategic vision and strengthening the fundamentals of the health system was diluted and superseded by a myriad competing programme plans and resource streams which were poorly coordinated by the NDoH.

The last decade has seen a refocusing on health systems goals, with policies on re-engineering PHC and the NHI in efforts to move the National Health System (NHS) towards UHC (35,41,43). The NHI is however a financing strategy and tool to support the achievement of UHC but has been prioritised over and detracted from setting and communicating the overarching public value goals of achieving quality UHC and health for all. Any health system seeking to establish UHC needs public value goals that are clearly re-articulated, communicated, and shared.

## Policy and systems design

The lack of clarity in legislation such as the Public Finance Management Act (PFMA), the Public Service Act (PSA), and the National Health Act (NHA) of 2003 have contributed to conflicting mandates between politicians and senior managers in the public health sector, across levels of government, and between the health sector and structures for community representation.

The design of the governance of statutory and regulatory bodies has also come under scrutiny as part of the overall system of checks and balances within the health system. The boards of bodies such as the Office of Health Standards Compliance (OHSC) and health professions councils are appointed by, and account to the Minister of Health. They are therefore not independent of the executive and cannot be regarded as providing external, independent oversight of health professionals and quality standards within the health system (4,151). Statutory bodies such as the Health Professions Council of South Africa (HPCSA) and South African Nursing Council (SANC) have demonstrated failure to align their plans and actions to the overall health system's strategic vision in terms of the training and production of health professionals or to provide the necessary oversight of health professions(54) .

The governance frameworks for such structures should be reviewed. The function of appointing board members should be separated from the function of over-seeing that boards' strategies, plans, and objectives align with national strategies and plans. Boards and other structures should be adequately capacitated and resourced to fulfil their mandates. Priority should be given to implementing the recommendations of the Presidential Compact on the Governance and Resourcing of Statutory Bodies, as well as the 2030 Human Resources for Health (HRH) strategy to revitalise HRH regulatory structures to enhance the education, performance, and accountability of the health workforce(41,152).

In terms of the private sector, the Health Market Inquiry (HMI) noted that "(t)he evolution of the market to its current form is a consequence of a changing regulation environment which saw periods of deregulation in the late 1980s and then partial re-regulation which has led to the status quo. The

end result is that facilities are not regulated beyond the requirement of a licence to operate, and practitioners are licensed to practise by the HPCSA but little more. The funder (demand) side of the market is characterised by significantly more regulation including open enrolment, community rating and a prohibition of risk rating. However, the funders' regulatory regime is incomplete." (44).

The HMI further noted that the "overall incomplete regulatory regime can largely be attributed to a failure in implementation on the part of regulators and inadequate stewardship by the Department of Health over the years" (pg. 9) (44). Of importance to this Report was the HMI finding that "[m]any of the recommendations we have considered are already provided for in current legislation but have not been implemented" (44). The HMI made several interrelated recommendations aimed at "improving transparency, accountability, and the alignment of interests of consumers and funders" (44). They also aimed to address the absence of measures of value, in particular healthcare outcomes; failures in pooling of funds; improved management of supply induced demand; and methods to address concentration in the market. The HMI recommendations are aligned with the national policy trajectory towards UHC (44).

## Decentralisation

The Panel noted that governance as a principle concerns the distribution of power, how decisions are made, and who or what informs those decisions (153). Several key informants raised concerns about a lack of delegated authority within the health system. Although the South African health system was planned as a decentralised DHS, authority for decision making has been largely centralised, with a command-and-control approach by national and provincial departments, leaving very little delegation and decision space for district, hospital, and frontline managers (15,33,56).

The DHS as envisaged by the 2003 NHA has never been fully implemented. The districts have never received powers as planned, which means that the true advantages of a decentralised system have not been achieved. Nor does the country have experience of the kind of well-functioning decentralised DHS from which to draw both positive and negative lessons. The key principle of decentralisation to facility managers has been implemented very weakly, with managers of central hospitals having limited power, despite being expected to manage multi-million-rand budgets. And yet the data collected on success stories at district level suggest that there is more capacity at this level than is generally recognised. The appointment of people who lack the necessary management competencies has contributed to a lack of trust in facility and district managers and has undermined delegated power.

Key informants confirmed the value of decentralisation and called for better frameworks to delegate decision-making power to people lower in the system and to create an environment and capacity to support such local decision-making, along with appropriate systems of checks and balances. It was felt that larger hospitals also need greater autonomy to provide increased scope for decentralised decision making.

## Health information

A decentralised health system needs support systems to facilitate delegated decision making. Key informants pointed out that current information systems were designed for reporting to central levels, with little attention to the collection and use of appropriate data for local facility decision making and accountability. A local study on the use of information for governance found, similarly, a health information system (HIS) designed for upward accountability within a largely authoritarian governance mode. In response, some local managers have successfully used more "co-production" governance modes by engaging with their staff, other managers, service users, and local stakeholders to obtain relevant information to support local planning and decision making (58).

Given this situation, it is clear that the implementation of UHC and an NHI system would require an integrated HIS that supports the collection and use of appropriate data to inform decisions at health facilities and within health districts. The HIS thus needs to support greater local horizontal accountability across peers and with users and communities. Although steps are being taken to establish a patient-based online HIS in the public sector, progress has been slow (154).

Particular types of data which will be needed for the NHI include improved patient health records, diagnostic coding, standard discharge summaries for every inpatient, and more outcome measures to enable reimbursements, resource management, and health system performance assessments (155,156). The integrated online patient-based information system in the Western Cape provides an example of what is feasible for improved patient management and public health surveillance within the South African context (157).

### Financing, strategic purchasing, and procurement

Other support systems such as finance and procurement are, similarly, not designed to support decentralised management at institutional or district level. For NHI design, therefore, it would be necessary to identify procurement and purchasing functions that can be decentralised, leaving only those that rely on economies of scale or require scarce technical expertise to be controlled centrally (33). Institutional governance structures would need greater autonomy, with for example, (as noted previously) hospital boards making decisions rather than merely playing an advisory role. The NHI experience of Thailand, where the purchasing authority is outside and independent of government, was cited as a successful example of such a decentralised purchasing system with stronger local governance. (See also Chapter 4.)

As suggested in Chapter 4, the introduction of strategic purchasing would significantly alter incentive arrangements and better match budgets to performance and value, with potentially transformative impact throughout the health system. Introduction of strategic purchasing should commence even before full implementation of NHI.

Procurement problems have emerged as among the most significant challenges to health governance. While corruption is one part of the problem, generations of reforms to control corruption and load multiple secondary objectives onto the procurement system have created such complexity that many health managers with excellent potential have found it impossible to navigate. Professionalisation of management may be part of the solution, but it is also essential to simplify the procurement system and delegate procurement to lower levels.

Although the public financial management system does create a basis for decentralised facility and sub-district budgets, much more could be done in this regard in order to increase powers of facility managers. Provinces and the national sphere on the other hand need to play a stronger role in narrowing inter-district inequities, potentially through district resource allocation formulas or/and reimbursement reform.

### Organisational “software”

Governance concerns also emerged from interviews and local studies with regard to human resources for health, in particular the complex relationship between governance and leadership (discussed in the following section), but also the macro aspects of national governance of human resources along with micro governance in terms of actors, relationships, and trust at the operational level.

At the macro level, several iterations of human resource policies have been developed, but the stewardship of implementation by the NDoH has been weak, with a failure by actors at various levels to operationalise policies.

The design and governance of South Africa's health system have focused largely on structural components and the "hardware" (material resources), while neglecting the organisational "software" (15,158,159). The organisational culture within the health system leans towards hierarchical and rational cultures that emphasise control, order, and stability, with little emphasis on people-centred aspects such as human relations, flexibility, and a developmental approach (56). A 2018 review recommended that the NDoH prioritise HRH, including its own capacity to perform its HRH governance functions and also address the "software" required to establish a shared HRH vision and manage actors effectively (54).

Decision makers within the health system need to recognise that organisational software is as important as hardware in building resilience and good governance (159,160). Health managers need to implement interventions to strengthen relationships and build trust with and between staff, and to establish practices to build relationships (161). It is important to cultivate an ethos of public service by valuing health workers who, in turn, are then more likely to value clients and embrace their own role in promoting the health of the population. There is also a need to measure and to monitor progress in practices that contribute to the organisational culture and to good governance of the health system.

## Participation and consensus orientation

These aspects are important, firstly for the interface between health managers and service providers, and secondly for the focus on community voice in health governance.

## Health leadership and management

Governance includes the operationalisation of policies and practice set at national level, by individuals at lower levels in the health system (12). Several organisational factors impact on the roles and behaviours of managers at all levels of the health system and their everyday practice of governance. Amongst the most important, according to many key informants, are the quality of management and ethical leadership.

Managers at many levels have experienced the top-down hierarchical organisation of the health system as disempowering and said that it hampered their participation in decision making and their ability to engage with communities and other stakeholders. Many health managers lacked necessary leadership and management competencies, often as a result of flawed selection and appointment processes, with anecdotal evidence of cadre deployment to key positions. Senior managers may want to delegate authority but lack confidence in managers who do not have the necessary competencies.

In addition to appropriate technical and management competencies, effective leadership and management require appropriate tools and a functional health system to enable them to do their work (162). Even the best managers struggle if they lack access to the necessary information or the authority to delegate financial or human resource decision making, or if they work in a culture of fear. Senior health managers increasingly come under pressure to meet short-term political interests. These factors have contributed to a high turnover in key leadership and management positions, with consequent instability and a lack of continuity in leadership. Gauteng Health Department, for example, had close to 10 heads of department (HODs) in as many years.

Ethical leadership emerged as a significant governance concern. Health managers require core ethical values to make the "right" decisions, to be transparent and accountable, and to resist political pressures, often at great personal and professional costs. In some provinces, building trust and peer accountability in teams, with a commitment to integrity and organisational values, helped to create a culture which supported ethical leadership (4). Competencies in relational approaches are seen as essential and complementary to bureaucratic competencies (158).

The Draft National Implementation Framework towards the Professionalisation of the Public Services, and in particular the professionalisation of health management, was seen as a positive development in enhancing leadership and management capacity, while also reducing opportunities for fraudulent practices. However, this will only benefit the health system and its users if the framework is implemented, if the right people are employed, and if systems are insulated from vested interests. Overall, there needs to be a stronger focus on appointing people with the required competencies, and more capacity building around distributed leadership with a focus on developing teams rather than individuals in leadership. More competency-based training is essential, including practical on-the-job training, action learning, coaching, and mentoring, within a systems approach. Partnerships with academic institutions and the private sector have provided some evidence of models that support management through mentoring, action learning, and systems strengthening (163).

Ongoing learning was seen as a characteristic of a functional health system and the foundation for system strengthening and resilience. Explicit action is required to intentionally design a learning environment(164,165). Developing a learning culture in the health system also requires the building of supportive teams and collaborations, with, for example, embedded researchers, patients, community members, and non-government community-based health structures, purposely selected to contribute their diverse strengths to strengthen decision-making practice (162,163).

Key messages were to strengthen distributed leadership by appointing the right people in leadership and management, creating the required management systems around them, and supporting them to do their job through appropriate forms of capacity building, including through partnerships with institutions that can support management capacity development. Focusing on the outcomes that people should achieve, rather than on how they should do their work, will encourage context-specific innovation around achieving outcomes.

## Community voice

Various mechanisms can channel community voice and participation in governance. These include formal structures such as health committees, organised civil society, and programmes such as community health worker (CHW) projects (166,167).

The current structures intended to give voice to communities in the South African health system (boards and clinic committees) were seen as essentially powerless. The absence of any co-creation of a vision and plans contributed to a disconnect between policymakers, leaders, and communities. Informants reported no meaningful impact of community voice on decision-making at local level and even less at higher levels of the health system where the most important decisions are made.

Key informants suggested several measures to address representation, legitimacy, and power of these structures. Most of these were in keeping with the guidance related to boards (see Box 4 in Chapter 5). In addition, a system is needed for tiered upward representation from health committees and hospital boards to district, provincial, and national level. Meaningful engagement by clinic committees and hospital boards requires greater formal recognition of their role and regular engagement spaces with feedback loops. To perform their roles, members need proper inductions, ongoing capacity development, and appropriate reimbursement in keeping with the real costs of participation (61,62). Health managers need more training on their roles in community governance; performance evaluations should include measures of their community responsiveness (65,168).

It was noted with concern that the NHI policy lacks any guidance or regulation on community participation within the combined public–private system of health provision. (67). A uniform approach for boards and clinic committees should be developed and extended to private sector provision.

Civil society organisations are seen as extremely important voices, particularly in representing underserved communities and patient groups neglected by current health policies and services. The constitutional imperative to consult citizens and communities should add value and ensure alignment with the needs and appropriateness of response (150). However, key informants expressed frustration that the government's openness to organised civil society has waxed and waned. The appetite of the government for listening is not good, reflected in poor responsiveness and the limited spaces and opportunities for organised civil society to contribute to policy. It was felt that access to these spaces was tightly controlled and depended on patronage, rather than on evidence or the needs of constituencies.

Informants stressed the under-utilised potential of organised civil society to contribute to policy, decision making, and monitoring to improve governance at many levels. Civil society needs to participate in high level "political" governance issues but also and as importantly in "operational" governance at the coalface. Constraints on the participation of organised civil society include vested interests, competition instead of collaboration between organisations, and a maldistribution of civil society voices, with better resourced urban civil society organisations having more clout than rural voices.

Government needs to create more spaces to engage with organised civil society, including rural groups, as important governance actors. Conversely, fragmented civil society movements need to be better organised, to collaborate, and to be politically astute in order to represent the needs of particular communities or patient groups.

Lastly, ward based outreach teams (WBOTs) are adopting community oriented primary care (COPC), a model premised on giving voice to communities (35). Formal policy recognition of the role of CHWs has led to agreements on the integration of CHW's within the public sector, providing stability and security for this important sector. However, with primary accountability to health facility managers and no clear accountability mechanisms to communities, these developments raise concerns about the governance of COPC. As an important link between health services and communities, there is huge potential for COPC to strengthen community voices in local governance of health. Clear channels for this to occur need to be defined and implemented as part of improving the accountability, transparency, and responsiveness of the health sector to communities (70–72).

## Being accountable

The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions, mainly around political or social goals, finances, and performance (169). Thus, accountability contributes to ensuring health systems performance, the achievement of the public value mission, and reducing abuse and corruption.

Concerns were raised about a lack of clarity of roles and responsibility and hence accountability at different levels within the health system, with examples of national health programmes venturing into the implementation space, often bypassing other levels. Key informants emphasised that each level of government should understand and deliver on its mandate in terms of the NHA. For example, the NDoH should be accountable for stewardship of the overall system, provinces for supporting districts and hospitals, and districts and hospitals for implementing health services. A benefit of greater shared responsibility in such a distributed governance system is that managers at different levels have clearly delegated responsibilities for which they are accountable, enhancing overall accountability within the health system.

The lack of effective delegation and accountability translates into insufficient consequence management by health managers at all levels. In the current system, it is problematic if all accountability and consequences fall on the HoD, especially if they have not been incompetent or fraudulent; this has



contributed to the high turnover in senior managers. In a distributed governance model, by contrast, managers at different levels are accountable for specific responsibilities and take the consequences. Accountability is essential but needs to be appropriate.

The parliamentary portfolio committee on health, established through the proportional representative party system, currently appears to be failing to meet its oversight potential because too much attention is paid to the interests of political parties and cadres appointed by the party. As a result, the committee struggles to represent the interests of the public and could do far more to prioritise the public value mission of the health system.

Governance structures such as clinic committees and hospital boards, established to provide accountability within communities, have been described as 'toothless' with no decision-making powers, and no upward representation within the health systems governance system.

Stewardship by government of statutory oversight bodies was seen as weak, while these bodies fail to fulfil their roles effectively in governing health professionals or service delivery in both the public and private health sectors.

The HMI found inadequate stewardship of the private sector, including the NDoH's failure to use existing legislated powers to manage the private healthcare market, to ensure regular reviews as required by law, or to hold regulators sufficiently accountable (44).

To ensure accountability for more effective governance of the health system overall, national government should play a stronger stewardship role, particularly around institutional arrangements within the public sector and with other actors (170).

## Being transparent

Political interference and patronage emerged as serious threats to transparency in decision making within the health system. In particular, cadre deployment to management positions often results in the appointment of people without the necessary management, technical, or ethical competencies. Informants proposed full transparency in appointment processes, with the option to involve health governance structures or public processes, for instance for district manager appointments.

Concerns were raised about the lack of transparency around health data collected throughout the health system. Previous reports documented how, despite extensive data collection, there is limited reporting of health outcomes and impacts. Core information is not captured electronically. Health information systems have poor interoperability. Many do not provide patient level data, and are incapable of reporting across public and private sectors or across levels of care or care pathways (4,44,171). Similarly, the HMI noted concerns about the accessibility of information collected by the OHSC on compliance of health facilities with national quality standards (44).

These constraints limit the accessibility of data not only for decision-makers within the health system but also, and even more so, for service users, health facility governance structures, communities, and other important stakeholders. The need for more accessible and reliable information on health systems performance and the quality of health care in the public and private health sectors becomes even more important within the context of the NHI system and for achieving the goals of quality UHC.

Strategies recommended previously included the creation of an integrated national health systems performance dashboard, and strengthened stewardship of the National Health Information System of South Africa (NHISSA) (171). Another is to capacitate citizens, health workers, and managers to use data for decision making and advocacy. As one example, citizen-led monitoring and data collection was

effective at more than 400 PHC facilities across eight Provinces in the Ritshidze Project. In response to the crisis in public clinics this project was developed by communities to hold the South African government and aid agencies accountable to improve overall HIV, TB, and other health service delivery at clinics. This has enabled citizens and communities to generate solutions to problems and to advocate to relevant decision makers for responsive health services (8,172).

The establishment of Contracting Units for Primary Care (CUPs) and, with the NHI, a shift from advisory to decision making governance structures mean an increased necessity for greater access to and transparency on decisions such as appointments, contracts, procurement, and performance at all levels.

## Addressing corruption

Corruption is defined as the abuse of resources, power, or connections for private gain (<https://www.transparency.org/en>). Official reports and studies have documented extensive fraud and corruption within both the public and private sectors of the South African health system (4,44).

Key informants expressed grave concerns about the growing levels of corruption within the health system which contribute to wastage and poor quality of care and threaten the safety and lives of health officials. Cadre deployment and top-down capture were seen as undermining health governance for narrow material interests, but incompetence was also considered a contributing factor, with health officials not recognising or knowing how to deal with corrupt actions. A lack of consequences for corruption created an environment of impunity within the health system.

Multiple strategies are important to address corruption. These include ensuring that the right people, with the right competencies and ethical values, are appointed to leadership and management positions within the health system. Leaders and managers need to be supported by clear policy and decision-making frameworks, and by values and a culture within the health system that reward integrity and ethical behaviour. Systems to detect and report corruption early are needed, along with clear, visible, and swift action to charge and penalise corruption, preferably by an independent agency. Managers should take disciplinary steps in cases of potential corruption and should know where to refer cases for criminal investigation. The system should also create mechanisms to protect whistle-blowers and provide them with legal support. Anti-corruption bodies such as the National Prosecuting Authority need to be properly resourced and to act timeously.

As noted above, procurement systems are a focus for addressing corruption, by strengthening competencies in procurement, professionalising health management, streamlining and digitalising procurement systems, and delegating procurement to lower levels.

Oversight bodies such as health professions councils, whose brief includes ensuring ethical conduct and professional behaviour of the health professionals under their jurisdiction, need to be proactive in fulfilling their role. The OHSC and the health ombud have a key role to play in identifying serious failures in the quality of care, including those due to fraud or corruption, and must be adequately resourced to respond accordingly. (4,151).

Other attempts to address fraud and corruption such as the NDoH Litigation strategy and a Health Sector Anti-Corruption Forum (HSACF) have demonstrated some successes in controlling corruption. It is imperative that the relevant authorities move more swiftly on matters of corruption in the health sector.

## Limitations

The Panel searched the literature for evidence on strategies to address health governance challenges but found limited evidence in several areas including that of addressing corruption. However, this Report draws on the best evidence available from South Africa and globally.

The Van Olmen definition of health governance seemed most suitable for this study but multiple definitions exist and others may have chosen a different definition. The Mikkelson-Lopez framework, which is informed by the WHO health systems building blocks, was useful in identifying health systems problems across five elements of governance. The Panel sought to address any shortcomings in this framework through reference to other, recent frameworks to explore the governance actors, their roles and the relationships between actors and across levels of the health system. The assessment was not designed to provide a comparison with other settings but to inform local decision-making and action on health governance within South Africa.

A wide range of governance actors were invited but the Panel was not able to interview everyone as planned. The key informants are therefore not completely representative of all governance actors, but the Panel were satisfied that they gained a range of important perspectives which were triangulated with other sources of evidence. They also drew on recent reports such as the HMI to reflect perspectives on governance of the private sector, along with several local studies of district and facility level governance in South Africa. The Panel recognises that improved health is achieved through various interventions both within the health sector and through collaboration with other sectors, such as housing, water, sanitation, social protection, and environmental protection. This consensus report did not deal with these important intergovernmental, intersectoral aspects of governance.

The Panel deliberated extensively on the findings of the study, and although there may have been differences in interpretation along the way, the final recommendations have the full support of all members of the panel. Panelists acknowledge that there are still various areas that need further exploration beyond the brief of this report.

This discussion, distilling the key challenges and opportunities for good health governance in South Africa, provides the basis for recommendations to advance good governance in the health system, presented in the next chapter.

## Chapter 7: Recommendations

The panel has sought to make recommendations which are clear, informed by evidence, respond to the governance challenges identified and are feasible to implement. Doing nothing has its own costs, which will, among other things, create greater inequality in health in South Africa and may in the long term prove more costly. It is a constitutional imperative to provide equitable access to health care in South Africa. As South Africa implements a National Health Insurance (NHI) to support quality universal health coverage (UHC), new governance and leadership challenges arise, requiring new approaches. 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. Some may not have the vision or appetite for this, but the Panel's interviews and review of the literature indicate that there are many actors in the health sector who do. Acting – and being seen to act – to effect positive and measurable improvements in governance will restore trust in the health system.

The Panel recommends the following eight steps to address the key governance elements of strategic vision and policy design, participation and consensus, accountability, transparency, and protection against corruption. The order of the list of recommendations does not imply prioritisation of any over others, as all are interdependent and should be addressed.

### 1. Define and communicate a clear public value mission and the mandate for each level of the health service and each governance actor.

The National Department of Health (NDoH) has a critical stewardship role to play for the entire health system. The department must engage all governance actors in the public value mission of achieving Universal Health Coverage (UHC) and communicate and institutionalise its goals throughout the health system. This means engaging all sectors, partners, and stakeholders in working towards that vision, including ensuring that statutory and regulatory bodies better align with and support the strategic vision of the national health system. The NDoH must set the terms of engagement, create governance arrangements to improve health outcomes, and improve institutional arrangements for accountability within the public and private sectors. Statutory and external regulatory bodies in the health sector, ombuds structures, and oversight boards should be prioritised, with an emphasis on protecting and reinforcing their independence, functionality and effectiveness.

Staff performance across the health system should be defined by what needs to be achieved rather than simply activities that staff should do. Incentives should promote behaviours and action that will realise the public service mission.

The NDoH should urgently review the recommendations from the Health Market Inquiry (HMI) and implement those that would benefit achieving universal access to quality health care, many of which may be achievable through the NHI. Of particular relevance are attention to licensing requirements for facilities and providers (public and private), scrutiny of contracts between purchasers and providers, health outcomes monitoring, and a supply-side regulator.

### 2. Update legislation and governance structures to insulate them from vested interests and give them executive rather than merely advisory functions.

Accountability structures need to be made effective by means of the following steps, among others.

- Amend conflicts within legislation that weaken or undermine the delegation of governance roles and accountability. Align the Public Finance Management Act (PFMA) and Public Service Act (PSA); clarify and strengthen the way the National Health Act (NHA) delegates

authority between levels of government, particularly to health districts and health facilities; and empower community governance structures through specifying meaningful roles and functions.

- Implement the recommendations of the HMI on private sector regulation.
- Institutionalise a public value mission in the goals of all health institutions, levels, and sectors which align with and support a national public value mission for the health system.
- Establish an array of arrangements to ensure the focus on the public value mission. For example, set up more than one supervisory entity in a given setting, including an external regulator, ombud, and or independent board.
- Effective accountability structures must prevent capture from above (politicians or senior managers) and from below (stakeholders' groups, professional groups, trade unions). Where stakeholder groups are involved, they may be best placed in advisory committees rather than decision-making committees.
- Boards (for example, of statutory bodies) must be structured to ensure that:
  - who can nominate and who can appoint are different entities
  - who appoints members and who removes members are different entities
  - removal requires a decision by more than one party
  - For the boards (for example, of hospitals) and committees to govern, they must have appropriate decision-making powers for the structure, rather than being limited to solely an advisory role.

These changes can and should be instituted immediately. There is no reason to wait.

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

Each actor must have the authority required to carry out and take responsibility for their work. If the right people were in place, it would be possible to delegate without (or with lesser) risk. Oversight structures at each level (boards as one example, or community groups that measure health outcomes or processes) that are insulated from vested interests would generate confidence that each level was operating within its mandate and to standard.

Properly resourced oversight and independent bodies such as the Office of Health Standards Compliance (OHSC) and the Auditor General (AG) provide additional information with which to measure performance against delegated functions. To supplement OHSC and AG reports, mechanisms to measure (for instance) disease-specific health outcomes, coverage rates for preventive services, and hospital occupancy and hospital infection rates would provide objective evidence from which to gauge the achievements of districts and hospitals. Having more than one oversight report mitigates against capture or distortion by vested interests.

Health outcomes monitoring efforts are already afoot, championed by both private and public practitioners. Indicating now that they will be an integral part of contracting and strategic purchasing will encourage such efforts across the sector.

The proposed NHI design potentially poses substantial risks to decentralisation by shifting many health service functions to the national level in order to establish the NHI fund. Although it is envisaged that these will be delegated back, history suggests that once functions are centrally assigned, they are not easily relinquished. The NHI bill was approved by the National Council of Provinces (NCOP) in December 2023 and is awaiting presidential approval. In considering its implementation, it is imperative that attention be paid to clarify roles and responsibilities of various players with respect to the NHI funds,

particularly around delegation of authority and decision making for structures such as Contracting Units for Primary Care, Hospitals and districts.

Lack of trust with regard to managing the NHI fund can be dealt with by making it independent of the Department of Health with appropriate independent oversight structures.

#### **4. Get the right people – ethical people with the appropriate competencies – into leadership and management positions within the health system.**

To achieve this, merit (demonstrating competencies appropriate to the post) must be the primary basis for appointment. Processes, including the criteria for appointments, must be transparent and open to public scrutiny, as an integral element in professionalising the civil service. A challenge is how to manage incumbents who may be wrongly placed. One option for consideration is to restructure departments and require all staff in a section to reapply for their positions.<sup>2</sup>

#### **5. Surround managers and leaders with functional fit-for purpose systems (including human resources, procurement, health information systems) so that they can do their work.**

South Africa's health system needs management support systems that are fit-for-purpose. Institutions need greater powers over hiring and firing and disciplinary procedures when appropriate. Within labour law and labour agreements, space must be made to allow managers to follow agreed procedures without sacrificing the public value mission of the service.

Procurement is a function governed by too many, sometimes contradictory rules; simplification of the rules and greater delegation to facility and district or sub-district managers is required. Overly complex procurement systems are inhibiting decentralisation, as the complexity of existing rules makes it difficult for decentralised managers. This does not mean that every facility should be issuing its own medicine tenders, but there is no reason why strong sub-district offices or larger facilities should not be ordering supplies off transversal tenders without multiple layers of high-level signoff. Primary care facilities should be able to get simple maintenance problems fixed timeously without waiting months or years for higher level or Public Works Department approval. This lack of delegated powers together with overly complex rules on budgets and procurement is crippling the effective functioning of many community facilities.

The transversal tendering system is a strength of the South African system. It achieves economies of scale and thus relatively good prices, for example for medicines, approximately 90% of which are purchased through this mechanism. However, transversal tenders apply to the purchase of only about 10% of medical supplies. Weak contract management is a persistent problem and a lack of norms and standards sometimes conceals outrageously expensive prices.

The range of reforms needed on procurement include:

- Greater delegation of procurement powers to facility managers, for example on ordering supplies off transversal tenders without multiple layers of signoff.
- Greater development and use of e-procurement systems, electronic catalogues with improved price benchmarking, electronic stock management systems, barcoding, and faster simplified electronic ordering systems. The automation of the procurement process will assist in tracking invoices, improve payment turnaround times to suppliers, and reduce the invoice aging period.
- Greater inclusion of medical supplies and medical equipment in transversal tenders to achieve economies of scale.

<sup>2</sup> This has been done previously in the public sector within the prescripts of the existing laws (personal communication M Orkin) but not in a service delivery context.

- Formalise the exclusion of the NHI Fund from certain procurement rules that might inhibit strategic purchasing and amend legislation to support this. For example, the model in which the NHI reimburses contracting general practitioners via capitation is not well suited to a tender approach.

Strategic purchasing should be introduced incrementally, starting immediately with public sector reforms to allow soft- performance-based contracts with hospitals and districts, alongside reimbursement reform such as the introduction of Diagnosis-Related Groups (DRGs) for hospital reimbursement and mixed reimbursement/funding models for primary health care such as risk adjusted capitation. Contracting with private providers can also be considered. This would establish the systems required by a future NHI fund.

Implementing the electronic National Health Information System of South Africa (NHISSA) is an urgent priority so as to collect patient-linked data in order to measure quality and patient outcomes whilst maintaining protection of privacy of patient information and improve interoperability across the health information system between sectors, statutory bodies, and levels of the health system. This is essential for achieving quality UHC as part of the implementation of the NHI. The NHISSA must also ensure that data is used at the local levels where it is collected and that feedback loops are closed. These data provide objective measures against which to judge sub-district or hospital performance, can complement OHSC or AG reports, and will set in place systems that will be central to NHI implementation.

**6. Support managers at every level with the resources, understanding, and ability to build teams and attend to the relationships that make complex systems work, focusing on both the people within the health system (providers) as well those whom the health system serves.**

Systems of accountability need to be strengthened. However, they must also allow for innovation and learning from mistakes, supporting mentorship and training. Currently, management is often inappropriately dominated by low-level audit issues, rather than focusing on the key objectives of the institution and attainment of quality care.

Resources across the country in both the public and private sector must be harnessed to improve management capacity. Partnerships with research and academic institutions have demonstrated success in the past and the NDoH should consider identifying districts to be supported by relevant university departments so as to strengthen their management capacity and approach. This would allow for multiple models to develop. Schools of Public Health and Management offer opportunities that can benefit both the institutions and health systems.

Previous experience of partnerships has demonstrated the value of local level, bottom-up, and evidence-based management processes. Capacity building should therefore emphasise bottom-up, incremental but sustained interventions to improve health quality and efficiency, not as a “free for all” but rather to support innovative approaches to capacity development and distributed leadership within the health system. An emphasis on building learning organisations must underlie initiatives at each site (sub-district or hospital), to support the everyday practice of governance by operational managers. More attention needs to be paid to the ‘software’ of the health system to create an environment which promotes and supports the everyday practice of governance. Health system managers need to implement and monitor interventions to strengthen relationships and build trust with and between staff and establish practices to promote relationship building.

Cross learning between districts and hospitals should also be encouraged by re-instituting national learning conferences where managers draw on their own data to describe their experiences in quality improvement.

## **7. Harness the potential of community participation in an authentic manner to ensure appropriate, respectful and responsive health services and to monitor health service outcomes and processes.**

For community governance structures, clear steps are needed to strengthen clinic committees, hospital boards, and other entities. These include (a) legislative reform to ensure harmonised policies on roles and functions of such structures across all provinces, along with extending community participation structures to the private sector; (b) a common policy that defines criteria and processes for appointments, role and functions, reimbursement of community committee members for costs, induction, and continuous capacity building; (c) restructuring system design so that upward representation ensures meaningful expression of community voice at higher levels of the health system where key decisions are made; (d) investment in capacity building for managers, providers, and community representatives in order to draw more effectively on community resources to strengthen the health system and involve community representatives in understanding and supporting quality improvement systems and improvement plans; and (e) adjusting performance management systems to reward community responsiveness amongst staff and managers.

Huge potential exists for ward-based outreach teams (WBOTs) to apply the Community Oriented Primary Care (COPC) philosophy and approach to strengthen community voices in local governance. Clear channels for this need to be defined, and implemented as part of improving accountability, transparency, and responsiveness of the health sector within communities.

Organised civil society can contribute significantly to monitoring governance at many levels, including 'operational governance' at the coalface. Government needs to create more spaces to engage with organised civil society as important governance actors but, at the same time, ensure that its systems design does not encourage the surfacing of vested interests, competition instead of collaboration between organisations, or inequities in the impact of civil society voices, with better resourced urban civil society organisations having more clout than rural voices. Opportunities for meaningful participation in governance by civil society, patient groups, and other stakeholders need to be formalised by appropriate structures with the necessary authority and legitimacy.

Authentic representation may be hard to achieve or measure, but as with Health Committees and Hospital Boards, robust criteria must distinguish well-functioning structures capable of voicing community interests. Applying such criteria would empower community structures to exercise legitimate governance responsibilities in the health system, as they would need to account to communities in exercising their roles.

Participation by and accountability to the community is a fundamental tenet of the Constitution and one for which the health system needs to make adequate provision.

## **8. Act on dereliction of duty and acts of corruption and protect whistle-blowers.**

To be effective in any system, governance must be understood to be a distributed function that has to operate at all levels. Role clarification and delegation of authority will promote distributed governance. Managers at different levels need clear delegation of responsibility for which they are also accountable, enhancing overall accountability within the health system. It is problematic for all accountability and consequences to fall on the head of department (HOD), especially if they have themselves not been incompetent or behaved fraudulently. In a distributed governance model, managers at different levels are accountable and take responsibility for the consequences of their actions. Accountability is essential but needs to be appropriate.



In terms of consequences, the public sector's human resources (HR) system in its current form does not advance accountability, as it does not sufficiently distinguish good from poor performance. Decisions such as promotion, continued employment, or incentives must be linked to objective assessment based on performance data on outcomes, particularly health outcomes, OHSC findings, or purchasing agreements. Health managers in particular need clearer alignment between HR performance assessment and consequence management.

Managers need to be empowered to act against dereliction of duty. Insufficient consequence management will encourage corruption and/or incompetent performance amongst subordinates. Managers who do not act against dereliction of duty must be held to account. Delegation and greater local control over HR processes will make this easier.

Action against corruption also requires intervention beyond the health system along with improved functioning by state investigative and related authorities. A package of interventions to prevent fraud and corruption is required, to provide measures to rapidly detect and decisively deal with corruption, along with adequate protection of and legal support for whistle-blowers in the health system.

## Implementation

These recommendations may not be simple to implement but failure to grasp these opportunities will render Universal Health Coverage even more unlikely and, instead, lead to the situation in which quality health care becomes available to only a minority of South Africans.

The Panel believes that these recommendations balance finely the centralisation–decentralisation tension that is present in all health systems. The recent passage of the NHI Bill through the National Council of Provinces emphasises the significant risks of implementing a NHI system within the current context of weak governance in both the private and public sectors, and at multiple levels within each. Instead, this critical opportunity invites the redesign and reset of health-system governance to ensure successful implementation of the NHI.

The Panel recognises the existence in South Africa's health system of many skilled people willing to work hard and ethically. They need to be given the space to do so. Governance is a task that requires personal responsibility. 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."

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## Appendices

### Appendix 1: Biographies of Panel Members

#### Lilian Dudley (co-Chair)

Professor Lilian Dudley is a South African medical doctor and Public Health Medicine specialist trained at the University of Cape Town (UCT) and registered with the College of Public Health Medicine of South Africa. She has a PhD in Public Health from Stellenbosch University and a Masters in Health Policy, Planning and Financing from London School of Hygiene and Tropical Medicine (LSHTM) and London School of Economics (LSE). Lilian is currently an emeritus Assoc Professor in Public Health Medicine at Stellenbosch University, where she was the founding director of the Centre for Health Systems Development and Head of the Division of Health Systems and Public Health at the Faculty of Medicine and Health Sciences (FMHS). Her career includes experience as an academic, a senior public health manager and as Chief Executive Officer of the Health Systems Trust (HST), a national health systems research organisation in South Africa. She has served on the boards and advisory committees of numerous national and international public health organisations. Professor Dudley's main research interests include approaches to improving the quality of health care; the quality and use of data for strengthening health care; and approaches to capacity development of health professionals and health leadership and management. Research methods of interest include systematic reviews, participatory action and evaluation research methods.

#### Flavia Senkubuge (co-Chair)

Professor Flavia Senkubuge is a medical doctor, Public Health Medicine specialist trained at the University of Pretoria, South Africa. She is the Acting Deputy Vice-Chancellor: Student Life and Deputy Dean: Health Stakeholder Relations in the Faculty of Health Sciences, University of Pretoria. Professor Senkubuge holds the following qualifications from the University of Pretoria: a PhD (Public Health), an MMed (Public Health Medicine), and an MBChB. Additionally, she holds an MBA from the Edinburgh Business School, Heriot-Watt University, UK, and a Fellowship of the College of Public Health Medicine (FCPHM) of the Colleges of Medicine South Africa (CMSA). Professor Senkubuge has held various academic and professional leadership positions, including being the 20th President of the Colleges of Medicine of South Africa (CMSA). She is a member of a number of research advisory groups notably is the current chair of the WHO/Afro region African Advisory Council on Research and Development (AACHRD). She is a Fellow of the Kofi Annan Global Health Leadership Fellowship and was recognised as one of 50 Powerful Women in South Africa by the *Mail & Guardian's Power of Women* in 2021. In 2022 she was recognised by Harvard Public Health as one of the 25 standout voices in African Public Health. Her areas of interest are health policy and management, tobacco control, global health, health systems and leadership in health.

## Sharon Fonn

Professor Fonn is Professor in the School of Public Health, University of the Witwatersrand and visiting professor at the School of Public Health and Community Medicine at the University of Gothenburg in Sweden. She is co-director of the Consortium for Advanced Research Training in Africa (CARTA). She is a medical doctor, a registered public health specialist and holds a PhD. She has worked extensively as a health systems researcher including a focus on quality of care. Professor Fonn was awarded the South African Ministry of Science and Technology's Distinguished Scientist Award for contributions to the quality of life of women (2005), was a Woodrow Wilson Centre Scholar in 2009 and a Fulbright Scholar in 2019, and was awarded an honorary doctorate by the University of Gothenburg in 2015. She has been appointed to several national committees by the Department of Health, Department of Science and Technology and the Department of Trade, Industry and Competition. She has served on numerous international committees. Much of her work has led to policy changes adopted nationally and has influenced international discourse. She has published extensively.

## Mark Blecher

Dr Mark Blecher is the South African National Treasury's Chief Director for Health and Social Development. He completed his medical training at the University of Witwatersrand and is a Public Health Medicine specialist. He also has a PhD in health economics from the University Cape Town. Dr Blecher has gained experience in public sector management, health financing, planning and management through employment at provincial and national government levels. His work focuses on health budgets in provinces with a special interest in the economics of health service delivery, and health programs. He has published several chapters on health financing in the South African Health Review and he also served as a member of the DCP3 Advisory Committee to the Editors (<https://dcp-3.org/advisory-committee-editors>), was cochair of UNAIDS Economic Advisory group and regularly collaborates with global organisations including World Health Organisation and the World Bank. He has over 70 publications – many of these can be downloaded from Researchgate.

## Leslie London

Professor Leslie London is a public health medicine specialist with an interest in human rights, public health ethics, farm worker health, prevention of alcohol related harms, the health hazards of pesticides and health policy. He is the head of the Division of Public Health Medicine, leads the Health and Human Rights programme and is an active researcher in the Centre for Occupational and Environmental Health Research in the School of Public Health at UCT. He provides technical support to the provincial XDR TB panel and to the public health functions of the Health Impact Assessment Directorate in the Western Cape Health Department. For the past 15 years, his research has focussed on how community participation in the health system can be harnessed to realise the right to health.

## Catherine Mathews

Dr Catherine Mathews is a Chief Specialist Scientist in the Health Systems Research Unit of the South African Medical Research Council. She was director of the Health Systems Research Unit at the South African Medical Research Council for nine years until her retirement in 2022. She is an honorary associate professor in the School of Public Health, University of Cape Town. She leads a portfolio of research which seeks to understand the social and health systems factors influencing the sexual and reproductive health of young adolescents, particularly in South Africa and sub-Saharan Africa; to use the findings of research to develop health systems interventions to promote adolescent sexual and reproductive health; to conduct intervention trials to examine the efficacy and effects of the interventions; and to use implementation science to evaluate the implementation of evidence-based health systems interventions. She has conducted health systems research to inform policies related to sexual and reproductive health of adolescents, people living with HIV, and other populations.

## Guinevere Lourens

Dr Guin Lourens is the National Nursing Manager for Evergreen Health in the private healthcare sector. She is also a research fellow of Ukwanda Centre for Rural Health in the Department of Global Health and an external lecturer, Department of Nursing and Midwifery, in the Faculty of Medicine and Health Sciences at Stellenbosch University, South Africa. She holds a PhD in Public Healthcare Management, Masters in Nursing, Baccalaureus Curationis (Stellenbosch University), with Diplomas in Nursing Education; Health Services Management; Primary Care and Occupational Health Nursing. Her research focuses on the pragmatic implementation of quality healthcare management best practices to promote patient-centred care and safety; staff wellness and technical quality, with a particular interest in healthcare organisations or health systems undergoing organisational development or change. She has published on healthcare management and education and been a research grant holder in the fields of rural health and nursing education. Her career has included academic positions at two higher education institutions, and as a manager in public and private healthcare. Her service leadership includes board or council membership of the Western Cape College of Nursing; Bergzicht, an NGO advocating to unlock youth employment; the Paarl hospital facility board; the Rural Health Advocacy Board, the Rural Nursing South Africa (RUNURSA and OHSC). Internationally, she was recognised by the International Council of Nursing (ICN) as a voice to lead health in 2017; and aligns to ISQua, an international society focused on quality improvement in healthcare.

## Appendix 2: Schedule of Panel Meetings

Panel meeting	Date	Venue/Meeting type
Meeting 1	3 September 2020	Conference call
Meeting 2	13 October 2020	Conference call
Meeting 3	18 May 2021	Conference call
Meeting 4	20 July 2021	Conference call
Meeting 5	21 October 2021	Conference call
Meeting 6	23 November 2021	Conference call
Meeting 7	24 January 2022	Conference call
Meeting 8: Writing Retreat	16-18 March 2022	Retreat and Conference Centre, Constantia, Cape Town
Meeting 9	13 April 2022	Conference call
Meeting 10	18 May 2022	Conference call
Meeting 11	28 June 2022	Conference call
Meeting 12	18 August 2022	Conference call
Meeting 13	23 September 2022	Conference call
Meeting 14	21 October 2022	Conference call
Meeting 15: Writing Retreat	25 November 2022	University of Pretoria, Future Africa Campus, Pretoria
Meeting 16	20 December 2022	Conference call
Meeting 17	16 January 2023	Conference call
Meeting 18	30 January 2023	Conference call
Meeting 19	7 February 2023	Conference call
Meeting 20	14 February 2023	Conference call
Meeting 21	21 February 2023	Conference call
Meeting 22	27 February 2023	Conference call
Meeting 23	6 March 2023	Conference call
Meeting 24	10 March 2023	Conference call
Meeting 25	16 October 2023	Conference call
Meeting 26	6 November 2023	Conference call
Meeting 27	27 November 2023	Conference call
Meeting 28	7 December 2023	Conference call
Meeting 29	12 December 2023	Conference call







MEDICAL

Health Care  
Doctor  
Hospital  
Pharmacist  
Nurse  
Dentist  
First Aid  
Surgeon  
Emergency

MEDICAL

MEDICAL

MEDICAL

MEDICAL

Health Care  
Doctor  
Hospital  
Pharmacist  
Nurse  
Dentist  
First Aid  
Surgeon  
Emergency

Health Care  
Doctor  
Hospital  
Pharmacist  
Nurse  
Dentist  
First Aid  
Surgeon  
Emergency



