

# What South Africa can learn from other countries for a successful implementation of National Health Insurance – a review of the literature

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## Abstract

**Objective:** This review paper aimed to provide a qualitative summary of evidence on how other countries that have had some success in implementing some form of Universal Health Coverage (UHC) have navigated the structural problems in the health system and used the lessons to inform the implementation of the National Health Insurance (NHI) in South Africa (SA).

**Methods:** The literature search was undertaken from December 2020 to December 2022 and included literature dated 2010 to 2022. The criteria for selecting the literature was limited to papers written in English and involving discussions on what and how all stakeholders (public and private sectors) can contribute to ensuring the smooth implementation of UHC. A narrative, rather than systematic review, was considered more appropriate.

**Results:** The review paper has identified opportunities that, if exploited, may clear the way for an all-inclusive stakeholder collaboration to see a successful delivery of the NHI project in SA. The opportunities identified sought to address leadership and governance, healthcare financing, service delivery and health workforce challenges. The challenges of managing the cost escalation and maintaining coverage for vulnerable groups were explored.

**Conclusions:** The NHI project requires a clear understanding and appreciation of the collaborative efforts expected from all stakeholders. The findings of the review suggest that while the NHI building blocks have been described in legislation, there is deficiency of the detail required to deal with the implementation nuances. This requires further research to unpack the detail required to exploit the opportunities identified for the implementation of the NHI.

**Keywords:** healthcare reform, health policy, health insurance, stakeholders, policy implementation, public health, private sector, health financing, health inequalities

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## Introduction and background

The National Health Insurance (NHI) is designed to pool funds and actively purchase services with these funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. This represents a substantial policy shift from the current segregated, unequal and more often ineffective healthcare system that sees a huge chunk of economic resources directed to approximately 18% of the population in the private sector whilst a huge section of the population relies on the state to provide health care.<sup>1</sup> The NHI White Paper details the challenges inherent in the current system as the inability to address the poor social determinants of health (SDH), the increasing burden of disease, and the structural problems in the health system.<sup>1</sup> According to the White Paper on the NHI, the structural problems are a consequence of the inability of the system to effectively implement the six healthcare system building blocks, being: (i) Leadership and governance; (ii) Healthcare financing; (iii) Health workforce; (iv) Medical products and technologies; (v) Information and research' and (vi) Service delivery.<sup>1</sup> It is the goal of the authors of this paper to review the strategies that other countries have followed to deal with the structural challenges or problems that adversely affect the implementation of the NHI building blocks.

The goal of Universal Health Coverage (UHC) becomes more realistic when a population has access to prepayment and pooling mechanisms.<sup>2</sup> The World Health Report on Health Systems Financing identifies three fundamental questions that governments face in striving to achieve the goal of UHC.<sup>2</sup> These fundamental questions are:

- i. How is such a health system to be financed?
- ii. How can people be protected from the financial consequences of ill-health and paying for health services?
- iii. How can the optimum use of available resources be encouraged?

This review paper aimed to provide a qualitative summary of evidence on how other countries that have had some success in implementing some form of UHC have navigated the structural problems in the health system, and to use their lessons and experiences to inform the implementation of the NHI in SA. Those structural problems are leadership and governance, service delivery challenges, health workforce challenges, availability of medical products and technologies and healthcare financing challenges. Availability of medical products and technologies were not discussed in this review since it is considered a subset of the policy issues, specifically health technology assessment (HTA) policy which is addressed in service delivery coverage.

## Methods

This review was not performed as a comprehensive, systematic review, because the goal was to answer a focused research question. The literature search was undertaken from December 2020 to December 2022 and included literature dated 2010 to 2022. Google Chrome was used to search for the relevant articles. The keywords used were:

- Implementation of Universal Health Coverage
- Universal Health Coverage
- National Health Insurance
- Stakeholders' Universal Health Coverage
- Public Private Partnerships
- Role of State in Universal Health Coverage
- Health care
- Implementation
- Role of Government
- Private Insurance
- Private Medical Aids

The criteria for selecting papers for review were limited to literature published in English; literature involving discussions of what and how all stakeholders (public and private sectors) could contribute to ensuring the smooth implementation of UHC in one form or another, and literature on how and what these stakeholders have contributed to the implementation of a specific form of UHC and the achievements attained.

The primary author identified the papers for review and shared the references with the supervisor who provided input on how these are likely to address the research question. The supervisor also provided possible papers for inclusion in the review.

The focus in this review was on literature concerning the contribution that all stakeholders (public and private) made in the implementation of some aspect of the UHC.

The literature review undertaken sought to unearth what other countries – where some level of UHC had been achieved – had undertaken their journey to address specific aspects of the healthcare system building blocks as identified in the NHI White Paper (2017). The outcomes of the review were then compared to the progress or otherwise of the NHI project in SA.

## Conceptual literature review

The aspects addressed below are all-encompassing and were not intended to address verbatim the six building blocks as per the NHI White Paper but to address the broad approaches or concepts that the different countries undertook.

### Leadership and governance

Leadership and governance continue to be one of the issues that impacts the attainment of the objectives for UHC implementation. Advocacy for multi-sectoral and participatory governance is a

core area of leadership and governance. These actions, though challenging, are directly needed for countries to be able to effectively and sustainably move towards UHC.<sup>3</sup> This aspect was considered at a side event at the 72nd World Health Assembly in Geneva on 22 May 2019 by high profile UHC specialists. The comments of the participants emphasised the importance of having a legislative framework to promote good governance. They argued that the legislative framework must focus on unpacking and understanding the dimensions of participation of all stakeholders, demonstrate political will, and define the responsibility of the private sector in making affordable medicines more accessible.<sup>3</sup>

The importance of ensuring a space for civic engagement, systems to deliver on the right to health for all without discrimination, responding to the needs of all, the ability to engage in decision-making and holding different actors to account was also viewed as one of the important implementation enablers.<sup>3</sup> Similarly, another review found that though countries in the Asia-Pacific region deployed all the necessary governance functions to facilitate progress towards UHC, those countries still face challenges with respect to governance for UHC.<sup>4</sup> This included difficulties in creating policies and management strategies that work across rural-urban settings and which affected both high- and low-income countries.<sup>4</sup> The authors contend that though leadership and governance are considered the most important function of governments in health systems, they are also complex and poorly understood.

Hence, the need for leadership to set direction and develop strategies, create institutions and organise people for implementation, to gather information for evidence-based policies and monitoring were seen as key to enabling progress in the implementation of UHC.<sup>4</sup>

According to Clarke et al. (2019), major gaps in knowledge about the benefits of private care provision remain. In addition, many countries do not have an explicit government policy position on the role of the private healthcare sector, nor concrete plans to implement public policy on the private sector.<sup>5</sup> Explicitly spelling out the role of the private sector will certainly go a long way in alleviating some of the contradictions and skepticism that exist between affected stakeholders.

In an earlier commentary, Greer et al. (2015) argued that politics and governance have been undervalued as key drivers for UHC. They purport that the attainment of UHC is political and cite the fact that governments are faced with the difficult task of prioritising the relative importance of “vertical” priorities such as disease eradication and broader “horizontal” system-strengthening proposals.<sup>6</sup> They assert that there is tension between global health politics and domestic health politics. On the other hand, they state that authoritarian regimes are less responsive to the broad population and often focus benefits on a narrower sector of the population.<sup>6</sup>

Leadership and governance configuration for the implementation of UHC is another important consideration. This does not only complicate delivery and in other instances compromise the attainment thereof, but it also affects the speed at which reforms are implemented.<sup>7</sup> A comparative study of organisational transformation within the health sector in four upper- and middle-income countries identified constraints posed by the complex relationships in the power dynamics in governance institutions and organisations in governments.<sup>7</sup>

These constraints are:<sup>7</sup>

- i. Seldom do health systems change after reforms, resulting in the homogeneous single model instead of a complex system of new interactions that emerge, that require new or adaptive leadership skills to navigate.
- ii. The exercise of responsibilities after the reforms often takes a different form from the expected or calculated change.
- iii. The MOH's ability to act alone and or stamp its authority is limited due to the widespread organisational transformation accompanying such changes.

Given the power dynamics in the governance institutions and organisations in governments, the study identified four mechanisms which a ministry of health (MOH) can use to drive organisational change.<sup>7</sup>

Those strategies aim to create political commitment through a high-level interministerial ministry, translate strategic decisions into implementable steps through a change team, modify the institutional environment to enable changes needed by enacting enabling legislation and by capitalising on political windows of opportunity.

### **Healthcare financing challenges**

Chu et al. (2019), in an article titled Health Financing Reforms for Moving Towards UHC in the World Health Organization (WHO) Western Pacific Region – a region covering 37 countries and areas in East Asia, South-East Asia, and the Pacific Islands – detailed the challenges faced by these countries. Chief amongst the challenges experienced were changes in their disease patterns and populations, rapid socioeconomic developments and the increasing expectations from citizens to access better quality health services. Despite these challenges, several Asian countries (in the WHO Western Pacific Region) in particular have accelerated their movement toward UHC.<sup>8</sup> This is said to be due to high political commitment to their health-sector reforms which is triggered by pressing health financing issues and the need to strengthen the foundations of primary health care.<sup>8</sup>

Likewise, high-income countries in the Western Pacific Region, such as Japan, the Republic of Korea, Australia, Singapore, and New Zealand, experienced similar challenges as they faced mounting pressures to address the financial sustainability of their health systems, including cost control measures and adoption of new medicines and technologies.<sup>8</sup>

Despite these challenges, the authors record that countries in the Western Pacific region have been introducing health financing policies that sought to advance UHC.

In addition, the study by Chu et al. (2019), showed that risk pooling helps in the redistribution of resources and protects against the individual risk of becoming ill and paying high costs for health services by spreading the risk across the greater population.<sup>8</sup>

Simplice Dagnan (2018) in "Health System Reforms to Accelerate Universal Health Coverage in Côte d'Ivoire, Health Systems & Reform" also deals with approaches to sustainable funding for health services to achieve health reforms. From an accountability perspective, the government has paired domestic resource mobilisation with efforts to increase transparency in resource management by implementing an internal audit function within the Ministry of Health and Public Hygiene (MHPH).<sup>9</sup>

In addition to pointing to the willingness of the countries to ensure sustainable funding of their UHC efforts, the review also showed that these countries took practical steps that made it possible for them to address the healthcare financing hurdles.

This again is debatable in the South African setting where uncertainty lingers on the exact funding policy arrangements.

According to an Econex study published in Health Reform Note 13, April 2011, Voluntary Health Insurance (VHI) – known as medical aid insurance in South Africa – plays a vital role not only in countries which have not yet achieved universal health coverage, but importantly also in countries which have already done so. The study set out to answer the question "what possible future role will the VHI providers play in the NHI" by focusing on the role of VHI providers in comparable countries with Universal Coverage (UC) schemes.<sup>10</sup>

The study points to an interesting phenomenon of co-existence of private health care in the form of VHI with universal health coverage in several Organization for Economic Co-operation and Development (OECD) countries. The study highlights the following as prevailing occurrences in OECD countries where some sort of UHC is in place:<sup>10</sup>

- i. That most private health insurance markets are voluntary with some exceptions.
- ii. Even some OECD countries which have a mandatory public healthcare system have an element of compulsory private health insurance.

Most importantly the study identified gaps (real and perceived), these being: waiting times; increasing demand for choice; and perceptions of inadequacy of public systems as factors that drive the extent of private health insurance or VHI in some of the OECD countries.

The Econex study cites the following issues relating to the role of VHI in the NHI project in SA:<sup>10</sup>

- i. Like other developing countries, there are still largely perceived quality differences between the public and private sectors, thus private VHI of a duplicative nature will enable individuals to seek better quality care.
- ii. The quality differences between the public and private sectors are likely to persist after the NHI implementation and, should this materialise, duplicative private VHI is likely to continue, however the affordability of VHI might be affected due to the proposed removal of tax subsidies for medical schemes' contribution. The possible effect of this in SA is the fact that those opting for VHI will feel that they are taxed twice.

In the same vein, a WHO health financing policy brief published on 12 September 2018, whose purpose was to explore the potentials and limits of VHI for progress towards UHC in low- and middle-income countries, concluded that unmanaged (where there is no public policy) VHI is likely to pose a threat to UHC goals.<sup>11</sup>

Closer to home, the impact of VHI was explored by Goudge et al. (2018) in their paper where they ask whether the Government Employees Medical Scheme (GEMS) has further institutionalised inequities in access to health care. They examined whether insurance status and socio-economic status influenced access to care, and secondly, by investigating whether the design of the scheme has contributed to inequities in utilisation of services. The authors conclude that while GEMS has widened the scope and breadth of coverage for some civil servants, in doing so it has increased inequities in healthcare access in the country as a whole.<sup>12</sup>

In SA, the policy uncertainty regarding the future role of private voluntary health insurance in the context of the NHI financing remains an elusive subject.<sup>13</sup> The Staff Writer reports that Price Waterhouse Coopers (PwC) has surveyed 31 C-suite leaders (senior executives) of the SAn healthcare public, private and donor organisations by conducting in-depth interviews and on-line digital surveys. The report found that the healthcare reforms on the role of medical aids has stagnated and, after decades of discussion, the non-state stakeholders are wary and do not trust each other. Another article in BusinessTech (June 2022) indicates that both government representatives and public commentators are concerned about the sources of funding for the NHI. Whilst government expresses the view that a large part of the NHI's funding will be made up of the reallocation of health funding as well as existing tax credits, it goes further to acknowledge that additional taxes in the form of increase in value-added tax (VAT), change in general taxation and additional payroll tax might have to be introduced. The reaction of commentators and opposition parties is that the planned NHI will be unaffordable since it is going to impose an additional tax burden on the middle class. They argue that only 9% of South Africans are contributing to the 40% of SA's total tax revenue.<sup>14</sup>

### **Service delivery challenges**

A review paper by Fusheini & Eyles (2016) explored service delivery coverage as being one of the essential building blocks for

NHI and points out that the District Health System (DHS) has been a backbone of every health system on the continent of Africa, and in SA the DHS has been central to the health system since 1997.<sup>15</sup> The implementation of the DHS is dependent on every country's local context. They point out that South Africa's path to UHC is complicated not only by its history but also by the size of the private health sector and its present political complexion, which is still dominated by liberation ideology and the importance of solidarity and inclusion.<sup>15</sup> The DHS model, with its indicative impact areas, is said to foster local government involvement. Using the DHS model, healthcare services are organised and coordinated at a local level using decentralised, area-based and people-centred approaches, and these approaches are seen as central to the SAn context.<sup>16</sup>

The study by Fusheini & Eyles (2016) aimed to establish whether the DHS could provide service availability, given the well-known inequities between districts with respect to population health status in the NHI. The study dealt with both the normative and ideological differences of the DHS, where the ideological approach is concerned with the need for decentralisation and community involvement and programme integration.<sup>15</sup> From a normative approach the focus on districts is underpinned by the fact that to achieve equity, the organisation of health care should be according to geographic sub-divisions of a country, managed through decentralised management structures.<sup>15</sup>

According to Fusheini & Eyles (2016), despite the challenges observed in the various districts, it remains to be seen whether the financial and ideological challenges will undermine this intent – achieving the WHO-defined goal of UHC.

Campos & Reich (2019) examined another aspect of implementation – the politics of policy implementation for the health sector, particularly the management of stakeholders in order to help change management teams to improve the chances of achieving policy objectives. In the paper "Political Analysis for Health Policy Implementation", the authors identified six major categories of stakeholder groups that are likely to influence implementation, namely, interest group politics, bureaucratic politics, budget politics, leadership politics, beneficiary politics, and external actor politics.<sup>17</sup> The authors stated that understanding and addressing conflict, resistance and cooperation among stakeholders were key to managing the implementation process. They advised that systematic and continuous political analysis can help decision makers and change management teams to improve the chances for successful implementation. The article identified different challenges posed by the complex interaction among the stakeholders and offered examples of effective strategies that can be employed to manage policy implementation.<sup>17</sup>

Still another role-player, the private sector, cannot be ignored in the implementation of UHC. According to Clarke et al. (2019), it is necessary to consider what role the private sector should play in delivering healthcare services. Certainty of the private sector involvement in the provision of health care in UHC must

be established. The role of (multi)national companies, non-governmental organisations, and non-profit entities involved in the supply of healthcare-related goods, healthcare financing and the direct provision of health care has been in existence for a long time; this being as a result of private actors already operating in healthcare provision. In cases where there is no engagement between the state and private sector stakeholders, a public policy vacuum exists regarding the private sector and UHC. According to the authors, in this vacuum, the private sector could pursue its own objectives, which may or may not be closely aligned to UHC; hence the need for streamlined government policy.<sup>5</sup>

Suggestions of the possible participation in UHC by the private sector has been espoused by authors in commentaries and reviews.<sup>18,19</sup> A commentary by Kai Hong Phua (2017) suggests that the reason why, for instance, the concept of public-private partnerships (PPPs) is attracting interest and being well-received in Asia, is because it avoids the often-negative effects of monopolistic public ownership and delivery of services on the one hand, and unbridled privatisation on the other. PPPs are thought to combine the best of both worlds: the private sector with its efficient management and use of incentives; and the public sector with its regulatory actions and protection of the public interest.<sup>18</sup> Hallo De Wolf & Toebes (2016) in their review state that the private sector could be involved in the provision of health care as payers or financers (private health insurance companies, charities), providers (private hospitals, pharmacies and clinics, healthcare personnel, civil society organisations and charities) and suppliers (pharmaceutical companies and suppliers of medical equipment).<sup>19</sup>

Of the two modes of possible participation by the private sector – privatisation and public-private partnerships – the authors noted that countries have had mixed experiences when it comes to privatisation efforts enabling the realisation of the right to health.<sup>19</sup>

The Working Party on Aid Effectiveness hosted by the OECD Development Assistance Committee (DAC), initiated a work stream to look at “The role of the private sector in the context of Aid Effectiveness” ahead of the 4th High Level Forum on Aid Effectiveness (HLF 4) that took place in Busan, Korea from 29 November to 1 December 2011. Some of the responses received by the workstream included the following:<sup>20</sup>

- Mobilisers of resources
- Contributors of financial and in-kind resources
- Providers of goods and services as implementers/contractors in aid projects, including recipients of funding
- Dialogue partners and advocacy
- Partners in PPPs through cost- and risk-sharing
- Drivers of innovation

The workstream report asserts that whilst there is no consensus on what roles the for-profit private sector should play in aid, several donors and partner countries stress “partners in PPPs”,

“implementers of projects” and “equal dialogue partners”.<sup>20</sup>

In a report published in 2018 titled “What works, the triple win, rethinking public private partnerships” by Klynveld Peat Marwick Goerdeler (KPMG) – a global network of professional firms providing audit, tax and advisory services – the authors showcased the success of a PPP that ensured the delivery of quality services to a population of more than 300 000 people in Portugal. The report notes the success of PPPs in developed countries in health care where these PPPs were seen to propel the development and renewal of infrastructure, where, for instance, hundreds of new hospitals and clinics were built across Australia, Canada, France, Spain, and the UK at a scale that could never have been afforded by their governments alone. On the other hand, investment partners were said to be unlikely to make investments in emerging economies where a host of legal, political, economic, and operational risks were deemed to be a challenge.<sup>21</sup>

Whilst identifying some common mistakes to be avoided to ensure the success of PPPs, the authors concluded that the success or failure of PPPs in helping to achieve UHC will stand or fall on the ability to combine the lessons of the past with the creativity of the future.<sup>21</sup>

The picture that emerges from the various presentations and conversations around NHI at stakeholder engagement is that hardly anyone is inherently against NHI, but people in public health circles, including public service managers in the Gauteng district, have several concerns about the details of how NHI, as outlined in the bill, might work.<sup>22</sup> This is the reason why the nuances of these concerns and the associated themes on how exactly the service delivery will be undertaken are worth unpacking.

### **Health workforce challenges**

A shortage and a maldistribution of qualified healthcare workers is one the most common barriers countries face in being able to expand and achieve UHC.<sup>23,24</sup> The WHO and the Global Health Workforce Alliance reported on the status of 186 countries where they estimated a deficit of approximately 7.2 million health workers globally and predicted that this shortage will grow to 18 million by 2030.<sup>24</sup>

In SA, this dynamic is further complicated by the unequal distribution of healthcare workers (HCW) between the private and public health sectors with the latter servicing the majority of the population (approximately 83%). Approximately 40% of general practitioners and nurses work in the private sector where they only provide services to those with private health insurance, which accounts for approximately 17% of the population.<sup>25</sup>

The state of affairs of health workers in SA has recently been described as “shocking” by the Minister of Health, Dr Joe Phaahla, citing a doctor-patient ratio of 1:3 198. This dictates a need to have a clearly outlined strategy to have “the right mix of skills and people” for the success of the NHI.<sup>13</sup>

The SAN context as described above spells an almost near chronic

and complex emergency that, according to a study by Cometto et al. (2020), requires government intervention to mobilise a political commitment. The study suggested that a mechanism for health workforce policy dialogue and planning be established, in addition to appropriate monitoring and financing mechanisms.<sup>23</sup> Kai Hong Phua (2017) identified how the public and private sectors complement each other to drive health workforce policy dialogue and planning. They state that the PPPs bring the private sector efficiencies and incentive management, and the public sectors regulatory actions and protection of the public interest which are important considerations for the health workforce policy dialogue and planning.<sup>18</sup>

The PPPs, according to Hallo De Wolf & Toebe (2016), will also bring providers from the private sector who can serve as healthcare personnel to alleviate the healthcare workforce shortage to the public sector.<sup>19</sup>

### **Other aspects related to healthcare financing challenges – managing cost escalation and overall population coverage**

For completeness it is worth discussing managing cost escalation without eroding coverage, as an aspect of healthcare financing challenges, as well as ensuring sufficient coverage for the ageing population.

According to the White Paper on NHI, irrespective of the structure and financing arrangements in place, the continuing management of cost escalation without eroding coverage becomes crucial due to the continued upward pressure on costs.<sup>1</sup> Another consideration raised in the White Paper on NHI is the linkage of overall population coverage – especially the ageing population – to broader social security reforms. Lessons on the two subjects can be drawn from the OECD report.<sup>26</sup>

The OECD report states that UHC is affordable for a large number of middle-income countries but requires strong political commitment and additionally often requires the active intervention by governments.<sup>26</sup>

The authors note that the ability to extend coverage to certain groups has been a bottleneck in many countries with contributory systems of UHC. These groups include the self-employed and smaller unregulated firms in Germany, and the previously uncovered – especially the poor – in underserved rural villages in Japan, Korea and Thailand. In all of the above instances the governments intervened actively in order to drive the attainment of UHC.<sup>2</sup>

The next prerogative that the Health Coverage and Health Outcomes Final Report (Paris, 22 July 2016) alluded to, was a need for UHC because of the ageing populations. The report stated that the rate at which populations age has recently accelerated in many emerging economies such as in Asia and elsewhere, and this is likely to increase further over the coming decades. The report stated that while on average OECD countries took 63 years to double the share of the population aged over 65, BRICS countries

(Brazil, Russia, India, China, and South Africa) will take only about 20 years, with the global average being 42 years. This also means that fewer and fewer working-age people will be able to support elderly populations.<sup>26</sup>

The report emphasised the fact that in many OECD countries the inactive pensioner and the unemployed have not been excluded because of health risks, but instead these countries have included policies to exempt welfare beneficiaries from out-of-pocket payments, and set the upper limits for cost-sharing depending on income, age, and case-mix for the disadvantaged population groups, including those with specific diseases and conditions.

These facts call for a more pragmatic approach in unravelling the policy directive to ensure a sustainable funding of the NHI without eroding or even interrupting cover as well as defining the role of private voluntary health insurance. Secondly, consideration and thought should be given to the cross-subsidisation of the elderly or invoking similar policy measures from the OECD countries such as exempting welfare beneficiaries from out-of-pocket payments, setting the upper limits for cost-sharing depending on income and age, and finally case-mix for the disadvantaged population groups including those with specific diseases and conditions.

### **Discussion**

This review on the implementation considerations for NHI in SA described several evidence-based primary findings relevant to the role of leadership and governance, healthcare financing approaches, impact of ideological and financial challenges on service delivery – called political economy – healthcare worker availability, as well as management of cost escalation.

Alongside each of the structural challenges or problems that adversely affect the implementation of the NHI building blocks, the review paper has identified key opportunities that have had a positive impact on the implementation of UHC as observed in other countries that could be explored in the NHI project for SA. These are displayed in Table I.

The White Paper on the NHI goes to great lengths to describe the challenges facing the health system transformation efforts that lie ahead that have to be overcome in order to achieve the NHI objectives.

Whilst the White Paper on NHI (2017) has spelt out the problems faced by SA and set the scene for the legislative framework as well as implementation parameters, there is an unmistakable gap in strategies to address the likely power dynamics emerging within the state itself as well as between the state and the private sector. Additionally, there is lack of clarity about the public and private sectors' institutional arrangements.

### **Leadership and governance challenges**

The findings of the review show that leadership and governance challenges continue to negatively affect the implementation requirements of the NHI. There are two main reasons according

**Table I: Structural challenges or problems that adversely affect the implementation of the NHI in SA and key opportunities**

NHI structural challenges	Opportunities identified/findings
Leadership and governance	A legislative framework to promote good governance <sup>3</sup> A space for civic engagement <sup>3</sup>  Set direction and develop strategies <sup>4</sup> Explicit government policy position on the role of the private health sector <sup>5</sup>  Balancing domestic health requirements with universal aspirations <sup>6</sup> Leadership and governance configuration <sup>7</sup>
Healthcare financing challenges	Funding approach is dependent on the context of the country <sup>8</sup> Accountability perspective addressed by transparency in resource management <sup>9</sup> Transparency of funding policies and co-existence of VHI with NHI <sup>10,11,12</sup>
Service delivery challenges	Implementation approach is dependent on every country's local context <sup>15</sup> Understanding and addressing conflict, resistance, and cooperation among stakeholders <sup>16</sup> A clear definition of all role players <sup>16</sup> A clearly defined, policy-informed role of the private sector <sup>5,18,19</sup>
Health workforce challenges	Prevent talent loss by dialogue with stakeholders <sup>23</sup>  Role PPPs to capacitate the production of the requisite healthcare workers <sup>18,19</sup>
Managing cost escalation and overall population coverage	Coverage arrangements must be linked with drivers of cost <sup>26</sup>  Identify and prioritise critical areas that should be aligned with political commitment to attain UHC <sup>26</sup>

to the 2011 South African Health Review (SAHR 2011) as to why leadership and governance matters to the health system transformative agenda in SA.<sup>27</sup> Firstly, the efforts to strengthen the health system through primary health care re-engineering and the introduction of the NHI are underpinned by complex policy implementation and place high demands on leadership and governance abilities. The new policies, according to the SAHR 2011, "have generated unexpected and sometimes negative outcomes", those negative outcomes being:

- throwing up barriers to access rather than removing them;
- resistance to equity-promoting health management action;
- undermining quality-of-care rather than improving resource use efficiency;
- undermining provider-patient relationships rather than strengthening them;
- undermining health provider motivation rather than strengthening it.

Secondly, leadership is required to spearhead the transformation of organisational structures and culture of the public sector to do business in a new way.<sup>27</sup> As for the second challenge – organisational structures and culture – the SAHR (2011) asserts that these often act as a barrier to new policies intended to establish a PHC-oriented health system and promote health equity and human rights.<sup>27</sup> The sentiments expressed by those employed in the public sector at every level are that they work in isolation and there is often a top-heavy and rigid management that imposes conflicting demands.

As a way of ensuring that the health transformation agenda remains on course, the following leadership and governance opportunities have been identified:

- i. A requirement by government to ensure that the set up and support of a legislative framework to promote good governance is met.
- ii. Government must provide a space for civic engagement for all relevant stakeholders.
- iii. Government needs to set direction and develop strategies in collaboration with all relevant stakeholders.
- iv. Government needs to be explicit about its policy position on the role of the private health sector.
- v. Government need to balance domestic health requirements with universal aspirations.
- vi. Government needs to ensure that there are appropriate leadership and governance configurations.

Exploiting the above opportunities will ensure that the challenges often experienced with policy implementation and challenges to organisational structures and culture are overcome.

### Healthcare financing challenges

The healthcare financing challenges have been elucidated in a number of studies.<sup>10,12,13,14</sup> Those challenges were identified as:

- i. The role of VHI, private medical insurance in the face of quality differences between the private and public sector.
- ii. VHI has increased inequities in access to health care – the GEMS study.
- iii. The future role of VHI.

iv. NHI being unaffordable since it is going to impose an additional tax burden on the middle class.

In the main, these healthcare challenges are an expression of a dire need to achieve the goal of strengthening the healthcare system in order to achieve equity in health care. This should strengthen the political commitment to forge ahead with the health-sector reforms which are triggered by pressing health financing issues and the need to strengthen the foundations of primary health care.

The opportunities identified align with the two stated features of the NHI. Firstly, progressive universalism where all South Africans will have access to much needed promotive, preventive, curative, rehabilitative and palliative health services that are of sufficient quality and are affordable, without exposing them to financial hardships.<sup>1</sup> Secondly, financial risk protection where individuals and households will not suffer financial hardship and/or not be deterred from accessing and utilising needed health services.<sup>1</sup>

There is therefore a need to ensure that there is a clear policy position on the future role of VHI or private medical insurance in the NHI environment, the level of care that NHI beneficiaries will be eligible for, as well as clarity on the utilisation of the tax regimen to fund the NHI.

### **Service delivery challenges**

The challenges with regard to service delivery were identified as:

- i. Whether the DHS could provide service availability, given the well-known inequities between districts with respect to population health status in the NHI.
- ii. Finding the right balance of cooperation and collaboration between the private and public sectors.

The review findings are that certainly the DHS has been the backbone of every healthcare system in Africa and for SA since 1997. The stated goal for the DHS model in SA is that healthcare services are organised and coordinated at a local level using decentralised, area-based and people-centred approaches and this approach is seen as central to the SA context.

Consistent with other studies, the findings of this review are that the DHS model is dependent on a collaborative district development requiring a shared vision by participants,<sup>28</sup> hence the need to capitalise on the opportunity to “have a clear definition of all role players” and “cooperation among stakeholders”.

A study by Tshabalala et al. (2023) highlights the sentiments that have an adverse impact on the realisation of the goal of the DHS. They state that fragile governance arrangements and functionality, fraught intergovernmental relationships (IGR), peripheral community participation or accountability, and resource constraints and contestations impact negatively on a functional DHS model. These need to be addressed to enable SA to benefit “by understanding and addressing conflict, resistance, and cooperation among stakeholders”.

### **Health workforce challenges**

The review found that there is no mechanism for health workforce policy dialogue and planning. In addition, appropriate monitoring and financing mechanisms need to be established.

The study by Kai Hong Phua (2017) addresses the role of PPPs’ ability to bring the good attributes of the public and private sectors together and accordingly this will aid in solving the health workforce challenges.

If SA were to adopt the lessons from other countries, the talent loss could be prevented since the policy dialogue with the health workforce would mobilise a political commitment. The “right mix of skills” will be achieved where there is strong public and private sector cooperation in the form of PPPs.

### **Other aspects related to healthcare financing challenges – managing cost escalation and overall population coverage**

The challenges identified are: (i) the management of cost escalation without eroding cover, and (ii) overall population coverage. The literature review pointed to the fact that countries found unique, country-specific ways of managing the cost of covering the vulnerable groups, the poor, previously uncovered, self-employed and those living in underserved communities. These social determinants match those in SA and hence the identified opportunities could be exploited to achieve coverage of those vulnerable groups and manage cost escalation without compromising coverage.

### **Conclusion and recommendations**

This review paper explored how other countries have managed the challenges that had a bearing on the implementation and achievement of the NHI objectives of providing quality health care to all without exerting undue financial pressures.

It further highlighted how the challenges that were identified were matched with opportunities, which, if exploited, could assist SA in overcoming its challenges and attaining the NHI objectives.

Addressing the NHI financing issues, the imperative is to protect people from the financial consequences of ill-health, paying for health services, and finding ways to encourage the optimum use of available resources. The study also contributes to the discourse of health system governance.

Further research to interrogate the opportunities identified to formulate a detailed implementation framework that will contribute to a coordinated roll-out of the NHI needs to be undertaken. The research should enable the stakeholders to find ways of exploiting the opportunities in a systematic and well-coordinated manner.

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The authors declare no conflict of interest.

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