NELSON MANDELA UNIVERSITY

THE BENEFITS AND PROBLEMS RELATED TO THE PROPOSED NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

By

THANDI THEODORE MAHAMBA

210270772

A RESEARCH TREATISE SUBMITTED IN PARTIAL FULFILLMENT FOR MPHIL IN DEVELOPMENT FINANCE

AT

NELSON MANDELA UNIVERSITY

SUPERVISOR: IDRISS MOUCHILI

APRIL 2021

NELSON MANDELA UNIVERSITY

DECLARATION

NAME : THANDI THEODORE MAHAMBA

STUDENT NUMBER: 210270772

QUALIFICATION : MPHIL IN DEVELOPMENT FINANCE

TITLE OF PROJECT: THE BENEFITS AND PROBLEMS RELATED TO THE PROPOSED NATIONAL HEALTH INSURANCE IN SOUTH AFRICA

In accordance with Rule G5.6.3, I hereby declare that the above-mentioned thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

SIGNATURE

01/04/2021

DATE

DEDICATION

I dedicate this dissertation to my beautiful wife Lutho and my daughters Sine an Ingu. A special dedication to my lovely Mom, Nomnikelo Mahamba for her support and words of encouragement. I also dedicate this dissertation to the rest of my family and friends who have supported me throughout this journey, their support was never in vain. Lastly and to the author and finisher of my faith, the Omniscient, loving God this dissertation is all to Thy glory.

ACKNOWLEDGEMENTS

A project of this magnitude can never be undertaken by one, all by himself, and this is particularly true in my case.

I wish to extend acknowledgement to Mr Idriss Mouchili, my Study Leader, for his academic guidance and supervision.

My Spiritual Leader, Pastor Njingolo, is also acknowledged for his continued spiritual support.

It is difficult to calculate the gratitude that family members deserve when a project of this nature is embarked on. I acknowledge my Mother, Nikki Mahamba, my siblings and my extended family for their prayers and support. My wife, MaHlathi, and my daughters Sinemihlali and Ingu-Mangaliso also deserve special recognition for their patience, prayers and support when I was preoccupied with this research project.

Above all, to my Creator, the Great Almighty, the fountain of wisdom and knowledge – for His support, I will remain grateful. To God be the glory!

ABSTRACT

Globally, the focus of many governments is on achieving universal health care for the citizens. In ensuring universal health care for South Africans, a National Health Insurance scheme has been established with a special focus on ensuring efficiency and effectiveness in the health sector. South Africa is reforming its health care system by the implementation of the NHI scheme which is seen by the South African government as the key to addressing the shortcomings and disparities in the health care sector in the country. The primary aim of this study was to review the available literature and policies related to the benefits and the problems around the NHI in South Africa. The study sought to determine the benefits associated with the implementation of NHI, to identify the possible challenges that may affect the effective implementation of NHI and to give recommendations based on the study on how the NHI can be implemented in a sustainable way. The Agency theory was adopted as a theoretical framework that guides the study. A qualitative research approach was utilised with the use of the exploratory and descriptive research designs. The data was collected through document analysis and thematic analysis was utilised to analyse the collected data. The findings show that the implementation of NHI in South Africa is beneficial as it will address issues of inequality and scarcity within the health care sector. Notably, there are some underlying shortcomings of the South African health care system which are likely to also affect NHI effective implementation. These include capacity of the government, corruption, mismanagement, wastage of resources, unequal distribution of health care professionals, and lack of knowledge on the part of the health care practitioners. This study concludes that these issues need to be addressed for the effective and efficient implementation of the NHI in South Africa. The study recommends strengthening monitoring and evaluation, accountability, training of more health professionals, conducting a baseline survey and building capacity of the government to implement NHI successfully.

TABLE OF CONTENTS

ABBREVIATIONS/ACRONYMS

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	African National Congress
DoH	-	Department of Health
DPME	-	Department of Planning, Monitoring and Evaluation
HIS	-	Health Information System
HIV	-	Human Immunodeficiency Virus
ICT	-	Information and Communication Technology
NHA	-	National Health Act
NHI	-	National Health Insurance
NHS	-	National Health Service
SHI	-	Social Health Insurance
UHC	-	Universal Health Coverage
WHO	-	World Health Organisation

DEFINITION OF KEY TERMS

TERM	DEFINITION
Financing	- It refers to the act of raising funds.
National Health Insurance	- This refers to a health system financing approach that is aimed at achieving universal health care access through strengthening structures that will ensure a comprehensive health services package for all citizens. (McIntyre & Van den Heever, 2007). The approach disregards citizens' social or economic positions.
Scheme	- It refers to an official plan or programme of action.
Sustainability	- It refers to the ability to last or continue for a long time.
Universal coverage	- The World Health Organisation (2000) conceptualises the concept of universal coverage as encompassing the provision of adequate and affordable health care to all citizens.

CHAPTER ONE

GENERAL OVERVIEW OF THE STUDY

1.1. INTRODUCTION AND BACKGROUND OF THE STUDY

The need to ensure national access to decent quality health care has gained momentum globally. As such, many countries have developed strategies to ensure that the goal of access to good universal health care is realised. The focus of countries such as France, the United Kingdom, Ghana and Taiwan has been to ensure that the citizens have unlimited access to health care whenever and wherever they need it (Arpoh-Baah, 2011; Mack, 2011). According to the National Health Insurance (NHI) policy framework (2017), the environment in which people live in and societal risk conditions, influence and are influenced by the health of individuals. Thus, it is imperative to ensure that individuals' health is catered for in order to reduce societal risks. Globally, countries are facing a notably increasing burden of diseases which consequently affect the health of the population as well as the economy. In South Africa, the country is faced with a series of diseases due to the high prevalence of Tuberculosis, HIV and AIDS; high maternal neonatal and child morbidity and mortality; rising disease burden of non-communicable diseases; and high levels of violence and trauma (ADM Annual Report, 2019). The recent corona virus (COVID-19) pandemic has added to this list of diseases, and has, as of May 2020, claimed the lives and health of over 2 million people worldwide (World Health Organisation, 2020).

In the South African context, the government proposed enormous reforms in the health care sector to ensure that there is adequate access to health care for all citizens. This was done in the form of an NHI scheme. However, the recent NHI scheme in South Africa is not the first attempt in the country to achieve universal health care. Fraser, Taylor and Kelly (2011) argue that there have been five main attempts to establish a successful NHI in South Africa which include the Health Care Finance Committee plan of 1994, the 1995 Committee of Enquiry, the Department of Health social health insurance working group of 1997, the Taylor committee of enquiry into comprehensive social security of 2002, and the Ministerial task team of implementing social health

insurance of 2002. All five plans were established with the aim of providing public insurance as well as requiring individuals who earn above a certain income threshold to contribute towards an NHI system. Fraser et al. (2011) further argue that these plans were based on a multi-tier system which offered social health insurance only to those individuals who would have contributed. Thus, these plans did not establish universal coverage as some citizens who could not afford to make financial contributions, were not provided for. This might have contributed to the failure of the plans.

The current NHI is therefore the first significant attempt to establish a universal coverage system in South Africa. The NHI policy framework (2017) argues that the NHI aims at providing a mechanism for the betterment of cross-subsidisation in the country's overall health system. The NHI was developed to address existing structural imbalances in the health system and reduce the burden of diseases. The existing structural problems in the South African health system stipulated in the NHI policy framework (2017) include leadership and governance issues, inadequate health workforce, service delivery, and health care financing challenges.

The rationale behind the formulation of the NHI was also rooted in the need to meet the requirements of Section 27 of the Constitution of South Africa (1996) which postulates that every citizen should have access to health care services. Thus, the rationale for pushing towards the implementation of an NHI scheme in South Africa is to achieve universal coverage in the health sector. The main issue related to the universal health care approach revolves around how to raise enough resources that would enable the financing of health care services to be effective and to cater for all citizens. This study therefore seeks to explore the current health care debate in South Africa. The focus is centred on analysing the feasibility of introducing an NHI scheme in South Africa, which has been made more pressing with the COVID-19 pandemic.

1.2 HISTORICAL OVERVIEW OF THE HEALTH CARE SYSTEM IN SOUTH AFRICA

South Africa is characterised by a two-tier health care system, the public and private sectors, which cater for the health needs of low-income and high-income earners, respectively. During the apartheid period, segregation characterised the provision of services including health care services. Mack (2011) argues that health care services

in South Africa were previously provided on work sites by employers to protect their employees' wellbeing. The health sector after the 1980s was commercialised with Government endorsing privatisation. Mack (2011) further argues that Government during that time ensured that funds were diverted to the advancement of the private sector through offering cash subsidies and tax breaks, which consequently resulted in beneficiaries of the private sector receiving quality health care.

Most South African citizens who relied on the services offered by the public sector had limited access to quality health care. Foreign missionary workers strived to bridge the gap and they were the main agents who sponsored the public sector (Brauns & Stanton, 2016; Mack, 2011; Maillacheruvu & McDuff, 2014). Despite the notable contribution of these missionaries, the health care needs for the populace were not adequately met, especially in the rural areas. During the apartheid era, the majority of black South Africans could not afford health care since services were provided for the white minority (Maillacheruvu & McDuff, 2014). Maillacheruvu and McDuff (2014) further argue that the deregulation of public health care in South African was one of the changes brought about by the apartheid government, which later resulted in the expansion of the private sector.

Furthermore, Shisana (2009) argues that the issue of National Health Insurance in South Africa had been in existence since prior to 1994 with the establishment of the Collie Committee which assessed the feasibility of the NHI. The debate on NHI later re-emerged in 1994 through the National Health Plan led by the African National Congress (Mack, 2011). Since 1994, government has made strides to ensure that there is equality in health care provision ensuring universal coverage. For instance, Burger and Christian (2018) stipulate that the provision of access to health care in South Africa was done through expanding health care facility networks as well as the abolishment of primary health care user fees. Despite these Governmental efforts to achieve universal access to health care, health outcomes in the country remain polarised (Sahn, 2013).

Public health institutions in South Africa are faced with a myriad of challenges that derail the achievement of universal health care such as inadequate salaries for health personnel, lack of motivation, mismanagement and shortages of staff. Newspaper headlines and magazine articles bear sad testimonies to the reality of these issues in

South Africa. For instance, *The South African* of 25 June 2016 reads: 'Massive nursing shortage in Gauteng leaves sick patients even more vulnerable'; the *Times Live* of 2 April 2019 reads: 'Gauteng health hamstrung by critical shortage of doctors and nurses'; and the *All4Women* of 18 September 2018 reads: 'SA's public health system in crisis because of negligence & mismanagement.' Thus, the NHI in South Africa was developed in order to address poverty and inequality inherited from the past and to address some ills which have affected public health post-apartheid. However, it is not the NHI alone that can be effective in solving all these issues.

Shisana (2009) notes that the implementation of the NHI scheme in South Africa was spearheaded by the Department of Health (DoH), and the proposal included contracting general practitioners, universal coverage as well as reducing the use of additional insurance. Unfortunately, the proposal was rejected as a result of its inflexibility (Mack, 2011). In 1995, a committee of enquiry into the National Health Insurance was set up by the South African government with the report of the enquiry based on the earlier proposal by the DOH.

The committee of enquiry recommended social health insurance, universal access to primary health care as well as regulation of the private medical schemes (Shisana, 2009). In 1996, the universal primary health care component was implemented together with regulation of medical schemes though this was partial. The DOH made use of the social health insurance proposal in 1997 to formulate a new committee of enquiry (Mack, 2011). Shisana (2009) asserts that the social health insurance system provided support for the public sector. However, this insurance did not cater for the entire population and the required funds necessary for health services improvement was not raised. This paved the way for the establishment of the Taylor committee in the early years of this century.

McIntyre, Theide, Nkosi, Mutyambizi, Castillo-Tiquelme, Gilson, Erasmus and Goudge (2007) argue that the Taylor committee recommended the implementation of the NHI in 2002. In order to ensure the effective and efficient implementation of the NHI, the African National Congress (ANC)-led government established a task team that focused on researching the solution for providing, as well as managing, health services in South Africa in a cost-effective manner (Khanyile, 2009). The task team also focused on expanding private-public partnerships in the health care sector. The DOH

(2011) believes that the NHI will work as a financing system that will make sure that every South African citizen and all permanent residents have access to basic health care despite their employment status or their ability to contribute financially to the NHI fund. However, the global outbreak of COVID-19 which has affected South Africa, has brought in new dynamics in as far as the NHI debate is concerned. Both the public and private sectors are pooling resources in the fight against this deadly disease. One of the outcomes of the COVID-19 pandemic may be to bring forward the implementation of universal access to health care and the lessons learnt are likely to affect the implementation of the NHI in South Africa (Armocida, Formenti, Ussai, Palestra & Missoni, 2020).

1.3 PROBLEM STATEMENT

The focus of many governments in both developed and developing countries is to ensure that there is the provision of quality and affordable health care. As such, many governments have developed initiatives that are aimed at achieving the above-mentioned goal. This is substantiated by the World Health Report (2010) which states that health promotion is fundamental to human welfare and sustainable economic growth.

In South Africa, there is a huge disparity between the poor and the rich, with a GNI coefficient of 0,62 (Stats SA, 2019). In terms of health care, South Africa is characterised by a two-tier system which distinguishes the rich from the poor, whereupon the rich access their health care from the private sector and the poor rely on the public sector. Mack (2011) argues that the public sector offers health services to approximately 47 million people who do not benefit from an effective and efficient functioning health sector. Mack (2011) further argues that only 7 million people in South Africa can afford quality health care owing to their ability to pay for the services since they belong to the high-income bracket.

In as much as Government strives to provide quality health care for its citizens, the realisation of this goal is often jeopardised by poor management in the health care sector. Abdirahman (2018) postulates that the DOH receives approximately R222 billion per year, to serve approximately 80 percent of the population. Despite the

financial contribution afforded to the DOH, the national Department of Planning, Monitoring and Evaluation (DPME) (2017:3) argues that there is:

> "*financial resource misalignment and challenges in the health work-force and human resource planning and management exacerbated by poor leadership and governance, shortages in pharmaceuticals and technology and challenges in using data and information for decision-making in the sector*…"

This has resulted in poor service delivery in the health sector leading to poor quality of health care services in the public health sector.

The poor health care outcomes of the public sector and Government's aim to provide effective and affordable health care to all citizens, as enshrined in the Constitution, have prompted the renewed debate to implement an effective NHI, which is able to pull resources in the most cost effective and quality manner, for the betterment of all citizens.

A key challenge with the adoption of the NHI, is how it will be financed so that the scheme can be effective and efficient. With the prevailing economic situation in South Africa, financing the NHI through taxation may make it difficult for the already strained taxpayers. This is substantiated by Amado, Christofides, Pieters and Rusch (2012) who argue that financing the NHI through taxation burdens the taxpayers. Therefore, it is imperative that research be conducted to review available literature and policies related to the benefits and the problems around the NHI in South Africa.

1.4 AIM OF THE STUDY

The main aim of this study was to review the available literature and policies related to the benefits and the problems around the NHI in South Africa.

1.4.1 Research objectives

i. To determine the benefits associated with the implementation of NHI in South Africa.
ii. To identify the possible challenges that may affect the effective implementation of NHI in South Africa.

iii. To give recommendations based on the study on how the NHI can be implemented in a sustainable way.

1.4.2 Research questions

I. What are the benefits that are associated with the implementation of NHI in South Africa?
II. What are the possible challenges that affect the effective implementation of the NHI in South Africa?
III. What are the strategies to ensure the implementation of a sustainable NHI policy in South Africa?

1.5 SIGNIFICANCE OF THE STUDY

A study on the benefits and challenges of the implementation of the NHI in South Africa is of paramount importance in the field of public health as it will contribute to the debate on its sustainable implementation. The recent outbreak of the COVID-19 pandemic has strained both the economy and the health system in South Africa. This is likely to influence the feasibility of the NHI, and it is therefore imperative to explore measures to reshape and fast track its implementation. This study aligns with the development strategies of South Africa that are aimed at ensuring the population's wellbeing, including access to effective and affordable health care for all citizens.

1.6 LITERATURE REVIEW

This section reviews the literature on global experiences on the financing and sustainability of an NHI scheme. The literature review will focus on the benefits and challenges encountered by other countries in the implementation of a universal health care system, especially regarding the recent outbreak of COVID-19.

1.6.1 Legislative framework

According to the Constitution of South Africa (1996), the state is obliged to make reasonable legislative measures which are aimed at achievin the progressive realisation of the right to access health care services for the citizens. Section 27 of the Constitution (1996) articulates the need for the South African government to develop

a mechanism that ensures access to health care services for all the citizens, and it states that:

> *"Everyone has the right to have access to health care services including reproductive health care..…. The State must take reasonable legislative and other measures within its available resources, to achieve the progressive realization of each of these rights. No one shall be refused emergency medical treatment" (*South African Constitution, 1996:33).

In line with the above, the National Health Act (NHA) is regarded as the most important Act that guides the implementation of NHI as it gives effect to the right of every citizen to have access to health care services. NHA is the culmination of key health system policies dating from 1994. According to the Health Professional Act, the key objectives of this HPA are the establishment of the Health Professions Council of South Africa, including professional boards.

1.6.2 Theoretical framework

Creswell (2014) argues that the use of theory is fundamental in conducting research since theories provide systematic guidance and comprehensive explanations to social phenomena. This study is supported by the Agency Theory and the rationale behind the selection of this theory is that it examines the conflicts of interest that can arise between the agent and the principal, as well as determining the responsibility of every party. The Agency Theory is better suited to analyse problems in the public sector than in the private one. It is of greater importance to note that Government, as the agent, has a responsibility to ensure that every citizen has access to basic health care as it is a right enshrined in the Constitution of 1996.

- **Agency theory**

The Agency Theory stipulates the connection that exists between the agent, as represented by Government and the principal, which means citizens. It is of critical importance for the agent to ensure that social justice prevails in the country. Health is fundamental for human life and human welfare. Weston (2006) argues that the right to survive is an essential entitlement of all humans, which should not be conditioned on their social, economic, cultural, or religious backgrounds. Society is bestowed with

the responsibility of defending these rights when the individual alone cannot ensure them; hence, the government, as the agent, works on behalf of the principal. The principal pays tax to the agent, which in turn uses the proceeds to improve health facilities and enhance citizens' wellbeing. In the Agency Theory, the public agent is supposed to defend social benefits and the private agent pursue self-interest.

In the South African context, often, public resources are misused. This is evidenced by the DPME's (2017) argument that there is mismanagement of public resources within the health sector. The lack of a coherent and integrated health information management system and the poor leadership at different levels of care in South Africa, have resulted in the sub-optimal provision of health services.

1.6.3 Strategies to finance National Health Insurance

Literature sources have shown that there are various strategies that can be employed by governments to finance NHI. The strategies to finance an NHI scheme include obtaining funds from individuals, households, companies, organisations, employees and foreign donors (Bonfrer, 2015; Gani, 2015; Mack, 2011). Both developed and developing countries have evolved strategies to finance NHI in their respective countries.

In South Africa, there is a progressive income taxation system which is in place to finance the implementation of an NHI (DOH, 2011; Gani, 2015). This taxation system is in place for individuals and is based on the belief that the rich should subsidise the poor. The South African Revenue Service (2011) argues that the more a person earns, the larger his contribution to the income tax system. Government will likely investigate alternative ways of raising funds to finance the NHI.

Fryatt (2011) suggests that a special levy on companies which have huge profits should be introduced, as well as taxation on currency transactions and tourism. These so-called wealth taxes imposed on individuals and companies could fund the NHI shortfall. In Ghana, which is amongst the first countries in Sub-Sahara Africa to introduce a universal health care system, the NHI is financed through a central National Health Insurance Fund sourced from the National Health Insurance Levy of 2.5% tax on selected goods and services and a 2.5% tax on Social Security and

National Insurance Trust contributions, which is mainly contributed by formally employed individuals (Alhassan, Nketiah Amponsah & Arhinful, 2016).

1.6.4 Global trends of implementation of an NHI scheme

Many countries have implemented NHI, with various levels of success, in order to facilitate access to good quality and affordable health care services in a non-discriminatory manner. This study reports on the experience of two developed countries; namely the United Kingdom (UK) and France, and two developing countries namely Taiwan and Ghana. The UK and France are regarded as countries with the best NHI policies in Europe and Ghana is the first country in Sub- Saharan Africa to implement the NHI policy. As for Taiwan, it has achieved an impressive faith in its universal health coverage (UHC) which benefits its entire population (Mack, 2011).

- **United Kingdom**

The health care system in the UK is universal and sponsored by Government. It is known as the National Health Service (NHS). The UK's health care system is largely funded by taxes and is mostly free at point of access. NHS is one of the largest health care systems worldwide (Grosios, Gahan & Burbidge, 2010). Cylus, Richardson, Findley, Longley, O'Neill and Steel (2015) argue that the UK established the NHS health care system in 1948 to serve England, Scotland and Wales in a similar manner, while Northern Ireland's health system operated semi-autonomously. To date, the NHS in the UK has evidenced a good performance in health care provision for its citizens (Papanicolas, Mossialos, Gundersen, Woskie & Jha, 2019).

Light (2003) argues that the UK has made easily transferable policies over the years in terms of universal health access through NHS, which other countries can emulate. These include ensuring that health care is free at the point of service, funding health care from income taxes, paying general health practitioners extra for treating patients with deprivations and from deprived areas, reducing inequalities in historic funding that usually favour the affluent, controlling prescription drug prices while rewarding basic research for breakthrough drugs, devising bonuses for general practitioners that reach population-based targets for prevention, and paying all subspecialists on the same salary scale. Thus, many countries should learn from the NHS in the UK, which has proven able to deliver high-quality universal health care for over 70 years.

In as much as the UK has a record of a successful and vibrant health care system, Papanicolas et al. (2019) argue that there is need for improvement in the NHS in relation to spending and patient safety which were found to be below average. The NHS has also been tested by the outbreak of the novel COVID-19 pandemic which has claimed the health of more than 100 000 people in the country with over 42 000 deaths as at 18 June 2020 (WHO, 2020).

- **Taiwan**

In Taiwan, the health care system is segmented into a two-tier system, at the local and central government level (Mack, 2011). The Taiwanese NHI scheme has covered the entire population including all legal residents since the introduction of the scheme in 1995. Li (2006) argues that the NHI scheme in Taiwan is administered by the Bureau of National Health Insurance (BNHI) within the Health Department. Financing of the NHI in Taiwan is sourced from individuals, companies and Government. In the case of an employed individual, s/he contributes 40 percent, the employer 33 percent and Government 27 percent towards NHI.

- **France**

Rodwin (2015) argues that the health care system in France is a model of NHI that provides health care coverage to all legal residents. France's current health insurance system was shaped over more than a century ago and health care is provided to citizens through a system known as Social Health Insurance (SHI) (Barroy, Jarawan & Bale, 2014). The SHI system is an example of public social security and private health care financing, which is coupled with a mixture of both public and private health care services provision. The SHI system in France reflects three fundamental political values which are liberalism, pluralism and solidarity.

The liberalism value entails allowing patients to determine for themselves the doctors and hospitals they prefer; pluralism relates to the provision of varied health care delivery options ranging from private fee-for-service practice, health centres and outpatient hospital consultations for ambulatory care, through a range of public non-profit and for-profit hospitals, and lastly, solidarity entails ensuring the well-off finance health services are also available to the poorer members of society. In 2016, the French public health care expenses accounted for about 79 percent of the total health

care expenses (Dress, 2016). On the other hand, private voluntary health insurance accounted for 13 percent, while out-of-pocket payments were around 8 percent.

The SHI is mostly funded by social security payroll taxes (64 percent) and the balance by a nationally implemented income tax on all wages, including dividends and interest from capital (16 percent), revenues from tax on tobacco, alcohol, the pharmaceutical industry and private voluntary health insurance (12 percent), state subsidies (2 percent) and contributions from other branches of social security (6 percent) (Dress, 2016).

- **Ghana**

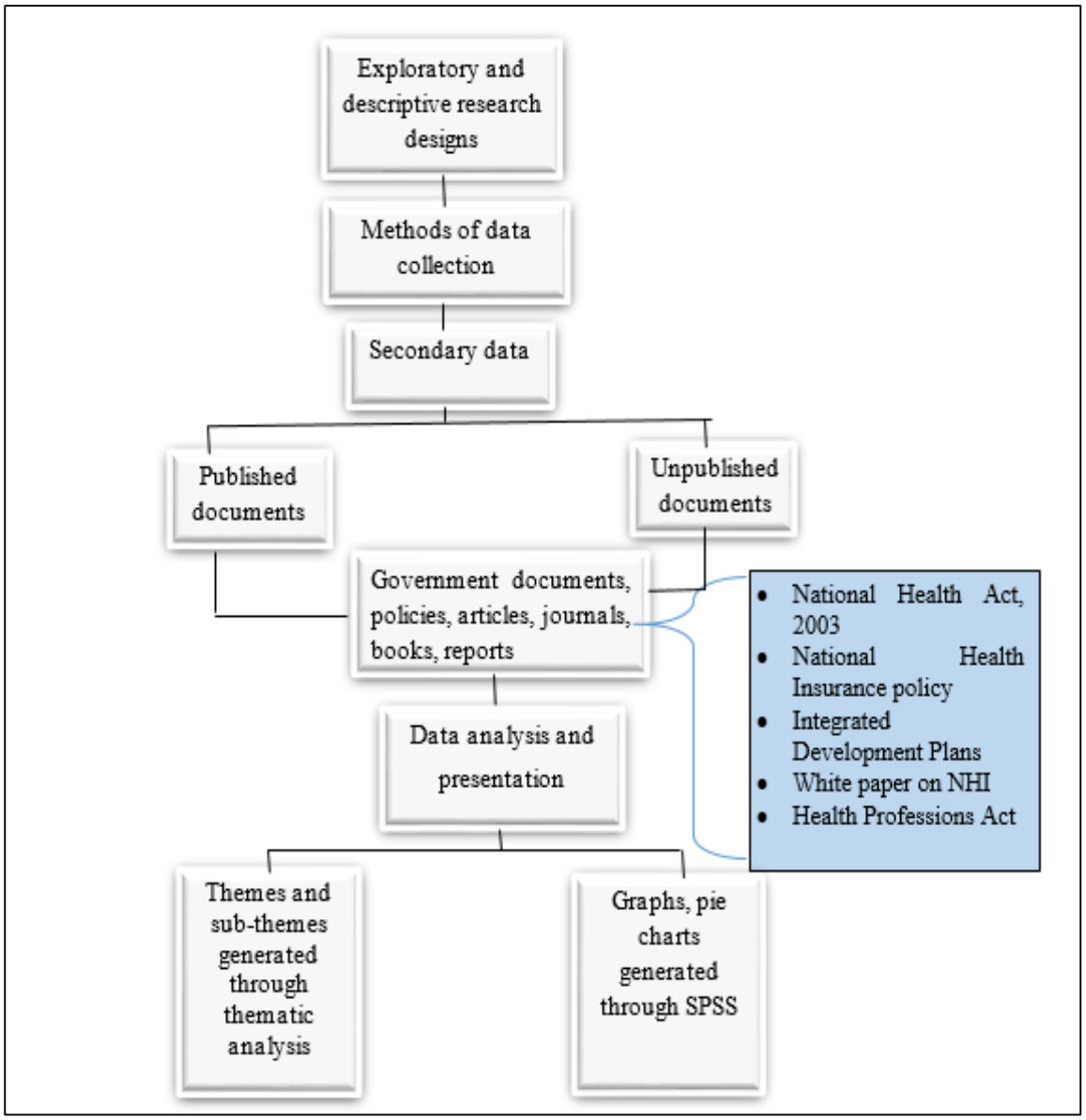
In sub-Saharan Africa, Ghana was the first country to introduce an NHI scheme, which was introduced in 2003 (Alhassan et al., 2016). The implementation of the scheme started in 2004 and it transformed the health care system of Ghana. In implementing NHI, Ghana promulgated the National Health Insurance Act (650 of 2003) which established an NHI Council to monitor and develop operations of the NHI (Mack, 2011). Ghana has three health insurance schemes, which are: Private Commercial Health Insurance Scheme (PCHIS), Private Mutual Health Insurance Scheme (PMHIS) and the District Mutual Health Insurance Scheme (DMHIS), with the citizens freely choosing to belong to any of the three. The introduction of universal health coverage has significantly contributed towards improved health service delivery. Wahab (2008) argues that prior to the introduction of NHI in Ghana, most of the citizens were not able to access health care services partly due to prohibitive costs. The introduction of the NHI in Ghana has positively impacted the country's life expectancy and disease prevention (Toyana, 2013). The discussion of the experiences of the UK, France, Taiwan and Ghana in providing universal health coverage, shows that it is feasible to develop and implement a successful NHI scheme. However, in as much as these health insurance options have documented records of success over the years, there are some inevitable issues that are likely to disrupt the health care system, such as the outbreak of diseases.

1.7 RESEARCH METHODOLOGY

Tan (2018) conceptualises research methodology as a phased research process encompassing the evolvement of research from formulation of a research problem up

to drawing of conclusions that provides an interrelationship between theory and evidence. Sahu (2013) also concurs with the above definition and asserts that research methodology is a systematic process of resolving a social or human problem. Thus, the approach adopted by an investigator to gather information and reach conclusions is considered as the research methodology. This study employed a qualitative research approach to investigate the benefits and problems associated with the implementation of NHI in South Africa. The research methodology is depicted in Figure 1.1 below.

Figure 1.1: Research methodology for the Study



Source: Researcher's own construction

1.7.1 Research approach

The research approach and research methods are two concepts that are used interchangeably in research. Myers (2009) defines a research method as a strategy for research investigation which moves from underlying assumptions to research design and data collection. In social science research, research methods are divided into three major categories which are the qualitative approach, the quantitative approach and the mixed methods research approach. This study utilises a qualitative research approach, which focuses on the meanings and interpretations attributed to a social phenomenon by individuals and is utilised for exploring, clarifying and generating of new theoretical insights (Hammond and Wellington, 2013). According to Gravetter and Forzano (2018), the qualitative research method is founded on remarks which are summarised and construed in a narrative report. The rationale for the utilisation of a qualitative approach is to enable the researcher to have an in-depth understanding of the benefits and problems related to the implementation of NHI in South Africa.

1.7.2 Research design

Research design is a plan of action which a researcher uses to communicate the framework for the study. Thus, a research design forms a fundamental characteristic of any research study since it dictates the scope of research. Tan (2018:5) defines a study's research design as "a systematic way of deciding how to execute the research to rule out alternative explanations." In this regard, a research design functions as a research blueprint that offers a detailed description of each and each facet of the investigation, ranging from research conceptualisation until the diffusion of study findings. In the context of this study, the exploratory and descriptive research designs are adopted, which enable the researcher to gather information from documents, gain new insights and increase the body of knowledge of NHI in South Africa.

1.7.3 Sampling of documents

According to Creswell and Clarke (2018:19), sampling is defined as "the segment or a subset of the population or elements of the study." In line with this study, the researcher employed a non-probability sampling method in sampling documents. Sahu (2013) postulates that in non-probability sampling, some entities have zero

chances of being selected. The research drew a sample from the Department of Health documents such as annual reports, previous dissertations and articles. The documents to be sampled are from the period 2013 to 2020, since they give more recent information regarding the subject matter. Purposive sampling is more appropriate for this study as there are a lot of documents that discuss NHI and this sampling technique assists in narrowing down to focus on the documents that would provide the answers to the research questions.

1.7.4 Data collection

Data collection involves a process of gathering information that is relevant for answering the research question. The qualitative research method is characterised by two methods of data collection; namely, primary data collection and secondary data collection methods. Primary data is considered as research information that is gathered by the researcher with the sole aim of addressing or solving the presented human or social problem identified for the research project. On the other hand, secondary data collection involves collecting data from already existing sources such as books, newspapers, articles and reports. Document analysis is a systematic procedure for reviewing or evaluating printed and electronic documents. This process requires data to be examined and interpreted in order to determine its meaning and gain understanding.

According to Cresswell (2014), documentary analysis is applicable particularly in qualitative case studies that are intensive in producing a rich description of a single phenomenon. Kumar (2011: 58) asserts that document analysis utilisation in research assists the researcher in developing an improved understanding of the studied topic. Document analysis is divided into two broad categories which are internal and external sources of data. The researcher utilised both published and unpublished secondary sources that included books, articles, dissertations from NMU and other institutions of higher learning as well as government documents inclusive of policies, audited annual reports and strategic plans.

According to Prior (2013), the main advantage of employing document analysis is that the information is readily available, and this method enables a researcher to have an in-depth understanding of the background of the phenomenon under investigation.

Using both print and electronic media the researcher was able to draw conclusions from the writings of other scholars who have worked on a similar topic. The specific use of document analysis is that documents can provide data on the context within which research participants operate- a case of texts providing context. In addition, documents contain information which can suggest some questions that need to be asked and situations that need to be observed in the research; furthermore, documents also provide supplementary data for the research. Moreover, documents give a means of tracking change and development and finally, documents can be analysed to verify findings or corroborate evidence from other sources.

The researcher adopted this method as it is an efficient method since it does not consume a lot of time; in addition, documents provide broad coverage as they cover a long span of time, many events and many settings (Yin, 2014). According to Bowen (2009), document analysis involves skimming, reading and interpretation, and this iterative process is a combination of content analysis and thematic analysis. Content analysis is defined as a process of organising information into categories that are related to the main questions of the study (Bowen, 2009). On the other hand, Braun and Clarke (2006) conceptualise thematic analysis as a method of qualitative analysis that entails the identification and interpretation of patterns, which are known as themes within the collected data.

Thematic analysis encompasses studying the data sets in order to find patterns of meaning that occur consistently. In the context of this study, the researcher formulated themes and sub-themes from the gathered data that are in line with the benefits and challenges in the implementation of the NHI scheme in South Africa. Feza (2015) asserts that the overall aim of thematic analysis is to unravel the relevant themes that are prominent in the data. The researcher will be guided by the phases identified by Braun and Clarke (2006) which are: familiarisation with the data, generation of codes, probing for themes, rereading themes, defining themes and constructing a write up.

1.7.5 Trustworthiness of the study

Since the study employs a qualitative approach, the researcher has to ensure the research quality of the study. Guba and Lincoln (1994) identify four criteria that ensure the trustworthiness of qualitative research and these are credibility, transferability,

confirmability and dependability. The researcher ensured that the research is trustworthy by ensuring that reliable and credible documents such as peer reviewed journal articles, dissertations, public policies and audited departmental annual reports and strategic plans were used. The researcher also assessed the documents for completeness in line with being comprehensive, thus covering the topic completely or selectively which meant covering certain aspects of the topic.

1.7.6 Ethical considerations

Ethics are defined as the values and principles which determine how the researcher must conduct himself by distinguishing right from wrong (Sotuku & Duku, 2015). The investigator should be guided by a set of ethical standards in conducting the study. Burns and Grove (2003:167) accentuate that researchers have an obligation to uphold ethical conduct during the study. Firstly, this researcher applied for an ethical clearance certificate from the University ethics committee. It was not anticipated that the study would need ethics clearance from any third party, because the information was collected from publicly available and credible sources. The researcher also avoided plagiarism through acknowledgement of all sources of information and referencing.

1.8 ORGANISATION OF THE STUDY

The research study comprises five chapters which are organised as below.

Chapter One: General Overview of the Study

Chapter one of the study is the introduction. In this chapter, the research topic is introduced with specific reference to the background of NHI implementation. Justification of the need to conduct the study also forms part of this initial chapter. The research aim, objectives and research questions are clearly defined.

Chapter Two: Literature Review

Chapter two of this study will build up on Chapter one and reviews the literature related to the rationale behind the implementation of universal health coverage in South Africa. This chapter also benchmarks the experience of selected countries.

Chapter Three: Research Methodology

Chapter three of this study will deliberate on the study's research methodology. The chapter aims at the conceptualisation of a framework to translate the analysis of relevant documents into a set of answers that address the research problem.

Chapter Four: Data Analysis and Presentation of the Findings

The focus of chapter four of this study will be the analysis and presentation of the research findings on the benefits and problems related to the NHI in South Africa.

Chapter Five: Conclusion and Recommendations

Chapter five will sum up the study and provide recommendations based on the research findings. Suggestions for future research are also provided in line with the findings.

1.9 SUMMARY

This chapter is the initial chapter of the study; thus, focus was on providing a general overview of the study. In this chapter a general overview of NHI schemes was given. The chapter also outlined the research problem, aim, objectives, research questions as well as the significance of the study. A preliminary literature review and research methodology were also outlined. The chapter ends by highlighting the structure of the whole study. The next chapter is a literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In this section of the study, the focus is on reviewing literature relating to the implementation of National Health Insurance across the globe. The NHI concept will be unpacked in detail in this chapter. Bryman (2016) argues that reviewing literature is an integral element in every research project because existing knowledge forms an important backdrop for social research. Thus, literature on global and regional experiences on the implementation of an NHI scheme will be reviewed to enable the researcher to link this study to existing knowledge. The literature will also focus on the benefits and challenges experienced by various governments in implementing the NHI scheme in their respective countries. Literature on the implications of disease outbreaks for universal health access will also be discussed, paying attention to the recent outbreak of COVID-19 which has affected the globe. The theoretical and legislative framework that underpins the study will also be discussed in this chapter. The study is underpinned by the Agency Theory which discusses the relationship that exists between the Agent and the Principal, which translate in this case to the citizens (principal) and the government (agent).

2.2 THEORETICAL FRAMEWORK

Creswell (2015) argues that the use of theory is fundamental in conducting research since theories provide systematic guidance and comprehensive explanations to social phenomena. This study was underpinned by the Agency Theory which was developed by Ross (1973) and Mitnick (1975).

2.2.1 Agency theory

Ross (1973) and Mitnick (1975) argue that the Agency Theory expands on the relationship that exists between the agent and the principal. The underlying assumption behind the Agency Theory is that the agent has an obligation or the responsibility of ensuring that the principal is satisfied (Mitnick, 1975; Nyman, Nisson

& Rapp, 2005; Ross, 1973). The agent is a person who acts on behalf of another; whereas, the principal is the person who receives the services of the agent (Ross, 1973). This theory was considered relevant in this study since the government is responsible for availing health care to the citizens. Thus, the government is the agent; whereas, the citizens are the principal. This theory will therefore be utilised to discuss the relationship between the government and the citizens in relation to health care.

In ensuring the provision of services that satisfy the principal, the government as the agent has implemented the NHI scheme which will afford the citizens access to universal and comprehensive health care. In this context it is important for the agent to ensure that social justice prevails in the country. People's health is fundamental for human life and welfare. Weston (2006) argues that an individual's right to survival is an essential entitlement of human beings that does not need be conditioned on their social, economic, cultural, or religious backgrounds.

In the context of South Africa, the argument is that the public resources that are entrusted to the hands of the DOH are believed not to be used as they are intended. This is evidenced by the DPME's (2017) argument that there is mismanagement of public resources within the health sector in South Africa. The lack of a coherent integrated health information management system, fragmentation and poor leadership at the different levels of care in South Africa, have aggravated the provision of quality health care, subsequently resulting in suboptimal conditions of quality health services delivery.

2.3 HISTORICAL BACKGROUND OF HEALTH CARE IN SOUTH AFRICA

South Africa is characterised by a two-tier health care system, one tier in the public and the other in the private sector, which cater for the health needs of high-income and low-income earners. During the apartheid period, segregation characterised the provision of services, including health care services. Mack (2011) argues that health care services in South Africa were previously accessed on work sites by employers to safeguard their employees' wellbeing. The health sector after the 1980s was commercialised with the government endorsing privatisation. Mack (2011) further argues that the government during that time ensured that funds were diverted to the

advancement of the private sector which consequently resulted in beneficiaries of the private sector receiving quality health care.

Most of the South African nationals who relied on the services offered by the public sector had limited access to quality health care. Foreign missionary workers strived to bridge the gap and they were the main agents that sponsored the public sector (Brauns & Stanton, 2016; Mack, 2011; Maillacheruvu & McDuff, 2014). Despite the notable contribution of these missionaries, health care needs for the populace were not adequately met, especially in the rural areas. The apartheid government had no interest in serving all the citizens of South Africa. During the apartheid era, the majority of black South Africans could not afford health care since services were provided for the white minority (Maillacheruvu & McDuff, 2014). Maillacheruvu and McDuff (2014) further argue that the deregulation of public health care in South Africa was one of the changes brought about by the apartheid government, which later resulted in the expansion of the private sector.

Furthermore, Shisana (2009) argues that the issue of National Health Insurance in South Africa had been in existence prior to 1994 with the establishment of the Collie Committee which assessed the feasibility of the NHI. The debate on NHI later resurfaced in 1994 through the National Health Plan led by the African National Congress (ANC) (Mack, 2011). Since 1994 the South African government has made strides to ensure that there is equality in health care provision ensuring universal coverage. For instance, Burger and Christian (2018) stipulate that provision of access to health care in South Africa was done through expanding health care facility networks as well as the abolishment of primary health care user fees. However, despite the government's efforts to achieve universal access to health care, health outcomes in the country remain polarised (Sahn, 2012).

Public health institutions in South Africa are faced with a myriad of challenges that derail the achievement of universal health care, such as paying inadequate salaries to health personnel, staff lack of motivation, mismanagement and shortage of staff. Newspaper headlines and magazine articles bear sad testimonies to the reality of these issues in South Africa. For instance, *The South African* of 25 June 2016 headline reads: 'Massive nursing shortage in Gauteng leaves sick patients even more vulnerable', the *Times Live* of 2 April 2019 headline reads: 'Gauteng health hamstrung

by critical shortage of doctors and nurses' and the *All4Women* of 18 September 2018 headline which reads: 'SA's public health system in crisis because of negligence and mismanagement. Thus, the NHI in South Africa was developed in order to address poverty and inequality inherited from the past and to address some ills which had been affecting public health prior to apartheid. Nonetheless, the implementation of NHI alone cannot solve these issues, but there is also a need for other initiatives that can complement the strengths of NHI.

Shisana (2009) notes that the implementation of the National Health Insurance scheme in South Africa was spearheaded by the Department of Health (DOH), and the proposal included contracting general practitioners, universal coverage as well as reducing the use of additional insurance. Unfortunately, the proposal was rejected as a result of its inflexibility (Mack, 2011). In 1995, a committee of enquiry into the National Health Insurance was set up by the South African government, with the report of the enquiry based on the earlier proposal by the DOH.

The committee of enquiry endorsed social health insurance, universal access to primary health care as well as regulation of the private medical schemes (Shisana, 2009). In 1996, the universal primary health care component was implemented together with regulation of medical schemes though this was partial. The South African DOH then made use of the social health insurance proposal in 1997 to formulate a new committee of enquiry (Mack, 2011). Shisana (2009) asserts that the social health insurance system provided support for the public sector. However, this insurance did not cater for the entire population and the required funds necessary for health services improvement were not raised. This paved the way for the establishment of the Taylor committee.

In addition, McIntyre, Theide, Nkosi, Mutyambizi, Castillo-Tiquelme, Gilson, Erasmus and Goudge (2007) argue that the Taylor committee was established in the early years of the 21st century. McIntyre et al. (2007) further argue that the Taylor committee recommended the implementation of the NHI in 2002. In order to ensure effective and efficient implementation of the NHI, the ANC led government established a task team that focused on researching the solution for providing, as well as managing, health services in South Africa in a cost-effective manner (Khanyile, 2009). The task team also focused on expanding private-public partnerships in the health care sector. The

South African DOH (2012) believes that the NHI will work as a health system that ensures access to basic health care for every legal citizen of South Africa together with permanent residents despite their employment status or their capability to contribute to the NHI fund. However, the global outbreak of the Corona virus which has also affected South Africa, has brought in new dynamics in as far as the NHI debate is concerned. Both the public and private sectors are pooling resource in the fight against this deadly pandemic.

2.4 FACTORS AFFECTING THE SOUTH AFRICAN HEALTH SECTOR

There are various factors that affect the health sector in South Africa that need to be addressed to ensure sustainable implementation of the NHI scheme towards achieving universal health care. An overwhelming body of literature has provided evidence that the health sector in South Africa has been and is still being compromised by a myriad of factors negatively affecting health care quality. Furthermore, these factors are more human induced. The DoH (2019) argues that the NHI is trying to address these structural barriers to universal health care in South Africa.

2.4.1 Poor service delivery

Poor service delivery has been noted as a challenge in the implementation of the NHI in South Africa. Maphumulo (2019) noted that the healthcare facilities in South Africa are shadowed with poor service delivery. For instance, there are reported cases on the media circulating regarding poor service delivery in these South African healthcare sectors such as bad attitude of health practitioners in Durban (African News Agency, 2020). The African News Agency (2020) argues that the bad attitude of the health workers in the healthcare facilities affects patients as the workers would be ill-treating the patients. In Durban, pregnant women are being turned away by healthcare workers in the clinics which is resulting in some women giving birth in taxis (African News Agency, 2020). Videos have been circulating all over the media bearing bad testimony of the ill treatment encountered by citizens in the hands of the healthcare practitioners. These issues need to be addressed for effective roll out of the NHI in South Africa.

2.4.2 Poor information management

The lack of a coherent integrated health information management system in South Africa within the health sector has affect the system negatively. For instance, the public

health care sector in South Africa is overshadowed by poor record-keeping which results in unnecessary delays for patients to access health care (Kama, 2017:80). Kama (2017) further argues that the patients' folders are sometimes lost or will be missing leading to long waiting period for the patients. He points out that poor record-keeping causes unnecessary delays for patients.

The DPME (2019) has argued that there is need for improvement in relation to information management within the health sector. If these issues are addressed, implementation of the NHI would be sustainable in South Africa yielding more benefits.

2.4.3 Human resource planning

Human resource planning relates to the management of the workforce (DPME, 2019). In South Africa, there is poor planning and management of key health care professionals to deliver quality health care to the citizens (DPME, 2019). There is also a mismatch between the distribution of the key health professional in the urban and rural areas. This has resulted in the unequal distribution of health care professionals (Maphumulo & Bhengu, 2019). Mostly, rural areas are disadvantaged as they have few health care workers, and the public health sector also encounter the same challenge (Van Rensburg, 2014). Similarly, Heywood (2014) argues that the public health sector in South Africa experiences a debilitating shortage of health professionals and skilled personnel compared to the private sector.

In addition, South Africa has experienced an exodus of health professionals to work for better income in other countries or in the private sector (Maphumulo & Bhengu, 2019). This is because the public sector is failing to retain the health professionals. Heywood (2014) has indicated that job dissatisfaction has also led to the loss of health care workers in South Africa.

2.4.4 Increased burden of diseases

In South Africa like in any countries, there is an increase of diseases (Maphumulo & Bhengu, 2019). Kahn (2011) argues that the burden of diseases in South Africa in increasing and it seems like the government is failing to combat it. Several deficiencies

and inadequacies caused by fragmentation of the health care system, coupled with racial and socio-economic issues, have resulted in further proliferation (Maphumulo & Bhengu, 2019). In support of this, the recent outbreak of the novel COVID-19 has also strained the South African health care system due to the intensity of the infections and mortality.

2.4.5 Corruption

Corruption is also another factor affecting the South African health sector. Literature has indicated that corruption has negative consequences for a patient's access to health care (Hsiao, Vogt & Quentin, 2019; Witvliet, Kunst, Arah & Stronks, 2013). Therefore, corruption within the health care sector should be an integral part of current efforts to reach UHC in South Africa (Hsiao et al., 2019). In addition, the WHO (2010) argues that the move from direct payments might reduce corruption because it eliminates the exchange of money at the point of access to care. Thus, the successful implementation of the NHI in South Africa may be effective in curbing corruption within the health sector which will subsequently result in an improvement in health care delivery.

2.4.6 Overcrowding

Overcrowding also has negative impacts on the South African health sector. In South Africa, there is an increase in the migration of people into cities which has resulted in overcrowding in the cities (Maphumulo & Bhengu, 2019). This sudden influx of people into cities forces the health care facilities to function beyond their capacity as they are serving a huge number of people. As a result, there is a lack of resources in these health care facilities and an added strain on an already overtaxed health care system, because in South Africa, it is unconstitutional to deny anyone access to basic health care services (Mokoele, 2012:56).

In addition, overcrowding will in turn cause a decrease in the quality of health care delivery in the urban health care facilities (Kamndaya, Thomas, Vearey, Sartorius & Kazembe, 2014). Thus, there is a need to contain the overcrowding to reduce the negative effects that are embedded within it, particularly in health care service delivery.

2.4.7 Fragmentation and poor leadership

According to the DPME (2019) leadership and governance issues are a cause for great concern within the South African health system. The health sector is characterised by fragmentation and poor leadership at different levels. This is witnessed in both the private and public health care sectors thereby compromising the quality of health care rendered.

In addition, the South African health care reports indicate a complete failure of the public health sector due to poor leadership and inadequate management (Pillay-Van Wyk et al., 2016). The poor leadership crisis within the South Africa public sector can be traced back to the early days of democracy whereby the government implemented policies to improve the living conditions in poor households (Maphumulo & Bhengu, 2019). The implementation of some of the policies such as the affirmative action policies had negative impacts such as the loss of institutional memory and resulted in the placement of inexperienced managers in senior positions in the health care system (Adejumo & Archibong, 2013).

2.5 LEGISLATIVE FRAMEWORK

The following Acts are critical in the development and implementation of NHI in South Africa as they govern and regulate NHI implementation.

2.5.1 Constitution of South Africa (1996)

The Constitution serves as the supreme law in the Republic of South Africa and all the laws within the land must be in line with it (Westhuizen et al., 2016). The Constitution gives effect to all labour law practices. According to the Constitution of South Africa (1996), the state is obliged to make reasonable legislative measures to achieve the progressive realisation of the right to access health care services. Section 27 of the Constitution (1996) argues that it is a constitutional obligation of the government to safeguard access to health care services by everyone:

> *"Everyone has the right to have access to health care services including reproductive health care..… The State must take reasonable legislative and other measures within its available resources, to achieve the progressive*

realization of each of these rights. No one shall be refused emergency medical treatment" (Republic of South Africa, 1996:33).

Thus, the government of South Africa has made efforts, and is still making efforts, to ensure that everyone has access to health care services. This has resulted in the establishment of an NHI scheme which was designed to realise this constitutional right.

2.5.2 National Health Act (2003)

The National Health Act (NHA) is regarded as a significant Act in NHI implementation since it gives effect to the right of every citizen to have access to health care services. Thus, the NHA is the foundational structure of key health system policies dating back from 1994. Ngqolowa (2017) argues that the NHA is a strategic legislative framework that guides the NHI scheme in South Africa to ensure that there is improvement in the national health system. Ngqolowa (2017) further articulates that the NHA creates the structure to train, retain and further build human resources for health care delivery.

Furthermore, this Act ensures that national health is regulated, and uniformity provided in relation to health care services in South Africa. Section 2 of the NHA states that this can be achieved by:

"(a) Establishing a national health system which-

(i) Encompasses public and private providers of health services; and

(ii) Provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;

(b) Setting out the rights and duties of health care providers, health workers, health establishments and users; and

(c) Protecting, respecting, promoting and fulfilling the rights of-

(i) The people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;

(ii) The people of South Africa to an environment that is not harmful to their health or well-being;

(iii) Children to basic nutrition and basic health care services contemplated in section 28(1) (c) of the Constitution; and

(iv) Vulnerable groups such as women, children, older persons and persons with disabilities" (South Africa,2003:17)

2.5.3 Health Professional Act (1974)

The major objective of the Health Professional Act (1974) is the establishment of the Health Professions Council of South Africa and professional boards. This mandate of the council is to provide for control over the education, training and registration for and practising of health professions registered under this Act. Thus, this Act also plays a significant role in ensuring universal access to health in South Africa since the management of health professionals is regulated by one board which ensures that there is universal training for all the health professionals.

2.5.4 Medical Schemes Act (1998)

The Medical Schemes Act was promulgated in 1998 with the aim of consolidating the laws which are related to all registered medical schemes. According to the Medical Schemes Act (1998), this act necessitated the need for the establishment of the Council for Medical Schemes as a juristic person:

- To offer the Registrar of Medical Schemes appointment.
- To ensure that some of the activities of medical schemes are controlled.
- To provide protection to members' interests.
- To establish coordination measures for medical schemes.
- To be responsible for incidental issues.

2.6 NHI IMPLEMENTATION IN SOUTH AFRICA

Arpoh-Baah (2011) conceptualises NHI as a pre-payment health scheme which is set up by the government on a national scale to facilitate equal access to health care services for all citizens in their time of need. NHI in many countries has been designed to pool funds and purchasing services to guarantee the provision of quality and

affordable personal health services with the funds. Many countries have resorted to implementation of a pre-payment health scheme as a way of closing the gap between the rich and the poor (Weimann, 2013). The DOH (2017) argues that the implementation of an NHI scheme in South Africa is being done in phases over a 14-year period starting from 2012 to 2026. NHI implementation is grounded on social solidarity principles, right to access to health care, equity, health care as a public good, efficiency, effectiveness and appropriateness (DOH, 2017).

2.6.1 NHI features

The NHI White Paper (2017) provides the necessary key features of NHI in South Africa which are as follows:

- **Comprehensive services**

This entails the NHI covering a broad set of health care services that will ensure the provision of a spectrum of care from community outreach, health promotion and prevention to other types and levels of care.

- **Financial risk protection**

This entails the NHI ensuring that individuals and families are not susceptible to financial suffering. It involves the need to ensure that individuals and families are not prevented from accessing and utilising the health services they require. It also encompasses eradicating different forms of direct payments for health care such as co-payments, user charges, and other direct out-of-pocket payments.

- **Mandatory pre-payment of health care**

This involves mandatory pre-payments by people for health care services in order to finance NHI. This includes out-of-pocket payments and voluntary pre-payment.

- **Publicly administered**

The administration of NHI will be established as a single fund which will administered publicly. The NHI will be liable for pooling and procuring health services through proper structures that are responsible for contracting accredited providers on behalf of the entire population.

- **Progressive universalism**

Progressive universalism in NHI implementation entails access to health promotion information, rehabilitative, palliative, curative and preventative health services by all South Africans. These services also need to be affordable and of an acceptable quality, without exposing the citizens to financial hardships. The right to access quality health services will be based on need and not socio-economic status. NHI thus seeks to protect the poor and vulnerable groups of the population to ensure that they gain as much as the well-off at every step of implementation, in line with achieving universal health care.

- **Single fund**

All sources of funding for NHI purposes will be integrated into an amalgamated health financing pool that will cater for the health needs of the citizens.

- **Single-payer**

The NHI scheme is designed as an entity that caters for all health care costs on behalf of all South Africans. A single-payer contracts health care services from providers, with the single-payer referring to the funding mechanism and not the type of provider.

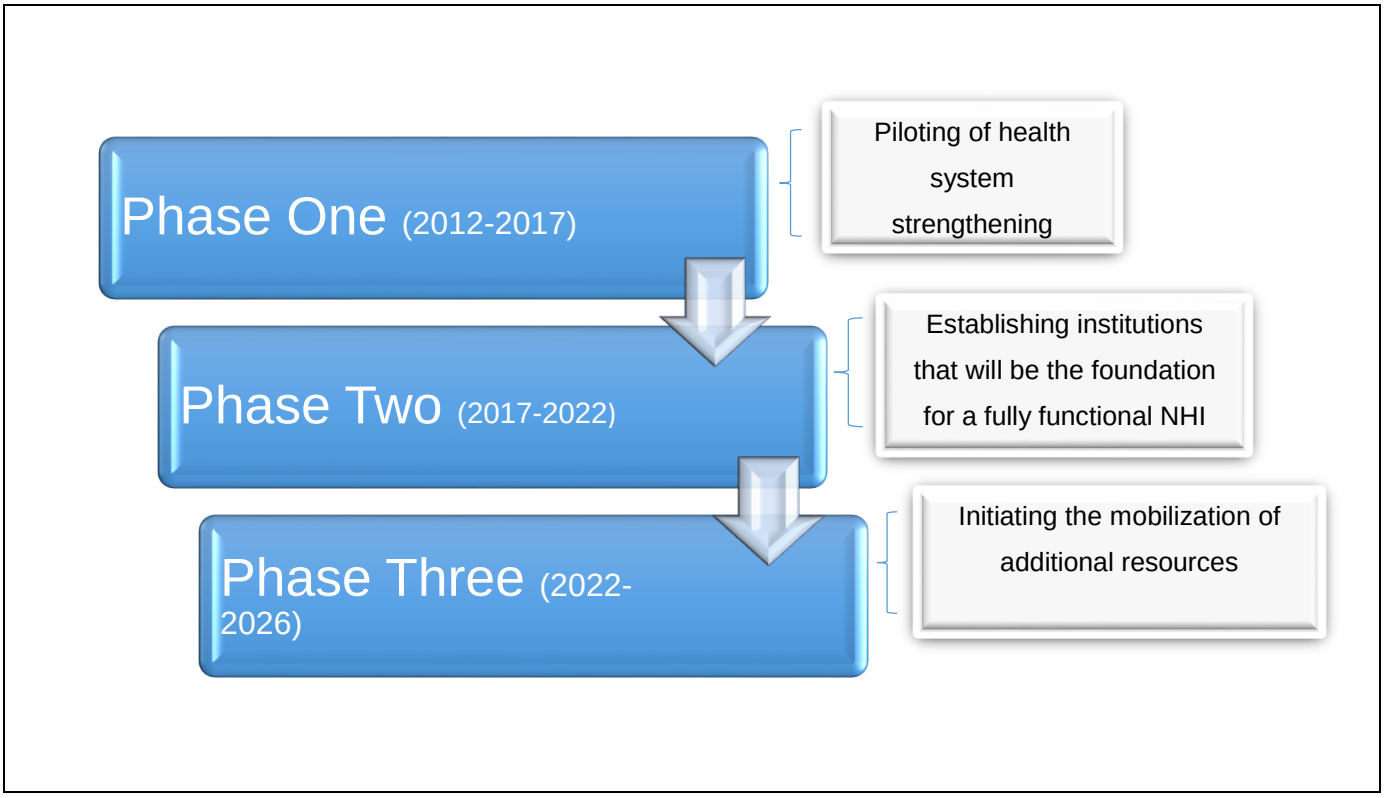
- **Strategic purchaser**

NHI is responsible for procuring services for everyone. It is an entity that relies on its power as the sole procurer to proactively identify the health needs of the entire population and decide on the most appropriate, efficient and effective mechanisms for drawing on existing health care service providers.

2.6.2 Phases of NHI Implementation

The DOH (2017) argues that the implementation of an NHI scheme in South Africa is being done in phases over a 14-year period starting from 2012 to 2026. The implementation of the phases is illustrated in figure 2.1 below.

Figure 2.1: Phases of NHI in South Africa



Source: Department of Health (2017)

- **Phase one**

Phase one of the NHI implementation in South Africa was from 2012 to 2017. Phase one of NHI was primarily a pilot exercise focusing on primary health care (PHC). The DOH (2019) argues that this phase focused on piloting the numerous interventions in preparing for the full implementation of the NHI programme. The pilot survey for NHI implementation was conducted in all provinces targeting one district from each province. Table 2.1 below shows the districts in which the pilot was conducted.

Table 2.1: NHI Phase One Pilot Districts

PROVINCE	DISTRICT
Eastern Cape	OR Tambo
Free State	Thabo Mbeki
Gauteng	Tshwane
KwaZulu-Natal (KZN)	Amajuba
KZN	UMzinyathi
KZN	uMgungundlovu
Limpopo	Vhembe
Mpumalanga	Gert Sibande
Northern Cape	Pixey ka Seme
North West	Dr Kenneth Kaunda
Western Cape	Eden

Source: Department of Health (2019)

The major focus of phase one was to improve, as well as strengthen the South African health system (DOH, 2019). The activities in this phase were funded through the National Health Conditional Grant and the Health Infrastructure Grants (DOH, 2017; DOH, 2019). This phase also resulted in the establishment of workstreams which focused on developing and refining NHI related policy. The NHI phase one also included the implementation of ten interventions which are explained in table 2.2 below. The results of the NHI phase one evaluation are also included in table 2.2.

Table 2.2: NHI Phase One Interventions and Results

INTERVENTION	EXPLANATION	RESULTS
Ward Based Primary Health Care Outreach Teams (WBPHCOTs)	The WBPHCOT were responsible for providing preventative health care and health promotion to citizens.	This intervention was successful.
Integrated School Health Programme (ISHP)	The ISHP was aimed at providing a wide range of health services which are promotional and preventative to school-going children at their institutions of learning.	The accomplishment of this intervention is reliant on the effective implementation of robust management systems for referrals.
General Practitioner (GP) contracting	The implementation of this intervention was to increase the number of GPs in all public health care facilities with the aim of improving the quality and acceptability of care. Contracting the GPs was to ensure close monitoring of the quality of services provided to patients seeking health care from the public sector.	This was viewed as an expensive intervention which required a lot of funding.

Ideal Clinic Realisation and Maintenance (ICRM)	The ICRM model intended to increase the quality of health services through establishing expected minimum standards.	The overall goal of ICRM intervention was weakened by the existence of excessive bureaucracy and inflexible guidelines that were incompatible with social, local and economic realities.
District Clinical Specialist Teams (DCSTs)	DCSTs were liable for supporting clinical governance, clinical work, conducting research and training. The DCST purpose was to support priority health programmes and ensure the improvement of both the quality of health care and health outcomes for new-borns, children and mothers. The focus of the activities of the DCSTs was to integrate, facilitate and coordinate staff, services, programmes and packages of care as well as monitoring and evaluation.	The initiative was not successful due to lack of uniformity in implementation.

Centralised Chronic Medicine Dispensing and Distribution (CCMDD)	This intervention was intended to facilitate improvement in medicine distribution to patients through providing chronic medication at selected pick-up points (PUPs) within the proximity of the pilot districts.	This initiative was viewed as successful by the evaluators.
Health Patient Registration System (HPRS)	The overall aim of this initiative was to establish an electronic system to keep records of patients. The initiative began with the capturing of patient data and generating files electronically.	This initiative had a successful record since facilities were successfully moved onto the system. However, there was unequal implementation of the initiative which resulted in frustrations.
Stock Visibility System (SVS)	SVSs were implemented in order to ensure improvement of stock through an electronic stock monitoring system. This thus reduces unavailability of stock and ensures that stock ordering is timely and appropriate.	The intervention has been successful as it resulted in a decrease in stock-outs in South Africa.
Infrastructure Projects	The aim of this intervention was to improve the	The initiative appreciates the importance of infrastructure in

	infrastructure facilities in order to increase access to health.	establishing a well-functioning PHC system. Thus, the need for proper maintenance of all health infrastructure.
Workload Indicator for Staffing Need (WISN)	WISN is a planning tool for the World Health Organisation (WHO) which was executed to assist institution managers in making efficient staffing decisions.	The success of WISN was limited as a result of the reduction of funding for human resources.

Source: Department of Health (2019)

- **Phase two**

The DOH (2017) argues that phase two of NHI implementation in South Africa is five years long extending from 2017 to 2022. The aim of this phase in the NHI scheme is to develop legislation and amendments to existing legislation that relates to NHI implementation. The DOH (2017) further articulates that phase two of the NHI comprises initiatives that are implemented with the intention of creating institutions that would be the foundation for a full NHI fund. Phase two of NHI implementation also entails the procurement of health care services for vulnerable groups - children, women, people with disabilities and the elderly. This phase also ensures continuity of implementation of strengthening initiatives for existing health systems. Table 2.3 below shows the institutions that will be established during phase two of NHI implementation in South Africa.

Table 2.3: NHI phase two Interventions and Results

INSTITUTION	DESCRIPTION
National Tertiary Health Services Committee (NTHSC)	The NTHSC is a technical implementation committee established by the Minister of Health which will oversee the development of the framework governing the tertiary services platform in the country.
National Governing Body on Training and Development	This committee will manage and monitor the implementation of the NHI policies as well as evaluating their impact.
Contracting Unit for Primary Health Care Services	The contracting unit will be formulated at a district level in a cooperative management arrangement.
Establishment of the NHI Fund	This fund will be set up through legislation and will assist in developing systems that ensure effective functioning and administration.
Establishment of Other Interim Structures in Preparation for the NHI Fund	The structures will be established before NHI legislation is finalised and these include: • Ministerial Advisory Committee on Health Care Benefits for National Health Insurance • National Health Service Pricing Advisory Committee

	• National Advisory Committee on Consolidation of Financing Arrangements
Health Patient Registration Process (HPRS)	This will be a continuous activity that will be visible throughout the life-cycle of NHI. Priority will be given to vulnerable groups of society which are children, women and people with disabilities. The registration of people will be facilitated by a unique identifier which is connected to the Department of Home Affairs' identification system. Access to services will be utilised with this registration information.
Development of Provider Payment Mechanisms	Alternative reimbursement mechanisms will be established which includes a risk adjusted capitalisation which will be used to pay contracted providers, and a case-mix system which will be utilised to reimburse medical specialists.
Legislative Reforms	Several legislations in existence will be reviewed such as the Health Professions Act, National Health Act, Medical Schemes Act and Nursing Act, amongst others.

Source: DOH (2019)

- **Phase three**

Phase three of NHI implementation entails ongoing health systems strengthening (HSS). Nonetheless, HSS activities are not only confined to phase three implementation but will be done throughout the lifecycle of the health system in South Africa (DOH, 2017). Phase three also focuses on initiatives aimed at mobilising additional resources which include financial revenue apportioned to the NHI Fund. There will also be selective contracting of health care services from private providers as well as introducing mandatory payment for NHI through NHI-specific taxes.

The next section of the literature review will focus on the global trends of NHI implementation in order to aid understanding of the implementation of NHI from a global perspective. The focus will be on selected countries which are the United Kingdom, France and Ghana.

2.7 GLOBAL TRENDS OF IMPLEMENTATION OF AN NHI SCHEME

NHI is a scheme developed in order to facilitate equal access to health care services in a non-discriminatory manner. This study will make use of two developed countries as case studies which are the United Kingdom (UK) and France, and one developing country, Ghana.

2.7.1 United Kingdom

The health care system in the UK is universal and government-sponsored and is known as the National Health Service (NHS) (Cylus, Richardson, Findley, Longley, O'Neill & Steel, 2015). The UK's health care system is largely funded by taxes and is mostly free at point of access. The NHS is one of the largest health care systems worldwide (Grosios, Gahan & Burbidge, 2010). Cylus et al. (2015) argue that the UK established the NHS health care system in 1948 to serve England, Scotland and Wales in a similar manner, while Northern Ireland's health system operated semi-autonomously. To date, the NHS in the UK has evidenced a good performance in health care provision for its citizens (Papanicolas, Mossialos, Gundersen, Woskie & Jha, 2019).

Light (2003) argues that the UK has made easily transferable policies over the years in terms of universal health access through the NHS which other countries can

emulate. These include ensuring that health care is free at the point of service, funding health care from income taxes, paying general health practitioners extra for treating patients with deprivations and from deprived areas, reducing inequalities in historic funding that usually favour the affluent, controlling prescription drug prices while rewarding basic research for breakthrough drugs, devising bonuses for general practitioners that reach population-based targets for prevention, and paying all subspecialists on the same salary scale (Light, 2003). Thus, many countries should learn from the NHS in the UK which has provided a health care system which has delivered high-quality universal health care for over 70 years.

In as much as the UK has a record of a successful and vibrant health care system, Papanicolas et al. (2019) argue that there is a need for improvement in the NHS in relation to spending and patient safety which were found to be below average to average. This effective health care system has also been recently shaken by the outbreak of the novel COVID-19 pandemic which has claimed the health of more than 100 000 people in the country with over 16 000 deaths.

2.5.1.1 Benefits

Dayan, Ward, Gardner and Kelly (2018) argue that the NHS in the UK is beneficial to the citizens as it improves public health. The NHS has shown great strength in managing long-term illnesses (Dayan et al., 2018). This entails illness such as diabetes and HIV/AIDS, where the affected will be treated and given medication for free. Through the implementation of the NHS in the UK there have been improvements in the health care sector which has reduced inequalities in access to health care (Mytton, Jackson, Steinacher, Goodman, Langenberg, Griffin, Wareham & Woodcock, 2018). This is an indication that implementation of the scheme has some benefits.

Another benefit of the NHS scheme that has been noted is that it increases widespread accessibility (Dayan et al., 2018). This entails every citizen being able to access health care whenever necessary without incurring any costs. In relation to this widespread accessibility, the NHS scheme in the UK also provides full medical coverage for the citizens (Papanicolas et al., 2019). Therefore, it is enough to argue that the implementation of the NHS in the UK is coupled with some important benefits for the citizens.

2.5.1.2 Challenges

In as much as there are arguments that support the benefits of the implementation of the NHS in the UK, there are also some problems associated with the implementation of the scheme. A review of literature has found that the challenge of NHS is that of long waiting times (Formosa, 2020). The long waiting time has basically been the main problem with universal health care in the UK through NHS (Formosa, 2020). People would be waiting for long hours to get treatment.

2.7.2 France

Rodwin (n.d) argues that the health care system in France is a model of NHI which offers health care coverage to all the legal residents. France's current health insurance system was shaped over more than a century and health care is provided to citizens through a system known as Social Health Insurance (Barroy, Or, Kumar & Bernstein, 2014). The SHI system in France is an example of public social security and private health care financing. The system comprises both elements of private and public health care provision. In France, the health care system reflects three fundamental political values of liberalism, pluralism and solidarity. The liberalism value entails allowing patients to determine for themselves the doctors and hospitals they prefer. The pluralism value relates to the provision of varied options relating to health care from fee-for-service practices, health centres and outpatient consultations for care within ambulances, through a range of public, non-profit and for-profit hospitals.

Lastly, the solidarity value entails ensuring that the well-off finance health services for the poorer members of society. In terms of financing, in 2016 health care in the French public sector amounted to about 79% of total health care spending (DRESS, 2016). On the other hand, private voluntary health insurance accounted for another 13%, with out-of-pocket payments around 8%, while social security payroll taxes accounted for 64% of the total funding needed. The rest was then funded by a national income tax on all wages, comprising interest and dividends from capital (16%), revenues from a tax on tobacco, alcohol, the pharmaceutical industry and private voluntary health insurance (12%), state subsidies (2%) and contributions from other branches of social security (6%).

2.7.2.1 Benefits

Barroy et al. (2014) argue that the major benefit of the SHI in France is comprehensive, uniform and good quality health care provision. The authors further argue that the SHI has ensured that the poorest citizens also access health care through this state-funded insurance scheme. Comprehensive health care in France is faclitated by strengthening the general practitioners in service delivery.

In addition, France has always been credited for its successful implementation of a health insurance scheme (Chevreul, Brigham, Durand-Zaleski & Hernández-Queved, 2015). France combines universal health coverage with a generous supply of health services, and has successfully met its goals towards full coverage, and access to health care without waiting lists. This shows that the implementation of SHI in France is successful as it has met the intended goals.

2.7.2.2 Problems

There are rising health care costs (Barroy et al, 2014). This is as a result of people utilising the health care services at any time because they would not be asked to pay for the services at the health facilities. This might also be the case in South Africa in relation to the implementation of the NHI scheme. There could be over- utilisation of the services by the citizens.

The discussion of both the UK and France case studies above has shown that it is feasible to develop and implement a successful NHI scheme. The NHS in UK and SHI in France have been successful in ensuring universal health care in both countries. However, in as much as these health insurances have documented records of success over the years, there are some inevitable issues that are likely to completely disrupt the success of universal health care access such as outbreaks of diseases. For instance, the outbreak of COVID-19 has resulted in significant increases in the need for health services. As a result, increased utilisation of health facilities from disease outbreaks and associated increased patient loads have compromised the quality of care rendered to citizens in these countries.

2.7.3 Ghana

In sub-Saharan Africa, Ghana was the first country to introduce a National Health Insurance scheme, which was introduced in 2003 (Alhassan, Nketiah-Amponsah & Arhinful, 2016). The implementation of the scheme started in 2004 and it transformed the health care system of Ghana. In implementing the NHIS, Ghana promulgated the National Health Insurance Act (650 of 2003) which established an NHI Council to monitor and develop operations of the NHIS (Mack, 2011). Ghana has three health insurance schemes which are: Private Commercial Health Insurance Scheme (PCHIS), Private Mutual Health Insurance Scheme (PMHIS) and the District Mutual Health Insurance Scheme (DMHIS), with the citizens freely choosing to belong to any of the three. The introduction of this NHIS has significantly contributed towards improved health delivery and utilisation. Wahab (2008) argues that prior to the introduction of the NHIS in Ghana, most of the citizens were not able to access health care services partly due to prohibitive costs. The introduction of the NHIS in Ghana has positively impacted on the country's life expectancy and disease prevention (Toyana, 2013). Thus, the NHI scheme was also introduced as a means of improving financial accessibility to health care.

2.7.3.1 Financing the NHIS in Ghana

Fusheini, Marnoch and Gray (2017) argue that Ghana finances its NHIS through multiple sources. Fusheini et al. (2017) further argue that the mixture of funding sources increases sustainability of the scheme. Alhassan et al. (2016) postulate that the NHI scheme in Ghana is financed through a central National Health Insurance Fund sourced from the National Health Insurance Levy of 2.5% tax on selected goods and services. There is also a 2.5% tax on Social Security and National Insurance Trust contributions, which is mainly contributed by formally employed individuals. Funds for the NHIS are also sourced from donations and the government. Toyana (2013) asserts that the NHIS in Ghana is also funded through out-of-pocket payment, tax, contributions from the Social Security and National Insurance Trust, and the Health Insurance Levy.

2.7.3.2 Prospects of the NHIS in Ghana

Kipo-Sunyehzi, Ayanore, Dzodzonu and Yakubu (2020) assert that Ghana has managed to successfully implement the NHIS to achieve universal health care. Kipo-Sunyehzi et al. (2020) further argue that the characteristics of the NHIS in Ghana are increased accessibility to facilities, large benefits package, disease coverage, and electronic renewals. In terms of disease coverage, the NHIS is beneficial as it covers about 90% of common diseases (Kipo-Sunyehzi et al., 2020). This means that most costs that can be incurred when an individual seeks health care are covered by the NHIS, which makes health care accessible for all. The NHIS in Ghana exempts other population groups from annual premiums, such as children, older persons and indigents (poor) (Fusheini et al., 2017; Kipo-Sunyehzi et al., 2020). These groups only pay registration fees and are covered by the scheme.

2.7.3.3 Problems

The implementation of the NHIS in Ghana also has some problems that affect its sustainability. Agyemang, Adu-Gyamfi and Afrakoma (2013) argue that one of the problems that affect the sustainability of NHI in Ghana is inadequate human resources. This entails the lack of qualified health care professionals to offer health care services to the citizens. Thus, even if the scheme is beneficial, the shortage of health care professional affects the effectiveness of the scheme.

Another problem with the implementation of the NHIS in Ghana is corruption (Agyemang et al., 2013). This problem is an issue of great concern as it affects effectiveness and sustainability of the health insurance scheme. Participants in a study conducted by Agyemang et al. (2013) in Ghana have stated that corruption within the administration of the NHIS affects the realisation of universal care. This is because corruption results in shortages of resources.

Furthermore, the NHIS in Ghana is on a voluntary basis meaning that citizens can choose to belong to the scheme or not (Kipo-Sunyehzi et al., 2020). Thus, some may not join the scheme which is likely to inhibit successful implementation towards achieving universal access. In 2013, only a quarter of the population was covered under NHIS (Averill, 2013). Thus, this voluntary nature of NHIS is a huge inhibiting factor towards universal access to health care.

A review of literature has also shown that Ghana as a developing country, is faced with enormous financial challenges (Agyemang et al., 2013; Kipo-Sunyehzi et al., 2020). These financial challenges are emanating from lack of adequate funds to finance the implementation of the NHIS. Thus, in as much as the NHIS implementation is for a good cause, its sustainability hindered by these financial difficulties, which therefore need to be addressed.

2.7.3.4 Lessons

Ghana is the first African country to implement an NHI scheme towards universal health care (Toyana, 2013; Fusheini et al., 2017) and has recorded notable success stories. The success of the scheme is attributed to political will, multi-source financing, good governance and innovation (Toyana, 2013; Fusheini et al., 2017). Mills (2002) asserts that the dominance of low taxation capacities and large informal sectors indicate that single source funding is not enough to generate revenue for the provision of universal health care. Thus, developing innovative multiple funding sources can result in the feasibility of an NHI scheme.

Fusheini et al. (2017) argue that the history and context of the establishment of an NHI scheme in a country determines the feasibility of that scheme owing to the need for the government to avoid past experiences. For example, in Ghana a lot of people died as a result of failure to pay for their health care (Agyepong et al., 2011). Thus, implementation of the scheme was partly aimed at addressing this challenge to reduce deaths related to financial issues. In South Africa, the history and context of establishing an NHI revolves around addressing imbalances of the past and poor management of health. This should therefore be a driving force towards successful implementation of an NHI, subsequently resulting in sustainability of the scheme.

The experience of Ghana in NHIS implementation demonstrates that adoption of an NHI scheme that is functional and feasible relies on customisation of healthcare systems. This implies that countries that aim to achieve universal health care through adopting health financing systems, need to tailor their systems, including policies to suit their socio-economic, political and administrative settings.

South Africa can also learn from the experiences of Ghana that there is a need for varied sources of funds to finance the implementation of NHI so that it is not affected

by lack of funds to purchase medication and equipment. In addition, the fact that Ghana made affiliation to the NHIS optional has affected implementation since the majority did not join. So, there is a need to ensure that NHI is somehow compulsory, as this will ensure universal coverage as people would seek medical care whenever necessary without being out of pocket as they would be affiliated to the scheme.

2.8 STRATEGIES TO FINANCE NATIONAL HEALTH INSURANCE

The literature has shown that there are various strategies that can be employed by governments to finance NHI. The strategies to finance an NHI scheme include obtaining funds from individuals, households, companies, organisations, employees and foreign donors (Bonfrer, 2015; Gani, 2015; Mack, 2011). Both developed and developing countries have created strategies to finance NHI in their respective countries. Some of the most common strategies to finance universal health care are as follows:

2.8.1 User Charges

Funds to sustain universal health care can also be raised through the user charge mechanism (Dahms, 2014). User charges refer to out-of-pocket payments. This entails the individuals paying health care providers for the services they use which are not covered by their medical aids, and medical fees paid by individuals who do not have medical aids (Gani, 2015). In utilising this mechanism of universal health care financing, a lot of revenue would be generated, and it will discourage individuals from unnecessarily using services which they are not really in need of. Gani (2015) also asserts that the utilisation of user charges can generate revenue which can enable national health funds to be fully or partially self-sustaining.

2.8.2 Taxation

Funding of NHI through the taxation mechanism entails collecting taxes from citizens (Gani, 2015). In South Africa, there is a progressive income taxation system which is in place to finance the implementation of an NHI (DOH, 2011; Gani, 2015). The taxation system is based on the idea that the rich should subsidise the poor. As such, this mechanism of NHI funding entails the high income earners contributing more to the pool of funds in the form of tax. Fryatt (2011) suggests that there is a need to

include a special levy on companies who have huge profits, taxation on currency transactions and tourism tax. These taxes imposed on both individuals and companies would make a huge contribution towards financing the NHI in South Africa. Dahms (2014) argues that the use of the taxation mechanism for raising funds for the NHI implementation subsequently results in an increase in value added tax on selected goods and services. Thus, the utilisation of this method can positively impact equity, efficiency and sustainability of health financing.

2.8.3 Donations

The utilisation of donations as a mechanism for health financing entails relying on external aid to provide health care for citizens. Gani (2015) argues that most African countries are heavily dependent on donor funding which in some instances can be in the form of loans. However, relying on this mechanism may result in alterations in the receiving country's policies to suit the needs and expectations of the funder. In most instances this mechanism does more harm than good if it lacks proper planning and management. Some countries that have recorded financing their health care systems through donations include Ghana, which has successfully implemented the NHIS (Fusheini et al., 2017).

2.8.4 Medical Savings Accounts

Gani (2015) argues that medical savings accounts can also be used as a mechanism for collecting finances to fund the implementation of NHI. This entails individuals making contributions regularly into medical savings accounts and they can then use the money for health services at the point of service. This therefore forms part of health insurance. Gani (2015) further argues that it is advantageous to utilise this form of financing since it ensures that services which are not within the domain of traditional medicine can be catered for out of this account.

2.9 FACTORS AFFECTING SUSTAINABILITY AND IMPLEMENTATION OF A NATIONAL HEALTH INSURANCE SCHEME

This section of the study will discuss factors that affect the effective and sustainable implementation of an NHI scheme.

2.9.1 Outbreak of Diseases

The WHO (2017) argues that universal health care is a need for all people. Outbreaks of diseases thus affect the health of all people (Clarke & Masson, 2017). Thus, outbreaks of diseases have a negative bearing on the effective implementation and feasibility of an NHI scheme. For instance, in as much as the developed countries have well established health care systems, their health care systems were and are still facing challenges as a result of the outbreak of the novel COVID-19 which has affected the globe, particularly developed countries. Thus, there is a need for countries that aim for universal health care to ensure that their health care systems should acknowledge future health disasters which may make it challenging or almost impossible to provide universal health care.

2.9.2 Resource Mobilisation

Results of the study conducted by Abdirahman (2018) have shown that most of the participants argue that resource mobilisation has an influence on the sustainability of universal health care. Abdirahman (2018) argues that resource mobilisation means all the activities which are involved in securing new and additional resources. Thus, resource mobilisation is a critical aspect in sustaining universal health care because the availability of resources is key. These resources entail both financial and human resources.

2.9.3 Monitoring and Evaluation

Abdirahman (2018) argues that monitoring and evaluation are critical towards ensuring sustainability of universal health coverage. Monitoring and evaluation begin by conducting a readiness assessment to set the baseline. Olivera and Velasco (2014) stipulate that inadequate monitoring and evaluation jeopardise sustainability of universal health coverage. Thus, it is imperative for governments to ensure that they have set up a monitoring and evaluation system to continuously observe and assess the implementation of NHI. This can be made possible through political will with the highest commitment and national champions (Abdirahman, 2018). The importance of a strong monitoring and evaluation system in universal health care is that it informs policy and proper planning if handled properly, subsequently resulting in quality service provision and supporting appropriate financing strategies.

2.9.4 Stakeholder Engagement

Another key aspect in ensuring sustainability of universal health care relates to stakeholder engagement. Abdirahman (2018) stipulates that stakeholder engagement affects the sustainability of a national health insurance. According to the World Bank (2013), sustainability of universal health care should encompass the engagement of stakeholders from all sectors in society. The involvement of stakeholders such as Non-Governmental Organisations (NGOs) to support the efforts of the government is key since many of these organisations are closer to the people. Thus, efforts of these stakeholders assist in dissemination of health information literacy, disease surveillance as well as provision of health information. In many instances, NGOs engage in research regarding various health issues. Therefore, the engagement of these stakeholders in supporting governmental efforts relating to universal health care will result in the development of new interventions resulting from stakeholders being prioritised and ensuring coordinated research.

2.10 SUMMARY

This chapter explored relevant literature on the feasibility and sustainability of a national health insurance scheme. It also discussed the implementation of NHI in South Africa as well as the historical background of the South African health sector. Global trends on the implementation of NHI were discussed with a special focus on the United Kingdom, France and Ghana. The chapter also discussed the factors affecting sustainability of a national health insurance and strategies to finance universal health care. The theoretical and the legislative frameworks that underpin the study were also discussed.

The next chapter will discuss the research methodology of the study focusing on the steps that the researcher followed in collecting data for the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter of this study reviewed existing literature that relates to NHI implementation from a global and regional perspective. This literature was reviewed in order to link this study to existing knowledge. In this section of the study, the focus is on describing the research methodology used to achieve the objectives which were presented in chapter one of this study. These objectives are to determine the benefits associated with the implementation of NHI in South Africa; to identify the possible challenges that may affect the effective implementation of NHI in South Africa, and to give recommendations based on the study on how the NHI can be implemented in a sustainable way.

Research methodology is defined as a step-by-step process from research problem formulation until research conclusion providing a link between theory and evidence (Tan, 2018). Sahu (2013) also concurs with the above definition and asserts that research methodology refers to the systematic process of solving a research problem. In this regard, it is the approach utilised by the researcher in a study to collect data.

In addition, the main aim of this study is to review the benefits and problems of national health insurance implementation in South Africa. In pursuit of this aim, this section of the study focuses on discussing the various steps and approaches utilised by the researcher in answering the research questions for the study. This chapter begins by discussing the adopted research approach and research design. The chapter also discusses data collection techniques and data analysis methods employed in the study. The trustworthiness of the study and ethical considerations will also be discussed.

3.2 RESEARCH APPROACH AND JUSTIFICATION

A research approach is also known as a research method. A research approach refers to a plan of enquiry in research which involves the techniques employed in conducting research operations (Sahu, 2013). Similarly, Creswell (2014) defines a research approach as the rationale and the philosophical assumptions that underpin a study in line with the scientific method and this is directly linked to the statement of the problem. The main aim of a research approach lies in gathering data that provides answers to research questions through utilising the necessary techniques. The literature has shown that there are basically three main approach in research which are the qualitative, quantitative and mixed methods research approach (Creswell, 2014; Creswell & Creswell, 2018; Sahu, 2013). Every research study is therefore underpinned by a certain research method which outlines the various techniques employed.

The qualitative research approach focuses on the meanings and interpretations ascribed to a social phenomenon by individuals and is utilised for exploring, explaining and generating new theoretical insights (Hammond & Wellington, 2013). According to Gravetter and Forzano (2018), a qualitative research method is based on observations that are summarised and interpreted in a narrative report. In contrast, a quantitative research approach deals with expressing the research findings in numeric terms. According to Mishra and Alok (2017:3), a quantitative research approach refers to a "systematic experimental analysis of observable phenomenon through statistical, mathematical or computational techniques in numerical forms such as statistics and percentages." The quantitative research approach originated from the natural science field and is used to explain causal relationships which can be generalised to a wider population (Gabrielian, Yang & Spice, 2008). The third approach in research is the mixed methods approach. Creswell and Clarke (2018) define a mixed methods research approach as the thorough collection and analysis of both quantitative and qualitative data in response to research questions. The rationale behind the utilisation of a mixed methods approach is to enable the research to have a complete understanding of the research problem both qualitatively and quantitatively. This study was underpinned by a qualitative research approach.

3.3 RESEARCH DESIGN

A research design in any research process is of paramount importance as it is the scope of research. A survey of literature has shown that a research design is a plan of the investigation used for collecting data, linking the data to the research questions and ultimately reaching conclusions (Creswell, 2014; Creswell, 2014; Jones & Lyons, 2004; Kothari, 2004; Yin, 2003:19;). According to Tan (2018:5), a research design is "a systematic way of deciding how to execute the research to rule out alternative explanations." In this regard, a research design serves as a research blueprint detailing every aspect of the study from conceptualisation up to the dissemination of research findings.

In the context of this study, the exploratory and descriptive research designs were adopted. Minerikar and Minerikar (2014) explain exploratory research design as a design that provides a better understanding of a concept or crystallises a problem. According to Burns and Grove (2003: 374), an exploratory research design entails collecting data in order "to gain new insights, discover new ideas, and for increasing knowledge of the phenomenon." The researcher made use of the exploratory design in order to explore and clarify the phenomenon under investigation. In the context of this study, the design was utilised to gather explanations that relate to the financing and sustainability of National Health Insurance in South Africa. The use of the exploratory research design made it possible for this study to clarify NHI concepts, providing adequate explanations of the NHI as well as gaining insight on the implementation of the National Health Insurance scheme in South Africa. This was done through an extensive review of literature.

In addition, a descriptive research design also underpinned this study. Descriptive research describes an occurrence and its characteristics and is more concerned with what, rather than how or why something has happened (Nassaji 2015). Thus, descriptive research focuses more on what is happening rather than why it is happening. Hence, the purpose of adopting this design was for the researcher to study what the NHI in South Africa entails. This design was utilised to systematically describe the financing and sustainability of National Health Insurance in South Africa.

3.4 DATA COLLECTION

Data collection in any research process entails the process of gathering information carefully, with least possible falsification in a bid to generate answers which are credible (Sapsford & Jupp, 2006). According to McLaughlin (2016), data collection is the systematic approach to gathering and measuring information from a variety of sources to obtain a complete and accurate picture of an area of interest. Similarly, Bryman (2016) delineates data collection as representing the key point of any research entailing the gathering of data from the selected sample to answer the research questions. The process involved in collecting data is systematic and enables the study to obtain a complete and accurate picture of the study area through the utilisation of a wide range of sources. The rationale for data collection is to generate answers for the research questions presented in the initial phases of the study.

All three common research approaches mentioned above are characterised by primary and secondary data collection. Both primary and secondary data collection methods can generate answers for a study and can be used in a single research study. According to Kothari (2004:95), primary data is regarded as data that is collected by the researcher which is, “afresh and for the first time, and thus happen to be original in character.” In the same vein, Sahu (2013) defines primary data collection as information gathered by the researcher solely for the purpose of that study with specific objectives in mind. Therefore, primary data collection is regarded as the gathering of original data. The common sources of data collection in primary data collection are interviews, survey and focus group discussions.

In addition, secondary data collection is the opposite of primary data collection. In secondary data collection, data collection is based on the gathering of data that was previously collected by someone other than the present researcher for other purposes (Kothari, 2004; Stewart & Kamins, 2012; Sahu, 2013). Therefore, secondary data entails data, which was not collected by the user, but it is data that was generated by some other users for other purposes. The sources of secondary data collection are both unpublished and published materials that contain data previously collected and summarised. In the context of this study, data collection was underpinned by secondary sources of data collection.

Furthermore, secondary data for this study was sourced from both unpublished and published secondary sources. Published data sources that the researcher relied on were sourced from government documents, journals, conference papers, books and newspapers, reports and publications of various organisations and reports prepared by research scholars. Unpublished data was sourced from unpublished scholars' reports, dissertations and government documents. In order to ensure the collection of reliable and adequate data the researcher only made use of reliable and valid data on financing and sustainability of the National Health Insurance in South Africa to address the objectives of the study.

Moreover, Gasa and Mafora (2015) argue that secondary data collection can be further divided into two broad categories which are internal and external sources of data. In distinguishing external from internal source of data, Gasa and Mafora (2015) assert that internal sources relate to data obtained from the organisation where one is registered or employed whereas external sources of data refer to data obtained from published materials. External sources of data are mainly obtained from local and national government agencies, trade and professional associations. The use of external sources of data collection was done in this study since the researcher is not directly linked with the organisation that facilitates the implementation of National Health Insurance in South Africa.

In line with the above, numerous government documents were used in this study as a source of secondary data to get insights on how the various policies and legislations prioritise and support the National Health Insurance in South Africa. These documents included the National Health Act of 2003, Health Professions Act of 1974, Medical Schemes Act of 1998 and the National Health Insurance Bill. The Department of Health Integrated Development Plan (IDP) document also provided information on NHI that aided the researcher in assessing the strategies aimed at financing the National Health Insurance scheme in South Africa. The study also utilised different sources from newspaper articles that bear the different views of both the government and the citizens in relation to the NHI implementation. These newspaper articles complement government reports and therefore the study presents a balanced view of regarding the implementation of the NHI.

3.4.1 Data Collection with Specific Research Questions

Table 3.1 below provides a summary of the research methodology adopted in this study as it links data collection with the specific research questions. The rationale for developing this table was to clearly illustrate the link between the presented research questions and the adopted research methodology for the study.

Table 3.1: Data Collection with Specific Research Questions

RESEARCH QUESTIONS	DATA COLLECTION	JUSTIFICATION OF DATA SOURCE	DATA PRESENTATION AND ANALYSIS	OUTCOME
What are the benefits of NHI in South Africa?	Journals; Textbooks; Reports	Data that outlines the benefits of implementing the NHI in SA was collected from numerous sources	Thematic analysis	Benefits of NHI in South Africa
What are the possible challenges that affect the effective implementation of the NHI in South Africa?	Journals; Textbooks; Reports	Previous studies, articles, reports and books were used to gather rich information of the challenges that affect effective implementation of NHI in South Africa	Thematic analysis	Challenges that affect effective implementation of NHI in South Africa identified
What are the strategies to ensure the implementation	Journals; Textbooks; Reports	Data from articles, reports and textbooks has shown trends and	Thematic analysis	Best practices in ensuring sustainable implementation

of a sustainable NHI policy in South Africa?		strategies adopted in implementing a sustainable NHI scheme and the researcher came up with the best strategies that can be implemented in South Africa in order to ensure sustainability of National Health Insurance		of the NHI in South Africa

3.5 DATA ANALYSIS

In every research process data analysis is of paramount importance as it translates the collected raw data sets into meaningful information. Neuman (2011) defines data analysis as the systematic organisation and integration of the collected information in order to look for patterns and relationships. Similarly, Cooper and Schindler (2008) accentuate data analysis as the reduction in volume of the data collected to a manageable size through which the researcher can start to identify trends and allows for a process of summarising it. Data analysis is regarded as the management, analysis and interpretation of the collected data (Bryman, 2016). Thus, when data is collected it will be in a meaningless form and the data analysis process attaches meaning to the data to aid understanding of the gathered information. In the context of this study, data was collected through secondary sources and the researcher analysed the data in relation to the NHI in South Africa that answers the research questions presented in the initial chapters of this study.

In addition, data for the purpose of this study was collected qualitatively. Hence, the data analysis process contained elements of qualitative analysis. Specifically, the researcher utilised thematic analysis. Quantitative data collection and analysis were conducted in order to obtain multiple perspectives on the implementation of the National Health Insurance scheme in South Africa.

3.5.1 Thematic Analysis

In qualitative data analysis, the researcher adopted thematic analysis to analyse the gathered data. According to Braun and Clarke (2006), thematic analysis is a method for identifying, analysing and interpreting patterns (themes) within data. Maguire and Delahunt (2017) define thematic analysis as a procedure that involves themes or pattern identification in qualitative data. Thus, thematic analysis involves studying the collected data sets in order to find patterns of meaning that occur consistently. The researcher formulated themes and sub-themes from the gathered data. Feza (2015) asserts that the overall aim of thematic analysis is to unravel the relevant themes that are prominent in the data. This study sought to identify the themes that emerged in relation to financing and sustainability of National Health Insurance. The researcher was guided by the six phases of thematic analysis identified by Braun and Clarke (2006) which are: familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining themes and producing a write up.

The first step of thematic analysis identified by Braun and Clarke (2006) relates to the researcher's familiarisation with the gathered data. Thus, the researcher was immersed in the data in order to become familiar with the gathered data. In this stage, the researcher read through all the gathered information and jotted down some notes based on the data. During this familiarisation phase, the researcher also searched for meanings in the data set.

Secondly, the researcher produced initial codes from the collected data to organise the data into meaningful groups. Maguire and Delahunt (2017) assert that at this stage the researcher starts to organise data in a meaningful and systematic way. Meaning was drawn through writing down brief notes from the data and the meaningful data was developed into major themes that answered the formulated research questions.

After data organisation, the data was sorted into potential themes. The search for themes was conducted through grouping data that was similar together to form one theme. Essentially, the researcher analysed different codes finding the relationship between them and sorted them into themes using mind maps and tables. At the end of this phase, the researcher had a collection of main themes, and sub-themes. The

relevant themes were then classified according to their relationship with the research objectives.

The fourth phase of thematic analysis involves reviewing and refinement of themes (Braun & Clarke, 2006). The potential themes that were identified during the previous phase were then reviewed and refined until the researcher was satisfied that the themes answered the questions and captured all the data. At the end of this phase, the researcher had a list of themes that emerged and how they fit together, and the overall story they tell about the data.

In addition, Braun and Clarke (2006) identified the fifth phase of thematic analysis as defining themes. The researcher in this stage named all the themes in preparation for presentation. The purpose of this step in data analysis was to identify the central idea and to identify whether themes relate to each other. Lastly, a report of the themes was produced.

3.6 TRUSTWORTHINESS OF THE STUDY

Loh (2013) argues that the trustworthiness of a qualitative study relates to the search for quality in the research. Therefore, in pursuit for quality, the trustworthiness of this study was determined by credibility, transferability, confirmability and dependability. Loh (2013) argues that credibility relates to internal validity. Continuous engagement with the research methodology and study findings was utilised towards ensuring credibility of the study. Transferability is also fundamental in ensuring trustworthiness of qualitative research. Loh (2013) defines transferability as external validity. According to Hammond and Wellington (2013), transferability requires that the findings of a qualitative study and the insights generated in the study's context be generalisable or applicable to other individuals or contexts. In the context of this study, transferability was ensured through a solid description of the methods utilised in gathering data on benefits and problems of the implementation of NHI in South Africa so that anyone can follow and replicate the findings.

In addition, trustworthiness of a qualitative research study can be determined by dependability which relates to reliability of the study. Thyer (2010) argues that dependability in research entails the degree to which the researcher can convince the reader that the study findings occurred in the way is claimed. In ensuring dependability

of the study, a dependability audit was conducted. The dependability audit entailed examining the methodology utilised in the study to ensure that data was collected and presented accurately.

Furthermore, confirmability is another determinant of a study's trustworthiness. Connelly (2016:435) argues that "confirmability is the neutrality, or the degree findings are consistent and could be repeated." Confirmability captures the traditional concept of objectivity in a study, and it also entails the ability of the study findings to be confirmed by another similar study. In the context of this study, the study findings, interpretations and recommendations were thoroughly examined as a way of ensuring that they are supported by data.

3.7 LIMITATIONS OF THE STUDY

Study limitations basically allow the assessment of research findings and derive further research gaps (Creswell, 2014). There main limitations to this research study can be summarised as follows:

- The first limitation was that many documents, which were of interest to the study were not easily accessible and were marked as confidential.
- The study is based on a desktop study; the study could have be enriched with primary sources of data and benefited from users' perspectives of health services

3.8 ETHICAL CONSIDERATIONS

Ethics refer to the principles and values by which determination of what is right and wrong is made (Sotuku & Duku, 2015). During the study, the researcher was bound by various ethical standards. Burns and Grove (2003:167) accentuate that researchers have an obligation to uphold ethical conduct during the study. Firstly, the researcher applied for ethical clearance from the University ethics committee before the commencement of data collection. The researcher also avoided plagiarism through acknowledging all sources of information and referencing.

3.9 SUMMARY

This chapter of the study focused on providing a detailed description of the research methodology employed towards the realisation of the research's broad aim and

specific objectives. This entails the research approach, research design, methods of data collection, data analysis, validity and reliability of the study, and ethical considerations. The present study is desk-top research, thus all the strategies employed focused on gathering data from secondary sources which were relevant to the study. The next chapter will focus on data presentation and discussion.

CHAPTER FOUR

DATA PRESENTATION AND DISCUSSION OF THE FINDINGS

4.1 INTRODUCTION

This section of the study is centred on data presentation and discussion of the study findings. The preceding chapter provided a detailed description of the steps that were followed in coming up with results for this study. Data was collected through document analysis and thematic analysis was used to analyse the gathered data. Thus, this section will present the results of the thematic analysis that was utilised. From the onset of this research, the aim was to review the available literature and policies related to the benefits and the problems around the NHI in South Africa. In pursuit of this aim, the study had three specific objectives which were:

I. To determine the benefits associated with the implementation of NHI in South Africa.

II. To identify the possible challenges that may affect the effective implementation of NHI in South Africa.

III. To give recommendations based on the study on how the NHI can be implemented in a sustainable way.

Therefore, the study results based on these objectives will be presented and discussed.

4.2 PRESENTATION OF FINDINGS

This section will focus on the presentation of the study findings which were collected through secondary data collection. The presentation of findings is based on the themes that were generated during data analysis. After following the six thematic analysis steps by Braun and Clarke (2006), the following themes and sub-themes were generated. The themes that relate to the benefits associated with the implementation

of NHI in South Africa are addressing inequality and scarcity, and comprehensive health care. The themes that were generated in relation to the possible challenges include financial problems and human factor problems. Lastly, themes that are aligned with the objective of giving recommendations are monitoring and evaluation, and accountability. The first two themes are associated with the benefits of NHI implementation in South Africa. The other two themes relate to the possible challenges of NHI implementation, and the last two themes are the recommendations.

Table 4.1: Themes and Sub-themes of the Study

THEMES	SUB-THEMES
NHI addresses inequality and scarcity of health care resources	Addressing inequality issues
	Addressing scarcity
Comprehensive health care	Preventative
	Promotive
	Curative
	Rehabilitative
Financial problems	Financing
	Cost inflation
Human factor problems	Lack of capacity
	Unequal distribution of health care professionals
	Lack of knowledge
	Corruption
	Mismanagement of resources

	Wastages of resources
Monitoring and evaluation	Establish one IT system
	Break monopoly in service delivery
Accountability	
Healthcare practitioners	

Table 4.1: Themes and Sub-themes of the Study

4.2.1 Theme 1: Address Inequality and Scarcity of Health Care Resources

One of the aims of this study was to identify the benefits associated with the implementation of NHI in South Africa. In relation to this aim, theme 1 addresses the benefits of NHI. The study has found that the major benefit associated with the implementation of NHI scheme is addressing inequality and scarcity of health care resources in south Africa. This relates to the improvement of service delivery in the health care sector. This is substantiated by many scholars who argue that the NHI scheme was long needed in South Africa since the two-tier system had widened the gap between the rich and the poor which subsequently resulted in inequality in health care service delivery (DoH, n.d; Obuaku-Igwe, 2015; Passchier, 2017; Maphumulo & Bhengu, 2019). This is an indication that the implementation of NHI has a positive impact on the health care system of South Africa. Notably, to some extent the NHI implementation encounters hiccups in its endeavour to address inequality issues and scarcity due to issues like wastage, mismanagement and corruption as will be discussed in theme 4.

4.2.1.1 Sub-theme 1: Addressing inequality issues

Inequality in relation to health care provision in South Africa has always been based on race and socio-economic status (Maphumulo & Bhengu, 2019). In addressing this inequality, the citizens would all benefit from health care service provision regardless of their race and socio-economic status, thus resulting in universal health care coverage. The inequality in health care access in South Africa was witnessed in

relation to access to health care with the poor often postponing seeking medical care because they cannot afford the health care costs (Gordon, Booysen & Mbonigaba, 2020). The main drivers of this inequality in health care in South Africa were attributed to affordability and ability to pay (Gordon et al., 2020), although there are public hospitals that cater for those who cannot afford to pay for their health care. Notably, the quality of services rendered at the public hospitals and at private hospitals is not the same.

Since the NHI implementation is focused on pooling resources together to fund universal health care access without paying out of pocket, it is likely that the previously disadvantaged individuals will be able to seek treatment without worrying about the costs. However, this has some disadvantages in that the system will be open to abuse as there will be wastage of resources (Sithole, 2015). Nevertheless, the implementation of the NHI scheme in South Africa offers a means to enhance the ability to pay for health care as well as addressing affordability of health care (Gordon et al., 2020). This is an indication that the implementation of the NHI in South Africa is significant.

4.2.1.2 Sub-theme 2: Scarcity

Implementation of an NHI scheme in South Africa also benefits the health care system and the population in that it will address the scarcity of resources within some of the health care facilities in the country. This study has found that NHI implementation is more likely to fill the gap that existed in relation to resource availability (Maphumulo & Bhengu, 2019). South Africa has always been characterised by scarcity of resources in the health care sector, both human and material resources (Brophy, 2015). This has resulted in disparities in the provision of health care across the nine provinces of South Africa. NHI implementation thus offers a means to address this scarcity of resources.

In addressing the scarcity of human resources, the Government has already taken measures to increase the number of health care professionals, by encouraging the return of South African health professionals working abroad and recruiting qualified health professionals from other countries (DoH, n. d). This is a positive step towards addressing the scarcity of health care personnel to spearhead access to universal health care in South Africa.

This study also found NHI implementation in South Africa as significant in addressing scarcity in terms of material resources such as medication and equipment. The DoH (2015) argues that through NHI implementation, funds will be pooled together which will create strong buying power, enabling it to procure health services at a reasonable rate. The NHI system will therefore aim to create fairness in the distribution of health care finance and other resources including skilled health care personnel to address scarcity (Sithole, 2015).

In addressing scarcity, the government has established a Stock Visibility System that ensures stock ordering electronically (DoH, 2019). The medical supplies would be pooled together and those districts and provincial health facilities that require medication would order the supplies from the online system. General practitioner (GP) contracting is also another initiative by the government to address scarcity in the health sector (DoH, 2019). The contracting of GPs is to ensure an increase in access to health care as the GPs would be within the reach of the citizens in their districts and provinces.

4.2.2 Theme 2: Comprehensive Health care

Another benefit of NHI implementation in South Africa is comprehensive coverage (DoH, n.d; London & Saunders, 2018). Comprehensive health care is multifaceted, and it includes the provision of health care services that are preventative, promotive, curative and rehabilitative (DoH, n.d). The study has found that this comprehensive provision of health care is beneficial in the prevention of diseases and promotion of a healthy nation (London & Saunders, 2018). In South Africa, the rationale for NHI implementation was and is, based on achieving universal health care coverage for all South Africans.

Through the implementation of the NHI in South Africa, every South African citizen has a right to be able to access comprehensive health care services at any accredited health care facility such as a clinic or hospital or private health practitioners without paying for the services rendered (DoH, 2015; Sithole, 2015). According to the DoH (2015), people would own NHI cards which they would present at the health care facilities closest to where they live. These comprehensive health care services are delivered to people with the aim of strengthening and reorganising the health care

system in the country (White paper, 2017). With the provision of preventive, promotive, curative and rehabilitative health care, it is more likely that the life expectancy in South Africa will increase as people will be accessing comprehensive care. Thus, the implementation of NHI in South Africa has inherent benefits associated with it.

Notably, the NHI does not entirely provide comprehensive health care since there are some aspects of health care that are excluded from the NHI package (DoH, n.d). The DoH (n.d) states that the excluded services include cosmetic surgery that is not necessary, diagnostic procedures outside the approved guideline, and dental procedures. This indicates that comprehensive health care has some limits.

4.2.2.1 Sub-theme 1: Preventative

This study found that comprehensive health care includes preventative health care. Preventative health care entails the provision of health care services that are aimed at the prevention of diseases and health maintenance (Adu-Gyamfi, Adjei & Owusu-Ansah, 2013). Preventative health care also entails early diagnosis of diseases and early identification of individuals who are at risk of developing specific health problems (Adu-Gyamfi et al., 2013). Through the implementation of the NHI scheme in South Africa, the citizens would be able to access free health education, screening tests, and vaccinations (DoH, 2015). This includes people being able to go for regular check-ups at health care facilities, which is beneficial in detecting diseases early. For instance, through regular check-ups, diseases such as cancer would be detected early and treatment would be given whilst it is still in the early phases. This helps to curb death due to late detection of diseases in South Africa.

In ensuring preventative health care, the government of South Africa implemented the Ward Based Primary Health Care Outreach Teams (WBPHCOTs) to provide preventative health care to the citizens through conducting home visits (Bongongo, Ndimande, Ogunbanjo, Masango-Makgobela, Nyalunga & Govender, 2019). These WBPHCOTs are therefore closer to the communities. The Integrated School Health Programme was also initiated by the government to cater for preventative health to school-going children within their schools (DoH, 2019). This programme will ensure early detection of ill health among school going learners on physical and mental health. (Rasesemola, Matshoge & Rumukuma, 2019).

4.2.2.2 Sub-theme 2: Promotive

This study also found that the implementation of the NHI scheme in South Africa affords the citizens access to promotive health care services without any financial cost (DoH, 2015; Freeman, Simmonds & Parry, 2020; Fusheini & Eyles, 2016). Promotive health care involves a combination of educational, economic, environmental, and organisational support systems that ensure that people's behaviour is conducive to health (Wendimagegn, 2019). Freeman et al. (2020) argue that health promotion is critical in ensuring that the NHI services are not overwhelmed by catering for diseases that can be avoided. Thus, through health promotion initiatives the social and economic determinants of health can be addressed.

The two interventions discussed above, the WBPHCOTs and the Integrated School Health Programme also play a significant role in promotive health within the communities. The Department of Health (2019) monitored the implementation of these initiatives and found that they were successful in making promotive health accessible to communities. Referrals would also be made in cases that needed attention with the health professionals (DoH, 2019).

4.2.2.3 Sub-theme 3: Curative

From the analysis of the gathered data, the researcher found that comprehensive health care provided through NHI implementation in South Africa would be curative in nature. Curative health care entails the treatment of diseases (DoH, 2015). Thus, NHI implementation in South Africa will afford the citizens a chance to access quality treatment for various diseases for free (Fusheini & Eyles, 2016). The curative part of comprehensive health care provision in South Africa through NHI implementation is likely to afford every South African good health restoration. In order to deliver curative health care, NHI will contract both private and public hospitals, as well as private health practitioners and public clinics, to provide curative services to the citizens (DoH, n.d).

Since the NHI does not cover other aspects of health care such as medicines not included on the national essential drug list (DoH, n.d), the comprehensive coverage is therefore questionable. The attainment of quality and complete curative treatment for some would therefore be limited.

4.2.2.4 Sub-theme 4: Rehabilitative

Another key feature of the NHI in South Africa is the provision of rehabilitative health care. The Disabled Children's Action Group (2016) argues that the NHI aims to provide rehabilitative care as part of comprehensive health care provision, with the rehabilitative care services being provided based on a multidisciplinary assessment. The aim is to address both activity limitations and impairments.

4.2.3 Theme 3: Financial Problems

In as much as the NHI is progressive in addressing inequalities in the health care sector and meeting the health needs of the nation, there are some issues that affect the realisation of this cause. Notably, the effective implementation of the NHI scheme in South Africa is threatened by financial constraints. This study has found that the most pertinent financial challenges that affect implementation of NHI in South Africa includes financing of the NHI itself, and cost inflation as will be discussed below.

4.2.3.1 Sub-theme 1: Financing

Implementation of the NHI in South Africa has been a great initiative towards improving the health care system in the country (Mack, 2011; DoH, 2015; London & Saunders, 2018). Notably, scholars have argued that there is no clear description of how the NHI is to be financed, as very few sources of funding have been mentioned (Hofman, McGee, Chalkidou, Tantivess & Culyer, 2015; London & Saunders, 2018; Sithole, 2015). London and Saunders (2018) argue that since there is little information provided in the NHI Bill (2018) regarding funding for the NHI in South Africa, taxation and an end to austerity budgets remain the available options.

There are therefore limited financing options for the NHI in South Africa (Sithole, 2015). This is a cause for concern since the aim of the NHI is to provide comprehensive universal health care. The realisation of this goal may be hindered by the lack of adequate financing sources which may result in poor implementation of the health insurance scheme. Although the NHI funding or financing is currently not well understood, except that the funds will be from the general tax revenue, there are also no clear descriptions of how the health care institutions would be strengthened financially (Sithole, 2015).

Due to these financing issues, the effective implementation of the NHI scheme to achieve universal health care in South Africa may be unattainable. However, it is also important to note that it is not only the financial issues that contributes to the successful implementation of the NHI scheme, but there are also other factors that need to be taken into consideration such as the availability of health care professionals and good governance of the system.

4.2.3.2 Sub-theme 2: Cost inflation

Cost inflation has been noted as one of the possible challenges of NHI implementation in South Africa. Cost inflation is related to the increase in tariffs (Erasmus, Ranchod, Abraham, Carvounes & Dreyer, 2016). Inflation has always been prevalent in the South African medical schemes' market, and therefore it is likely also to be a feature of the NHI scheme (Erasmus et al., 2016). The cost inflation is likely to be driven by utilisation increases since this results in an increase in the amount of health services consumed by the citizens. Fraud may also be a key contributor to cost inflation (Erasmus et al., 2016).

4.2.4 Theme 4: Human Factor Problems

Although financial problems play a significant role in negatively affecting the effective implementation of the NHI scheme in South Africa as noted by various scholars (DoH, 2019; Erasmus et al., 2016; Hofman et al., 2015; Mack, 2011; Sithole, 2015), human factors also have a role to play in derailing the effectiveness of NHI implementation. This study has found that human factor problems that present possible challenges for the implementation of the NHI in South Africa include government capacity and governance, unequal distribution of health care professionals, corruption, mismanagement of resources, wastage of resources and lack of knowledge on the roles of various professionals within the NHI framework. These possible problems are discussed below.

4.2.4.1 Sub-theme 1: Capacity and governance

The government has no adequate capacity to effectively implement the NHI scheme. Grewar (2017) states that the South African government is perceived to be unable to competently implement, administer and manage an NHI scheme that yields positive results. In as much as there are financing problems that exist, Passchier (2017) argues

that the main problem with the implementation of the NHI scheme in South Africa has to do with how the money for universal health care would be spent. This argument is based on the fact that several provinces in South Africa have gone into chronic budget deficit owing to corruption and lack of accountability (Baleta, 2012; Passchier, 2017).

The National Planning Commission (2015) also argues effective implementation of the NHI scheme in South Africa is likely to be constrained by the poor managerial capacity and administrative capacity of the government. The poor managerial and administrative capacity may be attributed to the lack of co-ordination at the national, provincial and district levels (Marais & Petersen, 2015). Proper co-ordination of these three is therefore fundamental in increasing the capacity of the government to implement an NHI scheme that is effective.

4.2.4.2 Sub-theme 2: Unequal distribution of health care professionals

The unequal distribution of health care professionals was also noted as a possible challenge for the effective implementation of the NHI in South Africa. Notably, the health professionals in South Africa are usually in the urban areas whereas the rural areas are characterised by shortages of health care professionals (DoH, n.d). Moreover, South Africa at large is experiencing a shortage of these health professionals (Brophy, 2015). Thus, if the country has a shortage it means that the rural areas suffer more owing to this unequal distribution of the health care professionals. This therefore affects the effective implementation of the NHI in South Africa since some areas would be lagging in terms of access to universal health care. The distribution of the health care professionals among rural, township and urban areas needs to be addressed to afford every citizen the chance to access universal health care which is the primary purpose upon which NHI is being implemented in the country.

4.2.4.3 Sub-theme 3: Corruption

The literature has indicated that corruption is a threat to effective implementation of the NHI in South Africa (Rispel, Jager & Fonn, 2016; Sithole, 2015). Key informants in a study conducted by Rispel et al. (2016) view corruption in the health sector as pervasive, with service providers and suppliers being implicated in corruption. Mitchley

(2019) argues that corruption will be a threat to NHI implementation in South Africa. Corruption within the public health sector has reached uncontrollable levels (Rispel et al., 2016). Thus, this study has noted that there is a need to address the factors that create opportunities for corruption in the South African public health sector for the NHI to thrive.

Centralisation of authority and decision making creates more avenues for corruption in the public health sector (Rispel et al., 2016). The main actors in public health corruption include doctors, nurses, administrators, politicians and suppliers because they have access to public funds (Pillay & Mantzaris, 2017). The corrupt practices that occur include, but are not limited to bribery, bureaucratic corruption and misinformation, theft, procurement and supply chain related purchases including pharmaceuticals, service provision by medical personnel, medicine distribution, quality regulation in services, facilities and products. This prompted Mitchley (2019) to stress the great need for the government to prevent, detect and act early on any allegations of corruption.

Corruption has detrimental effects on service delivery, staff morale and patient care (Rispel et al., 2016). This means that the patients end up receiving inadequate health care having negative implications for service delivery. Since the literature has attributed the failures of the public health care system to corruption (Mitchley, 2019; Pillay & Mantzaris, 2017; Rispel et al., 2016; Sithole, 2015), it is imperative for the government to address issues of corruption as a means of paving the way for the successful implementation of NHI in South Africa. If corruption within the public health care sector is unattended, it will be very difficult for NHI to thrive and achieve set goals. Thus, focus should be centred on addressing corruption to avoid situations where NHI implementation inherits failures of past systems in its attempt to improve health care in South Africa.

4.2.4.4 Sub-theme 4: Mismanagement of resources

This study has found that in South Africa there is mismanagement of health care resources which is detrimental to successful NHI implementation. Maphumulo and Bhengu (2019) accentuate that South Africa is overshadowed by financial mismanagement in the health care sector, which is more likely to affect NHI. Unless

this challenge is addressed, NHI implementation in South Africa may fail to achieve its intended goals. For NHI implementation to thrive in South Africa, the government needs to carefully address mismanagement of health care resources including state facilities and fiscal funds (Sekhejane, 2013).

In addition, South Africa had a poor ranking on health care in the Social Progress Index in 2017 owing to mismanagement in the health care sector (Roodt & Fleming, 2018). At a district level, mismanagement mounts unnecessary pressure on tertiary hospitals as the district hospitals would be referring almost all patients to the tertiary hospital (Timeslive 31 August 2017). Thus, there is a great need to address the issue of mismanagement of financial resources, human resources, infrastructure and equipment in order to curb deaths of patients, increase life expectancy, and ensure effective and efficient health care service delivery. If mismanagement in the health care sector is not addressed, the effective implementation of NHI in South Africa may be jeopardised.

4.2.4.5 Sub-theme 5: Wastage of resources

Corruption and wastage of resources are linked. Sithole (2015) argues that corruption accounts for the wastage of about 10% of health care resources in South Africa. Wastage of resources is also linked to purchasing of unnecessary resources leading to wasteful expenditure. For instance, a provincial health official mentioned that as a means of achieving the “ideal clinics” within the Ideal Clinic Realisation and Maintenance strategy, unnecessary equipment is purchased and it goes to waste (National Department of Health, 2019). This reflects badly on the achievement of NHI goals for the achievement of comprehensive health care provision as resources that would have catered for necessary equipment and medication would have gone to waste.

In addition, WHO has defined quality health care provision as the delivery of health care in a way that ensures resource maximisation and avoids resource wastage (The South African Medical Association (SAMA), 2016). Thus, achieving universal health care provision through NHI implementation may not be achieved if health institutions and personnel waste scarce resources (SAMA, 2016). This should serve as a wake-up call for the government to ensure that there are systems in place to curb wastage

of scarce resources in the health care sector to pave way for the successful implementation of NHI in South Africa towards universal coverage.

4.2.4.6 Sub-theme 6: Lack of knowledge

In as much as the implementation of the NHI in South Africa is beneficial and needed, one possible challenge that may affect the realisation of the aims of the scheme is lack of knowledge on the part of the professionals who are supposed to spearhead the implementation (DoH, n.d). This study has found that this lack of knowledge, particularly on the roles and responsibilities they should assume, is problematic. This is substantiated by a study conducted with community health workers by Tshitangano and Olaniyi (2018), which showed that the community health workers lack adequate knowledge regarding their roles within the ward based outreach teams.

Therefore, if the people responsible for the implementation of the NHI themselves are not quite sure about their roles it means that the successful implementation of the features of NHI might be unattainable in South Africa, unless proper skills development and training are done. In chapter 2 of this study it was outlined that the ward based outreach teams are the teams responsible for providing preventative health care and health promotion to citizens (DoH, 2019). This means that these teams would be working towards the attainment of the goal of affordable comprehensive health care since they would be providing preventative and promotive health care.

In addition, since the ward based outreach teams were perceived as unsure of their roles (Tshitangano & Olaniyi, 2018), the NHI benefit of comprehensive care as discussed above, may be jeopardised. However, the findings of the DoH (2019) on the implementation of phase one of the NHI indicates that the ward based outreach teams' intervention in communities was a success. These discrepancies between the findings show that there is a need for thorough monitoring and evaluation in all the districts and provinces about NHI implementation to get a clear picture of the implementation within South Africa as a whole.

4.2.5 Theme 5: Monitoring and Evaluation

This study sought to give recommendations based on how the NHI can be implemented in a sustainable way. The first recommendation is strengthening

monitoring and evaluation of NHI implementation in South Africa. The study found that there is a lack of monitoring and evaluation mechanisms within the South African health system which makes it problematic for effective implementation of the NHI (Marais & Petersen, 2015). Notably, there is a need for the establishment of proper and fully functioning monitoring and evaluation mechanisms at all levels – national, provincial and district levels to ensure effective implementation of the NHI in South Africa. With proper monitoring and evaluation mechanisms, the NHI implementation will yield the needed results. These mechanisms should be used to track South Africa's health status, quality of health care provided and the utilisation of health care (Passchier, 2017).

In addition, this study proposes monitoring and evaluation in all the provinces and districts of South Africa regarding NHI implementation. The monitoring and evaluation should not be a once-off exercise; rather it should be continuous, for example, the exercise may be done on a yearly basis at both the district and provincial level. This will be beneficial in determining which provinces or districts need assistance in implementing the NHI and avail that assistance. Monitoring and evaluation will check the targets against the actual work done (United Nations Development Programme, 2009) to determine progress towards attaining universal and comprehensive health care for all in South Africa. The effective monitoring and evaluation will enable the government to identify any barriers to successful implementation of the NHI and the barriers could be addressed earlier.

Notably, the costs of conducting these monitoring and evaluation activities may be higher than the cost of health services. This is an indication that the implementation of NHI has both inherent negative and positive outcomes. Thus, this study makes suggestions that can improve implementation of NHI in South Africa.

4.2.5.1 Sub-theme 1: Having one IT system

In relation to the management of patients' records, there is a need for the establishment and maintenance of a single IT system when implementing NHI. The establishment of this single IT system will enable easy access to patients' information and files. The DoH (2019) argues that there is the Health Patient Registration System which was established to keep records of patients. However, the implementation of

this system was unequal, and it has led to frustrations (DoH, 2019). The successful establishment and maintenance of a single IT system will therefore enable universal implementation and enable access of patients' data by health professional across the country.

In addition, Wright, O'Mahony & Cilliers (2017) argue that the National DOH has developed a Health Information System (HIS) to ensure a quality healthcare in public health facilities. However, these authors argue that the development of this HIS was done in silos and on an ad-hoc basis. This has made it difficult to effectively implement the HIS to serve the needs of the patient, healthcare worker, hospital manager and National Department of Health (Wright et al, 2017). Wright et al (2017) further argue that the existing HISs in South Africa are predominantly paper based and geared toward monitoring and evaluation, with no or little integration between the various systems.

There is no national master patient index and enterprise architecture that supports the national public health system in South Africa.

Wright et al assert that the technical system cannot be solely responsible for the failure of successful implementation of HIS but there are other factors which are the social systems. The social system comprises the employees and the knowledge, skills, attitudes, values and needs they bring to the work environment as well as the reward system and authority structures that exist in the organisation (Wright et al, 2017). Notably, managerial, cultural and financial issues play significant roles in the success of information technology projects. The HIS in South Africa may fail due to the attitude of the healthcare workers towards the HIS, computer literacy skills of the healthcare workers, and awareness on the benefits and purpose of using a HIS (National Health Laboratory Service, 2014; Reagon, Irlam & Levi, 2007; Wright et al, 2017).

Further, the high costs of implementing a HIS is also another challenge that affects effectiveness of the HIS in South Africa (Schulze, 2007).

4.2.5.2 Sub-theme 2: Breaking monopoly in service delivery

Naidoo (2019) argues that the implementation of NHI in South Africa may pay way for the creation of a state-run monopoly which will be susceptible to mismanagement and

corruption. Thus, in order to ensure effective and efficient implementation of NHI in South Africa, there is also needed to break monopolisation of health service delivery. All hospitals should be given an opportunity to compete for users. This will indirectly force the service providers to provide excellent health care services to the users.

4.2.6 Theme 6: Accountability

Accountability is key when serving the public. Thus, during data analysis, accountability was developed as a theme for the study in relation to the objective of giving recommendations for NHI implementation in South Africa. The study found that there is lack of accountability within the NHI system implementation. Passchier (2017) argues that there is a lack of accountability in the health care system in South Africa and the NHI implementation plan currently fails to address issues of accountability. Since there is a lack of accountability within the current health system, the NHI plan needs to provide a clear picture on how accountability will be done to prove the need for NHI in South Africa.

4.2.7 Theme 7: Healthcare Practitioners

The results of this study have shown that there is a shortage of health care practitioners in South Africa (Brophy, 2015; Sithole, 2015). Most of the hospitals and clinics do not have adequate staff to provide healthcare service to the citizens of South Africa. The situation is even worse for hospitals and clinics in rural areas as mot healthcare professional shun away from rural healthcare facilities.

4.3 DISCUSSION OF FINDINGS

According to the results obtained, the NHI implementation is characterised by both benefits and problems. The data presented above shows that the benefits of implementing the NHI in South Africa are that it addresses inequality and scarcity within the South African health sector that has been in existence for quite some time. The NHI also affords the citizens access to comprehensive care as alluded to in Section 4.2 above. This is an indication that the implementation of the scheme is significant for the health care system.

The above benefits of the NHI scheme in South Africa concur with the growing literature on implementation of universal health care schemes. For instance, in Ghana which is the first African country to implement a health insurance scheme, the implementation of the scheme was beneficial for the citizens of Ghana who were previously excluded from accessing health care due to their inability to pay for their medical care (Wahab, 2008). Thus, South Africa is also implementing the scheme with the aim of addressing the financial barriers to access medical care. The NHI thus pools together funds that would be channelled towards the health of the citizens including preventative, curative, promotive and rehabilitative health care (DoH, 2015).

In as much as the study has found that the implementation of the NHI has some benefits, the study also found that there are some problems that may affect effective implementation of the NHI in South Africa. These include financial problems and human factor problems as discussed above in Section xx. The financial problems include financing the NHI and cost inflation. The issue of financing the NHI has not been adequately addressed in either the NHI Bill or NHI policy itself (Sithole, 2015). The two documents only state that the scheme is funded through taxation. There is however limited descriptions or discussions of the sources of funding that would inject funds towards universal health care access in South Africa (Sithole, 2015).

This shows that there is a great need for the government to address the issue of sources of funding for NHI. By availing more avenues for the purpose of funding, the NHI implementation would be beneficial for the country as it would ensure the attainment of access to universal and comprehensive health care for all South Africans. These avenues that the government may need to explore includes implementing fund-raising programmes.

The researcher has collected data on budget allocations and government budget, and compared it with those of UK, France and Ghana which were used as case studies of the implementation of NHI in other countries. The figure below shows the general government expenditure on health from 2006 to 2017.

Table 4.2: Governments' Expenditure on Health

DOMESTIC GENERAL GOVERNMENT HEALTH EXPENDITURE (% OF GENERAL GOVERNMENT EXPENDITURE)					
Annual Average Growth	**Year**	**South Africa**	**Ghana**	**France**	**United Kingdom**
	2006	11,53	9,56	15,14	15,20
	2007	11,74	9,13	15,16	15,13
	2008	11,57	9,89	15,10	14,56
	2009	11,34	12,35	15,14	15,27
	2010	12,45	11,91	15,08	15,03
	2011	13,22	12,08	15,14	15,37
	2012	13,59	8,97	15,09	15,31
	2013	13,33	8,64	15,25	17,76
	2014	13,37	6,72	15,50	18,15
	2015	13,34	8,56	15,47	18,36
	2016	13,34	6,54	15,60	18,77
	2017	13,34	6,07	15,47	18,74
Annual Average Growth Rate		1,28	-4,01	0,20	2,16

Source: World Health Organization Global Health Expenditure database (2018)

The figure above shows that in 2017, government expenditure on health as a percentage of government general expenditures, for South Africa, Ghana, France and UK were 13.34%, 6.07%, 15.47% and 18.74% respectively. Looking at the expenditure

on health for South Africa and Ghana, it shows that African countries are failing to meet the requirements of the Abuja declaration which set the budget allocation for health at 15% (WHO, 2011). Moreover, South Africa's government expenditure on heath as a percentage of government general expenditures is on par with that of France, although the outcomes for the general population are hardly comparable.

More so, the other possible challenge of NHI implementation in South Africa has been found to be cost inflation. The history of medical aid schemes in South Africa revolves around cost inflation (Erasmus et al., 2016). This means that the people would be asked to do out of pocket payments when requiring medical attention with the justification that the funds contributed are not enough for medical care access. Cost inflation might be a challenge as the citizens may fail to pay extra money whenever they seek medical care.

Another cause for concern in South Africa that was noted in the data presentation is the shortage of health care professionals in the country (Burphy, 2015). This alone can contribute to the failure of the NHI implementation because the health care professionals are the primary drivers of NHI implementation to achieve universal health care in South Africa. The South African Minister of Health also stated that the country needs to at least triple the number of the available health professionals so that the NHI implementation can be a success (Baleta, 2012).

Mismanagement, wastage of resources, inadequacy of health care practitioners, shortage of medication, unclear accountability and corruption in the health sector in South Africa also needs to be addressed since they are causes for concern for effective and efficient implementation of NHI (DoH, 2019; Maphumulo & Bhengu, 2019; Mitchley, 2019; Passchier, 2017; Rispel et al., 2016; Sithole, 2015). Unless these issues are addressed, the NHI may fail to achieve its intended goals.

The study has discussed both the benefits and the possible challenges of implementing the NHI in South Africa. The discussion has shown that provision of primary and basic medical care is of fundamental importance (DoH, 2015), thus the implementation of the NHI will afford the citizens an opportunity to access primary health care without paying out of their pockets. This will improve the health seeking behaviour of people which will consequently result in improved health since illnesses

would be detected early and treatment administered before the diseases are at an advanced stage. Furthermore, the challenge that may arise when people are seeking medical care through NHI is that the people would over-utilise the services (Sithole, 2015). There would be an increased burden on the services.

Drawing from Ross (1973) and Mitnick (1975)'s Agency theory presented in chapter 2 of this study, the government as the agent is supposed to ensure service delivery to the citizens who are the principal. In this case, the government through the Department of Health should ensure that the NHI implementation yields the anticipated results of ensuring universal comprehensive health care to the citizens. To increase citizens' trust in NHI implementation, a clear indication of how the government will handle issues of accountability and mismanagement should be clearly disseminated. For this to be achieved, the study found that there is a need for monitoring and evaluation at district, provincial and national level to assess progress towards achieving the NHI goals. The Department of Health as the agent also needs to be accountable to the citizens about how the funds that would have been pooled together in the form of NHI, would be used so that the citizens have confidence in the government.

4.4 SUMMARY

This chapter presented the data that was obtained from document analysis in relation to the benefits and possible challenges of the implementation of the NHI in South Africa. From the analysis of the data gathered, the researcher developed six themes that provided answers to the research questions presented in the first chapter of this study. The themes were generated through thematic analysis. The six themes include addressing inequality and scarcity, comprehensive health care, financial problems, human factor problems, monitoring and evaluation, and accountability. These themes covered aspects on the benefits, possible challenges, and recommendations for NHI implementation in South Africa.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This section forms the last chapter of the study. This chapter is a build-up from the previous chapter of the study that presented the study findings. From the onset of the study, at the aim was to review the available literature and policies related to the benefits and the problems around the NHI in South Africa. The researcher had questions in line with this broad aim. In pursuit of the aim of the study, the following questions were asked:

I. What are the benefits that are associated with the implementation of NHI in South Africa?

II. What are the possible challenges that affect the effective implementation of the NHI in South Africa?

III. What are the strategies to ensure the implementation of a sustainable NHI policy in South Africa?

The data that provided answers to these questions was collected, analysed and presented in the preceding chapter. Since this is the last chapter of the study, the whole study will thus be summarised, and conclusions will be drawn based on the presented data. The researcher will also make recommendations based on the study findings including recommendations for future studies. The implications of the study findings for policy will also be discussed in this chapter.

5.2 SUMMARY OF THE RESEARCH FINDINGS

This section of the study will focus on summarising the whole study. In ensuring a holistic summary of the study, the researcher will summarise the findings based on the research objectives.

5.2.1 The Benefits Associated with the Implementation of NHI in South Africa

This study sought to determine the benefits associated with the implementation of the NHI in South Africa. During data collection in line with this objective, the researcher found that the implementation of the NHI in South Africa has some benefits for the citizens. During data analysis, these benefits that were identified were developed into themes and two sub-themes were generated, which are addressing inequality and scarcity, and comprehensive health care. The effectiveness and efficiency of the health care system in South Africa is also a goal of NHI implementation. From these themes, sub-themes were also generated (table 4.1).

From the results gathered, theme 1 is in line with the rationale for NHI implementation in the country. The literature has shown that the implementation of NHI will therefore benefit the South African citizens through addressing inequality and scarcity in the health sector. The funds for NHI will be pooled together and the government would be responsible for purchasing the goods and services, thus making it possible for everyone to access health care regardless of socio-economic status. The two-tier system that has been in existence in South Africa has widened the gap between the rich and the poor, with the poor failing to access health care due to affordability issues. Through NHI implementation, the poor can now also access health care.

In terms of scarcity, the study found that the South African health system has always been characterised by scarcity in terms of medication and human resources. Thus, through NHI implementation these issues would be addressed since it is solely the responsibility of the government with the support of the district and provincial structures to distribute health professionals and medication. Medication supplies would be made available through the Stock Visibility System which is done electronically and ensures that stock ordering is timely.

Another benefit of NHI implementation was found to be comprehensive care provision, and the sub-themes that were generated include preventative, promotive, curative, and rehabilitative health care. The study found that through government interventions in line with the NHI implantation in South Africa, the citizens are guaranteed comprehensive care. The interventions in line with this include the Ward Based

Primary Health Care Outreach Teams and the Integrated School Health Programme as discussed in the study findings (Section 4.2.2).

5.2.2 The Possible Challenges that may affect the Effective Implementation of NHI in South Africa

This study set out to identify the possible challenges that may affect the effective implementation of the NHI in South Africa. The study findings have shown that there are financial and human factor problems that are likely to affect successful implementation of NHI in South Africa. The financial challenges include NHI financing and cost inflation. The NHI financing challenge emanates from the fact that the NHI Bill and the NHI policy are both silent on the sources of funds for the implementation of NHI. The possible source of financing the NHI in South Africa is through taxation, which may not be enough to cater for the health needs of the population towards achieving universal health care for all.

In addition, the study found that the human factor problems that may affect successful implementation of NHI in South Africa include government capacity to spearhead NHI implementation, unequal distribution of health professionals and lack of knowledge regarding roles and responsibilities. The government has always been criticised for lack of capacity and good governance, thus making it a challenge for NHI implementation since the government is responsible for ensuring access to health care through the implementation of various programmes and initiatives at district, provincial and national level.

The study also found that South Africa has always been characterised by unequal distribution of health professionals as discussed in the preceding chapter, with many health professionals being concentrated within the urban areas and the rural areas are often neglected. Therefore, the possible challenge is that the successful implementation of the NHI may not be balanced. People in the urban areas would benefit more than their rural counterparts. Thus, there is an urgent need to balance the distribution of the health professionals throughout the country. Lack of knowledge regarding the roles and responsibilities of the health professionals within the NHI implementation was also found to be a possible challenge as the professionals would

not be able to fully execute their mandate. The study also found that the major challenges confronting the health system in South Africa which are corruption, wastage of resources and mismanagement of results if left unattended, may possibly affect the success of NHI implementation.

5.2.3 Recommendations based on the Study on how the NHI can be Sustainably Implemented

This study also sought to give recommendations on how the NHI can be implemented in a sustainable way in South Africa. The realisation of this aim was based on the study findings as well as this present chapter as recommendations would be proffered. The study results recommend the need for proper and effective monitoring and evaluation of NHI implementation to track progress and challenges. The monitoring and evaluation process should not be once-off but needs to be continuous to enable the government to identify problems at an early stage and address those problems in a timely manner. The government should also focus on the establishment and maintenance of a single IT system that keeps patients' data for easy access from the health practitioners. Focus should also be on breaking the monopoly of health care service delivery and allow everyone to compete for users. Since there is a shortage of health practitioners, government's focus should also be on training more health practitioners to address this shortage.

Notably, this may be a difficult process which will consume most of the finances since the current system is infiltrated by corruption and mismanagement (Sithole, 2015). Consequently, it may be difficult for the government to improve the current health system. Thus, channelling resources to the establishment of an efficient and effective NHI system may be beneficial although it may not be guaranteed that corruption and mismanagement will be addressed as there are no clear indications of how they will be addressed.

5.3 CONCLUSION

The results of the implementation of the NHI cannot happen overnight, there is a lot of effort that is needed to ensure successful implementation. From the data that was collected through document analysis, this study concludes that implementation of the

NHI is beneficial in South Africa as it affords all of the South African citizens an opportunity to access health care. The implementation of the NHI focuses on addressing inequality and scarcity of resources that has characterised the South African health system for ages. Notably, the citizens would benefit from NHI as they would be able to access comprehensive health care which is affordable and accessible.

However, the issue of equality is debatable as the private and the public health facilities cannot be offering the same services. In achieving equality there is a need for equal distribution of resources, both human and material resources including medication and equipment between the rural and urban heath care facilities.

The study concludes that it is possible for the government to successfully implement the NHI scheme in South Africa only if the possible challenges are to be addressed to avoid hiccups in implementation. The major barriers which are corruption, mismanagement, shortage of health practitioners and mismanagement need to be addressed. If all these barriers are removed, implementation would be effective. The involvement of all stakeholders is also vital in ensuring successful implementation of the NHI as they each have knowledge and expertise that the government can tap into. Therefore, collaboration is necessary.

5.4 RECOMMENDATIONS

This section of the study focuses on proffering recommendations based on the study findings.

5.4.1 Baseline Survey

This study recommends the commissioning of a baseline survey to find out the problems of the health care system in South Africa. If this baseline survey is conducted and the problems are addressed, focus should then be channelled towards addressing those identified problems so that the NHI cannot be susceptible to the same problems. This may increase the chances of successful implementation of an effective and efficient system.

5.4.2 Strengthen accountability

The results of this study have shown that there is poor accountability within the healthcare sector in South Africa. This study therefore recommends the government to be accountable towards users of health care facilities and the public at large as a way of supporting effective and sustainable implementation of the NHI. Focus on accountability in implementing the NHI in South Africa needs to be strengthened as it will yield positive results in as far as access to universal health care is concerned.

5.4.3 Strengthening Monitoring and Evaluation

As health policies are proffered, there is a need to monitor implementation. Thus, this study recommends strengthening of the monitoring and evaluation mechanisms to check on the progress and setbacks in relation to NHI implementation. The Department of Health should ensure regular monitoring and evaluation at district, provincial and national level so that the issues that threaten successful implementation of NHI in South Africa can be tackled earlier before they escalate to huge problems that may take forever to mend. For instance, the National Department of Health can support the provincial department in carrying out the monitoring and evaluation exercise whilst the provincial departments support the districts.

In addition, these evaluations can be conducted annually to determine the areas of success and failure. The district, provincial and national officials can therefore support each other in addressing the failures if any. This will be a great initiative towards ensuring successful implementation of NHI in South Africa.

5.4.4 Building Capacity

One of the possible challenges of NHI implementation in South Africa relates to capacity of the government in facilitating the implementation process. Thus, this study recommends the need to build government capacity. Building the capacity to implement the scheme has to do with the government capacitating and strengthening health facilities' managers in NHI implementation.

5.4.5 Financing the National Health Insurance

Another possible challenge of the NHI implementation that was identified in this study is the financing challenge. Both the NHI bill and the NHI policy are silent on financing the NHI, the only sources of funding that the government is relying on is taxation. This study therefore recommends the establishment of other NHI financing sources to ensure effective implementation of the NHI.

5.4.6 Training and Skills Development

Since this study found that there is a lack of knowledge regarding the roles and responsibilities of the health workers about NHI implementation, there is therefore a need for training and skills development. The study recommends skills and training development to capacitate all the stakeholders who support NHI implementation. The training can be conducted at district level so that the WBPHCOTs can also be trained on their roles and how they fit within NHI implementation. The rationale for this recommendation is that when people are knowledgeable about what is expected of them, they are likely to be productive, hence contributing positively to the success of NHI implementation in South Africa.

It is imperative to focus on training more health professionals. This may be done as a collaborative initiative by both the government and the private sector through awarding of scholarships for health-related programmes at tertiary level. The health professionals and the administrative staff also need training on implementation of the NHI system. This will aid in sustaining the system since all the staff will be well versed with what needs to be done, thus ensuring the yearned universal access and limiting poor service delivery at district and national level.

5.4.7 Focus on Rural Areas' Health Facilities

The rural areas are more neglected in relation to health care facilities in South Africa. Thus, this study recommends that government focus and put more efforts towards improving infrastructure and resource availability within the rural areas to ensure equal access to universal health care.

5.5 IMPLICATION OF THE FINDINGS FOR POLICY

There is probably a need to review the NHI policy and the NHI bill and some legal statutes regarding provision of health care in South Africa. The policies on NHI should provide detailed information regarding its implementation and financing. Health care facilities and health care professional should adhere to the provisions of the policies. The Department of Health should continuously monitor and evaluate the implementation to determine effectiveness.

5.6 FUTURE RESEARCH

For future research, this study suggests the collection of primary data by interviewing health care professionals to determine the benefits and challenges associated with the implementation of the NHI scheme in South Africa. This may provide better insight into the proposed NHI. For future research, there is also need for studies with mixed methods approach on the NHI implementation where input from other stakeholders can be sourced. The possible topics for future research include:

- Perceptions of health care professionals on the benefits and challenges of NHI implementation in South Africa.
- Implementation of the NHI in South Africa: An analysis of progress towards achieving universal health care.

5.7 CHAPTER SUMMARY

This chapter is the last chapter of the study. Therefore, the focus was on summarising the whole study as well as concluding the findings of the study. The implication of the study findings for policy were also discussed. In this chapter of the study, recommendations were also proffered. Lastly, the study suggested areas for future research.

References:

Abdirahman, A. S. 2018. Factors influencing the sustainability of universal health coverage in vulnerable livelihoods in Kenya: A case of Wajir County. Unpublished Masters Dissertation. Nairobi: University of Nairobi.

Adams, L. A. 2013. *Research ethics*. Available online at https://depts.washington.edu/bioethx/topics/resrch.html. [Accessed 8February 2020].

Adejumo, O. & Archibong, U. 2013. Affirmative action in South Africa: Are we creating new casualties? *Journal of Psychological Issues in Organizational Culture,* 3: 14– 27.

Adu-Gyamfi, S., Adjei, P. O. & Owusu-Ansah, D. 2013. Preventive healthcare strategies and impact among the Asante people of the early twentieth century gold Coast: A historical narrative and lessons for the present sanitation challenge in Kumase. *Journal of Studies in Social Sciences*, 5(2): 214-238.

Agyemang, K. K., Adu-Gyamfi, A. B. & Afrakoma, M. 2013. Prospects and challenges of implementing a sustainable national health insurance scheme: The case of the Cape coast metropolis, Ghana. *Developing Country Studies,* 3(12):140-148.

Agyemang, K.K. Adu-Gyamfi, A.B & Afrakoma, M. 2013. Prospects and Challenges of Implementing a Sustainable National Health Insurance Scheme: The Case of the Cape Coast Metropolis, Ghana. *Developing Country Studies. Vol.3 (12) pp 140-148.*

Agyepong, I. A. 2011. Building National health Insurance: Lessons from Ghana. In: W. Nkem, ed. *Joint Learning Network*. 2011. Available online at: http:// www.jointlearningnetwork.org/news/building-national-healthinsurance-lessons-from-ghana1. [Accessed on 17 May 2020].

Alhassan, R. K., Nketiah-Amponsah, E. & Arhinful, D. K. 2016. A Review of the National Health Insurance Scheme in Ghana: What Are the Sustainability Threats and Prospects? *PLoS ONE,* 11(11):1-16.

Alvi, M. H. 2014. A Manual for Basic TecNHIques of Data Analysis and Distribution. Available online at: https://mpra.ub.uni-muenchen.de/60138/. [Accessed 14 January 2020].

Amado, L., Christofides, N., Pieters, R. & Rusch, J. 2012. National health insurance: a lofty ideal in need of cautious, planned implementation. *South African Journal of Bioethics and Law*, 5(1):4-10.

Amathole District Municipality. 2017. Annual Report 2016/17. http://www.amathole.gov.za on Accessed on 26 November 2020.

Amathole District Municipality. 2019. *Annual Report 2018/19*. Available from: http://www.amathole.gov.za. [Accessed 14 April 2020].

Armocida, B., Formenti, B., Ussai, S., Palestra, F. & Missoni, E. 2020. The Italian health system and the COVID-19 challenge. *Lancet Public Health 2020.* Available online at: https://doi.org/10.1016/S2468-2667(20)30074-8. [Accessed 17 April 2020].

Arpoh-Baah, B. 2011. *Assessing financial sustainability of national health insurance scheme (NHIS) in Ghana. Case study: Mpohor Wassa East Mutual Health Insurance scheme.* Unpublished Masters Dissertation. Kumasi, Ghana: Kwame Nkrumah University of Science and Technology.

Averill, C. .2013 *Universal health coverage: Why health insurance schemes are leaving the poor behind.* UK: Oxfam International.

Baleta, A. 2012. South Africa rolls out pilot health insurance scheme. *Lancet,* 379(9822):1185.

Barroy, H,.Jarawan, E., & Bale, S. 2014. Universal Health Coverage for Inclusive and

Bonfrer,I. 2015. *Evaluating Health Care Financing Reforms in Africa.* Ipskamp Drukker. Accra.

Bongongo, T., Ndimande, J. V., Ogunbanjo, G. A., Masango-Makgobela, A. T., Nyalunga, S. N. & Govender, I. 2019. Awareness of the Ward Based Outreach Team and the services offered by the programme in the Tshwane health district, South Africa. *South African Family Practice*, 61(1): 1-4.

Bowen, G. A. 2009. Document Analysis as a Qualitative Research Method. *Qualitative Research Journal,* 9 (2): 27- 40.

Braun, V. and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3 (2): 77-101.

Brauns, M. & Stanton, A. 2016. Good governance and the implementation of national health insurance in the public health sector: a case of South Africa. *Journal of Governance and Regulation,* 4(4): 17-25.

Brophy, D. M. 2015. *Occupational challenges faced by nursing personnel at a state hospital in Cape Town, South Africa.* Unpublished Masters Dissertation. Cape Town: Cape Peninsula University of Technology.

Bryman, A. 2016. *Social Research Methods*. 5th ed. New York: Oxford University Press.

Burger, R. & Christian, C. 2018. Access to health Care in post-apartheid South Africa: availability, affordability, acceptability. *Health Economics, Policy and Law,* (2(3): 1-13.

Burns, N. & Grove, S.K. 2003. *The Practice of Nursing Research: Conduct, critique and utilisation*. Toronto: WB Saunders.

Byl, S. 2011. Funding NHI: a spoonful of sugar? Available online at: http://www.kpmg.com/ZA/en/ IssuesAndInsights/ArticlesPublications/General-Industries-Publications/Documents/ KPMG%20NHI%20Economic%20Impact%20Research%20brochure.pdf. [Accessed 08 February 2020].

Chevreul, K., Brigham, K. B., Durand-Zaleski, I. & Hernández-Queved, C. 2015. France Health system review. *Health Systems in Transition*, 17(3): 1–218.

Clarke, L. & Masson, V. 2017. *Shocks, stresses and universal health coverage: Pathways to address resilience and health.* London: Overseas Development Institute.

Constitution of the Republic of South Africa. (1996). Constitution of the Republic of South Africa. Pretoria: National Government Press.

Creswell, J. W. & Creswell, J. D. 2018. *Research design: qualitative, quantitative and mixed methods approaches*. 5th ed. Singapore: Sage Publications.

Creswell, J. W. 2014. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. 4th ed. California: Sage Publications.

Creswell, J. W. 2015. *A Concise Introduction to Mixed Methods Research*. USA: Sage Publication.

Cylus, J., Richardson, E., Findley, L., Longley, M., O'Neill, C. and Steel, D. 2015. United Kingdom: Health system review. *Health Systems in Transition*, 17(5): 1–125.

Dahms, J. 2014. *Financing South Africa's National Health Insurance: The impact on the taxpayer*. Unpublished Honours Dissertation. Potchefstroom: North-west University.

Dayan, M., Ward,D., Gardner, T and Kelly, E. 2018. *The NHS at 70: How good is the NHS?* https://www.nuffieldtrust.org.uk/research/the-nhs-at-70-how-good-is-the-nhs. Accessed on 21 August 2020.

De Vos, A., Strydom, H., Fouche, C. & Delport, C. 2011. *Research at the Grassroots: For the Social Sciences and Human Service Professions*. 4th ed. Pretoria: Van Schaik Publishers.

Department of Health (DoH). 2011. *National Health Insurance in South Africa Policy Paper*. Pretoria: Department of Health.

Department of Health (DoH). 2019. *Evaluation of the phase 1 implementation of the interventions in the National Health Insurance pilot districts in South Africa: Final evaluation report.* Pretoria: Department of Health.

Department of Planning, Monitoring and Evaluation. 2017. Annual report. Retrieved from: https://nationalgovernment.co.za/department_annual/193/2017-department:-planning-monitoring-and-evaluation-annual-report.pdf. Accessed on 27 September 2020.

Devi, P. S. 2017. *Research Methodology: A handbook for beginners*. Chennai: Notion Press.

Edmonds, W. A. & Kennedy, T. D. 2017. *An Applied Guide to Research Designs: Quantitative, qualitative and mixed methods.* 2nd ed. Los Angeles: Sage Publications.

Erasmus, D., Ranchod, S., Abraham, M., Carvounes, A. & Dreyer, K. 2016.*Challenges and opportunities for health finance in South Arica: A supply and regulatory perspective.* Place:??Insight Actuaries and Consultants.

Feza, N. 2015. Qualitative Data analysis. In C. Okeke and M. van Wyk (Eds) *Educational Research: an African Approach, 458-475*: Oxford University Press: Southern Africa. Pp??

France, and Japan. Oxford University Press. New York.

Fraser, K., Taylor, D. and Kelly, J. 2011. *National Health Insurance in South Africa: Implications for equity*. Honours dissertation. Durham, NC: Duke University.

Freeman, M. Simmonds, J.E & Parry, C.D.H. 2020. Health promotion: How government can ensure that the National Health Insurance Fund has a fighting chance. *The South African Medical Journal. Vol*. 110(3): pp 12-24.

Frogner, B. 2010. Health and Economic Gains: What is at stake in South Africa´s Health Reform? *World Medical and Health Policy*, 2(3): 2010.

Fryatt, R. 2011. *National Health Insurance conference: "Lessons for South Africa". National Consultative Health Forum.* Pretoria: Department of Health, Republic of South Africa, 34.

Fusheini, A. Marnoch, G & Gray, A. 2017. Stakeholders Perspectives on the Success Drivers in Ghana's National Health Insurance Scheme – Identifying Policy Translation Issues. *International Journal of Health Policy and Management: Vol 1(11): pp 24-44.*

Fusheini, A. & Eyles, J. 2016. Achieving universal health coverage in South Africa through a district health system approach: Conflicting ideologies of health care provision. *Health Services Research,* 16: 558.

Gabrielian, V., Yang, K. & Spice, S. 2008. Qualitative Research Methods. In K. Yang & G. J. Miller (eds). 2008. *Handbook of Research Methods in Public Administration.* Florida: Auerbach Publications.

Gani, S. 2015. *Factors influencing the financing of South Africa's National Health Insurance.* Unpublished Masters Dissertation. Pretoria: University of South Africa.

Gasa, V. G. & Mafora, P. 2015. The secondary sources of data. In M. M. Wyk, (ed). *Educational Research.* Cape Town: Oxford University Press Southern Africa.

Gravetter, F. J. and Forzano, L. B. 2018. *Research Methods for the Behavioural Sciences*. 6th ed. New York: Cengage Learning.

Grosios,K, Gahan, P.B & Burbidge, J. 2010. Overview of healthcare in the UK. *EPMA Journal* 1(1) PP 529-534.

Guba, E.G. & Lincoln, Y.S. 1994. Competing Paradigms in Qualitative Research. In N.K. Denzin & Y.S. Lincoln (Eds). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage. Pp?

Hammond, M. & Wellington, J.J. 2013. *Research Methods: The Key Concepts*. London: Routledge.

Heywood, M. 2014. *The Broken Thread: Primary health care, social justice and the dignity of the health worker*. Johannesburg: Political Studies Department, Witswatersrand University.

Hofman, K. J., McGee, S., Chalkidou, K., Tantivess, S. & Culyer, A. J. 2015. National Health Insurance in South Africa: Relevance of a national priority-setting agency. *South African Medical Journal*, 105(9): 739-740.

Hsiao, A., Vogt, V. & Quentin, W. 2019. Effect of corruption on perceived difficulties in healthcare access in sub-Saharan Africa. *PLoS ONE*,14(8): 1-12.

Kahn, K. 2011. Population health in South Africa: Dynamics over the past two decades. *Journal of Public Health Policy,*32: 30–36.

Kama, Z. S. 2017. *An evaluation of access to health care: Gugulethu Community Health Clinic*. Unpublished Master of Technology Treatise. , Cape Town: Faculty of Business Cape Peninsula University of Technology.

Kamndaya, M., Thomas, L., Vearey, J., Sartorius, B. & Kazembe, L. 2014. Material deprivation affects high sexual risk behavior among young people in urban slums, South Africa. *Journal of Urban Health,* 91: 581–591.

Khanyile, S. 2009. NHI proposal to lift tax by R100BN: task team set up to look at public- private solutions*. Cape Times*. 9 June, 2008.

Kipo-Sunyehzi, D. D., Ayanore, M. A., Dzidzonu, D. K. & Yakubu, Y. A. 2020. Ghana's journey towards Universal Health Coverage: The role of the National Health Insurance Scheme. *European Journal of Investigation in Health Psychology and Education*, 10: 94-108.

Kornai, J. & Eggleston, K. 2001. Choice and Solidarity: The Health Sector in Eastern Europe and Proposals for Reform. *International Journal of Health Care Finance and Economics*, 1(1): 59-84.

Kumar, R. 2011. *Research Methodology: A step-by-step guide for beginners*. New Delhi: Sage Publications India Pvt Ltd.

Light, D. W. 2003. Universal health care: Lessons from the British experience. *American Journal of Public Health*, 93(1): 25-30.

Loh, J. 2013. Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *The Qualitative Report*, 18(33): 1-15.

Mack, Z. L. 2011. *A critical analysis of the suitability of a national health insurance scheme in South Africa*. Unpublished Masters Dissertation. Cape Town: Cape Peninsula University of Technology.

Maguire, M. & Delahunt, B. 2017. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars*. Journal of Teaching and Learning in Higher Education*, 8(3): 3351-33514.

Maillacheruvu, P. & McDuff, E. 2014. South Africa's Return to Primary Care: The Struggles and Strides of the primary Health Care System. *The Journal of Global Health,* 4(8): 438-440.

Maphumulo, W. T. & Bhengu, B. R., 2019. Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis*, 42(1): 1-9.

McI ntyre, D & Van den Heever, A. 2007.South African Health System. *South African Health Review, Vol.* 1 (1): p. 71 – 87.

McIntyre, D., Theide, M., Nkosi, M., Mutyambizi, V., Castillo-Tiquelme, M., Gilson, L., Erasmus, E. & Goudge, J. 2007. Shield work package 1 report: A critical analysis of the current South African health system. Available online at: http://web.uct.ac.za/depts/hue/SHIELD/reports/SouthAfrica1.pdf . [Accessed on 08 February 2020].

McLaughlin, E. 2016. Data collection. Available online at: searchcio.techtarget.com/definition/data-collection. [Accessed on 10 March 2020].

Miani, A., Burgio, E., Piscitelli, P., Lauro, R. & Colao, A. 2020. The Italian war-like measures to fight coronavirus spreading: Re-open closed hospitals now. *EClinicalMedicine*. Available online at: https://doi.org/10.1016/j.eclinm.2020.100320 [Accessed 17 April 2020].

Mills, A.J. 2002. Studying the Gendering of Organizational Culture Over Time: Concerns, Issues and Strategies'. *Gender, Work & Organization*. Vol .9(3): pp 286-307.

Minerikar V. & Minerikar S. 2014. Research communication: A note on exploratory research. *AWheshkar*, 17(1): 95-96.

Mishra, S. B. & Alok, S. 2017. *Handbook of research methodology: A compendium for scholars and researchers.* New Delhi: Educreation Publishing.

Mitnick, B. 1975. The theory of agency: The policing paradox and regulatory behaviour. *Public Choice*, 24(1): 27-42.

Mokoele, J.M., 2012. 'Efficiency indices and indicators of poor performance among emerging small scale pig farmers, Limpopo, South Africa', *Onderstepoort Journal of Veterinary Research 81(1), PP 23-31*.

Mokoena, M. J. 2017. *Perceptions of professional nurses on the impact of shortage of resources for quality patient care in a public hospital: Limpopo Province.* Unpublished Master of Arts Dissertation. Pretoria: University of South Africa.

Mytton,O.T. Jackson, C. Steinacher, A. Goodman,A. Langenberg,C. Griffin, S. Wareham, N & Woodcock, J. 2018. The current and potential health benefits of the National Health Service Health Check cardiovascular disease prevention programme in England: A microsimulation study. *PLoS Med Journal.: 15(3).* Pp 132-144.

Naidoo, S. 2019. NHI plan will create another state monopoly, warns Wits professor. *Moneyweb,* 14,March. Available online at: https://www.moneyweb.co.za/news/soth-

africa/nhi-plan-will-create-another-state-monopoly-warns-wits-professor/ [Accessed on 15 November 2020].

Nassaji H. 2015. Qualitative and descriptive: Data type versus analysis. *Language and Teaching Research,* 19(2):129-132.

National Planning Commission, South Africa. 2015. *Diagnostic Overview*. Available online at: http://www.education.gov.za/Portals/0/Documents/Publications/National%20Planning%20Commission%20Diagnostics%20Overview%20of%20the%20country.pdf?ver=2015-03-19-134928-000 [Accessed 10 September 2019].

Neuman, L.W. 2011. Social Research Methods: Qualitative and Quantitative Approaches. DOI: 10.2307/3211488. Accessed on 21 June 2020.

Ngqolowa, D. D. 2017. *Legal Framework Regulating the National Health Insurance Scheme: Prospects and Challenges*. Unpublished Masters Dissertation. Polokwane: University of Limpopo.

Olivera, A. & Velasco, M. 2014. Delivering on the Promise of Performance Monitoring and Evaluation. In D. Plaatjies, ed. *The Future Inheritance: Building State Capacity in Democratic South Africa*, pp. 292-312, Johannesburg: Jacana.

Papanicolas, I., Mossialos, E., Gundersen, A., Woskie, L. & Jha, A. K. 2019. Performance of UK National Health Service compared with other high income countries: Observational study. Available from: | doi: 10.1136/bmj.l6326. [Accessed on 14 April 2020].

Parliament, S.A., 2003. National Health act no. 61 of 2003. Pretoria: Government Printers.

Passchier, R. V. 2017. Exploring the barriers to implementing National Health Insurance in South Africa: The people's perspective. *South African Medical Journal*, 107(10):836-838.

Pillay-Van Wyk, V., Msemburi, W., Laubscher, R., Dorrington, R. E., Groenewald, P. & Glass, T. 2016. Mortality trends and differentials in South Africa from 1997 to 2012: Second National Burden of Disease Study. *The Lancet Global Health,* 4: 642–653

Rasesemola, R. M., Matshoge, G. P. & Ramukumba, T. S. 2019. Compliance to the Integrated School Health Policy: Intersectoral and multisectoral collaboration. *Curationis,* 42(1):1-8.

Republic of South Africa. 1974. The Health Professional Act. no. 56 of 1974.Government Printer. Pretoria.

Rodwin, M. A. 2011. Conflicts of Interest and the Future of Medicine: The United States,

Roodt, M. & Fleming, M. 2018. *South Africa's National Health Insurance Scheme*. Johannesburg: South African Institute of Race Relations.

Ross, S. A. 1973. The economic theory of agency: the principal's problem. *The American Economic Review,* 63(2): 134-139.

Sahn, D.E. 2013. Health Poverty and Economic growth: An introduction. *African Development Review,* 24(4): 267-269.

Sahu, P. K. 2013. *Research Methodology: A guide for researchers in agricultural science, social science and other related fields*. West Bengal: Springer Publishers.

Sapsford, R & Jupp,V. 2006. Data Collection and Analysis. DOI:10.4135/9781849208802. Accessed on 30 September 2020.

Sekhejane, P. R. 2013. South African National Health Insurance (NHI) Policy: Prospects and challenges for its efficient implementation. *Africa Institute of South Africa,* Briefing 102: 1-4.

Shisana, O. 2009. No one should find health care unaffordable. *SA Media*: *1*, June 29.

Sithole, H. L. 2015. An overview of the National Health Insurance and its possible impact on eye healthcare services in South Africa. *African Vision and Eye Health*, 74(1): 1-6.

Sotuku, N. & Duku, S. 2015. Ethics in human science research. In M. M. Van Wyk, (Ed). *Educational Research.* Cape Town: Oxford University Press Southern Africa.

South Africa, Republic. 1996. *Constitution of the Republic of South Africa*. Pretoria: Government Printer.

Statistics South Africa (Stats SA). 2019. *Five Facts about poverty in South Africa*. Available online at: www.statssa.gov.za. [Accessed on 5 May 2020].

Stewart, D. W., & Kamins, M. A. 2012. *Secondary research: Information sources*

Sustainable Development. World Bank. Oxford.

Myers, M. D. 2009. "Qualitative Research in Information Systems," *MIS Quarterly* (3), pp. 241-242.

Tan, W. 2018. *Research Methods: A practical guide for students and researchers.* Singapore: World Scientific.

The South African Medical Association (SAMA). 2016. *Comments in respect of white paper for National Health Insurance for South Africa towards universal coverage*. Pretoria: The South African Medical Association.

Thyer, B.A. 2010. Introductory Principles of Social Work Research. https://dx.doi.org/10.4135/9781544364902.n1. Accessed on 27 October 2020.

Toyana, M. M. 2013. *A National Health Insurance management model to promote universal health care in South Africa*. Unpublished Masters Dissertation. Johannesburg: University of Johannesburg.

United Nations Development Programme. 2009. *Handbook on planning, monitoring and evaluating for development results.* New York: United Nations Development Programme.

Van Rensburg, H. C. J. 2014. South Africa's protracted struggle for equal distribution and equitable access – Still not there. *Human Resources for Health,* 12: 1–27.

Wahab, 2008. *What does the future hold for the NHS at 60?* BMJ.2008;337:a549. Accessed on 12 August 2020.

Weimann, E. 2013. *The National Health Insurance (NHI) in South Africa: scaling up health care provision: the consumers' perspectives*. Unpublished Masters Dissertation. University of Cape Town.

Wendimagegn, N. F. 2019. he integrated health service model: the approach to restrain the vicious cycle to chronic diseases. *BMC Health Serv Research.* 19 (3): 347-355.

Westhuizen, P., Mosoge, M.J., SwanepoelL, L.H & Coetsee, D. 2016. Organizational Culture and Academic Achievement in Secondary Schools. DOI: 10.1177/0013124505279959. Accessed on 21 July 2020.

Weston, B. H. 2006, "Human Rights." In *Encyclopaedia Britannica*. Available online at: http://www.britannica.com. [Accessed 21 May 2020]

Weston, M. 2006. Integrating generational perspectives. *Journal of Issues in Nursing*, 1192):2-15.

Witvliet, M. I., Kunst, A. E., Arah, O. A. & Stronks, K. 2013. Sick regimes and sick people: a multilevel investigation of the population health consequences of perceived national corruption. *Tropical Medicine & International Health*, 18(10):1240–1247.

World Bank. 2013. *Kenya- Health sector support project: Restructuring and additional financing.* Washington DC: World Bank.

World Health Organisation (WHO). 2010. *Health systems: improving performance*. Available online at: http://www.who.int/whr/2000/en/whr00_en.pdf [Accessed on 17 May 2020].

World Health Organisation (WHO). 2017. *Together on the road to universal health coverage: A call for action.* Geneva: World Health Organisation.

World Health Organisation. 2020. *Coronavirus disease situation report*. Available online at: http://www.who.int/whr/2000/en/whr00_en.pdf [Accessed on 23 May 2020.

Wright, G., O'Mahony, D., & Cilliers, L. 2017. Electronic health information systems for public health care in South Africa: a review of current operational systems. *Journal of Health Informatics in Africa,* 4(1): 51-57.

Yin, R.K. 2014. *Case Study Research Designs and Methods.* 5th ed. Thousand Oaks, CA: Sage Publications.

Appendices:

Appendix: A

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

Submission Author	Thandi Theodore Mahamba
Turnitin Paper ID (Ref. ID)	1468842311
Submission Title	Research Final
Assignment Title	Turnitin 2020
Submission Date	08/12/20, 20:08

Appendix: B

Editing Service: Lee Kemp

14 Carlisle St

Mount Croix

Port Elizabeth

6001

21 DECEMBER 2020

082 723 5408

TO WHOM IT MAY CONCERN

EDITING OF TREATISE: Mr T. Mahamba (s210270772)

This serves to confirm that I edited Mr Mahamba's MPhil Dev Finance Treatise.

The editing covered all aspects of language, punctuation and layout. I also crosschecked in-text referencing against the reference list. In addition, I edited a large part of the reference list.

Yours faithfully

Ms L. Kemp

B. A. (Hons English); MBA

Appendix: C

Technical Editing Service: Jason Collier

8 Ravenscraig Road

Green Point

Cape Town

8051

21 DECEMBER 2020

TO WHOM IT MAY CONCERN

TECHNICAL EDITING OF TREATISE: Mr T. Mahamba

This serves to confirm that I did a technical edit review of Mr Mahamba's MBA Treatise.
This covered page numbers, contents page, list of figures and tables.

Yours faithfully

Mr J. Collier

Appendix: D

NELSON MANDELA
UNIVERSITY

PO Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa mandela.ac.za

Chairperson: Faculty Research Ethics Committee (Human)
Tel: +27 (0)41 504 2906

Ref: [H20-BES-DEV-146] / Approval]

7 October 2020

Prof S Mago
Department: Development Studies

Dear Prof Mago,

TITLE OF STUDY: A REVIEW OF THE BENEFITS AND PROBLEMS RELATED TO THE PROPOSED NATIONAL HEALTH INSURANCE IN SOUTH AFRICA (MASTERS)

PRP: Prof S Mago
PI: TT Mahamba

Your above-entitled application served at the *Faculty Ethics Committee of the Faculty of Business and Economic Science*, (18 September *2020)* for approval. The study is classified as a negligible/low risk study. The ethics clearance reference number is **H20-BES-DEV-146** and approval is subject to the following conditions:

1. The immediate completion and return of the attached acknowledgement to Lindie@mandela.ac.za, the date of receipt of such returned acknowledgement determining the final date of approval for the study where after data collection may commence.
2. Approval for data collection is for 1 calendar year from date of receipt of above mentioned acknowledgement.
3. The submission of an annual progress report by the PRP on the data collection activities of the study (form RECH-004 to be made available shortly on Research Ethics Committee (Human) portal) by 15 December this year for studies approved/extended in the period October of the previous year up to and including September of this year, or 15 December next year for studies approved/extended after September this year.
4. In the event of a requirement to extend the period of data collection (i.e. for a period in excess of 1 calendar year from date of approval), completion of an extension request is required (form RECH-005 to be made available shortly on Research Ethics Committee (Human) portal)
5. In the event of any changes made to the study (excluding extension of the study), completion of an amendments form is required (form RECH-006 to be made available shortly on Research Ethics Committee (Human) portal).
6. Immediate submission (and possible discontinuation of the study in the case of serious events) of the relevant report to RECH (form RECH-007 to be made available shortly on Research Ethics Committee (Human) portal) in the event of any unanticipated problems, serious incidents or adverse events observed during the course of the study.
7. Immediate submission of a Study Termination Report to RECH (form RECH-008 to be made available

Please quote the ethics clearance reference number in all correspondence and enquiries related to the study. For speedy processing of email queries (to be directed to Lindie@mandela.ac.za), it is recommended that the ethics clearance reference number together with an indication of the query appear in the subject line of the email.

We wish you well with the study.

Yours sincerely

Dr A van den Berg
(secundus)

Cc: Department of Research Capacity Development
Faculty Research Co-ordinator: Lindie van Rensburg