

# INTRODUCTION

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According to Abdellatif (2003: 5), the concept of governance “encompasses the functioning and capability of the public sector, as well as the rules and institutions that create the framework for the conduct of both public and private business, including accountability for economic and financial performance, and regulatory frameworks relating to companies, corporations, and partnerships”. The United Nations Development Program (UNDP) defines governance as “the exercise of economic, political and administrative authority to manage a country’s affairs at all levels. It comprises mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences”.

In 1998, then UN Secretary-General, Kofi Annan, stated that ‘governance is perhaps the single most important factor in eradicating poverty and promoting development’ (United Nations Human Development Report, 2002: 14). One of the fundamental focus areas of the 2002 Human Development Report is on governance. It emphasises the importance of governance processes in development. According to Abdellatif (2003: 1) “governance nowadays occupies a central stage in the development discourse but is also considered as the crucial element to be incorporated in the development strategy”.

Public healthcare in South Africa remains an area in need of development. The practice of providing healthcare in a racially discriminatory manner during Apartheid South Africa has resulted in a society where the standard of healthcare and healthcare facilities remains lacking. According to Pillay, McCoy and Asia (2001) the newly democratically elected government of 1994 inherited a highly fragmented and bureaucratic system that provided healthcare services in an inequitable manner. Healthcare services for Whites were better than those for Blacks and those in the rural areas were significantly worse off in terms of access to healthcare services compared to their urban counterparts.

Lawn and Kinney (2009: 2) argue that unequal access to healthcare continues to be a problem in South Africa. McIntyre (2010) identifies the long distance people have to travel to access health facilities as an ongoing problem. The overall average travelling time to a health facility for the poorest 20% of households is nearly 40 minutes and a single visit costs on average 11% of the households’ monthly expenditure. Schaay, Sanders and Kruger (2011: 4) argue that there remains a significant human resource crisis, especially at community and primary healthcare levels in the public health sector, with a lack of health personnel in rural areas. In addition, weaknesses in training, support, and supervision, and a lack of managerial capacity and appropriate leadership to manage underperformance in the public sector are raised as issues of concern (Schaay, Sanders and Kruger 2011: 4). Deficiencies in stewardship, leadership, quality of care, inefficient management, and an absence of managerial oversight

and accountability further thwart any real progress. Other challenges include a health sector that is under-resourced, failure amongst political leaders to sustain the system, issues of remuneration, ageing infrastructure and the HIV/AIDS epidemic which create immense demand on South Africa's healthcare system. Coovadia, Jewkes, Barron, Sanders, and McIntyre (2009: 824) point out that there are marked differences in rates of disease and mortality between races, which reflect racial differences in the access to basic household living conditions and other determinants of health. Coovadia et al (2009: 817) maintain that while South Africa is considered a middle-income country in terms of its economy; it has health outcomes that are worse than those in many lower income countries.

In 1994, the South African government put in place a legislative framework to guide the realisation of equal access to quality healthcare. For example, the Constitution (Act 108 of 1996), in particular its Bill of Rights, acknowledges the injustices of the past, and binds the state to work towards the progressive realisation of basic human rights, including the right to health (Section 27):

1. Everyone has the right to have access to:
  - a. Healthcare services, including reproductive healthcare;
  - b. Sufficient food and water; and
  - c. Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights; and
3. No one may be refused emergency medical treatment.

Besides establishing a comprehensive legislative framework, Harrison (2009: 2) explains that the public health sector underwent substantial reorganisation post-1994 which involved the rationalisation and the amalgamation of previously separate health administrations located in the various Bantustans of South Africa.

Harrison (2009) indicates that despite progress made in establishing a legislative framework protecting people's rights to equal access to healthcare, many programmes that have been implemented have been thwarted by the severity of health issues facing the population of South Africa. HIV/AIDS for example, has reduced life expectancy by almost 20 years. The country is plagued by four other health problems described in the Lancet report (2009) as the quadruple burden of disease; TB (directly related to HIV/AIDS), maternal, infant and child mortality, injury and violence and non-communicable diseases. These diseases place an additional responsibility on an already burdened and underdeveloped public healthcare delivery system, struggling to overcome poor administrative management, low morale and lack of funding (Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, Jewkes, Karim, Flisher, Mayosi, Tollman, Churchyard, Coovadia 2009: 1023).

There are a number of policy documents and programmes that pertain to the provision of healthcare, (such as the Patients' Rights Charter, The Health Sector Strategic Framework 1999-2004, even the White Paper for the Transformation of the Health Sector in South Africa released in April 1997), and most recently the National Health Insurance policy. The underlying premise of this book is that the manner in which such public policies and programmes are implemented and managed, is a matter of governance.

The introduction of new legislation regarding transformation and service delivery brought about a change in which the South African public service functioned. The publication of the White Paper on the Transformation of the Public Service (Notice 1227 of 1995) serves as a point of departure for the transformation of the South African public service. One of the important political changes post-1994 was the translation of the 1993 Interim Constitution into a final constitution that guarantees amongst others access to health services for all citizens. The National Health Act (NHA) (Act 61 of 2003) can be regarded as a fundamental policy determining the legislative framework for healthcare delivery in South Africa, replacing all previous health policy. The White Paper on the Transformation of the Health System in South Africa (1997), established a detailed framework for healthcare delivery, and identified the manner in which Government intends to transform South Africa's healthcare system. It remains on the most important policy documents and is a benchmark that guides health sector transformation today.

It is posited here that - how such public policies and programmes are implemented and managed, is a matter of governance.

One of the aims of this book is to investigate why, after almost 20 years of democracy; substantial transformation in the healthcare sector; significant increase in national revenue allocation<sup>1</sup>; and numerous healthcare policy interventions; the South Africa government continues to struggle to provide public healthcare services. Furthermore, this book is aimed at understanding the policy implementation challenges facing the public healthcare sector from a governance perspective. It is posited here that there are a number of factors that affect governance in the public healthcare sector. These issues pertain to the legislative policy framework; the institutional arrangements within the public health sector; intergovernmental relations between the different spheres of government and the rules, mechanisms, processes and institutions which govern the relationships between the private and public sector. In order to examine these factors, this book will look at how the public healthcare sector is currently governed, and will consider the governance implications of the recently introduced National Health Insurance (NHI) scheme.

The National Health Insurance Green Paper was published by the Department of Health during August 2011. The Green Paper broadly outlines the insurance scheme, but it is clear that its implementation will involve a revamping

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<sup>1</sup> From 6.9% in 1995 to 9.9% in 2009 (Latest data obtained from World Health Organisation).

of primary healthcare in terms of district management teams, specialist support teams, district hospitals, community health centres, private healthcare clinics and community-based clinics. In other words, it will have serious governance implications.

According to Dr Aaron Motsoaledi, the Minister of Health since 2009, the NHI proposal is a plan to redirect the public health system. *“The present system of financing healthcare in SA is skewed. There needs to be universal coverage for all South Africans, not just those who can afford private healthcare”* (Department of Health, New Agenda 2012:14).

Pointing out that only 16% of the population have private cover (medical aid), Dr Motsoaledi argues that a system is needed to provide better healthcare for all citizens (Department of Health 2012:14). These sentiments were echoed in the recently released National Development Plan, which points to a ‘crumbling health system and a rising disease burden’ requiring major reform, including better management at institutional level (Republic of South Africa 2012c:51). The proposals entail a system of contributions for universal care to be paid in advance of an illness. The broad plan is for these contributions to be made by individuals (presumably families), employers and the state. There is no doubt that this effort represents a significant attempt to redistribute both the payment for, and the availability of healthcare.

The Green Paper makes it clear that NHI is a long-term scheme that will be implemented over a 14 year period. The first five years will concentrate on building the health sector and preparing it for a change. The paper states that the primary phases of NHI will focus on improving the services of the public healthcare system. The Green Paper introduces the start of a complete transformation of the country’s health system which would begin in a pilot phase in 11 districts.

However, the NHI has not been universally welcomed by those who benefit from the status quo. This is one of the reasons why the debate has become quite heated, as noted by a distinguished Australian health economist who observed much of the anger and resistance coming from the private medical schemes and healthcare providers (Mooney 2011:3).

This book is thus aimed at investigating and analysing the implications of the proposed NHI for the governance of public healthcare in South Africa.

Based on the ongoing challenges facing the public healthcare sector - inequitable healthcare financing, the high cost of private healthcare, the maldistribution of health professionals between the public and private health sectors, the unequal doctor-patient ratio, weak or poor management and the burden of disease - one of the key objectives of this book is to (i) explore and (ii) critically analyse the manner in which South Africa’s public healthcare system is governed.

South Africa has undergone major governance reforms since 1994. As a consequence, this book will additionally investigate the nature of these governance reforms with specific reference to the public healthcare system. This book aims to

explore the public healthcare reform process, its outcomes, and the implications thereof on the provision of public healthcare. In order to do this, the book provides a conceptual framework based on the literature on governance. It also considers the literature on public management and its various approaches.

This is a book in governance. It establishes a conceptual framework based on an examination of Weber's theory on bureaucracy and the New Public Management (NPM) paradigm. Weber's theory on bureaucracy regards government as having the rational-legal authority, making it forceful and effective and the fundamental basis for effective organisation. From this, he developed his concept of the ideal bureaucratic organisation (Naidu 1996: 81-82). Weber's work (although dating back to the early 1900s) has been credited for initiating studies on bureaucracy. His theory posits that if bureaucracy is organised in a rational and efficient manner, and if it is specifically designed for carrying out a specific task and given the necessary means – then specified outcomes will be achieved. His theory emphasized the importance of the specialisation of tasks and deployment of expertise in the public sector – all within a strict hierarchy of authority. Hogwood and Gunn (1984), cited in Hill and Hupe (2002: 50), support Weber's theory for a strong rational bureaucracy and argue for “a single implementing agency that need not depend upon other agencies for success, or, if other agencies must be involved, that the dependency relationships are minimal in number and importance”.

However, Weber's theory of a rational bureaucracy has been criticized for being misleading, because it offers ‘neither a desirable state nor an empirical reality’ (Stillman 2010). It is suggested that Weber over-emphasises the formal elements of bureaucracy i.e. rules, division of labour, hierarchy of authority etc. whilst ignoring the informal dimensions of communication, leadership and human relations. Still, other scholars portray Weber's concept as being both time-bound and culture-bound, idealising the German bureaucratic state that dominated that era (Stillman 2010). Despite the criticism of Weber's rational bureaucratic model, it continues to serve as an analytical tool for describing the structural characteristics of public institutions in the literature on governance and public administration.

Towards the end of the 1970s a paradigm shift emerged. According to Sharma (2007: 4) the emergence of NPM is associated with the changed role of the state and the growing demands for good governance practices worldwide. Robbins and Lapsky (2005: 111) identify several dimensions to NPM, which include: 1) the reorganising and restructuring of public services; 2) the arrival of a new management focus to displace old-style administration; 3) a more explicit role for management in a top down, hierarchical functional concept; 4) the stress on quantification as a means of demonstrating efficiency gains and 5) holding persons with responsibility accountable. Moreover, Zhange (2007: 557-558) mentions that NPM ideas include the retrenchment of public employees; reducing the scale of public expenditure; decentralisation; privatisation; contracting out; shifting out government services to the outside; importing private sector instruments to the public sector; deregulation; fostering a culture based on performance utilising

quality as measuring instruments; emphasising results and outcomes instead of processes as well as emphasising the priority of customers.

Phillip and Daganda (2013: 9) assert that the NPM advocates a basic change in the role of state in the society and economy. They assert that NPM aims at 3Es: i) economy - the eradication of waste; ii) efficiency - the streamlining of services and iii) effectiveness - the specification of objectives to ensure that resources are targeted at problems. Laxmikanth (2006) suggests that NPM is a series of shifts of emphasis in the way in which the public sector should be organized and managed to meet the new challenges of liberalisation, globalisation and privatisation.

The emphasis of new public management according to Phillip and Daganda (2013: 9) is on performance appraisal, managerial autonomy, cost-cutting financial incentives, output targets, innovation, responsiveness, competence, accountability, market orientation, quality improvement, contracting out, flexibility, competition, choice, information technology, de-bureaucratisation, decentralisation, down-sizing and entrepreneurialism.

The traditional bureaucracy (as espoused by Weber), founded on the principles of bureaucratic hierarchy, planning, self-sufficiency and independence (from the private sector) and direct control - are, according to the theory on NPM, now replaced by efficiency, individualism and a market-based public service culture. The philosophy of NPM, according to Fatemi and Behmanesh (2012: 42) rationalises government, decentralises management authority, and is motivated by efficiency and effectiveness.

The introduction of NPM has sparked a debate over the virtues of public versus private provision of public goods and services. Stein (2001: 36) mentions that proponents of private service providers maintain that the private sector can offer better services in a more effective manner at a lesser cost for the public sector. The private sector, it is argued, offers greater flexibility, involves less red tape and accommodates innovation which is lacking in the public sector. In addition, the public sector lacks skilled and experienced personnel to provide quality services. As a result, public service provision will be more efficient under private sector control.

However, the NPM approach to governance has been criticized in its own right. For example, i) it has been accused of compromising quality in favour of service roll-out; ii) savings haven't always been forthcoming; iii) accountability has been questionable; iv) job losses have resulted and v) opportunities for corruption have been created (Stein 2001: 36).

The two approaches to governance – Weber's insistence on a traditional bureaucratic model, and the NPM approach each have their strengths and weaknesses. This book examines these different types of governance approaches and considers their feasibility and relevance to the provision of healthcare services in the South African context.

Public healthcare in South Africa remains an area in need of development. The practice of providing healthcare in a racially discriminatory manner during

Apartheid has resulted in a society where the standard of healthcare and healthcare facilities remains lacking. The newly democratically elected government of 1994 inherited a highly fragmented and bureaucratic system that provided healthcare services in an inequitable manner.

Apart from the challenges of the high burden of infant and maternal mortality, elevated levels of TB and HIV/AIDS and incompetent management, the country is experiencing a shortage of qualified doctors and nurses. According to the Econex 2015 report, South Africa had 60 doctors per 100,000 citizens in 2013, the world average was 152 doctors per 100,000 citizens in the same year. The Econex 2015 report also points out that in South Africa, there are 500 nurses per 100 000 people. The World Health Organisation (WHO) recommends that there should be 200 nurses for every 100 000 people in a country. When this figure is broken down by removing enrolled nurses and nursing assistants, the figure drops to 246 professional nurses per 100 000 people. However, at least half of the country's nurse's work in the private sector, which services only 17% of the population that can afford private healthcare. The public healthcare sector provides treatment and care for 83% of the population, with the same number of nurses.

The 2012 National Health Facilities Baseline Audit reported on a survey of 3,356 clinics and community health centres that found that most clinics had facility managers, but nearly half of the clinics had no visiting doctors; 84% had no assistance from a pharmacist or pharmacy assistant; 11% had no lay counsellors; 57% had no administration support and 79% have no information management staff. The chronic shortage of healthcare workers inherited from apartheid had become an acute and catastrophic shortage.

According to Jobson (2015:6) the impact of the HIV/AIDS pandemic alongside trauma and interpersonal violence has created additional stress on the public health system and on its human and physical resources. Vacancy rates range from 13 to 40% across provinces with an average of 31% in South Africa.

More than 80% of South Africa's population depend on public healthcare. Yet, patients struggle to access care, particularly in the rural areas. Although South Africa has developed a robust system of social security which includes disability, care dependency and old-age grants, substantial barriers remain in receiving care even in the context of free PHC in the public health sector. For instance greater access barriers are experienced by rural communities compared to urban communities including distance, time and cost of accessing health services including emergency transport (Gaede and Versteeg 2011).

Weaknesses in training, support, supervision and of appropriate leadership to manage underperformance in the public health sector are additional issues of concern. Another major challenge for the public health service according to the ANC's National Health Plan for South Africa (1994) is the human resource crisis, especially at community and primary healthcare levels in the public health sector, with a lack of health personnel in rural areas. According to Schaay, Sanders and Kruger (2011: 6) weaknesses in training, support, supervision and of appropriate

leadership to manage underperformance in the public health sector are additional issues of concern. Moreover, deficiencies in stewardship, leadership, quality of care, inefficient management, and an absence of managerial oversight and accountability further thwart any real progress. Other challenges include a health sector that is under-resourced, failure amongst political leaders to sustain the system, issues of remuneration, ageing infrastructure and the HIV/AIDS epidemic create immense demand on South Africa's public healthcare system.

This book undertakes a broad analytical view of the provision of public healthcare services in South Africa. The objective is not to collect more qualitative or quantitative data than already exists in the public realm. Nor to review such data in depth since many studies have already done so. This book aims to identify and understand the underlying causes for the ongoing challenges experienced in the public healthcare sector in South Africa. It posits that South Africa's particular socio-economic, political and historical contexts are defining factors in the provision of public healthcare. More importantly, this book posits that public healthcare outcomes are largely a result of how the sector is governed. In order to improve access to public healthcare services, the governance of the public healthcare sector in South Africa needs to be understood and analysed.

This book adopts a desktop research approach. Desktop research refers to seeking facts, general information on a topic, historical background and study results that have been published or exist in public documents. According to Shajahan (2014) desktop research, also called secondary data, refers to information that has been collected by someone other than the researcher for purposes other than those involved in the research project at hand. Books, journals, manuscripts, diaries, letters, newspapers and government publications are all secondary sources of data as they are written or compiled for different purposes. Depending on the necessity and relevance, a researcher may use the data, findings or results incorporated in these documents. Van Thiel (2014: 106-107) points out that desktop research is suitable for research of a historic nature or when exploring the background or content of a certain research problem. The main requirement for desktop research is that there must be substantial objective unbiased data available from wide-ranging sources. The advantage of using existing data is that this research strategy is relatively efficient and cost-effective. Moreover the one can act independently, without the help of others, although assistance may be needed to gain access to documents and archives. Existing information can be both qualitative and quantitative.

There are three common methods for analysing existing data: content analysis, secondary analysis and meta-analysis. Content analysis requires one to study the content of the existing data, which will usually consist of written material or documents. The main interest lies in the message that the author of the text tries to convey to the audience. One can then select material that is relevant to the subject of study (Van Thiel 2014:108-113).



Secondary analysis involves the use of existing data, collected for the purposes of a prior study, in order to pursue a research interest which is distinct from that of the original work; this may be a new research question or an alternative perspective on the original question (Van Thiel 2014:108-113).

The meta-analysis approach transcends the level of just one piece of research, and makes use of several previously conducted studies. In a meta-analytical study, the results of all kinds of existing research – inductive or deductive, different strategies and methods, collecting qualitative or quantitative data – are brought together, with the aim of arriving at a new conclusion (Van Thiel 2014:108-113).

Desktop research can be applied for different purposes: description, explanation, testing, or diagnosis. Likewise the three data analysis methods distinguished above can be used for various types of research, although they differ in their emphasis. For example, content analysis is best used in exploratory research. Secondary analysis requires an existing body of (often statistical) data, which means that it is suitable for testing, but less so for exploration (Van Thiel 2014: 115).

The data analysis method for this book is meta-analysis. Various documents were examined. For example, academic literature, legislation, policies, managerial procedures, protocols, statistical reports, and so forth, in order to elicit meaning, gain understanding and develop empirical knowledge. The procedure entailed finding, selecting, appraising and synthesising data contained in these different types of documents. This study undertook an in-depth analysis of legislation and policies pertaining to public sector reform with particular reference to the healthcare sector. Datasets and publications from independent research outfits and non-governmental organisations (NGOs) focusing on public healthcare, such as the Centre for Health Policy, the Health Systems Trust (HST), and others, were analysed. The Health Systems Trust, for example, publishes annual District Health Barometers. These barometers detail comprehensive quantitative data on healthcare services across South Africa.

This book is comprised of the following chapters:

Chapter 1 presents the aims and objectives of the book. The principle theories that inform the conceptual framework guiding the study are presented. The chapter also provides a background to the study.

Chapter 2 endeavours to critically examine ethics in South Africa especially after the first democratic elections and later developments. Such an analysis will inevitably overspill to the quality of service delivery and participation. As such there is a need for ethics to be re-examined and investigate how this may be used to improve efficiency and effectiveness in the South African government service.

Chapter 3 reviews the literature on governance in order to facilitate an analysis of the governance of the South African public healthcare sector. Some of the key theoretical perspectives have been presented on how best to organise the state and its bureaucracy.

Chapter 4 reviews the efforts of the South African government in recognising development challenges of the post-apartheid era and assesses the approaches employed to bring about economic growth and to address inherited inequalities.

Chapter 5 presents an overview of the evolution of the healthcare system in South Africa. The structures set up under apartheid had implications for provision of public healthcare to South Africans and reveals how governance structures, systems and processes set up during apartheid had implications for the provision of public healthcare to South Africans.

Chapter 6 shows that for years it has been argued that implementation failure is one of the main reasons why policies do not yield the results expected. In South Africa, a version of this argument, which often features, is that good policies are drawn up but then not implemented. Government failure is a reality. Just as corporations survive according to whether they make good decisions, so to governments fall or are re-elected on whether they make good decisions. General argument in governance literature is that a wide variety of developments have undermined the capacity of governments to control events within the nation state. As a consequence the state can no longer assume a monopoly of expertise or of the resources to govern.

Chapter 7 contains a summary of the key arguments of the respective chapters and presents recommendations based on the findings of this study.