Factors that hamper the effective implementation of the building blocks for National Health Insurance in South Africa

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Abstract

Background: The National Health Insurance (NHI) project requires a clear understanding and appreciation of the collaborative efforts expected from all stakeholders and a clear policy perspective that identifies the role of all stakeholders and aligns them to the objectives of the programme.

The objective of the study was to investigate the factors that contribute to the inability of the health system to effectively and sustainably implement the six NHI building blocks: (a) Leadership and governance; (b) Healthcare financing; (c) Health workforce; (d) Medical products and technologies; (e) Information and research; and (f) Service delivery.

Methods: An exploratory, qualitative study design was used to investigate and describe these factors. This took the form of focus group discussions where a semi-structured questionnaire was used to collect the data for this research. There were five focus groups with participants varying from three to five depending on their availability. The participants were from health statutory bodies, voluntary bodies concerned with healthcare issues, medical aid schemes and medical aid administrators.

Results: Five themes and their attendant sub-themes were identified. These were found to embody the contributing factors to the inability of the healthcare system to sustainably and consistently implement the NHI building blocks. The sub-themes provided the detailed and pertinent areas where appropriate intervention needs to take place in order to ensure that the NHI project is a success.

Conclusion: The study suggests five key considerations to enable the effective and sustainable implementation of the NHI building blocks. These align to similar findings in related studies undertaken in low- to middle-income countries.

Keywords: healthcare reform, health policy, health insurance, stakeholders, public/private, policy implementation, public health, government, private sector, health financing

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Introduction

The end state of the South African (SAn) healthcare system is to ensure it is accessible and equitable and does not place undue financial pressures on the population, this is articulated in the provisions of the National Health Act (Act 61 of 2003: National Health Act, 2003), White Paper National Health Insurance (NHI).[1] This is echoed in the World Bank articulation of Universal Health Coverage (UHC) as a sustainable development goal.[2]

The White Paper singles out the fragmentation in funding pools as a major characteristic of the SAn health system. This is also one of the main thrusts of UHC as defined by the World Health Organization (WHO). The WHO states that UHC means that all people have access to the full range of quality health services that they need, when and where they need them, irrespective of financial hardship.[1] It is for this reason that SA envisions that the implementation will result in a significant and better spread of the economic and social benefits to the SAn population. The envisaged benefits, amongst others, include improved financial risk protection, reduced fragmentation in both funding and provisioning of health services in both the public and private sectors, reducing inequities and improving access to quality healthcare.

The introduction of UHC in the form of NHI, as it is known in SA, is informed by the disparate conditions which exist between the private and public healthcare sectors.[3] As part of the health transformative process, the National Development Plan 2030 (NDP 2030) also incorporated the implementation of the NHI which outlined the objectives of the NHI. The objectives seek to address access to health care by all inhabitants whilst considering right level of care, quality, and affordability. The phasing in of the NHI, with a focus on upgrading public health facilities, producing more health professionals, and reducing the relative cost of private health care is one of ten critical action points of the national development agenda or policy.[4]

Given this context, which includes the policy prioritisation and enormity of the challenges engulfing healthcare, it comes as no surprise that aspects considered to be structural problems in the healthcare system were identified in the NHI policy document.[1] Weighing in on all of this is a legitimate concern about whether SA will successfully transition to an NHI programme given its existing financial, operational, and institutional challenges.

Hence this study aimed to interrogate the factors influencing the structural problems in the key building blocks in the implementation of the NHI in South Africa.

Study design, setting, population sampling and sampling size

An exploratory, qualitative study design was used to examine and define the factors influencing the mutual understanding, buy-in and cooperation levels of affected stakeholders in the SAn setting for the implementation of the NHI. It was necessary to employ a qualitative research approach in order to capture the essence of how the participants feel about the NHI project and to document their experiences regarding the factors influencing the NHI implementation pillars as described in the NHI White Paper (2017). Busetto et al. (2020) in their definition of qualitative research captures this approach succinctly – "the study of the nature of phenomena", including "their quality, different manifestations, the context in which they appear or the perspectives from which they can be perceived", but excluding "their range, frequency and place in an objectively determined chain of cause and effect".[5]

Purposeful sampling was employed to identify the target populations who were the Statutory Health Councils, Regulatory Bodies, Medical Aid Administrators, Medical Schemes and Voluntary Bodies/organisations concerned with health issues. They were identified as leaders in health from an operational, policy and legislation level. The target population was selected on the basis that they are an important and interested stakeholder with the potential of contributing meaningfully to the NHI discourse due to their wealth of experience in the various spheres. In addition, they are at the forefront of the healthcare industry engagements, have a keen interest in the developments around NHI and have the capacity to influence sentiment.

A request for permission and a subsequent invitation to participate in the research was sent to these organisations requesting the participation of the CEO and Senior Management (at least two members per organisation). Five focus group discussions (FGDs) were proposed to accommodate the availability of the representatives from the identified stakeholders. The number in each group was determined by the responses received. Thirty invitations were sent out to senior management accompanied by a letter of introduction explaining the study. On receiving senior management's permission, a further letter of introduction and an informed consent (IC) form was sent to the representatives that were identified by the organisation to participate. Invitations to participate in the focus group discussions via the Microsoft Teams™ platform for the five sessions were sent to all representatives that signed the IC form. Table I below shows the number of participants invited per organisation type and the number of participants who accepted the invitation to participate in the FGDs. Care was taken to have only one person per organisation in the focus group meetings in order to avoid dominance of views from one organisation as well as avoid group-think as far as possible.

The size of the sample was determined by the responses received as per Table I.

Table I: Number of FGD invitees and participants per organisation type

Focus group #	Organisation	# Invited	# Participated
Focus group 1	Statutory councils	1	0
	Voluntary professional associations and industry representative organisations	3	3
	Medical aid schemes	2	0
	Medical aid administrators	1	0
Focus group 2	Statutory councils	1	0
	Voluntary professional associations and industry representative organisations	2	1
	Medical aid schemes	2	2
	Medical aid administrators	1	1
Focus group 3	Statutory councils	2	2
	Voluntary professional associations and industry representative organisations	1	0
	Medical aid schemes	2	1
	Medical aid administrators	1	0
Focus group 4	Statutory councils	1	1
	Voluntary professional associations and industry representative organisations	2	2
	Medical aid schemes	1	0
	Medical aid administrators	2	1
Focus group 5	Statutory councils	0	0
	Voluntary professional associations and industry representative organisations	2	2
	Medical aid schemes	1	0
	Medical aid administrators	2	2
Total		30	18

number

Data collection tool and procedure

Five focus group discussions were held over a period of about two weeks from 25 November 2021 with the last focus group discussion held on 6 December 2021. Focus group discussions were conducted on-line via the Microsoft Teams™ platform. The same semi-structured questionnaire was administered to the five FGD to collect the data for this research. The questionnaire had an introductory section that introduced the researcher, reminding the participants of the consent that they have given earlier in writing as per the introductory letter and informed consent letter sent to them. The participants were informed that the FGD was to be recorded and that the recordings were to be used to report the results, upon which consent was obtained from all. The objectives of the study were reiterated. The questionnaire consisted of questions that sought to elicit the response of the participants on the following issues:

1. Leadership and governance – policy to ensure there are appropriate controls and accountability.
2. Healthcare financing – strategies to get more value for money.
3. Addressing the health worker shortage and improving the performance of healthcare workers.
4. Finding the right mix of policies that help contain unnecessary cost growth without eroding coverage.
5. Service delivery coverage.

It is important to note that for each question that was asked, direct quotes from the participants are given after each theme. The attribution of the direct quotes to the participants is identified in square brackets as [Participant and a numeral, FGD and a numeral], where, for example, [Participant 1, FGD 3] refers to a quote from Participant 1 who was in Focus Group Discussion (FGD) 3. In addition, a summary or overview of the themes is provided as an introduction to the responses to each of the questions. Direct reference to study participants has been expunged.

Data analysis

The focus group audio recordings were transcribed and NVivo™ (A qualitative data analysis (QDA) computer-aided software) was used to analyse the data collected. To bring order, structure and meaning to the mass of data collected, a qualitative data analysis approach was taken.[6] Since the author was working with semi-structured interviews (where participants are asked the same set of questions), the heading style on Nvivo™ was used to automatically organise the responses. The responses were gathered per question in one place and auto coded into themes.

In order to see the connections between themes and move toward analytical insight, a list of codes was developed. At regular intervals, the list was groomed – checking whether related themes could be grouped together in a hierarchy.

Trustworthiness

The researchers adhered to the criterion to develop trustworthiness namely transferability, dependability, confirmability, and credibility.[7]

Transferability of the study[7,9] – the capacity of the findings to be applied in another context – was enhanced by using a purposive sampling method and providing a thick description of the sample requirements and how the participants were selected. To achieve dependability the research design and methods were clearly articulated to ensure that other researchers can replicate and reproduce the study.[7,9]

Confirmability of the research was adhered to to ensure that the researcher was unbiased.[6,7-9] To achieve credibility of the research, the researcher adhered to the documented research design and methods.[9] The participants' responses were transcribed from the recordings by an independent scribe. The independently transcribed responses were subjected to Qualitative Data Analysis (QDA) computer software for analysis out of which the themes were auto generated.

Results

This section provides a detailed analysis of the main themes and sub-themes that emerged based on the interrogation of the six health system building blocks, these being: (a) Leadership and governance; (b) Healthcare financing; (c) Health workforce; (d) Medical products and technologies; (e) Information and research; and (f) Service delivery as identified in the NHI White Paper (NHI 2017).[1] According to the NHI White Paper, the challenges facing the healthcare system, including the high burden of disease, are to a large extent, the inability of the health system to effectively implement these six health system building blocks.[1]

Table II depicts the themes and sub-themes which were found to embody the contributing factors to the inability of the healthcare system to sustainably and consistently implement the NHI building blocks. The subthemes provided the detailed and pertinent areas where appropriate interventions need to take place.

Committed political leadership

Based on the responses that were given, the participants are of the view that political leadership should be the overarching aspect to drive the performance of the healthcare system supported by managed care and healthcare administration. Others are of the view that the spectrum of stakeholders, including the medical aid administrators and the service providers must be part of an expert committee to drive healthcare innovation.

"One, the political aspect is important but of most importance is that one of the managed care organisations and an administrator to be put into the fold so that they're responsible because the political aspect looks at overarching aspects but does not get to the details." [Participant 1, FGD 2]

Still others see a need for closer collaboration and communication between subject matter experts and other stakeholders to bolster the political leadership to drive healthcare performance. As one of the participants puts it:

Table II: Themes: Factors influencing structural problems in the key building blocks for NHI in South Africa

Theme	Subtheme
Committed political leadership	Performance of the healthcare system. Closer collaboration and communication. Need for diverse skill contribution (both bureaucratic and technocratic). Source of expertise for implementation. The management of resources for public education about the NHI.
Continuity of leadership	Changes in leadership disrupt the speed of implementation. Conflicting priorities might lead to deviation on policy approach.
Stakeholder involvement, engagement, and policy socialisation	The controversies and uncertainties that surround the way in which policy makers intend to deal with medical schemes. Historically, policy issues were not sufficiently socialised with the stakeholders leaving the population at the mercy of unscrupulous healthcare professionals.
Implementation capacity and capability	Both positive and negative signs on policy-design and implementation. Failure to implement due to a lack of relevant human resources – specialists in those specific areas. Lack of interdepartmental collaboration to address the basic determinants of health.
Service delivery mechanism	A hybrid approach to a centralised and decentralised approach will assist the ability to deliver healthcare services.

"There is the need for multiple stakeholder engagement to enhance all perspectives, which range from political which has to deal with issues of technical elements that can lead to the success of NHI." [Participant 2, FGD 2]

The participants are of the view that no single layer of government would be able to pull off the challenge of the healthcare reforms from conceptualisation to implementation despite the best political will. The need for diverse skill contribution is echoed by several participants as evidenced by the following quotes:

"The technical elements would involve things like actuarial models, manage healthcare models which needs technical expertise." [Participant 2 FGD 2] and

"Those stakeholders that you've outlined will possess very specific and expert skills that would contribute to the policy as it were." [Participant 1, FGD 4] and

"Well, at a political level, there is a clear prerogative, the role of these subject matter experts, and stakeholders, the voices, and the collaboration becomes quite important, and I think that speaks to the statement that you're making." [Participant 3, FGD 4]

The participants indicate that the expertise for implementation lies with the stakeholders, being the healthcare providers who are the people who know the industry and have the detailed knowledge and in instances institutional knowledge of the healthcare operations. They think that it is important to have more people who are at the coalface of implementation, both in the public and private sectors, to be part of the dialogue, since they have many years of providing healthcare services to the population, as stated by one of the participants:

"And we need to have more coalface people into these discussions, bring them in to help with a way forward than having only politicians. The political leadership above, as you know, haven't been in private practice for many years or even in public sector in a role where they service the patient." [Participant 2, FGD 5]

The participants express a view that there is a need to translate policy, as expressed in the NHI bill, to a more technical document to enable implementation.

Implementation capacity and capabilities

Based on the responses that were given, the participants are of the view that SA is making sufficient progress in the design and implementation of policies within specific SAn context that will facilitate the implementation of the NHI when compared to other sub-Saharan countries with strong governments. The participants note that several Southern African Development Community (SADC) countries have looked up to SA on the implementation of several initiatives in health care. Those initiatives include pharmaceutical service policy, as one respondent stated:

"So, in a way if I used pharmacy as an example, I think we do well, and I'm saying so because we got a number of visits in the SADC countries coming to us to check on how South Africa is looking at pharmaceutical services." [Participant 1, FGD 1]

The participants are of the view that whilst the policy conception and design might be impeccable, the challenge is in the implementation, as was the case with the policy to improve access to pharmaceutical services, as one participant stated:

"A simple example, an opening of ownership of pharmacies, the intention was to create more pharmacies where there is no access to pharmacy services and what happened is we have actually got a bulk majority of pharmacies now in shopping malls and certain areas and less pharmacies in more rural areas." [Participant 3, FGD 1]

The participants also feel that though there is clear engagement and or consultation process on policy making, the policy makers often implement without due consideration of the inputs, and the feeling is:

"They did not have an open mind, you kind of felt, it's a tick box exercise." [Participant 1, FGD 1]

Yet other participants attribute the failure to implement to a lack of relevant human resources – specialists in those specific areas.

The participants note the need for dialogue, adequate consultation, open mindedness, and deployment of adequate skilled resources in public policy formulation and implementation as key in the implementation of the NHI.

Continuity of leadership

The participants are of the view that for the NHI project to remain on course, there must be continuity of leadership. Their view is that though leadership changes can take place due to normal democratic processes, policy should not change. They view such changes as stalling the implementation of policy initiatives such as the NHI. One participant said:

"So, if we had a strong proponent of National Health Insurance, and he's a president and he could be there for longer like some of the presidents north of Limpopo, then maybe, then there would be a better success." [Participant 4, FGD 2]

Another aspect of leadership discontinuity is also seen in the change of provincial and national health leadership as soon as there is a new political boss, or even as a result of complete change in a ruling party as was experienced in the 2021 local government elections where the governing party was unseated in major cities which might affect the NHI project. A participant stated:

"And I also completely want to agree that this business of having provincial and national health leadership sort of changing at the whim of the politicians is the biggest part of our problem, because there isn't that continuity in thinking and planning and coordination of implementation." [Participant 4, FGD 4]

This sentiment even goes as far as the 2024 national elections where they say we might have coalition governments and maybe even a coalition president which further derails the NHI project. A respondent said:

"People are already thinking that in 2024 we will have a coalition government; some are even bold to say we may have a coalition president." [Participant 1, FGD 1]

On the flip side, the participants are also wary of a situation where an individual stays in a position for a long time, to the extent that they might believe they own the NHI project.

Given the endless list of possible deviations or changes to the policy, the participants are of the view that the NHI task team, or structure put together to formulate policy, retain a composition that ensures institutional memory.

One participant said:

"So political leadership probably still needs to be there to provide the political strategy in terms of what the countries but I think there should be fundamental policies and guiding principle that would go beyond the politics and that needs to be driven by the technocrats, behind the scenes." [Participant 1, FGD 4]

Stakeholder involvement, engagement, and policy socialisation

The participants acknowledged that a lot of work has been done to enable the healthcare reforms, however they are quick to point out the controversies and uncertainties that surround the way in which policy makers intend to deal with medical schemes, as one participant retorted:

"The answer is no. So, if you just think, the whole issue of the role of medical schemes, how controversial and uncertain it was from the time the policy document came out." [Participant 4, FGD 2]

Specifically on the role of the medical aids, the participants feel that the policy makers just assumed that medical aids are going to disappear, and everybody will move to NHI, and all private sector infrastructure and resources will just fall under NHI, as pointed out by one participant:

"I actually want to say I think I get the feeling that no consideration was actually given in the drafting of the NHI bill on the existing entities. It was as if they just assumed all the medical aids are going to cease to exist, everybody's just going to move to the NHI fund and all the private sector suppliers, hospitals, doctors, whatever, are all just going to fall under NHI." [Participant 3, FGD 1]

The participants seem to point to a further deepening of the confusion around the future role of medical aid schemes.

The participants see these as more reasons for the provider/patient intervention mechanisms to be socialised with the relevant stakeholders. This, coupled with adequate compensation to ensure fairness in the process, is seen by participants as ensuring there is no exploitation and abuse of funds in the supply of services.

Service delivery mechanism

The participants noted that the decision on the approach of whether to centralise or decentralise the policy development and implementation initiatives for the NHI, will be context specific. They are of the view that the government is correct in their approach to centralise the funding of the NHI. They also think a centralised approach will assist in the delivery of healthcare services, since national government will be the central purchaser and as such has the ability to utilise scale and procurement power, as is evident in the procurement of medicine, especially HIV medicine.

To make the point, one participant cited the roll-out of the COVID -19 vaccination as follows:

"And I think if implementation of the vaccine was centralised, then I think we would have been in a worse position because we would have had probably a more generalised approach and wouldn't have been able to accommodate the specific underground issues that require a tailored solution and addressing a more targeted approach within the different regions." [Participant 3, FGD 4]

And another one said:

"So, if you were to be able to do this, I probably would be leaning towards more of a centralised approach with the strengthening of the municipality, at that level basically to be able to deliver." [Participant 1, FGD 4]

Still other participants believe that there is a need for a middle ground where government's role becomes that of centralised planning to ensure that all requirements are planned for on the one hand, and on the other hand the efficiency and infrastructure endowment of the private sector is utilised.

One participant said:

"And I think that's something if we do go decentralised, we must make sure there is written in steps and ways where National can step in and say this one is not functioning as a decentralised entity correctly and somebody should take charge." [Participant 3, FDG 1]

They also note that the country would have been in a worse position concerning the COVID-19 vaccination drive if this was centralised because it would have failed to recognise the implementation nuances at local level.

The participants go further to suggest a hybrid model where centralisation needs to happen with regards to management and policy making, and more accountability be devolved to the local level.

One participant said:

"So, this top-down approach of policy being drawn at high level and suddenly we expect that things will somehow happen at local level, I think has been a huge problem." [Participant 1, FGD 5]

Thus, the participants believe that the people on the ground (implementation level) should be empowered with the knowledge, and expertise – as well as being given adequate authority to run the project.

Discussion

Political leadership emerged as one of the major issues that has an impact on the delivery of UHC in the form of NHI in SA. In effect, for the NHI project to be successful, it must be embraced as a political goal, a view held by the World Bank,[10] espoused by Palu and Inden (2020) in World Bank Blogs,[11] and shared by Japan at the summit of the Group of Seven (G7) industrialised nations.[12,13] Leadership, and in particular political leadership, was identified as a major issue that will drive the performance of the envisaged healthcare system, guide the context for closer collaboration and communication among stakeholders and ensure that there is a recognition of diverse skills (bureaucratic and technocratic). This statement is supported by a number of studies, notable amongst those, an article by Witter et al. (2022) who stated that leadership and management are recognised as important enablers for improving programme performance, strengthening health system capacity, enhancing connections with target populations, increasing the ability of health systems to respond effectively to change and, at a high level, achieving country ownership of health policy goals.[14] This fact is attested to by Venkateswaran et al. (2022) where they assert that the drivers for universal health coverage go beyond the macro-economic context of a nation and the availability of solutions but the extent of political attention and prioritisation in influencing progress on health.[15] A World Bank press release on a study of low- to middle-income countries alludes to strong political leadership and long-term commitment as key policy messages for successful UHC adoption and expansion.[16]

This led to another theme that the participants referred to, that being the disruption in continuity of leadership which was seen as a co-contributor in slowing down the speed of implementation. The participants pointed out that conflicting priorities might lead to deviation on policy approach. This has been asserted by Venkateswaran et al. (2022) where they posit that attention by political leaders and policy makers increases the probability of policy reforms and that public investments are needed for progress on health reforms.[15]

Implementation capacity (including scaling up the health workforce) and capability along with participatory governance and responsive governance legislated in UHC policies, and sustained commitment to the policies, are important in ensuring UHC meets citizen health needs and sustainable UHC.[17] Viroj et al. (2019) argues that the early expansion of a strong public primary healthcare (PHC) system in Thailand set the foundation for future scale-up of UHC.[18] The participants lament failure to deploy available specialists in those specific areas, this against study findings stating that evidence-based human resources for health (HRH) policies and plans are critical in guiding the actions of the various actors towards achieving UHC and the Sustainable Development Goals (SDGs).[19]

The ingredients of responsive governance, a key goal for a health system, requires public participation and engagement in decision-making to improve public services, patient satisfaction, increase utilisation and compliance to treatment, with an overall contribution to better health outcomes and well-being of the population. The stated outcomes are unlikely to be realised in the SA context given the still lurking controversies and uncertainties over the way in which policy makers intend to deal with existing institutions providing healthcare services as private administrators, medical aids, etc.

On the ideal delivery mechanism for the healthcare services through the NHI, the participants agree that a hybrid approach of a centralised and decentralised governance policy will be ideal. This includes the utilisation of the existing private sector infrastructure and resources. This is consistent with the WHO undertaking that they will support member states to strengthen governance of mixed health systems and assure alignment of the private sector for UHC, to promote equity, access, quality, and financial protection for the population.[20]

Strengths and limitations of the study

The views of the participants expressed are of a systemic nature and can therefore be applied to the form and shape that the NHI project will take by similar communities.

The researcher obtained a large enough sample size, representative of the affected and relevant stakeholders and we believe that these views can be replicated in a similar sample.

However, the limitations could be related to the responses provided by the participants who may have been influenced by their specific contexts, various organisations' stance or position on elements of the implementation of the NHI and may therefore contain some bias.

Conclusion

The study revealed that though there are glaring gaps in addressing the building blocks for NHI in South Africa, the participants representing relevant stakeholders are keen to make a positive contribution for the success of the NHI project.

Their responses confirm their genuine concerns, highlighting clear precedence of where successes in projects of a similar nature to the NHI has been achieved. The paper suggests that acknowledging and taking on board existing capacity and capabilities, participatory governance and stakeholder engagement, as well as suited service delivery mechanisms, are key to addressing the NHI building blocks. Commitment and continuity in political leadership is viewed as an absolute necessity to maintain the impetus to achieve NHI. This conclusion aligns to the key policy messages arising out of related studies and commentary on countries that are in the process of implementing, or have implemented some form of NHI.

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Conflict of interest

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Ethical approval

Approval for the research study was obtained from the University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee (HSSREC). The Ethics approval reference number is: HSREC 00002565/2021.

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