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Health systems and social values: The case of the South African health system

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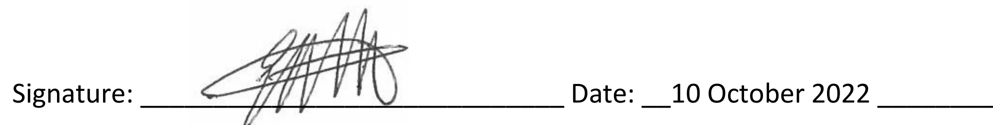
Signature:  Date: __10 October 2022 ________

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Abstract

Health systems are complex social systems – driven by people and the relationships between them, characterised by feedback loops and path-dependency, and open to contextual influences. This entails that social values are an important determinant of health system change. In addition, health systems play a vital social role as generators of social value. However, the influence of social values on health systems is an under-explored field of study, and the evidence-base on the topic is weakened by conceptual confusion, a lack of theoretical models to support rigorous research, a dearth of empirical evidence, and methodological challenges attendant to the study of intangible factors such as values.

In this theory-building study I explore the relationship between health systems and social values. Firstly, I use evidence mapping, interpretive synthesis and scoping review approaches to identify gaps in the existing evidence-base, develop an initial explanatory theory for the social value of health systems, and integrate insights from social sciences to establish a working definition of values, explore the social dynamics of values, and develop an account of the relationship between social systems – including health systems – and social values. Secondly, I conduct a case study of social values in the South African National Health Insurance policy process in its social and political context to gather empirical evidence on the role of social values in health system reform processes, and the mechanisms by which health systems shape social values. Lastly, I integrate the findings from the first two phases to develop a conceptual framework of the relationship between health systems and social values, and offer methodological and conceptual insights intended to support further research on the topic.

This study finds that social values, often borne out of social and political history, are cemented in health systems through daily practices and procedures. In this way, health systems serve to shape social values – by changing the way people think about what is just with respect to healthcare, their health rights and entitlements, and the appropriate role of the state in providing healthcare and regulating the behaviour of other health system actors.

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I am a person who worries about things – and I have been worrying about this PhD since 2017. It is not an exaggeration to say that I would not have gotten to the point of writing this acknowledgement section without the intellectual guidance, emotional support and constant encouragement of many, many people.

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It is important to me to also acknowledge the librarians at the Bongani Mayosi Health Sciences Library, in particular Wendy Smith. For me, so much of understanding new ideas involves understanding old ideas, and, at a time when one could be lulled into believing all the information you need is available on the internet, the ability to access papers and books that are only available in hardcopy, often in distant libraries, is a real privilege, and one which I do not take lightly.

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Acronyms and abbreviations

AHPSR	Alliance for Health Policy and Systems Research
AIDS	Acquired immune deficiency syndrome
ANC	African National Congress
ARV	Antiretroviral
ASGISA	Accelerated and Shared Growth Initiative for South Africa
ASSA	Actuarial Society of South Africa
CCSA	Competition Commission of South Africa
CMS	Council for Medical Schemes
COSATU	Congress of South African Trade Unions
CSSSA	Comprehensive Social Security in South Africa
DoH	Department of Health
DTC	Davis Tax Committee
FMF	Free Market Foundation
GDP	Gross domestic product
GEAR	Growth, Employment and Redistribution
GNU	Government of National Unity
GP	General Practitioner
HASA	Hospital Association of South Africa
HCFC	Health Care Finance Committee
HIV	Human immunodeficiency virus
HMI	Health Market Inquiry
HPA	Health Policy Analysis
HPSR	Health Policy and Systems Research
HSDF	Health System Dynamics Framework
HSF	Helen Suzman Foundation
HSR	Health system reform
IFP	Inkatha Freedom Party
IMF	International Monetary Fund
IRR	Institute of Race Relations
LMIC	Low- and middle-income country
MASA	Medical Association of South Africa
MCC	Medicines Control Council
MSA	Medical Schemes Act
NAMDA	National Medical and Dental Association
NDoH	National Department of Health
NEHAWU	National Education, Health and Allied Workers' Union
NGO	Non-governmental Organisation
NHI	National Health Insurance
NHIF	National Health Insurance Fund
NHRPL	National Health Reference Price List
NHS	National Health Service
OHSC	Office of Health Standards Compliance
PHASA	Public Health Assocation of South Africa
PHC	Primary healthcare
PHM	People's Health Movement
PMA	Pharmaceutical Manufacturers Association
PMTCT	Prevention of mother-to-child transmission (of HIV)

RDP	Reconstruction and Development Plan
REF	Risk Equalisation Fund
RSA	Republic of South Africa
SACP	South African Communist Party
SAMA	South African Medical Association
SANGOCO	South African Non-Governmental Organisation Coalition
SAPPF	South African Private Practitioners Forum
SHI	Social Health Insurance
TAC	Treatment Action Campaign
TRIPS agreement	Agreement on Trade-Related Aspects of Intellectual Property Rights
USA	United States of America
WHO	World Health Organization
WVS	World Values Survey

Glossary

Background ideas	The often unstated and widely taken-for-granted cognitive and normative beliefs that underlie actors' choices and institutional practices. These ideas are so pervasive that they delimit popular and policy-maker understandings of what is possible. Because they are largely unacknowledged and invisible, background ideas are resilient and resistant to change.
Complex adaptive systems	Complex adaptive systems are characterised by emergence, feedback loops, non-linear causality, openness (to contextual influences), path-dependence and sensitivity to initial conditions, and self-organisation.
Discourse	Discourses are ways of speaking and thinking that, in a particular social context, reflect, create and reproduce social realities, including meanings, assumptions and ideologies.
Emergent properties	Emergent properties are those properties of a system that are not properties of the component parts of the system. These properties emerge from complex interactions among component parts of the system.
Foreground ideas	As distinguished from background ideas (see above), foreground ideas are those explicit cognitive and normative beliefs that are strategically manipulated by policy elites to influence policy debates. Foreground ideas are regularly contested and are mutable.
Health systems	In this study health systems are conceptualised as complex social systems comprising hardware (such as financial and human resources, drugs and infrastructure) and software (including tangible software like bureaucratic procedures and expertise, and intangible software such as values and beliefs).
Ideational factors	Political and policy science scholars use the term 'ideational factors' as a blanket term for a variety of intangible factors, including ideas, beliefs, norms, values, cultural factors, discourses, arguments, metaphors and interpretations.
Institutionalism	Institutionalism is a dominant approach in political science that explains policy outcomes with reference to how political institutions and policy procedures either facilitate or prevent different actors from exerting influence in policy processes.
Institutions	Institutions are the formal and informal social rules, norms and conventions that govern individual conduct and inter-personal relations. In this sense, social institutions such as health systems and governance structures can be understood as sets of formal and informal rules and conventions that shape the beliefs and practices of the publics that interact with them.

Neoliberalism	Neoliberalism is a political and economic ideology that originated in the 1970s. Neoliberal policies include liberalisation, deregulation, privatisation, cuts in public spending on social welfare, and the introduction of cost-recovery or cost-sharing mechanisms. Neoliberalism also includes a range of normative assumptions such as distrust in the state as a funder or provider of social services; the free market as an appropriate arbiter of resource distribution; personal responsibility; individualism; freedom and choice; and austerity.
Rhetoric	Rhetoric refers to language used for persuasion and argumentation, and involves using values, norms and ideology, alongside factual claims to influence the audience's attitudes and choices.
Social values	Shared values that are common to a group of people. Social values are a product of socialisation as well as shared experiences such as historical forces, economic conditions and environmental factors, and interaction with social institutions such as legal, education and health systems.
Systems thinking	An approach to analysing health systems that considers systems as a network of subcomponents and highlights the connections and interactions between subcomponents and the impact of this interconnectedness on the capacities of the system.
Value systems	Sets of values ranked according to importance. Individuals and collectives ascribe to value systems, such that within the set of the various values ascribed to, particular values may be considered more or less important. While it is rare for a particular value to be rejected outright, values may rise or fall in priority over time, influenced by contextual events, issues and concerns.
Values	Values are universal and persistent affective ideas about what is desirable that influence or justify action or judgement, and that exist as part of a ranked set of values known as a value system.

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Introduction

> *"At the deepest level of analysis, it is value systems that are the foundations on which the superstructure of ideas and institutions are ultimately built." (Hudson et al. 2004)*

Social values in health systems

Because health systems are social systems, driven by people and the relationships between them, values influence health systems in myriad ways (De Savigny *et al.* 2009, Gilson *et al.* 2011, Sheikh *et al.* 2021). Values influence the behaviour of healthcare workers and other implementers (Franco *et al.* 2002, Walker *et al.* 2004), shape relationships between health system actors (Marchal *et al.* 2012), inform policy-maker decisions (Russell *et al.* 2008, Greenhalgh *et al.* 2009), shape the allocation of health resources (Kluge *et al.* 1998, Maseko *et al.* 2018), and influence the strength of inter-sectoral partnerships (Buse *et al.* 2000, Maseko *et al.* 2018). Furthermore, in Health Policy and Systems Research (HPSR) researchers sometimes refer to the social value of health systems. For example, Freedman conceptualises health systems as social institutions that "communicate norms and values" and are therefore "a vital part of the social fabric of any society" (2005). Similarly, Gilson writes that in addition to producing healthcare, health systems "are also the purveyors of a wider set of societal values and norms" (2003). The central project of this thesis is to explore the relationship between health systems and social values in order to better understand not only how social values shape health systems, but also how health systems come to have social value. The overarching research question this study seeks to answer is: *What is the relationship between health systems and social values?*

Of course, health systems are also complex adaptive systems, characterised by non-linear causality, path-dependency, and openness to contextual influences (De Savigny *et al.* 2009, Marchal *et al.* 2016). Because they are complex *social* systems, social dynamics will comprise an important facet of this complexity (van Olmen *et al.* 2010, Sheikh *et al.* 2021). As such, any account that ignores the socio-cultural complexities of health systems will be reductionist and incomplete (see Gilson 2012b, Ichoku *et al.* 2017). Accordingly, this study explicates the role of values in complex adaptive health systems *in their social and political context*.

To do so, two strategies were employed. Firstly, the focus of the study was purposefully refined to 'social values'. Perhaps reflecting the systems-level focus of HPSR, is it not uncommon for HPSR scholars to use the term 'social values' rather than simply discussing 'values' (see for example Walt 1994, Frenk 1995, Ridde 2008, Abelson *et al.* 2009, Buse *et al.* 2012, van Rensburg 2012, Sheikh *et al.* 2014, Parkhurst 2017, Vélez *et al.* 2020). While it was not clear from the preliminary literature review whether a clear conceptual distinction was being drawn between 'values' and 'social values', it was felt that honing-in on the relationship between social values and health systems as the phenomenon of interest would enable insight into health systems as social institutions embedded in social contexts, that might be obscured by a focus on values more generally. As such, the phenomenon of interest in this study is the relationship between social values and health systems. Refining our understanding of the distinction and relationship between values and social values, was an important aspect of the overall project, and is discussed at length in Chapter 3.

Secondly, the case examined in the empirical portion of this study – the South African National Health Insurance (NHI) policy process – was purposefully selected to allow for the examination of a system-

level intervention with an explicit value-based rationale and a well-recognised connection to the country's social and political development. By analysing the influence of social values in a real-world example of a health system reform (HSR) process in its social context, the study is able to explore the influence of social values on the health system, while simultaneously identifying ways in which the system itself influences social values, resists change and shapes the relationship between citizens and the state. In other words, this approach enables insight into how social values operate in complex social health systems.

In addition to a view of health systems as complex social systems, this study adopts a social constructivist epistemological perspective. Social constructivism is a relativist epistemological stance in that it understands reality to be subjective, context-dependent, and subject to change, as opposed to objective and immutable. As a particular branch of relativism, constructivism holds that the way we understand the world around us is not a reflection of how the world is in itself, but of how we are able to interpret, categorise and understand it (Larsen 2004, Harmer 2011). As such, constructivism suggests that "ideas, rather than material forces, structure our lives and construct our identities and interests" (Harmer 2011). This entails that how we understand the world is contextually specific and largely determined by our historical and cultural circumstances. This study understands health systems and health policies as socially constructed phenomena, contingent on this cultural and historical context. From this perspective, "health systems and policies are artifices of human creation, embedded in social and political reality and shaped by particular, culturally determined ways of framing problems and solutions" (Sheikh *et al.* 2011). For this reason, how health system actors interpret the policy problems and solutions, and how they seek to shape the understandings and interpretations of others, are central analytic considerations. Figure 1 illustrates the conceptualisation of health systems from this constructivist epistemic perspective.

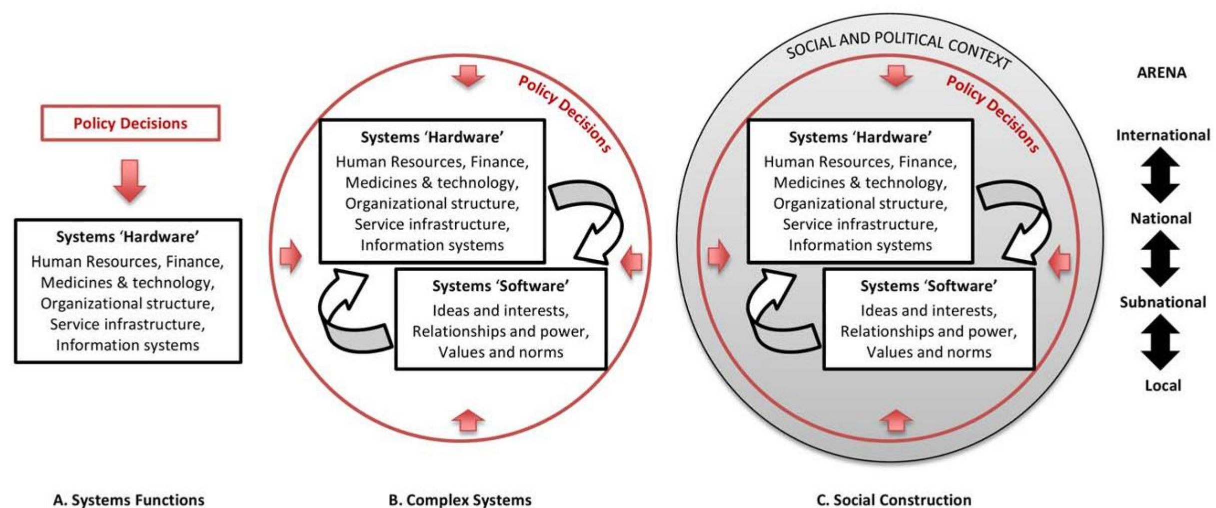

Figure 1: A social constructivist conceptualisation of health systems (Source: Sheikh et al. 2011)

This relativist stance also entails that the analysis put forward in this thesis is necessarily subjective – subject to the analyst's interpretation of the social world. A different researcher, or even the same researcher in 20 years' time, might offer a very different interpretation. Relativists cannot, and do not seek to, offer the same level of certainty as is possible in the positivist 'hard sciences' (Gilson *et al.* 2011, Grundy 2015). However, by triangulating across various types and sources of data, by consciously drawing on and testing theory, and by being reflexive in the process of analysis, the

analysis presented here endeavours to tell a convincing story that adds depth to the reader's own understanding of the social world.

Research aims

The role of social values in health systems is an under-explored area of study in HPSR. The lack of existing definitions, conceptual frameworks and theories means that there is a lot of foundational work necessary before a comprehensive body of rigorous empirical research can be developed. The work presented in this manuscript seeks to make a substantive contribution to this project. The study has three overarching and inter-related aims – to build theory, to gather empirical evidence, and to offer methodological guidance to future researchers. Firstly, with respect to the theory-building objective, the study interprets and synthesises existing evidence from HPSR and the social sciences to build an initial explanatory theory (i.e. an account of the mechanism by which social values influence health systems and vice versa, see Fischer 2003), and tests this theory through application to an empirical case. The study suggests that health systems play an important social role in that they generate social values, and that this capacity is an emergent property of health systems' complexity. Further, it suggests that social values also constrain health systems change. Secondly, with respect to the empirical objective, the study includes a comprehensive and in-depth analysis of the South African NHI policy process that reveals the particularities of the ways social values operate to shape health policy processes, and how the health system itself has served to shape social values. Lastly, with respect to the methodological objective, this study has served as a test-case for an approach to studying social values in health systems that combines an analysis of ideational factors using interpretive methods, with a focus on policy process in historical context. We present an analytical framework intended to guide researchers in more rigorously accounting for the influence of social values in health systems change processes, including as contextual factors that constrain change. Specific research objectives, and corresponding methodological approaches are presented in Table 1.

There is no doubt that the study of social values in HPSR is in its infancy and that future work will far outstrip the contribution of this manuscript. The work presented here is intended to catalyse the development of a rich repertoire of empirical evidence, and of well-grounded theory that reflects a diverse set of experiences.

Methodological approach

From a preliminary review of the HPSR literature on values and social values, it was clear that while the influence of values and social values is widely acknowledged, the evidence-base remains disjointed and under-developed. There are surprisingly few studies or papers that are explicitly values-focused, and even fewer empirical values-focused studies. In addition, most of the available evidence concerns the influence of values on one function or process of the health system – such as policy-making, implementation, or resource distribution – making it difficult to understand the dynamics of how values influence health systems. Furthermore, no consensus definition or conceptual framing seems to be emerging from the literature, and very few foundational HPSR theoretical models or frameworks explicitly account for values or offer insight into how future researchers might do so.

Given this discordance between the quantity of HPSR literature referring to values and social values, and the amount of substantive theoretical or empirical work on the topic, this theory-building study was designed to gather and synthesise existing knowledge on the topic within HPSR to develop an

initial theory, draw in conceptual insights from the social sciences, and then use an empirical case study to test and refine the theory. In order to encourage and enable the development of a stronger, more cohesive HPSR evidence-base on social values, the study culminates in the presentation of a conceptual framework to guide future research. The study is both exploratory (seeking to generate new insights into a little-understood phenomenon – the relationship between social values and health systems) and explanatory (seeking to identify the causal relationships that explain observable patterns in health systems) (Gilson 2012a).

Table 1: Research objectives and corresponding methodological approaches

Research objectives	Methodological approaches used
• To map the current HPSR evidence-base on social values	• Systematic mixed-methods evidence mapping review
• To explore conceptualisations of the relationship between health systems and social values within HPSR, and develop an initial explanatory theory for the capacity of health systems to generate social value(s)	• Interpretive synthesis of material included in the systematic evidence mapping review
• To identify insights from the social sciences with respect to the nature of values, the social dimensions of values, and the social processes that give rise to or change social values	• Interdisciplinary scoping review of social science literature on 'values' and 'social values'
• To gather empirical evidence on the relationship between social values and health systems, and test these conceptual and theoretical insights through application to an empirical case (the influence of social values on the South African NHI policy process from 1990 to 2018).	
o To develop a thick description of the case context and trace the policy process	o Interdisciplinary retrospective literature review of academic and grey literature
o To explore the influence of social values and beliefs on the South African NHI policy process	o Historical analysis and critical juncture analysis drawing on retrospective literature review
o To explore the role of social values in NHI policy rhetoric in South Africa	o Case study using discourse analysis and historical analysis
• To synthesise the insights of this research to develop analytical and methodological guidance to facilitate further rigorous research on social values in health systems.	

Phase 1: Literature review for theory-building

Phase 1 of this study is a literature review phase for theory-building and conceptual development. This phase comprises three distinct sub-studies, presented in Chapters 1, 2 and 3 of this manuscript. The first sub-study is systematic mixed-methods evidence mapping review on social values in HPSR, which identifies the evidence-gap this study is intended to fill. The results of this study are presented in Chapter 1, which was published in *Health Policy & Planning* in 2020 (Whyle *et al.* 2020). The analysis affirms the importance of social values as inputs to health system functioning by mapping the range of ways in which social values influence the behaviour and decisions of healthcare workers, managers, policy-makers and users, and shape both policies as well as programmes and services. However, this sub-study also suggests significant gaps and imbalances in the HPSR evidence-base on social values – including very limited empirical research on social values, particularly with regard to studies adopting post-positivist perspectives and employing social science methodologies that allow for the study of relational and ideational factors such values, power, ideas and language. As such, this sub-study demonstrates the substantive relevance of the overall project, and locates the contribution of this work within the broader HPSR literature on the topic.

The second sub-study is an interpretive synthesis of claims about the relationship between 'health systems' and 'social values' in HPSR literature on social values. The results of this sub-study are presented in Chapter 2, which was published in the *International Journal of Health Policy and Management* in 2021 (Whyle *et al.* 2021). This Chapter builds on the review presented in Chapter 1, using an interpretive synthesis of the included items to generate an explanatory theory for the relationship between health systems and social values. The analysis reveals four mechanisms by which health systems can produce 'social value', and suggests that the social value of health systems is an emergent product of the dynamic network of values-based interactions within the system. The mechanisms by which health systems can generate social value, and the theory that their capacity to do so is an emergent property of a dynamic network of interactions form the foundation for the case study analysis undertaken in Phase 2 of this study.

Having concluded in Chapter 1 that the HPSR evidence-base on social values could be strengthened expeditiously by drawing on existing theoretical and empirical work on social values in the social sciences, the third sub-study consists of an interdisciplinary scoping review exploring literature on social values from the social sciences. This work is presented in Chapter 3 and is not intended for publication. The analysis draws out insights from the social sciences of particular relevance to HPS researchers studying social values – including on the nature of values, the social dynamics of values, the various ways in which social institutions shape social values, and the power of policy actors to influence social values using linguistic and discursive strategies. The conceptual and theoretical insights synthesised in this Chapter are drawn on in the analysis of the case study.

Phase 2: Case study for theory-refinement

Phase 2 of this study tests the conceptual insights and theory developed in Phase 1 by applying them to the analysis of an empirical case – the influence of social values on the South African NHI policy process from 1990 to 2018. See Box 1 for a justification of the choice of case for this study.

In this Phase, in keeping with the systems thinking perspective, the study takes a broad view of health systems and assumes the health system to include public and private health sectors, in addition to the wide variety of individuals and groups that contribute to national health systems (including patients and citizens, healthcare workers, managers and decision-makers, and for-profit, and not-for-profit providers), and recognises that the health system is a product of the dynamic interaction between these actors (De Savigny *et al.* 2009, Gilson 2012a, Marchal *et al.* 2016).

In addition, this Phase of the study draws heavily on foundational concepts and analytic approaches from Health Policy Analysis (HPA). HPA is a central element of HPSR, and, in keeping with the 'social' perspective in HPSR, HPA understands health policy as people-driven processes, and focuses on the power dynamics and politics of efforts to influence health systems through policy change (Walt *et al.* 2008, Gilson 2012a, Gilson *et al.* 2018). While the focus of this sub-study is not on 'values in policy', but on 'values in health systems', HPA is an important element of this project for two reasons. Firstly, policies are the primary mechanism by which we strategically intervene to change health systems (Gilson 2012a). Accordingly, health policy processes are one aspect of health systems in which we can 'see' the influence of social values.

Secondly, HPA presents a range of methodologies and frameworks that are well suited to achieving the goals of this study. HPA is heavily influenced by the broader field of policy studies in which linear, rational models of policy-making are increasingly recognised as failing to account for the contestation and politics that characterise policy processes in the real world (Fischer 2003, Gilson *et al.* 2018). Accordingly, a positivist epistemology and a focus on rational responses to clear-cut evidence, has given way to relativist perspectives that see the social world as intrinsically open to interpretation, and focus on language, arguments and ideas, as well as the power of actors to manipulate these in line with their interests (Fischer 2003, Gilson *et al.* 2018). HPA is also informed by developments in the field of critical policy studies in which interpretive methods such as critical discourse analyse are used to explore how actors exercise power in policy processes through language and meaning-making (Fairclough 2013, Yanow 2015, Parkhurst 2017). Thus, in HPA and policy analysis more broadly, a host of interpretive methodologies are used to better understand the effect of intangible variables such as ideas, narratives, values, frames, and ideology, on policy processes (see for example Roe 1994, Schmidt 2000, 2010, Harmer 2011, Parkhurst 2012, Koon *et al.* 2016).

Box 1: The South African National Health Insurance

The Union of South Africa was created in 1910 through the unification of two British colonies and two Boer republics (Lipton 1986, Terreblanche et al. 1990). From 1948 until 1994 the country was ruled by a minority government – the National Party (NP) – which instituted the segregationist agenda known as 'apartheid' (Pauw 2021). In 1994, the African National Congress (ANC) came to power following the first democratic election. Contemporary South Africa is an upper-middle income country with a progressive constitution protecting an expansive set of social and economic rights (Francis et al. 2019). However, South African society in general, and the health system in particular reflect the country's long history of racial subjugation and segregation through colonialism and apartheid (Coovadia *et al.* 2009, Maseko *et al.* 2018). Currently, the health system comprises a public sector, funded through general taxation and serving the lion's share of the population including the most vulnerable, and the private sector, funded through voluntary contributions to medical schemes, and serving the wealthy (Rispel 2016, Ataguba *et al.* 2018).

Health system reform through the introduction of a social or national health insurance has been on the policy agenda since 1994. In fact, the introduction of NHI has been a policy position and electoral mandate for the ANC since it came to power (van Rensburg 2012, Waterhouse *et al.* 2017). However, HSR efforts have been hindered by a host of factors including global neo-liberal trends towards market-based mechanisms and the commodification of healthcare, disagreement between technical experts and political leaders, and competing priorities like HIV/AIDS (van Rensburg 2012, Waterhouse *et al.* 2017). The policy process has been contentious and politically fraught, and, despite the ANC recommitting itself to the introduction of an NHI in 2007, at the time of writing (in August 2022) the NHI is yet to be implemented (van Olmen *et al.* 2010, van Rensburg 2012, Gilson 2019).

This study takes this politically fraught policy-making context as a field of study in which to explore the complex relationship between social values and health systems. The South African NHI policy process presents an ideal opportunity to explore the relationship between health systems and social values for a number of reasons. Firstly, the extended duration of the policy processes allows for the examination of the influence of changing social and political values on the policy process, and, possibly of changing health system realities on social values. Secondly, the socially and politically contentious nature of the policy process means that value-commitments are often made explicit in arguments for and against the proposed policy. Lastly, the fact that the roots of the policy are coeval with the birth of the new democratic South Africa means that the social values invoked in policy discourse are often values of particular relevance to South Africans.

The case study phase begins with a comprehensive history of South African HSR efforts in social and political context from 1920 to 2019, presented in Chapter 4. While this Chapter is of interest in its own right as the only comprehensive history of South African HSR efforts in social and political context, in this study it also serves as a thick description of the case context, locating the case in its changing socio-political context. However, this chapter is largely descriptive, and, because it precedes the analysis of the influence of social values, it does not draw out or reveal the social values at play in the policy experience. Chapter 4 is intended for publication in *BMC Health Services Research*.

Chapter 5 draws on the historical analysis presented in Chapter 4 and uses foundational policy analysis and wider social science theory to demonstrate the influence of cognitive and normative ideas on the South African NHI policy process, and the influence of historical and contemporary healthcare

institutions on those cognitive and normative ideas. Based on the analysis of the South African health system, the Chapter demonstrates that, despite often being considered 'tools' wielded by actors seeking to affect policy change, normative ideas, including social values, can operate as independent variables to increase contestation and constrain policy change, because they become embedded in the health system in the form of practices and procedures, norms and worldviews. In other words, social values form part of the institutional, cultural and political *context* in which policy process unfold. This Chapter is intended for publication in *Health Policy and Planning*.

The final chapter of the empirical phase of this study presents a case study of social values in South African NHI policy rhetoric. Here, discourse analysis was used to identify the social values underlying NHI policy rhetoric. The results of the discourse analysis are presented in Appendix 6a. Chapter 6 itself considers each of the social values that were found to be influencing the NHI policy process, and explains, with reference to the social and political history of HSR efforts in the country, why those particular social values are salient in this policy experience. This Chapter is intended for publication in *Social Science & Medicine*.

All three case study chapters draw on the same body of evidence. This material was identified during the historical analysis through an iterative process involving electronic database searches and citation tracking for secondary data, and purposeful searches for primary data on particular events, processes and issues in the policy timeline. Secondary evidence inluded peer-reviewed academic texts on NHI, social health insurance (SHI) or HSR in South Africa in fields spanning African Studies, Anthropology, Development Studies, Global Health, Health Policy, Health Services Research, Medicine and Public Health, History, Economics, and Politics. Primary data included industry reports; policy documents; official written communication; speeches by officials in the Presidency, National Department of Health (DoH) and Treasury; political party manifestos; survey reports; media articles, and submissions to parliament by industry bodies and civil society.

Using a wide range of data sources was essential because, firstly, different types of communication reveal different values (or report values differently), and secondly because there is no way to 'validate' data on social values. For the case study, we used documentary evidence firstly, to map the policy timeline in context, and secondly to identify social values in policy discourse and rhetoric. For the historical study and process tracing, triangulating events and processes reported in the primary literature (such as media articles or speeches) against other data sources (such as peer-reviewed literature and parliamentary reports), helped to ensure validity of the extracted data. With respect to identifying the influence of social values, ensuring rigour is slightly more difficult. This is because there is no way to 'validate' policy discourse – primary and secondary forms of evidence are produced by actors with value-commitments of their own that influence how they speak and write. However, by analysing large swathes of data, it is possible to assertain whether particular arguments, social values and discourses recur across, for example, different media reports, speeches and policy documents, as well as over time. Those that do recur can be considered a 'significant' inidication of popular ideas, and therefore likely to be influencing policy processes.

Phase 3: Presentation of the conceptual framework and methodological insights

Chapter 7 integrates the findings of Phases 1 and 2. This Chapter presents an analytical framework to guide future research on social values in health system and policy change processes. The analytical framework draws attention to moments of policy decision-making in their historical context, and the

feedback loops between policy decisions, social values and health systems. Chapter 7 is intended for publication as a 'How to do...or not to do' article in *Health Policy & Planning*.

The research process

This study was prompted by two initial thoughts. The first was a sense that there were social and political complexities at play in the policy process for the South African NHI that were hindering reform efforts, and that a better understanding of what was going on would tell us something about the broader relationship between health systems and social values, beyond the South African case. The second was a feeling that values were a particularly under-studied element of HPSR 'software'.

The sequence in which each piece of work was undertaken reflects the order in which they are presented here: beginning with the systematic review and meta-synthesis of HPSR literature (presented in Chapters 1 and 2), followed by the interdisciplinary scoping review (presented in Chapter 3) – which together ensured a strong theoretical foundation for the empirical case study. While much of the 'scrounging' for relevant literature and reading of foundational theories and papers, particularly in the social science literature, was conducted prior to the formal instigation of the study, it was necessary to conduct the systematic review of HPSR first to make the substantive relevance argument for the study, and because that process helped identify the social science literature informing conceptualisations of values and social systems in HPSR.

The case study phase was begun once the literature review phase was completed and written-up. In the case study phase, the interdisciplinary retrospective literature review for the development of a comprehensive history of South African HSR efforts in social and political context was conducted first. The intention behind the historical review was to develop a timeline and history of the policy process to guide the analysis of the influence of values that would come later. Initially, this was not intended as an output of the study, as it is purely descriptive. However, given that no comprehensive history of the South African NHI in historical and political context is available, and considering that a good understanding of the policy timeline would be useful to readers of subsequent chapters, we have included it here as a research output.

After completing the historical timeline, the next analytical step was the discourse analysis to identify the social values at play in NHI policy rhetoric (presented in Appendix 6a). Once a set of social values had been identified, it was possible to undertake the process tracing and historical analysis described in Chapter 5, to explore the influence those social values on the NHI policy process. The final analytical step of the case study phase, presented in Chapter 6, was to combine the findings of the discourse analysis with the historical analysis to explain the particular social values at play in the South African NHI policy process with reference to the country's social and political history (in other words, to explain why those particular values matter in the South African context).

Finally, we developed the insights and analytical framework presented in Chapter 7 by reflecting on the research process to identify the methodological choices that were particularly enabling, and develop an analytical framework that would capture the key lessons of this study and facilitate further research on the subject of health systems and social values.

Inclusion of published papers

Two of Chapters of this manuscript comprise previously published papers, which are presented here in their published form. These include:

- Chapter 1: Whyle, E. B. and J. Olivier (2020). Social values and health systems in health policy and systems research: a mixed-method systematic review and evidence map. *Health Policy and Planning* 35(6): 735-751.
- Chapter 2: Whyle, E. B. and J. Olivier (2021). Towards an Explanation of the Social Value of Health Systems: An Interpretive Synthesis. *International Journal of Health Policy and Management* 10(July): 414-429.

In addition, Chapters 4, 5, 6 and 7 are intended for imminent publication and have been structured accordingly. However, this manuscript is not a compilation of relevant publications. All the Chapters, including those that are already published, were developed and written to contribute to the explicit and pre-determined aims of this research project. The argument of the thesis is developed sequentially. Each chapter makes a substantive contribution to the overall research project, and lays the foundation for the work conducted in subsequent chapters.

Reflexivity statement

I am a researcher with post-graduate degrees in Philosophy and Public Health. I am also a white South African with particular knowledge of, and experiences with, the South African health system. My positionality in this social and political context means that I have enjoyed various privileges, including being empowered to advocate for access to health and welfare services provided by the state, and having economic and social privileges that mean I can access private services. In fact, I was born in 1987 in one of South Africa's biggest public hospitals, where my status as a white person likely helped to ensure I received a high standard of care through a complicated delivery. On the other hand, my parents' economic status enabled them to send my siblings and I to a private school – the first multi-racial school in the country – where I enjoyed an early education protected from the political realities the country was experiencing. These and other experiences have no doubt shaped my worldview and informed my interpretation of the evidence collected for this research. The fact that this research uses interpretive methods to study social values generates particular vulnerabilities with respect to my personal biases.

To mitigate this risk, I have endeavoured to maintain a reflexive stance throughout the research process, and remain cognizant that my positionality, as shaped by my upbringing and socialization within a particular socio-political context, may introduce biases in my research. In maintaining this reflexive stance, I relied heavily on frequent conversations with my supervisor and other trusted colleagues to help ensure that alternative interpretations were duly considered. In addition, in explicating the social and political context in which this policy process unfolded, I used peer-reviewed literature from esteemed sociologists and political scientists to ground my interpretation. Further, in identifying the social values at play, I have taken care not to let my own personal values direct my investigation. This was particularly difficult given the challenges inherent in distinguishing values from ideas of other kinds. I employed a number of methodological strategies to avoid simply picking out ideas that cohered with my own values as relevant social values. Despite these efforts, it remains

undoubtedly true that the interpretation presented here is subjective, and that other interpretations are possible.

While recognizing the potential for my positionality to unduly influence this work and weaken the analysis, it is also worth noting that this project necessitated a deep knowledge of the context and a nuanced understanding of the social and political complexities at play. As such, I feel that my positionality is as much an asset as a threat to the rigour of this project.

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Chapter 1 – Social values and health systems in health policy and systems research: A mixed method systematic review and evidence map

Chapter 1: Social values and health systems in health policy and systems research: A mixed-method systematic review and evidence map

Overview: This Chapter presents the findings of a systematic mixed-methods evidence-mapping review on social values in HPSR. The Chapter demonstrates the centrality of social values within HPSR and highlights significant evidence gaps, including a lack of conceptual clarity, a mal-distribution of evidence that favours high-income contexts, a failure to draw fully on social science methodologies and relativist perspectives, and a dearth of empirical evidence on social values in health systems.

Contribution to the thesis: This Chapter makes the substantive relevance case for the thesis by demonstrating the gaps in the existing evidence-base, which this thesis will contribute to filling.

Publication status: This Chapter has been published as a review article in *Health Policy and Planning* in 2020 under the title: Social values and health systems in health policy and systems research: A mixed-method systematic review and evidence map.

Contribution of the Candidate: The candidate is the first author of this paper, while the supervisor is the second author. The candidate designed the study, collected the data, conducted the analysis, and was the lead author. The supervisor offered guidance on the data collection and analysis, and critically reviewed drafts of the paper.

Abstract

Because health systems are conceptualised as social systems, embedded in social contexts and shaped by human agency, values are a key factor in health system change. As such, health systems software – including values, norms, ideas and relationships – is considered a foundational focus of the field of health policy and systems research (HPSR). A substantive evidence-base exploring the influence of software factors on system functioning has developed, but remains fragmented, with a lack of conceptual clarity and theoretical coherence. This is especially true for work on 'social values' within health systems – for which there is currently no substantive review available. This paper reports on a systematic mixed-methods evidence mapping review on social values within HPSR. The study reaffirms the centrality of social values within HPSR, and highlights significant evidence gaps. Research on social values in low- and middle-income country contexts is exceedingly rare (and mostly produced by authors in high-income countries), particularly within the limited body of empirical studies on the subject. Additionally, few HPS researchers are drawing on available social science methodologies that would enable more in-depth empirical work on social values. This combination (over-representation of high-income country perspectives, and little empirical work) suggests the field of HPSR is at risk of developing theoretical foundations that are not supported by empirical evidence, nor broadly generalisable. Strategies for future work on social values in HPSR are suggested, including: countering pervasive ideas about research hierarchies that prize positivist paradigms and systems hardware-focused studies as more rigorous and relevant to policy-makers; utilising available social science theories and methodologies; conceptual development to build common framings of key concepts to guide future research, founded on quality empirical research from diverse contexts; and using empirical evidence to inform the development of operationalizable frameworks that will support rigorous future research on social values in health systems.

Key words: social values, health policy and systems research, evidence map

Key Messages

- A focus on health systems software, including values, norms, interests, ideas and relationships, is widely considered foundational to Health Policy and Systems Research
- The HPSR evidence-base on social values is substantive, and spans a wide variety of areas of work within the field.
- Problematically, there are significant gaps in the evidence-base with respect to low-income country contexts, and rigorous empirical work focusing on values
- Strengthening the evidence-base will require channelling resources into LMICs to enable locally-lead production of evidence utilising (often resource-intensive) social science methodologies. Continued conceptual and theoretical work is needed, but should be based on empirical evidence from diverse contexts.

"In addition to these concrete and tangible expressions of health systems, the 'software' – by which we mean the ideas and interests, values and norms, and affinities and power that guide actions and underpin the relationships among system actors and elements – are also critical to overall health systems performance" (Sheikh et al. 2011)

Introduction

It has long been recognised that health systems are social systems in which values constitute a key determinant of system change (Donabedian 1972, Lewis 1977, Roemer 1988). In the past, the understanding that health systems change is values-driven led many to question the utility of research on the organisation and delivery of health services (Lewis 1977) (see also Mechanic 1978). If changes in the system are dependent on changes in social values, rather than by research-informed intervention, it was argued, then while research may offer post-hoc explanations for system change, it cannot generate improvement in the same way that clinical research improves the practice of medicine (Myers 1973, Lewis 1977, Roemer 1988). Over the last 25 years, however, Health Policy and Systems Research (HPSR) has emerged as a distinct field of study, contributing to health systems development and improving health outcomes by providing a deeper understanding of the social structures and institutions through which health services are delivered (Remme *et al.* 2010, Yao *et al.* 2014, AHPSR 2019). As the field of study develops, theory, empirical evidence and research methodologies are emerging that reveal the role of values in health system change and may begin to indicate strategies for effective intervention.

The term 'values' is sometimes used to denote individual preferences (Shams *et al.* 2016), however within HPSR, and for the purposes of this paper, 'values' refers to the foundational normative beliefs *underlying* those preferences. In this sense, values, such as equity or autonomy, are abstract, or trans-situational, collective or cultural ideas "about what is deemed to be good or bad by a society" (Giacomini *et al.* 2004), that act as rationales for attitudes, motives and behaviours (Shams *et al.* 2016).

Because they are collectively or culturally generated and held, values are relatively stable and change-resistant (Spates 1983, Giacomini *et al.* 2004). For the same reason, while values can be held individually and shape individual behaviour, they are also socially constructed, and are often considered as characteristics of organisations and institutions, cultures, communities and societies (Rokeach *et al.* 1970, Rokeach 1974, Hofstede 1985, Minkov *et al.* 2012). Dominant values will therefore vary from country to country (Roberts *et al.* 2003).

A values-orientation has been foundational to the field of HPSR throughout its emergence and remains strongly evident in HPSR today (Sheikh *et al.* 2011, Gilson 2012a, Sheikh *et al.* 2014b). Because health systems are understood in HPSR to be social systems, shaped at all levels by human agency, and embedded in social and political contexts (Gilson *et al.* 2011b), values are recognised as an important dimension of health systems and health system change, and HPS researchers understand themselves to be producing "contextually relevant, values-driven research knowledge [for] people centred health systems" (Sheikh *et al.* 2014b).

In addition, the field is shaped by a 'systems thinking' perspective, and therefore frames the health system as a complex network of 'hardware' elements (structures, organisations, and technologies) and 'software' elements (people, relationships, cultures and values), and emphasises the interactions

and interrelationships between these systems elements, and between systems and their social and political contexts (Atun *et al.* 2008, De Savigny *et al.* 2009, Sheikh *et al.* 2011, Gilson 2012a).

Researchers in HPSR also pay close attention to the behaviours, norms, communications and relationship between actors and actor groups – acknowledged to be shaped by personal and shared values (Gilson *et al.* 2008a, Marchal *et al.* 2016) – and to issues of equity, social justice, human rights, and responsiveness to the needs and preferences of communities (Gostin *et al.* 2006, London *et al.* 2014, Gilson *et al.* 2017).

Sheikh *et al.* (2014a) argue that influencing real-world change through HPSR necessitates understanding health systems as social and political constructs, foregrounding human agency and values, and paying particular attention to context. In doing so, HPS researchers are able to understand the influence of values and generate knowledge with the potential for real-world impact. HPSR can also, therefore, contribute to promoting certain values within heath systems by "exploring the societal relevance and purpose of systems and interventions" (Sheikh *et al.* 2011), and "generating new knowledge to advance particular health systems goals" (Pratt *et al.* 2017).

As a result of this values-orientation, discussion of values pervades the HPSR literature and evidence-base. Values are highlighted in theoretical frameworks (see more below), such as the popular Health System Dynamics Framework (HSDF) (van Olmen *et al.* 2012a), and commonly applied in conceptual tools and heuristic devices such as the hardware/software distinction referenced above (Sheikh *et al.* 2011).

Values are also used to make sense of health systems change. For example, values are said to explain global trends in health system financing – as in Walt *et al.* (1994), who argue that "severe economic constraints and shifts towards neo-liberal values…have led to cuts in public health services…increased charges for health care, and liberalization of the health sector to promote private sector development". In fact, many theories of health policy change recognise that decision-makers are not entirely 'rational' actors, and therefore decision-making requires trade-offs between competing values, interests and beliefs (AHPSR 2004, Liverani *et al.* 2013, Langlois *et al.* 2018). Values are understood to shape policy-maker and public understandings of policy problems and the range of feasible or acceptable solutions to those problems (Gilson *et al.* 2011b), such as in the case of the formulation of policies to control the marketing of alcoholic beverages in South Africa, where various forms of evidence were accepted by different actors depending on their values and interests (Bertscher *et al.* 2018).

Values are also understood to shape collaboration between individuals in the health system and across health system dimensions through the establishment of trust, legitimacy, shared norms and ways of working (Bloom *et al.* 2008a), and therefore affect whether and how policies are implemented (Gilson *et al.* 2008b). Similarly, health system governance and management practices are acknowledged to be shaped by values (Fattore *et al.* 2013).

Perhaps to delineate between values understood as individual preferences and values understood as socially constructed, much of the HPSR work on values uses the concept of 'social values' (Shiffman 2007, Clark *et al.* 2012, Kieslich 2012, Koduah *et al.* 2018), or related ideas such 'dominant values' (Kehoe *et al.* 2003, Exworthy 2008, Abimbola *et al.* 2017), or 'political values' (Ham *et al.* 1994, Kruk *et al.* 2010, Broqvist *et al.* 2015). For example, Clark and Weale note that health priority-setting

requires a combination of technical judgements and social value judgements (2012). Similarly, Buse *et al.* (2012) note that for an idea to become a feasible policy solution, it must be consistent with dominant social values, and Nord *et al.* (1995) critique the unthinking application of economic evaluation techniques on the basis that it imposes a set of values out of sync with those held by most members of society. From a socio-historical perspective, Cady argues that "the mere existence of Canada's publicly funded health system is an indication of deeply held social values" (2016).

In addition to being shaped by values, health systems are understood to *have* a social value. That is, it is argued that health systems can build social cohesion, capture a sense of national identity, reinforce progressive conceptualisations of social justice, shape citizens' understandings of their rights and entitlements, or strengthen the relationships between citizens and the state (Gilson 2003, Giacomini *et al.* 2004, Freedman 2005, Kruk *et al.* 2010). For example, Gilson states, "rather than simply being shaped by the changing basis of societal values, a trusting and trusted health system can contribute to building wider social value and social order" (2003).

However, despite these indicators of the ways in which social values shape health systems and are therefore central to understanding health systems change, the HPSR evidence-base on the role of social values in health systems is relatively weak. While there is much 'values-talk' in HPSR, there seems to be little research *focusing* on values in health systems. What evidence there is, appears to be fragmented, with varied definitions and applications. For example, in publications by leading institutions such as the World Health Organization (WHO), the Alliance for Health Policy and Systems Research (AHPSR), and Health Systems Global (HSG), values are mentioned frequently but obliquely. The WHO's 2015 report on people-centred health services mentions values only as a caveat to its five recommended strategic directions, noting that strategies will need to account for local values.

Some researchers have suggested that rigorous empirical or conceptual HPSR work focusing on values remains very limited. Littlejohns *et al.* notes that the impact of social values on health policy decision-making remains unclear and is rarely recognized in a formal way (2012c). Similarly, Giacomini *et al.* argue that "despite widespread recognition of the importance of values, decision makers and stakeholders in health policy appear to disagree fundamentally over what values essentially are" (2004). Prior to the publication of Shams *et al.*'s concept mapping of values in health policy, no study had sought to systematically unpack definitions, conceptualisations and applications of values in any area of work within HPSR (2016). While Shams *et al.* made a valuable contribution, it was restricted to one aspect of the health system, so did not remedy the fragmentation of the evidence-base (2016). Furthermore, while the review systematically analysed the concept of values, data collection was not systematic, and findings were restricted to the conceptualisation of values. To date, no study has systematically mapped the evidence on social values in HPSR. This is striking given that HPSR is a values-driven field (HSG 2018), and that, as HPSR is an emergent, interdisciplinary field, there is an acknowledged need to actively and consciously develop a common language through deliberation and consensus building around key concepts, theories and definitions (Sheikh *et al.* 2011, Hoffman *et al.* 2012). We therefore undertook a systematic mixed-methods evidence mapping review of literature on social values within HPSR. The aim of this study was to describe the nature and distribution of HPSR theory and evidence on the topic, to identify gaps in the evidence-base, and to suggest strategies to guide future research.

Methods

Evidence mapping involves systematic synthesis, organisation and interpretation of a broad range of literature or evidence, using rigorous and replicable data collection strategies (Hetrick *et al.* 2010, Bonell *et al.* 2011, Miake-Lye *et al.* 2016, Danan *et al.* 2017). The approach is commonly used to describe the extent and distribution of literature on a topic, identify gaps, and indicate areas for future research, but can also be used to describe the range of study designs and methodological approaches used, and the topical areas covered, giving readers a base-line understanding of a body of evidence (Bragge *et al.* 2011, Miake-Lye *et al.* 2016). As such, evidence mapping reviews do not seek to synthesise findings or establish the strength of evidence, and therefore do not require the presentation of the results of included studies (Adam *et al.* 2018). 'Mixed-methods review' is a label given both to research that combines a review with another data collection approach, such as interviews (Grant *et al.* 2009), and to studies using review methodologies to collect both qualitative and quantitative evidence (Pace *et al.* 2012, Heyvaert *et al.* 2013). Here, we use the latter approach – employing systematic, transparent and reproducible data collection strategies (Heyvaert *et al.* 2013, Tricco *et al.* 2015) to explore and describe a range of qualitative and quantitative research on a complex subject (Pace *et al.* 2012).

As 'social values' is an abstract concept, used alternately with, and closely associated with related concepts, data collection and analysis was conducted iteratively, building the body of included literature in accordance with the researchers' developing understanding of key ideas and perspectives (see Boell *et al.* 2014, Greenhalgh *et al.* 2017). Searches were conducted systematically, with records kept of all searches. In keeping with the aim of the study, the review was limited to published peer-reviewed content, including internally reviewed reports from key institutions. To be eligible for inclusion, a paper needed to include 'social values' or a related term.

The search was conducted in five phases. Using an iterative multi-pronged data collection strategy is common for evidence mapping studies (Hetrick *et al.* 2010, Randall *et al.* 2012, Bonell *et al.* 2013, Adam *et al.* 2018), and has been used previously in review studies of HPSR literature (MacQuilkan 2016). In all five phases, searches were restricted to items in English, published within the last 20 years (roughly coinciding with the recognition of HPSR as a distinct field (Bennett *et al.* 2018)), although in phases three to five, this time limit was not strictly applied. The searches did not set geographic limits although HPSR generally has a field-based focus on low-and middle-income countries (LMICs).

<table>
<tr><td rowspan="2">String 1: HPSR</td><td>MeSH terms</td><td>Health Policy OR Public Health Systems Research OR Health Planning</td><td rowspan="2">In: Title/Abstract</td></tr>
<tr><td>Free text</td><td>health system OR healthcare system OR health care system OR health systems OR healthcare systems OR health care systems OR health policy OR healthcare policy OR health care policy OR health policies OR healthcare policies OR health care policies</td></tr>
<tr><td colspan="3">AND</td><td></td></tr>
<tr><td>String 2: Social values</td><td>Free text</td><td>Social values OR community norms OR cultural beliefs OR cultural norms OR cultural values OR dominant values OR national character OR national culture OR national identity OR political values OR public values OR shared values OR social beliefs OR societal norms OR societal values OR society norms OR society values OR value orientations</td><td>In: Text word</td></tr>
</table>

Table 1: Search strategy

The first phase of the search strategy consisted of a scoping review for work referring to 'social values' in health policy processes and health systems. During this scoping phase Google and Google Scholar were used, as well as informal consultation with field experts in public health and health policy and systems at the University of Cape Town, the University of the Western Cape, and the Institute of Tropical Medicine in Antwerp to identify relevant materials.

In the second phase, a systematic search strategy was developed for use in the PubMed, in consultation with a subject librarian, on the basis of the scoping review. Two search strings were developed, the first comprising 'social values' and variations thereof. The second string was designed to limit results to material taking a health systems perspective, and included field terms such as 'HPSR', and topic terms such as 'health system', 'policy', 'planning' (restricted to title or abstract).[1] See Table 1 for the full database search strategy. Due to the large number of results identified through the search, the 'most relevant' function was used to organize the results, and the title and abstracts of the first 600 results were scanned, after which search results became less relevant. The reference and full text of 'possibly relevant' material was downloaded to EndNote.

The third phase consisted of a systematic search of the published outputs of 23 prominent HPSR authors.[2] Authors were identified through a Scopus-based meta-analysis of the most commonly recurring authors in a search for 'HPSR OR health policy and systems research', as well as the formative scoping review, field expert consultation and database search. Most relevant publications for each author were then found through Google Scholar, through title and abstract screening.

In the fourth phase, a targeted search of key HPSR journal content was conducted (drawing from a selection of 11 journals identified by field experts). Each journal was searched using the 'social values' search string, and title and abstract screening was conducted.

Finally, we searched the publications lists of key HPS institutions – including the AHPSR, WHO, HSG, and the Collaboration for Health Policy and Systems Analysis in Africa (CHESAI) as identified by the field experts – by searching within each institutional database for the phrases in the 'social values' search string.

Materials from all five phases were gathered into an Endnote database for full-text review. After removal of duplicates, full-texts were screened to ensure the paper fell within the bounds of HPSR. Although the boundaries of the HPSR field are notoriously 'fuzzy' (Gilson 2012a, Hoffman *et al.* 2012), other studies have successfully reviewed concepts and topics within HPSR by 'bounding' their reviews (Pratt *et al.* 2017, De Allegri *et al.* 2018). This necessitates a certain level of subjectivity in selection of articles for inclusion. In this study the following criteria served as guiding principles:[3] addresses system-level issues (exclude purely programmatic or disease-focus, unless as a 'tracer' for systemic issues); utilises a prominent HPSR framework; one or more of the papers' authors list an institute or department focusing specifically on policy and systems as a primary affiliation; published in a policy

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[1] In order to keep the scope of the search manageable, and sufficiently sensitive to identify material on social values in relation to health policy and systems, a decision was made to restrict the first search string to title or abstract. This approach successfully excluded material that may mention health policy or systems, but that is primarily clinical, epidemiological or economic.

[2] 23 key authors in the field: Ghaffar, A; Gilson, L; Pratt, B; Bennett, S; El-Jardali, F; Theobold, S; George, A; Mills, A; Mirzoev, T; Tran, N; Agyepong, I A; Bigdeli, M; Marchal, B; Peters, D H; Uzochukwu, B; Adam, T; Boom, G; Daniels, K; Lehman, U; Molyneux, S; Abimbola, S; Sheikh, K; Hyder, A A.

[3] Many but not all the included papers met the initial four criteria. A few of included items met only two of these criteria.

or systems-relevant journal (so already screened through editorial and peer review). For borderline cases, two additional criteria were considered: is the other work of any of the authors largely HPSR-focused?[4], and does the reference list include a number of key HPSR texts? As a general rule, a stated focus on health systems (or issues such as policy, planning or health services), was not considered sufficient for the item to be categorised as HPSR – unless it also met one other criteria.

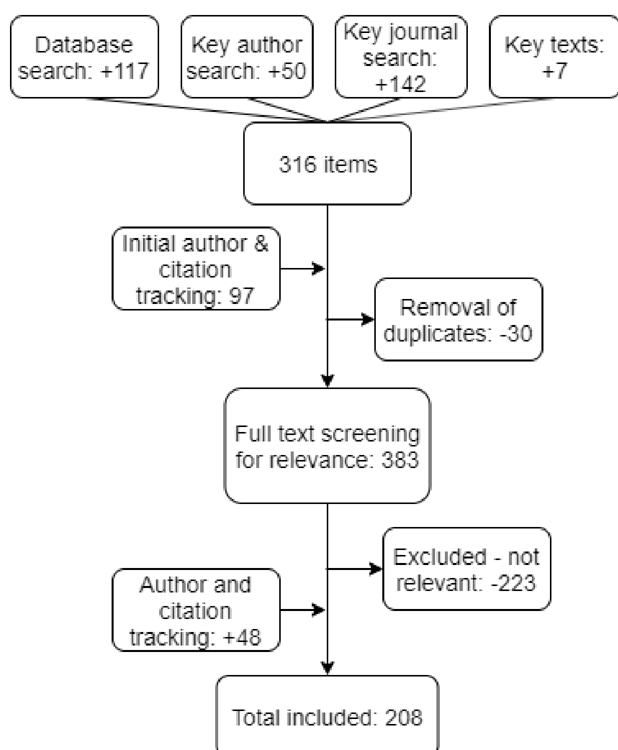


Figure 1: Flow diagram of study selection

Information from each included paper was extracted into a data extraction sheet, including: author names, publication date, publication source (e.g. journal), country of first author affiliation, topic, whether values was a main topic, disciplinary foundation, and the country of focus of the research. Data was also extracted on the suggested, demonstrated or assumed relationship between social values and the health system (synthesised into a simple relationship, but with key quotes also captured to retain the nuance of the author(s)'s phrasing).

Results

Full text screening was conducted on 430 items, with 208 identified for inclusion and coding (Figure 1). The full data extraction sheet is provided as supplementary material. A full list of reasons for exclusion is presented in Table 2. Of the 222 excluded items, 90 were categorised as 'not HPSR'. Almost half of the papers excluded on this basis consider social values in relation to healthcare or health system reforms; indicating that moments of change are liable to spur values-based reflection among various health system stakeholders and observers. Taken as a whole, this body of works reaffirms the importance of values across a wide range of health, healthcare and health system issues.

Reason for exclusion	No. papers
Not HPSR	90
Values not national/social	41
Insufficient information on values	32
Not national system focus (organisational/global)	27
Disciplinary or focused on research practice	21
No access to full text	7
Religion or theology	4

Table 2: Exclusions

The publication year of included papers spans 1994-2018, which coincides roughly with the formalisation of HPSR as a field, as does the steady increase in distribution of papers over time. Figure 2 presents the number of included papers per year, shown against a rough estimation of the growth in HPSR publications in general. The comparator graph – 'Social values' (top) – is based on a search for 'health policy and systems' and 'HPSR' and variations, conducted in Scopus. The similarity across the two trend-lines underscores the centrality of a values-orientation to the field of HPSR.

[4] This is an additional criterion because, for the most part, inclusion was decided on a case-by-case basis – i.e. a paper from a particular author might be excluded even if other work by that author was included.

Social/societal/society's values/value systems	86
Shared/community/communal/collective values/norms	26
Cultural/socio-cultural values/norms/beliefs	25
Social/societal norms	18
Public('s) values/attitudes/discourses	18
Political values/norms/culture/ideology	15
Dominant/predominant/popular/prevailing/common values	14
Ideology/worldview	13
Country/national/Country X's values	11
Citizen/democratic values	4
Local values	3
National culture/identity	3
Values orientation	2

Table 3: Terms used to denote 'social values'

The terms used to denote social or population values can be seen in Table 3, along with the number of papers using those terms. Attempts to offer a definition of ‘social values’ were exceedingly rare. Clark and Weale define social values as “the moral or ethical values of a particular society” (2012), while Stafinski *et al.* conceptualise them as the “distributive preferences of the public” (2011). Conversely Giacomini *et al.* offer a broader understanding that includes “ideologies, interests, principles [and] goals” (2004). The social values cited in the papers can be seen in Box 2. The most commonly cited social values were equity and equality, solidarity, justice and fairness.

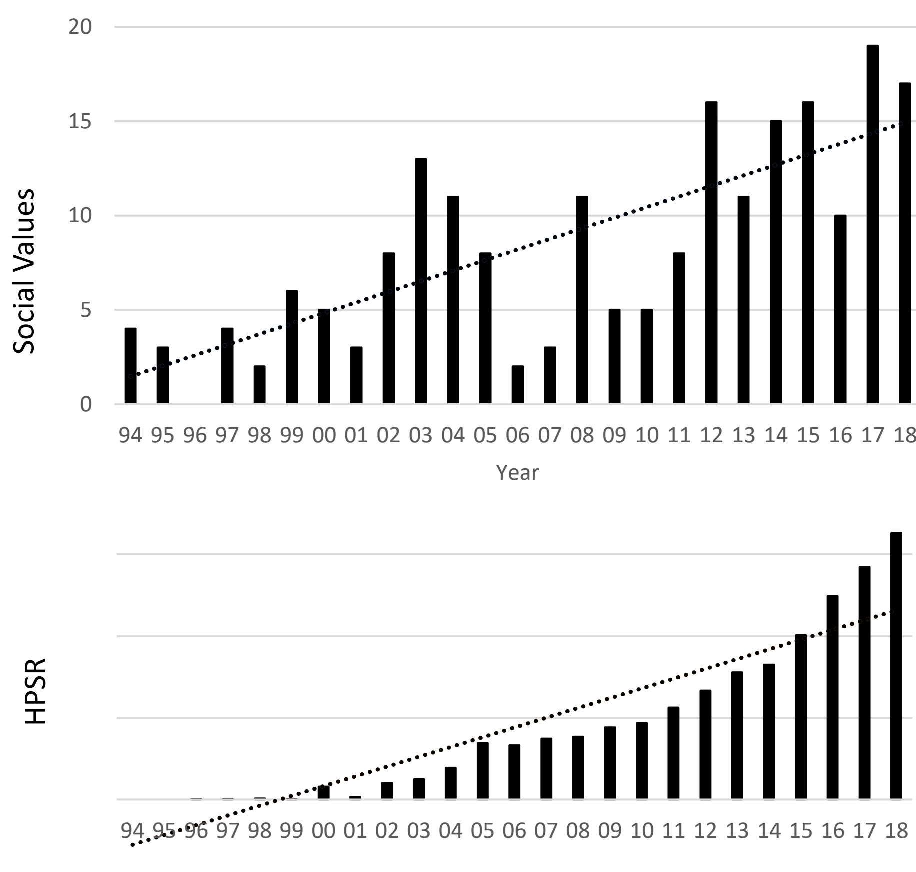


Figure 2: Number of papers per year

Equity and equality, solidarity, justice and fairness, access, autonomy, accountability, choice, transparency, participation and representation, efficiency, universality and non-discrimination, respect, quality, effectiveness, trust, and dignity.

Box 2: Commonly cited values

The relationship between health systems and social values

Across the included papers, connections are drawn between health systems and social values in various ways. We synthesised statements about the relationship between health systems and social values in terms of health system processes or functions, and health system elements or dimensions. Relational statements were analysed in the same way whether presented as a finding of empirical research, or suggested or implied in an introduction or background section. The statements were synthesised into their constituent parts – usually a connection between a dimension or element of the health systems, and a particular function or process of the health system. For example, Mou states that "collective values…are important in the politics around the public–private mix of health expenditure" (2013), and Roberts *et al.* argue that by connecting to symbols that relate to broad social values, health system actors can develop political strategies that gain them additional leverage in policy debates (2003). In other words, these authors suggest a relationship between social values and health expenditure patterns, or between social values and policy development, rather than between social values and health systems as such.

		Health system dimension or element						
		Health system	HCWs & managers	Policy	Policy-maker/elite	Intervention/ program/ service	User	Citizen
Health system process or function	Priority/agenda-setting	29		6				
	Behaviour/decision-making		36		35		14	3
	Success/effectiveness/ implementation/function	4		8		8		
	Change/reform	23		5				
	Finance/funding/resource allocation	23						
	Management/governance	2	1					
	Content/structure/framing	20		30		9		2
	Perception/expectation		2	1	8		4	10
	Goals/principles	12	2	1	1	3		

Table 4: Most commonly identified relationships

Table 4 shows the number of (included) papers suggesting a relationship between a particular health system dimension or element and the particular health system function or procedure. As this is a synthesis analysis, dimensions and functions named in very few relational statements are not presented. The most commonly suggested relationships are those between social values and the behaviour or decision-making of healthcare workers and managers. For example, Watt *et al.* show how "implementation can be constrained by…social norms shaping the interaction between providers and populations" (2017), while Berlan and Shiffman demonstrate that attempts to change implementer behaviour through information provision may have little impact because those behaviours are deeply ingrained through social norms (2012). Many papers also draw out the relationships between social values and policy-maker decision processes – such as Shankardass *et al*.'s suggestion that values "constitute the normative lens through which political elites…interpret and act upon social and political issues" (2018), and Gilson *et al.'s* claim that the "outcomes pursued by public

sector leaders are those judged as valuable by the public at large as well as by political stakeholders and policy makers" (2011a). A number of authors also identify a relationship between social values and the structure or framing of policies, such as Giacomini *et al.'s* demonstration that values can be used strategically in policy documents to declare values or demonstrate the prioritisation of one value over a competing value (2004).

Many authors identify an effect of social values on the health system as a whole through processes such as priority-setting, reforms and restructurings, financing and goal-setting. For example, Agyepong *et al.* (2017) state that values "shape the outcomes of health systems," and Sabik and Lie demonstrate that in Norway procedures have been put in place to establish shared values to inform prioritization decisions and ensure that they are in line with society's values and goals (2008). Similarly, Kieslich (2012) points out that values rooted in political traditions influence the organisational form of health systems, and Grundy (2015) argues that social values influence the direction of health system change and determine pathways for change towards universal health coverage. Claims like these underlie the common perception that values shape health systems.

The number of papers suggesting a relationship between social values and citizens' expectations and perceptions in relation to health systems – such as Mirzoev and Kane stating that public expectations are shaped by "socio-political societal views on health as a human right" (2017) – is noteworthy, and may indicate that social values constitute a mechanism by which health systems can be responsive to citizens. In the same vein, Schlesinger observes that as market-based ideologies become dominant in health policy, "these notions of fairness…become the primary way of judging equity" (2002) – suggesting a values-based relationship between citizens and the framing of health policies such that the social construction of policies drives changes in the public's understanding of what is fair and just in relation to healthcare. Similarly, Gilson states that social institutions, such as the health system, can 'promote' social values, stating, "social and political institutions embodying these norms [truthfulness, solidarity, fairness] promote affective trust in societies by committing and enforcing upon all those involved in them a specific set of values" (Gilson 2003). However, like many of the relationships presented in the table, these claims tend to be only briefly suggested or implied in the included papers, and not fully justified or explained. This analysis suggests that while the influence of values is acknowledged across a diverse array of system dimensions and functions, mechanisms of influence are rarely explicitly stated or fully explored.

Topical foci and frameworks

We applied thematic analysis to identify the topics or areas of work in which reference to social values is most commonly made. The analysis resulted in the identification of 11 recurring topics across the included studies. The most common topic was 'priority-setting' (n=38/208), which is indicative of widespread acknowledgement in HPSR that health systems are significantly shaped by resource-distribution decisions, which in turn are underpinned by social values. As Bennett and Chanfreau note, "rationing mechanisms reflect several underlying ethical theories [that] should reflect societal values" (2005). Other significant categories include health policy development, implementation or evaluation, health system analysis (including evaluation) and health system reform – collectively making up almost half of all papers. Table 5 shows the number of papers identified within each topic category.

The frameworks and conceptual tools available to researchers can influence the type of research conducted and the extent to which that research incorporates particular ideas and concepts. We

mapped the frameworks used in the included papers. The most commonly used framework is Sheikh *et al.'s* illustration of different perspectives of the subjects of inquiry within HPSR. This framework offers a conceptualisation of policy decisions as an outcome of an interplay between health system hardware elements (such as human resources, finance, etc.) and health system software elements (including ideas, power and values and norms), within social and political contexts (Sheikh *et al.* 2011).

Topic category	Number of papers
Priority-setting (including cost-effectiveness analysis, health technology assessment, economic evaluation, rationing, resource allocation)	43
Health system analysis (including structure, evaluation, resilience, responsiveness, trust, complexity & context)	36
Policy analysis (including agenda-setting, process, development, evaluation)	33
Health system reform	26
Service delivery (including patient-provider relations, implementation, trust, provider behaviour, training, and motivation)	16
Service delivery (including planning, management, accountability)	14
Public participation (including values and preferences, mechanisms)	9
Governance and leadership	9
Health Finance (including contracting, funding mechanisms)	9
Knowledge translation (including research to policy)	8
Equity (including access to services)	5

Table 5: Number of papers within each topic category

The framework is cited in nine included papers,[5] including, for example, Fattore and Tediosi's theoretical exploration of health systems governance, which argues that governance should be informed by, and align with, the values and principles that shape the system (2013).

Clark and Weale present a conceptual framework for exploring the role social values play in health priority setting, that is cited in eight included papers (2012).[6] In one, Tantivess *et al.* apply the framework to understand the role of social values in the reform of Thailand's Universal Health Coverage plan in 2009-2010 (2012). The authors conclude that, despite efforts to make the decision-making process "transparent, participatory, systematic and evidence-based," values such as welfarism, ethics and equity influenced prioritisation decisions, particularly through deliberations among decision-makers (Tantivess *et al.* 2012). The Clark and Weale framework presents not only a defined list of social values, but also offers a list of sites in which those values are likely to be seen within decision-making processes, and is thus readily operationalised by analysts.

Another noteworthy framework, Walt and Gilson's Health Policy Analysis (HPA) Triangle, was presented as a response to a tendency in HPA to focus on the content of policies, at the neglect of factors such as actors, process and context, and the interactions between them (1994). While the framework does not explicitly list social values as a contextual factor, "it understands…policy processes to be contested, involving multiple actors, with different concerns, interests and values" (Gilson *et al.* 2018). The framework is employed in five included papers[7], including a prospective policy analysis of suicide prevention in Sri Lanka to develop feasible policy solutions that align with existing values and interests based on expert panel discussions by Pearson *et al.* (2010).

Van Olmen *et al.*'s HSDF is noteworthy in that it considers the role of values in relation to the health systems as a whole (rather than one dimension or aspect of the system) (2010). However, the HSDF

[5] (Abimbola *et al*. 2017; Agyepong *et al*. 2017; Fattore & Tediosi 2013; Gilson *et al*. 2017; Langlois *et al*. 2018; Sheikh *et al*. 2014)
[6] (Ahn *et al*. 2012; Keren *et al*. 2012; Landwehr & Klinnert 2015; Littlejohns *et al.* 2012a, b, c; Mostafavi *et al*. 2016; Russell *et al*. 2014; Tantivess *et al*. 2012; Whitty *et al.* 2015)
[7] (Buse *et al*. 2009; Gilson 2012a,b; Grundy 2015; Koduah *et al*. 2018; Pearson *et al.* 2010)

positions 'values and principles' externally to the health system elements, more distal than even 'context', and does not include any particular linkages between 'values and principles' to any other system elements. This framework informs three reviewed papers,[8] including a conceptual study on attributes for health system performance assessment that finds the relationship with societal values to be a key attribute of such assessments (Tashobya *et al.* 2014). While the presence of such frameworks in the evidence-base reaffirms the centrality of social values to HPSR, this analysis also suggests that more easily operationalised frameworks might do more to facilitate rigorous empirical research on the topic (discussed further below).

Methodological approaches to social values research

To better understand the range of possible methodological approaches used in work on social values, we extracted data on the methods used in each paper – presented in Table 6.[9] The papers were fairly evenly divided between empirical (n=103/208) and non- or loosely-empirical[10] papers (n=105/208). Within the 103 empirical papers a wide range of methodological approaches were evident. Most (more than three quarters) were purely qualitative, with 12 quantitative studies, and 13 mixed-

Method	Empirical	Not empirical	Total
Qualitative - field (interviews, process evaluation, public deliberation, focus group discussions, participatory methods, observation)	41	3	**44**
Case study or descriptive piece	29	15	**44**
Review or evidence synthesis	25	19	**44**
Editorial; commentary; introduction	0	25	**25**
Reflection, perspective, opinion piece	0	25	**25**
Conceptual & theoretical, framework development or testing	0	16	**16**
Qualitative – desk-based (document analysis, policy analysis, discourse analysis, qualitative survey)	12	0	**12**
Quantitative	11	0	**11**
Mixed methods	10	0	**10**
Protocol development or methodological piece	0	5	**5**

Table 6: Methodological approaches

methods studies identified. The qualitative studies mainly applied primary/field-based (e.g. process evaluations, ethnographies, or action research) rather than secondary/desk-based approaches (e.g. document analysis, discursive methods, and qualitative surveys. Review and synthesis, and case study approaches were fairly ubiquitous across both the empirical and non-empirical studies.

Very few of the included papers report on studies seeking explicitly to investigate values (n=48/2018). We found only 24 empirical papers explicitly focused on values in health systems,[11] and only eight of these were about LMICs. A table summarising the aims, methods and findings of these papers is

[8] (Agyepong *et al*. 2017; Tashobya *et al*. 2014; van Olmen *et al*. 2012a, b)

[9] This data was captured as presented by the author in the abstracts or method section of the paper. For many papers, more than one method was used. As such, the totals in this table exceed the total number of papers included in the review.

[10] These were categorised as either non-empirical, or loosely empirical to capture the distinction between opinion pieces, editorials or commentaries, and articles in which methods and findings are not explicitly laid out, but which are nonetheless presented as based on common knowledge, existing evidence, or personal experience.

[11] It must be noted that categorising a study as 'about' values, is subjective – a study may have sought to explore values through a particular lens, and the title, and therefore the focus on values may not be reflected in the title or keywords, or made explicit in the methods. For this reason, papers were categorised as 'about' values, only if this was made explicit in the title, abstract or methods.

available as supplementary material.[12] Most of the empirical values-focused papers are either assessments of the values of health policy stakeholders, or analyses of values in policy documents or decision-making. The former set mostly use data from surveys or questionnaires (using both qualitative and quantitative analysis approaches), interview or focus-group discussions, or literature or document review to collect data on the values of users and citizens, healthcare workers and civil servants, or policy and decision-makers. While most of the empirical values-focused work uses qualitative approaches, four of the papers in this set were quantitative. For example, in a study on social solidarity in South Africa, Harris *et al.* (2011) conducted interviews with 1330 civil servants in the health and education sectors, and found that some cultural groups had more accepting attitudes towards cross-subsidisation than others. The authors suggest that understanding how social relationships and cultural identities shape values is central to achieving values-oriented reform (Harris *et al.* 2011).

Similarly, in an empirical study aimed at developing a clearer conceptualisation of trust in health systems, Abelson *et al.* (2009) use focus group discussions and a public opinion telephone survey to better understand the values of Canadians in relation to the health system. The authors find that individuals value collaboration and alliances with health providers that build trust, and note that this relationship can be extended to one between individuals and governments as health system actors (Abelson *et al.* 2009).

The papers exploring the role of values in decision-making processes mostly rely on data from document and literature reviews or interviews with decision-makers, or a combination thereof. For example, Giacomini *et al.* (2009) use a review of Canadian health policy documents to explore how ethics frameworks are used in Canadian policy documents. They find that while there are many common values elements across policy documents, no two documents use the same framework, and few documents attempt to justify the chosen values framework. Most of the papers in this category are applications of the Clark *et al.* (2012) framework for social values in priority-setting (see below). These papers tend to combine interviews with document and literature reviews to gather data on the role of values in specific priority-setting decisions, which can then be analysed using the framework. For example, Tantivess *et al.* (2012) use document review to understand the role of social values in coverage decisions for Thailand's Universal Health Coverage plan, and triangulate their findings through personal communication with decision-makers and other key stakeholders.

A small number of the empirical values-focused papers seek to establish or describe a relationship between social values of stakeholders and health system outcomes or characteristics. These papers use survey data, case study approaches, interviews, or a combination thereof to explore the health system impact of prevailing social values. For example, Landwehr *et al.* (2015) explore the effect of value congruence between society and social institutions, and its effect on public acceptance of prioritisation decisions, and trust in the health system at large. The authors compare across the UK, Germany and France using survey data and document review. As a whole the analysis of methodological approaches, particularly with regard to values-focused empirical studies, suggests that research on the topic is relatively labour and resource-intensive, often combining methodological

[12] See Appendix 1a

approaches spanning field-work, large-scale data collection through surveys, and documentary analysis.

A large number of papers (160/208) do not focus specifically focused on values, but nonetheless mention values in the introduction or background sections – as foundational or contextual knowledge – or as knowledge necessary to interpreting, understanding or explaining the findings. This suggests that in many cases it is necessary to incorporate an understanding of social values and their role in health systems in the interpretation of evidence on other topics. For example, Walker *et al.* (2004) use questionnaires and in-depth interviews to investigate how South African nurses in urban Community Health Centres experience the implementation of the free care policy. The study reveals that values influence nurses' experiences of, and responses to, policies and the authors conclude that in order to make sense of nurses' practices, it is necessary to understand them as social actors within social, historical, and professional context (Walker *et al.* 2004).

The non-empirical and 'loosely empirical' papers reviewed included perspectives and opinion pieces; editorials and commentaries; non-systematic reviews, conceptual and theoretical discussions, and framework development pieces; descriptive pieces; and methodological guidelines and protocols. As with the empirical papers, about a quarter (n=24/105) were explicitly focused on values, a third of which were 'loosely empirical'. For example, Saltman *et al.* (2005) use policy documents, social observations and personal experience to explore how Sweden's social and political context ensures that two core Swedish values (*jamlikhet*/equality and *trygghet*/security) influence national health policy-makers, resulting in system-wide resilience to outside pressures for change. The authors argue that "core social values tied to national culture play an essential role in defining both the structure of existing health sector institutions and the range of feasible policy options with which to modify these institutions" (Saltman *et al.* 2005).

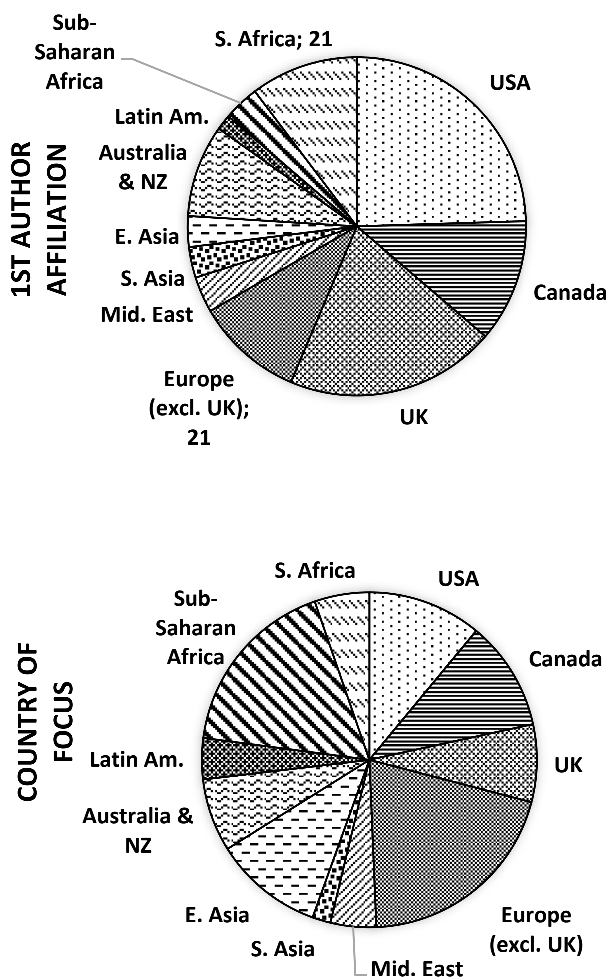


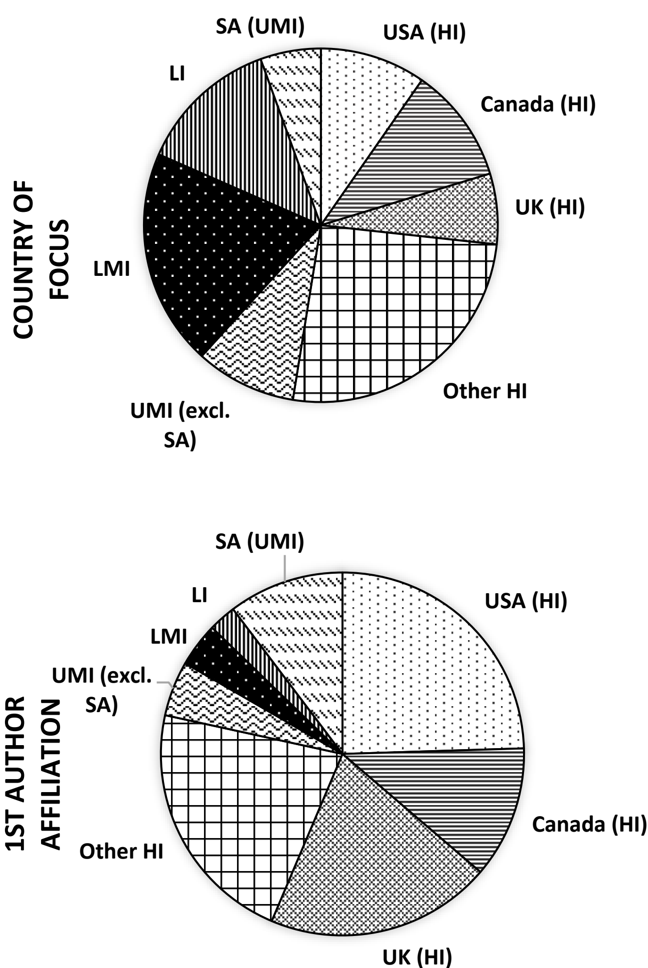
Figure 3: Geographic mapping by region

Another example is a book review by Reinhardt (2003), in which he argues that Canada's deep-rooted social values, reflected in their national health system, underlie the country's historical opposition to external cultural influences. However, he also cautions that changes in the

structure of health systems have the capacity to undermine national values (Reinhardt 2003). The analysis of methodological approaches suggests that the relative lack of empirical values-focused research, particularly in LMICs, may reflect the resource-intensive nature of the types of methodologies commonly used in this type of work.

Geographic distribution – country of focus and first author affiliation

The politics of where and how HPSR knowledge is produced, has been a growing concern within the field in recent years (Bennett *et al.* 2018, Gilson *et al.* 2018, George *et al.* 2019). In order to better understand the geographic distribution of the HPSR evidence-base on social values, we mapped the country of focus for each article by geographic region (Figure 3). This reveals a significant proportion of the research focuses on Canada, the USA and the UK, which together account for nearly a third of all research on social values in health systems. With 11 included papers, South Africa is noteworthy as the only middle- or lower-income country in which a relatively significant body of research has emerged.



Abbreviations: SA: South Africa; UMI: upper-middle income; HI: high

Figure 4: Geographic mapping by income group

This uneven distribution is more acute when the evidence-base is analysed according to the institutional affiliation of the first author of each study as a proxy for the geographic origin of the paper. Authors from Canada, UK and USA represent more than half of all the first authors, and less than a quarter of all papers had first authors based in Africa (excluding South Africa), Asia and the Middle East. Once again, South Africa is comparatively well represented (n=21/208 papers). When classified according to World Bank income classifications (World Bank 2019) rather than regional groupings, similar trends emerge, with most included papers focusing on HICs, and only five and eight papers produced by authors at institutions in low-income and lower-middle income countries respectively (Figure 4).

A quarter of the included papers did not focus on any specific country, region or income bracket. These articles are largely non-empirical pieces or global reviews and tend to make general claims about the nature of health systems that may be interpreted by readers as universally applicable. Almost all of

these papers were written by authors based in high-income (n=44/208) or upper-middle income countries (n=7/208).

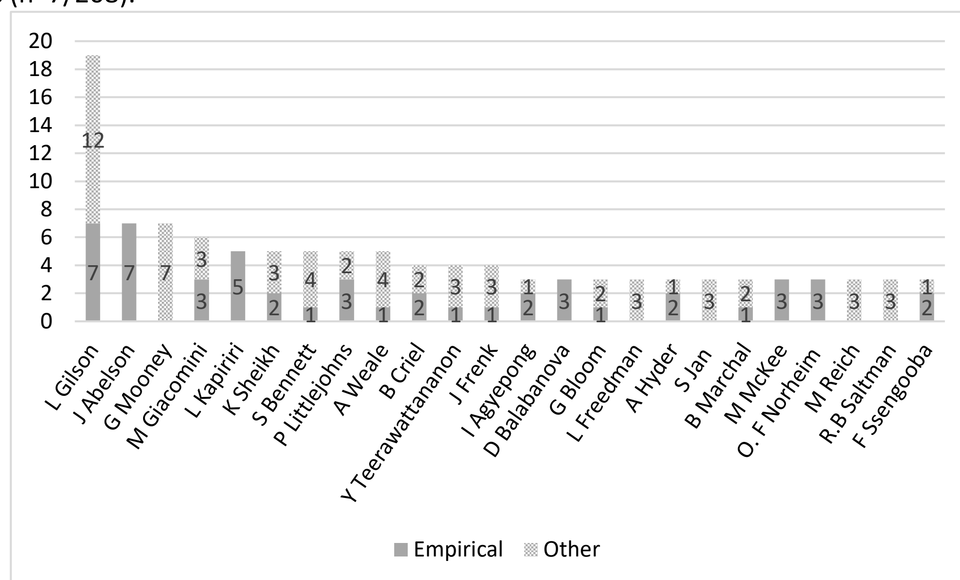


Figure 5: Number of papers per author

This analysis classifies papers according to the institutional affiliation of the first author only, so may not accurately represent the geographic distribution of all the authors contributing to the evidence-base. To account for this, we also conducted an analysis of the most commonly recurring authors, irrespective of authorship position. Figure 5 gives the number of empirical and other papers contributed by each author (excluding those with only one or two contributions). Many well-renowned HPSR authors are shown to have made a substantial contribution to the evidence-base, reaffirming the importance of social values to health systems research. Unsurprisingly, however, most of these authors are from high- or upper-middle-income countries. Only three of the authors contributing three or more papers to the evidence-base are affiliated with institutions in low- or lower-middle-income countries.

The geographic mapping suggests that paying attention to social values in relation to health systems is fairly ubiquitous – with research identified across all geographic regions – but unevenly distributed. In addition, much of the research on this topic is led by out-of-country actors.

Discussion

This study reviews the HPSR evidence on social values in health systems. While data collection was conducted systematically, the iterative, multi-phase search approach may have inadvertently missed some relevant literature. In addition, the designation of particular papers as either HPSR or not is necessarily subjective, and, although steps were taken to ensure this was done according to predetermined criteria, other researchers may have interpreted the criteria differently. Finally, the purpose of an evidence mapping review is to provide a broad assessment of the 'state of evidence' on a particular topic. The purposively broad review therefore has limits in terms of depth of analysis – for example, we do not compare or assess particular findings from empirical papers, or assess the 'best' health systems intervention involving the manipulation of social values.

Despite these limitations, the study reveals significant geographic, methodological and conceptual gaps in the literature, and suggests that these gaps have significant consequences for the development of this field of study.

Geographic gaps: The importance of context-specific and embedded research

The geographic mapping reveals significant gaps in the evidence-base with respect to research focusing on Eastern Europe, Latin America, South Asia and the Middle East (with respect to evidence published in English). This geographic distribution indicates a failure to adequately explore the important role social values play in the development and strengthening of health systems in these regions, and LMICs generally. This is problematic for a number of reasons.

Firstly, evidence of the role values play in health systems is likely more valuable and necessary for LMICs. While all health systems are inherently relational (Bevan *et al.* 2005, Freedman *et al.* 2005, Bloom *et al.* 2008b, Gilson 2012b), there is evidence to suggest that relational factors such as values might matter more in LMICs and fragile and conflict affects states where formal mechanisms and systems hardware may be weaker (Palmer *et al.* 2003, Batley *et al.* 2010). In addition, values-based health systems could play an important role in strengthening social and political institutions in these contexts. Evidence for the relationship between strong health systems and the development of just, democratic and cohesive societies is growing (Freedman 2005, Mackintosh *et al.* 2005, London *et al.* 2014, WHO 2016). For example, Kruk *et al.* (2010) draw on literature conceptualising health systems as social and political institutions to develop a logic model for the contribution of the health system to social cohesion, state-building, solidarity, and public trust in the state. Similarly, McIntyre *et al.* (2006) have demonstrated that the commercialised nature of the South African health system has undermined government’s efforts to institute reforms that would contribute to social development and social cohesion. This suggests that more inequitable, less cohesive societies have that much more to gain from evidence-based efforts in health systems strengthening that acknowledge the central role of values and relational factors.

Secondly, context-specific knowledge is essential. While social values are a central dimension of any health system, both the nature of the values themselves, and the extent of their influence, will vary between contexts. For example, Ridde (2008) argues that policy actors in Burkina Faso tend to prioritise efficiency over equity in the implementation of public health policies, largely because inequity has not been seen as a public policy issue in that context. In Thailand Teerawattananon *et al.* (2008) found that decision-makers felt that the public would simply not accept priority-setting decisions based on economic evaluation if “the societal values of equity or justice were not incorporated into decision-making." Similarly, while libertarian values of choice and freedom underlie the USA’s market-based health financing system (Schlesinger 2002, Roberts *et al.* 2003, Ruger 2008), in neighbouring Canada the universality of the health system is a point of national pride (Redden 1999, Axworthy *et al.* 2002, Giacomini *et al.* 2004, Daw *et al.* 2014). This suggests that dominant values may differ between settings, and therefore affect health system change in different ways. For this reason, as with most HPSR, findings about the way values operate in one context, may not be directly generalizable, and gaps in the evidence-base can only be filled with context-specific research (Bennett *et al.* 2011, Gilson 2012a).

Relatedly, given the well-established importance of a deep understanding of contextual realities and local value systems to conducting rigorous HPSR (Sheikh *et al.* 2014a, George *et al.* 2015, Edwards *et*

al. 2017, Hasnida *et al.* 2017), the mal-distribution of literature may also point towards a failure to adequately harness the existing capacity of LMIC researchers with deep tacit knowledge of their local contexts (Hasnida *et al.* 2017). This tacit knowledge is all the more valuable in under-researched contexts, for which there is likely very limited secondary data capturing contextual complexities.

The limited evidence on social values in LMICs is often produced by researchers based outside of the country they are researching. We identified a significant over-representation of authors from high-income countries in this regard, with a large proportion of the evidence-base being produced by authors in Canada, the USA, and the UK. This dominance is widely acknowledged as troubling within HPSR – a research field that "should be driven by understanding of local contexts" (Bennett *et al.* 2011), with the specific aim of contributing to health systems strengthening in LMICs (Adam *et al.* 2011, Hasnida *et al.* 2017) – reflecting global power imbalances in knowledge production (Bloom *et al.* 2008a, Gilson *et al.* 2008b, Yao *et al.* 2014, Hasnida *et al.* 2017).

While out-of-country researchers can, and regularly do, produce relevant and rigorous health systems evidence within LMICs, such evidence may be less likely to directly impact policy-making in those contexts. Evidence shows that embedded researchers are both more likely to have in-depth and nuanced knowledge of the system and the political and cultural context, and to be able to 'see' what is tacit or un-spoken (Franzen *et al.* 2017, Olivier *et al.* 2017a, Olivier *et al.* 2017b) – as values often are.

Furthermore, research is more likely to be taken up by decision-makers and practitioners when produced by actors embedded in, or with existing relationships within, the country (Ghaffar *et al.* 2017, Hasnida *et al.* 2017, AHPSR 2018, Cheetham *et al.* 2018). As such, work conducted by researchers who are not embedded in the context may be less relevant and have a more limited effect on health systems strengthening. Recognition of this has spurred growing interest in embedded research approaches in HPSR – in which researchers position themselves as *part of* the health system and build trust-based relationships with policy-makers and implementers over time, to ensure research questions are informed by real-world evidence needs, and to open communication channels for feedback of findings that inform practice (Olivier *et al.* 2017b, AHPSR 2018, George *et al.* 2019). In addition to the large body of work produced by out-of-country researchers, only one included study reported using an embedded research approach (Gilson *et al.* 2017).

The findings from this review mirror broader trends in HSPR. Despite the acknowledged need for HPSR about and from LMICs, the bulk of evidence currently tends to be produced in, and focused on, developed country contexts (Gilson *et al.* 2008b, Adam *et al.* 2011, Bennett *et al.* 2011, Erasmus *et al.* 2014, Hasnida *et al.* 2017). Further, the limited capacity for HPSR in LMIC contexts – the effect of structural and systemic barriers – results in an unfortunately high proportion of LMIC-focused HPSR being conducted by out-of-country researchers (Adam *et al.* 2018). This status quo is particularly problematic given the need for a thick understanding of local contexts in HPSR (Gilson *et al.* 2008b, Gilson *et al.* 2011b, Gilson 2012a), and is all the more concerning with regard to the study of social values, which arguably demands a deep understanding of local social and norms and cultural dynamics.

Methodological gaps: The need for more empirical research and the potential of methods rooted in social sciences

There are also significant gaps in the evidence-based with respect to the range of methodological approaches employed in research on social values. Firstly, as discussed above, a large proportion of the evidence-base is not empirical, and only a fifth of the empirical studies are asking research questions about values in health systems. Furthermore, we only identified seven empirical papers focusing on social values in LMICs. These findings mirror that of Gilson *et al.* (2008b), who reviewed work analysing health policy processes and found that fewer than half of the included studies were empirical studies focused on LMICs.

The almost even split between empirical and non-empirical work on the topic is concerning because, while rigorous conceptual or theoretical work is important and should not be under-valued (Bennett *et al.* 2011, Sheikh *et al.* 2011, Gilson 2012a, Edwards *et al.* 2017), this theory must be informed by empirical literature from a broad range of contexts, and, as noted above, theory developed on the basis of empirical work from a limited range of contexts is unlikely to be widely relevant. The paucity of empirical, values-focused research on LMIC settings indicates a risk that the growth of the theoretical evidence-base out-strips the empirical work from LMICs, resulting in a body of theoretical literature that is not sufficiently reflective of LMIC realities.

Similarly, the shortage of embedded approaches and in-country perspectives shaping the literature which forms the foundation for conceptual development and discourse-building risks the development of theory that fails to reflect local realities (Edwards *et al.* 2017). As almost all of the papers of purportedly general relevance (i.e. without a particular country of focus) were first-authored by researchers in high-income countries there is a potential for ‘conceptual capture’ – promulgating a particular perspective that may not adequately reflect the realities of LMIC settings (Giacomini *et al.* 2009, Shams *et al.* 2016). Producing empirical HPSR evidence on the role of values in health systems through context-specific research in under-researched settings is necessary to strengthen the evidence-base and inform representative theory.

The large number of non-empirical and loosely empirical papers making reference to social values suggests that commentary and reflective type publication formats allow HPSR authors to explore underlying assumptions or beliefs about values that would require a significant burden of proof if they were presented in empirical papers. Interestingly, of the authors contributing the most papers to the evidence-base, almost a quarter of those contributing three or more papers do so entirely through non-empirical or loosely empirical papers, suggesting, perhaps, that these ideas inform the author’s thinking, but nonetheless are not considered appropriate subjects for empirical research.

However, the limited number of empirical papers focusing explicitly on values is also likely a reflection of the relatively resource intensive nature of this work. Most of the empirical, values-focused papers utilise large-scale survey data in combination with interviews with healthcare workers or decision-makers, and/or review of policy documents, decision-making records or academic literature. These are relatively labour-and capacity-intensive research approaches which may well necessitate both a significant number of researchers on the team, and substantial funding to support them. Furthermore, in some contexts, relevant survey data may not be available, and availability of documentary records from decision-making processes is dependent on the extent to which these processes are transparent.

In these settings, empirical research on values would require additional resources to conduct surveys and interview decision-makers – and may well be impossible.

There is also a paucity of work drawing on social science methodologies. This is somewhat surprising given that a fundamental feature of HPSR is that it draws on a wide variety of concepts and methods from social sciences to explore complexity (Gilson *et al.* 2011b, Sheikh *et al.* 2014a), precisely because these approaches can help researchers tackle complex topics where multiple interpretations are possible (Gilson *et al.* 2011b, Topp *et al.* 2018), such as the relationship between social values and health systems. In addition, there is existing work on health systems and social values within the social sciences that is largely ignored in this evidence-base. For example, there is a body of work in medical anthropology that uses ethnography to understand how health systems influence citizens' understandings of their rights and entitlements in relations to the state (see for example Abadía-Barrero 2016, Dao *et al.* 2016, Prince 2017).

This gap is likely a reflection of the well-established 'disciplinary capture' in the field of HPSR (Sheikh *et al.* 2011). While HPSR is characterised as a necessarily trans-disciplinary field (Sheikh *et al.* 2014a, Bennett *et al.* 2018), many authors have commented on the persistent schism between positivist research with generalisable results, and relativist research in which context-specificity is key (Remme *et al.* 2010, Gilson *et al.* 2011b, Gilson 2012a, Hoffman *et al.* 2012). As a result of a growing need, largely funder-driven, to easily appraise the 'quality' of qualitative work (and therefore its readiness to directly inform policy) through assessments of "sampling, coding, validity, reliability and generalisability" (Torrance 2017) there is a tendency in the field to valorise research reflecting positivist knowledge paradigms and forms of qualitative social science research that are more readily quantifiable (Sheikh *et al.* 2011, Topp *et al.* 2018). In addition, it has been suggested that in some settings, particularly LMICs, there is a limited capacity to undertake rigorous qualitative research (Lewin *et al.* 2018). This is acknowledged to result in the under-utilisation of social science methodologies, and attendant knowledge paradigms, limiting the capacity of the field to conduct rigorous research on software factors (Gilson *et al.* 2011b, Sheikh *et al.* 2011, Gilson 2012a). Purposeful efforts to counter these forces, and actively draw on methodologies from the social sciences, may be necessary in developing the empirical evidence-base on the topic.

Conceptual gaps: Definitional clarity and the need for conceptual frameworks and theory

A lack of definitional and conceptual clarity is apparent. As noted, very few included papers offered a definition or explanation of 'social values' and no common definition was used across any of the papers. In addition, the definitions and explanations that are presented vary considerably. While a fixed, universal definition of the term is perhaps neither necessary nor desirable – because hasty concretization of a term risks "constraining the…natural development of the field" (Sheikh *et al.* 2011) – given scope of the evidence-base, and the fact that values have been considered central to HPSR since its inception, it is surprising that no consensus framings have emerged.

In addition to definitional issues, there is a general lack of specificity in the evidence-base with regard to the mechanisms or pathways through which values impact health system change. In the synthesis of statements about the relationship between health systems and social values a large proportion of the relational statements drew a connection between some element or function, and the health system as a whole. Such statements do not specify any particular dimension of the health system, and therefore make it difficult to identify the causal mechanism at play.

Similarly, the prominent conceptual frameworks identified rarely indicate how analysts can or should identify the influence of values. The Clark and Weale Framework for priority-setting (2012) is the exception, as it presents not only a defined and concise list of social values but also offers a comprehensive framework for analysis of those values – comprising a list of sites in which those values are likely to be seen within decision-making processes. In other words, the framework is operationalised, and all the researcher need do is apply it. The Clark and Weale framework seems to have given rise to a significant number of studies employing similar methodologies across a range or contexts, and therefore producing comparable results.

The other three dominant frameworks, however, seem to be used (within the body of included literature, at least) more conceptually – often combined with other frameworks and conceptual tools to inform or justify a particular understanding of health systems. In the case of the HPA Triangle framework this is somewhat surprising, given that the framework does offer an approach to analysis. However, both the HPA triangle (Walt *et al.* 1994) and the hardware/software distinction (Sheikh *et al.* 2011) constitute heuristic devices encouraging analysts to consider the effect of values and other software factors on the behaviour of health policy actors, but do not indicate *where* analysts should look. By positioning values as external to the rest of the health system the HSD framework van Olmen *et al.* (2010) indicate the importance of values, but does not indicate where this effect might be seen, nor suggest mechanisms or pathways of influence. By offering a common conceptual tool to organise research and analysis, frameworks can enable more rigorous research on particular topics (Gilson 2012a). It seems, however that the frameworks evident in the HPSR literature on social values achieve this only to a limited extent.

While the value of conceptual frameworks for making sense of complexity cannot be overstated, this review suggests that the operationalisation of the existing frameworks might encourage or enable further empirical work on the relationship between social values and health systems, and that the lack of such a framework presents a significant gap in the literature. One strategy for expanding the empirical evidence-base on the topic, therefore, may be to develop the available conceptual frameworks to be more readily operationalised.

The importance of values in HPSR

Despite significant gaps in the HPSR evidence-base on social values, the substantive body of evidence reveals the myriad of ways in which social values shape health systems and affirms that values are seen as central to understanding health system change across a broad range of HPSR literature – in keeping with broader literature described in the introduction (Sheikh *et al.* 2011, Gilson 2012a, Sheikh *et al.* 2014a). The scale of the evidence-base – seen in the relatively large number of papers referring to social values – as well as the scope of included papers (with reference to social values made across a diversity of areas of work), confirms that social values are a key concept within HPSR.

As suggested in the introduction, values were found to be used as explanations for health system change with respect to governance, implementation, interpersonal relationships between system actors, policy decision-making and health system change and reform. However, we also identified a significant body of work on the role of values in priority-setting, and a number of papers on financing, planning and management, public participation and knowledge translation. The particular prominence of values in work on priority-setting, health systems analysis, health systems reform, and policy

analysis indicates that in these areas of work the explicit consideration of values is becoming normalised, and perhaps expected, as an indicator of a thorough analysis.

In addition, the centrality of social values to understanding and conceptualising health systems functioning, posited by key HPSR authors (Sheikh *et al.* 2011, Gilson 2012a), is confirmed by the match between the growth of HPSR literature on social values and HPSR literature more generally. Finally, the large proportion of papers that are not specifically focused on social values, but nonetheless use social values either as foundational or background knowledge, or in the discussion and conclusion, confirms the foundational role values play in the field – indicating that reference to social values is often necessary background or contextual information for demonstrating the substantive relevance of an HPSR research question, describing the context in which the systems or policy problem exists, or interpreting the relevance of the study findings – even when values are not the subject being researched.

Simultaneously, theory and evidence is emerging on the *nature* of the relationship between citizens and the health system – evident in papers making causal claims about the influence of health system on social values. This literature suggests that in strengthening health systems through research paying close attention to "ideas, interests, values, norms, and relationships", we can harness the power of health systems to build more equitable societies (Sheikh *et al.* 2014a).

Strengthening the HPSR evidence-base on social values

To this end, the review points to a number of strategies for strengthening the HPSR evidence-base on social values. As a research community, HPS researchers, funders and guiding institutions must strive to harness the capacity of researchers in low-income and under-researched settings to strengthen the evidence-base of empirical work on social values conducted by in-country or embedded researchers with deep contextual knowledge of those settings.

In addition, HPS researchers should consciously strive to meet the trans-disciplinary aspirations of the field, and actively draw on social science methodologies in their work. However, it must be recognised that many of the methodologies that allow researchers to conduct high quality empirical work on values may well be particularly resource intensive, requiring longer study timelines and large-scale data collection efforts. Such research remains more challenging in LMICs where not only is funding more constrained, but also decision-making processes more opaque, and less likely to be captured in publicly available documents.

Conceptual tools that are easily operationalised and relevant across distinct areas of work within HPSR are necessary to building consensus framings and common language, and will likely facilitate and encourage empirical research. However, researchers doing conceptual and theoretical work must strive to ensure that their work is founded on quality empirical research from diverse contexts, and adequately represents the complex realities of LMICs. As the theoretical and empirical evidence-base grows, this knowledge should be used to inform the development of operationalizable frameworks that will support rigorous future research on the subject.

Strengthening the evidence-base will also require countering the still pervasive ideas about research hierarchies that valorise research centralising health system hardware, and reflecting positivist knowledge paradigms as more rigorous and of higher substantive relevance. Research need not have a direct policy influence to be valuable, and rigorous social science conducted from a relativist

perspective can indirectly bring about system change or provide crucial conceptual tools that shape policy-makers' assumptions and contribute to health systems strengthening.

Conclusion

In 1977 a study of health systems research and innovations published in the New England Journal of Medicine concluded that "there is little reason to expect such research to produce major alterations in the system, since these alterations are linked to changes in the values and expectations of society" (Lewis 1977). Since then, however, HPSR has emerged as a trans-disciplinary field of study with capacity to understand health systems as complex people-centred systems, and to produce evidence on values that contributes to stronger, more just health systems and societies.

To realise this potential of values-focused research, however, it is necessary to strengthen the body of evidence on values in health systems. This will require overcoming the systemic barriers within the field that result in imbalances in knowledge production between high-income and LMIC countries, seeking specifically to enable further empirical and conceptual work in low-income, under-researched contexts. Promoting empirical research on values in LMICs that can be used to inform representative and rigorous theory on the subject of values in health systems is also key, and will lay the foundation for the development of consensus framings, and operationalizable frameworks to support future work. In addition, it will be necessary to recognise the deep contextual knowledge of embedded researchers as a significant intangible asset in research endeavours, and invest in embedded research projects that take a longitudinal perspective and draw on social science methodologies. This also entails actively countering pervasive ideas about research hierarchies that prize systems hardware-focused studies using positivist methodologies as more substantively relevant or rigorous. As this review has shown, values play a central role in health system change, and a better understanding of this role will enable HPS researchers and practitioners to more effectively harness the power of values for progressive health system change.

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Chapter 2 – Towards an Explanation of the Social Value of Health Systems: An Interpretive Synthesis

Chapter 2: Towards an Explanation of the Social Value of Health Systems: An Interpretive Synthesis

Overview: This Chapter builds on the systematic review presented in Chapter 1. In this Chapter, we present an interpretive synthesis of HPSR literature on social values, focusing on claims about the relationship between 'health systems' and 'social values.' The Chapter draws on meta-ethnography as a methodological approach to synthesis claims about the relationship between health systems and social values under a common frame and present an initial explanatory theory of the capacity of health systems to generate social value. Ultimately, the paper argues that this capacity is an emergent product of a complex network of values-based interaction.

Contribution to the thesis: The interpretive synthesis suggests an explanatory account for the social value of health systems. This initial explanatory theory will be tested and refined through the case study (presented in Chapters 4, 5 and 6) and forms the foundation for the conceptual framework of the relationship between health systems and social values presented in Chapter 7.

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Contribution of the Candidate: The candidate is the first author of this paper, while the supervisor is the second author. The candidate designed the study, conducted the meta-analysis, and was the lead author. The supervisor offered guidance on the data analysis, gave input into the structure of the paper and critically reviewed drafts of the paper.

Abstract

Background: Health systems are complex social systems, and values constitute a central dimension of their complexity. Values are commonly understood as key drivers of health system change, operating across all health systems components and functions. Moreover, health systems are understood to influence and generate social values, presenting an opportunity to harness health systems to build stronger, more cohesive societies. However, there is little investigation (theoretical, conceptual, or empirical) on social values in health policy and systems research (HPSR), particularly regarding the capacity of health systems to influence and generate social values. This study develops an explanatory theory for the 'social value of health systems.'

Methods: We present the results of an interpretive synthesis of HPSR literature on social values, drawing on a qualitative systematic review, focusing on claims about the relationship between 'health systems' and 'social values'. We combined relational claims extracted from the literature under a common framework in order to generate new explanatory theory.

Results: We identify four mechanisms by which health systems are considered to contribute social value to society: Health systems can: 1) offer a unifying national ideal and build social cohesion, 2) influence and legitimise popular attitudes about rights and entitlements with regard to healthcare and inform citizen's understanding of state responsibilities, 3) strengthen trust in the state and legitimise state authority, and 4) communicate the extent to which the state values various population groups.

Conclusion: We conclude that, using a systems thinking and complex adaptive systems perspective, the above mechanisms can be explained as emergent properties of the dynamic network of values-based connections operating within health systems. We also demonstrate that this theory accounts for how HPSR authors write about the relationship between health systems and social values. Finally, we offer lessons for researchers and policy-makers seeking to bring about values-based change in health systems.

Keywords: Social Values, Interpretive Synthesis, Health Systems, Complexity, Emergence

"A just system must…be arranged so as to bring about in its members the corresponding sense of justice, and effective desire to act in accordance with its rules for reasons of justice…[Institutions] must be not only just, but framed so as to encourage the virtue of justice in those who take part in them" – (Rawls 1971)

Introduction

Health systems are complex social systems, and social values constitute a central facet of their complexity (WHO 2000, Gilson *et al.* 2005, Rickles *et al.* 2007, Ramalingam *et al.* 2008, The Health Foundation 2010, van Olmen *et al.* 2012a, Marchal *et al.* 2016). The influence of social values is evident across a myriad of elements, functions and interactions of the health system.

In an earlier systematic review on values in health systems, we found evidence of the influence of values across all health system components and functions (Whyle *et al.* 2020). For example, in service delivery, values are shown to influence preferences for private provision over public (Fox *et al.* 2015) and affect patient-provider relationships (Kruk *et al.* 2018), while with respect to human resources, values impact health provider motivation (Franco *et al.* 2004) and levels of absenteeism (Tweheyo *et al.* 2017). Within health system governance, values influence the functioning of community accountability mechanisms (Abimbola *et al.* 2017) and decision-making processes (Fattore *et al.* 2013), and determine macro-level financing arrangements such as the extent of cross-subsidisation (Ham 2001). Values considerations are also increasingly incorporated into technical decision-making processes around health technology assessment (Whitty *et al.* 2015). Critically, across all health system components, values inform the behaviour and choices of individual actors (Humphrey *et al.* 2004, Sheikh *et al.* 2014a), and shape relationships between actors (Marchal *et al.* 2012, Abimbola *et al.* 2017).

The sub-field of health policy analysis has produced substantial evidence suggesting that values influence policy-makers and shape policy-making processes (Walt 1994, Walt *et al.* 1994, Benington 2009, Buse *et al.* 2009, Gilson *et al.* 2018), and, as a result, inform the language of policy documents *and* policy goals (Boufford *et al.* 2002, Giacomini *et al.* 2004, Giacomini *et al.* 2009). Through this influence on policies, values shape the trajectory of health system development (Freedman *et al.* 2005, Sturmberg *et al.* 2012).

The earlier review also revealed that values were often positioned by Health Policy and Systems Research (HPSR) authors not only as an *input* influencing health system change, but also as a *property* of health systems. For example, Saltman *et al.* (2005) argue that social values determine the existing architecture of health systems and then "continue to influence proposed reforms to that structure", while Cleary, Molyneux and Gilson suggest that resource flows reflect the values of a health system (Cleary *et al.* 2013). Others observe that the design of health systems evidence the prevailing values of that society – for example when Kruk et al. state that "the design of a health system…conveys important social and political values" (Kruk *et al.* 2010), or van Olmen et al.'s (2012b) suggestion that the prevailing social values 'emanate' from the health system. Values are also described as an *output* of health systems. For example, Gilson *et al.* (2005) states that "a trusting and trusted health system can contribute to building wider social value and social order," and Abelson *et al.* (2009) argue that health systems contribute to the construction of social values in society. In the same vein, Frenk (1994) notes that it is possible for the state to legitimise certain ideologies through the provision of health

services. These ideas suggest a common understanding that not only are health systems *influenced by* social values, but that, as indicated by Rawls in the quote above, they also have the capacity to *influence* and *generate* social values in the societies they serve.

If this is the case, it is important to improve our understanding of the mechanisms underlying this phenomenon, and whether they can be harnessed to bring about positive social change.

This paper presents an interpretive synthesis of claims about the relationship between social values and health systems in HPSR literature, exploring conceptualisations of the social value of health systems, and developing an initial explanatory theory for the capacity of health systems to generate social value(s). The analysis adapts the steps of Noblit and Hare's (1988) meta-ethnography approach,[1] and proceeds by synthesising the claims about the relationship between health systems and social values (extracted from the literature) within a unifying frame, and presenting an explanatory theory on the basis of that overarching frame. The explanatory theory draws on foundational HPSR concepts such as emergence and complex causality to lay the conceptual foundations for an explanation of how social values influence, and are influenced and generated by health systems. Finally, we consider the implications of this explanatory theory for researchers and policy-makers – drawing out key lessons for those seeking to understand or contribute to values-based system reform in complex social systems.

Methods

This interpretive synthesis follows from a prior qualitative systematic review (reported in Chapter 1) and utilises that collection of evidence (Whyle *et al.* 2020). The systematic review applied an iterative approach, based on Boell & Cecez-Kecmanovic's (2014) hermeneutic review methodology. This allowed for the gradual accumulation of relevant evidence, in accordance with the researchers' emergent understanding of the key concepts (Greenhalgh *et al.* 2018). The review was limited to peer-reviewed content, including organisational reports, empirical and non-empirical literature, published in English between 1989 and 2018. Two-hundred and eight items were included. Inclusion depended on appearance of the term 'values' (or a related term) with a collective modifier (such as 'national', 'political', or 'community'). This restriction excluded materials using the term 'values' only in the numerical sense, or in the sense of 'importance' or 'benefit'.

The systematic review revealed the scope and quantity of HPSR evidence on social values, but concluded that further analysis, allowing for deeper engagement with the evidence, would be beneficial. In particular, we identified multiple relational claims that suggested that health systems can play an important social role in the societies in which they are embedded, and that values are a key determinant of how well systems perform this function. In addition, while the statements about social values in health systems identified in the primary material made a variety of different claims, the claims were not necessarily contradictory, but could be interpreted as complimentary – in other words as telling different parts of a single story. We therefore concluded that a further investigation utilising an interpretive approach, and synthesising the full diversity of claims, would be important for further theoretical development, which was clearly lacking in the existing literature. To this end, we re-reviewed the included papers, excluding those in which the nature of the relationship between social values and health systems was not clear (19 papers in total), and extracting further detailed

[1] Please see Appendix 2a for a fuller explanation of elements of the meta-ethnographic approach used in this study

information on how the relationship between health systems and social values was presented in each paper.

Data extraction was conducted by the first author (EW). Papers were read and claims about values in relation to health systems identified. These claims were extracted verbatim and then simplified. The extraction and simplification steps were then checked by the second author (JO). Relational claims that were open to interpretation or difficult to simplify were discussed between authors until a consensus interpretation was reached. During analysis, the simplified version of the claim was always viewed concurrently with the verbatim quotes to ensure that nuance was retained in interpretation.

Interpretive synthesis is useful to synthesise qualitative data from a range of qualitative and mixed methods evidence (Booth 2006, Greenhalgh *et al.* 2018). In contrast to integrative synthesis, which seeks to combine or amalgamate data, interpretive syntheses involves interpretation and induction in order to develop explanatory theory (Dixon-Woods *et al.* 2005). Interpretive synthesis seeks to move beyond the collation of primary data and allows for the development of new interpretations at a higher level of abstraction (Pope *et al.* 2007).

We did not extract contextual information about the country or countries of focus in each paper. As such, we were unable to consider in our analysis the impact of particular contextual factors, such as political organisation of the state or level of economic development, on the relationship between health systems and social values. We acknowledge this as a limitation of this synthesis, and hope that the explanatory theory presented here will facilitate future research on the relationship between political and economic contextual factors, health systems and social values.

Identifying and categorising claims about the relationship between health systems and social values

The process of interpretive synthesis began with extracting claims about the relationship between health systems and social values from the evidence-base, and then exploring and categorising the relational claims to identify apparent underlying assumptions and conceptualisations (see data extraction sheet in Supplementary File 1 for the full list of papers and claims extracted).

For the most part, the relational claims presented a simple connection or influence between social values and a particular health system component (such as policies, front-line workers, decision-makers or the health system as a whole), and/or function (such as governance, reform, decision making or goals) of the health system. Some examples of relational claims, along with the health system component and function they pertain to, are presented in Table 1.

Interpreting relational claims: The nature of the relationship between health systems and social values

Before synthesising these relational claims, it was necessary to explore and interpret the nature of the claims to ensure that their meaning and nuance would be retained through the analysis. As mentioned, claims were extracted from both empirical and non-empirical literature. As such, some relational claims presented the product or output of a formal study, while others were given as background knowledge or prescriptive assertions, laying the foundation for the interpretation of data or conceptual development. For the purposes of this study, all relational claims were considered to

offer valuable insights into how the relationship is being conceptualised, and were therefore analysed in the same way.

Relational claim	**System function**	**System component**
"Social values…form the guiding principles of the health care system and currently present a barrier to health priority setting…" (Kieslich 2012) "Much of this [health] priority setting is shaped by the values and perceptions of electorates." (Grundy 2015)	Priority-setting	Health System
"Countries need to customise systems to suit their socio-economic, political and administrative settings. Home-grown health financing systems that resonate with social values will need to be found." (Fusheini *et al.* 2017)"Health financing arrangements can convey important messages about political priorities and values." (Witter 2012)	Finance/ resource allocation	
"Conflict between the ideology of market-driven health finance and fundamental social and political values proved an even more powerful force for reorienting the competitive reforms than did interest-group opposition" (Harrison *et al.* 2000) "Government's regulatory role is noted to include structuring the system in line with social consensus on the ethical principles...on which it is founded." (Mills and Ranson as quoted in Gilson 2012)	Structure & reform	
"A number of authors highlight the importance of considering societal values and principles as they vary across societies, yet are crucial in determining system goals" (Tashobya *et al.* 2014)	Goals	
"Nurses' values and worldviews influence their responses to the free care policy" (Walker *et al.* 2004) "Health care workers provide care, adhere to guidelines, interact with each other and interact with patients according to their personal values, [and] social and professional norms...among other factors." (Schaaf *et al.* 2017)	Behaviour/ decision-making	HCWs & managers
"Values and political ideologies can be central to policy directions through providing a window of opportunity for change, particularly during political electoral cycles." (Grundy 2015)	Agenda	Policy
"the failure of the implementation of these policies, in terms of their equity objectives, can be largely explained by the fact that the absence of equity was never seen as a public issue. Yet for any situation to become a public issue...the question of values is obviously central" (De Allegri *et al.* 2018)	Success/ effectiveness/ implementation	
"The framing game to be played is dependent on the embedded values of the larger health policy arena...one may expect frames to center on the need to expand social policies to reflect the values inherent in existing programs (and thus, arguably, society)." (Daw *et al.* 2014)	Content/ structure/ framing	
"Policymakers contested the SMC research evidence mostly due to concerns such as political feasibility, cultural values and discomfort with complex messages." (Ssengooba *et al.* 2011) "Policy actors who prioritised severely ill…argued that the majority of the public would have the same ethical values and expectations for healthcare rationing." (Teerawattananon *et al.* 2008b)	Behaviour/ decision-making	Policy-maker /elite
"The cluster of ideas, beliefs, values and attitudes...constitute the normative lens through which policy-makers...interpret and act upon social and political issues." (Shankardass *et al.* 2018)	Perception/ expectation	
"Recognizing and aligning policy with 'values' underpinning health systems affect whether interventions...are succeeding." (Hanefeld *et al.* 2018) "When the principles of a policy have greater congruency with the social and cultural values within a health system, effective implementation is more likely to occur" (Petricca *et al.* 2018)	Success/ effectiveness/ implementation/ function	Intervention/ program/ service
"Policy frames incorporate particular norms of fairness." (Schlesinger 2002)	Content	
"The incongruences between societal values, institutions and decisions found in Germany may be a central cause behind the significantly lower satisfaction with the system." (Landwehr *et al.* 2015) "The public's acceptance of economic evaluation would be limited if the societal values of equity or justice were not incorporated into decision-making." (Teerawattananon *et al.* 2008a)	Perception/ expectation	Citizen

Table 1: Examples of relational claims according to the system function and component referenced

In interpreting the relational claims, three approaches to characterising the nature of the relationship between health systems and social values emerged. Firstly, many of the relational claims used causal language to describe the relationship between health systems and social values, but rarely suggest a simple, or direct causal connection. Secondly, many claims use metaphorical language that implies that health system change is causally dependent on social values (see Box 1). Lastly, we identified a number of relational claims that reverse the direction of influence, suggesting that health systems influence, and even generate, social values. These three types of relational claims will be explored in turn.

Box 1: Examples of use of metaphorical language to describe interactions and connections

'Shape' metaphors:

"The prevailing settlement underlying a welfare system, however, interacts with, and is shaped by, the changing value base of society" (Gilson 2003).

"We chose to place it predominantly as a value in this framework since we think values drive and shape the outcomes of health systems" (The Health Foundation 2010, Agyepong *et al.* 2017, Parkhurst 2017).

"Broader contextual influences seep into the daily practice of a health system through the…values that shape the behaviours of the actors within it" (Sheikh *et al.* 2014a).

'Drive' metaphors:

"The values of the community should drive health services" (Mooney *et al.* 1999, Rickles *et al.* 2007, The Health Foundation 2010).

"The technology assembly process is not arbitrary, but heavily values driven" (Giacomini 1999).

Structural metaphors:

"Social and political institutions embodying these norms [truthfulness, solidarity, altruism and fairness] promote affective trust in societies" (Gilson 2003).

"The dominant institutions underpinning these relationships are not economic incentives and regulatory rules. Instead, they are the rules, norms and values that confer responsibilities and rights" (Gilson 2012b).

"The cluster of values surrounding the evolution of the political and social systems sets the scene for the construction of different universal health coverage pathways" (Grundy 2015).

"Reforms often embody values contrary to those held by health workers" (Franco *et al.* 2002).

'Mirroring' metaphors:

"Health care services, like other human service systems, mirror the deeply rooted social and cultural expectations of society as a whole" (Saltman *et al.* 1997).

"The processes, laws and regulations that define how resources and authority are distributed in the health sector, as well as the volume and type of resources available…are a direct reflection of society's values" (Saltman *et al.* 1997).

"Key dimensions of a country's health care system reflect the core social norms and values held by its citizenry" (Saltman *et al.* 2005).

Causal language in the relational claims

When relational claims make use of causal language they suggest either that social values constitute one influence among many, or posit a causal connection that is dependent on congruence with social values. As an example of the former, Frenk (1994) lists 'ideology' as one of four forces leading to health system reform, alongside economic, epidemiological and political forces. Similarly, Renmans *et al.* (2017) state that "ideological inclinations and cultural values influence the design of a specific PBF [performance-based financing] scheme." In both these cases, social values are understood as a causal factor, operating alongside other causal factors. More explicitly, Saltman *et al.* (1997) argue that social values rank, alongside macro-economic factors and demographic issues, as *one of* the most influential contextual factors in health system reform.

In some cases, the relational claims indicate that the influence of social values is conditional – dependent on, or mediated by, alignment or congruence between social values and the health system element in question. For example, Liverani *et al.* (2013) list "the framing of evidence in relational to social values" as one of many political and institutional factors influencing the use of evidence in policy-making. In the same vein, Hanefeld *et al.'s* (2018) claim that "recognizing and aligning policy

with 'values' underpinning health systems [will] affect whether interventions…are succeeding" suggests a connection between intervention success and the intervention's degree of alignment with social values.

For these sorts of claims, the interaction in question is often between two health system components (rather than between social values and a health system component), but is dependent on or strengthened by social values. For example, Roberts *et al.* (2003) state that "even if [health reformers] lack material resources, [they] can still design political strategies that may give [them] substantial leverage in a policy debate, by wisely using symbols that connect to broad social values". This claim posits an interaction between policy-makers and policy outcomes that is contingent on social values.

In addition to claims suggesting that social values constitute one cause among many, and claims suggesting a causal connection that is contingent on social values, many relational claims also position social values as constraining, rather than bringing about, health system change. For example, Redden (1999) (writing on the US context) notes that individualistic principles that dominate the current system "preclude consideration" of collective identities and, therefore, of collective rights – entailing that reform efforts come up against the (in)flexibility of "fundamental American values". Similarly, Watt *et al.* (2017) suggest that implementation can be constrained by "competing management priorities and social norms shaping the interaction between providers and population."

Metaphorical language in the claims

Many relational claims also use metaphorical language that implies a causal connection. At times, the use of metaphor is explicit and purposeful, such as in Sturmberg's (2012) use of the idea of the "health care vortex" as a metaphor for the way in which shared values act as an 'attractor', guiding the behaviour of health system actors, while allowing them to "act in adaptive ways" to generate contextually-specific solutions.[2]

Often, however the use of metaphor is less purposeful (and could be unconscious). In these instances, metaphors usually take the place of verbs, and are used to describe how social values interact with health systems (see Box 1 for examples). As is the case with the claims using more literal language, the chosen metaphors often imply, but do not explicitly assert, that the connection in question is causal. However, even on the weakest possible interpretation, the metaphors suggest that a change in social values will result in a change in (some element of) the health system – in other words, that the nature of the health system is, at least partially, a consequence of social values.

Relational claims about the influence of health systems on social values

In other relational claims, the direction of influence is either reversed (i.e. considered as the influence of health systems on social values) or characterised as a mutual influence. For example, Daw *et al.* (2014) state that "public support for government programs is partly derived from the design of existing programs that shape public views on who deserves to be a beneficiary, to what extent, and for what services". In other words, the design of existing policies shapes users' ideas about justice and entitlement with regards to health care, which in turn influences how users will respond to new policies and programmes (Sheikh *et al.* 2014b).

[2] Sturmberg and colleagues published a number of subsequent papers utilizing this framework, but shifted away from using 'shared values' as the central attractor of the vortex, preferring a conceptualisation of 'core values', i.e. the system's "focus or goals" that "remain unchanged in a changing world" and "should be the health of every patient" (Sturmberg 2012).

As noted, a number of these converse relational claims – claims positing the influence of health systems on social values – indicate that the production or promotion of social values is conceived of as a core capacity of health systems. For example, Gilson (2003) conceives of health system as "purveyors" of social values – and argues that social institutions, such as the health system, can "promote" social values, stating, "social and political institutions embodying these norms [truthfulness, solidarity, and fairness] promote affective trust in societies by committing and enforcing upon all those involved in them a specific set of values." Similarly, Frenk (2006) suggests that health systems can "reflect and reinforce" social values, and therefore that health system reform efforts should begin by considering which values the health system should be designed to "promote." Indeed, Sage (2009) proposes that health system reform is an *opportunity* to "recalibrate" social values. These claims suggest that health systems have the capacity to influence social values.

Identifying a line of argument: The capacity of the health system to influence social values

Seeking to better understand how social values could be an *output* of health systems, we explored conceptualisations of the capacity of health systems to influence social values. The relational claims revealed four distinct but related mechanisms, which are explored in turn in this section.

Health systems can offer a unifying national ideal and build social cohesion

Firstly, health systems are frequently conceptualised as symbols of national identity that offer unifying ideals and build social cohesion. Canada presents a particularly striking example: Both Redden (1999) and Axworthy *et al.* (2002) argue that the Canadian public healthcare system is an important symbol and defining attribute of national identity. Similarly, Daw *et al.* (2014) suggest that Canadians' strong support for universal health coverage reflects the popular conceptualisation of the health system as a "fundamental cornerstone of Canadian identity" (see also Giacomini *et al.* 2004). More generally, Kruk *et al.* (2010) and Gilson (2003) propose that, particularly in countries destabilised by violence and conflict, governments can use value-based rehabilitation of health systems to contribute to social cohesion, and create a sense of shared identity.

Health systems can influence user's understanding of rights, entitlements and the appropriate role of the state in delivering these

Secondly, health systems are often seen to influence users' understanding of their rights and entitlements by legitimising ways of working that reflect values. For example Saltman *et al.* (1997) argue that the primary role of the state in the delivery of health services in some Western European countries has been legitimized over time through democratic elections and now constitutes a "deeply rooted norm" in those countries. Similarly, as noted above, Frenk (1994) suggests that the state can use healthcare workers to offer the public "alternatives to magical and religious" worldviews, and can therefore be used to "legitimize different modernising ideologies." In this way, health systems can communicate values to the public (Kruk *et al.* 2010).

More perniciously, both Kruk *et al.* (2010) and Freedman (2005) argue that user fees and other financial barriers to care legitimate the exclusion of population groups unable to pay. In other words, by systematically denying the poor access to health services, the system can actively shift popular perceptions about rights and entitlements, ultimately legitimising this inequality. This example demonstrates that this legitimizing process is not necessarily a product of users' direct engagement

with the health system, because values can also be legitimised by the "structure of a health system", as is the case with financial barriers that communicate the acceptability of inequality to users, those excluded, and the broader population (Freedman 2005).

One of the most clear examples emerging from the literature of this capacity to influence social values and popular norms is the influence of neoliberal economic reforms on the structure of health systems (the health system components that support service delivery, such as financing mechanisms, the role of political oversight, the relationships between them (Frenk 1994, Sheikh *et al.* 2011, Fox *et al.* 2013)), and the resultant shift in popular beliefs about the appropriate role of the state in the health system. Beginning in the 1980s, capitalism and neoliberal economic reforms that encouraged market-based mechanisms resulted, in many contexts, in a limiting of the role of the state, for example to the regulation and governance of non-state providers, or to provision only of basic services to the very poor (Heslop *et al.* 2003, Fox *et al.* 2015). The balance between state versus market in the provision of health care is commonly understood to be an ideological consideration, albeit primarily driven by global trends rather than local values and preferences (Walt *et al.* 1994, Bloom *et al.* 2008, Fox *et al.* 2013). For example, Reinhardt (2003) warns that the incorporation of USA-style private health insurance into the Canadian health system will ultimately shift Canada's "social ethics" to be more like that of the USA.

While the Canadian case reflects a rejection of neoliberal, market-oriented reforms on the basis of values, in other cases neoliberal values have become so deeply embedded as to be considered unchangeable. For example, Heslop *et al.* (2003) argue that in the USA, the dominance of market mechanisms for health service delivery has become normalised as a result of the interests of "an organized alliance of health insurance companies and delivery organizations" with an outsized influence on the legislative process, despite the fact that the values implicit in this approach do *not* reflect those of the majority of the US population. Others considering the US context, however, indicate that social values have been shifted over time as a result of the market-oriented health system structure. Schlesinger (2002), for example, states that "when goods and services are portrayed as marketable commodities, fairness is defined primarily in terms of individual choice and personal deservingness." These examples suggest that health system architecture influences popular social values concerning the appropriate role of the state in health systems.

Health systems can strengthen public trust in the state and legitimise state authority

In addition to the capacity of the health system to build a sense of shared identity and values, and influence popular beliefs about health rights and entitlements, a third mechanism by which health systems can contribute value to society is by improving levels of public trust in the state and legitimising state authority (Gilson 2003, Bouwman *et al.* 2015). Abelson *et al.* (2009) suggest that because "publicly funded health systems comprise such a large degree of state-citizen interaction…mistrust of health systems may contribute to a general mistrust of government." In other words, as a site of regular interaction between citizens and the state (Gilson *et al.* 2017), the health system has the capacity to build public trust in the state. This idea is reinforced by Gilson's (2003) suggestion that social institutions (like health systems) that embody social norms can garner public trust, and therefore strengthen the relationship between citizens and the state. Often, however, this trust is considered contingent on alignment between the values represented by the health system, and dominant social values. Kehoe *et al.* (2003), for example, conducted a study on values as a

determinant of trust in health policy-makers, and found that when policies are perceived by the public as misaligned with their values, public trust in government is negatively affected. Similarly, Abelson *et al.* (2002) argue that the trusting relationship between citizens, health professionals and the state that once characterised the UK's National Health Service (NHS), has been eroded by "consumerism" and "entrepreneurial values."

This potential of health systems to strengthen the citizen-state relationship by building trust in the state is likely partly a function of users' direct interaction with the health system, as Abelson *et al.* (2009) and Gilson (2005) suggest. However, other authors argue that accountability mechanisms (Schaaf *et al.* 2017), policy decision-making processes (Chinitz *et al.* 2009, Abelson *et al.* 2013), how a health system is financed (Gilson 2005), and a history of public action in relation to health systems (Gilson 2005) all impact the relationship between citizens and the state. This indicates that the architecture of health systems is as important to building value in society as is the direct interaction of patients with health providers. For example, in the UK's NHS, the system was perceived as 'fair' by users as a result of the absence of direct financial incentives affecting the behaviour of providers, which increase user trust in providers (Gilson 2003).

Health systems can indicate extent to which various population groups are valued by the state

The fourth mechanism for the generation of social value is the capacity of health systems to communicate values by indicating the extent to which various population groups are valued by the state. Because health care and other public services are the site of a large proportion of citizen's daily experiences of the state, and because the outputs of health policy make visible the states' prioritisation of scarce resources across inequitable societies (Kruk *et al.* 2010), the system signals the "value the state…places on different people" (Gilson *et al.* 2017). For example, Reinhardt (2003) suggests that by paying providers in a sector intended to serve the poor less than what is considered appropriate payment in a sector predominantly serving the rich, the purchaser, in this case, the state, signals that the health of the poor is less valuable than the health of the rich. Similarly, Gilson *et al.* (2017) argue that citizens' "experience of abuse at the hands of health care providers represents a soul-destroying confirmation that they are not valued or cared for by society." These claims indicate that as a site in which the consequences of prioritisation decisions are made visible to the public, health systems communicate the values of the state to the public.

Synthesising the relational claims into a common frame: Social values in dynamic networks

After exploring conceptualisations of the relationship between health systems and social values found in HPSR literature, and suggesting that, together, these relational claims suggest four mechanisms by which the health system can generate social value, we now present a synthesis of the relational claims and argue that this points toward an explanatory theory for this capacity of health systems.

The synthesis, presented in Figure 1, was achieved by combining the relational statements under a single frame in two analytic steps. First, we plotted each relationship claim as a values-based connection between health system components. In order to retain the nuance and complexity of the original conceptualisations, we noted the system functions referred to in each relational claim alongside the relevant component, and noted terms describing the nature of the connection. Each connection between two elements was drawn only once (regardless of how many claims suggested

it), and the various functions and characteristics mentioned in the relational claims were grouped under the relevant element of the health system. The direction of influence (where discernible) was indicated by arrows. The resulting diagram is presented in Figure 2.

Because some relational claims posit that social values influence one or more system components,

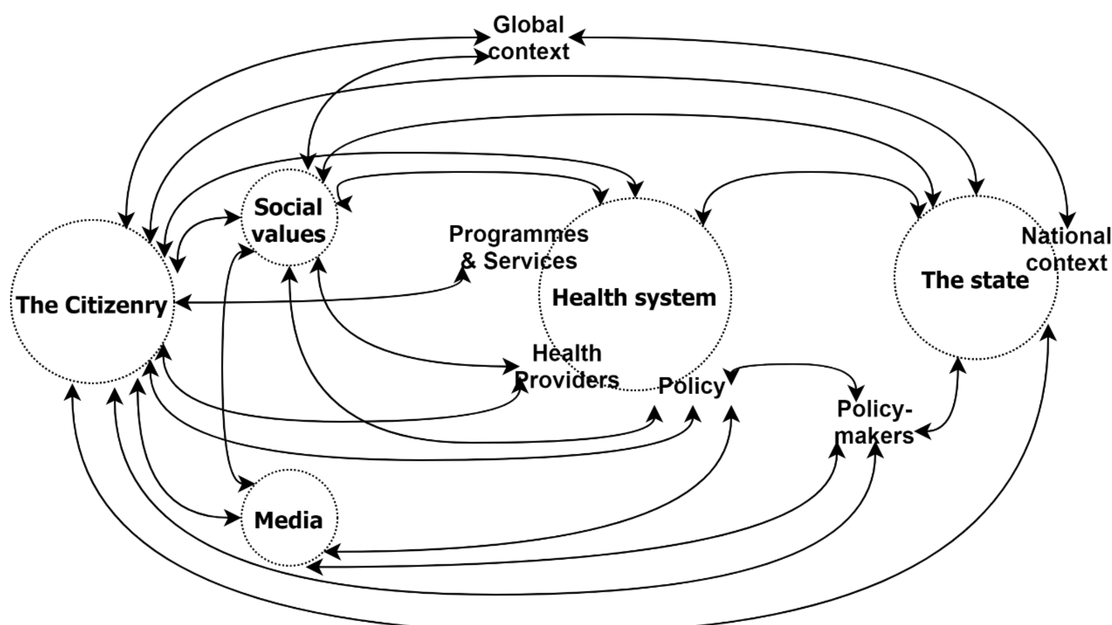


Figure 1: Relational claims synthesised under a common frame

while others suggest a connection between two health systems components that is conditional on, or mediated by social values (as noted above), social values are represented in the synthesis both as a component of the system and in the connections between components.

In addition, because the relational claims are all extracted from HPSR literature, it is not surprising that the idea of the health system as a network of interactions between hardware and software elements of the system (a core concept in HPSR) is common across all the claims. As such, all the types of relational claims discussed already – those asserting a direct causal influence, those suggesting a relationship of constraint rather than enablement, interactions that are conditional on alignment with social values, claims using metaphorical language that suggest dependent relationships, and claims about the influence of health systems on social values (as opposed to the influence of social values on health systems) – can be translated into connections between health system elements.

In the second step, in order to simplify the diagram visually, and aid interpretation of the synthesis, we grouped closely related health system components, removed the functions within each component, consolidated the connecting lines, and removed the descriptors of the nature of the relationship, resulting in Figure 1.

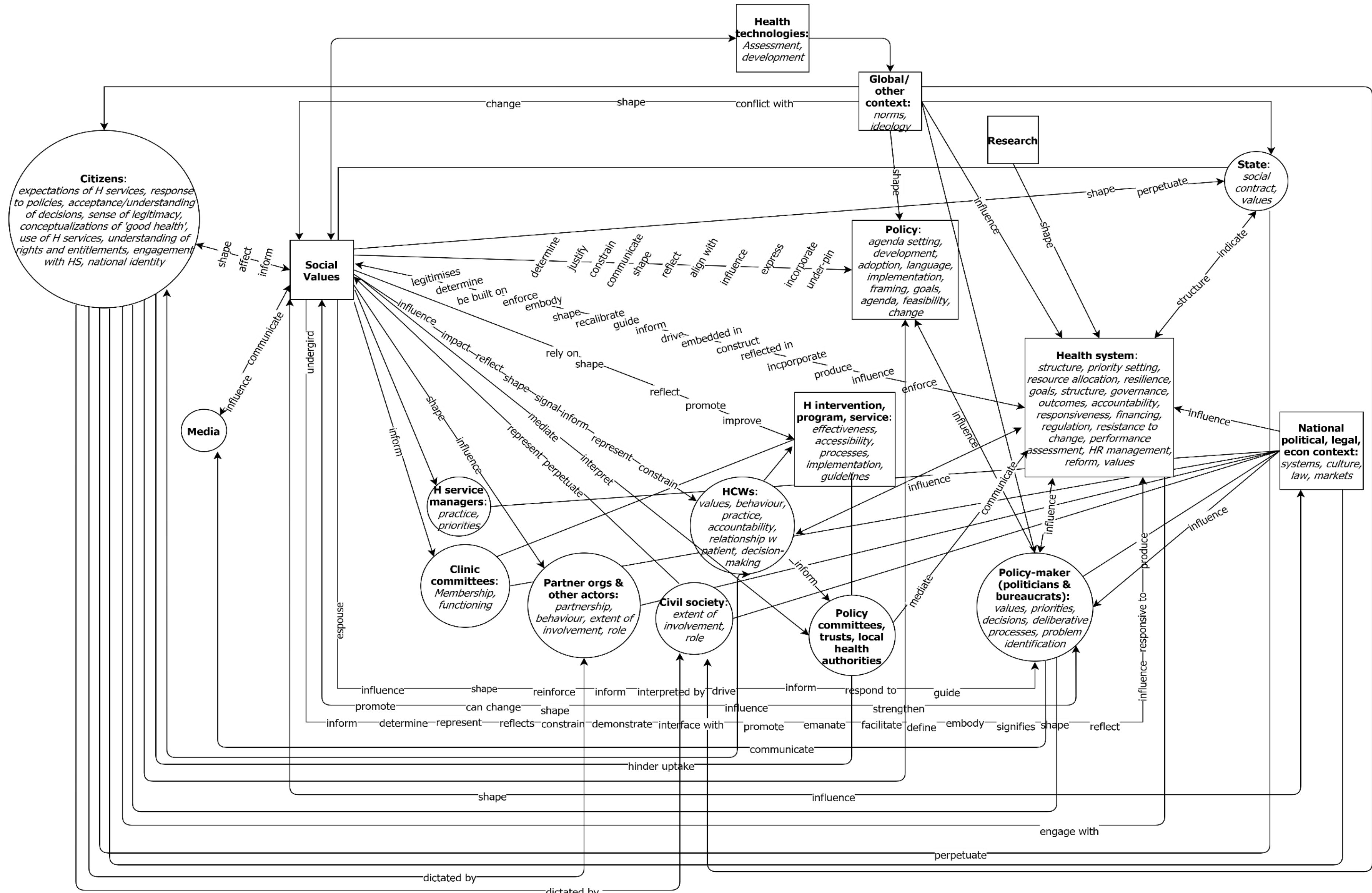
Neither figure is presented as a conceptual framework; the intention is not to simplify complexity for the reader, but rather to synthesise the relational claims within a single frame in order to capture and reflect the full complexity, while allowing the conceptualisations of the relationship between health systems and social values to be considered together (Noblit *et al.* 1988). Nonetheless, the synthesis reveals the dynamic network of interactions between social values and various components of the health system, and the role social values play therein.

Mapping the relational claims into a single frame reveals a complex network of connections not contained within each individual relational claim between health system elements, health systems and the societies in which they are embedded, and health systems and dimensions of the global context. For example, Percival et al.'s (2018) exploration of social norms that devalue women and girls, suggests that social values operate within health systems to influence the dynamic interaction between healthcare worker behaviour and programmatic outcomes. Combining this relational claim with others under a common frame reveals that the particular dynamic captured by Percival *et al.* (2018) is also influenced, for example, by health policy-makers' interpretation of available evidence, itself shaped by social values as demonstrated by Liverani *et al.* (2013). In short, the diagram reveals a dynamic network of values-driven influence between health system components.

Synthesising the multiple relational claims under a common interpretive frame also demonstrates the possibility for dynamic interaction between health systems and features of the national social and political context, such as laws, economic trends and the media. For example, George *et al.* (2015) argue that, in Brazil, the country's history of authoritarianism undermined the functioning of community health councils, an idea echoed by McCoy *et al.'s* (2012) claim that "the political, social and cultural features of society" shape popular attitudes towards community participation in health. This connection – between social and political characteristics and the functioning of public participation fora – exists in dynamic interaction with, for example, the strength and legitimacy of formal regulatory and governance bodies, itself acknowledged to be influenced by social values (Gilson 2012b). The synthesis also demonstrates the role of other social institutions, such as the media and civil society. As Abelson *et al.* (2017) note, for example, the media can generate awareness on issues that align with, or conflict with, public values, increasing the likelihood decision-makers are compelled to take those values into account. In addition the synthesis places both patients and healthcare workers in their social context, suggesting, for example, the influence of citizens values that may differ from patient values (Mooney *et al.* 2004), and the dynamic interaction between social values, political culture, organisational norms, governance arrangements and management practices in influencing the behaviour of healthcare workers (Atkinson 2002, Franco *et al.* 2004). In short, synthesising the relational claims under a common frame reveals the intricately embedded nature of health systems in their social contexts (van Olmen *et al.* 2012b, Grundy 2015).

In addition to complex networks of interactions *within* national health systems, and between health systems and their social and political context, the synthesis makes manifest another element of the embedded nature of complex systems: the influence of the global on the local. In some papers, the values-influence of the global is understood as a by-product of the natural uptake of technologies and interventions originating in other contexts. For example, Hanefeld *et al.* (2018) suggest that "international humanitarian interventions shape and interact with local values shared by health workers, patients and communities." Similarly, Reinhardt (2003) argues that as a result of geographic and cultural connections to the USA, as well as shared participation in international trade agreements that enable the export of health care products (such as private insurance policies) from the USA to other countries, Canada is at risk of importing a set of values entirely at odds with those embodied by the Canadian health system.

Figure 2: Diagrammatic synthesis of relational claims



However, the synthesis demonstrates that the flow of medical products and technologies takes place in a context of shifting norms at ideologies at the global level. As discussed, many of the papers that suggest global-national connections in relation to social values, focus their attention on neoliberalist ideologies and their pernicious influence on national health systems. Collins *et al.* (1999) describe neoliberalism as a "worldwide ideological hegemony" that steers health system reforms toward market-driven approaches, and Fox *et al.* (2015) concur that neoliberal reforms were ideologically inspired. As Lencucha *et al.* (2018) note, neoliberal ideologies that "shape the global economic order" may well be contrary to "social and cultural norms that express the right to health," – suggesting that the relationship between health systems and social values, is itself subject to the influence of shifting values at the global level.

While these examples suggest an influence of exogenous neoliberal values on national health systems, some relational claims go a step further to indicate that the influence of these exogenous ideas on national health systems can lead to changes in national values. For example, in a report on health care reform strategies in Europe in the 1990s Saltman *et al.* (1997) note that the reform process in many European societies was "influenced by the radical market-oriented thinking of the 1980s" and, as a result, those societies "increasingly perceive health care as a commodity that can be bought and sold on the open market" – suggesting that neoliberal ideologies can be internalised into society's conception of the nature of health and the entitlement to health care. Malone (1999) explores the role of language, and particularly metaphor, in this transference, and finds that in the USA, metaphors reflecting neoliberal ideologies came to supplant other ways of understanding healthcare, and therefore restrict what policy changes are considered acceptable or appropriate. Similarly, Walt *et al.* (1994) argue that the dominance of neoliberal ideas challenges, and may undermine or destroy, socially accepted ideas of "public purpose, public morality, and public accountability." Synthesised into a single frame, these relational claims position national health systems as conduits through which powerful ideas at the global level are transmitted to individuals and communities.

As a synthesis of the relational claims identified in the HPSR literature, Figure 1 presents a dynamic network of interactions between actors, organisations, institutions and processes, spanning local, national and global levels. In other words, it presents the relationship between social values and national health systems as a dynamic network of interactions, embedded within larger (global) systems, and subsuming smaller systems (including local, organisational and interpersonal dynamics) within them (Hoffman *et al.* 2012, van Olmen *et al.* 2012a). In the next section, we explore how this dynamic network of interactions explains the capacity of health systems to generate social values.

Offering an initial explanatory theory: Social value as an emergent product of complexity

Considering the relationship between health systems and social values in this way reveals a plausible explanatory theory for the social value of health systems. It suggests that the capacity of the health system to generate social value – by offering a unifying ideal, shaping the public's understanding of their rights and entitlements and the responsibility and legitimacy of the state to meet those obligations, improving popular trust in the state, and communicating the value the state places on various population groups – is an emergent property of a complex system (see Box 2). In other words, the interpretive synthesis indicates that complex adaptive systems theory provides an explanation for how social values operate within health systems, and how health systems in turn generate social

values. In this section, we demonstrate how this explanatory theory emerges from this interpretive synthesis.

Complex adaptive systems theory suggests that emergence, along with feedback, non-linear causality, openness, path-dependence, self-organisation and sensitivity to initial conditions, are fundamental characteristics of all complex systems (Rickles *et al.* 2007, Ramalingam *et al.* 2008, Marchal *et al.* 2016) (see also Box 2). The emergent properties of a complex system are those properties that arise out of the dynamic interaction of system elements, but which are not possessed by any element within the system (Atun *et al.* 2008, Jones 2011). In other words, by virtue of the complexity of interactions between elements of the system, patterns begin to emerge in the system as a whole, allowing the system to have properties that would not result from any one particular interaction between system components (Rickles *et al.* 2007, Ramalingam *et al.* 2008). Emergent properties are a function of feedback loops, which occur when interconnections between system elements create loops, giving rise to a circular process of cause and effect (Rickles *et al.* 2007, Atun *et al.* 2008).

Box 2: Systems thinking and Complex adaptive systems theory

'Systems thinking' considers systems as a network of subcomponents and highlights the connections and interactions between subcomponents and the impact of this interconnectedness on the capacities of the system.

'Complex adaptive systems theory' can be understood as a category of systems thinking. As a conceptual tool for understanding the behaviour of complex systems, it posits

Emergence: System characteristics emerge from complex interactions among component parts. The whole is different to the sum of its parts

Feedback: Information loops operate within the system

Non-linear causality: Changes have disproportionate effects. Outcomes of intervention are often unpredictable.

Openness: Boundaries are poorly defined. Systems influence and are influenced by larger context in which they are nested

Path-dependence: Systems are constrained by history

Self-organisation: Tend towards equilibrium, an apparent order underlies seemingly random interactions between elements

Sensitivity to initial conditions: Features of an initial state of affairs can have powerful effects over time.

References: (Rickles *et al.* 2007) (Ramalingam *et al.* 2008) (The Health Foundation 2010) (Grundy 2015) (Marchal *et al.* 2016) (Parkhurst 2017)

In HPSR, systems thinking – as an approach that applies complexity theory to health policy and systems (HPS) issues – considers health systems as complex systems, made up of connections, interactions and networks between systems elements, including actors (Ramalingam *et al.* 2008, Marchal *et al.* 2016). This perspective accounts for the social nature of health systems, and therefore considers the elements of the system from which complexity arises to include 'hardware' elements (structures, organisations, and technologies) and software elements (people, relationships, cultures and values), as well as the influence of the social, political, and economic context on the system (Sheikh *et al.* 2011, Gilson 2012a, Marchal *et al.* 2016). Here, we show that interpreting the complex network of interactions that form the relationship between health systems and social values from a systems thinking perspective accounts for how HPSR authors write about the relationship between health systems and social values.

Firstly, feedback loops and emergence account for the influence of health systems on social values and the ability of health systems to inform popular understandings of justice in relation to health care. A number of relational claims proposed a macro-level feedback loop between social values and the health system as a whole. For example, Paton (2013) argues that health systems shape ideology, but also, conversely, that ideologies can shape health systems. Similarly, Sheikh *et al.* (2014b) state that

"values drive people's decisions within the health system contributing to change, and conversely, system reforms can have impacts on people's values within the system." van Olmen *et al.* (2010) specify two likely feedback pathways, stating that health systems "are shaped by values and…enforce these values, through their structure and the inter-personal relationships." Conceptualising the operation of social values within health systems as a complex phenomenon with emergent properties suggests that these value-inputs shape health systems, and that, over time, the health system legitimises these values, which then come to be seen as appropriate, or even necessary. This is explained by the self-organising nature of complex systems – from the dynamic network of individual interactions, "patterns emerge which ultimately inform and change the behaviour of the agents and the system itself" (The Health Foundation 2010). So, for example, when Heslop *et al.* (2003) say that the structure of the US health system reflects the values only of the corporate elite, but others such as Schlesinger (2002) and Sage (2009) disagree, it may well be because the influence of the system on society as a whole is such that the values of the system have become, or are becoming, accepted as appropriate or just by the population.

Thinking of values as becoming institutionalised over time through feedback loops also accounts for instances in which social values are seen to constrain system change, as is the case when the current design of health programmes shapes "public views on who deserves to be a beneficiary, to what extent, and for what services" and therefore determines public support for or opposition to new programmes or policies (Daw *et al.* 2014). For example, in a study exploring provider-imposed access barriers in the context of access to family planning services, Calhoun *et al.* (2013) suggest that because providers take community and social values into account in deciding what advice and information to give to patients, they inadvertently reinforce social norms by reflecting community values back to patients. In such a case, a health systems intervention to counteract pernicious social norms through a public education campaign might have little or no effect if the behaviour of healthcare workers serves to reaffirm existing norms.

From a more macro perspective, health systems are generally understood to be resistant to change (De Savigny *et al.* 2009), and this can now be understood (at least in part) as a result of values being institutionalised and legitimised over time. As Freedman *et al.* (2005) state "the status quo implies acceptance of the values that currently drive health and health systems." In the same vein, Paton (2014) argues that "ideas about what is possible are influenced over time, and that can – over an even longer period of time – lead to those ideas coalescing into an ideology of what is desirable…[causing reformers to] trim not only their legislative ambitions, but also their very way of thinking about the issue." On this account, if health systems are complex social systems in which values are enforced, legitimised and institutionalised (Saltman *et al.* 1997, Freedman 2005, van Olmen *et al.* 2010, Seidman *et al.* 2016), it is because a myriad of interpersonal interactions over time continually reinforce the ideas underlying the status quo, which in turn determines the 'framework of values' (Giacomini 2005) within which decisions about the future are made. Thus, as a result of its complexity, the system develops path-dependence – the feedback loops become self-sustaining, and the system becomes increasingly resistant to change.

A systems thinking perspective also helps to explain how health systems can generate social value by presenting society with a unifying ideal. Meynhardt (2015) suggests this possibility, using the phrase 'circular causality' to describe a process of emergence of social values in which "interactions between

different elements (people, groups, etc.) leads to the emergence of collective properties (e.g. shared worldviews, norms and values) which in turn promote consensus, coherence and orientation in chaotic interactions at a microlevel." In other words, the system has the capacity to influence social values with respect to healthcare, and these values are legitimated, institutionalised and, therefore, reinforced over time – thereby generating a consensus that becomes more and more deeply rooted over time. Thus, the Canadian commitment to universalism in healthcare, and the role of the state in providing it (Redden 1999, Daw *et al.* 2014) (discussed above) might be understood as an emergent property of the country's health system.

The systems thinking perspective suggests a similar explanatory mechanism for the ability of the health system to communicate the extent to which various groups of the population are valued by the state. As discussed above, the health system is one of the sites through which citizens regularly interact with the state, providing the state "with one of the most visible outputs of policy" (Walt 1994) The synthesis presented in the previous section captures this relationship insofar as it positions health systems as a mediator of the relationship between citizens and the state – suggesting that information about value judgements flow, through a dynamic network of interactions, between citizens and the state. Over time, therefore, users' experiences of the health system may well begin to influence the extent to which they feel they are valued by the state, and either strengthen or weaken the state's legitimacy.

Systems thinking also suggests an explanation for the neoliberal phenomenon mentioned above – that of shifting popular perceptions about the appropriate role of the state in health care delivery, financing and governance. As was discussed, in some cases neoliberal values come to influence social values through their institutionalisation in the health system. In other cases, however, the values underpinning national health systems are too deeply rooted to be shifted, and neoliberal reforms are rejected. For example, Harrison *et al.* (2000) write of the Swedish experience that "the electorate and politicians…began to withdraw their support for market-type experiments and neo-conservative ideologies, once it became clear that exposure to market forces could weaken Sweden's social welfare system…and threaten the country's historic commitment to social equality." The fact that in some contexts neoliberal reforms are adopted, while in others they are roundly rejected, can be explained not only by the unpredictability of complex systems' responses to new stimuli, but also by the fact that, in complex systems, history matters (De Savigny *et al.* 2009, Gilson 2012a, Bloom 2014, George *et al.* 2015). The likelihood of adopting neoliberal reforms depends not only on present conditions, but also on historical conditions.

Within health systems the influence of social values is evident across a myriad of elements, functions and relationships. In addition, health systems play an important social role as *generators* of social value. This paper has proposed an explanatory theory for the capacity of health systems to generate social value. On this account, this capacity is an emergent property of the dynamic network of connections through which values operate within health systems, and between health systems and their social and political contexts. As such, the relationship between health systems and social values is causal, but complexly so. Complex causality, a defining characteristic of health systems and a foundational concept within HPSR (Gilson 2012a, Langlois *et al.* 2018), suggests that an effect need not be "linked by a linear and predictable path to a cause," but rather that an observed effect is likely the result of multiple-interacting causes (Gilson 2012a).

Conceptualising the relationship between health systems and social values as complexly causal, accounts for the ways in which the relationship is commonly conceptualised in HPSR literature. As noted above, where it is presented as causal, the influence of values is usually considered to be one among many influences – i.e. one connection within a dynamic network of connections. In other cases, it is presented as conditional on alignment between two sets of values, indicating that the potential influence of values depends on, for example the initial conditions of the system, or the interaction between system components and features of the broader socio-political context. In still other cases, social values are conceptualised as constraining system change – accounted for in this explanatory theory by the fact that values, and their institutionalisation over time, is one of the reasons for the change-resistant and path-dependent nature of health systems.

The idea of complex causality also makes sense of the prevalence of metaphor in the relational claims. As Sturmberg *et al.* (2010), “metaphors are central to the human understanding of complex issues,” because they allow us to subsume conceptually challenging or unfamiliar ideas with familiar, everyday ideas. As demonstrated above, most of the metaphorical language used in the relational claims took the place of explicitly causal language (such as ‘drives’, ‘underlies’, or ‘mirrors’, rather than ‘impacts’, influences’ or ‘causes’). It is likely that metaphorical language is so common because it allows authors to imply a complex causal interaction, or a dependence relationship, but not a direct, simple causal connection.

Leveraging the social value of health systems: Practical implications accounting for complexity

This synthesis is necessarily dense, and the explanatory theory, by nature, initial. Current thinking on social values in health systems is nascent, although agreed to be important, and has not been critically interrogated through ongoing dialectical engagement (Whyle *et al.* 2020). We explored the ways in which health systems are understood to be capable of contributing social value to the society in which they are embedded, and argued that this capacity is an emergent property of complexity in health systems. We also noted that complex systems are understood to be path-dependent and change-resistant, and that interventions are likely to have unpredictable consequences. This poses a particular challenge to health system reform efforts, which are often understood to be driven more by values and ideology than by evidence or reason (Saltman *et al.* 1997, Collins *et al.* 1999) and the policy decision-makers who seek to institute them. Here, we offer lessons for policy-makers and researchers seeking to bring about values-based change in health systems. 'A summary of lessons for policy-makers and researchers is given in Box 3 and Box 4, respectively.

Box 3: Summary of lessons for policy-makers

- Diffuse values-based change through multiple policies, programmes and interventions across the health system.
- Take advantage of policy development processes as opportunities for values-based dialogue and consensus-building.
- Ensure that the language used in policy documents and in public communication reflects values.
- Act as ‘interpreters’ to ensure that values derived from public consultation and engagement are appropriately reflected in policy.

Lessons for policy-makers

Health systems are change-resistant, in part, because values become institutionalised and legitimised over time. As a result, attempts to influence the status quo by introducing progressive values in one programme or policy, are unlikely to have a substantial effect on the system as a whole. As Freedman et al. state, attempting to bring about change by deploying equity oriented policies “around the edges

of a system whose structure is profoundly inequitable…will not work" (Freedman *et al.* 2005). This reflects the fact that, that values are communicated to citizens through their interaction with health providers, but also through the structure and organisation of the system as a whole (Freedman 2005, van Olmen *et al.* 2010, Gilson 2012a). As such, policy-makers should be cognisant that values matter – deeply, and in *every* policy change process. In order to shift the trajectory of the system, values-based change must be diffused *throughout* the system, and should take place through multiple interventions across system components – even in ostensibly technical policy arenas such as financing or technology assessment (Gilson *et al.* 1999, Littlejohns *et al.* 2012, Fox *et al.* 2013, Fox *et al.* 2015). This may require developing a values-based strategy for health system reform used to drive incremental change across health system components.

Box 4: Lessons for researchers

- Develop a disciplinary language that reflects the complex reality of causal connections in health systems.
- Employ synthesis approaches that capture nuance and complexity to inform systems-oriented interventions.
- Consider values as drivers of behaviour and decision-making in actors, but also as important contextual and historical factors.
- Conduct HPSR that has conceptual utility to policy-makers, and that promotes values-based change in health systems.

A second lesson is that the policy-making *processes* matter as much as the policies themselves. Health policy decisions only rarely involve a choice between conflicting social values, but more often require trade-offs between competing values – a process of deciding which value to prioritise (Giacomini *et al.* 2004, Weale *et al.* 2016). Thus, policy processes should be dialogic sites for deliberation and consensus-building (Frenk 1995), involving policy-makers "in partnership with an informed public" (Weale *et al.* 2016). A number of the papers discuss public participation mechanisms that involve deliberative methods as a way to draw out or make explicit social values (Redden 1999, Bombard *et al.* 2011, Abelson *et al.* 2018), but as Bombard *et al.* (2011) note, such processes are also an opportunity to *reinforce* social values by allowing for the identification of commonalities across citizen perspectives, or allowing "members to find common ground." Rather than simply a process of "securing a negative consensus on the shortcomings and deficiencies to be rectified," health policy processes should be used as opportunities to build a "positive consensus" about values that "are likely to lead the system to a higher stage of development" (Frenk 1995).

To do so, policy-makers should pay attention to language. Policy discourse, rhetoric and metaphor has an impact not only on how citizens perceive those policies, but also popular conceptualisations of what is right and just in relation to health policy (Malone 1999, Waitzkin *et al.* 2001, Schlesinger 2002). This entails that pernicious ideologies in policy discourse can become popularly accepted values. In this vein, Schlesinger (2002) argues that "policy frames incorporate particular norms of fairness. When goods and services are portrayed as marketable commodities, fairness is defined primarily in terms of individual choice and personal deservingness…[and] these notions of fairness would become the primary way of judging equity". However this also entails, that policy-makers and other actors have the power to start to shift dominant values by changing policy discourse (Exworthy 2008). Freedman *et al.* (2005) argue that "the more government signals its values through its decisions, proclamations, speeches, and actions…the quicker such values become normalized and part of the accepted discourse of the society." Therefore, policy-makers should pay close attention to language choices in the framing and communication of policies (Bennett *et al.* 2011, Gilson 2019).

Lastly, incorporating social values into policy decisions requires policy-makers to act as interpreters of social values. Social values change over time, and this requires that policy-makers be sufficiently in-tune with shifts in national values to understand what policy changes or system reforms are feasible in that particular context, and to formulate resonant rationale for proposing new policies (Giacomini 2005, Saltman *et al.* 2005). However, social values are not objective – even when evidence about the public's values and preferences is available, substantial interpretation is necessary before it can be used to guide policy (Tenbensel 2002). As such, policy-makers should consider themselves *in partnership* with informed publics and incorporate social values, evidence and their own judgements into policy decisions (Mooney *et al.* 1994, Martiniuk *et al.* 2015, Weale *et al.* 2016). In doing so, however, policy-makers should be wary of the self-regulating nature of health systems and guard against the tendency to allow the status quo to define what is possible or desirable (Paton 2014).

Lessons for researchers

The lessons for policy-makers require a change in perspective in the form of a values orientation and attention to complexity. HPS researchers can support this shift.

Firstly, HPS researchers working with values must strive to develop a disciplinary language that does not shy away from complexity – in this case explicitly identifying non-linear causal connections and considering the influence of contextual and other factors. While the use of metaphor may be an inescapable part of grappling with complexity, the *choice* of metaphor is important, because metaphors are not only a function of how we speak, but also shape how we think and how we act (Lakoff *et al.* 1980, Sturmberg *et al.* 2010). Using metaphorical language risks obscuring the complex but *causal* nature of the relationship between health systems and social values, and may therefore, inhibit policy-makers and others from considering health systems as levers for positive social change.

Secondly, researchers seeking to synthesise evidence about complex health systems to influence policy processes, should consider synthesis approaches that capture, rather than obscure or simplify, real-world complexity (Anderson *et al.* 2013, Langlois *et al.* 2018). Health systems are inherently complex and "can only be understood by observing the relations and interactions between the elements, not simply by analysing the system's elements in isolation" (Marchal *et al.* 2016). In this study, we borrowed methodological tools from meta-ethnography, and synthesised the relational claims by presenting them under a common frame. This allowed us to capture the complexity and nuance present in the original papers, and as a result, demonstrates the possibility for dynamic interaction. This, in turn, pointed toward emergence as an explanatory theory. This approach demonstrates the potential of reviews that seek to capture complexity, and reveal the interlinkages between system components (Langlois *et al.* 2018). Such evidence can then be used to inform "system-oriented interventions" (Langlois *et al.* 2018).

Thirdly, this study demonstrates the value of using systems thinking in health policy analysis to understand the role of values in policy processes. Policy analysts are compelled to pay close attention to the behaviour or health system actors, which is strongly influenced by social values (Walt *et al.* 1994, Gilson *et al.* 2018). In addition, "conflicts over values are particularly stark in the health policy arena," (Walt *et al.* 1994) and therefore health policy analysis presents a wealth of knowledge on the influence of values in policy processes. However, the focus on actors in Health Policy Analysis can mean that consideration of values is restricted to the influence of the values of key actors on policy

decisions, and there is a recognised need for more research to understand "the clash of values" that influence health policy processes (Koon *et al.* 2016).

This study demonstrates that a systems thinking perspective can aid health policy researchers to recognise, and account for, the broader influence of values – including in the influence of past policies, the structure of the health system, and the dominant values and political realities in the context and globally – alongside considering the values of policy actors. For example, while the review did not collect data on the political organisation of countries studied, many of the relational claims suggest that contextual particularities of political organisation will influence the behaviour of system actors and the shape of health systems, and are relevant to understanding the role of values in policy change and system reform (Frenk 1994, Harrison *et al.* 2000, Boufford *et al.* 2002, Liverani *et al.* 2013, Grundy 2015, Fusheini *et al.* 2017). This dynamic presents a fruitful potential area for future research using principles of systems thinking to understand the complex role of values in health policy change in context.

Lastly, while HPSR is, by definition, an applied field that seeks to "strengthen health systems so they can better achieve their health and broader social goals," (Gilson *et al.* 2018) it is important to remember that the value of research to policy-makers is not limited to its capacity to determine the best solution for a particular policy problem (Sheikh *et al.* 2011, Torrance 2017). HPSR can contribute to promoting values in health systems by "exploring the societal relevance and purpose of systems," (Sheikh *et al.* 2011) and by "shifting the framing of health policy debates, and gradually influencing the nature of dialogue" (Bennett *et al.* 2011). Policy problems and policy processes present considerable complexities in their own right, and research that offers conceptual insights of relevance to policy problems, and shapes the thinking of policy-makers, can have substantial impact in the long-term (Gilson *et al.* 2008, Bennett *et al.* 2011).

Conclusion

This paper has presented the results of an interpretive synthesis of HPSR literature on social values to generate a plausible and initial explanatory theory for an observed phenomenon. We have demonstrated that systems thinking can offer an explanatory theory for the social value of health systems as an emergent property of complexity. In the interpretive paradigm, any interpretation of the evidence is offered as one possible plausible reading of the phenomena being studied (Noblit *et al.* 1988) As such, the account presented here should be judged on its plausibility and coherence as an explanation for the capacity of health systems to offer social value.

Nonetheless, we intend the account presented here to have real-world utility in policy processes and be of conceptual use to policy-makers and researchers (Gilson *et al.* 2008). In offering a way to conceptualise the relationship between health systems and social values, and the capacity of health systems to generate social value, we hope to encourage HPS researchers and health policy-makers to more rigorously consider the potential of health systems to strengthen societies, and the effect their work has in this regard. In addition to aiding policy-makers grappling with values-based change in complex, path-dependent systems, we hope that this theoretical work will be further tested and refined by future researchers. If, by paying attention to values and how they operate in complex social systems, it is possible to use those systems to build stronger, more cohesive and more just societies, then endeavouring to understand how to do so is well worth the effort.

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Chapter 3 – What are social values? Interdisciplinary insights from the Social Sciences for Health Policy and Systems Research

Chapter 3: What are social values? Interdisciplinary insights from the Social Sciences for Health Policy and Systems Research

Overview: This Chapter presents a transdisciplinary scoping review on values and social values in the social sciences, drawing out insights of particular relevance to health policy and systems researchers, including on the nature of values and social values, as well as the relationship between social and political institutions and social values. The integration of insights from various social science disciplines suggests that social values are a product of shared experiences, including with social institutions, and therefore often develop along national boundaries. Furthermore, the analysis suggests that social institutions, like health systems, help to reinforce social values, and that the social processes by which social institutions evolve often lead to changes in social values, sometimes as a result of the strategic discursive action of policy actors.

Contribution to the thesis: The insights presented in this Chapter contribute to refining the concept of values and social values, and lend support for the explanatory theory presented in Chapter 2 regarding the capacity of health systems (or, in this case, social institutions more generally) to shape social values. In addition, this Chapter deepens understanding of the influence of language and discourse on social values, which is an important foundational concept underlying the analysis of the case presented in Chapters 4, 5 and 6. The ideas presented here also inform the development of the conceptual framework presented in Chapter 7.

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Introduction

In health policy and systems research (HPSR) ideational factors, often referred to as 'software' factors – such as values, norms, ideas, and discourse – are as important to understanding health systems as 'hardware' factors such as technology, financing, medicines and human resources (see for example Béland 2009, Shiffman 2009, Harmer 2011, Rushton *et al.* 2012, Sheikh *et al.* 2014a, Gilson *et al.* 2018).

Values, in particular, influence health policy processes and health system functioning in myriad ways (Whyle *et al.* 2020). Values play a role in shaping the perceptions and behaviour of decision-makers (AHPSR 2004, Gilson *et al.* 2011) and front-line providers (Franco *et al.* 2002), and they enable or constrain productive relationships between health system actors (Gilson 2003) and partnerships between organisations (Bloom *et al.* 2008). As such, values are central to successful policy agenda-setting, development and implementation (Walt *et al.* 1994, Gilson *et al.* 2008). Values also determine global and national trends in policy direction, and enable or constrain opportunities for policy change and system reform (Walt *et al.* 1994, Schlesinger 2002, Saltman *et al.* 2005, Buse *et al.* 2012). Indeed, the field of HPSR is widely acknowledged to be characterised by a strong 'values-orientation' (Sheikh *et al.* 2011, Gilson 2012, Sheikh *et al.* 2014a, George *et al.* 2019).

In addition, in HPSR and related fields scholars commonly use 'social values' (or synonymous terms such as 'dominant values' or 'national values') to explore the macro-level relationship between health systems and collective values (Whyle *et al.* 2020). For example, social values are used in health systems research seeking to understand the historical or cultural causes of current challenges (Kringos *et al.* 2013, Sheikh *et al.* 2014b), in health policy analysis to explain agenda-setting or policy development processes (Giacomini *et al.* 2009, Mostafavi *et al.* 2016, Seidman *et al.* 2016, Vélez *et al.* 2020), and in health services and implementation research to explain the behaviour of policy implementers and system users (Henry *et al.* 2004, Suphanchaimat *et al.* 2015). 'Social values' are also often referred to in health economics as important to judging the relative value of new interventions or technologies and as influencing decisions about rationing (Nord *et al.* 1995, Bombard *et al.* 2011, Whitty *et al.* 2015, Sabin 2018). Conceptualising values as a collective property, some HPSR scholars also posit that health systems play an important role in shaping social values in the societies they serve (Freedman *et al.* 2005, Kruk *et al.* 2010, Whyle *et al.* 2021).

However, despite the plethora of scholarship in which the role of social values in health policy and systems is acknowledged, values are rarely the focus of HPSR and the evidence-base remains fragmented, with a dearth of empirical research and little conceptual clarity or theoretical consensus emerging (Giacomini *et al.* 2004, Whyle *et al.* 2020, 2021). This weakness in the evidence-base is surprising given that HPSR is considered to be inherently trans-disciplinary, and that relativist perspectives and attendant methods for studying social and political phenomena such as values, culture and power are widely used in the social sciences (Gilson *et al.* 2011, Gilson 2012, Sheikh *et al.* 2014a, Storeng *et al.* 2014, George *et al.* 2015, Topp *et al.* 2018). Furthermore, a wealth of foundational conceptual and theoretical work on values as a social phenomenon is available in the social sciences, where values have long been considered central to understanding human and social experience (Schwartz 2012). The aim of this chapter is to address these weaknesses and strengthen the theoretical and conceptual foundations for values-focused empirical research in HPSR by presenting insights from the social sciences on the nature of values, the social dimensions of values, and the social processes that give rise to or change social values.

Methods

We conducted an interdisciplinary scoping review exploring literature on 'values' and 'social values' from the social sciences, with a particular focus on insights of relevance to health systems and HPSR. Interdisciplinary research is a process that allows for methodological flexibility, and the integration and synthesis of insights from multiple disciplines to produce a comprehensive understanding (Klein *et al.* 1996, Repko 2008). Interdisciplinary research does not usually aim to synthesise disciplinary 'perspectives' (the viewpoint that reflects and informs a discipline's choice of phenomena, methods and theories), only disciplinary 'insights' (Repko 2008). Therefore, the interdisciplinary researcher is usually not an expert in all disciplines traversed but acquires sufficient understanding of the insights to be integrated.

A scoping review can be utilised to map the foundational concepts underpinning an area of research, as well as the range of evidence available on the topic (Arksey *et al.* 2005), and is particularly useful for the clarification of key concepts and theories, and how they have been applied in prior research (Reeves *et al.* 2011, Tricco *et al.* 2016). In this review, we applied a scoping review approach to identify and integrate ideas, concepts and theories relating to 'social values' from various social science disciplines. We did not seek, necessarily, to identify a single coherent research 'storyline' within a particular field of study, or to explore contradictions and differences across disciplines (cf. Greenhalgh *et al.* 2004, Greenhalgh *et al.* 2005). Rather, we sought to identify consensus insights and helpful similarities from across the social sciences that may be of use to HPS researchers seeking to more rigorously account for values in their research.

We began data collection by tracking references to social science texts in HPSR papers to identify relevant texts, authors and areas of study in the social sciences. We then used a snowball approach to iteratively expand the search through database searches and author-tracking. To allow for identification of foundational texts, no time-limit was applied. Only English-language material was included. Data collection was continued in tandem with initial data analysis to enable areas of work emerging as relevant to be further explored. In keeping with Arksey and O'Malley's framework for scoping reviews, we present a narrative account of the literature that ensures the insights from the primary literature are clearly described and contextualised, and remain understandable for a reader of the review (Pawson 2002, Arksey *et al.* 2005). A disciplinary map of the key authorship clusters is presented in Figure 1.[1]

What are the defining characteristics of values?

The modern conceptualisation of values can be traced back to the sociologist Talcott Parsons' 1937 book, *The Structure of Social Action* (Parsons 1937). Prior to Parsons, values were mainly associated with 'worth', in the economic sense, and usually described as objectively determinable by the amount of effort or labour needed to obtain something (Spates 1983). Parsons, however, describes values as cultural ideas that act as rationales for action, or conceptions of what is *desirable* that influence behaviour (Parsons 1937, Spates 1983). Later, Parsons refines his initial theory of values to include 'universality' – that values are general in the sense that they are not situation-specific, and therefore are distinct from 'norms' (Spates 1983). This conceptualisation of values took hold across the social

[1] This Figure was developed iteratively over the course of the analysis and is intended to succinctly show the range of disciplines covered. It was not used or developed as part of the literature search.

sciences and persists today – with some refinements – in social and cross-cultural psychology, political science, anthropology, and sociology.

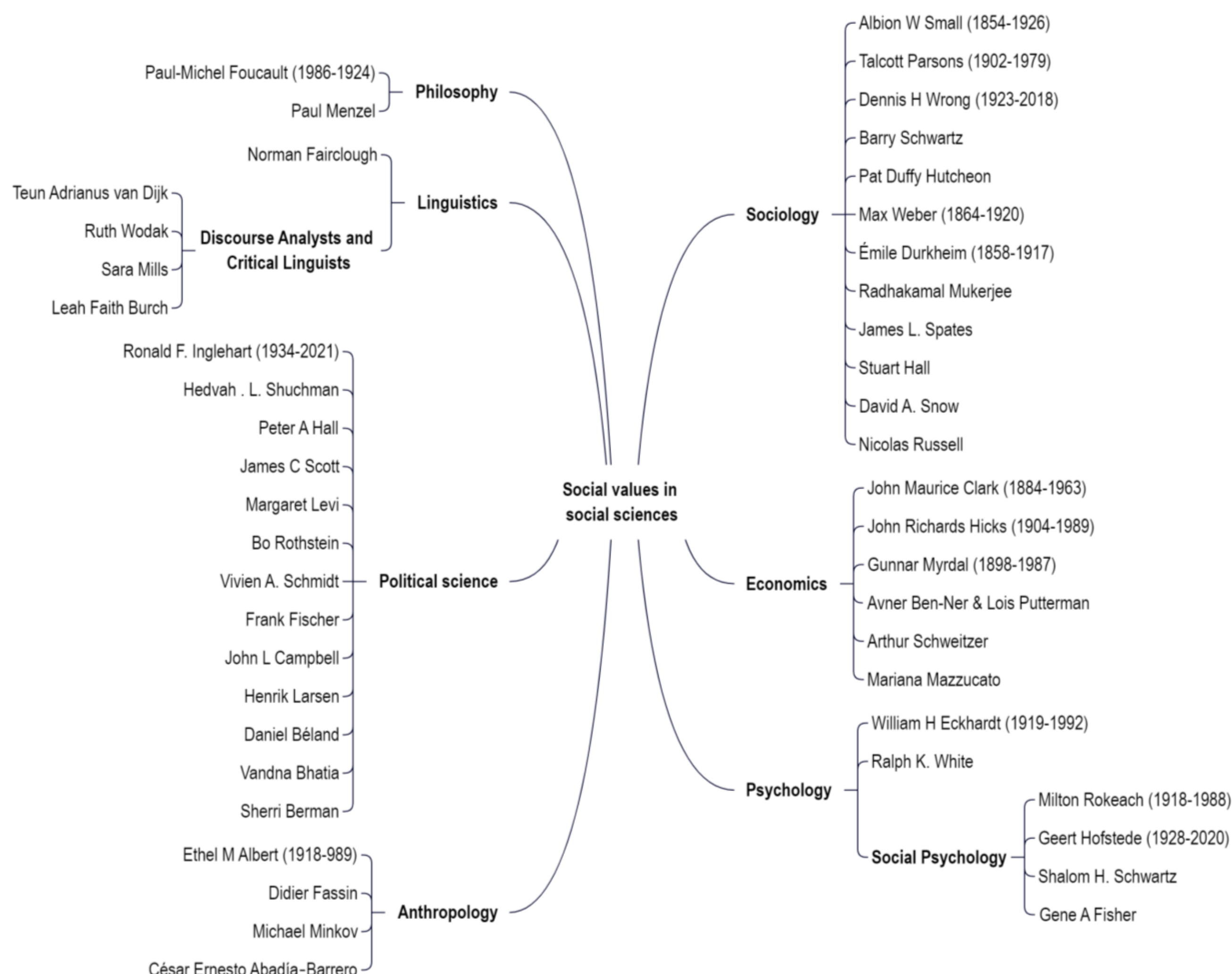

Figure 1: A disciplinary map of the included authors

Social and cross-cultural psychologists add the idea that values exist as part of a ranked system to Parson's foundational definition. Milton Rokeach, a prominent social psychologist, writes that "to say that a person 'has a value' is to say that he has an enduring belief that a specific mode of conduct or end state of existence is personally and socially preferable" (1968b). Here, Rokeach re-states Parson's 'desirable' in terms of a preferred 'end-state', and agrees with Parsons that values are enduring in that they transcend particular objects and situations (Rokeach 1968a). Rokeach also emphasises that values have "a strong motivational component," (1968b) and that they guide choices and behaviour (1968a), and describes values as "a standard that tells us how to act or what to want…that tells us what attitudes we should hold;…[that] we employ to justify behaviour, to morally judge, and to compare ourselves with others" (1968a). Additionally, Rokeach adds two important characteristics of values, noting, firstly, that values are learnt, and therefore groups of people will share common values, and secondly that the values a person holds make up *a value system* – "a hierarchical arrangement of values, a rank-ordering of values along a continuum of importance" (Rokeach 1968a).

More recently, Geert Hofstede, an influential cross-cultural psychologist, uses a similar formulation when he states that values can be understood as "a broad tendency to prefer certain states of affairs over others," (2001), and psychologist Barry Schwartz describes values similarly as "principles, or criteria, for selecting what is good (or better, or best) among objects, actions, ways of life, and social and political institutions and structures" (1990). Social psychologist Shalom Schwartz concurs that values refer to what is desirable, that they transcend specific situations, that they serve as criteria that guide judgements or evaluations, that they guide action, and that multiple values are ranked in order of importance to form value systems. However, he adds that values are affective – they are inextricably associated with feeling such that people experience discomfort when their values are threatened (Schwartz 2012).

This idea of values as guides for what to choose or conceptions of what is desirable is also used in political science, where Hedvah Shuchman defines values as normative standards that distinguish what is 'desirable,' and that have the capacity to influence choices and behaviour (Shuchman 1962). Schuchman notes that values are distinct from goals because they refer to what is desirable in the abstract, not necessarily what is *actually* desired (1962).

Anthropologist Ethel Albert concurs that values should be considered as abstractions, stating that "values are by definition distinct from conduct…a system of criteria by which conduct is judged and sanctions applied" (Albert 1968 quoted in Hutcheon 1972). Albert goes on to delineate four key characteristics of values. Firstly, as in social psychology and political science values are normative orientations that designate behaviours or goals as desirable or undesirable; secondly, they are persistent and consistent across situations; and thirdly (in keeping with Rokeach) values exist as part of patterns or systems of normative ideas that can be identified both in individuals and across cultures (1956). However, with regard to how to identify values, Albert adds that that values can be explicit but need not be, and may need to be inferred from behaviour that suggests approval or disapproval (1956).

In the same vein, sociologist Pat Duffy Hutcheon, seeking conceptual clarity on the nature of values that would support sociological enquiry that adequately accounts for values, emphasises both the ability of values to motivate action, and that they are abstract. Hutcheon suggests that values are learned criteria, influenced by "the ideals, norms, and established knowledge of…culture," that guide behaviour and predispose us to act in one way or another (1972). Further, Hutcheon distinguishes values from attitudes or preferences, by pointing out that while attitudes, norms, positions or judgements might differ from one occasion to another, values are the ideas that *underlie* these judgements or justify these decisions (1972). In this way, values are distinct from statements of belief, observable social norms, and espoused goals, and may not be directly observable from these (Hutcheon 1972).

Together, these definitions offer important insights for the study of values in HPSR. Firstly, there is cross-disciplinary consensus that values are ideas about what is desirable, and that values cannot be directly inferred from stated preferences or actions. This entails that values are normative in the sense that they are ideas about what *ought* to be, rather than beliefs about what is. Secondly, values are commonly understood as ideas that guide choices, attitudes, behaviour and judgements. This is relevant for our purposes because it suggests that while behaviours or choices are not necessarily good indicators of values, and actual values might differ from stated values, stated justifications,

rationale or defences are strong indicators of values. Thirdly, the definitions surveyed here suggest that values are abstract and enduring. While attitudes, preferences and norms might differ from one situation to the next, values are relatively stable normative beliefs that remain, irrespective of situational or contextual specificities. Fourthly, values exist as part of ranked sets that form value systems. This entails that values are not mutually exclusive – an individual can be committed to multiple values at once, but will experience some as more important than others. Box 1 presents a summary of these insights. Integrating these ideas to construct a working definition of values, we conclude that *values are universal and persistent affective ideas about what is desirable that influence or justify action or judgement, and that exist as part of a ranked set of values known as a value system.*

Box 1: Key insights on the defining characteristics of values

> Values are a type of idea. They are normative affective ideas about what is desirable that guide choices, attitudes, behaviour and judgement. They are abstract and enduring across circumstances, and remain relatively stable over time. They also form part of ranked sets or value systems, in which some values are prioritised over others.
>
> Therefore, a working definition of values can be stated as *universal and persistent affective ideas about what is desirable that influence or justify action or judgement, and that exist as part of a ranked set of values known as a value system.*

In what sense(s) are values 'social'?

While the above scholars for the most part consider values as beliefs held by individuals, they also hint at the social nature of values. Parsons suggests that values can be 'cultural ideas' about what is desirable, and both Rokeach and Barry Schwartz suggest that values include ideas about what is socially desirable and what social and political institutions and structures are desirable (Parsons 1937, Rokeach 1968b, Schwartz 1990). Furthermore, Albert's criteria suggests that values form systems or patterns that are characteristic of cultures, and Rokeach and Hutcheon both stipulate that values are 'learnt' from inputs that include the established ideals and norms of the individual's culture (Albert 1956, Rokeach 1968a, Hutcheon 1972). Reflecting these ideas about the social nature of values political psychologists Ralph K. White offers, instead of a definition of values, a method for their identification – suggesting that values are "any goal or standard of judgment which in a given culture is ordinarily referred to as if it were self-evidently desirable" (1951). In the following section we explore insights from the social sciences on the *social* dimensions of values.

Values are ideas of how society 'ought to be'

In social psychology, individual values are taken to include ideas about how society ought to be organised and what makes a good society. Rokeach, for example, uses a survey instrument with 36 distinct values (discussed below), including ideas about what is good for oneself, what is good for society, and what systems of social organisation are desirable, such as 'a world at peace', 'equality' and 'national security' (1968a). Similarly, Shalom Schwartz conceives of values as representations of what is required individually for social interaction and interpersonal coordination and for the social and institutional demands of group welfare (1987), and Barry Schwartz includes principles and criteria for evaluating "social and political institutions and structures" in his definition of values (1990).

In economics, long-standing contention regarding the relationship between values and the study of economic markets has given rise to insights on social values as ideas about how society ought to be, and therefore on the relationship between values and governance. Historically, logical positivism, including the objectivist tenet that scientific enquiry should be value-free, imported into economics in the early 1900s, led to the belief that normative considerations were not legitimate objects of

scientific enquiry, and that economics should be entirely free of value judgements (Heilbroner 1970, Schweitzer 1981, Drakopoulos 1997, Hands 2012). This perspective led to a broad acceptance of the idea that the market was an objective and impartial arbiter of value (Drakopoulos 1997).

However, some within the field maintain that values, distinct from market values, are necessary to inform decisions about how to manage markets in the best interests of society. The seminal economist John Maurice Clark seeks to bridge orthodox schools of economic thought with an institutionalist perspective, and advocates for an economics of social responsibility (Shute 2016). Clark accepts the above account of objective market values, but holds that it is an "imperfect standard of social value and social cost" (1917), because it does not adequately capture some values, including social values like accident prevention, job protection, and social welfare (Schweitzer 1981). In other words, there are two kinds of social values, the first being objectively observable from analysis of economic exchanges, and the second being unobservable but necessary for "socioeconomic goals for directing the economy" (Schweitzer 1981). These ideological goals cannot, according to Clark, be evidentially determined, but are nonetheless important topics of study if economists are to offer prescriptions for how economic systems ought to be regulated (Schweitzer 1981).

Swedish economist Gunnar Myrdal makes a similar argument, pointing out that neoclassical economics offers psychological explanations for economic choices and behaviours, but that these explanations are individualistic and therefore cannot give an indication of what is valuable for society as a whole (1953). Nonetheless, Myrdal argues that while the term 'social values' is generally avoided in economics, it is captured by conceptualisations of general welfare, or "collective housekeeping in the interest of society," that require a theory of social value (1953). Inevitably, such a theory will involve subjective judgements. As influential British economist John Hicks states, welfare economics "will inevitably be different according as one is a liberal or a socialist, a nationalist or an internationalist, a christian [sic] or a pagan" (1939).

More recently, economist Mariana Mazzucato offers a critique of orthodox economics that demonstrates how objective social values fail to account for much of what society finds valuable. Mazzucato demonstrates that gross domestic product (GDP), a standard by which we collectively, and apparently objectively, measure progress (and therefore the conception of the desirable on which we base policy decisions), is entirely based on assumptions about value (2018). Under the formulae used to calculate GDP, what is valuable is what is exchanged on the market, leading to an over-valuing of sectors that do little to improve people's lives, an under-valuing of free government services, care work and positive externalities like clean air and water (among many other things), and, therefore, to policy decisions that prioritise the private sector over the public (Mazzucato 2018). Rather than accepting that social values are just market values, Mazzucato argues for a "redirection of the entire economy" in line with "a new and deeper understanding of public values" (2018). Mazzucato defines public values as normative ideas about the rights to which citizens are entitled, the obligations of citizens to one another and "the principles on which governments and policies should be based" (2018).

Mazzucato's conception of public values is similar to one put forward by contemporary philosopher Paul Menzel (1999) in a paper evaluating economic tools for measuring values, which neatly delineates between three dimensions of value: individual utilities that reflect the welfare of each member of society; individual beliefs about the optimal state of affairs for their society, including relational and

distributive values; and lastly the social welfare function of society as a whole, i.e. the optimal distribution of resources. Governance then, requires governments to decide on 'societal missions' and to work to direct the economy in favour of 'publicly chosen goals' distinct from what is valued by the market (Jacobs *et al.* 2016).

So, while values are often considered to be held by individuals, and some values pertain to standards of behaviour for individuals, in both social psychology and modern economics, values include ideas about how social relations ought to be organised and how society ought to be governed.

Social and cultural groups share common values

Values are also considered to be social in the sense that they are the product of social factors, and, as a result, groups of people with similar experiences will share common values. Social and cross-cultural psychologists have used data from large-scale surveys to establish the distinct value systems of populations, cultures and groups. Rokeach, for example, uses experimental survey-based methods, and large sample sizes to identify value systems in various individuals and population groups. To do so, he developed a typology of values, comprising 18 terminal, and 18 instrumental values. Terminal values reflect "ideal end-states of existence", while instrumental values capture "ideal modes of behaviour" (Rokeach 1974). Each set of 18 values can be ranked by individuals according to their importance or significance for that individual. The complete set of 36 ranked values reflects the individual's value system. In other words, the value system of an individual is a set of values ranked according to importance (Rokeach 1968a). If the sample is large enough, the value rankings can be used to determine a collective value system for that particular group – for example distinguishing the value systems of Christian Americans from non-religious Americans (Rokeach 1969).

It is important to note that the Rokeach values survey captures individual values (albeit some with a social dimension) fitting into the first and second categories of Menzel's (1999) typology. In the Rokeach values survey, respondents are asked to arrange the values "in order of their importance to YOU, as guiding principles in YOUR life" and not to consider what values would make a good society (Rokeach 1974, capitalisation author's). While some of the terminal values offered to respondents are social in nature (as discussed above), the respondents are picking values that matter to them as individuals, rather than as members of a society.

Nonetheless, the in-group similarities revealed through the surveys, suggest that groups of people share value systems. For example, Rokeach uses his values survey to measure changes in American value systems between 1968 and 1971, and finds that particular values underwent significant change in that period, and that these changes reflected economic factors and the particular salience of certain social issues in the period (1974). Furthermore, Rokeach shows that this change will be collective – evident either in American society as a whole or in certain segments of the population (Rokeach 1974, 1979).

Shalom Schwartz seeks to develop a universal structure of human values in order to compare the relative importance different groups attribute to different values (Schwartz 1999, 2012). Schwartz's theory of values evolves over time, and ultimately includes 10 value types (self-direction, universalism, benevolence, tradition, conformity, security, power, achievement, hedonism, stimulation and self-direction), which are organised into a matrix on which different cultures can be located and compared (Schwartz 2012). His foundational work, however, organises seven values into three dimensions – the

first relating to the relationship between the individual and the group (conservatism versus intellectual and affective autonomy); the second relating to behaviours that maintain social order (egalitarianism versus hierarchy); and the third relating to the relationship between society and the natural world (harmony versus mastery) (Schwartz 1999). Values are organised along these dimensions because, for Schwartz, value systems of groups are dynamic in that the prioritisation of one value will entail the de-emphasis of the polar value (Schwartz 1999). Schwartz's tool allows for comparison of value systems between nations. For example, he concludes that intellectual autonomy is more important in Greece than it is in Poland or Nepal (Schwartz 1999).

At the global level, both Hofstede and political scientist Ronald Inglehart use data from the World Values Survey (WVS) to identify differences in value systems between countries and cultures (Inglehart *et al.* 2010, Minkov *et al.* 2011, Minkov *et al.* 2012, Inglehart *et al.* 2020). The WVS is a long-term project that seeks to track changing values and the impact of these on social and political realities across countries (World Values Survey 2020). Since its inception in 1981, the project has collected data in 7 'waves', each using a common questionnaire, allowing for cross-national comparisons (World Values Survey 2020).

While Hofstede initially worked with data from his own research projects (Hofstede 1983, 1984), his later work draws on data from the WVS (Minkov *et al.* 2012). Hofstede's doctrine, derived from this data, suggests that distinct value systems can be identified for countries, but for sub-national regions, and that similarities in value systems can be identified between regions in non-neighbouring countries, based on shared culture (Minkov *et al.* 2012). Rare cases aside, Hofstede's work suggests that the values of sub-national regions tend to be similar to other regions in that country, suggesting shared national values (Minkov *et al.* 2012). In fact, differences in norms and values between countries are evident even in situations where neighbouring countries share similar cultural, linguistic, ethnic or historical characteristics (Minkov *et al.* 2012).

Inglehart uses data from the WVS to place countries in a matrix along two value dimensions: traditional vs secular-rational values, and survival versus self-expression values (Inglehart *et al.* 2000, Inglehart *et al.* 2010). The first measures the importance of religion and traditional family values compared to the acceptance of non-traditional phenomena such as divorce and euthanasia. The second compares the importance of values relating to economic and physical security to the priority given to environmental considerations, tolerance for foreigners and participation in political decision-making processes (Inglehart *et al.* 2020). Inglehart and colleague Christian Welzel find that the differences in values held by those by members of different religious groups within a country, are smaller than the differences observed within religious groups in different countries (2000). Thus, the WVS data suggests not only that values can come to characterise groups within countries, as Rokeach shows, but also that values characterise country populations, because the factors that drive values change are often national-level factors.

Shared experiences create social values

Social psychologists posit that the explanation for shared values systems lies in the shared experiences that shape collective values, meaning that groups of people affected by similar environmental, social or political factors, will develop common values. Rokeach (1979), for example, finds that events and circumstances increase the salience of certain issues such as, women's liberation or ecological concerns, which, in turn, influence the values of those affected, either directly or indirectly, by those

events. In addition, changing contextual realities such as environmental conditions, socio-economic trends, and social movements, result in changes in social values (Rokeach *et al.* 1970, Rokeach 1974). Similarly, Shalom Schwartz holds that shared social values develop because in most societies there is "a single dominant language, educational system, army, and political system, and shared mass media, markets, services and national symbols (e.g. flags, sports teams)" (1999). In other words, the dominance of certain languages and religions, ecological circumstances, social and political institutions (such as educational system, army, and political system), as well as mass media and national symbols produce particular shared values (Schwartz 1992, 1999). Further, Schwartz suggests that while social conditions remain stable, major changes in collective value systems will be rare, but social values will change slowly over time in response to changing social conditions, or change dramatically in response to "major technological, economic, political, and security upheavals" (although these changes may be temporary) (1992). Inglehart's work affirms the relationship between social values and systemic factors, such as economic and technological development, political institutions, historical events and circumstances like war and colonialism, education systems, infrastructure and the free press (Inglehart 1977, Inglehart *et al.* 2000, Inglehart *et al.* 2009, 2020). Within social psychology, then, there is common agreement that social values are a product of a society's particular history, and that, in the absence major social or political upheavals or crises, social values change slowly (Rokeach 1974, Hofstede 1983, 1985, Schwartz 1992, 1999, Minkov *et al.* 2012).

Of course, this is not to suggest that all individuals within a population have identical values. Insights from sociology help to explain how, even though values are learnt and shaped by shared social and cultural experiences, individuals may retain values that are transgressive or counter-dominant. Sociologist Dennis Wrong, drawing on ideas from Émile Durkheim, notes that individuals are never entirely socialised (1961). Rather, even as individuals are inculcated into a system of values through social processes, they retain the ability, or the freedom, to speak, think and act counter to these social values (Wrong 1961, Hutcheon 1972). Some values, in other words, are generated from the 'bottom up' through personal experience, individual personalities and biological or material happenstance (Mukerjee 1946, Wrong 1961, Spates 1983).

Social and political institutions 'transmit' social values

Nonetheless, researchers in social psychology, political science, economics and anthropology agree that social institutions shape social values. In social psychology, the role of institutions, and the intricate relationship between institutions and social values, explains differences in social values between countries. In any country, distinctive institutions and institutional practices will emerge with respect to political, economic, religious, education, health and welfare systems that will bring about particular changes in collective values, or constrain value change in particular ways (Schwartz 1999, Hofstede 2001, Inglehart *et al.* 2010). For example, Shalom Schwartz's historical analysis of the social institutions of work and labour demonstrates that values are contextually dependent, and will change in response to changes in social institutions (such as the shift from feudalism to wage labour) (1990), and Inglehart and Welzel show that particularities of culture and values shape the design and regulation of educational institutions, which then serve to transmit those values to new generations of citizens (2000).

This idea – that values are transmitted by social institutions – is affirmed by political scientists. Political scientist Margaret Levi and colleagues argue that political institutions, such as democracy, set

standards of behaviour and change what people want (1998). For example, says Levi, practices that were once common – such as the sale of public office, and the purchase of substitutes for military service – are now widely considered morally abhorrent as a result of the rise of democratic institutions (1998). By 'modelling' the values they embody, social institutions can popularise new or less dominant values, transforming what was a norm of the few, into a norm of the many (Levi *et al.* 1998). Similarly, political scientist James Scott contends that 'ideological state apparatuses' including schools, the media, and democratic institutions do 'ideological work' that secures the consent of citizens to particular social arrangements and hegemonic ideas (1990)[2]. Thus, as Political scientist Sherri Berman puts it, normative ideas shape the formation of institutions, and therefor persist, embodied in those institutions, and continue to influence political life, independent of the actors who might once have espoused them (2013).

Political scientist Vandna Bhatia and a colleague, William Coleman, present a comparative study of policy change in Germany and Canada that suggests that one of the factors enabling policy change in Germany was that policy entrepreneurs developed a policy discourse that reflected two deeply held social values: solidarity and market liberalism (2003). In Canada, on the other hand, reform efforts failed because the policy discourse did not align with the social values of universality and accessibility (Bhatia *et al.* 2003). Further, Bhatia and Coleman suggest that those social values were particularly resistant to change because they were "deeply entrenched" in Canada's health system – indicating that social values can become embedded or entrenched in institutions (Bhatia *et al.* 2003). The prevailing morality of a society, then, is, in part, a product of its social institutions (Rothstein 1998).

A similar idea is espoused by economists Avner Ben-Ner and Lois Putterman. The authors argue that the relationship between values and institutions – including economic markets, families, schools and firms, and the norms, customs and rules that govern them – is a "two-way street" (Ben-Ner *et al.* 1998a, see also Ben-Ner *et al.* 1998b). This is because these institutions give rise to values and preferences, such as when markets instil values of competitiveness and individualism (Ben-Ner *et al.* 1998b, 1998a). In this way, institutions and economic arrangements can have unintended effects on the values of those who interact with them (Ben-Ner *et al.* 1998a).

Anthropological studies reveal more in-depth the mechanisms through which social institutions affect social values. Sociologist and anthropologist Eric Sabourin draws on the work of political economic Elinor Ostrom to argue that cooperative management of collective resources, or 'commons', is possible because relationships of reciprocity give rise to shared values, such as a sense of justice, belonging and trust (Sabourin 2022). Anthropologists Didier Fassin and César Ernesto Abadía-Barrero offer insights into the bi-directional relationship between social values and social institutions, or what Fassin describes as the circulation of values between the macrosocial and the microsocial (2012). Fassin employs Foucault's thinking on bio-politics, or the 'politics of life', to illuminate what he sees as a shift in European governance from bio-politics to bio-legitimacy – in other words from the governing of life, or power over life, to the power to determine the meaning or value of life (Fassin 2009, Abadía-Barrero 2016). Fassin argues that in the late 20th Century concern about the flow of migrants into Europe, and ideas about 'bogus refugees' led to increasing distrust about the veracity of asylum

[2] It is important to note that this is not Scott's final say on the matter. Scott's position is that this kind of institutionalisation reinforces a hegemonic ideology, but that hidden transcripts persist nonetheless – so that the dominant ideology exists alongside a challenging or non-dominant ideology (Scott 1990).

seekers, and a reduction in the number of refugees granted asylum (2012). Street-level officials charged with evaluating asylum applicants began rejecting a much higher proportion of applicants, which in turn reinforced the idea that most asylum applications were unwarranted (Fassin 2012). At the same time, in France, a 'humanitarian' law was introduced to grant legal status to migrants who were ill and could not access needed medical treatment in their country of origin (Fassin 2009, 2012). The combination of these two trends meant that biological vulnerability was more highly regarded by the French state than political vulnerability – the life of the unwell came to matter more than the life of a refugee (Fassin 2009). Global humanitarian institutions like Médecins Sans Frontières also used the idea of bio-legitimacy to argue for the rights of immigrants, thereby reinforcing the idea that the lives of the ill are more valued, and their claim to assistance more legitimate, than the lives of refugees (Fassin 2009).

Drawing on Fassin's ideas, Anthropologist Abadía-Barrero examines the case of the Colombian health system in which neoliberal policies for health financing and judicial judgements responding to contestation about the rights of individuals to healthcare in a health system organised on market principles, gradually transformed the "moral compass through which the right to health care is demanded, contested and won." (2016). One of the mechanisms by which the healthcare system shaped social values, was through discourses and 'techniques of language' that positioned the responsibility of the state in terms of the need to protect the financial sustainability of the healthcare market in the face of citizens making unjust claims to healthcare, rather than as protecting the rights of citizens to health services, or the health of citizens. As Abadía-Barrero puts it "the economic interests of insurance companies expressed in legal discourse…redefines the right to life and, consequently, rights in life" (2016). This analysis suggests that in addition to entrenching social values (as indicated by Bhatia et al.), social institutions, including health systems, can legitimate new ways of thinking about rights and entitlements, thereby changing social values, and that this occurs through citizens' interactions with and experiences within the institution, as well as through language.

Change in social values is a by-product of the social processes by which institutions change

A wealth of policy and political science literature explicates a complex relationship between the evolution of social and political institutions, the discursive processes by which they are legitimated to the public, and the creation or recreation of social values. Whereas Abadía-Barrero points out how values are communicated through citizens' interaction with and experience of institutions, in political science the focus tends to be more on how policy actors purposefully use social values to legitimate new policy ideas. Political scientist John Campbell explores the role of cognitive and normative ideas in policy debates and in institutional change (Campbell 1998, 2004). Campbell argues that policy processes are constrained by deeply embedded normative ideas – which he labels 'public sentiments' (Campbell 1998, 2002). Policy elites must make a judgement about social values, and either propose policy alternatives that align with these, or seek to engender support for an alternative policy proposal by explaining, defending or justifying it in ways that align with social values (Campbell 1998). In this way, policy actors use discursive techniques strategically to legitimise policy alternatives by demonstrating their appropriateness with respect to social values (Campbell 1998, Schmidt 2002, Campbell 2004).

Political scientist Vivienne Schmidt has studied the relationship between institutional reform, social values and discourse, and her work is particularly enlightening. Schmidt calls her analytical approach

'discursive institutionalism' because, while she sees policy change as institutionally constrained (that is constrained by formal and informal institutional rules of the game), she sees discourse (including normative and cognitive ideas) as a causal influence enabling policy change (2004). Schmidt's conceptualisation of social values holds that societies are characterised by unique value systems, with multiple, sometimes conflicting values that change over time, such that particular values matter more or less at different timepoints (Schmidt 2000). While social values, for Schmidt, are usually unquestioned or taken-for-granted, in moments of crisis or policy transition they are made explicit in policy discourse (Schmidt 2000). Schmidt studies examples of policies that are counter to the perceived interests of the constituency or to dominant national values, to explore how government discourse can enable policy change by changing, re-emphasising or reframing social values to better align with policy proposals (Schmidt 2000, 2002). Government actors appeal to values in order to garner the support of constituencies who perceive the policy proposal as counter to their interests (Schmidt 2000, Campbell 2004). Thus, "discourse that proffers a real shift in policy ideas may also promote the transformation of national values" (Schmidt 2002). For example, says Schmidt, a policy actor may try to reframe the value of solidarity to justify a reduction in state pensions by arguing that solidarity entails relieving younger generations of the burden of paying for the elderly (2000). So, while Abadía-Barrero argues that social values change as a result of discourse in official communication, Schmidt further suggests that policy actors can deliberately use discursive techniques to reconceptualise a social value, or prioritize one value out of the repertoire of the social value system, to legitimate their policy proposal (Schmidt 2000, 2002, Abadía-Barrero 2016). Furthermore, social, political or economic crises or upheavals often present an opportunity for actors to radically alter normative background beliefs, including social values (Campbell 2004, Schmidt 2008). In particular, dramatic ideological or political upheavals bring about what Schmidt calls a crisis of legitimation – calling into question existing value systems and ideologies, that then need to be reconstructed (2011). In short, actors use discourse to legitimate policy proposals – to present ideas for new institutions, structures and ways of working in ways that cohere with social values – and in doing so, shape social values (Schmidt 2002, Schmidt *et al.* 2004).

Similarly, in sociology, researchers have explored how actors use discursive techniques not only to demonstrate that a proposed policy intervention aligns with social values, but also to promote or amplify a particular value within society's repertoire or value system, or to legitimate a proposal that aligns with a previously low-priority value (Béland 2009). Snow and colleagues present findings from an empirical study on social movements that reveals that social movements can both 'amplify' and 'transform' social values (which Snow et al. refer to as aggregate values) (1986). When their intended intervention aligns with values that are of low social importance, social movements can 'amplify', 'reinvigorate' or 'elevate' a particular social value that may have "atrophied, fallen into disuse, or been suppressed" in order to mobilise support from the public (Snow *et al.* 1986). Alternatively, when their intervention is antithetical to, or discordant with, prevailing social values, social movements also plant new values, or re-define existing values, sometimes by reframing culturally meaningful events or activities, and imbuing them with new meaning (Snow *et al.* 1986).

Snow's research suggests that actors can strategically manipulate the social meaning of historical events to shape social values. This aligns with the theory of collective memory, initially introduced by sociologist Maurice Halbwachs (Russell 2006), but later expanded on by Barry Schwartz (1991).

Collective memory theory is a constructivist perspective that sees the past as a social construction shaped by the necessities of the present (Schwartz 1991, Russell 2006). In other words, social understandings of history are not immutable, nor are they objective – rather they are "deliberately created by strategically acting political entrepreneurs" (Rothstein 2000). So, while social values are shaped by history, they are also subject to strategic discursive action (Rothstein 2000). This is not to deny the importance of history in shaping social values, however, because, as critical linguist Ruth Wodak points out, collective memories must "maintain historical continuity by recalling relevant elements from the archive of historical memory" (2002). Consensus constructions of the past are resilient because reconstructions must be 'credible', or fit within current constructions to some extent (Schwartz 1991). However, actors can weave the threads of dominant communal memories and understandings of the past into new collective memories that continue to resonate with society at large (Rothstein 2000, Schmidt 2011).

Social values are communicated, recreated and reinforced through discourse

As mentioned, in social psychology large-scale values surveys are widely used to gauge social values. While repeated survey studies may offer some insight into the systemic and environmental factors that shape values at the population level, surveys do not offer insight into the social processes by which, as we have shown above, values are communicated, reproduced and reinforced. In response to this, in disciplines such as social psychology, political sciences, anthropology, linguistics and sociology, discourse analysis has been used, not only to gauge social values, but also to illuminate how actors use discourse to shape social values.

Schmidt (the political scientist discussed above), explores how normative ideas[3] are used to justify policy initiatives, revealing the dominant values of the polity (or, at least, policy-makers' understanding of these social values) (2000, 2010). Similarly, sociologist Leah Burch uses discourse analysis of a special education needs policy in England and Wales to reveal the ideologies that underpin the policy (2018). In the field of international relations, Henrik Larsen uses discourse analysis to identify the values that underlie European Union (EU) foreign policy discourse, and the values that characterise the EU as a collective international actor (2004). Social psychologists use discourse analysis to understand how hegemonic beliefs, such as racism or sexism, are reflected in what is said and what cannot be said, or what is taboo (Mills 2004).

The critical linguist Teun van Dijk uses discourse analysis to uncover the inferences and assumptions that underlie spoken or written ideas, to reveal the ideologies and attitudes that characterise dominant social groups, and to unearth ideological and attitudinal change at the social level (1993a, 1995). Van Dijk argues that ideologies – which he defines as the basic social characteristics of the group, constructed through group-based selection of social values – are commonly made explicit in discourse because actors use discourse to persuade others of their ideological commitments, or to manipulate the underlying assumptions of the audience to develop and reinforce values ideologies that are in the speaker's interests (Van Dijk 1993b, Van Dijk 1995).

This is possible because, for critical linguists, discourse is *constructive* in that it not only expresses social realities, but also shapes the way people think and act (Mills 2004). On this view, discourse not

[3] Schmidt's conceptualisation of 'normative ideas' aligns with Campbell's. Schmidt says that normative ideas are ideas about what is good or bad or what *ought* to be done (Schmidt 2008).

only reflects social reality, it constitutes social reality (Fischer 2003). The power of the state, for example, is a function of its being accepted as 'legitimate', which is achieved through discourse (Fairclough 2013). In other words, actors use discourse to construct a social reality, in this case that of a legitimate state (see Wodak 2001, Mills 2004). However, the power to influence values through discourse is not absolute, it depends on social power relations, and different audiences may be more or less resistant to discursive manipulation (Fairclough 2013). This coheres with Schmidt's analysis, which suggests that policy actors use different discursive techniques for different 'publics', and that particularly powerful or well-informed publics (including opinion leaders, journalists, political commentators, business leaders with an interest in the issue, organised interest groups, and academics) can either use their own discursive power either to directly push back against the policy programme and force a modification of the policy itself or of the framing of the policy, or to influence the general public's understanding of (and therefore acceptance of) the policy proposal or policy discourse (2002).

As such, discourse analytical approaches are particularly useful for the study of social values because discourse analysis sees discourse (including spoken and written communication) as the site of power struggles over how to interpret or make meaning of social realities (Fairclough 1989, Hall *et al.* 1992, Larsen 2004). Thus, discourse analysis not only offers insight into social values, but also into the discursive processes, struggles and techniques that actors engage in to influence social values (Fairclough 1989, Van Dijk 1993b). In addition, discourse analysis is sensitive to the intended audience, allowing insight into the different discursive techniques actors use for different audiences, including differences in which values will resonate with them (Fairclough 1989, Schmidt 2011).

Box 2: Key insights on the social nature of values

Individual values are social in the sense that they are learnt through a process of socialisation. Values can also be 'social' in the sense of ideas about how to organise society or structure social institutions, including the economy.

In addition, similarities in values and shared value systems emerge among social groups, including country populations. Large-scale survey data, collected by social psychologists, suggests that the value systems of groups of people change en masse in response to shared experiences and contextual upheaval such as war, colonisation or economic crisis. Social and political institutions – such as economic, democratic, religious, education, and health systems – also shape the social values of those who interact with them. Because these upheavals, experiences and institutions are often national phenomena, shared or dominant social values systems develop along national boundaries.

The relationship between social values and social institutions also offers insight into how social values change. This is because new social institutions, and changes to existing institutions, are often legitimated to the public using values discourse. Policy actors use discourse drawing on social values to legitimate new policy ideas by framing them as congruent with social values. In this way, policy actors can strategically manipulate social values in line with their interests, and dramatic shifts in policy can garner changes in social values, including by reprioritising previously low-priority values.

Because policy discourse is used to legitimate policy change in terms of social values, discourse can *reveal* social values, or be used as a lens for the identification and tracking of social values, particularly in moments of crisis or policy transition.

Conclusion: Key insights from the social sciences for HPS researchers

This scoping review was undertaken with the intention of strengthening HPSR on social values by drawing out and integrating insights from the social sciences on the nature of values and social values. The analysis revealed a surprising degree of cross-disciplinary consensus with respect to the nature of values, as well as the social dynamics that produce value systems at the social level. In fact, the integration of these insights has produced a cohesive account of the dynamic relationship between individual values (including ideas about social organisation and governance); the emergence of shared values through shared social, historical, ecological, economic and political experiences; the role of social and political institutions in transmitting and cementing social values; the social processes by

which social institutions evolve; and the power of policy actors to use discourse strategically to influence social values in line with their interests.

With respect to the nature of values, across social psychology, sociology and anthropology, values are commonly taken to be persistent, affective, learnt ideas about what is desirable (as distinct from what is actually desired) that underlie choices, attitudes and moral judgements, and that can be organised into ranked systems – with some values being more important than others. A tension that emerges from the various attempts to define values is that while values are often spoken of as influencing behaviour, they are also spoken of as abstract and not always directly observable. This is likely because values are one among many factors that influence behaviour (Hutcheon 1972). As such, while values cannot always be directly observed, they can be inferred from expressions of approval or disapproval, from judgements, and from justifications and rationale offered in defence of behaviour. In other words, when it comes to values, what is said is as important as what is done, and values can be *inferred* from what is commonly referred to as desirable (White 1951). This aligns with insights from economics which suggest that while market values are objectively determinable, social values – the values that are necessary to guide our decisions about how to organise social relations and govern society – are necessarily subjective. Combining these ideas with insights from critical linguistics and sociology about the role of discourse in the construction of social values indicates the utility of analysing language, and in particular discourse, to gain insight into social values and the role they play in processes of social and political change, including health policy processes.

The idea of a ranked system of values is also assumed to apply at the social level. Social psychologist Shalom Schwartz, in particular, as well as political scientists including Schmidt (2000, 2002, 2008), Campbell (1998) and Béland (2009), refer to the value systems or repertoires of societies and cultures. This conceptualisation helps to illuminate the social dynamics of values because it suggests that competing values can be held simultaneously by a collective, and that the prioritisation of one value will entail the de-prioritisation of competing values (Schwartz 1999). Schmidt's work suggests that change in social values involves the gradual de-emphasis of some values and the re-emphasis of others, in response to social and political events, rather than the outright exclusion of any particular value from the value system (2000). Considering values as part of dynamic value systems – in which values can be re-defined and reinterpreted, and become more or less salient over time, and in which competing values can persist side-by-side – may be helpful to HPS researchers because it allows for more nuanced analysis that accounts for the influence of both dominant and counter-dominant values in health systems and policy processes. Furthermore, combined with the insight that values are universal (in the sense that they are not restricted to one policy domain or situation), this suggests that social values that gain importance as a result of events in other social and political spheres (such as politics and education) will also gain salience with respect to health and healthcare.

There is also broad agreement across social science disciplines regarding the types of factors that give rise to social values and explain changes in social values. Box 2 presents a summary of these insights. While social psychologists explain shared value systems with reference to a wide range of historical and experiential factors (including ecology and geography, social and political events and upheaval, and economic realities), authors in social psychology, political science and anthropology also explore the relationship between social and political institutions (such as education, labour, and health systems) and social values. Social institutions not only 'transmit' social values – in other words

reinforce social values through citizens' experiences and interactions with them – they also 'cement' social values, in the sense that values embedded in institutions will be resistant to change. This suggests that health systems have the potential to transmit progressive values, and resist pernicious ones. If so, HPS research accounting for the influence of social values would be strengthened by considering values as a contextual factor or independent variable, cemented in institutions and operating as a constraint on change. Furthermore, in the analysis of proposed policy interventions, these insights suggest that it is important to pay closer attention to the effect the proposed changes are likely to have on social values.

Integrating insights from the social sciences also reveals the important role policy change processes – as the social processes by which social and political institutions evolve – play in shaping social values. Because values are affective and motivating, policy actors can use discursive techniques to create an ideational connection between social values and a policy proposal in to further their interests. Strategic policy actors use a variety of discursive techniques to create a sense of coherence between their proposals and social values – either reframing the proposal to align with important social values, re-framing or re-interpreting a dominant value to align with the policy proposal, or re-emphasising a low-priority value from the value system or repertoire (see Snow *et al.* (1986) and Schmidt (2000) in particular). This is possible because of the role discourse plays in constructing social realities, an idea founded on the theoretical insights of critical linguists. These insights are of particular relevance to HPS researchers, firstly, because they affirm the importance of ideational factors in policy change, and secondly, because they suggest that (at least some) actors can use social values to influence policy processes. As such, in addition to considering the power of values as personal values that shape the behaviour and choices of actors in health systems and health policy processes, it is important for HPS researchers to also consider the capacity of strategic policy actors to use values as powerful affective and motivational tools in their policy discourse, and to influence social values in doing so. However, when actors involved in policy change use values as part of discursive strategies to gain support for their proposals, they are limited to the social values already in this repertoire, because these are the values that have salience in that particular society (Campbell 1998, Schmidt 2000, Béland 2009). As such, while recognising the discursive power of policy actors to influence social values (in other words, centring the agency of policy actors) it is equally important to recognise the structural limits of this power in the socio-political context in which agents must work.

While this review found broad conceptual consensus across social science disciplines with respect to what values are and how shared values develop within societies, it is important not to overstate the consensus view. To say that national-level events, processes and institutions shape social values, is not to say that every society or nation has a set of social values that is widely shared and uncontested. Country populations can be more or less culturally and socially cohesive, and in modern, post-colonial contexts 'national values' might be particularly contentious (see, for example, Russell (2020)). Nonetheless, this review demonstrates a relationship of influence between social institutions, social values and policy change processes.

The depth of the knowledge-base on social values in the social sciences – with conceptual insights having accumulated gradually over decades – is of considerable benefit to HPS researchers. However, the scale of the evidence-base also posed a particular challenge to this review. Combined with the 'cognitive obstacles' to interdisciplinary research (the challenges inherent in understanding and

integrating insights from disciplines with different terminologies and epistemologies, see MacLeod 2018) the scale of the body of literature to be parsed meant that this review is, necessarily, incomplete. Given this, and the limitations inherent to scoping reviews of a large, undefined body of evidence[4], it is likely that some relevant insights have been missed. Future, more focused review work – such as a review of social science evidence on the influence of social values on health systems – will undoubtedly be of value. In addition, many of the insights presented here might not be relevant in all contexts all the time. While it is theoretically possible for social institutions to transmit social values, for example, it might be the case that health systems do so only under particular conditions. It must be noted, for example, that much of the available literature on social values assumes a high-income country perspective, and might not apply to LMICs. Further rigorous, empirical HPSR accounting for the influence of social values is needed to test these suppositions and explore the contextual specificities under which they hold for health systems and health system actors. However, doing this rigorous empirical research will require theoretical and conceptual clarity, and in this regard there is no need to 'reinvent the wheel'. Based on this analysis, we suggest that HPS researchers can do more to draw on conceptual and theoretical insights from the social sciences, and that doing so will enable them to more rigorously account for the influence of social values on health systems, and, indeed, the influence of the health system and health policy processes on social values.

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[4] See Pham et al. 2014 and Temple University Libraries 2022

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Chapter 4 – A socio-political history of the South African National Health Insurance

Chapter 4: A socio-political history of the South African National Health Insurance

Overview: South Africa's pursuit of universal health coverage through a National Health Insurance is the latest in a nearly 100-year history of health system reform efforts shaped by social and political realities. This chapter presents the results of an interdisciplinary, retrospective literature review to develop an account of how health system reform efforts have unfolded, shaped by the contextual realities of the moment. The analysis reveals the extent to which political imperatives, powerful interest groups, competing policy priorities and budgetary constraints, and ideational factors have determined what reforms were possible at various points in time. In particular, the country's political history has given rise to dominant ideas, values and ideologies that imbue health system reform with a particular social meaning.

Contribution to the thesis: This historical analysis of health system reform efforts allowed for the development of a comprehensive account of the history of health system reform efforts in South Africa, and the social and political context in which they unfolded. This thick contextual description lays the foundation for both the analysis of how ideational factors have constrained health system change in South Africa since 1994 (presented in Chapter 5), and for the case study of social values in NHI policy rhetoric (presented in Chapter 6).

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Contribution of the Candidate: The candidate designed the data collection and analysis approach, collected and analysed the data, and drafted the manuscript. JO offered guidance on the data analysis and the drafting of the manuscript. JO also read and approved the final manuscript.

Abstract

Background: Health policy processes are invariably shaped by social, political and historical realities. Spurred by the WHO's endorsement of universal health coverage as a universal health system goal, many countries are undertaking health financing reforms. The nature of these reforms and the process by which they are achieved will depend on context-specific factors, including the history of reform efforts and the political imperatives driving contemporary reforms. South Africa's pursuit of universal health coverage through a National Health Insurance is the latest in a nearly 100-year history of health system reform efforts shaped by social and political realities.

Methods: We conducted an interdisciplinary, retrospective literature review to develop an account of how health system reform efforts have unfolded, shaped by the contextual realities of the moment. We began the review by identifying peer-reviewed literature on health system reform in South Africa and iteratively expanded the search through author tracking, citation tracking and purposeful searches for material on particular events or processes referenced in the initial body of evidence. Data was extracted and organised chronologically into nine periods.

Results: The analysis suggests that in South Africa politics; the power of the private sector; competing policy priorities and budgetary constraints; and ideas, values and ideologies have been particularly important in constraining, and sometimes spurring, health system reform efforts. Political transitions and pressures, including the introduction of apartheid in 1948, anti-apartheid opposition, the transition to democracy, and corruption and governance failures, have alternately created political imperatives for reform, and constrained reform efforts. In addition, the country's political history has given rise to dominant ideas, values and ideologies that imbue health system reform with a particular social meaning. While these ideas and values increase opposition and complicate reform efforts, they also help to expose the inequities of the current system as problematic and re-emphasise the need for reform.

Conclusions: Ultimately, this analysis demonstrates the context-specific nature of health system reform processes and the influence of history on what sorts of reforms are politically feasible and socially acceptable. In addition, the analysis reveals the value of a historical perspective to understanding the challenges facing contemporary reforms.

Keywords: National Health Insurance, universal health coverage, health system reform, history, South Africa

"Devising and implementing health finance strategy is a process of continuous adaptation, rather than linear progress towards some notional perfection. It must start with a clear statement of the principles and ideals driving the financing system – an understanding of what universal health coverage means in the particular country." (WHO 2010)

Background

Because health policy process unfold within complex adaptive health systems (themselves embedded in and open to the influence of their socio-political context), health policy is a product of the complex interaction of contextual factors (Walt *et al.* 1994, Bloom *et al.* 2013). Contextual factors – including political factors (democratic norms, regime changes and political culture), the waxing and waning of ideas or ideologies (such as socialism or neoliberalism), history (such as colonialism), socio-cultural factors (like class divisions), and what Whitehead (1990) calls conjunctural considerations (accidents of timing and unexpected events) – all help to explain what happens in policy processes (Horowitz 1989, Whitehead 1990, Walt *et al.* 1994). In health policy analysis, therefore, paying close attention to the context in which policy processes unfold is considered central to understanding how and why policy processes unfold as they do, and history is acknowledged as an important element of that context (Walt *et al.* 1994, Collins *et al.* 1999, Storeng *et al.* 2014).

While the influence of history on health policy process is a relatively neglected topic (Grundy *et al.* 2014b), health policy and systems researchers are increasingly incorporating a historical perspective into their analyses, and a small but robust body of evidence is emerging (see for example Paim *et al.* 2011, Grundy *et al.* 2014a, Xu *et al.* 2019, Sriram *et al.* 2021). This growing evidence-base demonstrates the utility of a historical perspective in deepening understanding of contemporary challenges, revealing the lingering consequences of past decisions, exposing the extent to which powerful interests groups and institutional actors are able to influence reforms over time, and indicating the boundaries for what future reforms are feasible (Grundy *et al.* 2016, Xu *et al.* 2019, Sriram *et al.* 2021).

Universal health coverage (UHC) is included in the United Nations' Sustainable Development Goal 3 (United Nations 2015), and a number of countries are currently undertaking major health policy reforms in pursuit of UHC (WHO 2010, Prince 2017). While the definition of UHC is contested, the term generally refers to financing reforms intended to expand access to healthcare, improve quality of care and protect users from healthcare-related financial hardship (WHO 2010, Kutzin 2013, Smithers *et al.* 2022). UHC is considered to be a universal goal for health systems reform globally (Fusheini *et al.* 2016, Waterhouse *et al.* 2017), and has been described by the Director-General of the World Health Organization (WHO) as "the single most powerful concept that public health has to offer" (WHO 2012).

In most contexts, UHC reforms involve extending insurance coverage to more of the population, usually by increasing the involvement of non-state and for-profit actors in healthcare provision and financing (Waitzkin 2016, Smithers *et al.* 2022). However, the nature of the reforms and the process by which they are achieved will depend on a host of context-specific factors, including burden of disease, the capacity of the state to regulate the for-profit private sector, the country's public-private mix, the power of interest groups, competing policy priorities, popular ideas about the appropriate role of the state, and political ideologies (Fusheini *et al.* 2016, Morgan *et al.* 2016, Prince 2017, Sanders

et al. 2019). Indeed, the pressures and constraints shaping health policy trajectories are highly variable and contextually-specific, and UHC can have a variety of ideological interpretations and be used to support vastly different social and political agendas (Grundy *et al.* 2014b, Prince 2017).

In South Africa, UHC is currently being pursued through a policy proposal to implement a National Health Insurance (NHI) (Pauw 2021). At present, South Africa's health system is sharply divided between public and private sectors (Pauw 2021). Both public and private sectors are governed by the Minister of Health whose mandate includes setting national policy priorities and regulating all health sector actors (van den Heever 2016, Roll *et al.* 2021). The vast majority of the population (84%) receive means-tested, often free, care in the under-resourced and over-burdened public sector (van den Heever 2016, Pauw 2021). The large and powerful private sector – comprised mostly of for-profit providers and not-for-profit health insurance companies known as medical schemes – serves only about 16% of the population, but accounts for just less than half of all health spending nationally (Fusheini *et al.* 2016, van den Heever 2016). The private sector serves predominantly those who can afford medical scheme coverage, i.e. the socio-economic elite (van den Heever 2016, Pauw 2021). Together, means-tested public services and voluntary health insurance protect most users from catastrophic healthcare payments (van den Heever 2016). However, access and quality of care received still depend in part on socio-economic status and significant inequities persist, which the NHI is intended to eliminate (Pauw 2021, Roll *et al.* 2021). In addition, public perceptions of poor quality care in the public sector, corruption, and general mistrust of government as a service provider exacerbate frustrations at the inequities ingrained in the health system (Rispel *et al.* 2016, Pauw 2021). The implementation of an NHI would involve creating a single funding pool which would be used to purchase a standard package of services to ensure equitable access to healthcare for all (Fusheini *et al.* 2016, Roll *et al.* 2021). The single pool would be funded through mandatory prepayment mechanisms including taxes (Fusheini *et al.* 2016, Roll *et al.* 2021).

In 2012, then-Minister of Health, Aaron Motsoaledi, used the WHO's endorsement of UHC to defend the NHI, stating "there are people who wrongly believe that the…NHI is a pipe dream concocted by the ANC [the African National Congress]. I wish to advice [sic] them that…the World Health Organization is actively promoting this concept and describes it as Universal Health Coverage" (Motsoaledi 2012). However, the current efforts to achieve UHC through NHI are the result of a nearly 100-year history of varied attempts to reform the health system in line with universalist principles. In 1926, the Pienaar Commission on Old Age Pensions and National Insurance recommended social insurance for illness and unemployment (Seekings 2008, Republic of South Africa 2011), and in the 1940s the country embarked on reforms to make primary healthcare universally available which were halted by the introduction of apartheid[1] (Kautzky *et al.* 2008, Digby 2012, Freund 2012). In addition, universalist health system reform (HSR) has been a central aim of the African National Congress (ANC) – the country's governing political party – since it came to power in the first democratic elections in 1994 (Pauw 2021).

Although there is a substantial body of scholarship from Health Policy and Systems researchers, historians and political analysts on various aspects of the NHI, written at various points in the policy

[1] Apartheid was an institutionalised systems of regulation and control over black, coloured and Indian South Africans, alongside a state-directed programme of economic protections for white South Africans (Seekings 2016).

process[2], no comprehensive description of the policy process in its social and political context has been published, and most contemporary scholarship on the NHI touches only briefly on the early history of HSR efforts. In this paper, we present a more comprehensive account of HSR efforts in South Africa in social and political context from 1920 to 2019. By synthesising the long history of HSR efforts and the political and social contexts in which they occurred, this paper reveals how current and historical social and political realities have enabled and constrained the potential for reform, and are shaping the nature of current reform proposals. In doing so, the analysis reveals the particular social and political meaning of UHC in South Africa.

Methods

We conducted an interdisciplinary retrospective literature review of academic and grey literature offering insight into HSR efforts and the global and local contextual realities in which reform processes have unfolded. The review covers the policy process beginning in the 1920s, and culminating at the end of Minister of Health Aaron Motsoaledi's tenure in 2019.

We began the search for literature using Google Scholar to search for peer-reviewed literature on NHI, social health insurance (SHI) or HSR in South Africa. From that initial set of literature, we used a snowball approach including author tracking, citation tracking and purposeful searches for material on particular events or processes referenced in the initial body of evidence. In snowballing we also expanded the search for literature to grey literature including industry reports and briefs, policy documents, official communication, speeches, and political manifestos. We also purposefully searched for reports of surveys, relevant media articles, submissions to parliament by industry bodies and civil society, and speeches by officials in the Presidency, National Department of Health (DoH) and Treasury. The review was conducted iteratively, with the search for new material continuing throughout the process of data analysis. We continued to add literature until we felt that the information on the events, pressures and processes exerting influence on HSR efforts was sufficient to explain the observed changes in enthusiasm and policy progress for reform.

Ultimately, 623 items were identified for inclusion. Nineteen items had to be excluded due to the full text being unavailable. 289 of the included items were academic texts in fields spanning African Studies, Anthropology, Development Studies, Global Health, Health Policy, Health Services Research, Medicine and Public Health, History, Economics, and Politics. 334 items of grey literature were included, including 176 media articles. The oldest item was published in 1946, although the included texts were predominantly published in or after the 1980s.

The data analysis process for this review included reading each item and extracting relevant information into a data extraction sheet. The data extraction sheet was organised chronologically by year, and divided into socio-political context (including information relating to economic, political and social events, issues and pressures, as well as other policy processes and policy decisions happening at the time), health system context (including other health policy processes and decisions, disease outbreaks and contextual factors influencing the health system such as budget constraints), and NHI policy process (including committees of inquiry, parliamentary hearings, and public participation opportunities).

[2] See for example Gilson *et al.* 1999, McIntyre *et al.* 2003, van den Heever 2016, Waterhouse et al. 2017, Gilson 2019

Results: South African health system reform in social and political context

The analysis that follows presents a synthesis of the included material, organised into nine periods. Box 1 presents a summary of these periods. The first period begins in 1926, with the Pienaar Commission on Old Age Pensions and National Insurance, which signified the start of welfare policy-making in South Africa, and arguably the start of the country's HSR efforts (Harrison 1993, Seekings 2007a, 2008). At this time, South Africa was a self-governing dominion of the British empire, having been formed in 1910 through the unification of two British colonies and two Boer (Afrikaner) republics (Lipton 1986, Terreblanche *et al.* 1990, Seekings 2020).[3] The 1910 Act of the Union excluded Black people from political participation and spurred a series of legislative moves to formalise the racial segregation and oppression that had begun with the arrival of Dutch colonists (Lipton 1986, Terreblanche *et al.* 1990, Gibson 2004). An extensive system of controls was instituted to ensure Black people could not compete economically with White people, and to secure the Black population as a source of cheap labour for White-owned farms and mines (WHO 1983, Lipton 1986). This included the 1911 Mines and Works Act (which restricted wages for Black people), the 1913 Land Act (which designated 87% of land including all towns as 'White areas'), the 1923 Urban Areas Act (which confined Black people to segregated townships in urban areas, and 'Pass Laws' that restricted the movement of Black people in 'White areas' to the provision of labour (Lipton 1986, Terreblanche *et al.* 1990, Hall 2014). The ANC, which would become the cornerstone of the anti-apartheid movement, and democratic South Africa's ruling party, was established in 1912 to oppose the political oppression of the black majority (Coovadia *et al.* 2009).

Box 1: Summary of the nine phases of health system reform in South Africa (Source: Author)

1. 1926 to 1939. The election of the Pact Government enabled the institution of a South African welfare state comprised of direct grants for the elderly and disabled (in addition to other forms of social spending). At the same time, support for HSR was growing among health professionals and government officials.

2. 1940s and 1950s. The election of the United Party, and the publication of the Beveridge report, combined with support of health professionals and the appointment of Gluckman as Minister of Health set the stage for HSR. However, opposition from the Medical Association of South Africa, and the introduction of apartheid prevented implementation.

3. 1960s and early 1970s. The apartheid government begins tightly regulating the private health sector. Steps included the establishment of the De Villiers Commission showing the pernicious impact of the private sector on public health services, and the introduction of the Medical Schemes Act to protect private sector users.

4. Late 1970s and 1980s. Increasingly organised and militant apartheid opposition, combined with pressures on the public budget forces a change in the government's stance on private healthcare. Deregulation of the private sector allows racial discrimination to be replaced by socio-economic discrimination, while limiting political damage to the National Party. However, concern about increasing healthcare costs, fragmentation, and the abdication of the state's responsibility to provide health services reignites calls for HSR in the late 1980s.

5. 1990 to 1993. As the ANC prepares to govern the 'new' South Africa, political and economic pressures, reflecting the hegemony of neoliberal economic ideas, push the party's development policy toward more economically conservative proposals. In the HSR debate, these pressures, combined with the size and strength of the for-profit health sector, result in proposals that envision a continued role for private actors.

6. 1994 to 1998. After the first democratic election, the new government inherits significant governance and bureaucratic challenges. In the health sector these include service delivery challenges in the public sector, and cost-escalation in the private sector. The new Minister of Health initiates a series of deliberative fora for HSR, but their recommendations fail to align with the Minister's personal values, preventing policy progress.

7. 1999 to 2006. The government's refusal to roll-out an HIV treatment programme in the face of an escalating epidemic distracts policy-makers and civil society from HSR efforts, but also reaffirms the role of the state in providing health services and regulating the private sector. Recommendations for an SHI, laying the groundwork for more fundamental reforms are rejected as infeasible, and efforts to regulate the private sector to contain costs have limited success.

8. 2007 to 2015. Zuma is elected president of the ANC and then of the country. Zuma's pro-poor populism is distinguished from Mbeki's 'cold' neoliberalism, and Zuma reignites the HSR agenda by promising the implementation of the NHI. However, the policy development process is contentious, and Zuma's presidency is defined by grand-scale corruption and governance failures that undermine public trust in the state.

9. 2016 to 2019. In the shadow of state capture, Motsoaledi continues to drive the NHI policy process forward, hampered by contention surrounding the role of the private sector. Ultimately, Motsoaledi's stance on private sector involvement softens, but concern about the capacity of the state to regulate the private sector, deliver public health services, and manage NHI funds persists.

[3] Prior to 1910, from the 1652 arrival of the Dutch, South Africa was a Dutch and then a British colony (Coovadia et al. 2009).

1926 to 1939: The emergence of the welfare state and growing support for universalist health system reform

South Africa's journey towards HSR begins in this context. The coalition between English capitalists and Afrikaner farmers that enabled unification also established English control of South Africa's economy that would prove remarkably persistent (Terreblanche *et al.* 1990). However, by 1924, there was growing discontent with the leadership of the ruling party – the National Party – which was seen to be promoting the interests of capital above those of 'ordinary' white South Africans (Seekings 2016). The 'Pact Government' – a coalition between the socialist English Labour Party and the nationalist Afrikaans National Party – won power in the 1924 election and began instituting policies that combined a welfare state with a racialised labour market to protect white workers from competition from black workers, and from the hardships resulting from modernisation and urbanisation (Terreblanche *et al.* 1990, Nattrass *et al.* 1997, Seekings 2016).

As part of this project, in 1926, the Pienaar Commission was appointed, which laid the foundation for the 1928 Old Age Pensions Act (Harrison 1993, Seekings 2007a, 2008), and was the first public commission on healthcare that referenced National Health Insurance (CMS 2011). Rather than catering for the poor generally, the Pienaar Commission recommended social insurance for illness and unemployment that would cover only certain categories of 'deserving poor', in this case, those formally employed (Seekings 2007a, Button *et al.* 2018).

However, the recommendations of the Pienaar Commission prompted a conservative backlash and were not immediately implemented (Seekings 2007a, Nattrass *et al.* 2010a). In 1929, under a National Party government no longer influenced by the concerns of the Labour Party,[4] a new commission was established – the Carnegie Poor White Commission (Seekings 2007a). The 'reactionary' Carnegie Commission argued against welfare programmes that 'put cash in the pockets of the poor' on the grounds that they gave the impression such 'charity' was a right and the duty of the state, and that the Commission's recommendations were antithetical to the building of a welfare state (Seekings 2007a, 2008). The central tension between the Pienaar Commission and the Carnegie Commission was that the former offered a structural analysis that saw the alleviation of poverty as the responsibility of the state, whereas the latter offered an individual analysis focusing on 'psychological traits' as the cause of poverty, and suggested 'self-reliance', 'self-help' and 'poor relief' run by the church as the solution (Seekings 2008).

Despite the backlash and the recommendations of the Carnegie Commission, the event of the Great Depression and South Africa's consequent recession made a strong argument for the welfare state, and the gold-fuelled growth of the 1930s staved off the worst effects of the global economic depression and imbued the state with financial means and capacity to implement the recommendations of the Pienaar Commission at scale (Seekings 2008, Nattrass *et al.* 2010a, Marks 2014). By the end of the 1930s, South Africa had a well-developed institutional framework providing social welfare to the white and coloured population, including major spending on old-age and disability pensions (Seekings 2007a, Button *et al.* 2018).[5]

[4] The Labour Party had split from the National Party in 1928 and performed disastrously in the 1929 elections (Seekings 2008).

[5] It is important to note that while the Pienaar Commission recommended including Indian people (alongside white and coloured people) as beneficiaries, the resultant Old Age Pensions Act excluded both Indian and Black populations, and South

The 1930s also saw a gradual but steady increase in calls for universal HSR. In 1931, the president of the Medical Association of South Africa (MASA), Francis Napier, penned a plea, published in the South African Medical Journal (SAMJ), for a state-run 'unitary medical service' that would allow for better coordination of preventive and curative services, and would 'meet the needs of the whole population' (Harrison 1993). The editors of the SAMJ dismissed the idea, but also acknowledged that it reflected the beliefs of a growing number of professionals (Harrison 1993). In 1935, the idea of a 'sate medical service' 'without distinction of race or colour' was proposed in the House of Assembly (Harrison 1993). The proposal was rejected on financial grounds, but reignited debate on the topic and found a more receptive audience among health professionals seeking security after the economic shock of the Depression (Harrison 1993, Marks 2014). A Committee of Inquiry into NHI was established by the Public Health Department in 1935, which recommended, conservatively, an NHI to cover urban employees of all races earning below a certain threshold, and in 1939 prominent public health doctor and United Party member of parliament, Dr Henry Gluckman, voiced support for an NHI (Marks 1988, Harrison 1993, Marks 2014). While the calls were once again dismissed as impractical, by 1940 those in favour of establishing a national health service (NHS) made up an influential lobby including many of the country's most eminent physicians (Marks 1988, Harrison 1993, Marks 2014). Thus, by the end of the 1930s, alongside a rapidly expanding social welfare programme resulting from the Pienaar Commission, there was also growing support for HSR. Together with the support of medical professionals and political leaders, the electoral victory of the United Party in 1938 set the stage for revolutionary reform of the health system in the 1940s.

1940s & 1950s: Health system reform is nearly achieved, but prevented by the introduction of apartheid

The establishment of South Africa's first primary health centres (beginning in 1940) by Dr Sidney and Emily Kark (two pre-eminent and radical public health clinicians) demonstrated impressive results with well-kept statistics, and Treasury quickly made funds available to support the development of more health centres (Harrison 1993, Freund 2012, Paremoer 2018). Simultaneously, MASA (or a group of radical doctors within MASA) began advocating for the establishment of an NHS funded through general taxation, including a 1941 pamphlet using the language of 'socialised medicine' and calling for the elimination of competition and commercial elements from health care (Price 1989, Harrison 1993, Marks 2014).

Britain's landmark Beveridge report – which described a 'radical,' 'utopian,' and 'visionary' plan for the introduction of a universal[6] welfare state funded through general taxation – was released in 1942 to euphoric popular reception, and prompted global interest in welfare state-building, including in South Africa (Digby 2008, Harrington 2009, Seekings 2020). Gluckman was appointed as chair of the official National Health Services Commission, which released a detailed report on the potential for a state-run health service in South African in 1944 (Price 1989). The report drew inspiration from the Beveridge Report, and recommended the implementation of a centrally controlled NHS, funded through a national health tax that would deliver healthcare free to all South Africans regardless of any

Africa's early welfare state ultimately excluded Indian and Black people despite their contribution to general tax revenue (Seekings 2007a).

[6] Britain's 1944 white Paper laying out the plans for the NHS on the basis of Beveridge's recommendations states "everybody, irrespective of means, age, sex or occupation, shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available" (quoted in WHO 2000)

criteria other than need, including race or socio-economic status (Harrison 1993, Digby 2008, Waterhouse *et al.* 2017). Gluckman's recommendations focused on primary and preventive healthcare, founded on local health centres (like those established by the Karks), and a diminished role for the private sector (which had been allowed to grow significantly in the preceding years), arguing that doctors should be state employees[7] (Harrison 1993, Van Niekerk 2003, Kautzky *et al.* 2008). Both the Beveridge report and the Gluckman commission report displayed a revolutionary zeal and an appetite for bold, transformative change – the Gluckman report acknowledged that the proposals "may, perhaps be described as revolutionary for those who look to tradition and precedent as their guide" while the Beveridge report stated that "a revolutionary moment in the world's history is a time for revolutions, not for patching" (Digby 2012).[8] Thus, when Gluckman was appointed Minister of Health in 1945 (Digby 2008, 2012) health system transformation may well have seemed, if not inevitable, imminently possible.

However, unlike in Britain, in South Africa a host of factors conspired to prevent health system transformation. Firstly, MASA's support of the NHS was conditional on the provision that doctors be allowed to continue in private practice, and that curative care through health centres would be restricted to the very poor – a stance that Digby attributes to vested interests – which ultimately resulted in MASA opposing the implementation of an NHS (Harrison 1993, Blecher *et al.* 1995, Digby 2008, 2012). The strong anti-socialist discourse of the moment may also have contributed to MASA dismissal of the proposal as 'drastically revolutionary' (Harrison 1993).

Secondly, at this time, as urbanisation, landlessness and unemployment made the issue of poverty among black people more readily apparent and led to a weakening of kinship relations that previously may have ensured some informal social protection[9], the United Party government moved to deracialise the welfare system by extending welfare benefits to black men and women (albeit not at the same rates as for white and coloured people) and relaxing restrictions on spending on schools for black children (Seekings 2007a, Nattrass *et al.* 2010a, Seekings 2018). This de-racialisation of the welfare system led to a severe backlash from large segments of the white population and contributed to the defeat of the United Party at the hands of the National Party (which promised to implement apartheid) in the 1948 election (despite the United Party back-tracking on the policy prior to the election) and secured political priority for Afrikaners, who were the 'less well-off' white population (Lipton 1986, Nattrass *et al.* 1997, Seekings 2016). With the poor black majority disenfranchised, those who stood to gain the most from the implementation of the NHS lacked political power to vote for it (Digby 2012).

Under the National Party, there was little government support for the continuation of the health centres, and the death of Gluckman's successor, Minister Stals, intensified government opposition to the health centre concept (Harrison 1993, Digby 2008). Most health centres were closed or converted

[7] This is in stark contrast to the health system at the time, which was hugely fragmented (each racial group had its own National Health Department, every homeland and provincial administration had a Department of Health, and each of the 400 local authorities had their own Health Departments), hospi-centric, and encouraged the flourishing of the private health sector (McIntyre et al. 1995)

[8] It is important to note that while strongly influenced by Beveridge's universalist ideas, Gluckman did not substantially challenge mainstream racist values, and the proposed health centres were still segregated (Freund 2012).

[9] At the time, Britain's colonial office argued that Beveridge's proposals did not make sense for countries at an early stage of development, because in those contexts poor people were cared for by their kin (Seekings 2020).

to curative, outpatient departments (Harrison 1993). Likely influenced by the thwarted promise of the NHS and the health centres, the ANC's landmark Freedom Charter, published in 1955, called for a state-run preventive health scheme, and universal free medical care and hospitalisation for all (ANC 1955, Baker 2010, Madore *et al.* 2015). The Freedom Charter also called for the redistribution of land and mineral wealth (ANC 1955).

The period between 1940 and 1960 encompassed the rise and fall of South Africa's first attempt at HSR, with the introduction of apartheid scuppering efforts to implement an NHS. The idea for HSR presented in the MASA pamphlet, Beveridge Report, the Gluckman Commission Report, and the ANC's Freedom Charter would continue to influence HSR efforts in South Africa, but another opportunity for radical reform would not recur before 1994.

1960s and early 1970s: The apartheid government increases regulation of private healthcare

While an NHS was no longer on the policy agenda, in the 1960s and 1970s, the apartheid government's response to the growing for-profit private health sector did lay the foundations for a regulatory state that protected its citizens from market forces. By 1960, 80% of white South Africans had private health insurance (Hassim *et al.* 2007). Recognising the need to protect the users of the private health sector from the consequences of inadequate coverage, the apartheid state began to regulate medical schemes (Hassim *et al.* 2007). The Medical Schemes Act (MSA) 72 of 1967 introduced minimum benefits, eliminated risk-rating, and set reimbursement rates so that scheme members could be sure the fee charged by doctors would match what their scheme reimbursed (Hassim *et al.* 2007).

This move aligned with the general attitude of the National Party towards the private health sector that persisted until the 1970s – the for-profit private health sector was tolerated but tightly controlled, and government increasingly took over control of the not-for-profit mission hospitals providing care in rural areas (Price 1988, 1989). The 1974 De Villiers Commission into Private Hospitals and Unattached Operating Theatres argued that human resource drain from the public to the private sector (as a result of higher wages in the latter) was contributing to vacant public sector posts and undermining the strength of the public sector (Price 1988, 1989). The Commission further argued that the state not only had a responsibility to ensure adequate standard of care in all sectors, but also that the state should act as provider of hospital services as far as possible, and, ultimately, resulted in stricter regulation of private hospitals (Price 1989, Broomberg 1993).

Thus, in this period the role of the state in healthcare, with respect to regulation of non-state health services and the responsibility of the state to provide healthcare services, was reaffirmed. However, despite being more tightly regulated, the private health sector continued to grow (Price 1989, Waterhouse *et al.* 2017), and the subsequent decades would cement the position for-profit healthcare as a major actor in future HSR efforts.

Late 1970s and 1980s: Neoliberalism, financial crisis, and political pressures force privatisation and deregulation of private healthcare

In the late 1970s and 1980s, a combination of political forces (in the form of growing apartheid opposition), economic concerns, and global ideological influences began to force a shift in the National Party's relationship to the private sector. Firstly, the 1970s saw increased, more militant, opposition to apartheid from the black majority, the emergence of a lively anti-apartheid civil society, and a strengthening of black trade unions (Price 1986, Andersson *et al.* 1988). In addition, the institution of

a new Constitution in 1984 inadvertently fuelled aspirations for political and economic power among the black majority (Price 1986, Andersson *et al.* 1988). In response, the National Party began to make certain concessions with the aim of gaining the cooperation of a segment of the Black population, including reducing racial discrimination in old-age pension and other grant programmes, extending rights to home ownership, and reforming some discriminatory labour laws (Price 1986, Button *et al.* 2018). At the same time, South Africa's economic difficulties were exacerbated by pressure from anti-apartheid advocates on local and multi-national corporations to restrict capital flows in and into South Africa (Price 1994, McIntyre *et al.* 1995). In addition, pressure on the public budget was increasing due to a growing budget deficit; increasing resources needed in defence, security and policing to maintain political stability in the face of anti-apartheid activism[10]; and increases in the cost of public health provisions due to technological development, an aging population and rapid urbanisation (Andersson *et al.* 1988, Naylor 1988, Price 1989, McIntyre *et al.* 2006). In the face of these budgetary pressures, de-regulating the private sector to enable black people to enjoy private sector services was more feasible than extending welfare services to black people (Price 1989).

Secondly, around this time neoliberal economic policies were gaining popularity among industrialised states, and were increasingly being prescribed as a solution to the challenges of developing countries trying to recover from the debt crisis of 1985 (Price 1989, Nattrass 1994a). Neoliberal economic policies included fiscal discipline, limited public expenditure, deregulation of the private sector, privatisation and trade liberalisation (Nattrass 1994a).

In the health sector, the government's response to budgetary pressures reveals an acceptance of, and commitment to, neoliberal economic ideologies that legitimate the state's abdication of the responsibility for the provision of healthcare, the privatisation of service delivery and a focus on individual responsibility (Klopper 1986, Naylor 1988, Price 1994). In 1986, the Browne Commission Inquiry into Health Services, clearly influenced by a commitment to privatisation, conceded that there was no evidence that the private sector is more efficient, and that privatisation had no benefit to users, but nonetheless supported deregulation of medical schemes, including the acceptance of risk rating, threshold payments, and co-payments and deductibles (Naylor 1988, McIntyre *et al.* 2020, McLeod *et al.* 2020). In "an ironic reversal of the Gluckman commission" the Browne Commission also said that the development of primary health centres should be determined only *after* accounting for the likely expansion of the private sector (Price 1989).

A series of neoliberal policies were enacted in this period. Licensing requirements were relaxed to encourage construction of private hospitals (Price 1994). Public sector fees for paying patients were rapidly increased, to the point that it was more expensive for 'middle class' patients to obtain out-patient services in the public sector than to visit a private provider (Broomberg *et al.* 1991, Price 1994), and medical scheme membership was opened to people of all races (having been restricted to white people heretofore) (Waterhouse *et al.* 2017, McIntyre *et al.* 2020). The Medical Schemes Amendment Act – pushed through in the dying days of apartheid – abolished guaranteed payments to providers, removed mandatory minimum benefits, re-enabled risk rating, and excluded many of the most vulnerable from medical scheme coverage (McIntyre *et al.* 1995, Gilson *et al.* 1999).

[10] In 1983 the Government budget allocation to the military was 18% of gross national product, compared to 3% to the health budget (WHO 1983).

De-regulating and de-racialising the private sector, rather than actively extending public welfare services to the black population, also had important political benefits. Firstly, the policies appealed to the interests of the existing English business class and emerging Afrikaner entrepreneur class (Naylor 1988, Price 1994, Bond *et al.* 2019). Secondly, by transferring responsibility for the provision of healthcare onto the private sector, the state could dampen political tensions while ensuring that the racial hierarchy was sustained by wealth disparities between racial groups, replacing explicit racial discrimination with economic discrimination (Naylor 1988, Seekings 2007b). Thirdly, the move served to undercut apartheid opposition, because it enabled urban black, coloured and Asian workers with medical scheme coverage (a population growing as a result of trade unionisation) to access high quality private sector care, while those in rural areas continued to rely on the inadequate public sector (Andersson *et al.* 1988, Price 1989, Broomberg *et al.* 1991).

The result of these policy decisions was a dramatic expansion of the private health sector, particularly for-profit hospitals,[11] driven largely by increasing medical scheme membership among black people (Price 1994, McIntyre *et al.* 2020). However, as the private health sector grew, the challenges associated with private provision of healthcare became increasingly clear. Medical scheme membership fees rose dramatically over the 1980s, far outstripping inflation (Price 1994, Pillay *et al.* 1995). The re-introduction of risk-rating undermined cross-subsidisation and solidarity within schemes (Broomberg *et al.* 1990a, McIntyre *et al.* 2006). In addition, private sector costs rose rapidly as a result of fee-for-service payment mechanisms, and supplier induced demand (Broomberg *et al.* 1990b, Broomberg *et al.* 1991).

In addition, the growth of the private sector exacerbated the already extreme fragmentation of the health sector. By the early 1980s the distinct health authorities operating at different levels of the country included provincial authorities responsible for public sector hospitals and curative clinics; municipal authorities (including city and town councils) responsible for environmental, preventive and ambulance services; the Central Department of Health and Welfare delivering services like chronic psychiatric care and responsible for infectious disease control; and ten separate Ministries of Health for each of the 'bantustans'[12] responsible for all health services in the territory (Price 1986, Andersson *et al.* 1988, de Beer 1988). This is in addition to the private sector, which included a rapidly expanding group of for-profit providers, private medical schemes, industry heath providers (such as hospitals owned by mining companies), and non-profit organisations (de Beer 1988). The 1983 Constitution added three more departments of health, as 'own affairs' departments were created for white, coloured and Indian populations (Andersson *et al.* 1988, de Beer 1988, Van Niekerk 2003).

In this context, in the latter part of the 1980s, the debate on NHS gained renewed attention among progressive civil society actors and academics who were concerned about the state's abdication of responsibility for healthcare provision, fragmentation, rising inequities in access and quality of care between public and private sectors (and therefore between the rich and poor) (Broomberg *et al.* 1991,

[11] Until the 1970s, most private health providers had been mission hospitals and facilities owned by industry (such as mining companies) (McIntyre et al. 2020).

[12] As part of the National Party's grand Apartheid strategy, beginning in the 1960s, certain areas of South Africa were demarcated as ostensibly self-governing 'bantustans' or 'homelands' where black people could settle, justifying the non-enfranchisement of the black population in 'white South Africa' (Price 1986, Naylor 1988).

Gilson *et al.* 1999).[13] This attention, and the slew of research and strategy proposals it produced, informed the policy ideas of the ANC, which, by the early 1990s was preparing to lead the country into the new democracy (Gilson *et al.* 1999).

1990 to 1993: The ANC's policy proposals are constrained by political and ideological pressure

However, the ANC's internal policy debates were not immune to the influence of increasingly powerful neoliberal ideas, and between 1990 and 1994 the ANC faced considerable pressure to moderate their policy proposals. Historically, the ANC had been closely affiliated with socialist organisations including the Soviet Union – from which the movement received military equipment – and the South African Communist Party (SACP), with which the ANC had a long-standing alliance that was foundational to the fight against apartheid (Lodge 1987, Ellis 1991). Much of the ANC's early development policy, including the Freedom Charter, had socialist overtones, and by the late 1980s SACP members dominated the ANC leadership (Ellis 1991, Peet 2002, Baker 2010). In addition, the alliance between the ANC, the SACP and the Congress of South African Trade Unions (COSATU) – which operated as the dominant and most progressive arm of South Africa's budding trade-union movement – was key to the ANC's prospects of electoral victory, and allowed COSATU to ensure that the interests of the working class were reflected in ANC policy (Southall *et al.* 1999).

In the early 1990s, however, a significant tension emerged between the ANC's traditional socialist rhetoric, and the need to avoid alienating key allies, including the emerging black capitalist class (Nattrass 1994b, Cronin 2020). For example, on the day of his release after 27 years of imprisonment, in February 1990, Nelson Mandela reaffirmed the radical redistributive principles, including nationalisation, that had come to signify liberation to many of the ANC's supporters (Nattrass 1994b). Mandela's statement created fears of 'expropriation without compensation', and had a negative impact on the stock market, and the ANC faced significant pressure to soften its stance (Kentridge 1993, Nattrass 1994b, Peet 2002). Similarly, the 1990 ANC Discussion Document on Economic Policy reflected the influence of COSATU and called for nationalisation of recently privatised public utilities and mining, increased taxes on corporations and rich, and redistributive economic policies (Nattrass 1994b). Within the party, the discussion document sparked debate between moderate economic thinkers keen to encourage growth by appealing to international investors as 'business-friendly', those who felt that the abandonment of radical social rhetoric constituted a betrayal of the party's grass-roots supporters, and trade-unionists who were wary of kowtowing to big business (Nattrass 1994b, 1994a). Similarly, the 1994 Reconstruction and Development Plan (RDP), which would form the basis of the ANC's economic policy until 1996, was drawn up by a former COSATU member, in response to a COSATU ultimatum, and was relatively pro-poor, deprioritised investor confidence and emphasised the state's obligation improving social welfare through decommodification, rural development and affirmative action (Nattrass 1994b, Paremoer 2015). However, the RDP as implemented was significantly more conservative and neoliberal (discussed further below) (Pillay *et al.* 1995, Bond *et al.* 1997a, Gilson *et al.* 1999).

Ultimately, two dichotomous economic and political positions emerged: The liberal argument was that privatisation and free market principles would not only spur economic growth, but were also an appropriate redress to apartheid given that apartheid was a drag on growth and that black people

[13] See for example Benatar 1985, Coovadia *et al.* 1986, Klopper 1986, and Coovadia 1988.

would thrive given economic opportunities (Nattrass 1994a, 1994b, Price 1994). The radical argument was that apartheid and capitalism were ideologically intertwined, that South African business was complicit in apartheid, and that nationalisation and radical redistribution were necessary to liberation (Nattrass 1994b, Price 1994, Seekings *et al.* 2011).

Prior to 1994, the liberal side of the debate gained power as the ANC sought to alleviate 'white fears' and boost business and investor confidence, and ANC policies shifted away from radical redistribution, and towards fiscal discipline (Nattrass 1994a, 1994b, Van Niekerk 2007). This shift can be understood in part as consequence of the precarious fiscal position of the country at the time (by 1993 the budget deficit was nearly 8% of GDP and the possibility of a debt trap loomed) (Nattrass *et al.* 2010a, Aron 2011). However, it can also be interpreted as an inevitable consequence of the hegemony of neoliberal ideas, and, in part, as a result of systematic efforts on the part of international business elites to 'educate' and 'persuade' ANC leaders to adopt pro-market policies (Kentridge 1993, Seekings *et al.* 2011, Bond 2014b). The World Bank recruited ANC officials to work in Washington in the early 1990s, and select ANC leaders underwent training at Goldman Sachs in New York, while other ANC officials were recruited to work with the World Bank in Washington, which Cronin argues was a clear attempt by global capital to create a cadre of neoliberalists within the ANC (Bond 2014b, Cronin 2020). In addition, the Consultative Business Forum – established in 1988 as a progressive forum to allow business to contribute to the promotion of a 'fair and just society' in a 'non-racial democracy,' and a 'successful economy' – facilitated key meetings between the National Party and the ANC, and strengthened the relationship between the ANC and South African business (Seekings *et al.* 2011).

In 1991, in a speech in the USA, Mandela stated "the private sector must and will play the central and decisive role in the struggle to achieve many of [the ANC's] objectives…The rates of economic growth we seek cannot be achieved without important inflows of foreign capital" (quoted in Gilson *et al.* 1999). Similarly, the ANC's 1992 Draft Policy Guidelines were appreciably more 'business-friendly' and framed the private sector as a 'dynamic partner' (Kentridge 1993, Nattrass 1994b).[14]

In the HSR debate, there was a corresponding acceptance of the role of the private sector. The debate became defined by two opposing schools of thought. The first, recognising the rapid cost spiral in the private sector and concerned about increasing inequalities between public and private sectors, argued for the establishment of a single NHI, in which mandatory contributions by employees would be combined with general tax revenue to buy healthcare from a mix of public and private providers (Price 1994). The second, influenced by neoliberal principles and concerned that the strength of the private health sector made the first option infeasible, suggested leaving the private sector to continue to service those who could afford it, and concentrating on improving the public sector for the provision of adequate care to the poor (Price 1994). Across both sides of the debate, there was growing acceptance of the 'infeasibility' of a purely public tax-funded NHS, given the size and (political) strength of the private sector (Price 1994). The ANC's 1991 discussion document – 'Towards Developing a Health Policy' – suggested a tax-funded, unitary NHS in which most provision would be public, but would allow for the continued existence of private health care (Political staff 1991, Waugh 1991). More generally, reform debates began to prioritise reducing the funding gap between public and private sectors over unifying the health system, and focused on establishing the appropriate level

[14] The guidelines eventually adopted at the 1992 ANC conference were less conciliatory and more radical, no longer spoke of 'pragmatics over ideology' and included state controls of financial institutions (Nattrass 1994b).

of private sector involvement (Price 1994, Gilson *et al.* 1999, Doherty *et al.* 2000). However, even after the first democratic elections, the tension between radical socialism and economic conservatism would shape of the ANC's development agenda, and hinder HSR efforts. While the change of government presented an opportunity for progress, a failure to reach consensus would prevent HSR in the 1994 to 1998 period.

1994 to 1998: Possibility for health system reform is limited by ideological differences and neo-liberal macro-economic policy

In addition to this ideological tension, the new government also faced significant economic, bureaucratic and governance challenges. The interim constitution held that, to facilitate the democratic transition, all parties winning at least 10% of the vote would form a coalition government called the Government of National Unity (GNU). The ANC won 63% of the vote, and two-thirds of the seats in parliament, and Mandela was appointed president of the country and leader of the GNU (Gilson *et al.* 1999, Van Niekerk 2007). However, the civil service was bloated, inefficient, and corrupt, with state-private sector relations that enabled rent-seeking and patronage, and the negotiated transition had guaranteed existing civil servants their positions for five years, preventing a radical overhaul of the civil service (Nattrass 1994a, Schneider 1998, Gilson *et al.* 1999). Furthermore, the transition shifted liberation leaders inexperienced in governance into powerful positions, and the appointment of many activists to government positions, undermined the country's previously flourishing civil society and muted critical engagement on policy (Gilson *et al.* 1999). In addition, the ANC inherited a failing economy, with gross national product growing an average of only 8% per annum over the previous decade, and the transition took place in a global environment in which the mobility of capital severely constrained the ability of states to regulate and control capital (Nattrass 1994a, McIntyre *et al.* 1995). At the time, a quarter of South Africans lived in poverty (Seekings 2015), and the richest 10% of households accounted for 51% of annual income, while the poorest 40% received 4% of income, making South Africa one of the world's least equitable societies in the world (McIntyre *et al.* 1995).

Parallel challenges affected the health sector. Quality of care in public sector hospitals had been steadily declining since the mid-80s, equipment shortages were rife, and a shortage of human resources in the public sector[15] was being exacerbated by the 'brain-drain' to the private sector (Price 1994). Under the previous administration's privatisation policy, the public sector had also been subject to sudden budget cuts and dramatic decreases in public expenditure (Price 1994). In addition, the health system was hospi-centric (in 1995, 76% of public health expenditure went to hospitals) with limited investment in primary and preventive services (McIntyre *et al.* 1995, Gilson *et al.* 2017). Despite these challenges, the ANC was committed to drastically improving access to health and welfare services. Within the first 100 days of the Mandela presidency the Free Care policy was announced, making all healthcare free for pregnant women and children under six (albeit with no corresponding increase in funding to accommodate the dramatic increase in uptake) (Gilson *et al.* 1999, Ataguba *et al.* 2012).

[15] Human resource challenges were partly a consequence of the loss of international doctors at mission hospitals due to anti-apartheid boycotts, and of junior doctors fearing conscription under the apartheid government and fleeing political instability (Price 1994).

In the private sector, cost-containment and accessibility were the major challenges. Medical scheme membership rates were increasingly unaffordable, and between 1993 and 1994, 200 000 people lost medical scheme coverage (Pillay *et al.* 1995). Following the rapid growth of the for-profit hospital sector in the late 1980s, by the early 1990s it was clear that consolidation of control, market failures and perverse incentives were undermining the stability of the sector as a whole (McIntyre *et al.* 1995). Fee-for-service reimbursement mechanisms were creating supply-induced demand and driving up costs, and medical scheme contribution rates were consistently increasing, and were not matched by increasing benefits (McIntyre *et al.* 1995). By the early 90s, three hospital groups owned almost 45% of all private sector beds, and some doctors had vested interests in for-profit hospitals, resulting in unnecessary hospitalisations and further driving up costs (McIntyre *et al.* 1995). At the time, private sector users, who until 1995 were not permitted to choose to receive care in the public sector, were at the mercy of the market (McIntyre *et al.* 1995). Many schemes refused to enrol members over the age of 55, and either refused coverage to HIV-positive people or offered them drastically reduced benefit options (Hassim *et al.* 2007). Nonetheless, the rapprochement between the state and the private health sector held – in part, as a result of the acceptance of neoliberal ideas about the appropriate role of the state as regulator in a system of private sector delivery (Gilson *et al.* 1999).

In this context, the ANC began the policy process to transform the health system. Immediately after the election, in May 1994, the ANC released a discussion document – *A National Health Plan for South Africa* – outlining the plans for health sector reform (ANC 1994). The document stated that "a single comprehensive, equitable and integrated NHS will be created and legislated for" but was carefully worded to avoid alienating important stakeholders, and called for a process of consultation with "all interested parties, including employer, labour, professional, medical aid, and health insurance organisations" and for "detailed planning for implementation of an NHI if there is sufficient consensus on this option" (ANC 1994). The new Minister of Health - Nkosazana Dlamini-Zuma, a medical doctor with experience in rural areas and fairly radical stance on redistribution and redress of inequalities (Bond 1999, Gilson *et al.* 1999) – established the Directorate of Health Financing and Economics (DHFE) to coordinate policy development for health financing reform (Gilson *et al.* 1999). In June 1994, a Health Care Finance Committee (HCFC) was established to "examine appropriateness and feasibility of establishing an NHI system, or for other models to enable all South Africans to have access to comprehensive health services at an affordable cost" – the first of a series of special structures for the development of healthcare financing policy (Gilson *et al.* 1999). The committee included an influential Australian economist, Dr John Deeble, who advocated for radical reforms in the form of a universal NHI under which private health practitioners would be nationalised (Gilson *et al.* 1999, Thomas *et al.* 2004). While most members of the HCFC considered the Deeble model politically and financially infeasible, Deeble's ideas aligned with the Minister's personal values (Gilson *et al.* 1999, Thomas *et al.* 2004). The report outlined three possible options for health financing reform distinguished by coverage (universal or restricted to contributors) and benefits (primary healthcare (PHC) only or PHC and hospital care), but ultimately recommended the most moderate option – an SHI ensuring comprehensive benefits for contributors and their dependents, with existing medical schemes acting as financial intermediaries – as the only politically feasible option (Gilson *et al.* 1999, Republic of South Africa 2011).

However, when the report was leaked to the press, it received significant public attention.[16] The media described the NHI as 'socialist,' 'sinister' and a 'threat', and perpetuated a narrative that Dlamini-Zuma had a 'hidden agenda,' was 'gagging' those who would speak out against the plan, and was 'pushing through' the NHI, despite the HCFC having rejected the plan, by simply appointing a new committee[17] (see for example Breier 1995, Financial Mail 1995, Peacock 1995, Political correspondent 1995, Staff reporter 1995b, 1995a, Streek 1995).

Likely because the HCFC's recommendation did not align with the Minister's preferences, the HCFC's recommendations were not taken up (Gilson *et al.* 1999, Thomas *et al.* 2004). Instead, another committee was established – the Committee of Inquiry into NHI, co-chaired Minister's aide Olive Shisana (Republic of South Africa 1995, Thomas *et al.* 2004). While there had been no process of wider consultation in the HCFC, the Committee of Inquiry included wide-ranging consultation (Gilson *et al.* 1999). The terms of reference for the committee had initially been restricted to planning for the introduction of an NHI, but one of the chairs threatened to resign if they were not broadened to include consideration of other insurance-based models (Gilson *et al.* 1999, Thomas *et al.* 2004). The Committee of Inquiry also included Treasury officials who argued that funding the NHI through general taxation was not in line with the country's broader macro-economic policy – the RDP (Gilson *et al.* 1999). The committee relitigated the Deeble option, and concluded, once again, that it was not feasible – ultimately including in the report alternative, more palatable SHI models (alongside recommendations for strengthening the public health system) that would incite less backlash from the private sector (Gilson *et al.* 1999, Thomas *et al.* 2004). The recommended SHI model would cover hospital services for contributors only (because PHC was now free in the public sector), with reimbursement rates restricted to the cost of care in the public sector (Gilson *et al.* 1999, McIntyre *et al.* 2003). However these recommendations were opposed by Treasury and received little wider attention (Gilson *et al.* 1999, Thomas *et al.* 2004).

The Committee of Inquiry also called for a technical committee to take these recommendations forward – leading to the establishment in 1997 of the SHI Working Group and the Medical Schemes Working Group (Gilson *et al.* 1999). The SHI Working Group – a small and low-profile group of six analysts and DoH officials – was tasked with developing a detailed proposal for an SHI for public hospitals (Gilson *et al.* 1999, Thomas *et al.* 2004). The working group was also asked by Minister Dlamini-Zuma to reconsider the Deeble option, but once again rejected the idea as financially infeasible (Gilson *et al.* 1999). Instead, the Working Group recommended an SHI scheme targeted at employees who opted against (or could not afford) private health insurance, and made no effort to ensure cross-subsidisation between income groups – indicating a shift away from equity-oriented reforms and a concession to Treasury's concern that the high-income earners not be 'over-taxed' for reasons of 'fairness' (Gilson *et al.* 1999, Doherty *et al.* 2000, McIntyre *et al.* 2003).

Minister Dlamini-Zuma's ideological commitments aside, the Deeble option was also out of step with the pressure for health policy to conform to broader neoliberal trends (Bond *et al.* 1997a). The influence of the World Bank and remaining conservative bureaucrats (some of whom were apartheid-era civil servants) meant that the radical left-leaning elements of the RDP were dimmed in the white

[16] See for example, Breier 1995, Peacock 1995, Staff reporter 1995b, Streek 1995.

[17] This is despite the fact that the Committee of Inquiry reported to the Director General of the DoH and not the Minister (Gilson *et al.* 1999).

Paper on Reconstruction and Development released in November 1994, which shifted towards a contraction of the public sector, protection of property rights, and exposure of manufacturing to international competition (Pillay *et al.* 1995, Gilson *et al.* 1999). In 1996 the leftist-influenced RDP was replaced by GEAR – a purely neoliberal macro-economic policy influenced by the International Monetary Fund and the World Bank that emphasised free-market capitalism, fiscal conservatism, privatization and tax reductions for the rich (Baker 2010, Ataguba *et al.* 2012). GEAR "codified liberalization as the official ideology" of the government (Bond 2014b). In the health sector, GEAR's effect was to constrain health care spending, undermine health system transformation processes, and discourage regulation of the private sector (Baker 2010).

Stagnating financing, in combination with the explosion of HIV/AIDS and a series of related political scandals embroiling the DoH, largely pushed NHI off the agenda beginning in the mid-90s. AIDS began to emerge in 1980s, but was not prevalent in South Africa until the early 1990s (Schneider 1998, Marks 2002). The 1990 Maputo Conference on Health in Transition in Southern Africa connected the fight against AIDS to a broader struggle for socio-economic liberation, and AIDS was acknowledged as a serious threat to health system stability (Schneider 1998, 2002). Minister Dlamini-Zuma was on the drafting team of the comprehensive and progressive 1992 AIDS Plan, which laid the foundation for the plan adopted by the GNU in 1994 (Nattrass 2008).

However, by 1995, HIV prevalence among ante-natal clinic attendees was 4.3%, and the epidemic was spreading rapidly (McIntyre *et al.* 1995, Republic of South Africa 1995). In 1996, the first AIDS-related scandal gained public attention when it was revealed that the playwright's contract for the *Sarafina II*[18] AIDS-education musical was worth R14 million. There was popular outrage and civil society outrage at the size of the contract, push-back from the government's own AIDS Advisory Committee, and the Public Protector confirmed irregularities in the tender process (Schneider 1998, 2002, Hassim *et al.* 2007). While the facts of the case are undisputed, both Bond *et al.* (1997a) and Gilson *et al.* (1999) argue that the scandal was fuelled by 'business interests' seeking to discredit Dlamini-Zuma, whose strong political leadership was helping to shield the DoH's policy agenda from neoliberal imperatives and who had a tendency to take on those with vested interests (such as tobacco companies) (Bond 1999). Nonetheless, *Sarafina II* proved an unremitting source of criticism of the Minister until she left office in 1999 (Gilson *et al.* 1999).

Close on the heels of the *Sarafina II* debacle, in February 1997, a Cabinet press release announced the development of a new AIDS treatment, known as Virodene, by local researchers, Ziggie and Olga Visser (Schneider 1998, 2002, Nattrass 2008). After hearing claims by the researchers that pharmaceutical companies with vested interests were blocking research because it threatened their profits, as well as what Mbeki (then deputy president) described as 'moving' testimonies from AIDS patients being treated as part of an 'unofficial' clinical trial, Cabinet resolved to help the researchers gain approval for formal clinical trials (Nattrass 2008, 2011). However, the biomedical community, drug regulatory authority and Medicines Control Council (MCC) found that the drug had not passed basic biological or animal experimentation and had no benefit for AIDS sufferers, and the MCC refused permission for formal clinical trials of the drug even after undergoing a politically-motivated restructuring to make it more sympathetic to Minister Zuma (Schneider 1998, Fassin *et al.* 2003, Nattrass 2008). The Virodene

[18] The AIDS-education musical was launched on World AIDS Day 1995, and capitalised on the popular imagery of the *Sarafina!* musical and film (Bond et al. 1997a, Schneider 1998).

saga described above paved the way for a much larger HIV-scandal – AIDS denialism – which would continue well into the next decade and would cost South Africa hundreds of thousands of lives (Mbali 2005, Chigwedere *et al.* 2008, Nattrass 2008).

1999 to 2006: AIDS denialism erodes public trust and efforts to contain private sector costs have limited success

By the end of the GNU era, the opportunity to move forward with the HSR agenda seemed to have passed, and in the 1999 to 2006 period, the fight to compel the state to roll-out a HIV treatment programme garnered far more policy-maker and civil-society attention than the HSR agenda. In addition, while some efforts were made in this period to regulate the private health sector to control costs (and set the stage for HSR), successes were limited.

At the start of the new millennium, 20% of pregnant women and nearly half of the armed forces were HIV-positive, and AIDS was the leading cause of death in the country (Bond 1999, Fassin *et al.* 2003). In this context, the Vissers introduced Mbeki (soon to be South Africa's president) to a newspaper article by a magistrate with no training in medical science which drew on AIDS denialist rhetoric from the USA, and argued in defence of Minister Zuma, who was resisting the introduction of antiretrovirals (ARVs) for the prevention of mother-to-child transmission (PMTCT) of HIV (Nattrass 2008). Mbeki responded by attacking AIDS researchers, and delaying the introduction of ARVs in South Africa (Nattrass 2008). After being appointed Mandela's successor, Mbeki, along with new Minister of Health Manto Tshabalala-Msimang, questioned the connection between HIV and AIDS, the accuracy of AIDS tests, and the safety and efficacy of AIDS treatments, arguing instead that AIDS was a Western conspiracy based on racist stereotypes of African sexuality (Mbali 2005, Worden 2012). As a result of the government's failure to respond to the epidemic, by 2005 life expectancy in South Africa had fallen to 48, down from 64 in 1994 (Baker 2010).

The AIDS crisis and the ANC government's response thereto significantly undermined public trust in the state's ability to steward a public sector increasingly under strain, and, for some, exposed the Party's commitment to establishing a universal, equitable, PHC-focused health system as purely rhetorical (Schneider 1998, Kautzky *et al.* 2008). However, AIDS and AIDS denialism also set the scene for civil society action, led by the Treatment Action Campaign (TAC), that would offer a counter argument to neoliberal forms of governance in two areas: The limits of the state's responsibility to provide health care, and the obligation of the state to regulate markets for the public good.

The TAC was established in late 1998, initially to fight for a PMTCT programme that would ensure HIV-positive mothers had access to ARVs (Heywood 2009). In 1999 Minister Zuma claimed that budget shortfalls prevented the Department from rolling out ARVs to HIV-positive women (Bond 1999, Heywood 2003). At the time, the branded Azidothymidine cost $240 per month in South Africa, and it was generally assumed that AIDS drugs were simply too expensive for widespread use in developing countries (even though a generic version produced in India cost less than $50 per month) (Bond 1999, Robins *et al.* 2004, Bond 2014a). Generic substitution in the public and private sectors was a key tenet of the ANC's HSR policy proposal in 1994, and the 1997 Medicines Act, passed under Minister Zuma's leadership, made provisions for parallel imports and compulsory licensing (allowing the state to grant rights to local manufacturers to make generic versions of drugs without the permission of the patent-holder) (ANC 1994, Bond 1999). While both these provisions were allowed under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement) in health emergencies, the

implementation of the Act was blocked for 3 years by a challenge in the Constitutional Court brought against the South African government by a collection of multinational drug companies under the umbrella of the Pharmaceutical Manufacturers Association (PMA) (Bond 1999, Robins *et al.* 2004, Mbali 2005, Waterhouse *et al.* 2017). Alongside the legal challenge, United States officials and representatives (including vice-president Al Gore – whose presidential bid the following year was funded by pharmaceutical companies) launched a massive lobbying effort to pressure Minister Dlamini-Zuma to revoke the offending clause of the Medicines Act (Bond 1999). In 2001, the TAC was admitted by the Pretoria High Court as a 'friend of the court' on the case (Heywood 2009). The TAC argued that health is a constitutionally-enshrined human right that the state has a legal duty to protect, that excessive pricing of essential medicines by pharmaceutical companies violated these rights, and that the intellectual property rights imbued by the 1995 TRIPS agreement was not an inherent human right and therefore limitations on these rights were justified (Habib 2004, Heywood 2009). Eventually, massive public demonstrations and global advocacy efforts by international non-governmental organisations (NGOs) such as Médecins Sans Frontières and Oxfam garnered enough public pressure to compel the PMA to withdraw the case (Habib 2004, Robins *et al.* 2004, Heywood 2009, Bond 2014a).

However, the TAC's victory against the PMA occurred in the context of AIDS denialism – another hurdle to be overcome before South Africans would be guaranteed access to ARVs. In 2000, the findings of a local clinical trial supported the use of Nevirapine for the PMTCT (Heywood 2003). However, Minister Tshabalala-Msimang stalled, saying that even once Nevirapine was registered for PMTCT by the MCC, the provision of Nevirapine must first be tested for 'feasibility' at two pilot sites in each province (due to begin in March 2001), and even then implementation would be 'phased' (Heywood 2003). In addition, there were reports that the MCC's registration of the drug was deliberately delayed by some employees kowtowing to government (Heywood 2003). Eventually, the PMTCT programme was initiated but restricted to 'research and training' sites – leaving most in need of treatment without access (Heywood 2003, Hassim *et al.* 2007).

The TAC, together with a coalition of paediatricians and children's rights advocates, lodged a court case against Minister Tshabalala-Msimang for failing to implement a PMTCT programme that would ensure broad-based access to Nevirapine (Schneider 2002, Heywood 2003, Hassim *et al.* 2007). Amidst a TAC-led public mobilisation campaign that attracted much public support and media attention, a judgement was handed down in December 2001 in favour of the TAC's application, concluding that a "countrywide MTCT programme is an ineluctable obligation of the state" (Heywood 2003, Hassim *et al.* 2007). The Minister appealed the decision, and claimed the Department could not take a decision on whether to scale-up the roll-out of Nevirapine until the pilot sites had been running for a full year (despite an evaluation by the Health Systems Trust already recommending the expansion of PMCTC in all provinces), but a final judgement handed down by the Constitutional Court in July 2002 once again found in favour of the TAC (Heywood 2003, Bond 2014a). The TAC's successful fight to lower the price of AIDS drugs and compel the state to provide treatment for HIV arguably served to reaffirm the responsibilities of the state with regard to the regulation of the private sector and the provision of health services (Heywood 2009).

The HSR process stalled somewhat during the AIDS denialism era (Waterhouse *et al.* 2017). The 2002 Committee of Inquiry into Comprehensive Social Security in South Africa – the CSSSA or Taylor

Committee – explicitly called for a unified NHS in which the public sector would remain the 'backbone' of the health system, but only as a long-term strategy (CSSSA Committee 2002, McIntyre *et al.* 2007). In the short-term, the Taylor Committee recommended a particularly progressive SHI (Pillay *et al.* 2013). In 2005, a Ministerial Task Team established to decide which of the Taylor Committee proposals to take forward, concluded that NHI was not feasible, and suggested pursuing SHI which would include: a Risk Equalisation Fund (REF) and an income-rated earmarked tax to ensure cross-subsidisation; the removal of the medical scheme tax exemption; the introduction of fees at public sector facilities for those who can afford medical scheme coverage to encourage uptake; a standard covered benefit package and PHC to ensure equity in service access; and the introduction of a National Health Reference Price List (NHRPL) to control private sector costs (McIntyre *et al.* 2007, McLeod 2009c). However, support for an SHI among academics waned in this period due to concerns about the feasibility of an REF (which requires substantial technical capacity) and the challenges of adequate risk pooling in a multi-purchaser environment (Pillay *et al.* 2013, Waterhouse *et al.* 2017). As a result these recommendations were largely ignored until the idea began to re-emerge in 2007 (Pillay *et al.* 2013, Waterhouse *et al.* 2017).

While the AIDS crisis distracted public and policy-maker attention from the HSR agenda, it occurred alongside, and arguably exacerbated, growing health sector challenges caused by the public-private divide (Waterhouse *et al.* 2017, Gilson 2019). As stated above, despite growing inequities between public and private sectors – by the end of the decade 73% of all doctors worked in the private sector, and by the mid-2000s the value of the tax subsidy per medical scheme member exceeded government expenditure on health per public sector beneficiary and amounted to 20% of the entire public health budget (McIntyre *et al.* 2006, McIntyre *et al.* 2020) – in the early years of the new democracy no significant moves were made to regulate the private sector more tightly. However, in the late-90s, regulatory efforts were made with respect to both private providers and private funders.

With respect to private providers, the 1997 White Paper for the Transformation of the Health System in South Africa suggested the development of a unified NHS in which public and private resources would be pooled and private health practitioners would be integrated with the public sector (Republic of South Africa 1997). The White Paper also spoke of contractual arrangements and tariff negotiations to facilitate the utilisation of private sector beds by public sector patients, and introduced the idea of a certificate of need – which would ensure equitable geographic distribution of health facilities by limiting the licensing of new private facilities in areas with sufficient coverage (Republic of South Africa 1997). The idea of a certificate of need was raised again in the 1999 Health Sector Strategic Framework and the 2003 National Health Act, but was never implemented, and was eventually successfully challenged in the Constitutional Court in 2015 by the Hospital Association of South Africa and the South African Dental Association (Republic of South Africa 1999, Harrison 2009, Waterhouse *et al.* 2017). Little was done to tackle concentration of ownership in the private sector, and by 2007 84% of private hospital beds were owned by three hospital groups (McIntyre *et al.* 2007).

In addition, efforts to contain costs in the private sector proved unsuccessful. In 2003, complaints were registered with the Competition Commission against SAMA and BHF for the publication of industry-wide tariffs that set ostensibly fair rates for various medical services and that medical schemes used to guide reimbursement rates (Berger *et al.* 2010, Waterhouse *et al.* 2017). The Commission concluded that the tariff schedule was anti-competitive and demanded that SAMA and

BHF cease the practice (Berger *et al.* 2010, Waterhouse *et al.* 2017). However, by applying market logic in an industry where payments are made by a third party (medical schemes), this ruling further exacerbated high costs in the private sector. The 2004 National Health Act gave the Council for Medical Schemes (the regulatory body for medical schemes) the authority to establish an NHRPL to standardise what providers charge and funders reimburse (Berger *et al.* 2010). However, the NHRPL was non-binding and did not successfully contain costs – while medical schemes used the NHRPL to determine reimbursement rates, providers continued to charge rates in excess of the tariff, resulting in members paying the remaining amount out-of-pocket (McLeod *et al.* 2007, Berger *et al.* 2010, Hassim 2010).

More was done to regulate the private financing sector, beginning in 1998 with the MSA (Republic of South Africa 1998). The Act, which was implemented in 2000, regulated medical schemes in favour of beneficiaries in order to expand the group of people with medical scheme coverage, and although not explicitly stated in the Act, was understood to be an attempt to lay the foundation for SHI (Thomas *et al.* 2004, Pillay *et al.* 2013). Under the MSA, medical schemes are not permitted to risk-rate or exclude individuals on the basis of age or health status, and are prohibited from applying repayment limits and 'dumping' patients on the public sector when their benefits run out (Doherty *et al.* 2000, McLeod 2009a). However, the MSA was intended to be implemented in concert with the White Paper, and so while ensuring *de re* access to medical schemes, in the absence of a system of tariffs, these regulations did little to contain costs (Republic of South Africa 1997, Doherty *et al.* 2000).

Costs in the private sector continued to rise due to a combination of over-utilisation, over-servicing, and high administration fees[19] – and medical scheme membership contributions were increasingly unaffordable even for relatively well-off South Africans (McIntyre *et al.* 2006, McIntyre *et al.* 2007). Despite the MSA, medical scheme membership did not rise, and in 2006 medical scheme coverage was at its lowest point since 2002 (McIntyre *et al.* 2007, Omotoso *et al.* 2017). Rising private sector costs also meant increasing amounts of public funds being spent in the private health sector, for example, because the state subsidises the medical scheme contributions of civil servants, and through tax subsidies on medical scheme contributions (McIntyre *et al.* 2006, Hassim *et al.* 2007, Madore *et al.* 2015).

2007 to 2015: Zuma reignites the health system reform agenda, but corruption and governance failures further undermine public trust

In this context of an increasingly unaffordable and unsustainable private sector, and growing doubt and impatience about the ability of neoliberal macro-economic strategies to fulfil the promises of the new South Africa, the ascendence of Jacob Zuma to the presidency both brought renewed hope for the HSR agenda, and introduced a grand-scale corruption scandal that arguably presented the final nail in the coffin of public trust in the state.

Jacob Zuma was deputy President in Mbeki's government, but was dismissed by Mbeki in 2005 after courts found that Zuma was involved in a 'generally corrupt relationship' with infamous businessman Schabir Shaik (Camerer 2011, Seekings *et al.* 2011). Although he was not formally charged with corruption at the time, in 2007, shortly after decisively winning the Presidency of the ANC from Mbeki, Zuma was served with papers by the Scorpions (a dedicated anti-corruption unit set up by Mbeki to

[19] MSs are not-for-profit entities but are administered by for-profit companies (Gilson et al. 1999, Hassim et al. 2007). Between 1992 and 1998, the cost of non-health expenditure (administration and brokerage) increased 243.5%, and by 2003 the cost of MS administration was 4.5 billion (Hassim et al. 2007).

tackle corruption) to stand trial in the High Court on corruption charges (Camerer 2011, Hart 2014, Von Holdt 2019).

The political saga between Mbeki and Zuma crystalised a larger ideological tension that connects neoliberalism with rationality and the rule of law, and populism with corruption (Hart 2014).[20] Zuma was a populist president in that he encompassed authoritarian, anti-intellectual, militaristic, cultural and patriarchal respectability, and pro-poor ideas (Worden 2012, Bond 2014a, Hart 2014, Von Holdt 2019). In addition, Zuma's rise to the presidency took place in a period in which popular discontent at the consequences of neoliberal policies was growing (Bond 2014a),[21] and his presidential campaign took advantage of general disaffection with Mbeki's prioritisation of growth over redistribution (Pillay *et al.* 2013). In the Zuma-Mbeki divide, Zuma also had the support of the SACP and COSATU – both important to the ANC's political legitimacy and election prospects (Waterhouse *et al.* 2017). Zuma's political identity stood in sharp contrast with a vision of Mbeki as 'civilised', intellectual, rational, unfeeling, autocratic and neoliberal (Worden 2012, Hart 2014, Von Holdt 2019). Further, Mbeki can be understood as anti-revolutionary in that he sought not only to neutralise the revolutionary potential of the masses, but also to prioritise neoliberalism and an alliance with corporate capital (Hart 2014, Von Holdt 2019).

Thus, Zuma's presidency renewed hopes for a more developmental state and paved the way for HSR in the form of a NHI as part of a populist agenda (Pillay *et al.* 2013, Gilson 2019, Von Holdt 2019). In 2007, at the ANC annual conference in Polokwane (where Zuma was elected as ANC president), the urgent implementation of the NHI was adopted as official ANC policy, and an ANC NHI Task Team (led by long-time NHI proponent Olive Shisana) was appointed to further develop the policy (Vavi 2008, Pillay *et al.* 2013, Madore *et al.* 2015). COSATU lobbied strongly for the NHI at the conference, and would remain a strong supporter of a single-purchaser NHI throughout the Zuma presidency (Madore *et al.* 2015, Waterhouse *et al.* 2017). At the same conference, the ANC committed to a more radical approach to land reform which would see the market-driven, 'willing-seller, willing-buyer' approach (which had hereto prevented the government from reaching its redistributive goals) discarded (Bond *et al.* 1997b, ANC 2007).

The global context of the time may also have contributed to putting HSR back on the policy agenda. The 2008 global financial crisis "loosened neoliberalism's hold on policy" (Centeno *et al.* 2012). In an article entitled 'Beware brain washing' criticising the hegemony of neoliberal ideas in higher education, then Minister of Higher education, Blade Nzimande, warned that any policy proposal that challenged the "neoliberal agenda and elite class interests" would be met with resistance. In addition, in 2008 and 2009 United States President Barack Obama's plans for health care reform in that country

[20] While there is no doubt that Zuma was corrupt, it is also true that corruption was already flourishing in the South African government under both Mbeki and Mandela, and that Mandela in fact inherited a corrupt civil service from the apartheid government. In addition, some commentators have argued that given the neoliberal macro-economic strategy of the ANC, corruption and patronage were necessary in order to create a black capitalist class that could support the ANC politically and economically (Gilson et al. 1999, Hart 2014, Von Holdt 2019).

[21] In 2004, an election year, the strong Rand allowed the ANC to claim that neoliberal policies had 'worked', that while poverty increased from 94 to 2000, it decreased between 2000 and 2004, and to issue renewed promises for more generous social welfare (Seekings 2007b, Bond 2014a). In reality, inequality increased between 1994 and 2010, and while there is disagreement about whether poverty had declined, neoliberal macroeconomic policies had only resulted in modest growth (Seekings 2007b, Chopra et al. 2009, Bond 2014a).

was being widely reported in South African Press.[22] While some media positioned Obama as fighting for equity-driven, 'socialist' reforms against the back-drop of a profit-driven, free-market system (Sidley 2008, Nzimande 2009), others expressed disappointment at Obama's readiness to abandon the 'public option' as infeasible and to instead strive for increased insurance coverage through better regulation (Pollitt 2009, Vanden Heuvel 2009, Balz 2010). Also at around this time, in 2010 the WHO's World Health Report identified UHC, including purchaser-provider split and inclusion of the private sector in provision, as a guiding principle, and the idea quickly gathered momentum (Waterhouse *et al.* 2017, Smithers *et al.* 2022).

However, like in the United States, in South Africa NHI was still a contentious issue. A document containing the ANC NHI Task Team proposal – including the establishment of an NHI authority to take over funding and purchasing of the health care for the entire population and scrapping the medical scheme tax deduction – was leaked to the press, sparking backlash over the 'demise' of medical schemes, the cost of the NHI, and the 'undue' burden it would place on the country's tax-payers (Bateman 2009, du Preez 2009, Madore *et al.* 2015). In 2008 both the National Health Amendment Bill (seeking to provide for the appointment of a regulator for health pricing, and for a framework for collective and individual bargaining for health prices) and the Medical Schemes Amendment Act (seeking to establish a REF, and to make provisions for Low-Income Medical Schemes) – failed to pass through parliament (McLeod 2009c, Berger *et al.* 2010, van den Heever 2016).

In 2009, the ANC's election manifesto promised the introduction of an NHI that would be publicly funded, publicly administered, free at the point of service, and would engage with private hospitals and group practices to encourage them to participate in the NHI (McLeod 2009b). After taking office, Zuma used his first State of the Nation address to commit to the implementation of the NHI (Pillay *et al.* 2013). Shortly thereafter, an NHI Ministerial Advisory Committee (MAC) was established to advise the minster on policy and legislation for the NHI (McLeod 2009b, Madore *et al.* 2015). Like the ANC NHI Task Team, the MAC was chaired by Shisana, enabling the cross-pollination of ideas between the two (Madore *et al.* 2015).

Zuma also introduced Aaron Motsoaledi as the new Minister of Health, who unlike Tshabalala-Msimang, proved to be a passionate advocate for the NHI (Waterhouse *et al.* 2017, Gilson 2019). Motsoaledi's argument for the NHI centred on inequalities between the public and private sectors, and framed the NHI as an opportunity to pool the public and private sectors to eliminate these inequities and create a more efficient health system (Madore *et al.* 2015, van den Heever 2016).

By 2007, the number of private hospital beds per medical scheme beneficiary was twice that available to those dependent on the public sector, a general practitioner (GP) in the public sector served between seven and 17 times as many patients as a GP in the private sector, and there was a 23-fold difference in the number of specialist doctors per beneficiary between the public and private sectors (McIntyre *et al.* 2007). Accordingly, whereas the pre-2008 version of the NHI focused on expanding medical scheme coverage and introducing mechanisms for cross-subsidisation between pools, post-2008 the policy proposals cemented around a single-payer system with a single funding pool to ensure equity and social solidarity (Dhai 2011, Republic of South Africa 2011, van den Heever 2016).

[22] See for example Obama 2008, Sidley 2008 Pollitt 2009, Vanden Heuvel 2009 and Balz 2010.

Under Motsoaledi's leadership there was a flurry of policy development activity, demonstrating the technical, economic and political challenges of HSR. In August 2011, after an intensely political policy development process, the NHI Green Paper was released (van den Heever 2016). The Green Paper proposed a tax increase of 3% to fund the NHI, a reduction from the 5% previously proposed, reflecting concerns about the burden on tax payers (Republic of South Africa 2011, van den Heever 2011). Even so, in 2012, Minister of Finance Pravin Gordhan noted concerns about funding shortfalls for the NHI and said that additional funding options (including VAT increases, an employer's payroll tax, a surcharge on the taxable income of individuals, or the introduction of user fees) had to be considered (Gordhan 2012). In addition, the Green Paper extended the implementation timeline for the NHI from 5 years to 15 years, with the first 5 reserved for reforming the public health system (van den Heever 2011), while at the ANC's 2012 annual conference it was resolved that the NHI must be set up using state revenue by 2014.

The Green paper also made provision for the establishment of 10 NHI pilot sites – to begin in March 2012 – to resolve technical complexities and explore options for managing the public-private split, such as how best to contract and reimburse private providers, and Motsoaledi put the development of the White Paper on hold to allow time to learn from the pilot sites (Madore *et al.* 2015, Gilson 2019). The pilot sites revealed the challenges involved in contracting private providers to work for the public sector. Firstly, central government did not have the mandate for hiring and firing – this fell to Provincial governments which were not invested in the success of the pilot sites (particularly given that the NHI will likely see a reduction in the powers of provincial governments) (Heywood 2014, Madore *et al.* 2015). Secondly, very few doctors were willing to work in the pilot sites, perhaps because the reimbursement rates were too low (Heywood 2014, Madore *et al.* 2015).

In 2014, an election year, Zuma announced the launch of Operation Phakisa ('hurry up') – considered an important step towards improving the public sector in preparation for NHI – which would use data collected from a set of 10 Ideal Clinic learning sites established in 2013 to devise a set of initiatives that every clinic could use to improve service delivery (Madore *et al.* 2015, Waterhouse *et al.* 2017). Simultaneously, an inquiry into the South African Health Market (or the Health Market Inquiry – HMI) was initiated by the Competition Commission to examine the causes of high costs in the private sector – another significant challenge to implementation of the NHI (Madore *et al.* 2015).

Then, in 2015, a draft White Paper – National Health Insurance for South African: Towards Universal Health Coverage – was released for comment, describing a single-payer system in which a central authority contract with public and private GPs and specialists, and in which medical schemes would be reduced to providing 'complementary' coverage only (Republic of South Africa 2015, van den Heever 2016, Waterhouse *et al.* 2017). The White Paper was labelled 'Version 40' – an indication of the many iterations developed since 2011, and of the contentious nature of the issue (Waterhouse *et al.* 2017). In particular, during this intervening period, Treasury continued to argue for a multi-payer system combined with a 'solidarity tax', on the grounds that it would allow medical scheme members to keep their coverage (Madore *et al.* 2015, COSATU 2016). Motsoaledi himself said that the various iterations were due to his desire to respond to technical criticism from experts and academics, while ensuring that the White Paper would be understandable for 'every South African' (Madore *et al.* 2015).

Alongside this contentious policy development process, the country was suffering a series of corruption scandals and governance failures that significantly undermined public trust.[23] Perhaps the defining corruption scandal of the new democracy was the 1999 Arms Deal, under Mbeki's presidency[24], in which the 'Strategic Defence Package' to modernise South Africa's defence capacities saw contracts totalling tens of billions of rands improperly awarded to various arms manufacturers in exchange for bribes paid (reportedly) to Mbeki and Zuma, among others (Seekings *et al.* 2011, Koelble 2017, Von Holdt 2019). At the time, there was controversy over whether spending on defence was appropriate or necessary given the need for spending on social services (Crawford-Browne 2001, wa ka Ngobeni 2001, Koelble 2017). The scandal received significant media coverage that was reignited in the mid-2000s (Corruption Watch 2014, Koelble 2017). In May 2005, Shabir Shaik, long-time associate of Zuma, was convicted of having paid bribes to Zuma (then member of the Executive Council of the Economic Affairs and Tourism in KwaZulu-Natal) in connection to the Arms Deal (Camerer 2011, Koelble 2017, Budhram 2019). When Zuma himself was charged in 2007, he was able to build a network of supporters within, and exert political pressure on, the National Prosecuting Authority (NPA) to protect him from prosecution for his involvement in the Arms Deal, and subsequent corruption cases (Camerer 2011, Koelble 2017, Von Holdt 2019). Shortly before the 2009 general election, after Mbeki was recalled by the ANC and resigned the presidency, the NPA dropped all charges against Zuma (Camerer 2011, Worden 2012). After the ANC won the 2009 general election, and Zuma was installed as president of the country, he promptly disbanded the Scorpions (Camerer 2011).

From then on, Zuma's presidency was characterised by ongoing corruption and governance failures that drew significant public attention. In 2008, the country suffered its first round of load-shedding – wide-spread, planned power outages necessary to preserve the country's electrical power as a consequence of the operational and governance crisis in electrical parastatal, Eskom (Bowman 2020). Load-shedding is causally connected both to neoliberal privatisation and corporatisation policies (with investment in generation capacity having been undermined by attempts to unbundle Eskom and facilitate the entry of private generators[25]) and corruption (with Zuma having facilitated the appointment of Gupta-linked board members in 2011, and having been found to have an improper and corrupt relationship with the Gupta family)[26] (PPSA 2016, Budhram 2019, Von Holdt 2019, Bowman 2020). In August 2012, a miners strike in Marikana, North West Province (a mine owned by global company, Lonmin) descended into deadly violence, wherein 34 striking miners were gunned down by police (Bond 2014a, Hart 2014, Forrest 2015). Some of the violence was broadcast live by national and international media, and the brutality of the events, combined with the stark similarity of the images to the many instances of mass police brutality under apartheid, garnered significant

[23] It is important to recognise that corruption in South Africa is by no means unique to the Zuma government, or the ANC government more broadly. There were many instances of corruption under the apartheid regime (Budhram 2019), and fraud and corruption are also common in the private sector (CCSA 2019).

[24] The 'corrupt Zuma vs anti-corrupt Mbeki' narrative is questionable given that Mbeki both benefitted from, and quashed investigation into, the Arms Deal, but some commentators argue nonetheless that Mbeki's 'successful image management' means that the narrative holds true in the popular imagination (Hart 2014, Camerer 2011).

[25] These attempts were ultimately successfully resisted by trade unions (Bond 2014b).

[26] The Gupta family had a long-standing friendship and business relations with Zuma and his son, Duduzane Zuma, and through this relationship with Zuma gained the power to appoint government officials, control state-owned-enterprises, and ensure preferential treatments for themselves and their associates in government tenders and contracts, ultimately redirecting public funds (see PPSA 2016).

public attention (Forrest 2015). Zuma subsequently decided on the terms of reference of the commission established to investigate responsibility for the massacre and ensured that government institutions would not be held accountable, (Fogel 2013, Forrest 2015). In 2009, Zuma began security upgrades to his private residence at Nkandla, KZN, authorised by the Minister of Public Works, and media articles reported on the 'opulent' and 'excessive' expenditure, leading to one of the most controversial and illustrative corruption cases in the 'new' South Africa (PPSA 2014, Budhram 2019). The Public Protector launched an investigation in 2013, finding maladministration, and recommending that Zuma pay back a reasonable percentage of the costs of the upgrades (PPSA 2014, Budhram 2019). Following a 2015 Constitutional Court case brought by an opposition party finding that the recommendations of the Public Protector are binding, Zuma paid back R7.8 million by securing a loan from VBS bank, with the loan itself revealed as a product of corruption, and the bank being placed under curatorship shortly thereafter (Koelble 2017, Budhram 2019).

By October 2016, the scale of Zuma's corruption was clear and the idea of 'state capture'[27] was firmly cemented in the public consciousness and understood as a national crisis (Budhram 2019, Von Holdt 2019). Zuma's 'weekend cabinet reshuffle' in March 2017, understood as the final push in his attempt to co-opt the state for private gain, prompted a wave of civil society mobilisation, protest action, another motion of no confidence, and Zuma being recalled by the ANC as president of South Africa (Bhorat *et al.* 2017, Chipkin *et al.* 2018, Von Holdt 2019). Zuma finally resigned the presidency in February 2018, and was succeeded by Cyril Ramaphosa (Potgieter 2019, Von Holdt 2019).

Nattrass *et al.* argue that this corruption can be understood as the 'tawdry underside' of the ANC's project to develop a black economic elite, which resulted in close relationships between political and bureaucratic leaders and business (2010b). Bhorat *et al.* concur, and argue that Zuma's project can be understood as a political endeavour counter to the public interest but legitimated by association with radical economic transformation (2017) (see also Von Holdt 2019). This partly explains why, despite multiple 'no confidence' motions brought by opposition parties, the ANC repeatedly opted to protect Zuma (Budhram 2019, Von Holdt 2019). Nonetheless, these events, alongside other major Zuma-linked scandals[28] severely undermined public trust not only in Zuma, but also in the state (Wale 2013, Bond 2014b, Budhram 2019). After a brief moment of optimism in 2004-5, which some argue represent a pinnacle of trust in government, Zuma's presidential term saw a steady decline in trust in national government, the police and local government (Wale 2013, Bond 2014a, Potgieter 2019).

2016 to 2019: Zuma's shadow continues to plague health system reform efforts amid doubt about the state's capacity to regulate the private sector and deliver adequate public healthcare

While the NHI remained a key policy priority for the ANC, and Motsoaledi continued to drive the process forward, the loss of public trust and the fault-lines within government caused by state capture would intersect in various ways with the NHI policy process. After the release of the NHI White Paper in 2015, it was necessary to develop the details for financing and implementing the NHI. In 2017, an amended version of the NHI White Paper was released, alongside a policy paper on NHI

[27] 'State capture' refers to the "capture of the state apparatus by private interests seeking to utilize state powers or resources to their advantage…and is used [in South Africa] to describe mutually-beneficial corrupt relations between former-President Jacob Zuma and his political allies, and the Gupta family" (Bowman 2020).

[28] See, for example the Gupta private plane landing at the Waterkloof military air base in 2013 (Bhorat *et al*. 2017, Budhram 2019), and the Transnet controversy, beginning in 2014, in which a 'Zuma-centred power elite' brokered a multi-billion Rand train procurement (Chipkin *et al.* 2018, Budhram 2019, Von Holdt 2019, Bowman 2020).

implementation (Republic of South Africa 2017b, 2017a). The release of the Davis Tax Committee (DTC – an advisory committee established in 2013 to explore how government could raise revenue to meet its policy objectives, including NHI) report in 2017 raised concerns about financing of the NHI, saying that in the absence of sustained economic growth, the NHI is not financially sustainable in South Africa (Davis Tax Committee 2017). Despite this, and despite the fact that the detailed funding options for NHI promised by Treasury were not forthcoming, in June 2018 the NHI Draft Bill was gazetted and public comment invited by parliament (Waterhouse *et al.* 2017, Republic of South Africa 2018b). Along with the Draft NHI Bill, a Draft Medical Schemes Amendment (MSA) Bill, and Draft National Quality Improvement Plan were released. The MSA Bill was intended, among other things, to make the necessary changes to the private financing sector in preparation for the implementation of the NHI (Motsoaledi 2018, Republic of South Africa 2018a, Section27 *et al.* 2018).

However, the policy process was significantly more complex in the shadow of state capture and Zuma's ousting. Firstly, while the tumultuousness of the Zuma presidency weakened the ANC's hold on the country's electorate, with the result that NHI became all the more important to the Party's electoral prospects (Waterhouse *et al.* 2017), state-capture and large-scale corruption in parastatals such as Eskom were frequently used to justify resistance to NHI in public submissions on NHI policy documents.[29]

Secondly, Motsoaledi's legislative push was complicated both by conflicting views on the appropriate role of the private sector in the NHI, and (politically motivated) opposition from COSATU (Waterhouse *et al.* 2017). During the 2016 political crisis preceding Zuma's ousting, COSATU accused Motsoaledi and Treasury of deliberately sabotaging the NHI by kowtowing to private interests and 'handing over' the NHI to 'private interests', and called on Zuma (who COSATU supported until the cabinet reshuffle in 2016) to stop Motsoaledi's 'attacks' on the NHI (Madore *et al.* 2015, Waterhouse *et al.* 2017, Gilson 2019). At the same time, Zuma accused Minister of Finance Gordhan of being in the pocket of 'white monopoly capital' and tried to oust him through the cabinet reshuffle, while Motsoaledi was among those calling for Zuma to step down (Waterhouse *et al.* 2017).

Motsoaledi continued to argue passionately for the NHI on the grounds that the public-private divide created a two-tier health system that necessarily resulted in inequities (see, for example Staff reporter 2019). However, these arguments were seen as antagonistic to the private sector and alienated many private sector users, resulting in considerable contestation (Waterhouse *et al.* 2017). In addition, Motsoaledi was labelled as 'driven by ideology', unable to understand the technical and structural issues at play, and unwilling to listen to experts (Waterhouse *et al.* 2017). After the release of the 2015 White Paper on NHI, Motsoaledi, apparently responding to concerns within the ANC that restricting access to medical schemes would alienate much-needed middle-class voters, said that the White Paper gave the wrong impression by implying that under NHI people will not be able to opt-in to private medical scheme coverage (Medical Brief 2016).

The challenge of reaching popular consensus on the implementation of the NHI was further complicated by increasing doubt about the capacity of the state to deliver health services (Rispel *et al.* 2016). The Life Esidimeni tragedy was a high-profile governance failure within the health sector that exemplified the problem. In 2015, the Gauteng Provincial DoH, seeking to reduce costs, took the

[29] See IRR 2018, Section27 *et al*. 2018, Dullah Omar Institute 2019, SAMA 2019, Medical Brief 2022, Solanki *et al.* 2022.

decision to terminate a long-standing contract with Life Healthcare Esidimeni private hospital for the in-patient care and rehabilitation of patients with chronic psychiatric disorders, opting to discharge some patients, refer some to NGOs for further care, or transfer patients to public hospitals with psychiatric wards (Mdluli 2015, Mkize 2015). However, it soon became clear that, in addition to the transfer process being 'chaotic' and 'inhumane', many patients were transferred to NGOs without the appropriate capacity to care for them (Mkize 2016, Dhai 2017a, 2017b, Makgoba 2017). The Health Ombud found in 2017 that a total of 91 patients died, and that all 27 of the NGOs to which patients were transferred were operating without valid licenses (Makgoba 2017). The Life Esidimeni saga therefore reinforced existing public perceptions of poor quality care in the public sector (CCSA 2018, Maseko *et al.* 2018).

Major scandals aside, in general service delivery in the public health sector was described as characterised by leadership and governance failures, inept, unprofessional and uncaring behaviour on the part of healthcare workers and poor quality of care, and a 2018 Office of Health Standards Compliance report found that on average, the facilities inspected met less than 50% of the required quality standards (Rispel 2016, Waterhouse *et al.* 2017, Ramaphosa 2018). By 2019, the idea that the public health system had 'collapsed' was frequently touted in the media (Gilson 2019).

Whether the result of pernicious 'behind-the-scenes' lobbying by private actors, the need to placate middle-class voters and those concerned that the publicly delivered health services are inadequate, or a pragmatic recognition that the economic and political realities in South Africa mean the only possible NHI is one that incorporates private actors, over the course of his tenure Motsoaledi was increasingly open to engaging with the private sector in developing the NHI (Waterhouse *et al.* 2017).

However, in parallel to these developments, the HMI was wrapping up, and its findings would reveal the extent of the challenges facing the private health sector. A provisional report was released in 2018, soon after the publication of the draft NHI Bill and MSA Bill, and a final report released in 2019 (CCSA 2018, 2019, Paremoer 2021). The reports revealed a lack of regulation of the private sector and limited accountability of private providers resulting in over-servicing, supply-induced demand and rising costs, to the detriment of consumers (CCSA 2018, 2019). The commission also found significant consolidation of ownership in the private sector. The number of medical schemes had halved between 2000 and 2019, the country's largest medical scheme (Discovery Health medical scheme) increased its market share from 35% in 2005 to 56% in 2017, and the largest three administrators[30] accounted for 94% of the market. Similarly, among providers, the market share of the three largest hospital groups increased from 51% of acute beds in 1996 to 90% in 2016, and these groups accounted for 87% of all private sector admissions in 2016 (CCSA 2019).

These challenges were reflected in the lived experiences of private sector users. While overall health financing in South Africa was progressive, among medical scheme members, poorer groups were paying a larger percentage of their income than richer groups, making contributions increasingly unaffordable for many (Ataguba *et al.* 2018). In addition, medical scheme benefit packages were increasingly restrictive (meaning more and more services and products are not covered), and co-payments were common, with the result that many medical scheme members faced significant out-

[30] Medical scheme administrators are for-profit entities that manage members, information, data, benefit packages, and claims processing on behalf of medical schemes (CCSA 2019)

of-pocket expenditure (Ataguba *et al.* 2018, CCSA 2018). The final HMI report largely placed the blame for this state of affairs on the state's failure to regulate the private sector appropriately, and recommended the institution of a supply-side regulator of healthcare to regulate hospitals and practitioners, an outcomes monitoring organisation to provide patients and funders with information on the health outcomes of providers and facilities, and a single standardised benefit option to be available across all medical schemes to enable consumers to compare prices and benefits across medical schemes more easily (CCSA 2019).

In July 2019, shortly after Motsoaledi's tenure as Minister of Health came to an end in May, the National Health Insurance Bill was published (Gilson 2019, Republic of South Africa 2019). The Bill made provision for a single purchaser, single payer NHI, in which a National Health Insurance Fund (NHIF) would contract with 'accredited health care service providers' 'in the public or private sector' (Mcintyre 2019, Republic of South Africa 2019). Private medical schemes would only be allowed for services not covered by the NHI (Mcintyre 2019, Republic of South Africa 2019). The NHIF would be financed through general tax revenue, reallocation of medical scheme tax credit, employer and employee payroll tax, and an earmarked surcharge on personal income tax (Republic of South Africa 2019).

In this period, as had been the case throughout South Africa's history, HSR efforts were significantly influenced by prevailing political concerns. While the HMI report revealed the harmful consequences of inadequate regulation of the private sector, the series of corruption scandals and governance failures in recent years, both in the health sector and more broadly, gave rise to concerns that that the state lacks the capacity to manage the NHI. Nonetheless, the process to finalise the NHI Bill and move towards achieving UHC through NHI was ongoing.

Conclusion

This synthesis of the history of HSR efforts in South Africa reveals the myriad of historical and contextual forces that shape UHC reform processes, as well as the value of a historical approach to understanding why policy processes for UHC unfold as they do. The analysis suggests that in South Africa politics; the power of private sector; competing policy priorities; budgetary constraints; and ideas, values and ideologies have been particularly important in constraining, and sometimes spurring, HSR efforts. In this section, we explicate the effects of these factors to reveal how the history of HSR in the country has shaped the social and political meaning of UHC in this context.

Social and political specificities shaping health system reform policy processes in South Africa

Firstly, in keeping with Gilson's (2019) suggestion that health financing reform is a political process above all, political considerations have been a major determinant of what reforms are possible. For example, in the 1940s, the electoral victory of the National Party in 1948 scuppered HSR plans and led to the dissolution of the health centre project. In the late 1970s and 1980s, political pressure from anti-apartheid opposition, both locally and globally, alongside related budgetary pressures, informed the decision to deregulate and privatise the health sector. The effects of this decision are complex. On the one hand, the resultant policy changes led to private-sector growth (including increased numbers of black South Africans using private providers and medical schemes), with the consequence that post-1994 HSR efforts faced resistance from a strong and well-established private sector. On the other hand, concern that the state was abdicating its responsibility as a provider of health services and

regulator of the private sector reignited interest in HSR among academics and civil society actors, and de-regulation facilitated a cost-explosion that would make the need for HSR all the more evident.

In the post-1994-era, while the AIDS crisis and AIDS denialism acted as a policy distraction and pushed HSR off the policy agenda, Zuma's appointment as president successfully reignited the policy process for the NHI. However, the political saga of the Zuma presidency, including state capture and Zuma's eventual ousting, also increased opposition from COSATU to Motsoaledi's softening stance on the involvement of the private sector.

The influence of private sector, and popular ideas about the appropriate role of the private sector in the health system, have played a role in shaping what sorts of reforms are possible in South African since the 1920s. Both in the 1926-1939 period, and in the 1940s, MASA's support for universal HSR helped to push the policy process forward. However, in the late 1940s and 1950s MASA's position changed – partly as a result of vested interests in the continuation of private practice for GPs, and partly because of an ideological reaction to the socialist overtones of Gluckman's proposals – with the result that Gluckman was unable to make significant progress before the 1948 election of the National Party. Similarly, in the post-1994 era, the power of the private health sector has clearly shaped the nature of reforms. In the 1994-1997 period, technical experts deemed policy options that would exclude the private sector 'unfeasible' and gravitated toward policy options that would be more palatable to private sector actors and users. More recently, over the course of his tenure (2009-2019) Motsoaledi was compelled to soften his stance on the role of the private sector in the NHI and increasingly engage private sector actors in the policy development process.

While it is not clear whether the increased involvement of the private sector in the NHI is a reflection of behind-the-scenes lobbying, beneficiary politics that prioritise private sector users, or pragmatic considerations of the relative capacities of the public and private sectors, it is clear that the scale of the private sector in South Africa has contributed to determining what sorts of reforms are feasible (Waterhouse *et al.* 2017). Furthermore, this analysis suggests that the concerns of private sector users have exerted more influence on the HSR process than those of the majority of South Africans, who rely predominantly on the public sector (see also McIntyre *et al.* 2007, and Gilson 2019). This is evident, for example, in Treasury's persistent opposition to NHI reform proposals that would negatively impact medical scheme members and wealthier taxpayers. Despite both the 1974 De Villiers Commission, and the HMI (launched in 2013 and concluded in 2019) demonstrating the pernicious influence of the private sector on the public sector, and the host of challenges faced by private sector users and medical scheme members, policy options that entail a scaling-back of the private sector continue to garner significant opposition.

The persistent power of the private sector is a function of past policy decisions that facilitated its rapid expansion in the 1970s and 1980s but is also enabled by the specific media culture in the country and, likely, by low levels of trust in the state. In South Africa, the media tends to positively represent the private sector, and to reflect the concerns and interests of private sector actors and users (Waterhouse *et al.* 2017, Gilson 2019). Furthermore, public trust in government institutions generally has been declining since 1994 (Wale 2013, Potgieter 2017, Burns *et al.* 2018). Corruption scandals and governance failures in health and other sectors – including AIDS denialism, load-shedding, state capture, the Marikana massacre and the Life Esidimeni tragedy – combined with evidence of declining quality of care in the public sector, likely cement the idea that state cannot be trusted to deliver health

services or manage health funds, and that the private sector is a more appropriate mechanisms for the delivery of healthcare.

Furthermore, in the context of this low public trust in the state, values-based arguments for HSR will likely prove insufficient to garnering public support. McIntyre *et al.* (2007) point out that after the transition to democracy, there "was a considerable spirit of social solidarity and potentially a greater willingness to accept relatively large cross-subsidies," and Motsoaledi frequently drew on solidarity as a value when speaking of the NHI. However, whether or not the 'spirit' of solidarity' persists, public support for the NHI will remain low so long as there is broad popular doubt about the capacity of the state to manage reforms.

While a popular belief that the state lacks the capacity, to or cannot be trusted to, deliver NHI has made building popular support for HSR more difficult, it is also true that South Africa's political history renders the inequities of the current system particularly problematic. South Africa's history of racial segregation and oppression under colonialism and apartheid imbue the contemporary inequities in healthcare, and therefore the NHI, with a particular political meaning and social relevance. As McIntyre says, "given the political history of legislated discrimination on the basis of race under apartheid, there is clearly a desire to avoid health system differentials on the basis of class" (2007). In another context, UHC might have been achievable through a multi-purchaser model with tiered benefits. In South Africa, however, socio-economic inequities have a particular meaning that is connected to the country's past. As a result, tiering is particularly problematic in this context.

In addition, while reducing financial risk as a result of paying for healthcare, is a central goal of UHC reforms in most contexts (Smithers *et al.* 2022), South Africa's UHC reforms are taking place in a context in which financial risk protection is already fairly robust (van den Heever 2016). The challenges that persist however, and which HSR efforts are intended to address include private sector costs, the quality of care in the public sector, and the inequities between the two sectors (McIntyre *et al.* 2007). What UHC means in this context, therefore, is reforms that would ensure equity and solidarity, alongside financial risk protection. In the context of low trust in the state, however, this is difficult to achieve, and there is a risk that compromises made to increase popular and political support for reforms, such as the increased involvement of for-profit actors, could result in reforms that do not align with these social values (McIntyre *et al.* 2003).

The value of the historical approach

As noted, the process of UHC reform will be different in other contexts, shaped by particular social, political and economic factors. History – particularly past policy change – plays an important role in determining how HSR policy processes unfold (Grundy *et al.* 2014b). In this study, analysing the health policy process longitudinally allows an understanding of the influence of actor positions, relational dynamics, and ideational factors, and exposes the historical tributaries of contemporary challenges. In addition, the longitudinal analysis reveals dynamic interactions between factors that might have remained opaque in a narrower analysis.

In particular, the historical perspective enables a deeper understanding of the challenges inherent in HSR in contemporary South Africa in two main ways. Firstly, it that shows that declining trust in the state is likely contributing to popular opposition to HSR today. Further research on the influence of a legacy of corruption and governance failures, and the trust between the public and the state more

broadly, on HSR processes is needed. With respect to moving forward with UHC reforms in South Africa, this analysis suggests that in addition to increasing popular support for reforms through values-based arguments that connect to the country's particular history, policy-makers would do well to develop strategies to build trust in the state. Successful trust-building strategies would have to increase public trust in the state not only as a provider of health services (for example with well-publicised quality improvement projects) but also as a regulator and funder – both complex interventions.

Secondly, as Grundy *et al.* (2016) point out, historical analyses help to reveal the consistency of support or opposition by actors. In this case, for example, Treasury's opposition to HSR proposals has remained relatively fixed over time – which might suggest that their position has as much to do with institutional culture or ideology as with the economic calculations at any particular moment. Similarly, the strength and longevity of the private sector, combined with low levels of trust in the state, reinforces the idea that the state is not an appropriate mechanism for the delivery of health services. The longitudinal perspective also highlights the historical tributaries of this state of affairs, including neoliberalism and policy decisions made under apartheid. On both counts, strategies that recognise the ideational nature of the opposition might prove fruitful.

This analysis also makes explicit the particular meaning HSR has taken on in the South African context. Policy decision-making is an interpretive process that takes place within a social context of history, ideology, and dominant worldviews (Hall 1993, Heclo 1994, Campbell 1998, Fischer 2003). When seeking to understand the influence of ideas, values and ideologies, therefore "we should try as best we can to understand ideas as they were thought and in terms of the meanings available at given times and places" (Heclo 1994), by locating those decisions in the social, political and historical context. This includes understanding the issues and ideas that were foremost in the public (or various publics') consciousness at the time (Heclo 1994, Bloom *et al.* 2013). For this reason, a deeper understanding of the historical context of UHC reforms enables a more astute explanation of why policy processes unfold as they do (Steinmo 2008, Bloom 2014). We have argued that while South Africa may be counted among those countries undertaking health financing reforms in response to the global push for UHC, the country's HSR journey started well before the WHO endorsed UHC. The historical analysis reveals that both the process and the social meaning of UHC reforms in South Africa has been shaped by the country's particular social and political history of race-based political exclusion and oppression. This particular social meaning will continue to be influential in future system reform efforts.

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Chapter 5 – Health system reform and Path-dependency: How ideas constrained change in South Africa’s National Health Insurance policy experience

Chapter 5: Health system reform and Path-dependency: How ideas constrained change in South Africa’s National Health Insurance policy experience

Overview: This chapter uses an analysis of two apparent policy windows in the South African National Health Insurance policy process to explore the role of ideas in constraining health systems change. The chapter draws on wider political science theory to explain how ideas – borne out of historical contextual realities and past policy decisions – become embedded in social or cultural institutions and give rise to increased resistance and contestation. On the basis of these findings, we argue that ideas, norms and ideologies should be analysed as contextual factors, in other words, persistent features of the policy-making environment that constrain actors.

Contribution to the thesis: The account of how ideational factors constrain change developed in this chapter – particularly the mechanisms by which elements of the health system give rise to, and reinforce social values – informs both the analysis of case study of social values in NHI policy rhetoric presented in Chapter 6, and the development of the conceptual framework to guide the analysis of social values in health systems and policy processes presented in Chapter 7. In particular, the chapter tests the supposition that ideational factors can influence policy processes for health system reform and offers insight into the dynamic relationship between health systems and social values that helps to explain how social values constrain change.

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Abstract

Path-dependency theory says that complex systems, such as health systems, are shaped by prior conditions and decisions, and are resistant to change. As a result, major policy changes, such as health system reform, are often only possible in policy windows – moments of transition or contextual crisis that re-balance social power dynamics and enable the consideration of new policy ideas. However, even in policy windows there can be resistance to change. In this paper, we consider the role of ideas in constraining change. We draw on wider political science theory on the dynamic relationship between foreground ideas (policy programmes and frames) and background ideas (deeply held collective cognitive and normative beliefs) to better understand how ideas exert influence independently of the contextual conditions that give rise to them or the actors that espouse them. To do so, we examine two apparent policy windows in the South African National Health Insurance policy process, drawing on a historical review of the policy process in its social and political context. The analysis reveals how ideas, borne out of the country's particular social and political history, increased contestation and opposition. Further, the South African experience reveals how ideas can become institutionalised in tangible organisations and procedures (such as policy instruments or provider networks), as well as in intangible cultural norms – becoming hegemonic and uncontested ideas that shape the attitudes and perspectives of policy actors. In this way, ideas operate as independent variables, constraining change across policy windows. While health policy analysts increasingly recognise the influence of ideational variables in policy processes, they tend to conceptualise ideas as tool actors wield to drive change. This analysis reveals the importance of considering ideas (values, norms, and beliefs) as contextual factors – persistent features of the policy-making environment that constrain actors.

Key words: Ideas, path-dependence, health system reform, national health insurance

Introduction

Because health systems are complex adaptive systems, they are widely acknowledged to be 'path-dependent' (Bloom 2011, Marchal *et al.* 2016). Path-dependency theory says that 'history matters' – decisions made in the past create conditions that shape contemporary decisions and therefore constrain the potential for change (Kay 2005). As a result, stability prevails most of the time and policy change tends to be slow and incremental (Baumgartner *et al.* 2009, Gilson *et al.* 2018). However, path-dependency is an organising concept rather than an explanatory model – it cannot explain what happens because it does not suggest specific mechanisms that constrain change (Kay 2005). Thus, while it is generally agreed that 'history matters' there is a need to better understand the mechanisms by which history matters (Pierson 2004, Xu *et al.* 2019).

When dramatic policy change does occur, it is often enabled by major contextual transitions or upheavals that overcome the 'stickiness' of path-dependent systems (Sabatier 1998, Weible *et al.* 2012). These moments at which contextual factors converge to allow for a departure from path-dependency are referred to as 'conjunctures' (Wilsford 1994, Greener 2002). Regular political transitions (such as elections and the introduction of a new political administration) and dramatic political crises (such as coups or economic crises) help to overcome path-dependencies by introducing new actors with new ideas and delegitimizing old ideas, thereby making it easier to dismantle existing policies (Horowitz 1989, Kingdon 1995, Reich 1995, Fischer 2003). Social and political crises, in particular, spark intense ideological contestation in which actors' perceptions of their interests can change, and new policy paradigms emerge (Hay 2004).

Both Kingdon's *multiple streams model* and Baumgartner's *punctuated equilibrium model* suggest that policy change occurs as a result of contextual shifts that allow new ideas to gain primacy. The *multiple streams model* suggests that policy change occurs when the political reality and balance of power among decision-makers enables change, and, at the same time, the problem is well known and defined, and there is a policy idea that is recognised as a feasible solution (Kingdon 1995). Thus, a policy window often emerges from a change in administration, or a new issue capturing the attention of officials (Kingdon 1995). However, policy windows do not remain open indefinitely – usually because policy-maker's attentions turn to other things (Kingdon 1995). Similarly, the *punctuated equilibrium model* suggests that policy processes involve long periods of policy stability, which will be punctuated by periods of rapid change, sparked by "seemingly random initial events" such as the accumulation of unaddressed grievances, political transitions, focusing events such as a school shooting or a prominent technical study, or speeches by prominent figures (Baumgartner *et al.* 2001). The model explains stability in political systems as the result of institutional arrangements that grant certain actors access to the policy-making arena, and policy images (connecting powerful policy ideas to core political values that resonate with the public) that legitimate these institutions, creating negative feedback loops (Baumgartner *et al.* 2001, 2009). On the other hand, the punctuated equilibrium model suggests that 'bursts of rapid change' occur when new ideas 'catch fire' – issues are reframed, policy-makers realise that other policy-makers have begun to understand the issue differently, and new interpretations quickly gain popularity and diffuse from one policy arena to another, creating positive feedback loops that catalyse radical change (Baumgartner *et al.* 2001, Baumgartner *et al.* 2008).

In the analysis of *health* policy processes more specifically, ideational factors – including values, , attitudes, norms, frames and cognitive or programmatic beliefs – are increasingly recognised as important drivers of policy change (see for example Walt *et al.* 1994, Shiffman 2009, Fox *et al.* 2015, Koon *et al.* 2016). In this field, ideas are conceptualised as tools actors use to drive policy change – either as programmatic ideas about what the problem is and what should be done, or as frames and narratives with which to justify or legitimate policy proposals. For example, Russell *et al.* (2008) understand policy processes as the struggle for a dominant interpretation of policy problems, and consider how ideas are used in policy rhetoric to gain the support of other actors for a particular policy solution. Similarly, Harmer (2011), Fox *et al.* (2015) and Vélez *et al.* (2020) demonstrate that ideas play an important role in the construction of policy problems and the creation of policy coalitions and advocacy groups, and that actors use ideas in advocacy to legitimate policy proposals and convince others to support them. Balabanova *et al.'s* (2004) analysis of health financing reform in Bulgaria suggests that the embrace of policy ideas from other health systems drove reforms. In addition, some health policy analyses explore the influence of frames and framing – ways of interpreting and making sense of the world – on how evidence is interpreted, which issues draw the attention of policy actors, and which policy solutions are considered most appropriate (Shiffman 2009, Harmer 2011, Parkhurst 2012, Koon *et al.* 2016).

Clearly, in health policy analyses, the focus is on the agency of actors (c.f. Giddens 1979), and the role of ideas is usually considered in relation to policy change. However, as discussed above, health systems tend to be change resistant, and health system reforms often fail (Walt *et al.* 1994, World Bank 2003, Villalobos Dintrans 2019). This study explores the role of ideas in health systems' resistance to change in apparent policy windows. To do so, we analyse two apparent policy windows in the South African National Health Insurance (NHI) policy process in which policy change was resisted, drawing on institutionalist perspectives to reveal how ideational factors can act as independent variables that constrain policy change and ensure path-dependence.[1]

Background

We begin by outlining the institutionalist perspective and explaining how institutionalists account for the influence of ideas on policy processes – as necessary theoretical background – and then offering a brief overview of the South African context and the NHI policy process.

Institutionalism unpacked

As a dominant approach in political science, institutionalism explains policy outcomes with reference to how political institutions and policy procedures either facilitate or prevent different actors from exerting influence in policy processes (Immergut *et al.* 1992, Hall *et al.* 1996, Lieberman 2002). Institutions are the formal and informal social rules, norms and conventions that govern individual conduct and inter-personal relations (Hall *et al.* 1996, Denzau *et al.* 2000). On this account, institutions

[1] In the previous chapter (Chapter 3) we defined values as a type of idea, stating "*values are universal and persistent affective ideas about what is desirable that influence or justify action or judgement, and that exist as part of a ranked set of values known as a value system"*. In this chapter, we shift the subject of analysis from social values in particular to ideas in general. This is because, while the definition developed in the previous chapter was conceptually useful, it was methodologically less so. In fact, we found, in the analytical process for this Chapter and for Chapter 6, that it was impossible to distinguish between social values and other kinds of ideas used for rhetorical force, without imposing our own subjective feelings about what kinds of ideas should be categorised as values (i.e. without imposing our own value systems onto the analysis). This challenge is discussed in more depth in Chapter 6.

themselves are the product of ideas – institutions are created by actors with particular values and beliefs, and evolve at the hands of actors who change old institutions according to new ideas (Wilsford 1994, Steinmo 2008, Béland 2016). As Béland *et al.* (2011) put it, "ideas are the foundation of institutions. As ideas give rise to people's actions and as those actions form routines, the results are social institutions."

The institutional environment in which actors make decisions includes organs of the state, bureaucracies, politicians and executives, industrial relations systems, financial systems, and policy legacies (Heclo 1994, Hall *et al.* 1996, Denzau *et al.* 2000). Institutions influence policy processes because, as Weir *et al.* (1985) state, "the very theories, ideals, and goals articulated by experts or politicians are partially inspired by the administrative structures and capacities of the state structures in which they operate." Accordingly, institutionalist approaches explain path-dependence as a product of the constraints that existing social and political institutions place on contemporary policy processes (Wilsford 1994, Hall *et al.* 1996).

Two institutionalist approaches lend themselves to a more precise account of how ideas operate to constrain change – historical institutionalism and sociological institutionalism. Historical institutionalists emphasise the legacy of particular national experiences, and how this legacy shapes the organisation of social and political institutions, such that historical legacies constrain contemporary policy-making possibilities (Immergut *et al.* 1992, Berman 2013). From this perspective, institutions create path-dependencies because they shape the behaviour of actors in the system in two ways. Firstly, by setting the rules, procedures and ways of working in society, institutional arrangements shape social power relations such that some interest groups are able to participate in policy processes (usually working to preserve the status quo) while others are excluded (Hall *et al.* 1996, Steinmo 2008). Secondly, the institutional environment simplifies actor's decision-making by suggesting to policy actors what kinds of policy alternatives will be feasible and considered appropriate (Hall *et al.* 1996, Campbell 1998, Steinmo 2008). Thus, a key insight of historical institutionalism is its explanation of how institutions constrain the range of possible policy solutions that policy-makers consider (Campbell 1998).

Sociological institutionalism is a constructivist approach that emphasises the social and cognitive features of institutions, which are conceptualised as a set of cultural norms and practices, shared cognitive frameworks, collective attitudes, social values, political ideologies and worldviews (Finnemore 1996, Hall *et al.* 1996, Campbell 1998). These cultural ideas influence how actors make meaning of policy problems, and what kinds of policy solutions are in keeping with their self-concept and social legitimacy, thereby guiding collective decision-making and constraining the possibility for change (Finnemore 1996, Hall *et al.* 1996, Hall 1997a). Sociological institutionalism also helps to explain how exogenous ideas influence policy processes, because it reveals the social processes by which cultural norms and dominant ideas spread between contexts, either being transmitted by actors or diffusing[2] through epistemic communities (Hall *et al.* 1996, Campbell 1998). In a globalised world, ideas travel between contexts through international agencies with power to impose ideas from one context to another, or through a global policy discourse spread by academics, think-tanks and development organisations (Hall 1997a, Walt *et al.* 2008, Béland 2009).

[2] For more on cultural diffusion theory see Luke et al. 2002.

Campbell (1998) argues that comparing across institutionalist perspectives reveals a range of types of ideas at play in policy processes and presents a typology that distinguishes ideas along two dimensions: whether they are cognitive or normative ideas, and whether they are foreground or background ideas. Policy programmes and frames are (respectively cognitive and normative) foreground ideas. They are purposefully chosen and deliberately employed by policy actors to increase support for particular policy proposals (Campbell 1998). Policy paradigms and public sentiments are (respectively cognitive and normative) background ideas. Unlike foreground ideas, background ideas are widely shared and slow to change, often to the extent that they are taken-for-granted, invisible and unquestioned (Berman 1998, Campbell 1998, Schmidt 2008). While foreground ideas are used by policy actors in policy change processes, paradigms and public sentiments can constrain change by delimiting the range of policy solutions that will be deemed feasible or appropriate (Campbell 1998).

Taken together, therefore, historical institutionalism and sociological institutionalism help to explain how ideas can constrain policy change. Firstly, ideas can become embedded in tangible institutions such as bureaucracies, political parties, and organisations (Berman 2001).[3] Secondly, ideas can become embedded in intangible institutions when they become “accepted or instinctual parts of the social world and hence are experienced as ‘natural’ or as part of ‘objective’ reality” (Berman 2001). In this way, ideas become taken-for-granted by society or some sub-population within society, and are institutionalised in norms, cultures, and ideologies, which are widely shared and relatively durable (Campbell 1998, Bleich 2002, Berman 2013). In addition, institutions have an important ‘norm-setting function’ (Rothstein 1998). Through their daily interactions with institutions, people are habituated to certain ways of working, and ideas about what is feasible or appropriate are reinforced (Béland *et al.* 2011). In this way, institutions shape what future actors will regard as morally appropriate (Rothstein 1998). Through institutionalisation, the influence of ideas outlasts the socio-political conditions that gave rise to them (Berman 2013).

A brief history of the NHI policy process in South Africa

South Africa is an upper-middle income country with a progressive constitution that protects an expansive set of social and economic rights – however, it is also one of the most inequitable societies in the world, with half of South Africans living in poverty (Francis *et al.* 2019). The country also faces a quadruple burden of disease, including HIV and TB, maternal mortality and morbidity, non-communicable diseases, and injury and violence (Coovadia *et al.* 2009, McKenzie *et al.* 2017). The country’s epidemiological, social and economic reality is shaped by its apartheid history wherein race-based geographic and political segregation and oppression were imposed through policy since the 1940s (Madore *et al.* 2015, McIntyre *et al.* 2020). The African National Congress (ANC) led a programme of anti-apartheid civil-society mobilisation, which, combined with economic and

[3] Hall (1993) offers the example of how Keynesian ideas of economic governance were institutionalised into the processes and procedures of the British Treasury. These cognitive ideas about the nature of the economic world, about what kinds of social goals could be achieved through policy and what kind of policy instruments would work to attain them came to shape the operating routines and procedures of the Treasury (Hall 1993). With respect to normative ideas, Schmidt (2000) offers an account of the transformation of the UK welfare state under Thatcher and Blair. Although Schmidt’s focus is on the use of communicative discourse in legitimating policy change through rhetorical techniques that connect policy proposals to deeply ingrained social values, her analysis also suggests that neoliberal values were successfully institutionalised among the British public through the particular structures and programmes of the neoliberal welfare state. For example, she argues that instituting competition within the National Health System was a way of replacing ostensibly socialist values with capitalist values of entrepreneurship (Schmidt 2000).

international pressure, resulted in the dismantling of apartheid in and the first democratic election 1994 (Coovadia *et al.* 2009).

Under apartheid, as part of an effort to reinforce racial hierarchies, the health system was fragmented along racial lines, as well as between public and private sectors (McIntyre *et al.* 2020, Pauw 2021). Today, the public sector, funded through the general tax budget, serves the majority of the population, including those most in need of healthcare, and is severely under-resourced (Ataguba *et al.* 2018, Pauw 2021). The private sector serves the wealthiest members of society (about 16% of the population) (McIntyre *et al.* 2020). The private sector is mostly comprised of for-profit private providers (including general practitioners, hospitals), private funders (voluntary, not-for-profit health insurance associations known as medical schemes), and medical scheme administrators (for-profit companies that offer administrative services to medical schemes) (McIntyre *et al.* 2020). Although total health expenditure as a percentage of gross domestic product is relatively high, a large proportion of expenditure is attributable to private health insurance, which excludes the poor, and government expenditure on health has remained consistently below the Abuja target of 15% (Ataguba *et al.* 2018). As a result, while stark inequities still characterise the contemporary health system, inequities in access and quality are increasingly related more to class than to race (McIntyre *et al.* 2020).

Health system reform has been on the policy agenda since the early 1990s when the apartheid regime was dismantled. In the lead-up to the watershed 1994 democratic elections, there was widespread recognition that a significant overhaul of the inequitable, inefficient, fragmented and unsustainable health system was necessary, and ANC policy documents promised a National Health System that would incorporate compulsory Social Health Insurance (SHI) for the formally employed (ANC 1992, McIntyre *et al.* 2003, Gilson 2019). Since then, the policy process has been slow, contentious and highly political, and multiple iterations and variations of health system reform have been suggested (Waterhouse *et al.* 2017, Gilson 2019). After an initial period of policy progress following immediately after the 1994 election, the HIV pandemic pushed SHI off the policy agenda (Gilson *et al.* 1999, Gilson 2019). When populist president Jacob Zuma was elected in 2009, the policy processes was reinvigorated, but once again, progress was slow (Waterhouse *et al.* 2017, Gilson 2019). Most recently, the NHI Bill, tabled in Parliament in 2019, stipulated the introduction of a purchaser/provider split whereby health resources would be pooled in an NHI fund, which would purchase services from contracted providers on behalf of users (Mcintyre 2019, van den Heever 2019). This would drastically curtail the role of medical schemes, which would only be allowed to cover services excluded under the NHI – a provision which sparked considerable backlash[4] (Gray *et al.* 2019, van den Heever 2019).

Methods

In order to better understand the role of ideational factors in constraining policy change, we conducted a historical analysis of the South African NHI policy process, drawing on Capoccia's (2015) critical juncture analysis approach. Critical juncture analysis is an approach developed in political science for comparative-historical analysis, and provides a framework for studying moments of openness to change in path-dependent systems (Capoccia 2015). The approach assumes that in the development of institutions, such as political regimes and public policy processes, there will be

[4] See for example Staff Writer 2019a, 2019b, Medical Brief 2022.

moments of openness to change (triggered by exogenous[5] shocks) in which, despite the presence of antecedent conditions influencing their decisions, actors can make choices that would set the institution on a new path or trajectory (Capoccia 2015). Taking a broad temporal view, and analysing retrospectively, the analyst can use critical juncture analysis to explain the distal causes of the current institutional state of affairs (Capoccia 2015) (see for example Xu *et al.* 2019). The approach involves identifying apparent critical junctures by locating the exogenous shocks with which they are correlated, and 'testing' to establish whether major institutional change was possible in that moment (in other words whether actor choices *could* have established a new institutional trajectory) (Capoccia 2015).

In this study, we analysed policy windows as critical junctures in the policy process. To do so, we conducted a historical analysis, drawing on a retrospective literature review presented elsewhere (Whyle *et al.* 2022)[6]. We reviewed primary evidence including letters by prominent health sector actors to newspapers and academic journals, policy documents, submissions by the public to various official deliberative fora, and media articles and secondary evidence, and secondary evidence including peer-reviewed literature on the South African NHI policy process, the health system more broadly, and the historical and contemporary social and political context. Then, following the critical juncture analysis approach, we developed a timeline of the NHI policy process, identified policy windows,[7] and explored the factors constraining change across those policy windows. The timeline captures the policy process from 1990 to 2019 in detail, but also includes the history of reform efforts since 1910. A summary of the timeline is presented in Appendix 5.

Findings

We present an analysis of two apparent policy windows in the South African NHI policy process – the first following immediately from the transition to democracy and spanning from 1994 to 1999, and the second following the election of Zuma as president of the ANC (and later the country), spanning from 2007 to 2018. Both the 1994 transition to democratic governance and the 2007-2009 election of populist president Zuma are the kinds of upheavals that might be expected to give rise to a policy window. However, neither the transition to democracy nor the tenure of President Zuma, despite spurring much policy-making activity, resulted in major progression towards the implementation of NHI. We examine these two policy windows in order to gain a clearer understanding of how ideas interact with contextual factors to resist change in complex systems.

Policy window one: 1994-1999

In 1994, the policy problem was clear. The new government inherited a health system that was under-resourced, fragmented and inequitable (McIntyre *et al.* 1995, Gilson *et al.* 1999). The inequity and fragmentation was the legacy of apartheid-era policy decisions, including the racialisation of the public health system and the deregulation and growth of the private health sector (Gilson *et al.* 1999). Beginning in the 1980s, the previous government, led by the National Party, had systematically privatised and deregulated the health sector and curtailed public sector spending, resulting in a 'brain-

[5] Exogenous in the sense that they are external to the institution under investigation, but not necessarily exogenous to the national context (Cappocia 2015).
[6] In this thesis, this work is presented in the previous chapter, Chapter 4
[7] Following Cappocia (2015) we identified policy windows by looking for exogenous shocks and establishing which shocks had the largest impact on the power of actors to institute health policy reforms.

drain' of human resources from the public sector to the private sector (Price 1989, McIntyre *et al.* 1995). In addition, deregulation meant that medical scheme contributions were increasingly unaffordable, and the 1993 Medical Schemes Amendment Act (pushed through in the dying days of National Party rule) meant medical schemes could reject applicant members on the grounds of HIV status or age, resulting in many people losing coverage and increasing the burden of care on the public sector (Price 1994, McIntyre *et al.* 1995).

The ANC's victory in the 1994 election served as an exogenous shock that opened an apparent policy window. The transition to democracy enfranchised huge numbers of working and unemployed poor that would constitute the beneficiaries of universalist health system reform and gave political power to the ANC – a party with pre-existing commitments to redistributive and socialist development policy generally, and to universalist health system reform specifically (Gilson *et al.* 1999, Peet 2002, McIntyre *et al.* 2003). The change of government also brought the introduction of a progressive NHI advocate as the new Minister of Health, Minister Nkosazana Dlamini-Zuma. Minister Dlamini-Zuma was more radical than other newly appointed ministers in seeking redistribution and saw health system reform as a way to redress the inequities of apartheid (Bond 1999, Gilson *et al.* 1999).

Under Dlamini-Zuma's leadership, there was a flurry of NHI-related policy activity, as she steered the process towards a progressive version of NHI (Gilson *et al.* 1999, Thomas *et al.* 2004). This activity included the publication of the ANC's National Health Plan shortly after the election in May 1994, the establishment of the Health Care Finance Committee (HCFC) to examine the feasibility of an NHI in June of that year, the Committee of Inquiry into NHI in 1995, and the SHI Working Group between 1994 and 1997 (Gilson *et al.* 1999, McIntyre *et al.* 2003). The HCFC included local and international analysts and private sector stakeholders (including medical scheme industry representatives), but excluded trade unions on the basis that the mandate of the committee was 'technical' (Gilson *et al.* 1999). The Committee of Inquiry into NHI included a similar mix of local and international analysts, private sector representatives as well as Treasury officials (Gilson *et al.* 1999, Thomas *et al.* 2004). The more contained Working Group included only DoH staff and local analysists (Thomas *et al.* 2004).

The HCFC report presented three potential models for health system reform, differentiated by beneficiaries and benefit packages. The most radical, which came to be known as the Deeble model[8] included the nationalisation of private doctors, the elimination of medical schemes and 'tiering' (differentiated services for the insured and the uninsured), and universal access to primary healthcare through mandatory coverage under a centralised funding mechanisms (Gilson *et al.* 1999). The Deeble model was debated by both the Committee of Inquiry and the Working Group, but ultimately, the Working Group recommended a moderate SHI that would be restricted to the formally employed and did not involve cross-subsidisation between income groups, indicating a concession to Treasury's concern that the middle classes should not be 'over-taxed' (Gilson *et al.* 1999, McIntyre *et al.* 2003). However, the Working Group proposals did not result in any policy action (Gilson *et al.* 1999).

By 1999 the opportunity for radical change had passed, and the policy window was closed. In 1996 the (ostensibly) pro-poor and welfarist Reconstruction and Development Plan (RDP) macro-economic strategy was replaced by the neoliberal Growth, Employment and Redistribution (GEAR) (Pillay *et al.* 1995, Baker 2010). While Treasury officials were already convinced that NHI was out-of-step with the

[8] The model was proposed and championed by Australian health economist Dr John Deeble (Gilson *et al.* 1999)

macro-economic strategy laid out in the RDP, the adoption of GEAR solidified Treasury's resistance to tax-funded health system reform and further stagnated public spending on healthcare (Gilson *et al.* 1999, Baker 2010). In addition, around this time the HIV/AIDS epidemic began to command the attention of policy-makers and the public (Gilson 2019). AIDS first began to emerge in South Africa in the 1980s, but by 1998 23% of the population was HIV-positive (Schneider 1998, Marks 2002). A series of AIDS-related corruption scandals, beginning in 1996, and the government's persistent failure to respond appropriately to the massive public health emergency, sparked massive public and civil-society outrage (Schneider 1998, Nattrass 2008). Finally, In 1999, Minister Dlamini-Zuma was replaced by Minister Tshabalala-Msimang and the NHI policy process stalled (Thomas *et al.* 2004, Waterhouse *et al.* 2017).

What constrained change in the 1994-1999 policy window?

Despite clear evidence of major challenges in the public sector and stark inequities between the public and private sectors, and despite a change of government that empowered a political party long committed to universalist healthcare reforms, major policy change was not achieved in the 1994-1999 period. Ideational factors - born out of the pre-1994 political and social climate - underlie many of the constraints that served to resist change and ensure path-dependence.

Firstly, at this time, neoliberal ideas were hegemonic globally (Centeno *et al.* 2012). Neoliberalism emerged as a system of ideas, at first about economics and social welfare in the 1980s, and diffused throughout the world through the influence of international organisations like the World Bank and the IMF (Harvey 2005, Mudge 2008). Harvey (2005) defines neoliberalism as a political economic theory that proposes human wellbeing is best be advanced by "liberating individual entrepreneurial freedoms" in an institutional context of free markets and strong property rights. This approach is based on the assumption that the state does not have the necessary information or expertise to intervene effectively, and is subject to the influence of powerful actors that bias its decision-making (Harvey 2005). Thus, neoliberalism suggests a minimal role for the state (restricted to protecting this institutional context and providing or subsidising social services only for the poor), favours market-based solutions to social ills, and justifies the transfer of power from the state to the market and private capital (Harvey 2005, Centeno *et al.* 2012).

In South Africa, the apartheid government used neoliberal principles to justify privatisation of health services and a reduction in public health spending in the 1980s (Price 1989, Nattrass 1994). However, neoliberal ideas also had a continued influence in post-apartheid South Africa (Seekings *et al.* 2015, Chipkin *et al.* 2018). While the ANC had a long history of alliance with local and international socialist organisations and socialist-informed development and economic policies, the 1994 transition to democratic governance took place in a global context in which neoliberal ideas were omnipresent (Williams *et al.* 2000, Peet 2002, Centeno *et al.* 2012). Neoliberal ideas both softened commitment within the ANC to radically redistributive policies and informed the positions and recommendations of technical experts consulted in this period. Even prior to 1994, neoliberal ideas had begun to shape the thinking of many ANC decision-makers, including through the direct influence of global actors like the IMF and the World Bank (Bond 2014b). As a result, the ANC, which might otherwise have been ideologically unified was, in fact, divided between two schools of thought: on one hand a liberal commitment to free trade and small government, and on the other, an anti-capitalist commitment to redistribution and nationalisation (Price 1994, Glaser 1997). This ideological divide within the ANC

meant that when options for health system reform were offered by the committees and Working Groups initiated by Minister Dlamini-Zuma, while it was clear Minister Dlamini-Zuma supported the Deeble Option, there was not consensus support from the Party.

The neoliberal ideational context also informed the recommendations of the technical experts represented in the various deliberative committees established to move the policy process forward. Thomas *et al.* (2004) suggest that the limited progress in this period was a result of a disjuncture between what was feasible and what was desirable – experts on the committees failed to consider what would be acceptable to policy-makers, and policy-makers failed to delineate for the experts what would be politically feasible. When the Committee of Inquiry into NHI was explicitly asked to consider a policy option acceptable to the Minister (an NHI), the committee demanded that the terms of reference be expanded to include more economically feasible options (Thomas *et al.* 2004). The focus on what was economically feasible was a response to Treasury's concern that funding an NHI through general taxation was not in keeping with the country's macro-economic policy, that the burden on taxpayers should not be increased, and that growth in the for-profit health sector should be encouraged (Gilson *et al.* 1999).

Both the macro-economic policies in place in this period, RDP and GEAR, however, were products of neoliberal hegemony. While the RDP was originally influenced by trade union allies of the ANC and contained radically leftist ideas, the version of the policy codified and implemented after the election reflected the influence of global financial institutions, themselves committed to the tenets of neoliberalism, and specified a reduction in public-sector spending (Pillay *et al.* 1995, Gilson *et al.* 1999). GEAR was more explicitly neoliberal; it prioritised economic growth over redistributive social policy and the interests of capital over labour (Gilson *et al.* 1999, Baker 2010). Furthermore, Waterhouse *et al.* (2017) point out that while Treasury was no doubt ideologically opposed to NHI, it is also true that GEAR reflected the broad position of the government, not only those within Treasury. Thus, ideas, here specifically the principles of neoliberalism, informed both the decisions of technical experts and Treasury members, and also informed the macro-economic policies against which the feasibility of health system reform proposals were judged.

Furthermore, the policy process was also constrained by a pervasive idea among experts in the deliberative committees, that, as a result of the size and power of the private sector, the political feasibility of health system reform depended on opportunities for the continued involvement of the private sector. Having grown steadily throughout the 1980s, by the early 1990s the private sector was judged by analysts and decision-makers to have sufficient 'political strength' to successfully oppose reforms, resulting in a shift in focus from purely-public, tax-funded models to mandatory insurance models that combined public and private provision (McIntyre *et al.* 1990, Doherty *et al.* 2000, Thomas *et al.* 2004, Waterhouse *et al.* 2017). The emergence of hospital groups – networks of hospitals owned by a single company – and their domination of the private hospital industry helped to consolidate their power (McIntyre *et al.* 1995). Post-1994 strengthening government control of the private sector was no longer considered a primary goal of health system reform and the Centre for Health Policy, a proponent of NHI, argued that "the private sector was simply too extensive to disappear and so the only politically feasible approach was to work with it" (Gilson *et al.* 1999, see also McIntyre *et al.* 2006). Thus, while the Minister opposed proposals that allowed for continued medical scheme coverage, and therefore tiering, and regarded for-profit healthcare as 'repulsive', reform options that would align

with her views were repeatedly dismissed as politically infeasible (Gilson *et al.* 1999, Gilson *et al.* 2003). This divergence of worldviews between experts and the Minister, while partly a reflection of the actual growth and consolidation of the private sector, can also be viewed as the influence of neoliberal ideas about the appropriateness of private provision.

Secondly, Minster Dlamini-Zuma's beliefs had important historical tributaries of their own. The idea for universal health system reform in South Africa is rooted in a history that stretches as far back as the 1940s and includes policy proposals of the progressive anti-apartheid movement in the 1980s (see Whyle *et al.* 2022, Chapter 4). In the 1940s, soon-to-be Minister of Health and Member of Parliament, Dr Henry Gluckman proposed health system reforms that included a dramatically reduced role for the private sector, based on a belief that it was the responsibility of the state to provide healthcare, that "the medical profession should be socialised" (Gluckman 1946), and that private healthcare should be gradually phased out (Price 1989, Van Niekerk 2003). Gluckman's proposal was influenced by the revolutionary zeal of post-war Britain, and the idea that healthcare should be 'socialised,' can be understood in that context (Gluckman 1946, Digby 2008).

Although the advent of apartheid prevented the institution of Gluckman's National Health System, the ideas embodied in the Gluckman report informed the proposals of the progressive health movement in the 1980s (Gilson *et al.* 1999). At that time, the appropriate role for the private sector was a major point of contention – with some anti-apartheid allies, deeply distrustful of the for-profit health sector, drawing on Gluckman's proposal to argue for a British-style National Health System and the nationalisation of private healthcare, while others argued that the scale and power of the private sector made a National Health System infeasible (Gilson *et al.* 1999, Paremoer 2020). However, the ANC's longstanding alliance with the South African Community Party and the Congress of South African Trade Unions (COSATU)[9] helped to ensure that the idea of socialised medicine informed the ANC's proposals for health system reform put forward in the early 1990s (Coovadia *et al.* 2009, Baker 2010). In addition to Minister Zuma's views on for-profit healthcare, these ideas influenced COSATU's stance on NHI. COSATU opposed the health system reform proposals in the 94-99 period on the grounds that multi-payer models would not ensure cross-subsidisation from the rich to the poor and would, in fact, increase the financial burden on the working poor (COSATU 2000, Waterhouse *et al.* 2017). COSATU's opposition contributed to the stalling of the policy process after 1997 (Thomas *et al.* 2004).

In short, while the transition to democracy rebalanced the distribution of political power in the country by enfranchising many who would benefit from universalist health system reform and imbued new actors with decision-making power, ideas about the appropriate role of the private sector in health systems and the prioritisation of fiscal concerns over equity concerns constrained change. These ideas, being borne out of the pre-1994 context, ensured path-dependence across the policy window.

Policy window two: 2007-2018

The 2007 election of President Zuma – a populist president associated with the rejection of the neoliberal approach to governance that was a major constraint of health system reform post 1994

[9] COSATU is the country's largest trade union federation, and the alliance between the ANC and COSATU is crucial to the Party's electoral prospects (Van Heerden 2018).

(Hart 2014, Von Holdt 2019) – would also have been expected to create the policy window needed to achieve implementation of NHI. By 2007, the health sector was suffering from the effects of the implementation of GEAR, which constrained health spending and hindered regulation of the private sector (Baker 2010, Doherty *et al.* 2015). In 2005 GEAR was replaced by the less neoliberal Accelerated and Shared Growth Initiative for South Africa (ASGISA) (Barolsky 2013, Francis *et al.* 2019). However, the health system was still characterised by a mal-distribution of human and financial resources that favoured the rich, including through direct subsidisation of private sector from public budget (McIntyre *et al.* 2006). At the same time high costs in the private sector meant that medical scheme membership was declining, and costs were continuing to rise as a result of over-servicing and high administration fees (McIntyre *et al.* 2006, McIntyre *et al.* 2007). Attempts to control costs by implementing standardised tariffs had been stymied by the Competition Commission's decision that the practice was anti-competitive (Berger *et al.* 2010, Waterhouse *et al.* 2017). In addition, beginning in 2005, the World Health Organisation (WHO) began promoting the concept of Universal Health Coverage (UHC), including health system reform with purchaser-provider split and public-private mix in provision (Smithers *et al.* 2022).

In this context, Zuma's ascendence to the presidency of the ANC in 2007, and of the country in 2009, spurred a flurry of policy-making activity and public debate in relation to NHI (Gilson 2019). The ANC committed itself to the urgent implementation of NHI, an NHI Task Team was appointed, and the Party's 2009 election manifesto promised the implementation of a NHI (McLeod 2009, Pillay *et al.* 2013, Madore *et al.* 2015). After assuming the presidency, Zuma appointed Dr Aaron Motsoaledi as Minister of Health, a passionate advocate of NHI (Waterhouse *et al.* 2017, Gilson 2019). Under Motsoaledi, an NHI Ministerial Advisory Committee was established to advise the Minister on NHI policy and legislation, the NHI Green Paper was released in 2011, in 2012 ten NHI pilot sites were established, and in 2014 the HMI was initiated by the Competition Commission (McLeod 2009, Republic of South Africa 2011, Madore *et al.* 2015, Gilson 2019). Waterhouse *et al.* (2017) suggests that efforts to move the policy process forward redoubled in 2015 as a result of the ANC's poor performance in the 2014 local government elections. The Department of Health established six workstreams to provide technical support in the development of NHI policy, and drafts of the NHI White paper were released in 2015 and 2017 (Republic of South Africa 2015, 2017, Waterhouse *et al.* 2017). UHC was incorporated into policy documents[10], and Motsoaledi sometimes equated NHI with UHC, using the WHO's support for UHC to justify NHI (Motsoaledi 2012, Madore *et al.* 2015). A few months after Zuma was ousted in 2018, a draft NHI Bill was gazetted (Republic of South Africa 2018). However, throughout this period, Treasury repeatedly delayed publishing funding plans for the NHI and continued to push for a multi-payer model (Madore *et al.* 2015, Waterhouse *et al.* 2017). When Motsoaledi's tenure ended in 2019, the health system looked almost exactly as it had in 2007, and at the time of writing in April 2022, the NHI Bill was before parliament, and NHI had yet to be implemented (Mcintyre 2019, Republic of South Africa 2019). Whether NHI will be implemented in the near future remains to be seen, but by 2019 with Zuma having left office, and Motsoaledi's tenure as Minister ended, the policy window seemed to have closed.

[10] See Republic of South Africa 2011, 2015, 2017.

What constrained change in the 2007-2018 policy window?

Once again, despite clear evidence of a policy problem, and a change of government that realigned the balance of political power in favour of health system reform, ideational factors contributed to constraining change in this period. In particular, two ideas, closely linked to neoliberalism, seemed to increase contestation and constrain change in this period: firstly, the idea that the state cannot be trusted to manage healthcare resources, and secondly the idea that interests and freedoms of the country's tax-base (the middle class), need to be safeguarded. By 2007, the NHI policy idea was beginning to solidify into a proposal for an NHI characterised by centralised financing and purchasing by a NHI authority, and a purchaser-provider split that would allow health services to be purchased from public and private providers, combined with a funding injection to the public sector (van den Heever 2016). The 2019 Bill specified contracting accredited public and private providers for primary care, but left the role of private hospitals unclear (Gray *et al.* 2019).

Much of the contestation in this period centred on the replacing of private medical scheme coverage with NHI coverage[11], the role of private providers, the inadequate quality of healthcare in the public sector, and whether the state could be trusted to manage a centralised funding pool (Madore *et al.* 2015, Gilson 2019, Medical Brief 2022). While there were very real service delivery challenges in the public sector, there is also evidence to suggest that perceptions of low quality care in that sector were not based on direct experience, and quality issues in the private sector were largely ignored (CCSA 2018, Maseko *et al.* 2018). Nonetheless, the idea that care provided by the state was of low quality informed much public opposition to NHI (McIntyre *et al.* 2009).

In addition, Zuma's presidency was marred by a series of grand-scale corruption scandals and governance failures that served to further undermine trust in the state. Zuma was charged with corruption shortly after being appointed president of the ANC in 2007, but successfully pressured the National Prosecuting Authority to protect him from prosecution (Koelble 2017, Von Holdt 2019). In 2008, energy provision became a major issue when South Africa's parastatal energy supplier was forced to introduce a system of planned outages, known as load-shedding, as a result of being unable to produce sufficient energy (Bowman 2020). Eventually, it was revealed that load-shedding was, in part, a consequence of Zuma having appointed corrupt individuals to Eskom's board for his personal gain (Budhram 2019, Bowman 2020). In 2012, the killing of 34 striking miners by police was broadcast on television, recalling apartheid-era police violence and generating significant public attention (Bond 2014a, Forrest 2015). By 2016, the idea that the state had been 'captured' by corrupt officials and foreign businessmen was firmly cemented in the public consciousness (Budhram 2019, Von Holdt 2019). As a consequence of these, and other examples of high-level corruption,[12] trust in the state declined significantly (Potgieter 2017).

While amplified by contemporary events, the idea that the state cannot be trusted had historical roots. Firstly, the idea that the state lacks the capacity to adequately deliver health services and manage health resources is a central tenet of neoliberalism, as discussed above (Rushton *et al.* 2012, Packard 2016). As such, neoliberal ideas were not only antithetical to NHI insofar as NHI would entail a larger role for the state in managing the health system and an infringement into the market for healthcare that currently operates, but also insofar as NHI requires a belief that the state can and will

[11] For examples of media coverage on the 'threat' to medical schemes see Beresford 2008, du Preez 2008, 2009a, 2009b.

[12] See Chapter 4 for a more detailed account of corruption under President Zuma.

manage healthcare funds effectively, efficiently and impartially. Secondly, Nattrass *et al.* (2010) argue that grand-scale corruption, and the accompanying loss of trust in the state, can be understood as a consequence of the close relationship between ANC politicians and business elites that began in the late 1980s when South African business sought to position themselves as anti-apartheid allies. Thirdly, negative popular perceptions of service delivery in the public sector were inevitably rooted in the fragmentation and mal-distribution of resources of the Apartheid era, but also likely arose from policy decisions made in the early days of the new democracy – for example the decision to implement the Free Care policy without a corresponding increase in budget or human resources (Charney 1995, Gilson *et al.* 1999).

The idea that the state cannot be trusted to manage health resources complicated the position of important actors, as is evident in the subtle shift in policy position of COSATU. In the Zuma-era COSATU was generally supportive of NHI[13] (Madore *et al.* 2015, Waterhouse *et al.* 2017). COSATU championed an NHI that was a "state-mandated, state-administered system in which a single authority organises health finance aimed at ensuring that all persons, irrespective of financial status, have free access to healthcare at the point of service" (Vavi 2008). In addition, COSATU's 2011 submission on the Green Paper endorsed the dissolution of medical schemes (COSATU 2011). As such, the current NHI proposals are very close to COSATU's preferred model.

However, during the political contestation that preceded Zuma's eventual resignation, COSATU (possibly motivated by a desire to demonstrate support for Zuma) condemned Treasury, the Ministry of Health, and Minister Motsoaledi for supporting a multi-payer model in the case of Treasury, and for 'selling out' the NHI to private interests in the case of Motsoaledi and the Ministry (COSATU 2016, Pamla 2016, Waterhouse *et al.* 2017). COSATU, viewing NHI as a mechanism for radical redistribution, had long been vocally opposed to the involvement of the private sector in the NHI (at times advocating for the incorporation of all private health resources into the public sector) and to any kind of tiering within the NHI, and committed to an expansion of public health service delivery (Thomas *et al.* 2004, Waterhouse *et al.* 2017).[14] In 2016, COSATU's statements began to reflect a stronger stance against for-profit healthcare in all its forms (Dlamini 2017, Staff reporter 2017). Thus, while COSATU continued to push the ANC to speedily implement NHI, it also continued to question the role of the private sector in the NHI (see for example Pamla 2016, Dlamini 2017), as, over the course of his tenure Motsoaledi increasingly signalled willingness to engage with the private sector and accommodate the interests of private providers in the policy itself[15] (Waterhouse *et al.* 2017). After Motsoaledi was replaced by Minister Zweli Mkhize in 2019, COSATU resumed its public unequivocal support for NHI, including calling for its urgent implementation (COSATU 2019). Since then, however, even COSATU has joined the chorus of stakeholders questioning the state's capacity to manage the NHI fund and citing dysfunctional service delivery by the state (Medical Brief 2022).

In addition to the idea that the state cannot be trusted, ideas about what constitutes an appropriate tax-burden, and an appropriate infringement on the freedoms of taxpayers continued to inform Treasury's resistance to a single-payer NHI and constrain the potential for change in the 2007-2018

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[13] At times, COSATU's support of the NHI was tempered by concern about the specifics of financing and implementation (see for example COSATU 2011, 2016b)

[14] See for example COSATU 2002, 2003, Beresford 2008, Vavi 2008, IMSA 2010.

[15] While the NHI Bill suggests that private providers will be contracted by the NHI Fund to deliver services, medical schemes would have no role under the NHI and their ability to operate outside of the NHI would be severely curtailed.

period (Madore *et al.* 2015, Gilson 2019). As discussed above, in 1997 Treasury expressed concerns that an increased tax-burden on the middle class to finance NHI would not be 'fair' as they were already over burdened (Gilson *et al.* 2003, Thomas *et al.* 2004, McIntyre *et al.* 2007). Similarly in 2004, a Treasury official argued that a redistributive NHI could not work in the context of increasing medical scheme membership rates and declining benefits (Dawes 2004). In addition, between 2011 and 2015 Treasury argued for a multi-payer NHI that would allow medical scheme members to retain their medical scheme membership and contribute to NHI through a 'solidarity tax,' on the grounds that they were already 'accustomed' to premium benefit packages and high per capita expenditure (Madore *et al.* 2015, COSATU 2016). A senior Department of Health official suggested that there were individuals within Treasury who opposed NHI because they felt that taxpayers should not be 'offended' (Waterhouse *et al.* 2017). Paremoer (2021) points out that contemporary NHI proposals ask the minority of the population who have grown used to using the private sector to expose themselves to the 'lived experience' of the majority – "entrusting the state with their basic needs". This 'minority' consists of those who can afford medical scheme membership, and so also represents a significant portion of the country's tax-base. Treasury's position on NHI proposals and public justifications thereof reveal the extent to which a certain segment of the South African population had become habituated to accessing healthcare in the private sector and suggest that the interests of this segment of the population is given priority in Treasury's decision-making.

The dominance of the idea that the interests of the wealthy need to be protected might also have been a consequence of the hegemony of neoliberalism. As noted above, neoliberalism emphasises the individual's freedom to pursue their interests and goals in the institutional context of the free market (Harvey 2005, Cardona 2021). This entails what Paremoer (2020) calls 'economic citizenship' – citizens as self-reliant individuals "unhindered by government regulation aimed at the promotion of social welfare." In addition, neoliberalism tends to prioritise the interests of capital and business over, for example, the interests of labour and the poor (Seekings *et al.* 2015). Despite the transition from GEAR to ASGISA, a neoliberal worldview continued to inform economic governance (Barolsky 2013). Thus, in the post-apartheid state, social services, including public healthcare, were still largely considered to be for the very poor, and middle-class citizens were not considered as beneficiaries of the welfare state, and therefore should not be subject to infringement by the welfare state (Paremoer 2020, 2021). Treasury's hindering of the policy process, including repeatedly delaying a promised NHI funding plan, likely reflected not only economic realities, but also a general prioritisation of the concerns of the middle class, ideas about what is 'fair' and appropriate vis-à-vis taxpayers and medical scheme members, and a reluctance to alienate the private sector (Surender 2014, Waterhouse *et al.* 2017).

This analysis demonstrates that ideas, shaped by history, can help to constrain change, even across policy windows, or apparent opportunities for change. A summary of the key ideas, their historical tributaries and their role in constraining change is presented in Table 1. In both of the policy windows described here, ideas informed by neoliberalism (such as private provision of healthcare, a limited role for government in financing and provision, and the prioritisation of markets and capital), clashed against ideas informed by socialist governance regimes, embedded in the history of the ANC (such as discomfort with for-profit healthcare, and redistribution through social welfare). All of these ideas are connected to South Africa's particular social and political history, and also to contemporary events

and contextual realities. Thus, this analysis suggests that ideas help to explain path-dependence because ideas arise out of historical circumstances and continue to influence policy processes thereafter.

Table 1: Summary of ideas, their historical tributaries and their role in constraining change

HISTORICAL TRIBUTARIES	IDEA	ACTORS	CONSTRAINING EFFECT
Apartheid resource distribution decisions, Apartheid prioritisation of the private sector, Free care policy	Publicly provided healthcare is low quality	General public	Increased contestation and resistance to NHI
Gluckman's proposals, British National Health System, Socialist ANC	Health system reform should be redistributive	COSATU	COSATU opposition in policy window 1
Neoliberalism (1980s), close relationship between state and business, Low quality in public sector, Zuma-linked corruption scandals	The state cannot be trusted to manage healthcare funds	General public, COSATU	Increased contestation and resistance to NHI
Neoliberalism (1980s)	Governance should prioritise markets and capital, role of government should be limited	Treasury, experts	Divided ANC, no consensus support for Deeble option in policy window 1 Treasury opposition in policy window 2
Neoliberalism (1980s)	The interests of the middle class should be prioritised	Treasury, experts	Expert's suggested model incompatible with Minister's views in policy window 1 Treasury opposition in policy window 2
Apartheid-era policy decisions	The private sector is too powerful for dramatic reduction to be feasible	Experts	Treasury's opposition to Deeble option/single-payer model in policy window 1, Divergent views between Minister and deliberative committees/experts in policy window 1
Gluckman commission, Socialist ANC and role of redistributive ideas in anti-apartheid movement	For-profit healthcare is inappropriate	Dlamini-Zuma, COSATU	Divergent views between Minister and deliberative committees/experts in policy window 1 COSATU opposition in policy window 2
Neoliberalism, Apartheid decision-making (growth of private sector) Quality issues in public sector	Healthcare market and private healthcare provision are appropriate for those who can afford	General public, Treasury	Divergent views between Minister and deliberative committees/experts in policy window 1 Popular opposition to NHI

Discussion

We have demonstrated that the South African NHI policy process is an example of path-dependence and change resistance despite apparent policy windows and suggested that ideas played an important role in constraining change. In this section, we draw on institutionalism as a political science theory to develop an explanation for the power of ideas to constrain change.

Historical and sociological institutionalism both suggest that ideas can, over time, become institutionalised – in other words, cemented in social and cultural institutions. In the South African NHI policy experience, these ideational dynamics are evident in two related sets of ideas: neoliberal ideas about governance, and the appropriateness of for-profit healthcare.

Institutionalism suggests that ideas diffuse across contexts through actors and epistemic communities (Hall *et al.* 1996, Campbell 1998). In this case, in the 1994-1999 period, neoliberal ideas were taken up both by the apartheid government and by the ANC, and cemented in tangible and intangible

institutions. Neoliberal ideas were accepted by the apartheid government, which used them to justify the privatisation and deregulation of healthcare (Hilton 1988, Price 1994). As a result, neoliberal ideas about health service provision were institutionalised in private healthcare as a social institution – the network of funders, administrators and for-profit providers that would seek to influence the policy experience in line with their interests, and the daily practices of privately delivered healthcare that would become the norm for many South Africans.

Neoliberal ideas were also transposed into the ANC directly through global institutions, and indirectly through the pressures associated with operating in a global context in which neoliberal ideas were dominant (Pillay *et al.* 1995, Bond 2014b, Cronin 2020). As discussed, this ideological shift resulted in weakening party support for Minister Dlamini-Zuma's preferred policy option. In addition, however, neoliberal ideas of economic governance were tangibly institutionalised into macro-economic policy – most obviously GEAR – that severely limited public spending (Gilson *et al.* 1999, Baker 2010, Bond 2014b). In turn, GEAR justified the opposition of key actors, primarily Treasury, to health system reform (Gilson *et al.* 1999, Baker 2010). Furthermore, as argued above, the hegemony of these ideas influenced the perspective of experts in the various deliberative fora established in this period, with the result that these committees conceded to Treasury's view that a progressive NHI was not financially feasible because increased taxation was inappropriate (Gilson *et al.* 1999, McIntyre *et al.* 2003). In the second policy window, although GEAR had given way to the less explicitly neoliberal ASGISA (and neoliberal ideas were no longer tangibly institutionalised in this way), it seems that these ideas had been intangibly institutionalised within Treasury (see Barolsky 2013) – with the result that Treasury opposed the reform models being suggested and constrained policy change.

A second set of ideas also became institutionalised over the course of this policy experience – ideas about the appropriate role of for-profit actors in healthcare provision. The private health sector in South Africa is a social institution that is a product of policy decisions taken in the 1980s, motivated by political imperatives, and justified by neoliberal ideas about the appropriate role of the state in healthcare (Price 1994, McIntyre *et al.* 2020). In the early policy window, Minister Dlamini-Zuma was against for-profit healthcare on ideological grounds (Gilson *et al.* 2003). Conversely, the idea that the private sector was simply too big to be curtailed – which was accepted by experts in the deliberative fora of the 1994-1999 period – may have been a 'political reality' but also inevitably reflects the hegemony of the idea that for-profit healthcare is appropriate and inevitable. As Centeno *et al.* (2012) put it, "causality flows from the reality of economic life as well as from its interpretation."

Furthermore, over the course of the policy experience, as private healthcare provision continued to shape the experience of healthcare for middle-class South Africans, the idea that for-profit healthcare is appropriate became intangibly institutionalised within this population. This would explain Paremoer's (2021) suggestion that public services are perceived as being exclusively for the poor. The cultural hegemony of this idea is arguably evident in the report that Treasury felt that the standard of care and (inequitably) higher per-capita expenditure experienced by medical scheme members should be protected, as well as in the Competition Commission's ruling against tariffs (Berger *et al.* 2010, Madore *et al.* 2015, Waterhouse *et al.* 2017). The related and pervasive ideas, discussed above, that public healthcare is of low-quality and that the state cannot be trusted to manage funds or provide services no doubt reinforce the cultural hegemony of the idea that the private sector is the most appropriate mechanism for the delivery of health services, as does the tendency of the media to

amplify the concerns of that segment of the population habituated to private healthcare provision (Waterhouse *et al.* 2017, Gilson 2019). This suggests that these ideas, tangibly institutionalised in the private health sector, are becoming intangibly institutionalised – in other words are becoming background normative and cognitive assumptions, that will be very difficult to change, and will have significant consequences for future health system reform efforts.

Conclusion

This analysis reveals how ideas – including values and beliefs – can contribute to resistance to policy change, thereby helping to constrain change and ensure path-dependence. In addition, we have put forward an account of the process by which ideas become part of this context, and therefore an explanation for the ability of ideas to resist change. By becoming tangibly and intangibly institutionalised ideas continue to exert influence long after the historical circumstances that gave rise to them and independently of the actors that espouse them. This suggests that ideas should be considered as elements of context, rather than simply as one element in the arsenal of strategies actors use to propel policy chance. Analysing ideas as elements of the social, political and cultural context in which reforms take place allows for a better accounting of the role of ideas in resisting change.

Health systems are complex social systems, embedded in, an open to influence by, social and political contexts, which influence policy processes in a myriad of ways (Collins *et al.* 1999, Gilson 2012). In addition, the significant role ideas play in policy processes is widely recognised (Gilson *et al.* 2018). However, as noted above, most health policy scholarship, and policy science more widely, focuses on foreground ideas – on ideas as policy proposals or policy frames – and, therefore, the focus on ideas is secondary to the interests and actions of the actors who wield them (Campbell 1998, Fischer 2003). From this perspective, ideas play a powerful role in policy processes, but their power depends on how much support they receive from actors, and how much power those actors have in the policy process, which, in turn, depends on the institutional context of the policy process (Campbell 1998). In other words, ideas are a tool, wielded by policy actors to either enable or constrain policy change, and institutions mediate the influence of ideas.

However, our analysis suggests that, in addition to ideational tools wielded by actors, ideas can become institutionalised such that they become part of the structure within which actors must work (c.f Giddens 1979), and operate as cognitive or practical constraints on actors. Because hegemonic ideas shape how actors make sense of the world, they are fundamental to any form of collective action, and should, therefore, be analysed as independent variables, ontologically primary to the actors that espouse them, the institutions that reinforce them, or the socio-political circumstances that gave rise to them (Hall 1997a, Berman 2001). In other words, once ideas become institutionalised – either as culture, shared values or ideology, or in the procedures and processes of institutions – they become independently influential (Hall 1997b, Berman 2013).

In addition, to the extent that institutions and cultural ideas are relatively stable and persistent, they form part of the context within which actors must work and should be considered in policy analyses as such. Often, policy experts are assumed to be ideologically neutral, and above-the-fray of politics (Fischer 1987, Rich 2005). However, all policy actors, including experts and policy-makers, are products of social contexts and hegemonic ideas, which will influence their policy positions (Fischer

1987, Stone 1996, Rich 2005). The 'ideological terrain' within which actors operate will determine what kinds of programmatic ideas will be considered legitimate and what sorts of frames will be persuasive (Hall 1997a). Analysing ideas as contextual factors, in the sense that they are inherited from history and largely beyond the control of policy actors, not only more accurately reflects the dynamic nature of ideational variables – that they are programmatic ideas about what should be done, the frames by which actors justify these programmatic ideas, *and* are part of the stable social context within which actors must operate – but also will help analysts to better understand why ideational variables enable change in some policy experiences and constrain it in others.

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Chapter 6 – Social values and health system reform: A case study of social values in South African National Health Insurance policy rhetoric

Chapter 6: Social values and health system reform: A case study of social values in South African National Health Insurance policy rhetoric

Overview: This chapter presents a single case study of social values in the South African National Health Insurance policy rhetoric from 1990 to 2019. We used discourse analysis to identify the social values shaping NHI policy rhetoric and interpreted the findings in combination with a historical analysis of health system reform in South African since 1926 to explain the salience of social values with reference to historical and contemporary social and political realities. The analysis reveals 10 main social values underlying NHI policy rhetoric, some of which differ from the values explicitly stated in policy documents. We offer an account of the historical and contemporary contextual realities that explain the particular salience of these values to health system reform efforts in South Africa.

Contribution to the thesis: This chapter offers further insight into the relationship between health systems and social values. In particular, it offers empirical evidence of the influence of dimensions of the health system – such as past policy decisions, and financing and service delivery architecture – on social values. It also generates evidence to explain why particular social values have salience in health policy processes in particular contexts. As such, the Chapter presents an opportunity to test some of the theory developed in the foregoing chapters and generates evidence that informs the conceptual framework presented in Chapter 7.

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Abstract

Values shape health policy processes in multiple ways. Large-scale health system reforms involve decisions about the distribution of scarce resources and are therefore ideologically and politically fraught. In democratic contexts, policy-makers must legitimate policy proposals by demonstrating their coherence with dominant social values. As such, social values delimit the range of policy solutions that will be considered politically feasible. Therefore, health policy reform processes cannot be understood in isolation from social values. We present a single case study of social values at play in the South African National Health Insurance policy rhetoric from 1990 to 2019. We collected primary and secondary data from a range of documentary sources, including speeches, submissions to parliamentary inquiries, published letters, print media, and policy documents, and applied discourse analysis to surface the social values at play in NHI policy rhetoric. In addition, we interpret the findings in combination with a historical analysis of health system reform in South Africa since 1926 to explain the salience of social values with reference to historical and contemporary social and political realities. The analysis reveals the main social values underlying NHI policy rhetoric, which include national unity, socialism and redistribution, redress and reconciliation, healthcare as a public good, fiscal conservatism, rationality and ideological neutrality, transparency and impartiality, and private provision of healthcare. These values differ in important ways from the values that are explicitly stated in NHI policy documents. The analysis suggests that while social values remain fairly stable over time, their salience to policy debates waxes and wanes in response to contextual factors. For policy-makers and analysts, this indicates that paying attention to the history of policy processes and looking beyond explicitly stated values can enable a better understanding of which social values shape policy debates in the public sphere. Such an understanding can inform the development of more persuasive rhetoric.

Keywords: Social values, health policy process, reform, national health insurance, discourse analysis, case study

"There can be few countries where the rhetorical and ideological role of health care is so blatant." (Andersson et al. 1988)

Introduction

Values shape health policy processes in multiple ways. Values and interests shape the behaviour policy actors, but values can also transcend self-interest (Walt *et al.* 1994, Fischer *et al.* 2012). Values also shape relationships *between* health system actors (Marchal *et al.* 2012). Differences in values between policy actors give rise to contestation and resistance (Gilson *et al.* 2018), and shared values connect and propel interest groups, policy communities and advocacy coalitions that catalyse policy change (Walt *et al.* 1994, Fischer *et al.* 2012). More fundamentally, values determine which issues are viewed as policy problems, how policy-makers understand these problems, and which policy solutions are considered feasible or appropriate (Ingram *et al.* 2007).

Values also guide how policy actors interpret evidence and use it to develop policy recommendations (Walt 1994, Parkhurst 2012). In addition, when evidence is scarce or inconclusive, policy-makers' values guide decisions about what policy option is most appropriate (Campbell 2002). Health policy processes, particularly in low- and-middle income countries, also often involve international financial institutions and other non-state actors that hold ideological commitments of their own, which influence the policy solutions they advocate (Walt *et al.* 2008, Liverani *et al.* 2013). Furthermore, health policy processes often involve politically fraught decisions about the distribution of scarce resources, with life and death consequences and numerous vested interests (Reich 1995, Walt *et al.* 2008). In such cases, policy-makers also draw on value judgements about particular target populations to justify decisions about which groups to prioritise (Ingram *et al.* 2007, Walt *et al.* 2008).

However, while policy-makers' personal values influence their choices and behaviour, they are also constrained by the dominant values of the society in which they operate. Health policy processes unfold in social, political and institutional contexts that determine the range of possible policy solutions, and values constitute an important contextual influence on policy processes (Hall 1980, Walt *et al.* 1994). In democratic political systems, policy decisions will often have significant impacts on electoral politics, and policy-makers must take into account the electoral consequences of adopting positions on policy that are out of step with dominant social values (Ingram *et al.* 2007). Policy actors also appeal to popular values to justify policy decisions or to increase public support for policies (Reich 1995, Koon *et al.* 2016). In addition, governments and political parties have value commitments of their own, with which policy positions must cohere if they are to receive broader political support (McConnell 2010). For a policy solution to be politically feasible, therefore, it must be consistent with dominant social values, and in this way, social values delimit the possible range of policy options available to actors (Sabatier 1998, Surel 2000).

The central role values play in health policy processes means that policy change cannot be understood in isolation from social, political and ideational realities (Fischer 2003). However, much of modern policy analysis takes an empirical or positivist orientation, ignoring the politics inherent in policy change processes and seeking generalisable findings (Fischer *et al.* 2017). Fischer (2013) suggests that a 'post-positivist epistemology' in policy analysis directs attention to communication and argumentation in policy processes, and therefore allows us to understand policy processes as social

action embedded in political contexts. Walt *et al.* (2008) similarly recommend the use of interpretive methods that allow researchers to account for values and ideas.

Paying attention to policy discourse – how policy proposals are communicated and argued for – can help reveal the social values at play (Fischer *et al.* 2012). Schmidt (2010) uses the terms 'coordinative-' and 'communicative discourse' to distinguish between the primarily cognitive discourse policy-makers use to develop policy proposals, and the cognitive and normative discourses they use to communicate and legitimate these policy ideas to wider publics. Communicative discourses are constructed by a wide range of policy actors – including political leaders, media, interests groups and civil society – and combine cognitive ideas with normative ideas in order to justify or legitimate policy proposals by demonstrating their alignment with social values (Schmidt 2011, Baker *et al.* 2019).

In this paper we present a case study of social values in the South African National Health Insurance (NHI) policy rhetoric. We describe the social values shaping communicative discourse of health system reform (HSR) in South Africa and identify the role they play in policy rhetoric. In addition, by exploring these social values alongside an analysis of the social and political context in which the policy process unfolded, we reveal the historical and contemporary contextual factors that give these particular values salience in the South African context.

Methods

A case study is an empirical, in-depth investigation of a case (or small number of cases) that triangulates multiple sources of data (Exworthy *et al.* 2012). Case study design enables the exploration of phenomena in context, because it supports a 'thick description' of experiences that allows the phenomenon to be explained by reference to contextual factors (Yin 2009, Gilson *et al.* 2011). Case studies can also offer a longitudinal perspective that reveals the influence of history and changing contextual realities (Exworthy *et al.* 2012). In this study, we used a single (holistic) case study approach to explore the social values shaping NHI policy rhetoric and explain their salience in relation to historical and contemporary social and political context.

To do so, we used discourse analysis to identify the social values, and historical analysis to develop an account of the context in which the policy process unfolded. The historical analysis traced the policy process in context from 1926 to 2018, and is reported more fully elsewhere (Whyle *et al.* 2022a). The discourse analysis assessed policy rhetoric between 1990 and 2019 and drew on a range of primary and secondary data sources. Secondary data sources included academic literature on South African social values and the South African NHI policy process. Primary data sources included policy documents; print media; press releases; speeches by policy-makers and political actors; public letters of opinion by policy insiders; and submissions by civil society, professional bodies and industry actors to various parliamentary committees and official inquiries. Data collection and analysis were conducted iteratively, and we continued to search for new material according to our evolving understanding of critical junctures in the policy process and wider context, and emerging discourses. For print media, press releases, speeches and submissions, we continued to add new items until saturation was achieved in the sense that no new dominant discourses were identified (Jäger *et al.* 2001, Mautner 2008), while for policy documents we sought completion (to gather complete sets).

Due to the challenges of doing critical discourse analysis on translated text, we only included material in English.[1]

Discourses are ways of speaking and thinking that, in a particular social context, reflect, create and reproduce social realities, including meanings, assumptions and ideologies (Wodak 2002, Walton *et al.* 2016). In this way, discourses reflect dominant public perceptions, frame debate, and legitimate social power relations (Walton *et al.* 2016). Critical discourse analysis is an approach to unearthing the ideas, values, and ideologies that underlie written and spoken communication (Wodak 2001, Mills 2004). Critical discourse analysts draw a distinction between what is explicitly said and what underlies what is explicitly said. Beyond analysis of the content of text, a fine-grained analysis of language can reveal the implications, insinuations, symbols and metaphors that are part of the way speakers exercise their social power to convince an audience (Jäger *et al.* 2001, Meyer 2001). These underlying ideas are the assumptions, allusions, presuppositions and polarizations that are a function of the speaker's cognitive frameworks and socially shared beliefs (Van Dijk 2001, 2009). Particularly in political discourse, such a fine-grained analysis can reveal the assumptions and ideological commitments that are understood by the audience, but that it might be impolitic to state explicitly (Fairclough 1989). Van Dijk (2001) refers to these underlying ideas as 'local meanings' because they are chosen by speakers according to what they believe will resonate with, or make sense to, their audience.

In this study, recognising that the social values influencing NHI rhetoric are likely often not explicit, we used critical discourse analysis to analyse sets of arguments drawing on the same discourse to identify the social values used for rhetorical power, whether or not they were made explicit. In addition to explicit values, we purposefully sought to identify the value-commitments that are not explicitly stated but that the audience must share in order to be persuaded by the argument. In other words, this analysis reveals the social values actors in the NHI policy process think reflect the values of various audiences.

The analysis drew on three discourse analytical approaches. We drew on rhetoric analysis (Posch 2018) to understand how social values are employed in arguments for or against NHI. Rhetoric refers to language used for persuasion, and involves using values, norms and ideology, alongside factual claims to influence the audience (Reisigl 2008, Russell *et al.* 2008). As such, rhetoric analysis can expose the values actors think the audience shares (Russell *et al.* 2008). We also used media analysis, because print media represents the social mainstream and therefore offers insight into, and serves to reinforce, dominant discourses and ideologies (Mautner 2008). Finally, we drew on Wodak's discourse historical approach, in which the analysis and interpretation of language is contextualised with empirical background information, to aid in making judgements about what ideas are dominant or prioritised at any time (Wodak 2011).

To identify the discourses and value-commitments underlying policy rhetoric, we began by reading the collected material to identify discourses – understood as ways of talking about or understanding HSR. Having identified an initial set of discourses, we reread the material to identify arguments, understood as strings of phrases or ideas used to persuade the audience to either support or oppose HSR. These arguments were then categorised depending on the discourse they drew on. In this process

[1] Please see Appendix 6c for an overview of the media landscape in South Africa.

we also expanded our set of discourses to accommodate arguments that did not fit in the initial discursive categories. The results of the discourse analysis are presented in Appendix 6a.

Operationalising 'social values' for analysis

In this study we understand values to be are universal and persistent affective ideas about what is desirable that influence or justify action or judgement, and that exist as part of a ranked set of values known as a value system (Whyle 2022). In the course of analysis, however, some challenges inherent distinguishing social values from popular attitudes and widely held beliefs became apparent. For example, a persistent assumption that the quality of care provided in the private sector is superior to that of the public sector might reflect a popular attitude, a widely held cognitive belief, or a deeply embedded assumption that the private sector is a more appropriate site for the provision of health services. In deciding how best to analyse an idea like this, there is a risk that the decision will be (unduly and inappropriately) informed by whether the idea aligns with ones' own social values.

Furthermore, an additional complexity to this challenge is that cognitive beliefs can become normative ideas over time. This is because social institutions cement cognitive ideas in every day practices and shape the experiences of those who engage with them, such that the ideas they embody come to be accepted as just or appropriate (Rothstein 1998, Whyle *et al.* 2022a). In this way, a cognitive belief – such as a belief that the services provided in the private sector are superior quality to those in the public sector – might, over time, become a deeply embedded, widely shared and difficult to question normative belief that the private sector is a more appropriate site for the delivery of health services than the public sector.

For these reasons, rather than rely on what 'feels' like a social value (which would risk simply imposing the analysts' own values onto the analysis), or restricting the analysis to values commonly explicitly stated in public discourse, decisions about which ideas to analyse as social values (as opposed to attitudes, cognitive beliefs or other types of ideas) we were guided by two considerations. Firstly, drawing on pre-eminent political psychologist Ralph K White's conceptualisation of values as "any goal or standard of judgment which in a given culture is ordinarily referred to as if it were self-evidently desirable" (White 1951) we asked whether the idea in question was being used for affective rhetorical power, and whether the idea was framed in normative or cognitive terms in the policy discourse. Secondly, our judgement on which ideas to include in the analysis was informed by secondary evidence on social values in both South African public discourse and health system reform more generally (gathered as part of a contextualised historical analysis of the South African NHI presented in Whyle *et al.* (2022b)). In this way, we were able to capture both ideas that do not 'feel' like values, but that are framed as normative and used for their affective power in policy rhetoric, and ideas that may once have been 'cognitive ideas' but are institutionalised to the extent that they are, or are at risk of becoming, 'normative ideas' about what is appropriate, just or acceptable.

Findings

Ten related but distinct social values are evident in NHI policy discourse in South Africa. In this section, we briefly outline the study setting (the health system and socio-political history of South Africa), and then present the social values identified, and explain how they are used in NHI policy discourse. Finally, we connect these values to historical and contemporary events and issues to explain their particular salience in this context.

Study setting

South Africa's health system is shaped by a long history of racial oppression under colonialism and apartheid. A timeline of major events in both the social and political context and the health system is presented in Figure 1. The 1909 South Africa Act, which created the Union of South Africa, excluded black people[2] from political participation and led to a period of repressive legislation which dispossessed them of their land (Terreblanche *et al.* 1990). In this era, health services were racially and geographically fragmented, the majority of Government health spending was directed to tertiary hospitals, and there was a thriving and largely unregulated fee-for-service private sector, supported by medical schemes which were introduced to serve (white) mine workers and remained restricted to white people until the 1970s (Van Niekerk 2003, McIntyre *et al.* 2020).

In 1948 racial segregation and white supremacy was formalised through the institution of apartheid, by the National Party (Van Niekerk 2003, Pauw 2021). The National Party ensured geographic and political segregation through the creation of ostensibly independent 'homelands'[3] in which 13% of South Africa's land was demarcated to black people, who comprised 80% of the population (Price 1986). Under the apartheid government the health system was fragmented and inequitable. Each racial category had its own national department of health (NDoH), and each homeland and provincial administration had a department of health (McIntyre *et al.* 2020). Resource flows were hospi-centric, urban-focused and racialised, and healthcare for the black majority was largely neglected (Pauw 2021). Once in power, the National Party regulated the private sector tightly until the 1980s, when it introduced an explicit policy of deregulation and privatisation, which prompted dramatic growth of the for-profit private sector (McIntyre *et al.* 2020).

A massive anti-apartheid movement led by the African National Congress (ANC), and eventually supported by international pressure, resulted in negotiations to end apartheid and move towards a participatory democracy beginning in 1990 (Coovadia *et al.* 2009, Pauw 2021). Democracy was achieved in 1994 when the ANC won the first democratic election, and the party has won every general election since then (Pauw 2021). The ANC government has sought to rectify apartheid-borne inequities through health and social welfare reforms, including free primary healthcare for all (Rispel 2016, Pauw 2021). The Constitution of South African was established in 1996, enshrining the right to healthcare services and social security, and stating that that "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights" (Republic of South Africa 1996). The 1997 White Paper for the Transformation of the Health System laid the legislative foundation for the establishment of a unified national health system (Republic of South Africa 1997). Today, South Africa is a multi-racial democracy, but remains one of the most unequal countries in the world, in which socio-economic inequities along racial lines persist, both in the health sector and more generally (Coovadia *et al.* 2009, McIntyre *et al.* 2020).

[2] In this paper we use racial categories such as 'black' and 'white' to explain historical injustices and acknowledge their bearing on contemporary inequities. These apartheid-era categorisations are still used in contemporary South Africa, and racism and white supremacy continue to drive inequities and imbalances of power. While they are not derogatory terms, we recognise that they are contested and problematic, and our use of these terms is not intended to infer their legitimacy.

[3] 'Homelands' or 'bantustans' were ostensibly self-governing territories to which the apartheid government assigned black people to justify their disenfranchisement in 'white South Africa' (Price 1986, Naylor 1988) (see Appendix 6b).

Decade	Year	Event	Period
1900s	1909	South Africa Act creates Union of South Africa	
1910s	1913	Land Act introduces racist geographic segregation	
1920s	1926	Pienaar Commission on Old Age Pensions and National Insurance	
	1928	Old Age Pensions Act	
	1929	Carnegie Commission established	
1930s	1935	Committee of Inquiry into National Health Insurance (The Collie Committee)	
1940s	1941	MASA pamphlet argues for 'socialised' medicine	
	1942	National Health Services Commission led by Dr Henry Gluckman	
	1948	Introduction of apartheid by the National Party	Apartheid
1950s	1955	ANC Freedom Charter	
1960s	1967	Medical Schemes Act removes protections for MS members	
1970s	1973	Alma Ata declaration	
	1974	De Villiers Commission into Private Hospitals and Unattached Operating Theatres	
1980s	1984	Constitution of South Africa	
	1986	Browne Commission of Inquiry into Health Services	
	1986	Amendment to Medical Schemes Act of 1967 removes protections afforded to MS members	
1990s	1990	ANC unbanned and negotiations to end apartheid instigated	
	1991	ANC discussion booklet: 'Towards developing a health policy'	
	1992	ANC releases 'Ready to Govern' policy document	
	1993	Medical Schemes Amendment act excludes most vulnerable from MSs	
	1994	ANC win first democratic election and Government of National Unity formed	Mandela presidency
	1994	Dlamini-Zuma appointed Minister of Health	
	1994	ANC releases National Health Plan for South Africa	
	1994	Health Care Finance Committee established to investigate appropriateness and feasibility of establishing NHI system	
	1994	Reconstruction and Development Programme introduced	
	1994	Directorate of Health Financing and Economics established by Dlamini-Zuma	
	1995	Committee of Inquiry into a National Health Insurance System	
	1995	Promotion of National Unity and Reconciliation Act establishes Truth and Reconciliation Commission	
	1996	Constitution of South Africa	
	1996	Sarafina II AIDS prevention play scandal	
	1996	Growth Employment and Redistribution macro-economic strategy introduced	
	1997	White Paper for the Transformation of the Health System: Towards a National Health System	
	1997	Social Health Insurance Working Group established	
	1998	Medical Schemes Act introduces protections for MS members	
	1999	Thabo Mbeki elected president	Mbeki Presidency
	1999	Arms deal	
2000s	2002	Committee of Inquiry into a Comprehensive System of Social Security (Taylor Committee)	
	2002	Ministerial Task Team for Implementing SHA established	
	2004	National Health Act gazetted	
	2005	Consultative Investigation into Low-Income Medical Schemes	
	2005	Ministerial Task Team for SHI report sent to NDoH	
	2007	ANC Polokwane conferece - Zuma elected president of the ANC and ANC recommits itself to NHI	
	2007	ANC NHI Task Team formed	
	2008	Load-shedding' introduced	
	2008	Mbeki recalled by ANC	
	2009	Ministerial Advisory Committee established to advise the Minister on NHI policy and legislation	Zuma Presidency
	2009	Zuma implicated in Nkandla scandal	
	2009	Zuma presidency begins, and Zuma uses State of the Nation Address to reiterate commitment to NHI	
	2009	Motsoaledi appointed Minister of Health	
2010s	2011	Green Paper on NHI	
	2012	Marikana Massacre	
	2013	Competition Commission launches Market Inquiry into competition in the private healthcare sector (HMI)	
	2015	White Paper on NHI	
	2015	Rhodes Must Fall protests begin	
	2018	Draft NHI Bill	
	2018	HMI provisional report	
	2018	President Zuma recalled by ANC and resigns presidency	
	2019	NHI Bill approved by Cabinet and tabled in parliament	
	2019	HMI final report	

Figure 1: Timeline of South Africa's socio-political and health system history (Source: Author)

The contemporary health system comprises public and private sectors, with the private sector serving an elite minority and the under-resourced and over burdened public sector serving the majority (Pauw 2021). The integrated and comprehensive public health system provides care for a population burdened by concurrent epidemics of HIV and tuberculosis, maternal and child mortality, non-communicable diseases and high rates of injury and trauma (Tucker *et al.* 2019). Total health expenditure is divided fairly evenly between public and private sectors, but more than 80% of the population is dependent on the public sector, resulting in significant inequities (McIntyre *et al.* 2020). In addition, 7% of total health expenditure is out-of-pocket (McIntyre *et al.* 2020). In the public sector, fees are charged for secondary and tertiary services (although fee exemptions are available for the poor and vulnerable) (McIntyre *et al.* 2020). Only the wealthiest South Africans are able to afford medical scheme coverage, without which care in the private sector is prohibitively expensive, and racial disparities in access to medical scheme membership persist (van den Heever 2019a, McIntyre *et al.* 2020).

Health system reform, in the form of National or Social Health Insurance (NHI or SHI), has been on the ruling party's policy agenda since 1994, but the policy process has been slow, contentious and politically charged (Gilson *et al.* 1999, Burger *et al.* 2020). A Green Paper on NHI was released in 2011, followed by a White Paper in 2015, and a NHI Bill in 2019 (Republic of South Africa 2011, 2015, 2019). At the time of writing, in June 2022, public input on the Bill to the Portfolio Committee on Health had been completed, but the final Bill had not yet been released.

Social values in South African NHI policy rhetoric

In this section we present the social values shaping NHI policy rhetoric. After comparing the social values drawn on in NHI policy rhetoric (arguments for or against the policy in the public sphere, including speeches by politicians and policy-makers, media articles, submissions to parliament from stakeholders, and public letters) to those explicitly stated in policy documents, we describe the social values identified more fully, and explain the rhetorical role they play in NHI policy discourse, discussing each value in turn.

NHI policy documents often make explicit reference to a range of social values. For example, the 2011 Green Paper specified the right to access, social solidarity, effectiveness, appropriateness, equity and affordability as the principles of NHI (Republic of South Africa 2011), while the 2019 NHI Bill states "the universal health coverage system is a reflection of the kind of society we wish to live in: one based on the values of social solidarity, equity, justice and fairness" (Republic of South Africa 2019). The social values explicitly stated in NHI policy include equity, efficiency, justice and fairness, solidarity, sound governance and 'democratic values', human rights, health as a public good, and universality (Republic of South Africa 2015, 2017, 2018). Some policy documents also explicitly connect NHI to redressing apartheid (Republic of South Africa 1997, 2018).

Beyond the policy documents themselves, a related, but distinct set of values underlies NHI policy rhetoric. National unity, fiscal conservatism, socialism and redistribution, redress and reconciliation, healthcare as a public good, the free market, personal responsibility, rationality or ideological neutrality, and transparency and impartiality are all used for rhetorical power in NHI policy discourse (unpacked below).

Much NHI policy rhetoric in support of HSR uses social values of socialism, redistribution or anti-capitalism for rhetorical power – drawing on discourse that connects HSR involving income cross-subsidisation or the nationalisation of private health resources to the post-apartheid redistributive project. Another discourse evident in arguments supportive of reform is discourse that connects NHI to the de-commodification of healthcare. These arguments also draw on socialist or anti-capitalist values for their rhetorical power. For instance, in a 1987 presentation to the National Medical and Dental Association, Coovadia (1988) argues for the institution of a National Health Service (NHS) by describing the nationalisation of health services as an example of socialised medicine. Similarly, in 2009, the South African Communist Party (SACP) argued for the NHI by positioning those against the NHI as “the capitalist classes” (quoted in McLeod 2009b).

Conversely, a counter-discourse that connects NHI to socialism but assumes socialism is a threat or is pernicious is also evident in NHI policy rhetoric. For example, a 1994 news article states that some elements of the ANC’s health plan “smacked of nationalisation” (Robbins 1994). Interestingly, many of these arguments do not explicitly defend market-based health systems, and most of those that do proffer justification or support for this ideological assumption are later in the policy process. In 2004, an article titled ‘High risk medical plan’ describes the proposed reforms (which, at that time, included risk-related cross subsidies, income-related cross subsidies and mandatory cover) as a “socialist intervention of the worst kind” in which “you rob some so that you can pay for others in the system” (Star 2004). In the same vein, the Free Market Foundation’s (FMF) 2011 submission on the Green Pape presents evidence of failed socialised health systems to argue against the proposed NHI.

Some arguments against reforms also use personal responsibility as a value, drawing on discourse that connects cross-subsidisation or decommodification as antithetical to personal responsibility. A letter to the editor published in the South African Medical Journal in 1986 argues against a universalist NHS on the grounds that it will “give rise to a don’t-care attitude…the reasoning being that the State will care for us” (van Wyk 1986). This individualist discourse is also sometimes evident in arguments against purely public provision of healthcare. However, personal responsibility as a social value is less evident in more recent policy rhetoric.

National unity was also apparent as a social value employed in policy rhetoric. Such rhetoric draws on the discourse of South Africa as a divided society to argue for HSR, assuming that it will unify society. National unity is often used in rhetoric in support of cross-subsidisation and solidarity-based approaches. Health Minister Zweli Mkhize’s appeal for South Africans to “join hands in a way that really counts” (Mkhize 2019) is one such example. Arguments drawing on national unity as a value are overwhelmingly made by policy-makers themselves, and are not evident in media articles.

Relatedly, some policy rhetoric supportive of reform draws on discourse that connects HSR to the post-apartheid recovery process, using redress of apartheid as a social value. This includes rhetoric that frames NHI as a way to ‘heal’ the divides of the past (Ngcaweni 2018), as well as arguments that suggest NHI will end racial disparities in access to healthcare. In 2019, for instance, the Chairperson of the Ministerial Committee on NHI said NHI “is an instrument to end the race, class, gender divisions that continue to plague South Africa. For example, 76% of medical scheme members are white, and

only 10% are black" (quoted in Staff Writer 2019).[4] Once again discourse that connects HSR to apartheid redress is mostly evident in rhetoric used by policy-makers themselves, although this is often uncritically reported in print media.

Healthcare as a public good is also used for rhetorical power in arguments in support of HSR, particularly proposals for a single-payer model with public provision and with very limited or no role for the private sector. The Congress of South African Trade Unions' (COSATU) critique of the 1997 White Paper uses public provision as a value, demanding a "conscious strategy to move systematically towards a public health care system and away from private provision" (COSATU 1998).

On the other hand, some NHI policy rhetoric draws on discourse that positions HSR as a threat to private health services or the private health sector. A 2008 news article entitled 'Your medical scheme's survival under threat', for example, describes NHI as inevitably involving the 'demise' of medical schemes (du Preez 2008). This rhetoric draws on private provision as a social value. However, rhetoric drawing on private provision as a social value is only evident after 2008 and is not dominant. More often, the free market and freedom from government interference are used for rhetorical power in a range of arguments opposing reform. Such arguments draw on discourse that positions NHI as government 'over stepping' and infringing on an assumed right to participate in a healthcare market. For example, the FMF's comments to the 2015 Davis Tax Committee argues that government should concern itself only with the poor, stating, "when it comes to health care, government should concentrate its efforts…on the poor. For…those who can afford healthcare, leave them alone to seek out the cover that would suit them best" (FMF 2015). The 'right' to participate in a market for healthcare also appears in the report of the 1995 Committee of Inquiry into a National Health Insurance System (NHIS), which assures the public that the committee's proposals "recognise the right of individuals to use private sector providers for their [primary healthcare] services" (Republic of South Africa 1995).

In addition to discourse that suggests NHI is a threat to the right to participate in a healthcare market, much of the NHI policy rhetoric uses discourse that assumes the state cannot be trusted to provide, finance or regulate health services. This discourse is evident in the Helen Suzman Foundation's critique of the 2011 Green Paper, which argues that public-private partnership is necessary to improve the 'hospital system' (HSF 2011), as well as in critiques of the NHI by opposition parties that argue that minimising the role of the private sector will 'disrupt' the health system (Madore et al. 2015). As Paremoer (2021) writes, debates about NHI reveal a resistance among those who can afford to opt out of the public sector to "entrusting the state with their lives and wellbeing." This discourse suggests that private provision of healthcare is a social value in the South African context.

Fiscal conservatism and economy are also often invoked in arguments against HSR. Arguments drawing on these values often frame the unaffordability of NHI as a brute fact (see Streek 1995, ASSA 1997, Archer 2014) and position NHI as incompatible with a healthy economy, such as Breier's (1995) claim that NHI will 'bleed the economy'. As such, these arguments draw on discourse that suggests

[4] This claim incorrectly presents the proportion of the black population with medical scheme access, as the proportion of medical scheme members who are black. In reality, while only about 10% of black South Africans are medical scheme members, 48.6% of medical scheme members are black (van den Heever 2019a, b).

economic conservatism is 'ideologically neutral' or 'rational' – indicating that ideology is often taken to be pernicious and that value-free policy-making is a social value.

Ideological neutrality as a social value is also drawn on in NHI policy rhetoric that characterises the NHI or its supporters as 'ideological' or 'idealogues' to oppose reforms. In an article reporting on the 2016 White Paper, an industry insider suggests that policy-makers advocating a limited role for medical schemes are 'ideologues' (Medical Brief 2016). Similarly, in a 2014 commentary, an industry insider accuses the Health Minister of "painting a picture…that simply cannot be, unless…one ignores and disregards the realities of South Africa's budgetary and human-resource constraints" (Archer 2014). Arguments drawing rhetorical power from fiscal conservatism as a social value, and arguments employing value-free or 'rational' decision-making as a social value, also draw on distrust of the state with respect to policy-making and managing funds, for example by characterising costing predictions as 'unrealistic' or simply incorrect. This discourse is apparent in both media and civil society submissions.

Finally, social values of transparency and impartiality are often used for rhetorical power in arguments both for and against NHI. These values are evident in arguments claiming that the policy-making process has been 'sinister' or 'hidden.' A 1995 media article refers to Health Minister Dlamini-Zuma's 'hidden agenda' (Staff reporter 1995a), and Breier (1995) writes that "there is something secret and sinister about the whole thing." These arguments sometimes draw on discourse that suggests the state is untrustworthy, and sometimes connect to discourse that casts private sector actors as powerful and untrustworthy. Arguments drawing on the latter discourse seek to discredit reform proposals using discourse of 'vested interests' and 'capture' by private sector actors, drawing on the values of transparency and impartiality for rhetorical weight. A 2008 media article suggests that private sector actors were able to halt the progress of a new Bill by lobbying the ANC (Khanyile 2008). Similarly, in 2016, the COSATU national spokesperson accused the ANC and then-Minister of Health Motsoaledi of 'sabotaging' the NHI by 'handing it over' to 'big business interests' (Pamla 2016). Transparency and impartiality are commonly employed in media pieces, but many policy submissions (both supportive of and critical of the HSR) also argue for modifications to the policy to protect against corruption.

Table 1 compares the social values (often hidden) underlying in NHI policy rhetoric to the values explicitly stated in policy documents. While there is some overlap, such as between national unity and a unified health system, and between redress and reconciliation and 'healing the divides of the past', there are also some notable differences. For example, socialism and redistribution, ideological neutrality and the free market are often invoked in NHI policy rhetoric but are not explicit in policy documents. Conversely, equity, fairness and human rights are often explicitly stated in policy documents but were not evident in NHI policy rhetoric. In addition, some of the values identified in NHI policy rhetoric are closely related to explicit policy values but are subtly distinct. Fiscal conservatism might be considered inappropriate as a policy value, for instance, but can be alluded to through the more acceptable 'efficiency'. Similarly, 'redress' is a politically fraught issue, while 'social justice' is vague enough to be inoffensive. In other words, the social values that have rhetorical power sometimes differ, either subtly or completely, from the social values that can be explicitly endorsed. This raises important questions: Why do these particular values have rhetorical power in the South African context, and what political realities explain the difference between the named values of the

NHI, and the values that have rhetorical salience? In the next section, we seek to explain the salience of these particular social values in NHI policy rhetoric by contextualising them in relation to South Africa's contemporary and historical social and political realities.

Social values underlying NHI policy rhetoric	Social values explicitly stated in NHI policy documents
National unity	Unified health system
Socialism and redistribution	
Redress and reconciliation	Social justice and healing the divides of the past
Healthcare as a public good	Healthcare as a public good
Fiscal conservatism	Efficiency
Free market	
Personal responsibility	
Rationality and ideological neutrality	
Transparency and impartiality	Sound governance and democracy
Private provision of healthcare	
	Fairness
	Equity
	Human rights

Table 1: Comparing social values underlying NHI policy rhetoric to social values explicitly stated in policy documents

Explaining the salience of social values with reference to social and political context

To locate the social values identified in NHI policy rhetoric in social and political context, in this section we discuss each value in turn, connecting them to the issues, events and upheavals that help to explain their salience in the South African context.

Healthcare as a public good

As noted above, most NHI policy rhetoric draws on 'healthcare as a public good' or public provision of health services as a social value. This is clear, for example, in Coovadia *et al.*'s (1986) argument that privatisation "in practice means abdication of the State's responsibility to provide care for all." In South Africa, the idea that healthcare is a public good, and that the state has a responsibility to deliver health services has a long history. The 1926 Pienaar Commission on Old Age Pensions and National Insurance recommended social insurance for illness and unemployment for the formally employed, and marked a significant shift from social welfare as the purvey of religious institutions, to a core responsibility of the state (Seekings 2016). Between the 1940s and the 1970s, this idea persisted, and the private health sector was (until the 1970s) tolerated but tightly regulated by the apartheid government (Price 1989, 1990).

More recently, the advent of the AIDS epidemic in South Africa, in particular the state's attempt to abdicate responsibility to those affected and the massive civil society movement that emerged in response, helped to reprioritise the welfare state and public provision as social values, and likely underlies the value contemporary South African's place on healthcare as a public good.

The ANC government's first macro-economic policy, the Reconstruction and Development Programme (RDP), emphasised that housing, healthcare and education were state responsibilities (Paremoer 2015). However, by requiring the state to redistribute funds and expand healthcare services to meet the needs of the poor, the AIDS crisis tested the limits of this commitment. Under President Thabo Mbeki (Mandela's successor who was president from 1999 to 2008) the government resisted rolling

out an HIV treatment programme – a catastrophic delay that cost many lives, justified by a combination of AIDS-denialist rhetoric and budgetary constraints (Nattrass 2011) (see Appendix 6b for an explanation of the AIDS epidemic and AIDS-denialism in South Africa. A massive civil-society effort, led by the Treatment Action Campaign (TAC) eventually compelled the government to implement an HIV treatment programme, and in doing so, forced the state to redirect resources to the poor (Heywood 2009). As Robins *et al.* (2004) point out, the TAC's advocacy in the face of government's arguments that the available treatments were simply too expensive, presented an ideal case with which to test the state's obligations to citizens. Thus, the success of the TAC's campaign likely increased the importance of the value of the public health services, especially relative to fiscal conservatism (discussed below).

In addition, commentators argue that the struggle for AIDS rights introduced a discourse with which to counter the personal responsibility discourse that supports the state's abdication of the social welfare role. Responses to the AIDS crisis put the responsibility on the individual not only with respect to prevention ('condomise or abstain') but also with respect to treatment – as antiretroviral (ARV) treatment requires people living with HIV to adhere to complex treatment regimens indefinitely. Thus, the realities of HIV treatment, if not always the civil society movement for ARVs (which sometimes employed individualist discourses that emphasise personal responsibility)[5] made clear what kinds of health system and social support are necessary in order for citizens to become 'responsibilised', including education and supportive and accessible service provision (see Robins *et al.* 2004, Paremoer 2015). In other words, the HIV epidemic helped to push responsibility back onto the state, and re-emphasised the importance of public health services.

However, although the fight for HIV treatment likely reprioritised discourses drawing on healthcare as a public good as a social value, this value is less evident in arguments after the early 2000s, suggesting that it gradually lost salience. This is likely the result of a combination of factors including the rise of neoliberalism in South African politics, and a loss of trust in the state, driven by corruption and poor service delivery (discussed below).

Personal responsibility

Personal responsibility as a social value is also evident in NHI policy rhetoric, as visible in the Actuarial Society of South Africa's submission on the 1997 White paper which argues against HSR using individualist values, stating that it would involve "too few active people who are required to pay for too many old people" and suggesting that individuals should be allowed to opt out of the NHS, "in order to provide for themselves via the private system" and should then not be allowed to "fall back on State support" (1997).

[5] Paremoer (2015) suggests that some of the TAC's tactics may have reinforced the neoliberal idea of personal responsibility by legitimising a conceptual distinction between the 'deserving poor' and the 'undeserving poor'. In the landmark 2001 Hazel Tau case, for access to ARVs, the TAC made a rights-based argument that hinged on the economic contribution of workers – pointing out the economic benefits of ensuring the health of workers. Paremoer (2015) argues that this rhetoric reflects the dominance of neoliberal ideas at the time because it framed "the 'working poor' as an especially deserving subgroup of the 'deserving poor'" and therefore legitimates the idea that some individuals will 'over-use' essential services, and that those who do not 'contribute' to society are not deserving of social protections (see also Price 1994). The idea that social assistance should not be universal because some individuals are more deserving than others, even among the poor, is widely accepted in South Africa (Button *et al.* 2018, Seekings 2018).

The salience of this social value in South Africa was clear as far back as the 1920s when the Pienaar Commission that introduced the idea that the state has a responsibility for health service provision also sparked a conservative backlash that drew on personal responsibility as a social value to argue against health and welfare as public goods (Seekings 2008a) (see Appendix 6b). Later, in the 1970s and 1980s, the National Party's privatisation policies, and the uptake of neoliberal ideas within the ANC reemphasised personal responsibility as a social value.

Despite the tighter regulative environment instituted by the National Party from the 1940s, the private sector continued to grow, and in the late 1970s and early 1980s a combination of neoliberal economic ideas, political imperatives, and fiscal constraints shifted the National Party's attitude toward the private sector (Price 1994, Waterhouse *et al.* 2017). The Party undertook a purposeful programme of privatisation in the health sector beginning in the mid-1980s (Naylor 1988, Price 1988). The result was a contraction in public spending on health, privatisation of health services, and deregulation of the private health sector (Naylor 1988, McIntyre *et al.* 2006). This included relaxing licensing rules to encourage the construction of new private facilities, increasing public sector fees to encourage patients to use private services, and amending legislation to remove protections afforded to medical scheme members (Price 1994, Gilson *et al.* 1999, McIntyre *et al.* 2006).

By de-regulating and de-racialising the private sector, the National Party was able to reduce public spending, and dampen political tensions by making private healthcare accessible to black people who could afford it (thereby co-opting black elites), without having to make the ideological concession entailed by extending equitable public health services to people of all races (Andersson *et al.* 1988, Naylor 1988, Price 1988, 1989). Relieving the state of the burden of healthcare provision meant that the contentious issue of the difference in quality of public healthcare for different racial groups could be resolved by market forces – race-based discrimination would be replaced by class-based 'selection', and therefore 'de-politicised' (Naylor 1988, Price 1989). Thus, as Seekings (2007b) puts it, the "state-imposed privileges of being [w]hite" are transformed into "advantages of class that were rewarded by markets", so that those privileges could be continued even while policies of formal racial discrimination began to be dismantled.

The deliberate unburdening of the state of the responsibility for healthcare provision was justified by individualist social values (Broomberg *et al.* 1991). The 1984 Constitution, for example, justifies market-based mechanisms for social welfare with rhetoric that emphasised the responsibility of the individual 'for her own welfare' (Hilton 1988). Similarly, the report of a 1985 NDoH meeting on privatisation stated explicitly that "unlimited free healthcare is a privilege not a right," that "the individual is responsible for his/her own health," and calls for "shedding government functions to the private sector" (Naylor 1988). A 1986 Commission of Inquiry on health services argued similarly that the state is only responsible for the healthcare of the indigent (McIntyre *et al.* 2020), and that "the community must learn to help and organise itself" (Andersson *et al.* 1988). Increasing fees in the public sector also meant that whether they accessed care in public or private sectors, most individuals had to bear some responsibility for paying for their own care (Price 1994, McIntyre *et al.* 2020).

In addition, contextual realities at the time likely contributed to cementing personal responsibility as a social value. Seekings (2018) suggests that rapid urbanisation, spurred by the abolition of the 'pass laws' in the mid-1980s (which restricted movement of black people, see Appendix 6b), contributed to

the acceptance of personal responsibility as a social value, because it entailed a weakening of kinship relations that would previously have formed an informal social safety net.

Rhetoric drawing on personal responsibility as a social value was also used by the ANC both before and after the transition to democracy. For example, the ANC's 1992 'Ready to Govern' election manifesto frames social welfare as 'handouts' (ANC 1992), and Mandela stated in his inaugural presidential address that 'development' and 'job creation' were needed, not 'handouts' (Seekings 2015, Button *et al.* 2018). This was in keeping with the ANC's adoption of neoliberal ideas and a concordant commitment to building a developmental state rather than a welfare state (discussed further below) (Seekings 2015). Accordingly, the early 2000s saw social services "increasingly reduced to mere commodities" (Bond 2014a) (see Appendix 6b for an account of the commodification of water in this period).

Thus, personal responsibility as a social value and discourse that positions public services as only for the 'deserving' poor (Seekings 2018) proved to be a persistent pattern in welfare policy debates in South Africa. Efforts to expand child support grants, in the early 2010s, for example, were met by a conservative backlash that emphasised personal responsibility and contrasted it with 'dependency' on the state (Button *et al.* 2018). This discourse was incorporated into policy and reinforced by policymakers (Button *et al.* 2018). For example, in 2015, in a speech to traditional leaders, President Zuma (who succeeded Mbeki and was president from 2009 to 2018) characterised teenage mothers as irresponsible and bad parents, arguing that they were cheating the system by claiming child support (Button *et al.* 2018). In 2016 then-Minister of Human Settlements argued that giving people houses for free would create 'dependency' and that the state should instead give subsidies that encouraged people to build houses for themselves (Xaba 2016). Similarly, the 2012 White Paper on Social Development emphasised 'self-reliance', rejected 'dependency' and downplayed the obligation of the state (Button *et al.* 2018).

Socialism and redistribution

The uptake of personal responsibility rhetoric within the ANC was at odds with the Party's longstanding connection to socialist values, which have been used in arguments for HSR since the 1940s (see Appendix 6b). This value is evident, for example, in the argument made by academics and health professionals in the 1980s that the commodification of healthcare is inherently problematic (see for example Benatar 1985, Coovadia *et al.* 1986). However, rhetoric drawing on socialist values to argue for HSR is less prominent after the 1980s and is mostly evident in the rhetoric of academics and civil society and rarely in the media.

The socialist roots of the ANC and the central role of the ANC and socialist values in the struggle against apartheid (Cronin 1986, Peet 2002) help to explain the salience of this value in NHI policy rhetoric. Historically many ANC principals were members of the SACP, and the ANC employed anti-capitalist rhetoric to unite an ideologically diverse coalition in the project of overthrowing apartheid (Williams *et al.* 2000, Lodge 2009). The ANC's 1955 Freedom Charter contained prominent redistributive rhetoric, for example, stating that "the mineral wealth beneath the soil, the banks and the monopoly industry shall be transferred to the ownership of the people as a whole," and promised a universal, state-run health scheme (ANC 1955, Williams *et al.* 2000). In the 1980s when the apartheid government began implementing deregulation and privatisation policies, policy debates were shaped by the "antagonistic positions of apartheid and the (revolutionary) opposition in the political sphere,

and monetarism and its more or less socialist critiques in the sphere of economic policy" (Price 1994). Furthermore, the ANC's alliance with the SACP and COSATU ensured a socialist and pro-poor tendency in the Party's policies that persisted until the late 1990s (Southall *et al.* 1999, Williams *et al.* 2000, Baker 2010). COSATU, in particular, supported a publicly-administered NHI, over proposals for a more moderate SHI, on the grounds that it enabled moving away from private provision and incorporating private sector resources into the public sector (COSATU 1998, 2000).

In the 1980s and early 1990s, in the context of rising inequities in access and quality of care and the abdication of the state's responsibility for health services provision, the idea of universalist HSR was supported by progressive academics and health activists (Gilson *et al.* 1999, Doherty *et al.* 2000). Drawing on proposals for radical HSR introduced in the 1940s (see Appendix 6b), and influenced by the Alma Ata declaration of 1973, a number of civil society and academic actors were also arguing explicitly against privatisation and commodification, and for a NHS that would supplant the private sector[6] (Price 1994, Gilson *et al.* 1999). The 'nationalisation' of health services was discussed within radical segments of the ANC and health-focused civil society until the early 1990s (Van Niekerk 2007). This loose coalition produced a wealth of research and policy proposals in the late 80s and early 90's that influenced the development of the initial health policy proposals of the ANC, which was soon to win power in the Country's first democratic election (Gilson *et al.* 1999, McIntyre *et al.* 2003).

Accordingly, the initial stages of the ANC's health policy development reveal the influence of socialist values. A 1991 ANC discussion document entitled 'Towards developing a health policy' states that the private sector should 'become part of' the NHS, and describes financial resources for health as being 'caught up in' the rich private sector (Waugh 1991). Similarly, the 1992 *Ready to Govern* policy document, released as the ANC prepared to take power, demonstrated a residual influence of socialist ideas insofar as it promoted 'growth through redistribution' and used rhetoric of de-commodification with respect to social services (Williams *et al.* 2000, Van Niekerk 2007).

However, in the late 1980s and early 1990s, a range of political, ideological, and economic factors began to push the ANC toward a more orthodox social and economic policy position. Beginning in 1986, as a result of evidence of economic stagnation in Marxist and radical nationalist countries, and the collapse of communism between 1989 and 1991, the ANC's ideological position and rhetoric shifted away from socialist and nationalist ideas and towards liberal democracy (Glaser 1997, Gilson *et al.* 1999). 1994, the moment when the ANC was at last able to establish itself as the democratic government of South Africa, was a "moment of globalisation and the ascendancy of neoliberalism" (Von Holdt 2019). In addition, the ANC was under significant economic pressure to reassure international investors that economic growth would be prioritised under the new government, and to avoid alienating South African established capital and the emerging black capitalist class (Seekings *et al.* 2011, Bond 2014b). On the day of his release from prison, in 1990, the head of the ANC and soon-to-be president, Nelson Mandela, made a speech affirming the Party's commitment to radical redistribution and nationalisation (Nattrass 1994b). These statements prompted a considerable backlash and had a negative effect on the stock market, and Mandela later said that nationalisation would only be considered if it made economic sense (Kentridge 1993, Peet 2002). Furthermore, the political negotiations that ensured a peaceful transition to democracy entailed that all parties winning

[6] See for example Benatar 1985, Coovadia 1986 and De Beer *et al.* 1990.

at least 10% of the vote in the 1994 elections would form a Government of National Unity (GNU). As such, while the ANC won 63% of the vote, and Nelson Mandela was appointed president, the GNU (which governed from 1994 to 1999) fused revolutionary socialism with democratic nationalism (Gilson *et al.* 1999, Van Niekerk 2007, Baker 2010).

The neoliberal doctrine became increasingly hegemonic even within the ANC, and began to shape the Party's macro-economic policy agenda (Williams *et al.* 2000, Van Niekerk 2003). By 1993, the ANC had dropped all explicit reference to socialism from policy documents (Kentridge 1993), and in 1994 Mandela was quoted in a newspaper saying "in our economic policies…there is not a single reference to things like…nationalisation, and this is not accidental. There is not a single slogan that will connect us with any Marxist ideology" (quoted in Baker 2010). This shift toward neoliberalism as a dominant ideology helps to explain why socialist values are less salient in contemporary policy rhetoric.

However, although the ANC's commitment to nationalisation waned in the face of economic and political pressure, the ideational link between NHI and socialist values persisted. Health Minister Dlamini-Zuma, appointed in 1994, had a relatively radical stance on redistribution and redress, and was described as 'socialist' and an 'idealogue' (Bond 1999, Gilson *et al.* 1999). Dlamini-Zuma established a series of deliberative committees to support policy development for HSR, including the Health Care Finance Committee (HCFC) to establish the feasibility of an NHI in South Africa (Gilson *et al.* 1999, Thomas *et al.* 2004). The HCFC included Australian economist, Dr John Deeble, who advocated for a 'radical' form of NHI under which private health practitioners would be nationalised – a position that appealed to the ideological stance of the Minister (Gilson *et al.* 1999, Thomas *et al.* 2004). HCFC reports describing the Deeble option were leaked to the press (some argue this was done purposefully to drum-up opposition to a more radical HSR), and the plan was described disparagingly as 'socialist' in a number of news articles (Breier 1995, Staff reporter 1995c, Gilson *et al.* 1999). Ultimately, the HCFC recommended a more moderate SHI under which benefits would be restricted to contributors and their dependents, and medical schemes would act as financial intermediaries (Gilson *et al.* 1999). Two successive deliberative committees were established – the Committee of Inquiry into NHIS in 1995 and the SHI Working Group in 1997 – but both considered the Deeble option infeasible (Gilson *et al.* 1999, Thomas *et al.* 2004). Many media articles reporting on the process drew on anti-socialist discourses and discourses that assume state actors are untrustworthy to oppose radical HSR (Gilson *et al.* 1999). For example, a 1995 article states that the scheme was "devised by socialist Australian health economist John Deeble," and quotes an opposition party spokesperson as saying that "Dr Zuma and her 'apparatchiks' were determined to appoint one committee after another until they found one that would rubber stamp their health plan" (Breier 1995). The ideational association between Dlamini-Zuma and HSR efforts likely cemented the idea that the NHI is a socialist reform, and the changing global ideational climate enabled stronger counter arguments that draw on anti-socialist values.

The free market

Some such arguments opposing reforms use discourse that connects market-based mechanisms to value-free decision-making or discourse that frames participation in markets as a right, thereby drawing on the free market as a social value for rhetorical power. For example, in 2008, the ANC's opposition, the Democratic Alliance, argued that NHI proposals "remove many of the elements from the market for health care that have been shown across the world to be essential components of any

properly functioning market, and competition and choice in particular" (quoted in McLeod 2009a). Similarly, a 1995 media article argues that it is 'bad reasoning' to suggest that "rich people should not be allowed to buy better healthcare than the poor" "simply because of the desirability of universality" (Staff reporter 1995b).

The salience of these values in the South African context likely reflects the current realities of the divided health system. As noted above, until the 1970s, the South African government operated on the assumption that the provision of health services was primarily the responsibility of the state (Price 1988, 1989, Seekings 2008a), and until the mid-1980s it was relatively uncommon for South Africans to seek care in the private sector, with most medical scheme members receiving public sector care which was paid for by the medical scheme (CCSA 2018). Neoliberal privatisation policies in the 1980s, however, allowed the National Party to 'de-politicise' healthcare provision, and led to the rapid growth of private provision of healthcare (McIntyre *et al.* 2020). Because neoliberal privatisation and deregulation policies are based on the idea that the private sector can provide healthcare more efficiently, they exonerate the state of the responsibility to provide healthcare in the public sector (Klopper 1986) and reinforce the idea that "unregulated markets are legitimate arbiters of fundamental political questions" (Paremoer 2021).

Under the ANC government, neoliberal macro-economic policies ensured the continued growth of the private sector, and resulted in a decline in government commitment to health care (Ataguba *et al.* 2012). While the ANC's pre-election policy guidelines committed to regulation of the private health sector, in the years immediately following the democratic transition, the government's health policies focused predominantly on strengthening the public sector, and neglected, almost entirely, the regulation of the private sector (ANC 1992, McIntyre *et al.* 2006). McIntyre *et al.* (2006) argue that this failure to regulate the private sector was a result of "deep-seated ideological concerns about the private for-profit health sector, and a distrust of its motives and objectives."

Later attempts to regulate the private health sector proved largely unsuccessful. The National Health Act of 2003 introduced two notable provisions intended to prepare for HSR by addressing high costs in the private sector and inequities in access to private healthcare (McIntyre *et al.* 2020). Firstly, the Act gave the NDoH authority to regulate the construction of new, or expansion of existing, private health facilities through a Certificate of Need provision (Republic of South Africa 2003, CCSA 2018). However, in 2015 the Hospital Association of South Africa and the South African Dental Association successfully challenged the provision in the Constitutional Court (Harrison 2009, Waterhouse *et al.* 2017), and the Certificate of Need policy was never implemented (SAPPF 2018).

Secondly, the National Health Act imbued the NDoH with the power to publish a reference price list (Berger *et al.* 2010). The inclusion of this provision was a response to the Competition Commission finding against the South African Medical Association and the Board of Healthcare Funders (in two separate investigations) that the publication of collectively determined tariffs was anti-competitive (Berger *et al.* 2010). However, neither the NDoH nor the Council for Medical Schemes (to which the responsibility was initially delegated) have published a reference price list since 2006, and in 2010 a provincial High Court struck down the relevant regulations, saying that due process had not been followed, that the NDoH could not use information garnered from the private sector to establish benchmark prices, and reinforcing the idea that private healthcare should be treated as a commodity like any other (Berger *et al.* 2010). Berger *et al.* (2010) suggest that this case demonstrates the power

of the private sector to oppose regulations that are against its interests. In addition, however, the ruling reflects a prioritisation of market-values over the interests of medical scheme members, who are liable for the difference between what is charged by the provider and what is covered by the medical scheme (CCSA 2018). The initial inattention to the responsibility of the government to regulate for-profit providers, and subsequent failures to do so, reinforces the idea that it is appropriate for healthcare to be left to 'the market'. In addition, the size of the private sector, and the length of time for which it has been a major element of the South African health system, means that many South Africans, comprising a politically powerful majority, are habituated to receiving privately delivered healthcare.

Furthermore, distrust in the state as either a provider or regulator of healthcare further prioritises the value South Africans place in a healthcare market free from government interference. As a result, the ideational connection between President Zuma (who took office in 2009) and NHI, means that free market values have particular salience in the South African context.

After the NHI policy process slowed during the Mbeki presidency (1999-2007) (Waterhouse *et al.* 2017), the ascendence of Jacob Zuma to the presidency of the ANC in 2007, and of the country in 2009, reignited the policy process (Gilson 2019). Zuma had been Mbeki's deputy president, but was dismissed by Mbeki after courts found he was involved in a corrupt relationship with businessman Schabir Shaik (Camerer 2011, Seekings *et al.* 2011). However, the charismatic Zuma, who was known as a populist with a close relationship to leftist groups including SACP and COSATU, was able to take advantage of general disaffection with Mbeki's 'cold' neoliberal macro-economic stance (Lodge 2009, Von Holdt 2019). Mbeki was recalled by the ANC in 2008 shortly before the end of his presidential term, and a year after Zuma had won the presidency of the ANC at the annual conference in Polokwane (Camerer 2011, Pillay *et al.* 2013). Zuma's ascendence represented a significant boon for NHI policy development, both because it led to political support for NHI as part of the ANC's populist platform, and because Zuma appointed a charismatic and passionate advocate of NHI, Dr Aaron Motsoaledi, as Minister of Health (Pillay *et al.* 2013, Gilson 2019). Zuma also had the support of the SACP and COSATU, including COSATU's support for a radically redistributive NHI (Waterhouse *et al.* 2017).

However, Zuma's presidency was characterised by governance failures and corruption scandals (see Appendix 6b), and Zuma himself came to be popularly associated with 'state capture'[7] in which Zuma used his power as president to reorient state institutions towards the enrichment of a select group of elites (Bhorat *et al.* 2017, Budhram 2019). Zuma's eventual political demise began in March 2017 when he reshuffled the cabinet over the weekend in order to gain control over the national treasury – an action which sparked massive protest action and a vote of no confidence in Parliament (Bhorat *et al.* 2017, Von Holdt 2019). In 2018, Zuma resigned the presidency after being recalled by the ANC (Potgieter 2019, Von Holdt 2019).

The political saga between Mbeki and Zuma cemented a broader ideological tension between neoliberalism, rationality and the rule of law on one hand, and populism and corruption on the other (Hart 2014). As such, the close association in the public consciousness between Zuma and grand-scale

[7] State capture refers to a state of affairs where small groups of elites are able to use state functions and processes for private enrichment through domination or corruption of state officials or influencing laws and regulations in their own interests (Desai 2018).

corruption also likely further prioritises the value of the free market (or a healthcare market free from government interference) and strengthens arguments based on distrust in the state. In NHI policy rhetoric, the failure of state-owned-entities, particularly the national power utility, is frequently raised as a concern in relation to whether the state has the capacity to run the NHI, even by actors generally supportive of HSR.

Transparency and impartiality

Aids denialism, state capture, high profile governance failures, the betrayal Zuma's promised populism, and the battle to oust Zuma from the presidency contributed to a significant loss of trust in the state (Wale 2013, Potgieter 2019), which also reprioritises the values of transparency and impartiality. These values are evident, for example, in a 2009 long-form article by a private-sector industry insider which suggests transparency as the first of four principles for HSR, and asserts "thus far, the NHI debate has been held behind closed doors" (Broomberg 2009). These social values are used in policy rhetoric to discredit the policy process for HSR by suggesting that they have been unduly influenced by private interests.

The salience of these social values seems to have increased in response to both low levels of trust in the state, and the NHI-related politicking that unfolded under President Zuma. In 2006, the Zuma-allied Gupta family hired a UK-based public relations firm to divert public attention away from the state capture project by, among other strategies, using disinformation and propaganda to push the idea that 'white monopoly capital' was preventing economic liberation (Bhorat *et al.* 2017). Those within Zuma's 'power elite' used the term 'white monopoly capital' to argue that the state was not captured by Zuma and the Guptas but rather that the 'real state capture' was at the hands of established white capital (Desai 2018). Zuma accused the Minister of Finance at the time, who was thought by some to be blocking the NHI or allowing private interests to influence NHI policy-making, of being in the pocket of 'white monopoly capital' and tried to oust him through the cabinet reshuffle (Waterhouse *et al.* 2017).

On the other hand, then-Minister of Health Motsoaledi, who was perceived by many as working under the thumb of the private health sector to institute a private-sector-friendly NHI, was among those calling for Zuma to step down (Waterhouse *et al.* 2017). Thus, in addition to discourse that assumes the state cannot be trusted to manage health funds because of the corruption of public officials, some of the NHI policy rhetoric using transparency and impartiality as social values draws on discourse that assumes the state cannot be trusted to develop NHI policy because of the influence of private sector actors. As such, while transparency and impartiality were also evident in rhetoric from the late 1990s, they are clearly made more salient by the political dynamics surrounding the NHI policy process, and by a general loss of trust in the state.

The right to choose and private provision

While some policy rhetoric uses discourse that suggests the policy process has been unduly influenced by private sector actors, Motsoaledi was perceived by many as brazenly *hostile* to the private sector (especially later in his tenure), and his 'strongly-worded critiques' and 'general intolerance' of the private sector were widely reported in the press (Waterhouse *et al.* 2017). This enabled arguments against the NHI that position NHI, Motsoaledi or the ANC as a threat to medical schemes, the private sector, or medical scheme members, and draw on access to private healthcare as a social value to do so. The salience of this social value likely reflects the political role access to private healthcare played

under apartheid, the ANC's promotion of a black capitalist class with access to private healthcare and education, and popular perceptions of low-quality care in the public sector in contemporary South Africa.

For the apartheid government, access to private healthcare was an important political tool. The National Party's deregulation policies resulted in considerable growth in private funders and providers in the late 80s and early 90s, as noted above. This growth was driven, in part, by increasing medical scheme membership among the black population, and reflected the undignified and poor quality of care black people received at public hospitals under apartheid (Price 1989, 1990). Indeed, one of the objectives of the National Party's privatisation policies was to undercut opposition to apartheid and co-opt black elites by making quality healthcare available to urban, employed and wealthy black people. In addition, because medical scheme membership was unaffordable in the absence of full-time employment and a regular income, it was more common among members of trade unions, and many trade unions advocated strongly for medical scheme membership for their members (Price 1989, Broomberg *et al.* 1991). These realities meant that, certain segments of the black population could access private healthcare services "which [were] equal to the care available to whites, in a non-segregated, and racially non-discriminatory setting" (Price 1988) and "would no longer experience the segregated, unequal and grossly overcrowded health facilities provided by the government for the majority of blacks" (Price 1989). In this way, access to private healthcare took on an ideational significance as a valued symbol of freedom and empowerment.

Furthermore, for the ANC, or at least some factions within the ANC, the creation of a black capitalist class was a political imperative, an idea that may well have helped to cement the importance of access to private healthcare among South Africa's economic elite. By the time the ANC came to power through the first multi-racial and democratic election in 1994, an ideological tension between socialist and neoliberal ideas had developed within the party (Madore *et al.* 2015). For some in the Party, the anti-apartheid movement was necessarily anti-capitalist, because capitalism and apartheid were part of a single oppressive project, and liberation meant nationalisation and radical redistribution. Others believed the redress of apartheid necessitated the economic liberation of the black majority and the creation of a black capitalist class (Seekings *et al.* 2011, Worden 2012, Cronin 2020).

In addition, the rise of neoliberalism in the ANC (discussed above) gave rise to the discursive challenge of "making this ideology 'work' for the 'new South Africa'" (Van Zyl Slabbert quoted in Gilson *et al.* 1999). The solution was a nationalist ideology that promised the creation of a black elite and would unify the diverse interests of white capital and global capital (who wanted to see growth in the local economy), the growing black middle class, the aspiring black majority and organised labour (Baker 2010, Hart 2014). This persistent ideological commitment within the ANC holds that the promotion of a black capitalist elite is appropriate, just and in the best interests of the country (Seekings *et al.* 2011).

Under Mbeki, the political project to develop the 'new black elite' was achieved through privatisation and deregulation, legislation to accelerate black economic empowerment, and the creation of state-owned entities (Hart 2014, Von Holdt 2019). Under Zuma the ideological commitment to the creation of a 'new black elite' through radical economic transformation was used as a rationale for corruption

(Von Holdt 2019).[8] Given the conservative macro-economic strategies the ANC had committed itself to, and the power and economic domination of white capital, the informal political economy was the only possible way to address "the aspirations and burning sense of injustice of black elites and would-be elites in post-apartheid South Africa" (Von Holdt 2019). The result of this ideological project is increasing class divisions within the black population that are reinforced by socio-economic markers like private healthcare and education (Worden 2012). In this context, then, access to private healthcare takes on an unusual importance as a marker of political and economic liberation, and, for some, a symbol of the success of the anti-apartheid project.

In addition, the salience of private provision as a social value likely reflects concerns about quality of care in the public sector. Quality of care in the public sector had been declining since the 1980s, but the trend continued under the new administration (Gilson *et al.* 1999, McIntyre *et al.* 2009). In the early years of the new democracy, the ANC government undertook reforms to address apartheid inequities in the health sector – for example through dramatic budgetary redistribution to address geographic inequities, and making primary healthcare free of charge in public facilities through Mandela's free care policy (Gilson *et al.* 1999). However, these changes, combined with stagnating budget allocations and human resource challenges, led to a decline in quality of care which was extensively reported on in the press, and contributed to a general perception that public sector health care is low quality (Gilson *et al.* 1999, McIntyre *et al.* 2006). Weak leadership and management, governance failures, and human resource shortages and morale issues have continued to plague the public sector, and are regularly reported in the press[9] (Rispel 2016, Maseko *et al.* 2018). The 2015 Life Esidimeni tragedy, in which 144 mental health patients died after being transferred to unlicensed facilities (see Appendix 6b), received massive press coverage[10] and exacerbated negative perceptions of public sector healthcare (Durojaye *et al.* 2018, Gray *et al.* 2018).

In addition, there is a popular belief that care provided in the private sector is superior (CCSA 2018, Maseko *et al.* 2018). This perception persists despite the fact that there is no standard quality assessment mechanism and very little reliable information on the quality of care provided in private facilities (CCSA 2018). An Inquiry into competition in the private healthcare market by the Competition Commission (known as the Health Market Inquiry or HMI) found various 'market failures' and 'inefficiencies' that were driving dramatic escalations in healthcare and threatening to make medical scheme membership unaffordable (CCSA 2019). However, these are described, both in the HMI report and in the media, in technical and financial language, in stark contrast to the stronger and more evocative discourse used to describe public sector failures. For example, the term 'overservicing' refers to the provision or prescription of treatment that is not medically and clinically indicated and without due regard to the health interests of the patient. This is certainly an issue of quality of care, and the HMI report acknowledges that it "may even be disadvantageous to patients' health" (CCSA 2019). Nonetheless, for the most part, the issue is considered as problematic only insofar as it drives healthcare costs up and not as an indicator of poor quality (see Broomberg *et al.* 1990, Old Mutual 2005, Harrison 2009, CCSA 2019).

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[8] Of course, in reality the informal political-economic system expanded to undermine the functioning of the state, and the sheer scale of the corruption meant that the diversion of resources was unsustainable (Von Holdt 2019).

[9] See for example The Star 2004, Sokopo 2008, Sikakhane 2010, City Press 2011, Makhubu 2015

[10] See for example Mkize 2015, Citizen Reporter 2016, Germaner 2016, Mkize 2016

While there is no doubt that the public sector faces very real service delivery challenges and that many users experience poor quality care, there is also some suggestion that public perceptions of poor quality care in the public sector are a product of negative media reports rather than personal experience of poor quality care (McIntyre *et al.* 2009, Maseko *et al.* 2018). In addition, private sector care seems to be looked on more favourably regardless of evidence of 'market failures' and a lack of reliable information about the actual quality of care. That access to private healthcare is a social value in South Africa would help explain this persistent tendency. However, rhetoric explicitly citing private healthcare as a social value is relatively rare. More commonly, arguments are couched in terms of the right to participate in the healthcare market or the freedom to choose providers.

National Unity and reconciliation

Another set of social values evident in NHI policy rhetoric are national unity and reconciliation, sometimes including redress of apartheid-era inequities. South Africa's colonial and apartheid history imbues these values with particular discursive weight. As a result, racial disparities in access to private healthcare are, in South Africa, inherently problematic because they are an indicator of a failure to meaningfully recover from apartheid.

Above, we discussed apartheid privatisation policies in the 1980s as an attempt to de-politicise healthcare and undercut opposition from certain segments of the black population by allowing access to desegregated quality care in the private sector, and how inequities in access to private healthcare have reinforced class divisions in South African society. In truth, health and welfare policies in South Africa have been used deliberately to reinforce social divisions along racial lines since the 1920s (see Appendix 6b). The apartheid government used the health system as a mechanism to ensure differences in the quality of life enjoyed by different racial groups, by fragmenting the public health system along racial and geographic lines (Price 1986, McIntyre *et al.* 2006). In the 1980s, there were 10 distinct health departments for each of the 10 homelands (see Appendix 6b), four provincial health departments responsible for public hospitals, and three health departments for white, coloured and Asian administrations (Andersson *et al.* 1988, Coovadia *et al.* 2009). Official apartheid ideology held that, with respect to health and social welfare, each racial group was responsible for its own members (Seekings 2008b).

The transition to democracy urgently required a cultural and ideological shift to create national unity, i.e. a deliberate state-led project to engineer a sense of a united, coherent and reconciled South African society (Chipkin 2007, Paremoer 2020). In the mid-1990s, the discourse of the 'rainbow nation', including the idea of non-racial national unity, was key to the post-apartheid nation-building project and the creation of the 'new South Africa' (Seekings 2008b, Hart 2014). Rainbow nation discourses are associated with Mandela and the 'ecclesiastical' discourses of forgiveness and reconciliation that characterised the Truth and Reconciliation Commission (Hart 2014, Paremoer 2020).[11]

Nation-building requires increased interaction and shared experiences between South Africans of different racial groups and the erosion of disparities in quality of life (Gibson 2004, Seekings 2008b). Post-1994, Mandela recognised healthcare as central to the nation-building project (Doherty *et al.*

[11] The Truth and Reconciliation Commission was established in 1995 by the Promotion of National Unity and Reconciliation Act as part of the nation-building project. The core challenge was to create a sense of a united South African society (Chipkin 2007, Hart 2014).

2015) and used health policy as a tool for transformation through which those previously excluded and disenfranchised would become ‘beneficiaries’ of ‘compassionate health policy’ (Mandela 1997). Over the years, the ANC government has introduced a number of equity-oriented policies aimed at redressing the harms of apartheid, including, in the health sector, primary healthcare and ARV programmes which focus explicitly on redressing apartheid inequities (Rispel 2016).

However, despite the increase in medical scheme membership among the black population in the late 80s and early 90s (discussed above), inequities in access to private healthcare in South Africa continue to run along racial lines. Membership fees increased dramatically in the decade before 1994, and were increasingly unaffordable (Pillay *et al.* 1995, Republic of South Africa 1995). This trend continued under the new government and into the new millennium (McIntyre *et al.* 2006, Madore *et al.* 2015). In 2010, 17.6% of the population had medical scheme coverage, but while 70.9% of white people, and 46.8% of Indian people were medical scheme members, only 21.8% of coloured people, and 10.3% of black people were covered (Mayosi *et al.* 2012). Since then, the percentage South Africans who are members of a medical scheme has remained fairly constant at around 16% (Madore *et al.* 2015, McIntyre *et al.* 2020). However, while 73% of white people are medical scheme members, only 17% of coloured people and 10% of black people are medical scheme members (van den Heever 2019a). Accordingly, present discrepancies in access to private healthcare are still ideationally associated with racial inequities and apartheid (Maseko *et al.* 2018).

The long history of deliberate inequities in the health sector, and the importance of ‘national unity’ in the transition to democracy, help to explain the salience of this value in NHI policy rhetoric. Creating a coherent and unified national health system in the form of a NHI – a health system which all South Africans would use – is sometimes explicitly positioned as part of the nation-building project (Bateman 2009). In addition, national unity is often used to justify social solidarity in HSR proposals – such as when Health Minister Zweli Mkhize stated that the NHI “depends on our willingness to SHARE as ONE NATION” (emphasis speaker’s) (Mkhize 2019).

However Hart (2014) argues that the ‘rainbow nation’ was undermined by “ideological cleavages of class and race” and that its ideational power soon dissipated (Hart 2014). Under Mbeki, the nation-building project transitioned from a focus on forgiveness and the non-racial rainbow nation, to positioning the ANC as advancing the battle against racism (Hart 2014). The re-emergence of the land reform as a pressing policy issue in 2007 (see Appendix 6b) and later the Fees Must Fall student’s movement in 2015 served to highlight the shortcomings of ‘rainbow nationism’ and the ‘forgive and forget’ approach to reconciliation, and to reprioritise more radical forms of redress. The Rhodes Must Fall and subsequent Fees Must Fall protests on South African Campuses saw student activists, catalysed by student housing crises and colonial iconography on campuses, mobilise behind a demand for free higher education and the decolonisation of higher education. (Pillay 2016, Hodes 2017, Francis *et al.* 2019). The protests drew attention to the substantive shortcomings of the transformation project and the sense of betrayal that emerged from Zuma’s corruption scandals, and signified “an end to the politics of hope and patience” (Pillay 2016).

In fact, the vast majority of South Africans believe that black people are still poor and white people still wealthy as a result of apartheid, and that redress of this inequities is important (Potgieter 2017, 2019). In recent years, reflecting a recognition that South African society is still sharply divided along racial lines, nation-building and social cohesion have re-emerged in policy discussions (David *et al.*

2018). Correspondingly, alongside arguments based on national unity and reconciliation, NHI is sometimes more explicitly connected to the inequities and injustices of apartheid and positioned as a mechanism for redress. Such arguments draw on redress as a social value, rather than on national unity.

Rational or 'value-free' policy-making

McIntyre *et al.* (2007) agree with Hart (2014) that the power of national unity as a social value diminished fairly quickly following the transition to democracy, writing that the "spirit of social solidarity" and corresponding "willingness to accept relatively large cross-subsidies" that were inspired by the political transition of 1994 soon waned (McIntyre *et al.* 2007). In addition, the collapse of the Soviet Union, and the global hegemony of neoliberal ideas in the GNU-era weakened anti-capitalist and redistributive positions and made possible arguments that assert neoliberal policy solutions as 'common-sense' (Baker 2010) (see Appendix 6b for an account of the social values associated with neoliberalism). Thus, the ideological shift in the ANC's rhetoric and policy in the early years of the new democracy (discussed above) can be understood as a shift from the radical to the orthodox, given the extent to which global economic institutions were very actively promoting neoliberal policies (Nattrass 1994a, Nattrass *et al.* 2001). Kentridge (1993) writes that those expounding the virtues of a free-market approach felt that their argument was self-evident, and that ANC members had to be 'educated' to the 'economic realities of the world.' Media responses to the ANC's 1992 Ready to Govern document similarly dismissed any alternative to neoliberalism as 'non-sensical' (Williams *et al.* 2000). By 2003, proposals for a progressively financed SHI with substantial cross-subsidisation were widely considered 'too idealistic' to be feasible (McIntyre *et al.* 2003).

In this discursive context, arguments against NHI need only imply that a proposal or decision is motivated by ideology to discredit them, reflecting the power of 'rational' or 'value-free' policy-making as s social value. Accordingly, much NHI policy rhetoric suggests universalist reforms are inappropriate because they are 'ideological', drawing on discourses that assume market-based mechanisms are economically and technically 'rational' or value-free. For example, an article in the Financial Mail, entitled 'Will Zuma back off?' reads, "speculation is rife as to whether any of the discredited socialist principles of the Deeble model will survive...Zuma is said to favour the Australian-authored model but industry consensus is that commonsense [sic] will win the day" (Staff reporter 1995c). While the content of the NHI policy proposals shifted over time to be more accommodating of the private sector (van den Heever 2016, Waterhouse et al. 2017), arguments that NHI is too radical to be realistic, and that those proposing or defending it were ideologues, persisted.[12]

Fiscal conservatism

The salience of 'rational' policy-making in NHI policy rhetoric is also used to support arguments based on the unaffordability of reforms. Despite the experience of the AIDS epidemic – which, as argued above, reprioritised the salience of healthcare as a public good, even in the face of fiscal constraints – much policy rhetoric opposing HSR, especially in the media, presents the unaffordability of HSR as brute fact (see CMS 2011, Mcintyre 2019). For example, Streek's (1995) article on the draft HCFC report opens with the claim "we simply can't afford reforms." Similarly, in a 2014 published commentary, an industry insider accuses Motsoaledi of "painting a picture…that simply cannot be,

[12] See for example Citizen 2004, Duncan 2009, AfriBusiness 2016

unless…one ignores and disregards the realities of South Africa's budgetary and human-resource constraints" (Archer 2014).

However, the role of National Treasury in the policy process makes clear that decisions about what the country can afford are themselves values-based. In the years immediately following the 1994, Treasury repeatedly opposed any reforms that would increase the tax burden (Gilson *et al.* 1999). This opposition was a result of a normative judgement about what levels of taxation are 'fair' or appropriate (Gilson *et al.* 1999, Doherty *et al.* 2000).

Social values of personal responsibility and fiscal conservatism are also drawn on in media articles and submissions throughout the policy process in arguments that reject HSR on the basis of its burden on taxpayers. A 2004 media article, for example, characterises policies which would mean medical scheme members subsidise the healthcare of the poor as "punishing those earning a higher income because they are better off" (Pather 2004). These arguments assume that cross-subsidisation, or cross-subsidisation beyond a certain level, is unfair or illegitimate.

This ambivalence toward financial cross-subsidisation reflects a conceptualisation of the health system, and South African society more broadly, as being divided sharply in two – rather than, as Paremoer (2021) puts it "constitutive of a single society with a shared fate" – with the private system being solely for the rich, and entirely independent from a public system that serves the poor. As such, the social value of fiscal conservatism, alongside that of personal responsibility, helps to counter arguments based on national unity as a social value. In addition, the hegemony of neoliberal ideas meant that fiscal conservatism became a default position[13], which further empowered arguments that position HSR as ideological and therefore illegitimate.

Conclusion

A particular set of social values shapes NHI policy discourse in South Africa and the salience of these values in this context can be explained by historical and contemporary events and issues. As is often the case (Freedman *et al.* 2005), the ten social values that underly NHI policy rhetoric in the South African context differ in surprising ways from the values explicitly used in policy documents. The values driving policy discourse are a result of a combination of the global ascendance of neoliberalism, the recent political upheaval in the transition from apartheid to democracy, and the plethora of corruption and governance failures the country has experienced, among other contextual factors, and are therefore likely particular to South Africa. In other words, the relationship between contextual specificities and the social values in policy rhetoric means that, to a large extent, salient social values will differ between contexts. Nonetheless, this case study offers some insights into the nature of the relationship between health systems, social values, policy processes and contextual realities that may be generalisable to other contexts.

Firstly, in addition to being influenced by changes in the wider social and political context, this analysis shows how health systems help to shape social values. In this case, past policy decisions, daily experiences and practices, and health system architecture all serve to reinforce particular social values. For example, the politically driven liberalisation of the health sector by the apartheid

[13] Tooze (1993) suggests that the hegemony of neoliberalism meant that it became a 'reality' used to evaluate policy positions.

government in the 1970s and 1980s not only created a set of private sector actors with vested interests in the status quo, but also normalised ideas about the private sector as an appropriate site for healthcare services, and, for some, as a symbol of post-apartheid liberation. In addition, for many South Africans, privately delivered healthcare is 'the norm'. As Smithers *et al.* (2022) write, "ideas become hegemonic through…institutions that gain societal acquiescence to ideas and policies that the society might not otherwise accept." In other words, lived experiences become normalised over time, changing ideas about what is acceptable and appropriate, and influencing social values. To some extent, then, the salience of private provision as a social value can be understood as a product of health policy decisions made by the apartheid government.

Similarly, people's experiences with the health system shape popular understandings of rights and entitlements as they relate to healthcare. In 1997, then-president Mandela argued that the health system of the new South Africa was the site where 'democratic transformation' was 'most keenly felt' because ensuring universal access to healthcare had "transformed the majority of South Africans from being neglected outcasts into beneficiaries of a compassionate health policy" (Mandela 1997). However, only primary healthcare services are free to everybody, and while the poor, pregnant women, children under six, the elderly and the disabled are exempt from paying fees in public health facilities, and fees are income-rated, in neither the public nor the private health sectors is secondary or tertiary healthcare free of charge (McIntyre *et al.* 2020). The 'marketisation' of social services, including user fees for basic services (even where exemptions are available), transforms users from citizens with substantive rights-based claims on the state, to fee-paying customers or clients (Greenberg 2004, Miraftab 2009). As such, both user fees in the public sector and contribution-based insurance in the private sector likely transform healthcare from a right to a commodity in the public consciousness and reinforce 'personal responsibility' as a social value.

Health system architecture can also contribute to or weaken social cohesion. In South Africa, the public-private divide likely undermines social cohesion and changes attitudes towards cross-subsidisation. Potgieter (2019) suggests that trust between society and the state and access to, or exclusion from, social goods are important determinants of social cohesion. While the relationship between public trust (in the state and health systems specifically) and social values is an area requiring further research (Gille *et al.* 2021, Topp *et al.* 2022), the South African experience offers valuable insight. In this case, the country's long history of health and other welfare services reinforcing race-based and class-based social divisions no doubt undermines social cohesion (see Coovadia *et al.* 1986). As Paremoer (2021) argues, the post-apartheid state's efforts to introduce reforms based on solidarity 'fail to resonate' with a public committed to a sharp segregation between the commercial or for-profit sphere, and the public sphere, which is perceived to be exclusively for the poor.

Secondly, the analysis suggests that while social values remain fixed, their salience waxes and wanes over time. In this case, the set of social values evident in policy rhetoric remained fairly stable – in other words, the values that shaped policy debate in the 1920s, 1940s or 1980s are still evident in contemporary policy rhetoric. 'Personal responsibility' was used to argue against the institution of a social welfare programme in the 1930s and is still used today to argue against increased cross-subsidisation. This aligns with existing literature from social psychology suggesting that social values are slow to change (see Rokeach 1974), and with political science theory suggesting that the normative beliefs underlying specific policy proposals and frames are difficult to contest (see Campbell 2004).

What does change, however, is the salience of social values. Transparency and impartiality were evident in HSR rhetoric in the GNU-era (1994-199), for example, but are more salient in the context of grand-scale corruption and general decline in trust in the state.

For health policy analysts and policy actors, this case study offers valuable lessons. One lesson is the importance of being aware of the differences between explicit and implicit values, and of surfacing the unsaid. For analysts, this entails using more interpretive analytical approaches that go beyond what is explicit (as opposed to, for example, content or framing analysis). Another lesson is the utility of analysing historical and contemporary context to understand what values are likely to have rhetorical weight in a particular context. We have shown that historical analysis can offer insight into the social values shaping policy rhetoric, but also that more recent or contemporary issues and events determine what social values have particular relevance. For policy actors, using historical analysis to identify social values, and then paying close attention to contemporary contextual realities that influence the salience of individual values, might enable more accurate judgements about the values that are likely to be most resonant for a particular audience at a particular time. These judgements can then be used to develop more persuasive and arguments and rhetorical strategies. Finally, an important lesson from this study is that past policy decisions and contemporary health system architecture can shape social values, in particular influencing popular ideas about the appropriate role of the state, shaping understandings of rights and entitlements with regard to healthcare, and contributing to or undermining social cohesion and social solidarity. For policy actors, drawing attention to the negative ideational effects of contemporary health system architecture might prove a useful rhetorical strategy in advocating for reform.

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Chapter 7 – How to do (or not to do)…analysis of social values in health system change

Chapter 7: How to do (or not to do)…analysis of social values in health system change

Overview: This chapter presents an analytical framework to guide health systems and policy analysts in more rigorously accounting for the role of social values and other ideational factors in health systems change. While it is well recognised that social values play an important role in driving systems change, we argue that, because social values can become institutionalised in health systems, they also serve as constraints on systems change. The analytical framework centres moments of policy decision-making in their ideational context; emphasises the points of interaction between health systems, policy decisions and social values; and points the analyst towards the tangible contextual realities that shape the ideational context. We argue that rigorously accounting for the role of social values in health systems change requires recognising this complexity.

Contribution to the thesis: This chapter draws on the theory developed in Chapter 2, the conceptual insights presented in Chapter 3, and empirical insights garnered through the empirical exploration of the South African NHI (presented in Chapters 4, 5 and 6) to present a theory of the relationship between health systems and social values, and an analytical framework to guide research that more rigorously accounts for the complex nature of this relationship. In this chapter we also draw on the case study of the South African NHI for illustrative examples.

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Abstract

Health systems are complex social systems and play an important role in communicating and reinforcing social values. We suggest that the capacity of health systems to communicate social values is a product of their complexity, and that, over time, social values become institutionalised in health systems. This means that social values are not only drivers of policy change, but also form part of the context in which policy processes unfold, and serve as a constraint on health system change. However, in health policy and systems research, social values are often studied only as drivers of policy change. Drawing on a study of the relationship between health system and social values that included theory development and an empirical case study to check that theory, we present an analytical framework to guide analysts in accounting for values-based complexity in analyses of health systems change. We argue that rigorously accounting for social values in policy processes requires recognising that policy processes unfold in complex social health systems, themselves embedded in social context; that social values comprise part of the ideational context that constrains actor choices; that this ideational context may change in important ways over the course of the policy process; and that past policy decisions embed values in social institutions creating feedback loops that constrains change. The analytical framework centres moments of policy decision-making in their ideational context; emphasises the points of interaction between health systems, policy decisions and social values; and points the analyst towards the tangible contextual realities that shape the ideational context. We advocate for applying a systems thinking perspective to the analyses of policy change that recognises both social dynamics and complexity, and suggest that, in doing so, it is possible to rigorously account for social values as both driving and constraining change.

"The assumptions underlying attitudes and practices within any welfare system can be seen to reflect the settlement on which it was founded, that is the macrolevel relationship established between it and broader societal values through the incorporation of these values into the arrangements and practices of the system." (Gilson 2003)

Introduction

The Gilson quote above forms part of an argument about the contribution of health systems to society (2003). Gilson's argument is that, in addition to being shaped by changing social values, health systems are 'part of the social fabric' of society and are 'purveyors' of social values. In fact, a number of health policy and systems scholars suggest that health systems influence social values – by shaping popular ideas about who is deserving of public support and what kinds of services they are entitled to (Saltman *et al.* 1997, Freedman 2005, Daw *et al.* 2014), building social cohesion and a sense of shared identity (Redden 1999, Axworthy *et al.* 2002, Kruk *et al.* 2010), and improving levels of social trust in the state (Kehoe *et al.* 2003, Abelson *et al.* 2009, Bouwman *et al.* 2015). This means that health systems can play an important social role – reinforcing and promoting progressive values and strengthening the relationship between citizens and the state (Whyle *et al.* 2021).

This social value of health systems is, in part, a product of the direct interaction between users and healthcare workers, as values are 'signalled' by the way providers treat patients (Freedman 2005). However, it is also a function of the structure of the health system (van Olmen *et al.* 2010). For example, values are communicated through systems that differentiate between the rich and the poor such as user fees, access that is dependent on pre-payment, or reimbursement schemes that pay providers more to treat one segment of the population than another (Gilson 2003, Reinhardt 2003, Freedman 2005, Paremoer 2021).

While the above authors conceptualise social values as an *output* of health systems, values are far more often considered as *inputs* to health system change, particularly in health policy analyses. The mechanisms by which values influence health systems include determining which issues are recognised as 'policy problems' (Buse *et al.* 2012, Béland 2016), influencing the choices and behaviour of implementers (Franco *et al.* 2004, Walker *et al.* 2004, Sheikh *et al.* 2011), informing what evidence is used to inform policy and informing how evidence is interpreted (Liverani *et al.* 2013, Langlois *et al.* 2018), shaping relationships between individual actors and forming the foundation for collective action (Sabatier 1998), and determining what changes will be politically feasible (Buse *et al.* 2009, Fox *et al.* 2013). In addition, policy actors often invoke social values to justify and legitimate policy proposals. This is because, in many contexts, actors in policy processes must demonstrate that their policy proposals 'fit' with dominant social values to garner support and dampen opposition (Ingram *et al.* 2007, Koon *et al.* 2016, Baker *et al.* 2019).

So, health systems both shape and are shaped by social values. This indicates a dynamic, bi-directional relationship between health systems, values, and society that is in keeping with the systems thinking approach (De Savigny *et al.* 2009). According to this approach, health systems are complex social systems (Pawson *et al.* 2005, Sheikh *et al.* 2021). They are characterised by feed-back loops, change-resistance, and unpredictability, and have emergent properties (Marchal *et al.* 2016, De Savigny *et al.* 2017). They are also open systems in that they are embedded in, and interact with their context,

creating feedback loops between the system and its context (van Olmen *et al.* 2010, Marchal *et al.* 2016). As complex *social* systems, health systems are also driven by people, their values and interests, and the power dynamics and relationships between them (Marchal *et al.* 2016, De Savigny *et al.* 2017). The emergent properties of the system are those that develop as a result of the myriad of interactions between individuals within the system, such as shared processes, norms and behavioural patterns (Gilson *et al.* 2014).

The systems thinking approach helps to explain the capacity of health systems to generate social values (Whyle *et al.* 2021). By emphasising the embedded and open nature of health systems – in other words situating health systems within their social, political and institutional context – this perspective clarifies how health systems can both shape, and be shaped by, ideational factors in the wider context. Similarly, by drawing attention to the role of interactions between actors (including decision-makers, implementers and users) in giving rise to emergent properties of the system, systems thinking helps to illuminate how relationships between people can give rise to (or erode) mutual trust, common goals, and shared meanings and values (Morgan 2005, Gilson *et al.* 2014). In addition, the concept of feedback loops helps to explain how inputs generate outputs – for example how a policy decision that differentiates access on the basis of ability to pay, can reinforce those values in the wider public by establishing programmes and routines that come to be considered normal or acceptable (as discussed above). In other words, systems thinking helps explain how value-commitments become institutionalised in health systems.

Institutionalist perspectives on policy change recognise that institutions influence behaviour by defining what policies, goals or courses of action are legitimate and appropriate (Finnemore 1996). Depending on the strain of institutionalism, 'institutions' can refer to formal and tangible rules structures, or informal and intangible norms, prevalent ideas and dominant ideologies (Finnemore 1996, Hall *et al.* 1996). Formal institutions shape behaviour by determining which actors have power to influence a policy process or take a particular action, and where their interests lie. Informal institutions shape behaviour by determining the cognitive shortcuts actors take in decision-making, and the range of policy solutions or behaviours they will consider appropriate or acceptable (Finnemore 1996, Hall *et al.* 1996). An Institutionalist perspective, then, offers further insight into the creation of feedback loops in complex social systems: past policy decisions, in which ideas, norms and values are embedded, give rise to ways of doing and thinking that are constrained by, and therefore perpetuate, existing institutions (Hall *et al.* 1996, Schmidt 2008). These deeply embedded norms and values are often referred to as 'background' beliefs – because they become so familiar that they appear neutral and go unnoticed (Campbell 1998, Rushton *et al.* 2012). So, through institutionalisation, social values can go from tools wielded by policy actors to legitimate policy proposals, to background ideas that constrain change.

This also entails that social values can influence health systems independently of any particular actor to espouse them (see Hall 1997, Berman 1998). In health policy analysis, policy change is often understood, following Walt *et al.* (1994) as an actor-driven process, in which the actors use their power to propel policy processes in line with their values and interests, and their ability to do is constrained or enabled by features of process, content or context (Gilson *et al.* 2018). Contextual factors are usually outside the control of policy actors, and include economic factors like recession, historical factors like colonialism, political factors like electoral cycles, social factors like culture, and

what Wilsford (1994) refers to as 'conjunctures' – unexpected upheavals such as wars and epidemics (Walt *et al.* 1994). We suggest that 'ideational context' should be considered alongside political, social, economic and historical contextual factors as an independent variable. By ideational context we refer to dominant worldviews, ideologies, discourses and social values that are embedded in tangible and intangible institutions, and that decision-makers are subject to, whether or not they align with their own personal worldviews and value-commitments (Schmidt 2011, Berman 2013).

Importantly, although social values are resistant to change insofar as they are collectively generated and usually beyond the strategic influence of policy actors (Spates 1983), they are like other contextual factors in that they do change. Social psychology tells us that social values are a product of shared experiences and that they change, at the collective level, in response to changes in environmental, socio-economic and political realities (Rokeach 1974, Inglehart 1977, Schwartz 1992). In addition, social values are part of ranked sets of values – usually referred to as value systems or value repertoires – in which multiple (even competing) values are held simultaneously (Schmidt 2000, Whyle 2022). Value systems are historically determined, path-dependent and persistent (Hofstede 1985, Inglehart *et al.* 2000), but the values within them can increase or decrease in importance fairly readily, in response to contemporary issues and events (Rokeach 1974, Schwartz 1994, Schmidt 2000). As such, the ideational context in which health system actors must work changes over time.

Rather than considering social values only as an input, we encourage a systems thinking perspective on the influence of social values in policy change that acknowledges social values as part of a bi-directional relationship, as both an input and an output of health systems, and that accounts for the attendant feedback loops and emergent capacities. In this paper we present an analytical framework intended to guide analysis of health systems and policy change that accounts for the dynamic influence of social values (Figure 1). The framework points the analyst towards the sites of interaction and feedback loops that are necessary considerations in rigorously accounting for the role social values play in policy change processes.

The insights and analytical framework presented here are a product of an inter-disciplinary, mixed methods health policy and systems study on the relationship between health systems and social values. The study was conducted in two phases: an initial phase of literature review and theory development (presented in Whyle *et al.* 2020, 2021, Whyle 2022), and a case study to test theory (presented in Whyle *et al.* 2022c, 2022a, 2022b). The case study phase comprised a longitudinal analysis of the of South African National Health Insurance (NHI) policy processes, including a historical analysis of the policy process in its social and political context to develop a 'thick' contextual description, an analysis of two particular moments of potential change to explore the role of values and ideas in constraining change, and a discourse analysis of the social values in health system reform rhetoric and the historical and contextual tributaries of those values. The South African NHI, as a particularly politically fraught policy processes, intimately connected to the country's recent transition to democracy, and unfolding over the course of nearly 30 years (with policy debate going back much further), offers an ideal test case for the role of social values in real-world policy change processes. In what follows, we describe the analytical framework and each of its elements, offering illustrative examples from the case study of the South African NHI.

Accounting for social values in health policy analysis

Above, we presented an account of the relationship between health systems and social values in which social values are both an input and an output of health systems, and in which social values comprise an important element of the context within which health system actors must make decisions. We argue, in summary, that rigorously accounting for the role of social values in health policy processes requires recognising:

- That health policy processes unfold in complex social systems, which are themselves embedded in a wider social context.
- That social values can be part of the strategic action by which policy actors drive change, but also comprise part of the ideational context that is beyond their influence and constrains their choices.
- That policy processes, particularly for large-scale reforms, often unfold over a number of years, and that the ideational context may change in important ways over the course of the policy process.
- That past policy decisions embed values and ideas in social institutions that continue to reinforce these social values over time, creating feedback loops that constrain change.

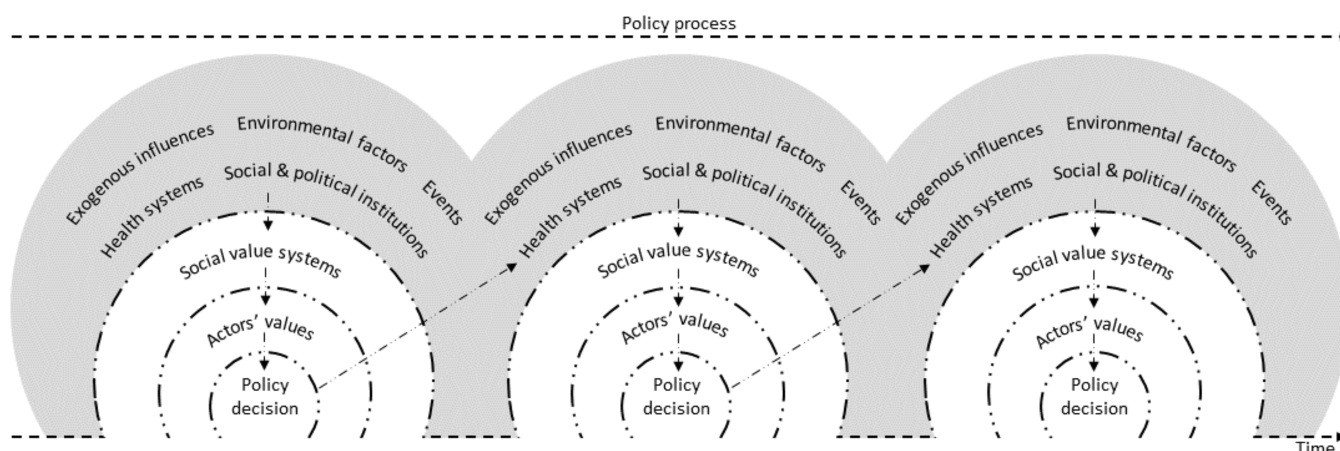

Figure 1: Analytical framework for accounting for social values in systems and policy change processes (Source: Author)

Policy decisions in ideational context

Moments of policy decision-making form the core of this analytical framework. Health policy processes proceed in fits and starts. At times, contextual factors combine to produce policy windows – moments in which policy change is possible (Wilsford 1994, Kingdon 1995). In such moments, however, the ideational context might remain relatively static. This is because, as discussed above social values, worldviews, and cultures are historically determined, reinforced by existing institutions and slow to change (Spates 1983, Finnemore 1996). Heclo (1994) describes political decision-making as a product of both the decision-maker and of the set of "historically-transmitted social understandings" that 'orient' her choices. In other words, political actors are faced with choices about what to do, but the meaning of those choices is a product of socio-historical context (Heclo 1994).

At different times in the policy processes, then, depending on the socio-political context, policy decisions have different meanings, and understanding those meanings is key to understanding why policy processes unfold as they do. One way to do this, is to develop a policy timeline that includes major social and political upheavals, dominant ideas, and pressing policy concerns that can help the analyst in making judgements about the social meaning of policy decisions at that time. In the South African case, for example, the historical analysis revealed the global dominance of neoliberal ideas at

the moment of the democratic transition, which helped to explain the conflicting value-commitments and policy proposals of various actors (Whyle *et al.* 2022a). In the absence of this type of analysis, it would have been difficult to understand what was constraining change.

Actors and the ideational limits on their agency

While moments of policy decision-making form the core of the analytical framework, policy actors are an important element in the dynamic relationship between health systems and social values. Clearly, the individual values of decision-makers and other policy actors will guide their choices and behaviour in the policy-making process (Ugalde 1978, Walt *et al.* 1994). However, it is difficult for the analyst to determine the extent to which an actor's choices are value-driven, and what particular value-commitment determined their choice (see Berman 1998). In addition, two factors mediate the influence of actors' values on policy decisions. Firstly, because values are learnt through socialisation, the value systems of individual actors will be shaped by dominant social value systems (Spates 1983, Schwartz 1999).

Secondly, although actors can use social values as tools to gain support for a policy proposal – by using frames and discourse either to demonstrate alignment between the policy proposal and social values, or to reprioritise or redefine social values to align with the policy proposal (see for example Schmidt 2002, Roberts *et al.* 2003, Shiffman 2003, Campbell 2004) – their power to do so is not absolute. In fact, the empirical exploration of social values in the South African NHI policy process (Whyle *et al.* 2022c, 2022a, 2022b) suggests that this potential is fairly limited, relative to other factors. The case study revealed ample evidence of policy actors presenting values-based justifications for policy proposals (Whyle *et al.* 2022b). This involved, for example, justifying policy decisions with reference to exogenous ideologies (demonstrating that a policy decision was in line with the dominant ideology of global organisations) or creating ideational connections between the policy proposal and the social values of a defining historical moment (Whyle *et al.* 2022a, 2022b). However, the extent to which these strategies were effective in gaining popular support, shifting the position of opposed stakeholders, or reprioritising social values was unclear. For this reason, recognising the nuances of the structure-versus-agency debate (Giddens 1979, Hall *et al.* 1996), we suggest that in accounting for the influence of social values, analysts should take care not to over-emphasise the agency of actors with regard to their capacity to influence social values, or indeed to use social values to propel change. Rather policy actors should be understood as mediators in the relationship between social values and policy decisions.

The dynamics of social value systems

We argue that rigorously accounting for the role of social values in policy and systems change requires recognising social values as part of the ideational context, exerting influence independently of any particular actor that holds them. However, we have also argued that social values, and the ideational context of policy-making more broadly, are mutable and historically contingent. This poses a particular challenge for analysts because it requires developing an understanding of intangible contextual realities that may not be explicitly articulated by policy actors.

A number of approaches may be of use in overcoming this challenge. Firstly, the use of interpretive analytical methods like discourse analysis can reveal the assumptions and value-commitments underlying explicit statements by policy actors (Fischer 2003, Kay 2009, Yanow *et al.* 2015). Secondly, large-scale survey data on social values (where available) can reveal the dominance of particular ideas

and values. In our analysis, for example, we drew on the reports of an annual representative public opinion survey for insights into the changing levels of public trust in the state. Thirdly, paying attention to the range of *tangible* factors that shape the ideational context can aid the researcher to better understand what ideas and values dominate in that context. The analytical framework presented in Figure 1 highlights the role of exogenous influences, environmental factors and events, and social and political institutions, including health systems, in shaping social values.

Exogenous influences

Firstly, social values are often influenced by ideas from outside – either from other country contexts or from global institutions. In the South African NHI case, at various points sets of cognitive and normative ideas diffused into the national policy process. This included, for example, the influence of the Beveridge report (a landmark document laying the foundation for the British National Health Service) in the 1940s on local ideas about health system reform, including the values underlying reforms (see Whyle *et al.* 2022c). To be clear, these imported ideas are not social values per se, but sets of policy ideas with attendant value-propositions, the diffusion of which is enabled by globalisation and global policy networks (Walt *et al.* 1994, Luke *et al.* 2002, Roberts *et al.* 2003).

Environmental factors and events

Secondly, social value systems and the relative salience of particular social values, are influenced by environmental factors and (contemporary or historical) crises and events. Environmental factors refer to fairly stable socio-economic realities, ecological constraints and technological developments which can influence social values (Rokeach 1974, Schwartz 1992, 1999). Crises and events are more temporally defined and include war, political transitions, natural disasters, as well as social movements such as women's liberation. Collective memories of these crises and upheavals mean that they can continue to shape social values long after they are resolved (Schwartz 1991, Russell 2006). Schmidt (2011) suggests that social and political upheavals and sudden transitions bring about a crisis of legitimation, because old ideas are suddenly revealed as inappropriate or incompatible with new realities. In the South African case, for example, some of the social values evident in the policy discourse were clearly linked to the political transition from apartheid to democracy, to the HIV epidemic, and to corruption scandals (Whyle *et al.* 2022b). In addition, because values are universal – in the sense that they apply across issues or policy domains – policy processes outside of the health sector can also influence social values. In the South African case there was some suggestion that controversies around water privatisation policies and social movements for free education had an contributed to prioritising certain values in health system reform debates (Whyle *et al.* 2022c, 2022b).

Social and political institutions, including health systems

Thirdly, social and political institutions play an important role in shaping social values. These include the institutions that shape the daily experiences of the polity, such as welfare and education systems, the police, religious institutions, civil society and the media (Schwartz 1999). These institutions are a product of dominant values (Schwartz 1999), which are reinforced through the public's interactions with and experiences of these institutions (see for example Rothstein 2000, Abelson *et al.* 2009, Abadía-Barrero 2016, Gilson *et al.* 2017). In this way, institutions also serve to resist change by embedding ideas into daily practices and procedures. Of course, health systems themselves are one of the social institutions that shape social values, as discussed in the introduction to this article. In the South African case, for example, a long history of private healthcare, the political meanings of private

health care that had accrued over time, and the extent to which receiving care from for-profit providers had become a norm for many people, resulted in private provision of healthcare becoming a social value (Whyle *et al.* 2022a).

History and path-dependence

Lastly, social value systems are shaped by history. Historical events like war or revolution have a lasting influence on social values. Partly this is because social values are shaped by historical events (Hofstede 1983, Schwartz 1992), and because values tend to become more deeply ingrained and more resistant to change over time (Spates 1983). Schmidt (2000) for example demonstrates how long-held social values help to explain popular opposition to, or acceptance of, welfare reforms. In addition, policy actors can draw on values with historical salience to gain support for particular policy proposals, or reconstruct collective memories of historical events to reprioritise social values (Rothstein 2000, Schmidt 2011, Brody 2014), and in doing so, ensure the contemporary significance of historical events. Lastly, various, often competing, ideas about what the policy is, and why it matters, can accrue over time. In the case of the South African NHI, some policy actors were committed to a radically redistributive version of the policy, reflecting historical associations between the proposal for health system reform and wider social struggles (Whyle *et al.* 2022b). This resulted in increased contestation as the policy proposals shifted over time (Whyle *et al.* 2022a). As such, a comprehensive understanding of historical context can provide insight into the ideational context in which policy decisions are made. Taking a long view of the policy process, and locating moments of policy decision-making in temporal context, is therefore central to understanding how social values influence health policy processes and health systems.

Complex causality and partial explanation

The analytical framework presented here is not a conceptual model of the complex relationship between health systems and social values. To produce a usable analytical framework, we have ignored a host of other factors that *also* influence health systems and health policy processes. In reality, in attempting to understand the influence of social values on health systems and health policies it is difficult to disentangle the influence of ideational factors from the influence of other factors (see Hall 1997). It is even more difficult, sometimes impossible, to 'get inside the head' of any particular actor, to determine whether her behaviour is motivated by values, and if so, which particular values (see Berman 1998).

What is possible, however, at least in retrospective analyses, is to place what happened in its historical ideational context – to understand what ideas and values were dominant at relevant points in the policy process. In doing so, we can posit social values as at least *part* of the explanation for what happened. This is in keeping with the understanding of complex causality that defines health policy and systems research, and that posits that any effect is the result of multiple, interacting causes (Gilson 2012, Marchal *et al.* 2016, Whyle *et al.* 2021). Insights from such an analysis can then be used to inform cautious forecasting of path-dependencies and, therefore, potential challenges to future policy change. In addition, because it allows for the explication of how social values are used in policy rhetoric, retrospective interpretive analysis is an important and valuable approach to exposing and countering pernicious background ideas ideas and the regressive policy change they legitimate.

Conclusion

As part of the social fabric of society, health systems play an important social role. We have argued that health systems are not only shaped by social values, but also shape social values in turn. This means that progressive health systems reforms are valuable not only because they will improve the lives of health system users, but also because they will contribute to building more just and more cohesive societies. In addition, it means that inequitable and unjust health systems will reinforce regressive social values, increasing opposition to progressive reforms, reinforcing pernicious values – making reform all the more urgent.

However, while social values can be used to drive health system and policy change, they also often serve to constrain change. To understand ideational factors only as drivers of policy change is to ignore the complexity of the complex social systems within which health policy processes unfold. In addition, better understanding the mechanisms by which social values constrain change will be key to developing effective strategies to overcoming these constraints. We advocate for applying a system-thinking perspective to analyses of policy change, that recognises both social dynamics and complexity, and suggest that, in doing so, it is possible to account for social values as both driving and constraining change.

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Conclusion

"We can, at least on some occasions, decide which norms shall prevail in the society we live in, because we can choose how to design our political institutions."
(Rothstein 1998)

The argument of this thesis

In health policy and systems research (HPSR), the influence of social values is widely recognised across a myriad of health system dimensions and fields of study (Gilson 2012, Shams *et al.* 2016). A systematic mixed-methods evidence mapping review on social values within HPSR, presented in Chapter 1, found that while a significant body of HPSR literature recognising the influence of social values has emerged, a number of serious challenges undermine the strength of the evidence-base. Firstly, while there is a wealth of literature acknowledging the influence of social values on health systems, only a small proportion take social values as the primary phenomenon of interest. Secondly, there is a lack of definitional and conceptual clarity on the nature of social values, and no consensus framings are available to guide the development of a cohesive body of evidence. In addition, much of the available literature asserting a relationship between health systems and social values stops short of specifying any particular causal mechanism by which social values influence health systems. There are also no conceptual frameworks to guide researchers on how to recognise the influence of social values. Thirdly, the review found very little HPSR acknowledging the role of social values in Latin American, South Asian and the Middle Eastern contexts, and a dearth of research focusing on low- and middle-income countries (LMICs) more widely. In addition, available research on these contexts, and the HPSR evidence-base on social values in general, is overwhelmingly produced by researchers affiliated to institutions in high-income countries. Lastly, the review revealed that there is a dearth of empirical research on social values, particularly by researchers with deep, tacit knowledge of the research context. In addition to a host of systemic issues that reproduce this trend across HPSR, the dearth of empirical evidence on social values is likely a reflection of the labour- and time-intensive nature of the work, and of the fact that values-focused research may have less direct influence on policy, and therefore be more difficult to fund and less frequently undertaken. In addition, the review suggested that drawing on concepts and methodologies from the social sciences could facilitate more rigorous, empirical research on social values.

This thesis has therefore sought to strengthen the HPSR evidence-base on social values and fill some of the abovementioned gaps. Chapter 2 presented an interpretive meta-synthesis of HPSR literature on social values that sought to develop conceptual clarity on the macro-level relationship between health systems and social values. Noting the number of claims in HPSR literature that suggested social values could be a function or a property of health systems, and seeking an explanatory framework to make sense of this capacity of health systems, the interpretive synthesis adapted a methodological approach from meta-ethnography to allow the relational claims to be synthesised under a common frame.

Doing so revealed a complex network of causal relationships across health system dimensions and functions that were predicated on social values. As such, the meta-synthesis presented in Chapter 2 suggested that, because health systems are complex social systems, social values should be understood as an emergent product of their complexity. In addition, across the HPSR literature on

social values we identified four mechanisms through which health systems can influence social values: by offering a unifying national ideal and building social cohesion, by shaping the public's understanding of their rights and entitlements with regard to healthcare and the appropriate role of the state in providing healthcare services, by strengthening public trust in the state and legitimating state authority, and by indicating the extent to which various population groups are valued by the state. Importantly, as the product of multiple feed-back loops, these properties emerge over time – as values are communicated and reinforced through the daily interactions of the polity with the health system.

Seeking to rectify the lack of conceptual clarity in the HPSR literature on social values identified in Chapter 1, we also undertook an interdisciplinary narrative scoping review exploring literature on social values from the social sciences, presented in Chapter 3. From this review we developed a working definition of values which draws on insights from scholars in social psychology, political science and anthropology. We defined values as universal and persistent affective ideas about what is desirable that influence or justify action or judgement, and that exist as part of a ranked set of values known as a value system.

In addition, integrating insights from the social sciences produced a more in-depth understanding of the nature of nature of social values and the relationship between social values and institutions. Chapter 3 suggested that shared values emerge within cultures, groups and societies firstly, because values are learnt through socialisation, and secondly, because shared experiences produce common values. These shared experiences include every-day experiences and interactions with social and political institutions. Social and political institutions 'transmit' or 'model' social values by influencing the discourse, behaviour, or conceptions of those that interact with them. Based on these insights, we argued in Chapter 3 that social institutions can shape the social values of groups. Further, because many such institutions operate at the national level – for example, health and welfare systems, education systems, government institutions, or economic institutions – shared value systems develop among national populations.

Also in Chapter 3, we synthesised insights from the social sciences that suggest that actors, seeking to bring about changes in institutions, often use discursive strategies that change popular conceptions of what is appropriate or acceptable, thereby influencing social values. This is possible because discourse not only reflects social realities, but also is the site in which social realities are constructed or reconstructed – often in line with the interests or concerns of strategic actors. On this basis, Chapter 3 concluded that discourse analysis is a particularly apt methodology for analysing social values.

The first three Chapters of this thesis, the review chapters, were devoted to conceptual clarity and theoretical development. Together, they suggest that that social values are an important factor shaping health systems, that health systems (as social institutions in which values are embodied and which, in turn, reinforce values) can shape social values, that discourse (as a tool for interpreting and communicating social realities) plays an important role in the production and reproduction of social values, and that discourse analysis can reveal both social values and the strategic use of discourse to influence policy processes and shape social values.

The second phase of this thesis applied these insights to an analysis of the South African National Health Insurance (NHI) policy process. With this phase we sought to contribute to filling the gap in

empirical values-focused research on LMIC contexts identified in Chapter 1, while also testing the conceptual insights and theoretical assumptions about the relationship between health systems and social values developed through the review phase, and refining them where necessary. From Chapter 2, it was pre-established that the dynamic relationship between health systems and social values was, firstly a product of the embeddedness of health systems in social and political context, and, secondly, unfolded over a fairly long time – as both social values and health systems change slowly. The South African NHI was chosen as a case partly because the length of time over which the policy process unfolded allowed for an exploration of the relationship between changing social values and the health system reform efforts. In addition, the NHI policy process is intricately tied up with the country's political history, and the contentious nature of the policy means that values-based rhetoric is at the forefront of public debate about the NHI.

We prepared for the case study by conducting a retrospective iterative literature review of the South African NHI to develop a comprehensive history of the policy process in its social and political context, presented in Chapter 4. In order to locate the current policy experience in historical context, we analysed health system reform efforts beginning in the 1920s. This analysis revealed health system reform efforts in South Africa have been shaped by social and political specificities of the context that determine what sorts of reforms are feasible in any historical moment. In addition, social and political realities, as well as the history of reform efforts, shape the social meaning of health system reforms. The historical analysis revealed that both the problems intended to be solved by the policy, and the ideational associations of the policy (how the policy proposals are understood and what they are interpreted to mean), emerge from the policy's history and accrue over time. In this way, Chapter 4 also demonstrated the value of historical policy analysis for understanding why policy processes unfold as they do.

In Chapter 5 we sought to identify some of the ways that cognitive and normative ideas, including social values, had influenced the health policy process in the case of the South African NHI. We argued that while health systems are recognised as path-dependent, the mechanisms that ensure path-dependence are poorly understood. In addition, while ideational factors are commonly recognised as relevant to explaining policy change (in other words, as drivers of policy change) they are rarely considered as constraints on change. To explore the role of ideational factors in constraining change we drew on the historical analysis presented in Chapter 4, and analysed two policy windows, understood as periods when the prevailing conditions might have been expected to enable dramatic policy change. We found that while progress was made in the development of the policy in both these periods, ideas – both cognitive ideas about what is feasible and normative ideas about how health systems ought to be organised and whose interests ought to be protected – served to increase contestation and resistance, and exacerbate the complexity of the policy process. To explain this phenomenon we drew on social science theory that suggests that ideas can become institutionalised – embedded in and reinforced by – tangible and intangible social institutions. We argued that, in the South African case, particular ideas about the appropriate role of the state in funding, regulating and delivering health services have become embedded in daily practices and procedures, but also in ways of talking and thinking. These ideas are products of particular historical moments but are reinforced by the institutions in which they are embedded, and so continue to exert influence. So, while the analysis enabled a better understanding of how ideas about the appropriate role of the state in

delivering health services and managing healthcare resources have become dominant ideas shaping health system reform efforts, it also explained how ideas can constrain change and ensure path dependence in complex systems.

The final chapter of the empirical phase, Chapter 6, presented a case study of social values in NHI policy rhetoric in South Africa. In this Chapter we used discourse analysis of policy documents, speeches, parliamentary submissions and print media to identify the social values shaping the policy rhetoric (presented in Appendix 6a). Then, by interpreting these social values alongside the history of health system reform in South Africa presented in Chapter 4, we sought to explain the particular salience of these values in the South African context. We argued that the *set* of social values that shape policy rhetoric in South Africa have remained relatively fixed over time, and are reflected in and explained by the country's long history of health system reform efforts, and political context. However, we also found that the *salience* of particular social values waxes and wanes in response to contemporary issues and events. In addition, this chapter confirmed, to some extent, the theory developed in Chapter 2, as it suggested that the structure of the health system serves to reinforce and reprioritise certain social values, but also suggested that this effect is likely only pronounced enough to be observable when other features of the context prioritise the same values.

Together, the empirical phase of this study, Chapters 4, 5 and 6, reveal a dynamic and complex bi-directional relationship between health systems and social values, in which health systems are not only shaped by social values, but also shape social values. In addition, the empirical analysis revealed the ways in which this relationship is mediated by the influence of contextual realities. In Chapter 7, we drew on findings of both phases to develop an analytical framework to guide future research in more rigorously accounting for the influence of social values in health system change. We argued that in addition to conceptualising social values as a driver of health systems change, they should also be acknowledged as contextual features serving to constrain change. In order to aid analysts in accounting for this complexity, the analytical framework centres moments of policy decision-making and draws attention to the historical and contextual factors that shape the ideational context in which these decisions are made. We argued that understanding moments of policy decision-making in their own ideational context, and recognising the feedback loops between health systems and social values, is vital to rigorously accounting for the influence of social values in systems and policy change processes.

Where to from here?

HPSR on social values remains relatively underdeveloped and one of the aims of this thesis was to contribute to strengthening the evidence-base on this important topic. Some valuable additions to the evidence have recently emerged (see for example Mattison *et al.* 2020, Vélez *et al.* 2020a, Vélez *et al.* 2020b, Topp *et al.* 2022), but much more remains to be done.

Firstly, there is a need for more values-focused analysis of policy processes in LMICs. While it is not always helpful to over-emphasise the distinction between high-income and LMIC contexts, policy processes in LMICs do involve some particular values-based challenges that might make health policy reform more complex. Firstly, they are more likely to involve multi-lateral organisations, bilateral donors and international NGOs that have value commitments of their own and (as this research has shown) are a key mechanism for the diffusion of exogenous social values to local contexts (Walt *et al.*

1994, Gilson *et al.* 2018). Secondly, LMIC contexts are more likely to be conflict-affected or have more recent experience of major social or political upheaval, which, as the findings of this study suggest, might mean that particular social values are driving reforms or resistance to reforms.

This study also highlights the utility of interpretive methods to values-focused research. Given how often explicit values differ from the values that actually shape rhetoric and decision-making (Gilson *et al.* 2004, Freedman *et al.* 2005), a phenomenon confirmed by the empirical analysis of the South African NHI, methodological approaches that allow researchers to understand the value commitments underlying what is explicitly said are crucial. Interpretive methods pose a challenge to researchers because, while introductory material is available, there is no universally-applicable step-by-step methodological guide for interpretive research, and because they require the analyst to form her own interpretation, which is particularly discomforting for researchers trained in more positivist traditions to avoid subjectivity and 'bias' at all costs (Yanow 2003, Willig 2014). In this study, drawing on critical analyses from political science, history and sociology helped to triangulate the findings and build confidence in the interpretation, and such an approach might be of use to other researchers.

In addition, longitudinal analyses of policy processes in social and political context are rarely conducted on LMICs. Grundy has conducted longitudinal and comparative analyses of health systems in Asia, with fascinating results, and argues that a historical view can offer insights into the likely challenges for future policy change (see for example Grundy *et al.* 2014a, Grundy *et al.* 2014b, Grundy *et al.* 2016). Similarly, Sriram *et al.* (2021) explore the origins of medical regulation in India and demonstrate that contemporary reform debates can only be fully explained by analysis that accounts for the country's colonial history. In the present study, the longitudinal approach was particularly helpful not only in identifying the historical roots of current challenges but also in understanding and explaining the social meaning that reforms have taken on. Combining the interpretive analysis with the longitudinal perspective proved particularly fruitful because it helped to explain the trends observed in the policy, which, in turn, helped to build trust in the emerging findings.

Even so, however, the study surfaced some further analytical challenges inherent in values-focused research – namely the operational challenge of distinguishing between social values, widely held attitudes, and deep-seated cognitive beliefs. While the definitional work presented in Chapter 3 helped to conceptually distinguish social values from other ideational factors, in practice it was often difficult to decide which ideas to analyse as social values. In order to avoid being unduly subjective in this regard (by allowing consideration of whether the value in question aligns with ones' own values to influence the analytical decision), we drew on the text itself (whether the idea was presented as normative or cognitive), and wider secondary evidence for guidance. The result was that some of the ideas analysed as social values (such as 'private provision of healthcare' and 'the free market') did not 'feel' like social values, and that the boundaries between values, attitudes, cognitive beliefs and, at times, institutions, were difficult to maintain. Nonetheless, given that a central argument of this thesis is that social institutions help to shape social values (and that, by corollary, ideas can become social values over time), and out of a desire to ensure analytical rigour, we trusted the analytical process over our own instincts in this regard. Future researchers might find this experience helpful in overcoming similar challenges relating to what factors to analyse as social values.

Another important area for future work is in comparative case studies on social values and other ideational factors. In this study, the single-case approach was justified by the design of the overall

project, which allowed for the development of a working theory, and then for the use of the South African NHI as an exemplary case with which to test the theory (Yin 2012). Nonetheless, there is no doubt that being able to compare across cases would offer further, more generalisable, insights. The scale of the task of producing thick descriptions of the history of policy processes and the challenge of conducting interpretive analyses without a deep understanding of the social context may make comparative case studies challenging, however. One way to overcome this challenge would be through collaborations between embedded researchers from different contexts, conducting parallel case studies that could then be used for cross-case comparisons. Such research would be of substantial value.

The primary objective of this study was to build theory to enable future HPSR on social values. However, the study was also motivated by a desire to better understand the challenges of the South African health system – how South Africa came to have such an inequitable and wasteful health system, and why it is proving so difficult to implement reforms to make the health system more equitable and just. The empirical analysis has helped to explain the intractable nature of the problem, but it is still not entirely clear what 'should' be done to advance reforms or 'fix' the health system, and no obvious policy prescriptions have emerged.

What is very clear, however, is that public trust in the state has (for obvious and very real reasons) declined significantly in recent years and that this loss of trust is a major determinant of popular opposition to the NHI. In addition, given that public understanding of the particularities of the current policy proposal is low (Gilson 2019, Mcintyre 2019), it seems clear that changes to the policy with regards to the governance structure of the NHI (while necessary) will not be enough to counter the pervasive perception that the state cannot be trusted as either a provider, financer or regulator of healthcare. Further, the lack of trust is a product of governance failures outside of the health sector, but is exacerbated by a perception of low quality care in the public sector and by the failure to adequately regulate the private health sector. As such, any trust-building strategy must involve demonstrating that the state can be trusted to deliver health services, to manage funds, and to regulate for-profit health sector actors.

In addition, public discourse on the NHI is overwhelmingly oriented towards the interests of the middle class and the private healthcare sector. In part, this is a result of a bias in the media, which tends to prioritise the interests of wealthy (Waterhouse *et al.* 2017). Policy-makers engaging more pro-actively with the media might go some way to ameliorating this imbalance. However, media organisations themselves need to take some responsibility for ensuring balanced reporting, including reflecting the perspectives of the poor in media coverage on the NHI, and providing more critical reporting on the failures and challenges that pervade the private sector.

Lastly, this thesis has argued that while social values are rooted in history and are relatively stable, their salience with respect to any particular policy issue changes more readily in response to current events in the wider context. Effective rhetorical strategies must, therefore, respond to current public concerns even when these are borne out of issues beyond the health sector. In addition, however, in a country where social values are strongly tied to the transition to democracy, rhetorical strategies that draw attention to the historical roots of current challenges might prove particularly effective. For example, positioning the scale and power of the private health sector in contemporary South Africa as result of apartheid decision-making, and also drawing attention to injustices inherent in for-profit

healthcare, might go some way to countering the implicit trust South Africans seem to place in private healthcare providers.

At the outset, this research project was inspired by a sense that there were complexities at play in South Africa's attempts to reform the health system that were social in nature. While it was clear that designing and implementing an NHI would be technically challenging, that there were economic constraints at play, and that political battles were playing out alongside the policy process, it seemed to also be true that South Africans had come to think and talk in particular ways about what the NHI is and what it means to us, and that those social complexities were constraining change.

What was discovered, and what became the central claim of this thesis, is that health systems play an important social role that can involve strengthening the relationship between citizens and the state, and ensuring social solidarity. Currently, however, as a result of a long and complex history of politically-motivated decision-making and opposition to progressive reforms, the health system is reinforcing regressive values and contributing to social division. Moving forward, it is vital to recognise the powerful role social values and other ideational factors play in health system reform processes to predict and pre-empt opposition from powerful stakeholders and to develop communication strategies that reinforce progressive values. Doing so, will help to ensure that the NHI as implemented is the most progressive possible version of the policy.

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Appendices

Appendix 1a: Link to published paper (Chapter 1) and data extraction sheet

This systematic mixed methods evidence mapping review is available online at https://academic.oup.com/heapol/article/35/6/735/5831176. The data extraction sheet (pages 1-31) for the paper is available online at: https://academic.oup.com/heapol/article/35/6/735/5831176#supplementary-data

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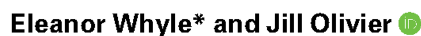
Review

Social values and health systems in health policy and systems research: a mixed-method systematic review and evidence map



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Abstract

Because health systems are conceptualized as social systems, embedded in social contexts and shaped by human agency, values are a key factor in health system change. As such, health systems software—including values, norms, ideas and relationships—is considered a foundational focus of the field of health policy and systems research (HPSR). A substantive evidence-base exploring the influence of software factors on system functioning has developed but remains fragmented, with a lack of conceptual clarity and theoretical coherence. This is especially true for work on 'social values' within health systems—for which there is currently no substantive review available. This study reports on a systematic mixed-methods evidence mapping review on social values within HPSR. The study reaffirms the centrality of social values within HPSR and highlights significant evidence gaps. Research on social values in low- and middle-income country contexts is exceedingly rare (and mostly produced by authors in high-income countries), particularly within the limited body of empirical studies on the subject. In addition, few HPS researchers are drawing on available social science methodologies that would enable more in-depth empirical work on social values. This combination (over-representation of high-income country perspectives and little empirical work) suggests that the field of HPSR is at risk of developing theoretical foundations that are not supported by empirical evidence nor broadly generalizable. Strategies for future work on social values in HPSR are suggested, including: countering pervasive ideas about research hierarchies that prize positivist paradigms and systems hardware-focused studies as more rigorous and relevant to policy-makers; utilizing available social science theories and methodologies; conceptual development to build common framings of key concepts to guide future research, founded on quality empirical research from diverse contexts; and using empirical evidence to inform the development of operationalizable frameworks that will support rigorous future research on social values in health systems.

Keywords: Social values, health policy and systems research, evidence map

In addition to these concrete and tangible expressions of health systems, the 'software'—by which we mean the ideas and interests, values and norms, and affinities and power that guide actions and underpin the relationships among system actors and elements—are also critical to overall health systems performance (Sheikh *et al.*, 2011, p. 2).

Introduction

It has long been recognized that health systems are social systems in which values constitute a key determinant of system change (Donabedian, 1972; Lewis, 1977; Roemer, 1988). In the past, the understanding that health systems change is values-driven led many

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Appendix 1b: Table summarising the aims, methods and findings of empirical papers explicitly focused on values in health systems

Author, date	Title	Aim or Research question and methodological approach	Main findings	Type
Giacomini, Kenny & DeJean. 2009	Ethics frameworks in Canadian health policies: foundation, scaffolding, or window dressing?	To describe ethics frameworks and how they are used in Canadian health policy documents and to identify some features of a robust, coherent and meaningful ethics framework. Qualitative. Policy document review of publicly available, strategic health policy documents concerning the topics of health reform, biotechnology, infectious disease, or health technology assessment.	Ethics frameworks typically appear as a list of principles or values. They vary widely, and many are better characterized as goals. No two ethics frameworks matched, despite common topic areas and broadly shared values within the Canadian health system. Few frameworks use the term "ethics", many more use terms such as "principles" or "values". Frameworks seldom justify the elements included. Common elements include access, accountability, autonomy, client-centredness, collaboration, efficiency, equity, and (research) evidence.	Analysis of values in policy documents or decision-making
Giacomini, Hurley, Gold, et al. 2004	The policy analysis of 'values talk': lessons from Canadian health reform	What sorts of entities do Canadian health reformers typically call 'values'? How do Canadian health reformers use the idea of values in health reform rhetoric? Qualitative, interpretive analysis of 36 publicly available Canadian health reform documents published during the period 1990–1999. Included documents were published by Health Canada, provincial ministries of health, or government-mandated commissions and other national-level non-governmental associations	some documents refer to the Canadian health system itself as a 'value'. Common values included universality, accessibility, portability, comprehensiveness, public administration, and equity. Health states are also sometimes invoked as values. Many values touch on relationships either among citizens, or between citizens and the health system's governance or providers. Many values touch on relationships either among citizens, or between citizens and the health system's governance or providers. Tied goods and balancing one value against another (e.g. equity vs efficiency) emerging as value systems or rankings.	Analysis of values in policy documents or decision-making
Hyder, Merritt, Ali, et al. 2008	Integrating ethics, health policy and health systems in low-and middle-income countries: Case studies from Malaysia and Pakistan	to describe the ethics processes in play when public-health mechanisms are established in low- and middle-income countries Case study. Developed a framework for ethical analysis of health system events, and tested the framework against two cases (one in Malaysia, and one in Pakistan) where ethics played a crucial role in producing positive institutional change in public-health policy.	While ethics is gradually being integrated into public-health policy decisions in many developing health systems, it is often implicit and undervalued. Three core public-health values – prevention, accountability, and social justice – were found to frequently arise at the ethics/public-health policy interface.	Analysis of values in policy documents or decision-making
Ahn, Kim, Suh, et al. 2012	Social values and healthcare priority setting in Korea	To understand the role of social values in setting healthcare priorities in Republic of Korea. Qualitative. Using the Clark and Weale framework, each value is tested against Korean healthcare decision-making processes on drugs, medical devices, and diagnostic methods/procedures, through interviews with decision makers and analysis of drug and health technology review decision-making documents.	Clinical considerations given highest weighting in decision making processes. Occasional consideration of economic values such as cost effectiveness and budget impacts. Process values such as transparency and accountability influence decision making more than content values such as Justice/equity, solidarity, and autonomy which are rarely evident. Public participation is limited.	Analysis of values in policy documents or decision-making (using C&W FW)
Kieslich, 2012	Social values and health priority setting in Germany	To provide an overview of health priority-setting structures in Germany. It reflects on how and which social values may influence decision making, Qualitative. Application of Clark and Weale's framework of analysis for Social Values and Health Priority-setting to the German context through exploration of health priority-setting structures in Germany (Institute for Quality and Efficiency in Health Care) and how they operate within the German Statutory Health Insurance (SHI) system.	Germany has made unique methodological and structural choices that reflect the social values and institutional traditions that underpin its self-governing statutory health insurance (SHI) system. The principle of solidarity is upheld as a core value in health priority-setting. No structural element exists in the decision-making bodies analysed that enables deliberative-democratic consultation of members of the public about difficult decisions. The emphasis on the principle of solidarity and its interpretation as an individualistic rather than a utilitarian value decreases the chances that medical interventions will be weighed against each other. Social values form the guiding principles of the health care system and present a barrier to health priority-setting as it is understood in other national settings.	Analysis of values in policy documents or decision-making (using C&W FW)

Littlejohns, Yeung, Clark, et al. 2012	A proposal for a new social values research program and policy network	To demonstrate that the Clark and Weale framework could be applied to publicly available data, and to explore the concordance between the framework values and those present in the statements of decision-making protocols of Health Technology Assessment Agencies. Qualitative. The web sites and documentation of three public bodies involved in HTA in the UK were searched for references to social value statements and assessed according to the social values framework in order to identify references to and descriptions of social values by those organizations.	There was a close match between the values in the draft framework and those contained in documents published by the HTA bodies. The HTA bodies mentioned three values that were not included in the draft framework: independence, timeliness, and innovation. The values of accountability and transparency were used interchangeably. The value of solidarity (a value most typically associated with European social insurance systems) finds only indirect expression in the guidance notes of all.	Analysis of values in policy documents or decision-making (using C&W FW)
Mostafavi, Rashidian, Arab, et al. 2016	Health Priority Setting in Iran: Evaluating Against the Social Values Framework	To examine the role of social values in the health priority-setting in the Iranian health system. Qualitative. Case study using three data sources were used: literature, national documents, and interviews with purposefully selected key informants. National documents were selected based on a review of the literature and consulting senior policymakers. Interviews and documents were analysed through thematic framework analysis, and interpreted based on the Clark-Weale Framework.	Social values are considered in the health priority decisions in limited ways. An appropriate value-based framework for priority-setting and public participation are lacking. Values such as equity, public participation, transparency, freedom, solidarity, and accountability are commonly emphasized. The transparency of the decisions and the accountability of the decision makers are low. Equity and solidarity are considered in different levels of the health system. Process values were described less than content values in the documents. The importance of social values has recently increased in the national documents, but to what extent these values are considered in practice remains uncertain. Most of participants stated that they had never precisely thought about social values in the health sector.	Analysis of values in policy documents or decision-making (using C&W FW)
Tantivess, Velasco, Yothasamut, et al. 2012	Efficiency or equity: value judgments in coverage decisions in Thailand	To analyse the roles of social values in the reform of coverage decisions for Thailand's Universal Health Coverage (UC) plan in 2009 and 2010. Qualitative. Qualitative techniques, including document review and personal communication, were employed for data collection and triangulation. All relevant data and information regarding the reform and three case study interventions were interpreted and analysed according to the thematic elements in the Clarke and Weale framework.	Social values determined changes in the UC plan in two steps: the development of coverage decision guidelines and the introduction of such guidelines in benefit package formulation. The former was guided by process values, while the latter was shaped by different content ideals of stakeholders and policymakers. Analysis of the three interventions suggests that in allocating its resources, the UC authority took into account not only cost-effectiveness, but also budget impacts, equity and solidarity. These social values competed with each other and, in many instances, the prioritisation of benefit candidates was not led solely by evidence, but also by value judgments.	Analysis of values in policy documents or decision-making (using C&W FW)
Whitty, Littlejohns. 2015	Social values and health priority setting in Australia: an analysis applied to the context of HTA	To describe the role of social values in priority-setting related to health technology assessment processes and decision-making in Australia. Qualitative. The processes and decision criteria of the Pharmaceutical and Medical Benefits Advisory Committees are described based on literature and policy sources, and analysed using the Clark and Weale framework for identifying social values in priority-setting. The descriptive analysis was informed by a search of the published literature to identify key sources on the PBAC and MSAC processes, and the potential role of social values in these; and a search of the PBAC, MSAC and DoH websites to identify key policy documents providing insights into the application of social values in decision-making.	Transparency and accountability of processes are apparent. Participation balances inclusiveness and effectiveness of decision-making, but presents an opportunity to enhance priority-setting processes. Clinical and cost-effectiveness are important content considerations. Social values related to justice/equity are considered, without quantification of criteria weights for equity relative to other factors. HTA processes support solidarity through subsidising approved technologies for all Australians, whilst retaining autonomy by permitting non-subsidised technologies to be accessed privately, leading to possible tension between the values of solidarity, autonomy and equity. PBAC and MSAC recognise the importance of social values in their decision-making. There is generally little explicit information available on how these social values are derived, how they are considered in decision-making relative to clinical and cost-effectiveness, or what contexts might engender particular values such as equity to be considered.	Analysis of values in policy documents or decision-making (using C&W FW)
Littlejohns, Sharma, Jeong, 2012	Social values and health priority setting in England	To provide an overview of the organisational and procedural arrangements for priority-setting in England and Wales, including the role of social values in the decision-making process. Qualitative. Decisions made by the UK's National Institute for Health and Clinical Excellence analysed using the Clarke & Weale framework.	Each country has established different systems that reflect the social and legal framework underpinning their health systems. Both the process and outcomes of appraisals are reflective of and receptive to contemporary values and ethical principles held by society. These include an obligation actively to consider health inequalities. Since its inception the NHS in England has provided universal care free to all at point of entry, based on the patient's need for treatment. This value of solidarity remains as strong as ever. Social values are often discussed in the guise of judgements on effectiveness. Comparisons between countries shows the differences in the way that social values are institutionalised.	Analysis of values in policy documents or decision-making (using C&W FW)

Mou,2013	The political economy of the public–private mix in heath expenditure: An empirical review of thirteen OECD countries	To investigate the factors (including development of private health insurance, income inequality among voters, and political ideology of the electorate) that may have influenced the public–private mix of health expenditure in 13 OECD countries from 1981 to 2007. Quantitative. Using a sample of 13 OECD countries, the authors conduct a statistical analysis of correlation among key variables including population characteristics, health system financing, political ideology, and voting patterns.	Greater income inequality and population aging are associated with a smaller share of public health expenditure in total health expenditure. The more ideologically left-leaning the electorate is, the larger the share of public health expenditure. Private health insurance tends to erode the political support for the public health care systems in countries with private duplicate health insurance, but not in countries with private primary health insurance. Collective values and social beliefs are important in the politics around the public–private mix of health expenditure.	Assess social values of public relative to/congruence with HS outcomes/ characteristics
Kringos, Boerma, van der Zee, et al. 2013	Political, cultural and economic foundations of primary care in Europe	To explore the relationship between the strength of primary care and a country's economic development, political orientation, type of healthcare system, and prevailing values, and to identify the conditions favouring the development of strong PC. Quantitative. Multivariable regression analyses were performed using data from European states. Independent variables included: wealth, political composition, structure of a healthcare system, prevailing values, and strength of primary care.	Having a left-wing government has a significantly positive association with strength of PC. Strengthening PC means mobilising multiple leverage points, policy options, and political will in line with prevailing values in a country. Countries where people value a stronger involvement of the government to ensure that everyone is provided for, were associated with a higher accessibility of PC.	Assess social values of public relative to/congruence with HS outcomes/ characteristics
Landwehr, Klinnert. 2015	Value congruence in health care priority setting: social values, institutions and decisions	To assess congruence between a society's values and its institutions and formulate expectations on its effects on the public acceptance of prioritization decisions, and of the health care system at large. Qualitative. Compare across three countries (Germany, UK and France) using existing survey data and document review to assess whether social values regarding priorities in health care are coherent or incoherent with the values institutionalized in the health care system in general and in priority-setting agencies in particular and whether social values are reflected in the decisions of these agencies and the justification of their decisions.	Social values in the population are congruent with institutionalized values and decisions in the UK, less congruent in France and incongruent in Germany. In the UK, support for efficiency and equality criteria is reflected in the institutional design of the health care system at large and in the design of institutions. Criteria of personal responsibility for health enjoy some support in the British population, which is not reflected in institutional design or decisions. In Germany, the strong concern with equality is not at all reflected in institutions and decisions, while the rejection of personal responsibility for health as a criterion in allocation decisions is discrepant with institutionalized norms and justifications for decisions. The public acceptance of prioritization decisions, and eventually of the health care system at large, will ultimately depend not only on considerations of procedural fairness, but also on the congruence between a society's values and its institutions.	Assess social values of public relative to/congruence with HS outcomes/ characteristics
Mladovsky, Ndiaye, Ndiaye, et al. 2015	The impact of stakeholder values and power relations on community-based health insurance coverage	To test the hypothesis that values and power relations inherent in social networks of CBHI stakeholders can explain levels of CBHI coverage. Qualitative. Study used a multiple case study design to analyse three Senegalese CBHI schemes. Interviews were conducted with stakeholders (individuals who affected or could affect the CBHI scheme) identified using purposive snowball sampling. Transcripts of interviews with 64 CBHI stakeholders were analysed using inductive coding.	The five most important themes pertaining to social values and power relations were: voluntarism, trust, solidarity, political engagement and social movements. This study found that the interconnected social values were employed by stakeholders to expand CBHI population coverage. There was a belief that the values which they saw CBHI to embody were not upheld by politicians. Many stakeholders discussed CBHI in the context of social movements perceived to be founded on shared values. Given the ambiguity of CBHI as a mechanism for promoting solidarity, it is possible that CBHI schemes could decrease dropout and increase enrolment by bringing CBHI more in line with local values.	Assess social values of public relative to/congruence with HS outcomes/ characteristics
Steinberg & Baxter 1998	Accountable communities: how norms and values affect health system change	To explore the relationship between community norms and values and health system change in the USA Qualitative. Researchers conducted site visits to twelve randomly selected markets and conducted structured interviews between with a broad array of leaders from the health sector, business, and the community.	Community values can be a strong factor in shaping health system change and can influence decisions regarding network arrangements, product offerings, and the means used to control the delivery of care. Respondents espoused values around the importance of consumer choice of providers, comprehensive benefit packages, and clinical autonomy. Increasing economic and competitive pressures are forcing health care organizations and professionals to forsake their missions or values to pursue more bottom line–oriented strategies. The ability of communities to influence health system change depends on common values.	Assess social values of public relative to/congruence with HS outcomes/ characteristics

Chinitz, Meislin, Alster-Grau. 2009	Values, institutions and shifting policy paradigms: expansion of the Israeli NHI Basket of Services	To examine the roles of policy paradigms, in particular new public management and regulated competition in different areas of health policy in Israel. Mixed-methods. Quantitative data was based on a series of four surveys of the attitudes of the Israeli public and physicians regarding priority-setting for the standard basket of services provided by four health plans. Surveys included questions on knowledge and attitudes regarding the standard basket and the process used to determine it, and asked respondents to rank health vignettes and make trade-offs among competing services. Qualitative content analysis was based on documentation of the priority-setting process regarding the standard basket, in depth interviews and focus group discussions, primarily with primary care physicians and key informants in hospital settings.	The public indicates increased relative preference for treatments adding quality of life, shifting from prioritizing extending life, even in the case of life extending treatments in non-terminal conditions, towards increased relative preference for treatments adding quality to life. Higher than expected levels of trust in institutions dealing with health. Over two thirds of the general public indicated trust or some trust in the system. Physicians exhibit higher levels of trust in the system.	Assessing or eliciting social values of/from stakeholders
Harris, Nxumalo, Ataguba, et al. 2011	Social solidarity and civil servants' willingness for financial cross-subsidization in South Africa: Implications for health financing reform	To assess South African civil servant's familiarity with ideas of social solidarity and social insurance, and whether their need for health care is linked with their approach to income cross-subsidization. In addition, to examine whether willingness to cross-subsidize varies by socio-demographics such as race, gender, and socio-economic status. Quantitative analysis of qualitative data. Administered a structured questionnaire to 1330 health and education civil servants. Purposive sampling strategy to ensure representative sample.	One third of the respondents were willing to cross-subsidize others and half favoured a progressive financing system, whereas 7.8 per cent held the view that 'everyone should pay for their own health care'. White respondents, men, and those with low education were less likely to express willingness to pay for others. Senior managers, black Africans, or those with tertiary education more likely to choose these options than lower-skilled staff, white, Indian or Asian respondents, or those with primary or less education. Findings suggest different values or belief systems along cultural lines impact attitudes towards cross-subsidisation.	Assessing or eliciting social values of/from stakeholders
Kehoe & Ponting 2003	Value importance and value congruence as determinants of trust in health policy actors	Examines levels and determinants of trust in a health care system and in key actors in the health policy community. Quantitative. Multiple regression analysis of survey data from randomly selected participants in Calgary, Canada to identify the determinants of three different types of trust.	Value importance and value congruence on equal accessibility are found to be important factors explaining variation in all three types of trust and outweighed most other determinants identified in the trust literature. The study found moderate levels of trust in the Alberta medical system and surprisingly low levels of trust in key actors in the health policy field. The propensity of Calgarians to withhold high levels of trust might be due to government having broken an emotional bond between Canadians and their health system.	Assessing or eliciting social values of/from stakeholders
Ridde, 2002	Equity and health policy in Africa: Using concept mapping in Moore (Burkina Faso)	To present the usefulness of concept mapping as a methodological approach in to understand the views of equity among local stakeholders in an African context. Qualitative. A case study of an international cooperation project of a non-governmental organization in Burkina Faso. Concept mapping was used to understand the local views of equity (translated as corresponding to social justice) among stakeholders. Two CMs were done among two different groups of local stakeholders (9 nurses and 7 village health committee members). Participants generated statements about their interpretations of social justice, which were then grouped into conceptually similar ideas. Multivariate analysis was used to allow each statement to be positioned in relation to the others in accordance with the strength of association.	The local perception of equity seems close to the egalitarian model. The actors are not ready to compromise social stability and peace for the benefit of the worst-off. For the nurses, social justice is perceived as attributable not so much to individual behaviours, but rather to the way the whole society, and particularly the State, operates. The most important concept for them was rational and efficacious use of aid. The concept which least represents the nurses' idea of the concept of social justice is that of social security. For the village health committee members, the most important concepts were honesty, truth, and transparency, mainly terms opposed to corruption or to the misappropriation of aid. Action was also an important notion for members.	Assessing or eliciting social values of/from stakeholders
Schlesinger. 2002	On values and democratic policy making: the deceptively fragile consensus	To demonstrate that the USA consensus favouring managed competition is deceptively fragile, with support riven by cleavages in the values used to judge fairness in the allocation of medical care. Qualitative. Context is explored through historical analysis. Thereafter, a unique data set of matched questions asked of both policy elites and the general public is used to assess the prevalence of support for market-oriented reforms and to determine the preferred allocations of responsibility among market proponents and opponents. Respondents were asked to consider the desirability of different strategies for social policy to meet	the consensus favouring managed competition is deceptively fragile, with support riven by cleavages in the values used to judge fairness in the allocation of medical care. Among congressional staff there was substantial support for market reform. Market advocates among policy elites embraced allocations based on individual choices but also preferred allocations linked to productivity and were less enthusiastic about norms of need or equality. Only 41 percent of the public endorsed the market frame for social policy reform and market advocates among the public are slightly less likely to endorse individual responsibility for medical care. These differences help explain the current policy-making	Assessing or eliciting social values of/from stakeholders

		"basic needs" in society. The study incorporated 179 intensive interviews among respondents from the general public and elites.	context. The coalition of elites favouring market reforms is inherently unstable, because liberal and conservative advocates of the market base their support on radically divergent values.	
Stafinski, Menon, Marshall. 2011	Societal values in the allocation of healthcare resources	To identify factors around which distributive preferences of the public have been sought, to create a list of social values proposed or used in current resource allocation decision making processes for new health technologies, and to review approaches to eliciting such values from the general public. Qualitative. Three approaches were used to identify material. A comprehensive review using a structured search strategy in electronic databases to identify empirical studies of public preferences; an analysis of non-technical factors or social value statements considered by technology funding decision making processes based on website searches; a review of appeals to funding decisions on grounds in part related to social value judgments.	The key factors/patient characteristics addressed through policy statements and around which distributive preferences of the public have been sought included severity of illness, immediate need, age (and its relationship to lifetime health), health gain (amount and final outcome/health state), personal responsibility for illness, caregiving responsibilities, and number of patients who could benefit (rarity).	Assessing or eliciting social values of/from stakeholders
Abelson, Miller & Giacomini. 2009	What does it mean to trust a health system?	To develop meaningful conceptualizations of trust and health systems that can inform the pursuit of more trustworthy health systems. Qualitative. Review multi-disciplinary literature on trust and health systems to situate and aid interpretation of empirical qualitative findings from FGDs on Canadian's values in relation to health systems.	Patient provider relationship at the centre of trust in the HS. Govt at times seen as external to HS, and as an actor working AGAINST shared interests of patients and HCWs. Common distrust of for-profit actors. Ownership matters. For-profit ownership evokes mistrust. To assess trust in health systems, or to restore apparently lost trust, we need to understand how people think about health systems and their relationships to them. "High levels of concern about falsehoods and deceptive practices, suggest transparency is highly valued. Restoring or strengthening trust in health systems will only succeed if it is conceived within a broader political and institutional context.	Eliciting social values from members of the public
Bombard, Abelson, Simeonov, et al.	Eliciting ethical and social values in health technology assessment	To elicit a set of ethical and social values from citizens that could be used to guide Ontario's HTA evidentiary review and appraisal process, and to explore the feasibility of using participatory approaches to elicit these values. Qualitative. A 14-person Citizens' Reference Panel on Health Technologies was established. Informed, deliberative discussions were combined with pre- and post-questionnaires, which assessed the relative importance of various ethical and social values as well as their stability over time.	Core values identified by panel members were universal access, choice and quality care. Public engagement offers an informed and participatory approach to eliciting ethical and social values for HTA. Deliberation about the use and diffusion of new health technology fostered a process of making public values explicit.	Eliciting social values from members of the public
Bouwman, Bomhoff, De Jong, et al. 2015	The public's voice about healthcare quality regulation policies	To explore possible discrepancies between public values and opinions and current healthcare quality regulation policies. Quantitative. Developed questions reflecting the concepts of the theory of 'responsive regulation', 'high trust, high penalty', and 'tripartism'. The questionnaire was submitted to a sample of 1500 members of the Dutch Healthcare Consumer Panel. For each sector (healthcare, education and food service) respondents could rate responsibility on a five-point scale for each of the seven stakeholders.	Respondents felt the Inspectorate should bear most responsibility for the quality of healthcare. Next in ranking came the care providers, the minister, and then managers. Patients were rated to bear the least responsible for quality of healthcare. Most respondents agreed that the Inspectorate should publish poor care delivery on its website. Slightly more than half indicated that the Inspectorate should issue a fine when poor care was provided. The majority of the public do not support decentralisation of responsibilities of the regulator, but do agree that the patients' voice and especially their complaints should play a pivotal role in regulatory policies.	Eliciting social values from members of the public

Appendix 2a: Link to published paper (Chapter 2), including list of papers and claims extracted for interpretive synthesis

This systematic mixed methods evidence mapping review is available online at https://www.ijhpm.com/article_3902.html. The data extraction sheet (pages 1-48) for this paper is available online at: http://www.ijhpm.com/data/ijhpm/news/Whyle-Supple-File-1-IJHPM.pdf.

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Meta-Synthesis

Towards an Explanation of the Social Value of Health Systems: An Interpretive Synthesis

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Abstract

Background: Health systems are complex social systems, and values constitute a central dimension of their complexity. Values are commonly understood as key drivers of health system change, operating across all health systems components and functions. Moreover, health systems are understood to influence and generate social values, presenting an opportunity to harness health systems to build stronger, more cohesive societies. However, there is little investigation (theoretical, conceptual, or empirical) on social values in health policy and systems research (HPSR), particularly regarding the capacity of health systems to influence and generate social values. This study develops an explanatory theory for the 'social value of health systems.'

Methods: We present the results of an interpretive synthesis of HPSR literature on social values, drawing on a qualitative systematic review, focusing on claims about the relationship between 'health systems' and 'social values.' We combined relational claims extracted from the literature under a common framework in order to generate new explanatory theory.

Results: We identify four mechanisms by which health systems are considered to contribute social value to society: Health systems can: (1) offer a unifying national ideal and build social cohesion, (2) influence and legitimise popular attitudes about rights and entitlements with regard to healthcare and inform citizen's understanding of state responsibilities, (3) strengthen trust in the state and legitimise state authority, and (4) communicate the extent to which the state values various population groups.

Conclusion: We conclude that, using a systems-thinking and complex adaptive systems perspective, the above mechanisms can be explained as emergent properties of the dynamic network of values-based connections operating within health systems. We also demonstrate that this theory accounts for how HPSR authors write about the relationship between health systems and social values. Finally, we offer lessons for researchers and policy-makers seeking to bring about values-based change in health systems.

Keywords: Social Values, Interpretive Synthesis, Health Systems, Complexity, Emergence

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Introduction

> *"A just system must…be arranged so as to bring about in its members the corresponding sense of justice, and effective desire to act in accordance with its rules for reasons of justice…[Institutions] must be not only just, but framed so as to encourage the virtue of justice in those who take part in them"*—Rawls 1971.[1]

Health systems are complex social systems, and social values constitute a central facet of their complexity.[2-6] The influence of social values is evident across a myriad of elements, functions and interactions of the health system.

In an earlier systematic review on values in health systems, we found evidence of the influence of values across all health system components and functions.[7] For example, in service delivery, values are shown to influence preferences for private provision over public[8] and affect patient-provider relationships,[9] while with respect to human resources, values impact health provider motivation[10] and levels of absenteeism.[11] Within health system governance, values influence the functioning of community accountability mechanisms[12] and decision-making processes,[13] and determine macro-level financing arrangements such as the extent of cross-subsidisation.[14] Values considerations are also increasingly incorporated into technical decision-making processes around health technology assessment.[15] Critically, across all health system components, values inform the behaviour and choices of individual actors,[16,17] and shape relationships between actors.[12,18]

The sub-field of health policy analysis has produced substantial evidence suggesting that values influence policy-makers and shape policy-making processes,[19-23] and, as a result, inform the language of policy documents *and* policy goals.[24-26] Through this influence on policies, values shape the trajectory of health system development.[27,28]

The earlier review also revealed that values were often positioned by Health Policy and Systems Research (HPSR) authors not only as an *input* influencing health system change, but also as a *property* of health systems. For example, Saltman and Bergman argue that social values determine the existing architecture of health systems and then "continue to

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Appendix 2b: Meta-ethnography

Developed by Noblit and Hare, meta-ethnography is an interpretive approach that allows analysts to synthesise qualitative data, including assumptions, approaches and findings of primary texts (Noblit *et al.* 1983, Pope *et al.* 2007) to elaborate "current understandings and render them more interpretable" (Noblit *et al.* 1983). Emerging as a response to qualitative synthesis approaches that obscure the richness of the primary data, offering "summations rather than explanations," and therefor making it difficult to draw any explanatory conclusions from the synthesis, meta-ethnography compares data across sources, to enable new, holistic interpretations that are based in, but go beyond that data, and offer a theory that explains the data (Noblit *et al.* 1983, 1988, Pope *et al.* 2007). Insofar as meta-ethnography is generative rather than summative, it is an ideal approach for synthesis that seeks to retain the nuance and complexity of primary data to build new interpretations and explanatory theory (Noblit *et al.* 1988).

Given the particular nature of the data to be synthesised—qualitative data from a range of sources offering various conceptualisations of the relationship between health systems and social values—it was necessary to find an approach to data analysis that would allow us to combine underlying assumptions with explicit findings in the same set of primary data. In addition, we sought an approach that would allow us to use the primary data to develop a unified argument about how the health system could possess this productive capacity. Meta-ethnography allows for the combination of underlying assumptions and findings within a single data-set, and, in certain circumstances[1], facilitates the identification of the relationship between data points in terms of a single line of argument, or in this case, explanatory theory (Noblit *et al.* 1983, 1988). Accordingly, we drew on meta-ethnographic analytic tools to determine how the raw extracts were related to one another, translate extracts from primary texts into a common frame and synthesise data to facilitate comparison across extracts, and ultimately use the synthesized data to generate new explanatory theory.

Steps for meta-ethnography

1. Getting started—Identify an area of interest worthy of synthesis

The need for this synthesis is a product of the findings of the original review, which suggested that HS have the capacity to generate social values, but did not suggest an explanation for this capacity.

2. Purposive searching and selecting of relevant studies

Data selection was conducted iteratively through a qualitative systematic review of social values in HPSR literature reported fully in Whyle *et al.* (2020).

3. Reading the studies to identify raw data for the synthesis

Texts were read in full. Claims about the relationship between health systems and social values extracted verbatim. Apparent underlying assumptions or conceptualisations of this relationship were noted.

4. Determining how the studies are related—either directly comparable, oppositional, or together sustain a line of argument.

[1] Noblit and Hare (1988) suggest that presuming a common line of argument across the primary data is appropriate when the primary papers are not opposition, but are also not directly analogous.

Taken together, the data from the primary literature can be interpreted as a single line of argument—suggesting an explanatory theory for the social value of health system. This explanatory theory represents a new interpretation or theory that encompasses and applies across the primary data set.

5. Translating the studies into one another—mapping concepts onto one another to identify similarities and differences
We mapped the relational claims identified in the primary literature in a single diagram allowing for interpretation based on a common metaphore. This was possible because the relational claims are founded on a common conceptual foundation: that of the health system as a network of relationships.

6. Synthesising the translations by identifying concepts, frameworks or theories that transcend individual texts and produce new interpretations and explanations
Applying concepts from complex adaptive systems theory, we present an explanation for the capacity of health systems to generate social values as an emergent property of complexity.

7. Expressing the synthesis in a way that is intelligible to the intended audience of the original data set
We introduce the reader to key concepts from complex adaptive systems theory, and illustrate the explanatory theory using examples from the original data set.

Sources: Noblit et al. 1988, McCormick et al. 2003, Pope et al. 2007

Appendix 5: Timeline of health system reform efforts in context

Year	Social, political and economic context	Health system context	Policy process
1910s	1910 - Creation of the Union of South Africa from British colonies and Afrikaner republics 1912 - African National Congress (ANC) formed 1913 - Native Land Act	1918 - Influenza pandemic in South Africa 1919 - Public Health Act - first union-wide public health act	
1920s	1923 - Urban Areas Act ('pass laws') 1924 - Pact Government (coalition of Afrikaner National Party and English Labour Party) wins election 1926 - Commission on Old Age Pensions and Social Insurance (Pienaar commission) 1927 - Immorality Act 1928 - Old Age Pensions Act 1929-32 - Carnegie Poor White Commission		1926 - Pienaar commission included proposal for NHI
1930s	1929-1932 - Great depression Mid-1930s - Gold-fuelled economic growth 1936 - Land Act 1938 - United Party wins general election		1935 - Health system reform 'without racial distinction' proposed in House of Assembly Collie Commission on NHI 1938 - Establishment of segregated health services for Black people, jointly administered by Dept of Public Health and Dept of Native Affairs
1940s	1944 - Moves towards de-racialisation of welfare system 1948 - National Party wins election and formalises apartheid	1942 - National Health Service Commission (Gluckman commission) initiated 1942 - Beveridge report released (would form the foundation of the UK NHS) 1944 - Statement by the Prime Minister accepted the adoption of 'Health Centres' as the foundation of NHS 1945 - Gluckman appointed Minister of Health 1948 - Implementation of UK NHS 1948 - A J Stals appointed Minister of Health	1941 - Cooperative medicine pamphlet
1950s	1959 - Promotion of Bantu Self Government Act establishes Homelands		1955 - ANC Freedom Charter envisions a preventive health scheme, free for all, to be run by the state
1960s	1961 - South African becomes a republic following narrow referendum win		1967 - Medical Schemes Act
1970s	Early 70s - Increased, more militant, opposition to apartheid, including labour strikes and growth of Black trade unions	Late 70s - Shift in government policy toward privatisation Medical Scheme membership opened to all races	1974 - De Villiers Commission into Private Hospitals and Unattached Operating Theatres

Year	Social, political and economic context	Health system context	Policy process
1980s	Monetarist ideas used to legitimate South African economic policy decisions Early 80s - Debt crisis 1984 - New Constitution 1985 - National State of Emergency to repress opposition to apartheid 1986 - Abolition of 'pass laws' 1987 - Stock market crash	HIV/AIDS emerges in South Africa 1986 - National Party explicitly endorses privatisation policy 1989 - Amendment to Medical Schemes Act includes deregulation of Medical Schemes	1980 - National Plan for Health Service Facilities 1986 - Browne Commission of Inquiry into Health Services
1990	Unbanning of the ANC, and SACP Mandela released from prison. Reaffirms ANC's commitment to nationalisation ANC Discussion Document on Economic Policy World Development Reports warns of the impact of structural adjustment on the poor	Maputo Statement on HIV and AIDS in Southern Africa NEHAWU-led hospital worker strike against privatisation	National Policy for Health Act focused on individual responsibility, cost recovery and private provision
1991	CODESA negotiations for the end of apartheid beginNational Peace Convention initiated by Consultative Business Forum results in National peace Accord	HIV/AIDS recognised as a threat to stability of the health system	National Health Service Delivery Plan focuses on PHC and addressing health needs of entire populationANC Discussion Document advocates single comprehensive NHS financed with public funds
1992		Measles epidemic National AIDS Committee of South Africa (NACOSA) formed	Centre for Health Policy puts forward NHI proposals ANC Ready to Govern policy guidelines propose the 'the creation of a comprehensive, equitable and integrated NHS'
1993	CODESA negotiations achieve compromise between ANC and National Party on fiscal and governance strategy. Included provisions for GNU and protection of jobs for civil servants for 5 years following democratic transition	Medical Schemes Amendment Act further deregulates medical schemes at expense of consumers Introduction of Tobacco Control legislation	
1994	RDP published - emphasises transformation, development, obligation of the state for social welfare ANC wins election. GNU inaugurated under Mandela Interim constitution entrenches Bill of Rights	Dlamini-Zuma appointed Minister of Health Free Care policy removes user fees for children under six and pregnant and lactating women	Directorate of Health Financing and Economics established ANC's National Health Plan introduces proposals for mandatory health insurance Health Care Finance Committee (HCFC) established
1995	TRIPS agreement under WTO	HIV/AIDS epidemic expanding rapidly	Committee of Inquiry into NHI recommends SHI scheme covering hospital services for contributors only
1996	Constitution of RSA entrenches right to healthcare and introduces fiscal federalism GEAR replaces RDP - neoliberal-influenced investor-friendly policy, commits to reduced public spending Truth and Reconciliation Commission hearings commence	Free care policy expanded to all permanent residents for PHC services Sarafina II scandal breaks Constitution makes national and provincial governments jointly responsibility for health care	
1997	Mbeki inaugurated as ANC president Subramooney case tests limits of socio-economic rights, finds in favour of state	HIV/AIDS epidemic - prevalence among pregnant women reaches 16% Virodene scandal breaks Medicines Act makes provision for compulsory licenses and generic substitution	White Paper for the Transformation of the Health System envisages NHS/SHI Social Health Insurance (SHI) Working Group reconsiders Deeble model Medical Schemes Working Group established

Year	Social, political and economic context	Health system context	Policy process
1998	Intergovernmental Fiscal Relations Act increases authority of provinces over resource allocation	Treatment Action Campaign established Compulsory community service introduced Soobramoney case: Courts accepts rationing of health care on the basis of cost	Medical Schemes Act reforms medical scheme in preparation for NHI
1999	Mbeki presidency begins (with Zuma as deputy president)	Tshabalala-Msimang appointed Minister of Health Patients' Rights Charter 16% of population is HIV+ Pharmaceutical Manufacturers Association of SA v. Nelson Mandela	SHI included in ANC election manifesto
2000	Unemployment and inequality rising since 1994	AIDS accounts for 1/4 of all deaths KZN cholera outbreak as a result of water disconnections	Committee of Inquiry into a Comprehensive Social Security System ('Taylor Committee') established
2001	Black Economic Empowerment begins (but implementation slow) Grootboom housing rights case	Uniform Patient Fee Schedule (UPFS) policy includes means-rated cost recover Pharmaceutical Manufacturers Association of SA v. Nelson Mandela case withdrawn TAC launches legal challenge over ARTs to PMTCT (Minister of Health v Treatment Action Campaign)	
2002	World Summit on Sustainable Development held in JohannesburgTaylor Committee reports 45-55% poverty rate	Approx. 23% of population is HIV+Minister of Health v Treatment Action Campaign - Constitutional Court rules in favour of TACHazel Tau and Others vs GlaxoSmithKline and Boehringer Ingelheim over excessive pricing of ARVs	Taylor Committee calls for NHI as a long-term strategy Ministerial Task Team on Social Health Insurance
2003	National Prosecuting Authority announces prima facie case of corruption against Zuma	Cabinet revolt against Minister Tshabalala-Msimang over resistance to HAART roll-out Competition Commission launches complaint against SAMA and the Board of Healthcare Funders over healthcare tariffs	National Health Act includes provisions for Certificate of Need policy and (non-binding) NHRPL
2004		HAART roll-out begins	National DoH and Treasury clash over NHI funding
2005	Zuma dismissed by Mbeki over corruption charges Accelerated and Shared Growth Initiative for South Africa (ASGISA)		National DoH established Ministerial Task Team to establish with Taylor Committee proposals to take forward - decides NHI not feasible
2006	Rand value crash Phiri Water Rights case launched		
2007	Zuma replaces Mbeki as leader of the ANC BEE becomes Broad-Based BEE	Mbeki fires Deputy Minister of Health Madlala-Routledge	ANC adopts NHI policy at Polokwane conference ANC NHI Task Team formed

Year	Social, political and economic context	Health system context	Policy process
2008	Global financial crisis Mbeki recalled from office, then resigns Load-shedding - widespread power outages as a result of operational crisis at Eskom	USA healthcare reform proposals gaining attention Aaron Motsoaledi appointed Minister of Health	National Health Amendment Bill released, then put on hold Medical Schemes Amendment Bill gazetted and then withdrawn
2009	Constitutional court declare pre-paid water meters and discontinuation of water services 'lawful' Corruption charges against Zuma dropped by National Prosecuting Authority shortly before election Economic recession spurred by 2008 financial crisis		Establishment of NHI Advisory Committee ANC NHI Task Team's draft proposal leaked to the media
2010	SA hosts Soccer World Cup - absorbs huge proportion of public funds	Hospital Association of South Africa v Minister of Health and Another - Constitutional Court declares NHRPL invalid	PHC re-engineering policy adopted
2011			NHI Green Paper published
2012	Marikana Massacre		ANC resolves the NHI must be established 'urgently' by 2014 Phase 1 NHI implementation: pilot sites initiated National health Amendment Bill
2013	Public Protector Nkandla report leaked	Health Market Inquiry launched	
2014	Load-shedding' recurs		Operation Phakisa - Expanded Ideal Clinic campaign
2015			
2016	Public Protector releases 'State Capture' report		
2017	Public Protector launches case against Zuma Fees must Fall protests	HASA and SADA successfully challenge Certificate of Need policy in constitutional court	NHI White Paper published
2018	Cyril Ramaphosa appointed President		HMI Provisional Findings released Draft NHI Bill released Presidential Health Summit

Year	Social, political and economic context	Health system context	Policy process
2019		Zweli Mkhize appointed Minister of Health	HMI Final Report released NHI Bill approved by Cabinet and tabled in Parliament

Appendix 6a: Full discourse analysis report of social values in NHI policy rhetoric

This Appendix presents the full discourse analysis of social values in South African National Health Insurance (NHI) policy rhetoric from 1990 to 2019. Because discourses include the hidden assumptions and value commitments underlying ways of talking about a particular topic (in this case NHI), presenting the findings of a discourse analysis involves a considerable amount of argumentation and explanation to make clear the discourses underlying what is explicitly said. As such, studies using discourse analysis are commonly severely constrained by the word-count limitations in publication, which makes it difficult to offer a full account of the discursive analytical approach and the outputs of the analysis. The article presented in Chapter 6 provides the full analysis of the case study, including much of the analysis presented here. However, in order to demonstrate the rigour of the analysis, we have included the analytics on which that article is founded.

We conducted the discourse analysis by identifying arguments and their discursive underpinnings, and categorising arguments according to the discourse they draw on, to enable the identification of social value-commitments underlying those arguments. Here, we present each discourse we identified along with the arguments drawing on that discourse. At times, where necessary, we have also briefly unpacked the discourse to make clear the discursive connections between arguments.

Acronyms used in this appendix

ASSA	Actuarial Society of South Africa	**NAMDA**	National Medical and Dental Association
COSATU	Congress of South African Trade Unions	**NHI**	National Health Insurance
FMF	Free Market Foundation	**NHS**	National Health Service
HASA	Hospital Association of South Africa	**PHASA**	Public Health Association of South Africa
HCFC	Health Care Finance Committee	**PHM**	People's Health Movement
HMI	Health Market Inquiry	**SACP**	South African Communist Party
HSF	Helen Suzman Foundation	**SAMA**	South African Medical Association
HSR	Health system reform	**SANGOCO**	South African Non-Governmental Organisation Coalition
IFP	Inkatha Freedom Party	**SAPPF**	South African Private Practitioners Forum
IRR	Institute of Race Relations	**SHI**	Social Health Insurance
MASA	Medical Association of South Africa	**TAC**	Treatment Action Campaign

Discourse: NHI as socialist or redistributive

In a 1987 presentation to the National Medical and Dental Association (NAMDA) Coovadia (1988) argues for the institution of a National Health Service (NHS), describing the nationalisation of health services as an example of ‘socialised medicine’. The 1992 Ready to Govern policy document states that African National Congress (ANC) health policy will be “guided by the aspirations…enshrined in the Freedom Charter” which includes radical socialist and redistributive language and speaks of social services as mechanisms for equitable redistribution through social investment (Peet 2002, Van Niekerk 2007). Much of the academic and professional support for health system reform (HSR) in the 1980s also used the immorality of commodifying medicine to argue for a NHS (Benatar 1985, Coovadia et al. 1986), and a 1991 ANC discussion document entitled ‘Towards developing a health policy’ states that the private sector should ‘become part of’ the NHS, and describes financial resources for health as being ‘caught up in’ the rich private sector, which serves only 20% of the population (Waugh 1991). The ‘nationalisation’ of health services was discussed within radical segments of the ANC and health-focused civil society until the early 1990s (Van Niekerk 2007).

In 2009, the South African Communist Party (SACP) argued for the NHI by positioning those against the NHI as “the capitalist classes” (quoted in McLeod 2009b). In 2019, then-Health Minister Zweli Mkhize was quoted in news article insisting that the NHI Bill was not tantamount to “the nationalisation of private healthcare” (Child 2019). Less explicit, but nonetheless ideationally linked,

are arguments that suggest the NHI should be undertaken in order to redistribute resources from the private to the public sector. This argument was drawn on regularly under Minister Motsoaledi who argued that relative to other countries, health spending in South Africa was more than sufficient, but that the public-private divide prevented efficient use of those resources (Madore *et al.* 2015, van den Heever 2016).

Counter discourse that assumes socialist ideas are pernicious

However, likely enabled in part by the collapse of socialist states in the late 1980s (which undermined the ANCs ability to base their policies on the socialist model (Baker 2010, Pick 2010)), the ideational link between NHI and socialism is also used among detractors of the NHI. These types of argument are most evident in media coverage of the series of committees formed in the early days of the new democracy but persists throughout the policy experience. For example, a 1994 article in The Star states that some elements of the 'ANC's health plan' "smacked of nationalisation" (Robbins 1994). A 1995 article describes the Deeble model as "the controversial proposal to offer basic care by virtually nationalising doctors" (St Leger 1995), while another critical article describes NHS as "a controversial health insurance scheme devised by socialist Australian health economist John Deeble" (Breier 1995). Similarly, in an article questioning the transparency of the Health Care Finance Committee (HCFC) describes Minister Zuma as favouring a plan by the 'socialist' Australian economist, Deeble (Streek 1995) (see also Gilson *et al.* 1999). In 1998, a member of parliament from the Inkatha Freedom Party (IFP) was quoted as calling the plans detailed in the White Paper "a blueprint for a failed Marxist health policy" (Rabinowitz 1998).

Much of this discourse also draws on a mistrust of Minister Zuma as being politically or ideologically motivated (Gilson *et al.* 1999). For example, a 1995 article states that the scheme was "devised by socialist Australian health economist John Deeble," and quotes an opposition party spokesperson as saying that "Dr Zuma and her 'apparatchiks' were determined to appoint one committee after another until they found one that would rubber stamp their health plan." (Breier 1995). An article entitled 'Will Zuma back off' reports "the Broomberg/Shisana Committee of Inquiry into a national health insurance system is due to report back this month and speculation is rife as to whether any of the discredit socialist principles of the Deeble model will survive." (Staff reporter 1995c) Another article, reporting on the 1995 Committee of Inquiry into NHI is titled 'Socialism is a Eurocentric failure', and suggests that a nationalised health system is a 'threat' that has been set back by the findings of the committee, but has not disappeared (Financial Mail 1995) (See also (Breier 1995, St Leger 1995).

Later, in 2004, an article titled 'High risk medical plan' describes HSR under Tshabalala Msimang, including risk-related cross subsidies, income-related cross subsidies and mandatory cover, as 'socialist intervention of the worst kind' in which 'you rob some so that you can pay for others in the system' (Star 2004). Similarly, the Free Market Foundation's (FMF) submission in response to the 2011 Green Paper says that the NHI is South Africa's version of "a centrally planned, socialised health system" and accuses the government of ignoring evidence from countries with socialised health systems showing that they are inefficient, expensive, unsophisticated, inequitable, low quality and characterised by long wait times (FMF 2011). In 2018, the Institute of Race Relations' (IRR) submission on the NHI Bill characterises the NHI as part of "the ANC's commitment to the national democratic revolution (NDR): a strategy developed by the Soviet Union in the 1950s to take former colonies from capitalism to socialism and then communism" (IRR 2018).

Individualist discourse that connects cross-subsidisation or public provision to an abdication of personal responsibility

Closely related to popular suspicions of socialist ideology with respect to the NHI are arguments that, in contrast to the principles of solidarity, frame financial cross-subsidisation as unfair to the rich. In 1996, the Committee of Inquiry into Social Health Insurance (SHI) proposals assume that it would be 'unfair' if the SHI resulted in high-income earners being 'over-taxed' (Gilson *et al.* 1999), reflecting a prevalent feeling in the Department of Finance that middle- and high-income taxpayers were already unduly burdened (Doherty *et al.* 2000, McIntyre *et al.* 2003, Thomas *et al.* 2004). Such arguments draw

on discourse that contrasts cross-subsidisation with incompatible with personal responsibility. A letter to the editor published in the South African Medical Journal in 1986 argues against a universalist NHS, on the grounds that it will "give rise to a don't-care attitude…the reasoning being that the state will care for us" (van Wyk 1986), implying that people ought to take responsibility for their own health and healthcare. Similarly, the Actuarial Society of South Africa (ASSA) submission on the 1997 white paper adopts an individualist position in arguing against solidarity-based reforms on the grounds that it involves "too few active people who are required to pay for too many old people" and suggests that individuals should be allowed to opt out of the NHS "in order to provide for themselves via the private system" and should then not be allowed to "fall back on state support" (ASSA 1997). A senior Department of Health official in 2017 characterised some individuals working in Treasury as being 'ideologically captured,' due to their belief that policy decisions should take care not to offend the 'rich' who are paying taxes (reported in (Waterhouse *et al.* 2017). A 2004 media article characterises policies which would mean medical scheme members subsidise the healthcare of the poor as "punishing those earning a higher income because they are better off" (Pather 2004). This discourse is also evident in the FMF's submission on the 2016 White Paper, which argues that free healthcare will result in people failing to take responsibility for their own healthcare needs. Then-Minister Motsoaledi highlighted this discourse in a 2018 speech to the Public Health Association of South Africa (PHASA), saying "people always challenge me – they say this is private money, this is my money, go and bother others" (Motsoaledi 2018).

Discourse that assumes South Africa comprises two separate societies

This ambivalence toward financial cross-subsidisation reflects a conceptualisation of the health system, and South African society more broadly, as being divided sharply in two, rather than, as Paremoer (2021) puts it "constitutive of a single society with a shared fate", with the private system being solely for the rich, and entirely independent from a public system that serves the poor. For example, a 2005 media article states that "access to healthcare has divided the population of this country in two - the haves and the have-nots" (The Star 2005). Thus, those arguing for the NHI are forced to also argue for a sense of national unity. In a 2018 speech to PHASA, then-Minister Motsoaledi characterised those opposing the NHI as believing "everyone is an island – that what I do does not affect those around me. Nothing I do affects those who stand next to me. That man thinks he can run his healthcare system alone" (Motsoaledi 2018). The goal of the 2018 Presidential Health Compact is formulated as "One Country, One Health System" (RSA 2018) (see also (Ramaphosa 2019b), and the preamble of the 2019 NHI Bill positions NHI as a response to the need to "heal the divisions of the past" (Republic of South Africa 2019). In his 2019 Budget Speech, Minister Mkhize argues that the NHI "depends on our willingness to SHARE as ONE NATION" (emphasis original) and is a chance "for South Africans to join hands in a way that really counts" (Mkhize 2019).

These ideas are also sometimes used in arguments that explicitly seek to justify a 'two societies' approach. For example, the FMF's comments to the 2015 Davis Tax Committee argues that government should concern itself only with the poor: "When it comes to health care, government should concentrate its efforts and scarce taxpayer resources on the poor…for those who can afford healthcare, leave them alone to seek out the cover that would suit them best" (FMF 2015). FMF's 2016 submission on the White Paper argues against tax-based funding for healthcare among 'those who can afford it' on the grounds that this is 'interfering' – implying that only the poor are the responsibility of the state (FMF 2016). As Paremoer (2021) argues, debates around NHI in South Africa are characterised by a striking perception that public health institutions are exclusively for 'the poor.'

Discourse: NHI as a way to build social cohesion or to redress apartheid NHI

Thus, one line of argument for the NHI is that it is a tool to build social cohesion, and to reconcile the social divides wrought by apartheid. In 1988, Coovadia (1988) argued that "redistribution of resources is a requirement for the creation of a just society and forms a basic demand of organisations at the forefront of the struggle for freedom. An NHS would be one aspect of this redistribution." The 1994 National Health Plan explicitly acknowledges that the apartheid government "developed a health care

system which was sustained through the years by the promulgation of racist legislation" and that the institutions of that health system "were built and managed with the specific aim of sustaining racial segregation and discrimination in health care" (ANC 1994). This aligns with a statement by then-president Mandela in 1997, in which he said that the transformation to democracy had been felt most keenly in the form of universal access to health facilities and argued that free care policies had "transformed the majority of South Africans from being neglected outcasts into beneficiaries of a compassionate health policy" (Mandela 1997).

Later, in 2010, the Congress of South African Trade Union (COSATU) General Secretary said, "the apartheid fault lines persist. While the mainly white wealthy can buy world-class healthcare in the private sector, 86% of mainly black poor have to struggle to get any service at all in an under-funded, understaffed public sector…where rights of patients are hung on the wall but not their living reality" (quoted in IMSA 2010). The COSATU's submission on the 2011 Green Paper argues for the NHI by stating that "the NHI will go the long way to rectification injustice of the past" (COSATU 2011). Similarly, COSATU (2016b) argued in 2016 that NHI is "key to radical transformation". In 2019, President Ramaphosa, at the signing of the Presidential Health Compact, said "we are working together towards the achievement of redress. We are working together for the public good, for social cohesion, for economic progress and, as Madiba said, for peace" (Ramaphosa 2019b). Here, Ramaphosa also referred to NHI as "the most-far reaching policy for social transformation this country has seen since 1994" (Ramaphosa 2019a). This also allows for racial disparities in access to medical scheme coverage and private healthcare to be used in arguments for the NHI. For example, in his Health Department Budget Vote speech in 2016, Motsoaledi asked, "politically, economically and socially, how do we continue to justify a healthcare system where 16% of the population which in essence is the cream of the Nation, have pooled their funds together in their own corner away from the masses in the form of medical aid schemes only for the elite? Pooling these funds together for the cream of the nation means substantial resources including human resources are sitting in that corner alone, hiding away from the rest of society" (Motsoaledi 2016). In a 2018 speech at a NHI consultative meeting, President Ramaphosa argued that ensuring that quality healthcare is available universally, rather than only to the rich, is particularly important because the current two-tier health system is 'racialised' (Ramaphosa 2018, 24 August). Similarly, in 2019 Olive Shisana, then Chairperson of the Ministerial Committee on NHI said NHI "is an instrument to end the race, class, gender divisions that continue to plague South Africa. For example, 76% of medical scheme members are white, and only 10% are black." (Staff Writer 2019), and President Ramaphosa was characterised in a media article as saying that those opposed to NHI were opposed to transformation (Gerber 2019). Many NHI policy documents also explicitly place NHI in the context of the need for transformation and reconciliation. For example, the 2019 NHI Bill recognises "the socio-economic injustices, imbalances and inequities of the past; the need to heal the divisions of the past and to establish a society based on democratic values, social justice and fundamental human rights" (Republic of South Africa 2019).

Discourse: NHI as ideological or irrational

Discourse that assumes health policy should be value-free

The analysis also revealed a number of arguments that argue against the NHI by positioning it as 'ideological'. For example, an article published in January 1994 quotes then health minister Venter as saying that the NHI is "idealistic," a 'wish-list,' and would be "difficult if not impossible" to implement (Robbins 1994). Similarly, an article in the Financial Mail, entitled 'Will Zuma back off?' reads, "speculation is rife as to whether any of the discredited socialist principles of the Deeble model will survive...Health Minister Nkosazana Zuma is said to favour the Australian-authored model but industry consensus is that *commonsense* [sic] will win the day" (emphasis added (Staff reporter 1995c). That same year, the Medical Association of South Africa (MASA) responded to the reports of plans for an NHI by the Committee of Inquiry by saying that it was "imperative that the terms of reference allowed the committee to look further than at a single plan or ideology" (Strachan 1995). An article critical of "a state-dominated national health insurance model" published in the Financial Mail in 1995 quoted

a New Zealand health economist as saying that efforts to create an 'egalitarian' health system would not work because "inequality is a fact of economic life - to change this is to wish for heaven on earth" (Staff reporter 1995b).

To some extent this discourse reflects the reality that an ideological chasm had developed between the Minister and the technical experts who made up the various committees and task teams who kept proposing reform strategies that she felt did not do enough to redress inequities (Gilson *et al.* 2003). The close association between Minister Zuma and HSR efforts (Breier (1995) refers to the NHS as 'Zuma's plan) added weight to this framing, as she was popularly understood to be passionate about redressing inequity in the health sector, as well as 'radical' or 'revolutionary' and to be motivated by ideology (Gilson *et al.* 1999). This dynamic is most clear in media reporting of the various committees established to investigate HSR in the late 90s.

While the content of the NHI policy proposals shifted over time, to be more accommodating of the private sector (see van den Heever 2016, Waterhouse *et al.* 2017) arguments that NHI is too radical to be realistic persist. A 2004 letter to the editor reads "simply put, the notion of all-embracing, almost free healthcare is not viable" (Citizen 2004). Later, an article about responses to the leaked NHI Task Team report notes that the report is "the product of an almost exclusively internal ANC process and has not been subject to scrutiny from experts" (Duncan 2009) – this is despite the fact that Shisana (chair of the Task Team) was chief executive officer of the Human Sciences Research Council, and health economist Di McIntyre was reported to the on the Task Team (Khanyile 2009, HSF 2011, Madore *et al.* 2015). In 2010, Motsoaledi's attempted to 're-legitimise the normative justifications for the NHI, saying, "we have no option morally, economically, socially or otherwise but to move in this direction. South African needs it more than any other country that you can think of" (Motsoaledi 2010). Drawing on the idea that NHI is utopian or unrealistic, Archer (2014) also says Motsoaledi is "painting a picture…that simply cannot be, unless…one ignores…the realities of South Africa's budgetary and human-resource constraints." In fact, Motsoaledi was commonly perceived as "driven by ideology" and not willing to base decisions on evidence or advice of experts (Waterhouse *et al.* 2017). AfriBusiness' (2015) comment on the 2015 White Paper argues that the policy decision was entirely political not based on any analysis. In an article reporting on the NHI after the release of the 2016 White Paper in an industry newsletter, an informant suggests that policy-makers seeking advocating for limiting the role of medical schemes in the NHI are 'ideologues' (Medical Brief 2016).

Discourse that connects economic conservatism to value-free or orthodox policy-making

In contrast to universalist reforms being positioned as 'socialist', neoliberal reforms are commonly presented in arguments against NHI as 'common-sense' or value-free. Walt *et al.* (1994) warns that economists are sometimes "seen as 'neutral technocrats, harbingers of rationality and conveyors of objectivity', although they are, as any other actors, fuelled by particular values which may or may not be articulated (or even recognized) explicitly." In the 1980s, a number of think tanks and professional bodies (including MASA) argued that in addition to de-politicising the issue of healthcare provision, privatisation made 'economic sense', and Price (1994) argues that, because of the number and power of groups making this argument, the idea became hegemonic. Similarly, the 1994 HCFC was considered to be working on financing issues that were purely 'technical,' and therefore did not need to be representative or transparent (Thomas *et al.* 2004). Demonstrating the hegemony of neoliberal ideas, the Democratic Alliance's response to NHI in 2008 argues that the proposals "remove many of the elements from the market for health care that have been shown across the world to be essential components of any properly functioning market, and competition and choice in particular" (quoted in McLeod 2009a). This discourse is evident still in 2016, when the Helen Suzman Foundation (HSF) submission on the White Paper, states "whether health care is a public or private good is not a matter for normative specification. It depends on the facts of the case" suggesting that the issue is purely technical (HSF 2016).

Arguments based on economy and affordability

This discourse – that positions neoliberal ideas as orthodox or common sense, in opposition to socialist or universalist reforms that are assumed to be 'ideological' – also underlies arguments that the NHI is 'unaffordable'. Media reports frequently claim that NHI is unaffordable (CMS 2011, Mcintyre 2019). For example, Streek's (1995) article on the draft HCFC report opens with the claim "we simply can't afford reforms,". Another article from that year warns that an NHS could "bleed the economy" (Breier 1995). A 2004 news article argues that the NHI is 'poorly thought out' and "almost certainly unaffordable" (This Day 2004). Similarly, a news article reporting on the ANC's NHI Task Team report criticises the absence of any formal costing of the NHI and argues that the Task Team has not 'proven' that the NHI will be affordable (du Preez 2009). In a 2014 published commentary, an industry insider accuses then- Minister Motsoaledi of "painting a picture…that simply cannot be, unless…one ignores and disregards the realities of South Africa's budgetary and human-resource constraints" (Archer 2014). Counter to this pervasive discourse, Mcintyre (2019) suggests that media reports that NHI is unaffordable are "largely based on a fundamental misunderstanding of the nature of the proposed reforms".

This discourse of NHI as unaffordable is also evident in some of the submissions from civil society organisations and professional bodies. The ASSA argued, for example that SHI "will simply make our country's economy even less competitive" (ASSA 1997). Similarly, Hospital Association of South Africa submission on the 2015 White Paper argues "South Africa cannot afford a comprehensive package of health services for all of its population, even with additional revenue from some form of mandatory contribution" (HASA 2016). In a submission on the NHI Bill, the South African Private Practitioner's Forum (SAPPF) questions the 'affordability' and 'sustainability' of the NHI (SAPPF 2018).

Arguments in the submissions also draw attention to the failure of policy-makers to properly assess the affordability of HSR. The HSF's submission on the 2015 Draft White Paper states, "there are no prizes for guessing solutions which lie outside the budget constraint" and argues that the NHI "requires a great fiscal leap at a time of weak economic growth" (HSF 2016). The South African Medical Association's (SAMA) submission "laments the preponderance of groundless financial/economic assumptions and claims in the White Paper" and argues that "the costing information provided in the White Paper is based on unrealistic assumptions" (SAMA 2016)

Discourse: The market for healthcare is legitimate

Discourses that assume the commodification of healthcare is appropriate

The analysis also revealed argument strains of argument arguing *for* the commodification of healthcare. On one hand, some arguments against HSR suggest that when health services are free people will use them inappropriately and therefore that healthcare should not be free for everyone. For example, the ANC's National Health Plan suggests that user fees may be necessary to "discourage *inappropriate* use of the health services" (ANC 1994). Similarly, the FMF's 2016 submission on the White Paper argues that 'free' healthcare will encourage 'over-utilisation' and a failure to 'take responsibility' for one's own medical requirements (FMF 2016).

Discourses that assume the right to participate in the healthcare market

On the other hand, many more arguments against HSR suggest that the public has a right to participate freely in healthcare markets. For example, a 1995 news article reports that the MASA supports the NHI plan because it preserves "patients' freedom of choice in regard to health care practitioners and insurance" (The Argus 1995). In the same year, an article critical of NHI argues that it is 'bad reasoning' to suggest that "rich people should not be allowed to buy better healthcare than the poor" "simply because of the desirability of universality" (Staff reporter 1995b). Similarly, a 1998 press article by an IFP Member of Parliament argues that "instead of imposing a national health insurance on workers whether or not they pay for private schemes, all South Africans should belong to a medical scheme of their choice" (Rabinowitz 1998) – implying that the right to *choose* takes primary over equity concerns. Later, a 2009 article assuring readers not to 'panic' over the 'demise' of their medical scheme coverage, quotes health economist Di McIntyre as saying that it would be "politically and

constitutionally wrong to deny people the option to choose medical scheme cover in addition to a mandatory health system" (du Preez 2009). That the idea of the right to 'buy' private health insurance is a motivating idea in South Africa is also clear in following quote from an industry insider explaining the Department of Health's apparent 'walk-back' of the limitations on medical schemes proposed in the 2016 White Paper: "The middle classes sympathetic to the ANC won't stand for being told they can't buy medical scheme cover" (Brian Ruff quoted in Medical Brief 2016). This discourse also appears in the report of the Committee of Inquiry into a National Health Insurance System, which assures the public that the committee's proposals "recognise the right of individuals to use private sector providers for their primary healthcare services, and to insure themselves for the use of these services" (Republic of South Africa 1995).

'Big government' discourses

Discourse that assumes an expanded role for the state in the delivery of healthcare

The analysis also reveals that those defending the introduction of HSR must counter neoliberal assumptions about the appropriate role of the state in health financing and delivery. In 1986, in a letter to the editor of the South African Medical Journal, Coovadia *et al.* (1986) argued that privatisation "in practice means abdication of the state's responsibility to provide care for all". Pillay (1993), in an article arguing that unions should demand adequate funding of the public sector rather than access to the private sector, wrote that "access to health care is a right and unions should demand that the state guarantees this right" and the COSATU submission on the 1997 White Paper demands a "conscious strategy to move systematically towards a public health care system and away from private provision" (COSATU 1998).

Discourse that assumes a wider role for the state in regulating the private sector

The analysis also reveals discourses that attempt to re-emphasise the role of the state in regulating the private sector to protect those who rely on it. The ANC's 1994 National Health Plan, under 'Guiding Principles' states that "every person has the right to achieve optimal health, and *it is the responsibility of the state* to provide the conditions to achieve this" (emphasis ours) (ANC 1994). It goes on to say that health and other social services "must not be allowed to suffer as a result of foreign debt or structural adjustment programmes" (ANC 1994, see also Van Niekerk 2007). In 2002, the report of the Committee of Inquiry into a Comprehensive Social Security System attempted to counter this discourse by arguing that "the ultimate responsibility for the overall performance of a country's health system lies with Government...The oversight and effective regulation of the private sector has to form part of the overall Government response and must be high on the policy agenda" (CSSS Committee 2002). The South African Non-Governmental Organisation Coalition's (SANGOCO) submission on the 2003 National Health Act attempts to counter a number of neoliberal discourses simultaneously, including the primacy of 'affordability' and the abdication of responsibility of the state. The submission takes issue with repeated use of phrase 'limits of available resources' in the Act and argues that instead the Act should push towards 'progressive realisation' of 'adequate, quality, free public healthcare for all, stating clearly that "that it is the responsibility of the Department of Health to provide access to adequate quality health care services for all," and suggests the bill define a package of services to which everyone is entitled at both public and private health facilities (SANGOCO 2003). Similarly, Section27 and The Treatment Action Campaign's (TAC) submission on the Draft NHI Bill argues that the Health Market Inquiry (HMI) is necessary because the government had repeatedly failed to regulate costs in the private sector (Section27 *et al.* 2018). The HMI report itself states that stewardship of the private sector has been 'inadequate' and that the Department of Health has failed to use its "legislated powers to manage the private healthcare market" (CCSA 2019).

Discourse: The state cannot be trusted

The discursive struggle about the appropriate role of the state in healthcare exists in a context of declining trust in the state spurred by AIDS denialism and corruption (Kautzky *et al.* 2008, Wale 2013, Potgieter 2019), and finds expression in arguments for or against HSR. Both the quality of services provided in the public sector, and the manner in which the state goes about policy-making, financing

and regulation for healthcare are used as part of a no-faith in the state discourse in arguments against the NHI.

Discourse that assumes the state (as provider of health services) cannot be trusted

A 2011 article reported a Democratic Alliance spokesperson as arguing that the ‘real problem’ to be solved by NHI was not ‘financial accessibility,’ but rather ‘low quality healthcare in the public sector’ (Health writer 2011), and this argument is also found in IRR’s (2018) submission on the 2018 NHI Bill. The 2011 Green Paper’s extension of the proposed implementation period and framing the initial 5 years as an opportunity to reform the public health system, can be understood as a response to this discourse (Republic of South Africa 2011, Van den Heever 2011). Motsoaledi acknowledged this discourse in 2018 when he said, “this issue of poor quality of Public Healthcare is clearly being used as a big stick to beat back the advancement of NHI” (Motsoaledi 2018, June 21).

Discourse that assumes the state (as financer, regulator and policy-maker) cannot be trusted

The analysis also reveals arguments based on significant distrust in the state with respect to financing, regulation and policy-making processes. In the late 90’s media discourse on the NHI drew heavily on the mistrust of Minster Zuma discussed above and describes the policy-making process as secretive or sinister. Media articles in 1995, for example, refer to Zuma’s ‘hidden agenda’ (Staff reporter 1995a), refer to the leaked HCFC committee report as a ‘secret report’ kept hidden by Minister Zuma (Streek 1995), and to the Committee of Inquiry on NHI as a ‘sinister probe’ (Political correspondent 1995). Similarly, Breier (1995) quotes an opposition party spokesperson as saying, “there is something secret and sinister about the whole thing,” referring to the series of deliberative committees established by Minister Zuma.

This discourse persists beyond Minister Zuma’s tenure. For example, a 2004 news article critically reporting on Minister Tshabalala-Msimang’s plans to introduce a SHI argues that the Minister is “playing with other people's money,” that “the state is not a good agency for collecting, storing and distributing assets,” and that state lacks the technical capacity to implement a risk-equalisation fund (Star 2004). Similarly, a 2009 news article responding to the leaked NHI Task Team proposal alleges that “some elements in the ANC are trying to force a universal healthcare system proposal that would cost South African taxpayers R100bn” (Duncan 2009). A long-form article by private-sector industry insider Jonathan Broomberg suggests transparency as the first of four principles for HSR, and asserts “thus far, the NHI debate has been held behind closed doors, with no public or stakeholder participation” (Broomberg 2009). A 2011 news article reported the opposition party the Democratic Alliance as arguing that NHI will do more harm than good because it will increase the corruption that already exists in the public sector (Health writer 2011). SAMA’s submission on the 2015 White Paper states “A unique aspect in the South African context is the question of trustworthiness of government. It is recognised that trust must be earned. This chapter strongly points out that the apparent societal (South African) suspicion on (and diminishing confidence in) political leaders and/or government institutions has relevance in the search for right solutions” (SAMA 2016). Similarly, the IRR’s submission on the 2018 Draft Bill questions “whether the NHI Fund can realistically be shielded from the gross inefficiency and rampant corruption which increasingly plagues Eskom and other state monopolies” (IRR 2018). The SAMA submission on the 2019 NHI Bill states that SAMA members “demonstrate little faith in the National Health Department to get beyond stages of planning and strategizing and actually implement anything meaningful as far as change management and quality improvement go” (SAMA 2019). In the same document SAMA states “the establishment of the NHI as a single monopolistic purchaser for healthcare opens its structures up to large-scale corruption.” (SAMA 2019).

Interestingly, these arguments are also presented by left-leaning institutions that are supportive of universalist HSR. For example, the Section27 and TAC’s submission on the 2018 draft NHI Bill states that “a public distrust in large funds and state owned entities, stemming from national experience with SASSA, the RAF, Eskom, SAA and others, necessitates careful consideration of the need for centralisation of funds and the mechanisms that will be adopted to protect such funds and assure

decision-making in the interests of the people of South Africa" (Section27 *et al.* 2018). Similarly, the Dullah Omar Institute's submission on the 2019 NHI Bill objects to the centralisation of power with the Minister, noting that "Our national experiences of the capture of State Owned Entities has taught us grave and costly lessons about the risks of over-centralising these powers in one Minister" (Dullah Omar Institute 2019). This indicates that a loss of trust in the state has particular discursive power in that it brings together actors across a wide ideological spectrum.

While this discourse is clearly dominant in the media and in stakeholder submissions, a 2009 study by McIntyre *et al.* (2009) found that two-thirds of a representative sample of respondents would trust a government-linked organisation over a private organisation to administer an NHI. The study found that only the richest 20% of the population said they would prefer the NHI to be administered by a private organisation (McIntyre *et al.* 2009). This likely reflects the fact that, as Waterhouse *et al.* (2017) argues, the views apparent in the media reflect private sector interests and middle class concerns. This would also explain the Financial Mail's argument in 1995 that "some form of rationing is always necessary and rationing by affordability is preferable to queues" (Financial Mail 1995).

The emerging discourse that positions NHI as an antidote to market failures

For the most part, the discourse on corruption is exclusively connected to the public sector, indicating an acceptance of the neoliberal idea that the state is more corrupt than private actors. However, a shift occurred in 2008, spurred by the global financial crisis, the leadership of Minister Motsoaledi and later by the Health Market Inquiry into private healthcare (launched in 2013), that offered a counter-narrative to trust in the market with respect to both quality and costs, and enabled the emergence of a more explicit (although not necessarily coherent) anti-capital or anti-neoliberal counter-discourse.

Recognition of quality failures in private healthcare

With respect to submissions, SAMA argued in their 2016 submission on the White Paper that the delicate issue of quality of care in the private sector has been overshadowed "by high costs and inefficiencies" and that "stereotypical assumptions of superior quality in the private sector" mean that the quality failings of the sector are not recognised (SAMA 2016). This assumption in evident in the HSF's critique of the 2011 Green Paper, which uses a quote from the Minister of Finance's 2010 Budget Speech to argue that public-private partnership is necessary to improve the 'hospital system' and critiques the lack of mention of public private partnership in the Green Paper (HSF 2011), and in critiques of the NHI that argue minimising the role of the private sector will 'disrupt' the health system (Madore *et al.* 2015).

However, the issue of over-servicing (undoubtedly an aspect of poor quality) is more widely recognised, particularly after the publication of the provisional HMI report (CCSA 2018). For example, Gifford (2018) reports that the 2018 provisional HMI report found that doctors and specialists who order too many tests or too readily admit patients to hospital were driving up costs. Similarly, López González (2018) reports on an "epidemic of overtreatment", and Mphahlele (2018) notes that "over-servicing…is leading to soaring private health-care costs" (see also (Nicolson 2018). Similarly, Ngcaweni (2018), in an article entitled 'NHI is vital to heal [South Africa],' writes that the medical schemes industry is "plagued by issues of fraud, waste and abuse", and that "members are…experiencing increased rates of out-of-pocket payments and unaffordable premiums…that leave millions vulnerable not just to market forces but to worsening health status and mortality". Nonetheless, the sanitised language in which market failures in the private sector are discussed is indicative of the dominance of neoliberal discourses in the NHI policy process.

Soft critiques of quality failings in the private sector

Nonetheless, while there is some critique of high costs and inefficiencies in the private sector, there is very little discussion of quality issues, and when there is, it is usually couched in econometric euphemism and ignore the consequences for patient well-being. For example, the HSF's submission on the 2011 Green Paper references corruption in relation to the public sector but refers only to 'market-imperfections' when talking about the private sector (HSF 2011). This trend was criticised by Nicholas Crisp – then head of the NHI office under then-Minister Mkhize – in an interview with the

Daily Maverick newspaper, when he proclaimed himself "baffled" by the notion that corruption was only a problem in the public sector when there is clearly "massive institutionalised, organised" fraud in the private sector (Heywood 2019). Journalist Mark Heywood went further to say, "we may not call it theft, but over-servicing and what the HMI euphemistically calls 'supply induced demand' is jimmying the system for private gain" (Heywood 2019).

Discourse that counters trust in the market or in the private healthcare system

Some arguments for the NHI, or against the status quo, use a more explicitly challenging discourse that counters neoliberal ideas of trust in the market. Then-general secretary of COSATU, Zwelinzima Vavi, publicly addressed SAMA in 2008, arguing that the private sector "treats private health care as a commodity/business" in a "market-driven…system based on avoiding the sick" rather than treating the sick (Vavi 2008). Vavi lays the blame on privatisation and a "macro-economic policy that weakened the building of a well-resourced, well-remunerated public health care system" (Vavi 2008). The PHM's 2011 submission on the Green Paper argues that neoliberal policy decisions, including "the introduction of GEAR, fiscal discipline, privatisation, retrenchment of health workers and deliberate strengthening of the private sector" are part of a purposeful effort to undermine the public health sector and subsidise the private sector (PHM 2011). The submission recommends an inquiry to look into "possible unlawful practices in the private sector which are driving the cost of health care" (PHM 2011). Later, COSATU's submission to the HMI reads "we believe that many…members of the medical schemes are…on the receiving end of price-gauging and rent-seeking that is prevalent across the 'value chain' of the private health industry" (COSATU 2016a). Similarly, SAMA's 2016 submission notes that the cost of care in the private sector hinders access and should be understood as a quality issue (SAMA 2016).

This counter-discourse is also evident among policy-makers, and in policy documents. The 2011 Green Paper blames for cost escalation in the private sector on the "uncontrolled commercialism of healthcare" (RSA 2011). Motsoaledi attempted to counter the idea that health should be left to the market in the wake of the 2008 global financial crisis when he argued that while "problems in the health system are said to be existing only in the public sector" and while many believe that "the private sector must be left alone to some wayward phenomena called market forces," "market forces dismally failed to stop, or more appropriately caused, the most recent global economic collapse" (Motsoaledi 2011). The next year, in the 2012 budget speech, Motsoaledi quoted Margaret Chan as saying "the world woke-up to the dangers of assuming that market forces by themselves, will solve social problems. They will not" (Motsoaledi 2012, April 24). In a 2018 speech, Motsoaledi said "[to say that healthcare is a right] means it is a right for everyone…it shouldn't' be sold" (Motsoaledi 2018). Paremoer (2021) suggests that for the ANC, NHI "is envisioned as an intervention that should subvert the capacity of for-profit institutions to steer health policy at the expense of public health."

This rhetoric is relatively rare in news media, however, with a few exceptions. In a letter to the editor published in the Mail & Guardian the writer argues in favour of the NHI by positioning the 'downtrodden black majority' as being 'held to ransom' by ' invisible spirits of the market' (Gumbi 2016). A 2018 news article stated that the provisional HMI report found that the private sector was "working in favour of profits rather than good care and value for money" (Gifford 2018). Similarly, Friedman (2018) writes "it is inevitable that whatever proposals [the HMI] comes up with will be attacked as an assault on the free market. This will ignore the reality - that there is no market in health care in South Africa, at least not one which works the way markets should work."

NHI (or the policy process) is corrupted by vested interests

There is also evidence of a discourse that argues in favour of the NHI by positioning critics as motivated by self-interest or draws on distrust and discomfort with the relationship between capital and the state. This discourse picks up particularly after 2008 and is likely strengthened by growing concerns about corruption. A 2008 news article by Khanyile (2008), writes that the halting of the National Health Act Bill (which contained provisions for a national health reference price list) was a result of private sector actors lobbying the ANC. Similarly, a media article about the leaking of the NHI policy draft in

2009, reports the ANC's policy research coordinator as suggesting that critics of the NHI proposal had 'vested interests' (Khanyile 2009). In a 2011 speech, Minister Motsoaledi said that those who were against the NHI were "consumed by self-interest and greed that will shame even the devil [and have] …vowed to do anything in their power to stop NHI" (Motsoaledi 2011). Later, in the 2016 Health Department budget vote speech, Motsoaledi explicitly pointed out the conflict of interest inherent in policymakers and civil servants' use of the private health sector, asking "How do we…justify that you and I…representatives and humble servants of our people, together with the judges of our courts…benefit from resources in a very expensive medical scheme of our own – for us only?" (Motsoaledi 2016). In the same year, COSATU national spokesperson accused the ANC and Minister Motsoaledi himself of 'sabotaging' the NHI by 'handing it over' to private interests and 'big business interests' (Pamla 2016). Waterhouse *et al.* (2017) argue that a lack of consultation and transparency in the NHI policy process gives rise to distrust about what interests are influencing the policy processes (whether they are corporate or individual vested interests), which likely further strengthens this discourse.

NHI (or Motsoaledi) as a threat to medical schemes or private healthcare

On the other hand, there is also a discourse that position's Motsoaledi or the NHI as a threat to the private sector. Waterhouse *et al.* (2017) notes that Minister Motsoaledi's 'strongly-worded critiques' and general 'intolerance' of the private sector were widely reported in the press, and that Motsoaledi was perceived as brazenly hostile to the private sector. This idea is used in a counter-narrative that draws on the 'distrust in the state' discourse to frame NHI, Motsoaledi or the ANC as a threat to medical schemes, the private sector, or medical scheme members. For example, a 2008 news article entitled 'Your medical scheme's survival under threat' describes NHI as inevitably involving the 'demise' of medical scheme (du Preez 2008). Motsoaledi satirised this idea in his 2009 budget speech saying that South Africans are being "urged to run for cover because the NHI is going to be a marauding monster that will destroy everything that you hold dear in the health care system of the country" (Motsoaledi 2009). Similarly, in 2012 Motsoaledi pushed back against this discourse in a news article where he stated that the ANC was not 'fighting' or 'abolishing' private healthcare, but only "excessive prices which even the middle class can no longer afford" (Parker 2012). In 2014, in a letter to the Mail & Guardian the chief executive officer of the SAPPF accused Motsoaledi of saying that he (Motsoaledi) was at 'war' with the private sector and argued "the private sector is not the enemy of the people that Motsoaledi persists in trying to portray it as" (Archer 2014). In this vein, the South African Dental Association's submission on the 2015 White Paper highlights the tendency "to be suspicious of the motives of private health sector players and to challenge the very legitimacy of private health provision" and calls on the government to "to initiate a calmer and more constructive debate" (South African Dental Association 2015). A media article in 2015 (before the release of the draft HMI report in 20018) framed Motsoaledi as unfairly blaming private doctors for cost escalation in the private sector, saying it looked "like Motsoaledi had made up his mind about the drivers of costs in private healthcare despite a commission of inquiry into high costs not making any findings as yet" (Fokazi 2015). Similarly, the IRR's submission to the 2018 draft NHI Bill draws on the 'NHI is socialist' discourse, saying that the ANC's 'Soviet' strategy to move from capitalism to communism underlies the Party's ideological hostility to business, "deep suspicion of the 'profit' motive in private health care" and repeated 'stigmatisation' of the private sector as "costly, selfish, and uncaring" and driven by "profits before people" (IRR 2018).

Appendix 6b: Further background and examples

Land politics in South Africa

Pre-apartheid, movement and land ownership among black people were restricted by a series of legislative measures. The 1913 Land Act designated 87% of South Africa's land as 'white areas', the 1923 Urban Areas Act confined black people living in 'white areas' to segregated townships, and 'pass laws' restricted the movement of Black people in 'White areas' to what was necessary for the provision of labour (Terreblanche et al. 1990, Hall 2014).

The apartheid government's 'grand apartheid' strategy, beginning in the 1960s, involved the establishment of demarcated areas known as 'homelands' or 'bantustans' where black people could live, segregated by 'tribe' and race (Naylor 1988). The homelands were ostensibly self-governing, which justified the non-enfranchisement and denial of services to black people in 'white South Africa' (Price 1986, Bottomley 2016). Hundreds of thousands of people were forcibly relocated to the homelands (Naylor 1988).

Post-apartheid, land reform was strongly implied in the ANC's 1995 Freedom Charter, and had been on the agenda since 1994 as part of the RDP, justified by 'redress' as an imperative of transformation (Republic of South Africa 1994, Hall 2014). However, the RDP did not go far enough to confront the tensions between the private property rights protected by the interim constitution and transformation through land reform, choosing to use market-based approaches of 'willing buyer, willing seller' to implement the policy, with the result that it was widely considered a failed policy (Pillay et al. 1995, Greenberg 2004). By 2001, land reform was not a pressing issue for the general public, and had fallen from the policy agenda (Nattrass et al. 2001). Like with a radical NHI, actually implementing land reform policies was considered infeasible (Van Niekerk 2003).

However, at the 2007 Polokwane conference, the ANC recommitted itself to land reform, as well as to reviewing the 'willing seller, willing buyer' approach, which protected property rights and therefore hampered land redistribution efforts (ANC 2007). Health Minister Motsoaledi (2018) has compared the contentious nature of NHI debates to those on land reform, saying "equalizing society is not a Sunday school business."

The introduction of the welfare state and the preservation of the racial hierarchy

In the 1920s, the Pact Government (a coalition government comprising the Afrikaans National Party and the English Labour Party) introduced, first, a non-contributary old-age pension, and later, disability grants and unemployment insurance – laying the foundation for South Africa's welfare state. The impetus for the creation of the welfare system was the 'poor whites problem.' At the time, poverty among white people was seen as particularly problematic because it threatened the racial hierarchy. It was necessary, therefore, to raise poor white people out of poverty to ensure that their standard of living was sufficiently differentiated from that of black people living under similar conditions. In addition to instituting constraints on land ownership and movement of black people, the Pact Government instituted welfare reforms to lift white people out of poverty. In short, "South Africa's welfare state has its origin…in the Pact Government's general strategy of racial segregation" (Seekings 2007a). This differentiation persisted until the mid-1940s when the Old Age Pension was extended to black people.

Sources: Seekings 2007a, Nattrass et al. 2010, Bottomley 2016.

The Old Age Pension programme and the Carnegie Commission

The introduction of the Old Age Pension programme in 1928 sparked a significant backlash against the welfare state and resulted in the establishment of the non-governmental, privately funded, Carnegie Commission, which ran from 1929 to 1923 (Seekings 2008a, Bottomley 2016). The Carnegie Commission reports argued that social welfare created dependence, and that poor white people were poor as a result of individual deficiencies, including 'psychological traits' and the wrong 'type of mentality', rather than structural issues such as trade cycles and mechanisation, and other "circumstances over which the individual has no control" (Seekings 2008a). The Carnegie Commission reports advocate 'self-reliance' and 'self-help,' and suggest that social welfare creates 'dependency' that places an undue burden on the country's tax-payers, and gives rise to an inappropriate expectation that the state has a duty to provide for the poor (Seekings 2007a, 2008a).

While the backlash against the Old Age Pension was not sufficient to halt the Pact government's building of the welfare state, it was part of a "more general moral panic" (Seekings 2008a). Thus, the Carnegie Commission laid the groundwork for the social value of personal responsibility, which is often used in arguments against solidarity-based reforms, and for the abdication of the responsibilities of the state, which would later be re-emphasised by privatisation policies undertaken by the apartheid government.

The Gluckman Commission and the 'socialist' health system reform agenda of the 1940s

The Pienaar Commission recommendations framed social welfare as a part of the struggle against capitalism – an idea that enjoyed wide appeal (Seekings 2007a) and despite the backlash against the Commission's recommendations, the use of socialist or anti-capitalist social values in arguments for HSR persisted. The economic depression made health professionals receptive to the idea of a universal national health system and support for a NHI grew over the course of the 1930s (Harrison 1993, Marks 2014). In 1941, the Medical Association of South Africa (MASA) released a pamphlet on cooperative medicine that argued for a NHS that would "eliminate commercial element and competition from medicine" (Price 1989, Terreblanche et al. 1990) and made reference to "socialised medicine" (Marks 2014). In 1942, the National Health Services Commission, led by Dr Henry Gluckman (a prominent public health practitioner and advocate of NHI), called for the nationalisation of health services (Van Niekerk 2007). The commission drew inspiration from Britain's landmark Beveridge report (the founding document of the British NHS) to recommend a centrally-controlled, tax-funded, universal (and de-racialised) NHS under which doctors would be employed by the state, and the role of private healthcare would be greatly diminished (Van Niekerk 2003, Digby 2008). The proposal was criticised as 'communist' (Harrison 1993).

The election of the National Party and introduction of formalised racial segregation in the form of apartheid in 1948 changed the political climate and prevented further steps towards implementing universalist HSR (Nattrass et al. 1997, Digby 2012, Madore et al. 2015).

The AIDS epidemic and AIDS-denialism

AIDS first emerged in South Africa in the 1980s, but by 1995 the epidemic was expanding rapidly and efforts to control the spread of the virus had limited success (Schneider 1998, Gilson et al. 1999, Hall 2014). In 1996, the first of a series of AIDS-related scandals emerged when it was revealed that that the government had paid an exorbitant sum to the playwright of an AIDS-education musical and the

Public Protector confirmed that the tender process for the project had been ‘irregular’ (Schneider 1998, Lodge 1999). The scandal quickly “took centre stage of politics” (Schneider 2002).

By 1999, 20% of pregnant women were HIV-positive, and by 2000 AIDS was the leading cause of death in South Africa (Bond 1999, Fassin et al. 2003, Baker 2010). However, then-Health Minister Dlamini-Zuma was resistant to the roll-out of antiretrovirals (ARVs) to prevent mother-to-child transmission of HIV. Government resistance to ARV roll-out solidified when Thabo Mbeki, who was chief among a group of AIDS-denialists who believed that AIDS was harmless, took the presidency, and persisted under the new Minister of Health, Manto Tshabalala-Msimang (Nattrass 2008, 2011).

Although the reasons for the state’s reticence regarding ARV provision are inevitably complex and opaque, it is clear there was a desire to “protect the government's budget from the cost of buying and rolling out HAART [highly active antiretroviral therapy]”, and that ‘affordability,’ alongside aids-denialist discourse, was used as a public-facing justification for this decision (Nattrass 2008, 2011, Nunn et al. 2012).

The government’s failure to respond appropriately to the AIDS crisis prompted a massive civil society movement led by the Treatment Action Campaign (TAC) to compel the government to roll-out HIV prevention and treatment programmes (Robins et al. 2004, Heywood 2009). The TAC lodged a case in the Constitutional Court against the Minister of Health (Schneider 2002). To counter the claim that the government could not afford to provide ARVs, the TAC’s legal arguments drew on the idea that “in a system of governance in which rights are supposed to be pivotal to policy making” and in which the Constitution’s explicit requirement that “people’s needs must be responded to”, “decisions on spending on crucial socio-economic rights should not be determined only by what state treasuries (in their own wisdom) decide is affordable” (Heywood 2009). The Court sided with the TAC, and HAART roll-out eventually began in 2004 after a cabinet revolt forced the Minister’s hand (Heywood 2003, Nattrass 2008, 2011).

The commodification of water

In the water sector, policies of corporatisation and commodification, while facilitating an expansion of water infrastructure, also included price increases and cost-recovery mechanisms that resulted in both water insecurity and cut-offs as a result of paying for water (McDonald et al. 2002). Throughout the early 2000s, there were a number of protests over the practice of disconnecting households who fall behind on water payments, including in Johannesburg where, after water management was outsourced to a French company, anti-privatisation protests against the installation of pre-paid water meters resulted in the arrest of 52 activists (de Beer 1988, Bond 2014a) (see also Hart 2014). In 2006, the Coalition Against Water Privatisation supported poor residents of Phiri, Johannesburg to lodge a legal case to declare pre-paid water meters illegal and compel Johannesburg water to provide a free basic water supply (Bond et al. 2008, Bond 2014a). The high court found in favour of the applicants, but the case was overturned in 2009 in the Constitutional Court, which argued that water disconnections constitute only a ‘dis-continuation’ of services and not a ‘denial’ of water services (Bond 2014a), thereby sanctioning the idea that individuals bear responsibility for paying for basic services.

Zuma's corruption scandals and governance failures

Both Zuma and Mbeki were implicated in the 1999 Arms Deal (the new government's first major corruption scandal) in which they (reportedly) took bribes in exchange for billions of Rands awarded to various arms manufacturers (Budhram 2019, Von Holdt 2019). However, Mbeki's more successful 'image management' means that he "finds himself cloaked in the robes of an anti-corruption crusader," while Zuma is closely associated with corruption in the public imagination (Camerer 2011, Hart 2014). In 2005, the Arms Deal scandal was reignited and received significant press attention when businessman Schabir Shaik was convicted of having paid bribes to Zuma in connection with the deal (Budhram 2019, Von Holdt 2019).

In 2008, major governance challenges within Eskom, the national power utility, led to the first round of 'load-shedding' (scheduled power outages designed to relieve pressure on the power grid) (Bowman 2020). Zuma was found to have facilitated and benefitted from the appointment of members of the Gupta family (prominent businessmen and Zula-allies) to the Board of Eskom as a part of the 'state capture' project (PPSA 2016, Budhram 2019). In 2009 Zuma improperly used public funds to finance lavish upgrades to his private residence (PPSA 2014). In 2012, Zuma used his influence to ensure that the government would not be held accountable for the events of the Marikana massacre, in which 34 striking miners were shot by police (Fogel 2013, Bond 2014a, Forrest 2015). In the 2014 'Transnet controversy' a multi-billion Rand train procurement deal was found to have benefitted Zuma and his allies (Chipkin et al. 2018, Von Holdt 2019).

The Life Esidimeni tragedy

The Guateng Provincial Department of Health had a longstanding contract with a private health facility owned by Life Healthcare, known as Life Esidimeni, to provide in-patient psychiatric care. This contract was terminated to reduce expenses, and between late-2015 and mid-2016 nearly 2000 patients were either discharged or transferred to public hospitals or NGO-run facilities. The transfer process was chaotic and inhumane. In addition, many of the NGO-run facilities to which patients were transferred were unlicensed and lacked the capacity to care for the patients appropriately. Ultimately, 144 patients died, many were 'unaccounted for,' and three senior Department of Health officials resigned. The tragedy received a massive amount of attention in the press.

Sources: Dhai 2017, Makgoba 2017, Durojaye et al. 2018, Gray et al. 2018.

Neoliberalism and associated social values

Neoliberalism emerged as a mainstream political and economic ideology in the 1970s, and quickly became a globally hegemonic idea. While it finds expression in economic and other policy outcomes (including liberalisation, deregulation, privatisation, cuts in public spending on social welfare, and the introduction of cost-recovery or cost-sharing mechanisms), neoliberalism is better understood "as a network of policies, ideologies, values and rationalities that work together to achieve capital's hegemonic power" (Miraftab 2009). Distrust in state institutions as more corrupt and less efficient than private ones, and an assumption that the private sector is an appropriate delivery mechanism for social services are key tenets of neoliberalism

Neoliberal ideas about governance and economics entail ideological assumptions in which a range of values are embedded. These include private provision of social services; distrust in the state as a

funder or provider of services; the free market as an arbiter of resource distribution; personal responsibility; individualism; freedom and choice; and austerity.

Sources: Nattrass 1994a, Rose 1996, George 1997, Mudge 2008, Ataguba et al. 2012, Centeno et al. 2012, Ichoku et al. 2017.

Appendix 6c: The South African media landscape

Post-apartheid South Africa enjoys a well-functioning and relatively diverse media sector (Jacobs *et al.* 2007). In 1994, governance and regulation of the media shifted from apartheid-era government control in the name of 'the national interest' to media self-regulation in the name of the 'public interest' (Wasserman *et al.* 2005), and the South African Bill of Rights explicitly affirms the freedom of the media (Republic of South Africa 1996, Rodny-Gumede 2015).

Television, radio and print media reach a vast majority of South Africans (Jacobs *et al.* 2007), and South Africans consume a significant quantity of print media (Ledwaba 2022). Much of the print media consumed, however, is in languages other than English, which were not included in this study, and language barriers fragment the media landscape significantly (Rodny-Gumede 2015). The mainstream print media landscape includes 46 newspapers distributed nationally or regionally, 25 of which are in English (Ledwaba 2022). While English language publications dominate with respect to number of publications, several publications in other languages enjoy particularly high circulation (Ledwaba 2022). The South African Reconciliation Barometer survey found that radio and television were the most highly trusted and common sources of political news for South Africans, but that 36.7% of South Africans trusted print media as a source of political news (Potgieter 2017, 2019). However, language barriers, together with socio-economic factors that hinder access to media, continue to fragment the media landscape (Rodny-Gumede 2015, Gopal 2018).

Different publications serve the interests of different constituencies. The Daily Sun is a print newspaper that purposefully highlights the struggles of the poor (Wasserman *et al.* 2016). The Daily Sun has a circulation almost 31 000 (Ledwaba 2022), compared to more 'upmarket' print media publications such as the Mail & Guardian and Business Day, which have circulations of around 10 000.

Nonetheless, commentators and analysts widely agree that the South African media in general, and print media in particular, tends to reflect the concerns and interests of the comparatively wealthy and politically-connected elites, including private healthcare users (Jacobs *et al.* 2007, Daku *et al.* 2012, Reid 2016, Wasserman *et al.* 2016, Waterhouse *et al.* 2017). For example, service delivery protests, which largely affect the poor, are often reported unfavourably, as an 'inconvenience to the middle-class' (Wasserman *et al.* 2016). There is a related lack of ideological diversity in mainstream media content, with many commentators noting that particular ideas and ideologies, including a pro-capitalist leaning, dominate South African media (Reid 2016). This segment of the media also holds particular power in that it informs the views of decision-makers and opinion leaders. As Jacobs *et al.* (2007) state "a very small slice of the mainstream media, one that caters to a comparatively small, elite section of society, really 'counts' in terms of opinion formation and key policy issues in South Africa."

In addition to diversity in content, there is also concern with respect to diversity in ownership of media companies (Daku et al. 2012; Reid 2016). Challenges such as declining advertising revenues, budget cuts, retrenchments, 'juniorisation' and the online migration have contributed to concentration of ownership (Wasserman *et al.* 2016, Fontyn 2017, Potgieter 2019). Four major commercial publishing groups own the majority of English-language publications (Gopal 2018). In addition, China and Chinese-owned conglomerates play an increasingly large role in South Africa's media landscape (Wasserman 2016). There is concern that increasing concentration of ownership in the sector is

undermining press freedom, and empowering large corporates at the expense of community media (Daku *et al.* 2012, Gopal 2018, Potgieter 2019).

There is also tension between the print media sector and the ANC. On the one hand, while South African print media is regarded as independent (Daku *et al.* 2012), there are cases of media groups being owned by or affiliated with individuals with close ties to the ANC, again raising questions about press freedom (Wasserman 2016). On the other hand, the ANC government has frequently, in recent years, accused the media in general, and print media, in particular, of catering only to the wealthy or the white minority and of being resistant to the government's policy agenda (Rodny-Gumede 2015, Reid 2016). Given the pivotal role the media plays in South Africa's democracy (Potgieter 2019), these issues are of grave concern.

Sources: Republic of South Africa 1996, Wasserman et al. 2005, Jacobs et al. 2007, Daku et al. 2012, Rodny-Gumede 2015, Reid 2016, Wasserman 2016, Wasserman et al. 2016, Fontyn 2017, Potgieter 2017, Waterhouse et al. 2017, Gopal 2018, Potgieter 2019, Ledwaba 2022.