The Centre for Health Policy
Health Policy and Systems Research

POLICY BRIEF

August 2017

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The mediating influence of the sub-national: working through lower levels of government to enhance the implementation of national UHC initiatives

Introduction

Over the last 15 years, the concept of universal health coverage (UHC) has become ever more central to international health policy discussions.

Many countries have adopted UHC - the essence of which is that people should receive the quality, essential health services they need without financial hardship - as an important goal and a way of framing national-level healthcare delivery improvement initiatives.

Sub-national levels of government such as states, provinces and districts often play a central role in the implementation, and eventual success or failure, of national attempts to achieve and deepen UHC.

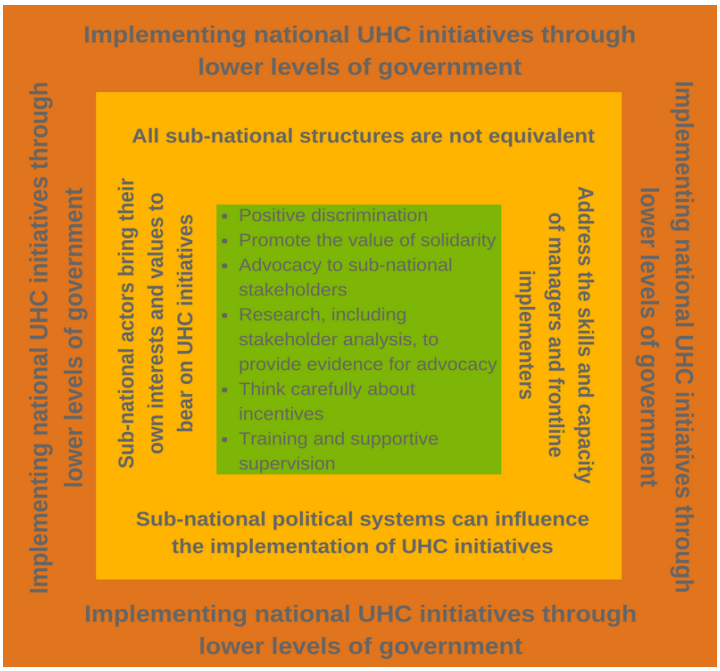
In the implementation chain, the political, economic, social and policy contexts of sub-national levels of government mediate national UHC initiatives, so that they might not be automatically implemented or not be implemented as intended.

Sub-national levels of government are therefore key to the fidelity with which national initiatives are implemented and have a major impact on how citizens experience the frontline delivery of these initiatives.

This policy brief synthesizes the results of research in Nigeria, Ghana and South Africa to highlight key lessons for enhancing the implementation of national UHC initiatives through sub-national levels of government.

Conclusions and policy implications

- Sub-national structures can have different institutional readiness for service delivery, disease burdens and socio-economic contexts, suggesting the need for positive discrimination to overcome constraints that are crucial to realizing UHC and the promotion of solidarity, which underpins such positive discrimination.
- Sub-national political systems can influence the implementation of UHC initiatives. Instead of assuming the cascading of their initiatives, national policymakers need implementation strategies such as stakeholder analysis and advocacy to sub-national stakeholders.
- Actors' own interests and values affect the implementation of UHC initiatives. It is thus necessary to engage with the values of sub-national actors and think carefully about implementation incentives and mitigating their potential unintended consequences.
- There is a clear need - through training, supportive supervision, and mentoring – to address the capacity and skills of sub-national managers and implementers.



Methods

The studies		
Evaluating the sub-national fidelity of national initiatives in decentralized health systems: Integrated Primary Health Care Governance in Nigeria	**Implementation challenges of the National Health Insurance Scheme in selected districts in Ghana: evidence from the field**	**Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision**
This study evaluated the implementation fidelity of Nigeria's Primary Health Care Under One Roof (PHCUOR) strategy. A scorecard was used to assess 9 implementation domains, and semi-structured interviews were conducted with state-level managers to explore implementation processes and constraints. Data collection in 2015 covered all 36 states and the Federal Capital Territory.	This study explored the implementation process, challenges and outcomes of the National Health Insurance Scheme (NHIS) in 4 districts in northern and southern Ghana. 33 interviews were conducted with key actors, including the National Health Insurance Authority (NHIA), district offices, service providers, policymakers, NGOs and donors. The interviews were conducted in 2011/2012.	This study explored the opportunities and challenges of achieving UHC in South Africa through the district-based health system. It entailed an extensive literature review of peer-reviewed studies and other literature, including policy documents, government reports, working papers, textbooks, annual reports and websites. The information search took place in 2014/2015.
The contexts		
PHCUOR was introduced in 2010 by the Federal Ministry of Health to improve uniformity in access to and quality of care. By mandating the creation of a single state-level agency, it sought to remedy a situation where PHC structures, functions and resources were scattered across different government levels. Since introduction, state governments, to varying degrees, have complied with the implementation requirements.	The NHIS was introduced in 2004 to ensure more equitable, free healthcare. The NHIA regulates ±150 district mutual health insurance schemes (DMHIS) / district offices, which are responsible for purchasing services and monitoring quality. At the time of the research, the NHIS had a minimum benefit package and fixed premium, although in practice this varied across DMHIS. This has since been harmonized across the country.	Linked to UHC, South Africa is currently developing National Health Insurance (NHI), which is being piloted through selected districts, spread across the country. It is envisioned that, through mandatory pre-payment, resources will be pooled in a single fund that will purchase services for the entire population. The intention is to eliminate direct payments by users such as co-payments or out-of-pocket payments.

Results

These studies suggest four key lessons on implementing national UHC initiatives through sub-national levels of government.

Lesson 1

Within a country, sub-national structures are not equivalent: states, provinces or districts can be different with respect to their institutional readiness for service delivery, as well as their needs, disease burdens and socio-economic contexts.

This is apparent in South Africa where problems such as staff shortages, inadequate infrastructure and budget constraints are to some extent shared, but where the differences between provinces and districts can also be stark. For example, HIV prevalence rates in the poorest districts are double those of the most well-off districts, while provinces such as Limpopo and North West have comparatively few health professionals outside of registered nurses, with some provider groups practically non-existent in certain districts.

Similarly, the NHI pilot districts have been shown to differ greatly in their readiness to offer the full package of primary healthcare services.

Sub-national differences were also key in Ghana, where the generally poorer, more sparsely located communities in the north endure a significantly bigger doctor-to-population ratio than around Accra, poorer access to services such as community-based health planning, as well as longer travel distances and travel times to facilities.

Therefore, a key implication for policymakers and managers directing national UHC initiatives is that there might well be, in addition to the resources generally devoted to and the minimum services generally included in the UHC initiatives, a need for positive discrimination or additional help and resources for selected sub-national units to help them overcome the service readiness gaps and contextual constraints that are crucial to the realization of UHC.

In addition to material and practical support, this will also entail committed leadership from policymakers and managers to promote values such as solidarity, which help to underpin this positive discrimination and make it sustainable over time.

Lesson 2

In addition to the health bureaucracy and the stakeholders that ordinarily make and implement health policy decisions, the broader political systems at sub-national levels of governance can significantly influence how UHC initiatives are implemented and the success they achieve.

This is illustrated by Nigeria's PHCUOR policy, where it was assumed that this initiative of the National Council on Health would translate into policy at the level of state government. At this level, however, the elected governors and state legislatures, who are not obliged to adhere to national decisions on health and who must be convinced about the importance of initiatives such as PHCUOR, are the ultimate decision-makers.

Within the governor's executive committee, the commissioner for health must argue, in the context of demands from other sectors and commissioners, why specific health policies and initiatives must receive priority. On certain issues, the executive committee must, in turn, convince the legislature to take action. Unsurprisingly, "in the course of these processes, many national initiatives get modified, under-implemented or even rejected".

It is therefore clear that national-level policymakers and managers cannot assume the cascading of UHC initiatives to lower levels. Instead, they require active strategies to implement and sustain their initiatives, possibly including continuous and consistent advocacy to sub-national stakeholders on the relevance and benefits of the initiative and conducting relevant operational and implementation research, including stakeholder analysis, through which evidence can be fed into the advocacy strategy.

Although tempting, the Nigerian evidence suggests that the strategy of direct national intervention at the sub-national level should be used with caution – it might stimulate short-term policy priority and implementation, but could lead to poor sub-national ownership and sustainability over the longer term.

Lesson 3

Sub-national structures and actors, whether part of the broader political system or the health service, can engage with national-level UHC

initiatives through their own interests and values.

In the case of PHCUOR in Nigeria, the national government sought to incentivize implementation by channeling funds to states that created the stipulated organizational structures.

However, acting in their own financial interest, some states appear to have done the minimum of passing legislation and opening some offices to access the funds, instead of truly engaging with the need for PHC reform and establishing fully functional structures in line with the 9 domains envisioned in the policy.

Financial self-interest also affected NHIS implementation in Ghana. For example, agents earned commission to enroll community members into the scheme, while many membership cards remained uncollected after registration due to long travel distances and a lack of healthcare facilities in some areas. In addition, fraud emerged during initial implementation, including practices such as providers claiming reimbursement for services never rendered and payments being made to non-existing providers.

There is thus a need for national-level policymakers and managers to engage, through stakeholder analyses or other processes of consultation, with the values and interests of sub-national actors, to think carefully about the nature (financial or otherwise) of the incentives provided and what exactly people are incentivized to do, and to think strategically about how to mitigate unwanted or unintended consequences that might result from the intersection of the UHC initiative / policy and the values and interests of sub-national actors.

Lesson 4

Finally, in implementing national UHC initiatives, there is a clear need to take account of and, where necessary, intervene in the skills and capacity of managers and frontline implementers at the sub-national level.

In South Africa, district expenditure on management is variable, suggesting a lack of capacity amongst those districts that spend the least. The implementation of the Ghanaian NHIS has suffered both from a lack of technical capacity and change management capacity. Technically, service providers often lacked capacity for and knowledge about claims management, while scheme managers' lack of insurance or health economics knowledge put them at a disadvantage when purchasing services from medical professionals. An example of limited change management capacity was some service providers' failure to anticipate an increased demand for their services and to expand their infrastructure accordingly.

Change management capacity was also key to the Nigerian PHCUOR experience, where tasks such as stakeholder engagement and reorientation to the new system, as well as the creation of strategic and operational plans to support policy implementation were often neglected.

In addition to the implementation strategies already highlighted, the central importance of management and frontline implementer capacity suggests the relevance of well-targeted training, investment in supportive supervision, and the provision of mentoring to those working in sub-national structures to implement national UHC

Sources and funding

1. Eboreime EA, Abimbola S, Obi FA, Ebirim O, Olubajo O, Eyles J, Nxumalo NL, Mambulu FN. 2017. Evaluating the sub-national fidelity of national Initiatives in decentralized health systems: Integrated Primary Health Care Governance in Nigeria. BMC Health Services Research, 17:227.
   (EAE was supported by a postgraduate training scholarship from WHO TDR; JE, FNM and EAE were also supported by South Africa's National Research Foundation Research Chair's programme (SARChI)).
2. Fusheini A, Marnoch G, Gray AM. 2016. Implementation challenges of the National Health Insurance Scheme in selected districts in Ghana: evidence from the field. International Journal of Public Administration, 40(5).
3. Fusheini A, Eyles J. 2016. Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision. BMC Health Services Research, 16:558.
   (South African National Research Foundation)

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