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Can South Africa Have the National Health Insurance (NHI)?

An Exploration of the OR Tambo Municipality District.

By

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List of Acronyms:

ANC African National Congress

AID Acquired Immunodeficiency Syndrome

BRICS Brazil, Russia, India China and South Africa

CEO Chief Executive Officer

DOH Department of Health

ECHCAC Eastern Cape Health Crisis Action Coalition

GP General Practitioners

HIV Human Immunodeficiency Virus

HSS Health Strengthening Systems

MDGs Millennium Development Goals

NDOH National Department of Health

NHI National Health Insurance

NHIF National Health Insurance Fund

SDG Sustainable Development Goals

TB Tuberculosis

UHC Universal Health Coverage

WHO World Health Organisation

Abstract

The National Health Insurance (NHI) in South Africa is in its early stages of implementation. With the first phase of pilot project implementation underway there is a lot of cynicism surrounding the states capacity to implement a policy as large as the NHI. South Africans have lost faith in the government's ability to provide basic services as well as address issues at ground level. Rather than accept failure the government tends to produce short-term solutions that ultimately end up burdening the people, namely the poor majority. The research investigates the feasibility of policy implementation in the delivery of healthcare in regard to the relationship between the national and local levels of governments. It then goes onto discussing how this relationship translates into a national policy being implemented at local level in a rural setting. It makes the argument that the NHI governance structures entrenched in the principles of good governance need to be adhered to in coordinated and collaborative manner between the national and local tiers of government in order for the NHI to envision a successful implementation. Finally, it argues that the NHI in rural areas needs adjustments as the health disparities experienced in rural areas are not only a result of financial incapacity but also the socio-economic, infrastructural and topographical nature of these settings.

Section One: Introduction, Literature, Methodology and Case Study

Chapter One: Introduction and Background

1.1. Introduction

"South Africa's colonial and apartheid inheritance is one of substantial social, economic and health inequality" (John E. Ataguba, 2014) . Prior to democracy in 1994 the South African health system was largely as well as legally distinguished by race and geographic inequalities: "There were fourteen Departments of Health, each servicing a different racial and geographic-specific population group, and each establishing its own policy objectives" (Jerome A Singh, 2005) , and this meant that adequate healthcare services were concentrated in mostly white urban areas, while the non-white areas were given departments with extremely lower budgets. This to a large extent resulted in not only the inferior standard of healthcare for people of colour but also the lack of access to healthcare especially for rural communities. "While the system offered curative medicine and expensive medical technology to the affluent white minority, the overwhelmingly poor black majority had inferior access to preventive medicine and primary healthcare" (Jerome A Singh, 2005). This was, not only a denial of access to healthcare for the black poor rural population but also a denial of universal health coverage (UHC). These structures and inequalities were inherited by a democratic South Africa led by the African National Congress (ANC), making healthcare transformation priority for the party. Here the idea was to redress the historical inequalities and provide essential healthcare to the previously disadvantaged by transforming the system into an integrated, comprehensive national service.

26 years into democracy South Africa continues to witness a significant gap between the rich and poor. The country is facing a crisis, one of the biggest income inequalities globally, which has unfortunately for South Africa led to the lack of access to healthcare for the black poor and rural majority of the population. As it stands it could be said the black poor and rural majority have limited

access in that it is restricted to basic health services. It should be noted that "although South Africa is considered a middle-income country in terms of its economy, it has health outcomes that are worse than those in many lower income countries" (Hoosen Coovadia, 2009). Globally the idea of Universal Health Coverage (UHC) has picked up, and to a certain extent South Africa has taken up this notion of Universal Health Coverage (UHC) through the National Health Insurance (NHI) Bill. The motive behind this bill is the transformation of the highly unequal health system that is perpetuated by class and race discriminates.

South Africa has a large population that reside in the rural areas of the country and due to the legacies of apartheid the country still sees a concentration of healthcare services in urban areas, which has resulted in an imbalance between urban and rural healthcare services (Ewing & Morris-Paxton, et al,2020). Although steps have been made in the provision of healthcare, South Africans still do not have equal access to healthcare and these disparities in access bring to light the poverty, inequality and lack of even progress in the country. "The poorest members of the society often live in the remotest areas, with the least access to healthcare services, which, additionally, often do not meet the expected national standards" (Ewing & Morris-Paxton, et al, 2020, p. 2). Urban-rural disparities in regards to accessing healthcare services more often than not discriminate against the poor and according to Booysen "in certain cases disparities are even worse in urban areas, although levels of service delivery admittedly are consistently worse in rural areas. People in rural areas are generally more dependent on public and other health care services than on private services, compared with people living in urban areas" (Booysen, 2010). One of the cases is that of the Eastern Cape province in South Africa, specifically the north-eastern area, also known as the wild coast, where the OR Tambo district is located. This area "is the most deprived area in the country with a disproportionate burden of unemployment, poverty and disease… the area falls below national and regional standards for clean water, employment and access to healthcare services" (Ewing & Morris-Paxton,et al, 2020, p. 2). The rurality of the OR Tambo district has hugely impacted the delivery of healthcare services in this area and has brought to light the urgent need of an infrastructural overhaul of the healthcare

system in the district. The proposed NHI bill brings about hope for the community as it promises transformation in the healthcare system that could potentially develop and provide equitable access to healthcare services in the OR Tambo district.

"The South African constitution binds the state to work towards the progressive realisation of the right to health" (Hoosen Coovadia, 2009). Even 26 years after democracy the country still faces massive health inequalities which is seen in the different rates of disease as well as mortality between races, thus reflecting the racial differences in access to basic household living and other determining factors of health. The divided public and private health system structure in South Africa currently sees a minority of the population using private health services, especially those covered by private medical aid (health insurance), while the rest of the population relies heavily on public healthcare services. Thus, in its current state the healthcare system is not universal, in the sense that UHC means all have access to healthcare services at any point of service without denial as well as the financial hardship. The result is a highly unequal system based on race and class where "17% of the population is covered by the private sector while the rest (83%) of the population utilise public healthcare" (John E. Ataguba, 2014). This situation prompted the need for transformation given the high levels in inequality of service delivery.

The NHI comes from the need to bridge this gap and the health disparities in this country. The NHI policy was first officially announced in 2011 through a Green Paper open for public opinion, here the main idea presented was a policy that seeks to ensure that everyone has access to appropriate, efficient, equitable and quality health services. As stated by the Green Paper the "National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI is intended to ensure that the use of health services does not result in financial hardships for individuals and their families" (Green Paper on National Health Insurance in South Africa, 2011). This green paper also went on to provide a blueprint for

policies that would move South Africa towards UHC, it explained that the NHI would be implemented over a period of 15 years in phases from 2012 to 2026. The development of the South African NHI, saw a series of revisions after the initial release of the Green Paper in 2011. These revisions occurred in the form of the following: a White Paper released in 2015, a Further White Paper in 2017 and finally the National Health Insurance (NHI) Bill in 2018. A lot of refinements have been made as the bill is essentially the official version of the NHI policy. The important thing to note here is that while these releases show refinements to the bill, the period of 2012 – 17 saw the first "implementation phase commence in 2012, with its overarching focus being the piloting of health system strengthening (HSS) initiatives; the establishment of the NHI Fund and key institutions; and the moving of central hospitals to the national sphere" (PMG, 2019). In 2019 the bill was introduced to Parliament, which it then went under consideration by the National Assembly Portfolio Committee on Health, from here the bill "will go through the stipulated parliamentary processes, which will include a public participation period, which might inform some amendments to the Bill, before it is put before the National Assembly for a vote" (PMG, 2019).

As a remedial policy the NHI proposes to resolve the issue of access to quality healthcare, through the creation of the NHI Fund to essentially provide insurance to all South Africans. The bill sets out to resolve the issue of access in terms of finances, in that South Africa finds itself with a majority rural population that cannot afford the exorbitant prices in the health system which has resulted in them relying heavily on public healthcare. The bill has linked the issue of accessibility to quality healthcare to one's lack of financial means rather than the infrastructure that hinders the delivery of quality healthcare. This assumption presents a number of threats to the implementation of the NHI. First being the structure of the NHI Fund, that consists of a CEO as well as 11 directors who hold all accounting authority which is then accountable to the Minister of Health (Haffajee, 2019). This speaks directly to the issue of the lack of oversight mechanisms that leave the NHI open to corruption. Second is the fact that the heaviest burden of the NHI will be the population, where the vast majority consists of the poor. The dependency on such a scheme requires strength to accommodate such a

large population. This along with the current state of the healthcare doesn't speak to that. It speaks rather to a cooperative and coordinated relationship between the healthcare system and the NHI. Lastly from this stand point there seems to be two distinct and independent entities: the NHI and the healthcare system, which both fall under the Minister of Health. This presents conflicting interests and gaping holes for corruption and capture. The lack of devolution and decentralisation in the bureaucratic structures of power is a concern.

Given that currently the NHI is in its first phase of implementation and has introduced the pilot projects in eleven districts as part of its health strengthening systems (HSS) initiative in preparation for rollout the NHI in 2026. The research report thus makes use of a qualitative approach and case study analysis of a rural area for the collection of its data to develop an understanding of the performance of the health district in its first phase implementation of the NHI. It focuses on the following interlinked elements of the NHI policy to demonstrate how it fits into the rural contexts of South Africa: "1. Accountability trough effective leadership and governance which requires collaboration between sectors to address social determinants of health; 2. The prioritisation of health promotion, protection and the prevention, treatment as well as rehabilitation of the conditions that make up South Africa's burden of disease; 3. Its 'people centred approach' which requires community participation in order to attain good health; and 4. The achievement of an equitable healthcare system through resource allocation and distribution of resources to ensure quality healthcare service delivery" ((DOH), 2011).

1.2 Research Question(s)

South Africa has demonstrated mixed result in terms of successfully implementing the NHI pilot projects, demonstrating limited success in some parts and virtually none other parts. The uneven results from the 11 pilot projects where the NHI has been piloted, has demonstrated relevant success in some areas as compared to the more rural and underserved areas. Are the political, social, economic and infrastructural challenges inhibiting the successful implementation of the NHI in these settings.

The interconnectedness of these indicators comes from the fact that they are simultaneously challenging the implementation of the policy, which will further be elaborated throughout the development of the research report. The point of the research questions that follow is to ask why rural areas have exhibited the high levels of failure that they have, using the OR Tambo (a rural underserved region) as a case study.

1. What difficulties are most likely experienced by rural areas when implementing the National Health Insurance (NHI)? What determines them?

Sub-question:

2. How can policy (the National Health Insurance (NHI)) at national level be implemented at local level in a rural settings such as the OR Tambo district?

1.3. Rationale

The NHI comes at a time of need in the South African healthcare as there are stark divides in the level of healthcare provided in the public and private sectors of health. The provision of public healthcare becomes more complicated as there are even more disparities when the rural context is taken into consideration. The lack of access to equitable healthcare services in rural areas highlights the vulnerability and inequality being experienced but also indicates that a broken health system perpetuates deprivation and poverty.

The motivation for this report is to touch on a gap in the literature that speaks to whether the proposed NHI in rural settings will have the desired effects on access, equitable and quality in healthcare delivery as well as services. The existing literature to a large extent speaks to the effectiveness of UHC in the delivery of healthcare services from both an international and South African perspective. Through the South African lens, the literature is centred around understanding the NHI as well as the effectiveness of implementing the NHI in terms of improving the standard of healthcare service delivery in the country. “Rural areas are characterized by a number of intrinsic disadvantages that have particular relevance to the ideal of universal coverage proposed by NHI: there is a higher burden

of poverty; the social determinants of health have a more direct influence on health; the cost of accessing health services is higher; management capacity is relatively weak; and there is a relative paucity of private practitioners and specialists in rural areas" (Rural Doctors Association of Southern Africa & Rural health Advocay Project, et al, 2011, p. 3). The report comes from the idea that more contextuality is needed when discussing healthcare reform as implementation success is dependent on good governance structures as well as setting. The aim then of the research is to higlight or elucidate that the reasoning of fiancial contrainst to accesing healthcare by government disregards the other barries to accesing health in rural communities such as the lack of healtcare facilities, the distances traveled to the available facilities, the absence of affordale and reliable public transport as well as the high levels of poverty that feed into the overall poor health outcomes. Thus the report concerns itself with how the NHI fits into the rural contexts of South Africa. It then goes onto a vital compontent of the bill which is the potential governance structures of the NHI as they will have a direct impact on the districts performances at local level, in that the relationships between the tiers of government translates to the overall implementation that requires good govenance and accountability to ensure the adeqate delivery of healthcare services under the NHI.

The case study of the OR Tambo presents a vital point of investigation as it is located in of of the most rural parts of the Eastern Cape and has performed the most poorly. The uneven results from the first phase implementation of the NHI needs to be investaged, as it demonstrates that one of the areas in most need of healthcare development still struggles to meet the needs of the people as well as the national standards of health. The overall success of the NHI is dependent of the performance of local level (the districts) and if the local levels perform poorly the NHI cannot envison success.

1.4. Introducing OR Tambo

The case study observed is the OR Tambo district pilot project in the Eastern Cape in efforts to assess the progress made in the first phase implementation process. The OR Tambo district municipality is one of the eleven pilot districts in the country and the only NHI pilot district in the Eastern Cape. Of all the districts it is the worst performing health district thus the aims of this research report is develop

an understanding of the pilot projects performance, through a rural context lens as well as to assist in providing remedial recommendations. Moreover, how a lack of efficient preparation and capacity attribute to the under-performance of this district.

The OR Tambo NHI pilot project has been in place since 2012 and there are a number of infratructural problems that still persist with the delivery of healthcare services in this district, which includes but is not limited to "long queues caused by a shortage of staff or demotivated staff, unavailability of medicines, lack of infrastructure, and an escalating number of medical claims" (Msomi, 2019). These issues cannot only be placed at ground level as it speaks to a lack of coordination, communication and cooperation between the levels of government in the delivery of healthcare services as well as a lack of community participation. As such, the community in the district continues to experience barriers to accessing healthcare outside of the financial aspect given its rural setting. The rurality of the district even with the pilot projects still sees trends of a rural population having higher levels of certain diseases mainly as a result of the socio-economic conditions worsend by the lack of healthcare resources, facilities and the means to access healthcare services availbale to them. From a transformative and social justice perspective, government in relation to its tiers has an obligation to not only take into account the rural context of the OR Tambo site when implementing a healthcare service policy but also the role it plays in policy implementation failure and under-performance.

The social injustice within the healthcare system as seen with the OR Tambo district stems mainly from the impact the apartheid-era segregation has had on the access and quality of public healthcare. At ground level the healthcare system is faced with a variety of infrastructural challenges which include but are not limited to "delays in care delivery, the high incidence of preventable errors, insufficient human resources, prolonged waiting times and severe overcrowding". The OR Tambo district along with the rest of the Easten Cape's health system has lagged behind in regards to equal access to healthcare services, even with the presence of a NHI pilot project in one the most rural areas, it continues to underperform in the delivery of healthcare services. The NHI seeks to address the issue

of accessibility, thus it can be said that the policy is governments way of addressing the social injustice within healthcare by providing affordable and accessible healthcare to all which also forms part of a broader goal of UHC. It is with this understanding that this research report seeks to address the gap in the relationship of governance between the tiers of government and how that translates into how a national policy such as the NHI is implemented at local level in a rural setting.

1.4.1. Defining Rural

The defining of urban and rural areas in South Africa has a long history. There is still no standardised definition in the country; nevertheless the report finds that the categorisation of areas as either rural or urban remains very relevant for government's growth and development strategies. The rural-urban dichotomy requires definition for the understanding of both dynamics on the ground in order to achieve effective policy implementation. Rurality has no standard definition, meaning that there is no government-wide, officially agreed and accepted definition of rural. More often than not "government bodies, research institutions and other stakeholders use a range of criteria to define rural – or do not use rural as a variable at all" (Gaede & Versteeg, 2011, p. 100). Thus the attempts that have been made to develop definitions typically revolve around the use population densities, town sizes, state of infrastructure and predominance of agriculture. Rurality in South Africa has no direct definition but areas can be identified rural given that it is generally characterised by the following core features: "inferior infrastructure, low income, poor site conditions, unreliable water availability, and poor access to health facilities" (In On Africa, 2013).

The issue that comes out of the lack of definition is that when it comes to policy there is no clear indication of what is being prioritised and how the policy being implemented will address the infrastructural inequalities of the rural-urban disparities. The rural health advocacy project in its repose to the White Paper on the NHI suggested that "it is necessary for these departments to select health specific factors - such as utilisation, burden of disease and unmet need - that are most appropriate and relevant for that department, policy or intervention and combine them with factors

such as population density and socio-economic status to develop operational definitions for policy purposes" (Rural Health Advocacy Project, 2016, p.16). The broad typologies used in this regard often do not express the needs and experiences of those in rural communities rather it generalises the criteria of rurality often times missing the actual issues on the ground. In South Africa rural often times refers to a type of place that is "sparsely populated areas in which people farm or depend on natural resources, including villages and small towns that are dispersed throughout these areas… They include large settlements in the former homelands, created by apartheid removals, which have an economy based on external transfers for their survival (e.g. migratory labour, social grants and remittances)" (Department of Performance Monitoring and Evaluation, 2012).

The lack of definition makes it hard for policy effectiveness as the infrastructural dynamics differ and react differently to policy. What this highlights is that both rural and urban areas require effective policy catered to their specific dynamics to ensure the sustainability and development of healthcare in order to achieve equal access to healthcare for the successful implementation of the NHI. When looking at the NHI policy the report finds the rural health advocacy project to have most fitting criteria to define an area as rural, here the term rural is used in relation to health access that is characterised by the following: "1.Geographical remoteness and long distances between levels of care; 2. Typographical features that hinder physical access to healthcare, for instance, mountainous landscapes and poor road conditions; 3. Low population densities; 4. High cost of service delivery due to lower economies of scale and more expensive travel to facilities; 5. Difficulties to recruit and retain health care workers because of distance from amenities like shopping malls, internet services, gyms etc; 6. Often characterised by higher levels of deprivation than urban areas, compounded by intra-district variations in access to care" (Rural Health Advocacy Project, 2013). For the report it is vital to have a clear understanding and definition of rural as the aims of the research is to investigate how the NHI policy fits into the rural contexts of South Africa. When looking at the criteria the OR Tambo district is considered extremely rural.

1.5. Overview

The report aims to establish how the NHI will fit into the existing health system in rural areas of South Africa with the use of the OR Tambo pilot project located in one of the most rural areas in the Eastern Cape province as a case study. The research report consists of two sections, section one which deals with the introductory information. Here in answering the research question the report first introduces the study by offering background and context to the research as well as the pilot project site, in order to outline the contribution, it intends to make to the discussion of the feasibility of the NHI. 'Chapter two' goes onto provide a review of the literature in which the study is grounded. The literature outlines the setting of the NHI in South Africa and provides a background to the study. Lastly the methodology section in 'chapter three' details the research design which encompasses the manner in which the data was collected and analysed.

Section two of the report presents the findings, discussions, and analysis of the study in its attempts to answer the research questions. Chapter four' the first chapter of this section provides an in depth case study into the OR Tambo pilot project and ties in the broader contexts of the site's location, conditions as well as its progress with the first phase implementation. Chapter five investigates the governance structures and implementation of the NHI in South Africa. 5.2 discusses the concepts of governance and good governance. 5.3 looks into the governance structure of the NHI and the implementation of the NHI thus far and how the two work in practice. 5.4 offers observations and recommendations for how the principles of governance in the implementation of the NHI can be better managed to envision a successful running NHI in South Africa. The chapter provides an understanding of how governance and the first phase implementation has played out in the OR Tambo pilot project.

Lastly chapter six discusses how the NHI directly addresses the healthcare rural settings in the country. 6.2 will address the level of access to efficient healthcare services in rural areas. 6.3 discusses the NHI's ability to reduce the health inequalities from the first phase pilot project invention. 6.4 provides an observation and recommendation for the NHI's ability fit the needs in terms service

delivery in the rural settings of the country. The chapter also investigates the relationship between healthcare, poverty as well as the poor health outcomes that are a result of that combination and how it could possibly negatively affect both the performance and implementation of the NHI at national and local levels of government.

The report thus attempts to demonstrate that while the NHI is needed in the country, for rural communities' access to healthcare services is more complex given it socioeconomic settings, thus ultimately ones' proximity to healthcare institutions determines the success of the NHI. As such the report establishes that access to healthcare services for rural areas in the country is more than just the financial constraints which the NHI proposes to resolve. Rural areas face more barriers to accessing healthcare services than just the financial aspect, which the NHI should seek to address before its rollout as these are infrastructural challenges that government urgently need to investigate as it has the potential hinder the overall success of the NHI and further contribute to the health inequalities of the country.

Chapter Two: Literature Review

2.1 Introduction

This chapter links South Africa's national health insurance reform policy to the notion of universal health coverage (UHC) while situating it in the trends of healthcare system reforms taking place globally. This is done in order to understand the complexities of the proposed NHI in the South African setting, where there are major disparities in healthcare between rural and urban spaces, are a direct implication of the apartheid system and its policies that underserviced rural areas. Thus, this section will begin by discussing the literature on the global trends of universal health coverage (UHC) in its fight for social justice which has had a huge impact on democratic South Africa's proposed National Health Insurance (NHI) policy given it inherited racially fragmented healthcare system from the Apartheid-era. The chapter will then go onto discuss and unpack South Africa's take on universal health coverage and look into the developments and debates that have taken place since the introduction of the NHI in 2011.

2.2 Universal Health Coverage (UHC)

Twenty ten saw the World Health Organisation (WHO) Assembly release a declaration that called for all countries to "aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity" (WHO report, 2010), along with this declaration a report on achieving UHC was released. Here UHC was defined as "ensuring that all people can use the promotive, preventative, curative and rehabilitative health services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship" (WHO report, 2010). This is to some extent a response to the global trend of public healthcare systems often reverting to short-term solutions to healthcare services along with the privatization of healthcare services as well as the poor ultimately being burdened with user-fees and lack of adequate healthcare services. Over the years the world witnessed the shift in healthcare being a right and/or entitlement

to a privately owned commodity, while economic inequality remained a key issue, which ultimately hindered and continues to hinder equitable access to quality healthcare (Prince, 2017, p. 154). In twenty fifteen there was another agreement that health coverage should be universal which led to the United Nations General Assembly adopting UHC as part of the commitment to the Sustainable Development Goals (SDG). SDG 3.8 sets the following target for 2030: "achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all." (Ke Xu, 2018, p. 6). This means that achieving of UHC will require a commitment from all countries to mobilise sustainable amounts of resources and redistribute them to ensure equity and accessibility.

This global shift towards UHC opens up room for discussion around redistribution, public goods and the redefining of the role and responsibility of the state. Notably, the BRICS countries (Brazil, India, China, Russia and South Africa) are pushing for this reform. South Africa being a member nation of this alliance, BRICS becomes vital to the progress of UHC in these countries. BRICS "represent almost half the world's population, and all five national governments recently committed to work nationally, regionally, and globally to ensure that universal health coverage (UHC) is achieved" (Robert Marten, 2014, p. 2164). It is important to note that while UHC makes up part of the development agenda and is being pushed by BRICS as a unit, the achieving of UHC is done individually as there are a number of differences such as wealth, population, and health indicators between the states that makes the process different and unique to each. However, the fact still remains that each of these countries have a level of commitment to the right to healthcare coverage, as such similar issues in achieving UHC may arise. These issues include "raising insufficient public spending; stewarding mixed private and public health systems; ensuring equity; meeting the demands for more human resources; managing changing demographics and disease burdens; and addressing the social determinants of health." (Robert Marten, 2014). In terms of progress towards UHC China and India are relatively new having only started their reforms in the last decade, while Brazil and Russia began

the reform over two decades ago and South Africa had only recently started its reform in the health sector (Robert Marten, 2014).

2.2.1. Healthcare Reform and the Global Perspective of Justice

Countries around the world are going through healthcare reform with the rolling out of UHC. Globally universal healthcare reform typically refers to national healthcare system where every person has insurance, "though universal health care can refer to a system administered entirely by the government, most countries achieve universal health care through a combination of state and private participants, including collective community funds and employer-supported programs" (Gale, 2019). Over several decades there have been great strides in the expanding of ability to improve human health in many regions globally where significant health gains have been achieved, yet the extreme deprivation in health is still widespread (Ruger, 2004, p. 1075). With the rapid global change and persistent health disparities, the moral and philosophical foundation of global healthcare reform needs to be unpacked. The global disparities of health offers the perspective that it is incorrect to assume that better and more healthcare is all that is needed to improve health, the impact of healthcare is rather dependant on the type of care as well as other factors (Ruger, 2004, p. 1076). Thus, when looking at the global trends of health reform not only does it require both health and health policy to be placed in a larger policy context, but also requires a greater understanding of social justice.

The question then arises how a socioeconomic policy as such should be evaluated. It has been suggested that "policies be judged according to their relevancy to socioeconomic issues and the likelihood of their enactment" (Karsten, 1995, p. 130). Policies gain meaning if and when they directly address issues of the people and its validity is determined by its chances of implementation, thus when a socioeconomic policy has both validity and meaning it is to say that its focus is on the daily lives of people (Karsten, 1995, p. 130). This is directly related to the idea of social justice, in this case it is the right to healthcare services on the basis of human dignity and equality. Social justice in this regard is understood through John Rawl's conception of a just system. Here a just system is one in which 'fundamental social problems, in particular those of coordination, efficiency, and

stability' are addressed (Karsten, 1995, p. 132). Social justice in this sense speaks to the equal distribution of all social primary goods, opportunity, income and wealth as well as the basis of self-respect. Essentially at the core of Rawls conception is the economic structure of the state; how fundamental rights, duties, opportunities and social conditions are assigned, for there to be injustice he explains there needs to be "inequalities that are not to the benefit of all" (Karsten, 1995, p. 132).

UHC seeks to achieve social justice through distributive justice which in this sense is the addressing of how people receive healthcare in terms of the assignment of benefits and burdens according to some standard of fairness. Rawls's theory of justice provides a starting point for the argument that it is the state's duty guarantee a level of healthcare for all its citizens. A 'Theory of Justice' (1971) by John Rawls[1] questions the conception of the role of the state, he does this by differentiating formal equality of opportunity from fair equality of opportunity and offering an argument for fair equality of opportunity. Here the idea behind fair equality of opportunity is that "it is the job of the state not only to protect its citizens from discrimination in competition for jobs and offices, but also to take positive measures—such as providing universal education—toward ensuring that each citizen has a fair chance of obtaining them" (Sachs, 2008, p. 149). Rawls discusses healthcare in "Justice as fairness' and does this within a broader discussion on the index of primary goods. The index of primary goods comes from the idea of the basic capabilities of citizens where the list of basic liberties is drawn up in accordance to the idea of a free and equal citizen. The method in which this is done is through a four-stage sequence where for three of the four-stages the basic liberties are spelled out under a partial veil of ignorance. The four-stage sequence is as follows "The first stage is the original position. In the second stage, a constitution is drawn up in accordance with the principles agreed upon in the original position. In the third stage, legislation is enacted in accordance with the constitution. Finally,

[1] The report acknowledges that that there are various theories of social justice and Rawls theory is contested in the broader debates taking place on universal health coverage. However, the report found John Rawls theory of justice most suited in its investigation of the NHI as he developed a theory of justice that suggested the principles of justice be determined by individuals that do not yet know their position in society. As such societal institutions would be structured in accordance to these principles to establish a fair social system. What the NHI is attempting to do is redress the past and establish a societal institution (in this case healthcare system) that is just, fair and speaks to the needs of the people, which in turn can be looked at through the lens of social justice.

in the fourth stage, the judicial stage, legislation is adhered to by citizens and enforced and interpreted by the judiciary" (Sachs, 2008, p. 155). The idea and purpose of the veil of ignorance is that at no point during the drawing up of basic liberties do the decision makers know their position socially, thus they are more inclined to fair and equal distribution of primary goods regardless of one's social status. It should be acknowledged that the list of basic liberties is not imposed on society, but rather society's to construct as they move through the four-stage sequence.

According to Sachs (2008) in 'Justice as Fairness' Rawls makes the claim that "healthcare is necessary to underwrite people's capacity to take advantage of their liberties" (Sachs, 2008, p. 157). As long as a just system is upheld, Rawls theory of justice is designed to apply to society regardless of its stage of development given that the parties involved in the agreement of principles do not yet know their position in society, thus making them more inclined to establish a fair equal society with institutions that best suits their needs. It needs to be taken into consideration that "human societies came into existence before health care did, so a consequence of their not having this information is that they are ignorant as to whether there is any health care to distribute" (Sachs, 2008, p. 157). Given the advancements in healthcare that have taken place over the years and the current global push for universal healthcare, it's important to go back to Rawls discussion on what should be taken into consideration when it comes to the categorization of primary goods. Although in "Justice as fairness" Rawls states that the index of primary goods includes only those that could be agreed upon in the original position, he however goes on to say that "each primary good may be further specified, and primary goods may be added to the list, after the veil of ignorance is lifted" (Sachs, 2008, p. 157). Even though Rawls did not include healthcare in the original list, it does not mean that healthcare is not a primary good. It should be noted that Rawls does go on to state that publicly-funded healthcare should be considered a primary good as people are entitled to it. From this point it can be said that where justice is concerned health should be at the core and when looking at the liberty principle healthcare should be provided to all citizens in order for the principle to be fulfilled. This is not to say that Rawls theory is the only valid conceptualization of social justice through universal healthcare

but rather to put forward that Rawls offers an ethical rationale which speaks to notions of social justice in regards to the most vulnerable users of healthcare within the context of universal health coverage. For the report, Rawl's theory provides a theoretical framework to analyse the aims of social justice within the NHI policy. Rawls highlights healthcare as a primary good, that should be available to citizens equally and fairly. He also goes onto highlight the importance of health in determining one's ability to fully utilise their liberties. This is vital for the report, as policy implementation in South Africa takes on a people centred approach which Rawls states is required to have a just society.

When looking at the move towards universal healthcare, it can be said that it is a shift in policy aimed at achieving a global perspective of justice. Most states recognise the basic right of access to healthcare, and is often times considered as a positive welfare right as well as an expression of human dignity. The drive for universal healthcare would suggest that "the right to health care access is crucial to the pursuit of an effective equality of opportunities in a free and inclusive society" (Nunes, et al. 2017, p. 1). The global push for universal healthcare carries the vision of distributive justice which speaks directly to the aims of democratic states. The idea of redistributive justice goes back to the Rawls' conception of social justice which heavily relies on the notion of the social contract, which at its core carries the fundamental values of individual freedom and equal access to primary social goods. This is to say that universal coverage advocates for the idea that all people start their lives with the same social levels (health circumstances), so that individual development occurs around the principal of individual freedom. The disparities of healthcare across the globe speak to a level of inequality within individual states, both public providers of healthcare as well as the large out-of-pocket expenditure in relation private providers of healthcare. The 21st century notions of equality suggest that the drive for universal healthcare is a moral right built on the fundamental idea that all man should be given access to healthcare of appropriate quality.

There are various implications when it comes to policy in regards to health, however there are a few that stand out when looking at a broad topic such as UHC. The first implication when it comes to

such a policy is the assessing of social inequalities and the evaluating of the effects of social policy on broader health determinants. This is to say that "health and its determinants must be valued against other social ends in a broader public exercise of policy priorities" (Ruger, 2004, p. 1076). Meaning that such a task is required to be inclusive, democratic and representative of the processes regarding public reasoning. Another policy implication in this regard is that "although health care is only one of many health determinants, its influence on health should not be denied" (Ruger, 2004, p. 1076). Here there needs to be a universal understanding of how vital healthcare is due to its influence on health, thus it needs to be socially guaranteed. The guaranteeing of healthcare socially is on the basis of the overall improving of health and reducing the health inequalities that are a result inadequate healthcare. The broadness of UHC raises a number of issues in that it does not specify which type of healthcare should be guaranteed and to what level. This raises issues as its narrow view "recognises the need for further specification through a democratic process that combines both procedural and substantive principles" (Ruger, 2004, p. 1077). The notion of UHC provides guidelines to increase access to healthcare, thus individual state policy formulation centres around the idea of having a minimal level of an individuals functioning health wise. On this basis the question then arises of how health should be equally distributed, given that there is no guideline as to how much priority should be given to 'society's worst-off individuals', thus the view "promotes the use of 'public reasoning' to forge a compromise between strict maximisation and prioritisation" (Ruger, 2004, p. 1077). Fourth, "the equity implications of access to those goods and services cannot be separated from the equity implications of financing them" (Ruger, 2004, p. 1077), UHC requires medical assistance to be accessed on the basis of medical need and not ability to pay. The understanding of universal health coverage is protective security through health insurance thus "the economic burden of health care should be justly shared by all through the redistribution of funds from the well to the ill and the rich to the poor, using progressive financing" (Ruger, 2004, p. 1077). Lastly the various methods of the conceptualisation and measurement of health and inequalities brings forth a number of implications. There various methods to measuring health equity "ranging from health domains to the weights

attached to those domains. Another consideration is the choice of groups for stratification" (Ruger, 2004, p. 1076). Ultimately each state would need to determine what set of inequality measures would best suit the aim of their health reform towards UHC.

2.3. South Africa and the national Health Insurance (NHI)

Democracy according to Kolar means "that all the people should be able to have their say in one way or another in everything that affects their lives" (Kolar, 2005, p.1). In other words, democracy is a government by the people for the people. Democracy in this sense is expressed in policy and policy-making as these develop through the needs expressed by the people. The policy process can be looked at as a means to find out how the task team reach a decision on what government chooses to do or not as well as how it should and will be made mandatory. The states obligations' specifically to health can be found in Section 27 of the South African Constitution of 1996 which speaks to everyone having the right to have access to healthcare services and that this right should be established on the values of human dignity and equality(27(1)(a)). This section goes further to outline the extent to which government must meet its obligations: "the state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of these rights" (27(2)). For the NHI this is where law and policy making come in. The delivery of universal healthcare through the NHI cannot achieved only through support or that the people want it to, it has to be designed to provide universal healthcare.

The Republic of South Africa Constitution of 1996 recognises equity in health care, which is detailed in Sections 27(1)(a), 27(2) and 27(3). All spheres of government are responsible for creating environments to meet the constitutional rights of South Africans. The supremacy of the constitution of 1996 requires these rights to be upheld. The right to health is one that is not just about access to doctors and medication, it is also about governments duty to ensure that the conditions people live in do not harm this right but rather promote and fulfil this right (Adila Hassim, 2007). A clear expression of this can be found in the preamble of the WHO which states "The enjoyment of the highest

attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." (Adila Hassim, 2007, p. 133).

The idea of equitable access to healthcare has long been a part of the democratic South Africa plans in redressing the past. Various attempts in changing policy focus to UHC by the ANC-led government dates back to 1994. The department of Health (DOH) proposed the idea of National Health Insurance "which included universal cover, contracting of GPs paid through capitation, with no room for additional voluntary insurance. This plan was not accepted because it was considered inflexible, even though it would have contained costs and met the constitutional mandate of access to care for all" (Shisana, 2009). Following this the government set up "a committee of inquiry into the national health insurance and in 1995 the department of health opted for Social Health Insurance (SHI) which included universal access to primary health care as well as the regulation of private medical schemes" (Shisana, 2009). This was implemented in 1996. 1997 saw the department of health use the social health insurance (SHI) system as a basis for a new committee of inquiry into social security. Here the social health insurance system "would support the public health system, there would be mandatory cover for those who earned above a specified tax threshold, and all employed persons and their dependents would have public hospital health cover" (Shisana, 2009). However, the problem with this was that "it did not cover the entire population, did not raise sufficient funding to improve the services provided and did not adequately link primary health care cover with hospital cover" (Shisana, 2009).

2.5. The launch of the National Health Insurance (NHI)

The launch of the National health Insurance proposed four key interventions "i) a complete transformation of healthcare service provision and delivery; ii) a total overhaul of the health care system; iii) a radical change of administration and management; iv) the provision of a comprehensive package of care underpinned by a re-engineered system of primary healthcare" (Naidoo, 2012). This proposal comes as a response to the issue of poor service delivery in terms of public healthcare that

has long been a problem in South Africa. The national policy sets out to redress the past and its effects on the South African health system, as it is it was one that was fragmented and racially biased in ways that largely benefited the white minority. This proposal comes from a long time ANC-led government mission in that: "Following democratic elections in 1994 the process of creating a single, non-discriminatory healthcare system was thwarted by the de facto development of a two-tiered approach, public and private, largely based on social class determinants, which perpetuated inequalities" (Naidoo, 2012). Furthermore, South Africa faces the burden of quadruple disease that is made up of Tuberculosis (TB), HIV/AIDS, maternal and childhood diseases as well as non-communicable diseases.

The transformation proposed by the policy is one that seeks the establishment of a 'single-tiered' system, in that the NHI will purchase services from providers both public and private. The current structure of the health system is a 'two-tiered' system, also known as public and private, which is largely based on social class determinates that continue to perpetuate the health inequalities. In other words the NHI will be the single purchaser of health services in order to "ensure the equitable and fair distribution as well as use of health care services; sustainable and affordable access to health care services and protection against financial risk" (Spurret, 2011). Thus, the role of medical scheme providers is expected to change upon implementation in that, once implemented medical schemes will only provide benefits not covered by the national health insurance (complementary cover).

Ultimately through this policy the government's intention "is to provide healthcare for all South Africans on the basis that many citizens do not have access to proper healthcare, particularly the historically marginalized and disadvantaged populations. This coupled with the reality that the majority of South Africans have difficulty monetarily to access private healthcare through medical aid schemes, because of the exorbitant costs" (Karodia, 2016, p. 13). This structure has much to do with the past, and the realisation that post-Apartheid South Africa has two healthcare systems (private and public) that determines where one is placed on the basis of whether one has medical aid along

with the depths of one's pocket. The fragmented structure of the healthcare services poses a threat to the NHI in that the previously disadvantaged which makes up the majority have access to public healthcare but are the subject to inefficient healthcare. The objective of the NHI and the NHI Fund is to provide improved access to quality health services for all its citizens. According to Naidoo "It [South Africa] bases its approach largely on the Brazilian experience and focuses on a 're-engineered primary healthcare system' that will focus mainly on community outreach services using a defined comprehensive primary care package of services" (Naidoo, 2012).

The NHI proposes the following: the NHI fund will cover all South Africans and legal long-term residents; the establishment of a single pool of healthcare funding for private and public healthcare providers alike; there will be no fees charged when people visit healthcare providers as the "NHI Fund will cover the costs for one's medical care in the same way medical aids do; the NHI Fund will be funded through general taxes, contributions of persons earning above a set amount and monthly contributions made by the employees to the fund; employers are to assist the NHI Fund by ensuring workers contributions to the fund are collected and submitted; and lastly NHI will not replace medical aid schemes, however , after the implementation the role of medical schemes will change as they will provide cover for services not reimbursable by the NHI Fund" (Parliament of the Republic of South Africa, n.d). These objectives are important for the report to note as they speak to the broader debates that are taking place in relation to governments control when it come to the NHI. What this is to say, is the government in its entirety will need to establish structures that strengthen the relationship between the National Department of Health and the Departments of Health in order to have a single functioning health system as from this there will be no alternative for the services it provides.

2.5.1. The National Health Insurance (NHI) and its Developments

The Green Paper release on the NHI explained the phases of implementation over the fifteen period. The first phase during the period of 2017 to 2022 would see the emphasis on "investing in improving access to and the management and quality of public sector health services, particularly at the primary

health care level" (John E. Ataguba, 2014). Followed by the second phase from 2022 till 2026 is "intended to introduce a strategic purchasing mechanism, by establishing a semi-autonomous National Health Insurance Fund (NHIF)" (John E. Ataguba, 2014). Although "tax funded "through allocations from general tax revenue and possibly additional earmarked taxes" (John E. Ataguba, 2014), the idea still remains that the NHI Fund will still allow for universal entitlement to comprehensive health services. This will be accessed through primary healthcare (PHC) and follow a referral route thereafter.

Since its announcement in 2011 there have been a number of pilot projects that have taken place in 10 districts, one in every province and two in KwaZulu-Natal (KZN). These pilot districts are as follows: "OR Tambo (Eastern Cape), Thabo Mofutsanyana (Free State), Tshwane (Gauteng), UMgungundlovu and uMzinyathi (KZN), Vhembe (Limpopo), Gert Sibande (Mpumalanga), Pixley ka Seme (Northern Cape), Dr Kenneth Kaunda (North West), Eden (Western Cape). Amajuba district was the additional district included by KZN" (NDOH, 2019, p. 12). According to a report released in 2019 the findings thus far in terms of the implementation of the pilot interventions varied across the districts, it stated "where successful, we identified a few common factors: strong political will, adequate human and financial resources for implementation, good coordination and communication, and good monitoring systems put in place at the time of implementation. However, the interventions also faced a number of challenges, and, to varying degrees, these factors hindered their success: inadequate planning, lack of resources, inconsistent communication, a lack of coordination where necessary and insufficient mechanisms to monitor progress to ensure course correction" (NDOH, 2019, p. 14). The varied outcomes from the implementation of the pilot projects, shows that there is a potential for the NHI to perpetuate the current unequal system that only caters to some. It also brings to light that different settings (rural and urban) respond differently to policy based on the systems in place. Thus, the current problems in the healthcare system cannot solely be fixed through the implementation of a new policy, rather government needs to attend to the issues before implementing a healthcare policy.

Since the initial release of the NHI policy an amended version of the policy has been released every few years up until the NHI bill which was tabled in Parliament in 2019. The draft bill of 2018 and the version released in August of 2019 show that not much has changed between the two drafts. The most notable change in the bill is the power of the minister. The 2018 bill showed the governance structure of the bill being over-centralised and unaccountable. The bill of 2019 "centralises the Fund even further than the 2018 Bill. Its governance hangs largely on the Minister of Health. The word independent is removed from the description of the Board of the Fund and it is rendered accountable to the Minister, rather than to Parliament. It is appointed by the Minister rather than by Parliament. The Minister, rather than Cabinet, appoints an ad hoc panel to conduct interviews and recommend candidates to the Minister for appointment. The Minister may remove members of the Board or dissolve the Board. The Minister, rather than the Board itself, also now appoints the Board chairperson" (Stevenson, 2019). This poses a problem as the governance structure of the fund is extremely important given that it will be responsible for both large amounts of money and the making of important decisions. It should ensure transparency and provide for checks and balances. Another component of the bill that has changed is the population coverage. The level of population coverage has shown improvement, which has been seen "between the 2018 and 2019 bills in that refugees are now entitled to the same coverage as South African nationals and all children are entitled to an undefined set of basic health care services" (Stevenson, 2019). "In the 2019 Bill, asylum seekers and undocumented migrants are entitled only to pre-hospital emergency medical services and services for notifiable conditions of public health concern (conditions such as Ebola, cholera, tuberculosis, etc)" (Stevenson, 2019).

What has remained unclear in the development process of the NHI even in the 2019 bill is the role of the provinces. The 2019 "bill spells out for the first time that the provincial equitable share (the funding that pays for almost all services in the public sector), will be shifted to the Fund. Despite the loss of funding, the provinces are meant to be managing agents of service delivery" (Stevenson, 2019). It is unclear how this task will be carried out. Lastly the Office for Health Products

Procurement is a new addition to the 2019 bill. This office is to be responsible for "setting the parameters for the public procurement of health related products, including medicines, medical devices and equipment. It appears that any health facility providing services under NHI (whether public or private) must purchase health related products from a Formulary established by the Office for Health Products Procurement, which provides for both the product in question and the approved suppliers of that product" (Stevenson, 2019).

2.5.2. The National Health Insurance and its Structures

The NHI presents a vital moment of transformation in the South African health sector as since 1994 there have been a number of reform policies aimed at fixing the fragmented system. These reforms have "included merging more than 10 'homeland' Ministries of Health as well as 14 departments organised by race and province into one coordinated health system" (Rensburg, 2018). The problem the health system faces now is that "this merger was not enough to address the inequities of the previous system, and it is important to note that despite significant expansion in health expenditure, these inequities remain" (Rensburg, 2018). The former homelands of which the OR Tambo district falls under sees a legacy of neglect, poverty and stagnation which affect the overall poor health outcomes in these areas which remain largely rural and underdeveloped. "These inequities have persisted as evidenced by the continued under investment in rural health services. The OR Tambo District in the Eastern Cape, despite its rural nature, consistently features as one of the lowest PHC per capita spenders, suggesting that primary healthcare services are significantly underfunded" (Rensburg, 2018). When looking at the NHI policy and its aims it is clear that government intends to rectify these inequalities through achieving UHC.

The structures of the NHI have a vital role to play in the successful implementation of the policy, especially in rural areas where development and access is limited. Given that the role of the NHI Fund will be to purchase services from both public and private sectors the concern it raises is whether it is the right mechanism to determine the package of care. Given the ever-changing social determinants

of health, the different areas will require continuous reviewing to ensure that the package of treatment being offered fits the nature of needs on the ground. The bill outlines that the primary services will be provided on a risk-adjusted capitation basis which means that the Minister and the board will determine the range of services provided. The problem then is that the "risk-adjusted capitation allows for budgets to be determined by health need, but without clarity on the scope of services offered, there is a likelihood that funding will not address the health need as a package of services approved by the Minister, particularly for rural communities where access to services is constrained by far travel distances and huge out-of-pocket expenditure" (Rensburg, 2018). Thus clarity on how the healthcare package under the NHI and the NHI Fund will be determined is needed.

The phased implementation of the bill makes it so that UHC would be something achieved in the long-term, the first phase implementation through pilot projects took a number of years and it is still not certain when the NHI will fully be play. "While the release of the Bill is seen as the completion of phase 1, there is little evidence as to the extent to which the PHC reengineering (on which the phase was premised) delivered the required results. Phase 2 is dominated by the legislative environment required to make the NHI a reality, with over twelve pieces of legislation requiring repeal or amendment" (Rensburg, 2018). The issue with the lengthy period of the overall implementation is that the healthcare crisis needs urgent repair and as such "it is imperative that the Minister in identifying the required health system strengthening initiatives, uses this opportunity to chart a path for the reorganisation of the ailing public sector health system" (Rensburg, 2018).

The intergovernmental relations structures under the NHI principles of good governance and accountability that will strengthen the healthcare system and ensure that the NHI achieves its objects of access to equitable healthcare services. The Bill does not clearly indicate the role of the district offices, "with a number of district health functions being subsumed into the CUP, the role of district offices under the Bill is relegated to large oversight functions, including monitoring the performance of service providers" (Rensburg, 2018). The relationship between the contracting units of primary

healthcare (CUPs) and the district management is unclear and this could lead to confusion of roles that could negatively affect the implementation of the NHI. This, coupled with the fact that currently the access and quality of healthcare services is dependent on the capacity of provincial departments of health implementations of national policies, in turn leaves the capacity to implement policy reliant on the allocation resources to be efficient and equitable. The beginning of the first implementation phase witnessed issues with the lack of adequate budget guidance from the department of health which saw budgets being spent late. "By the end of the 2012/13 financial year, only 77% of the budget allocated to the pilot districts through conditional grants had been spent. Most problematically, 90% of the available funds were used only in the fourth quarter of the financial year"

Ultimately according to Rensburg (2018) "what is however required is decisive and constructive leadership to take the NHI forward and make it the panacea of health care for all who live in South Africa. Without adequate leadership and a clear management strategy, the degeneration of the health system will continue to undermine progress towards the achievement of universal health access in South Africa to the detriment of large sections of the population who continue to suffer from unequal and insufficient health access" (Rensburg, 2018). It is clear from this that the governance of the NHI will hold the structures in place to ensure successful implementation, which means that there needs to be clear and concise coordination and communication between the tiers of government and a high level of community participation or there will be a gap between the needs of the population and the services provided. The case of the OR Tambo becomes a vital component of the report as it brings to the forefront issues of underperformance and lack of structures which need to be further investigated as it would appear that there seems to be a mismatch of policy in terms of what is being offered and the needs of the people, considering the barriers to accessing healthcare outside of the financial risk protection at the points of service. The rural nature of the district serves as a learning curve in assessing the needs of the rural population in regards to services required.

2.5.2.1. The Concept of Governance

Governance is not a new notion, according to Chibba it has been "an integral part of societies since the dawn of civilisation, and especially so with respect to what values, ethics and rules of conduct and justice should be upheld, how societies should be organised, and who should hold power and authority" (Chibba, 2009, p. 79). In this regard governance "is more than the effective prevention of irregularities, fraud, financial misconduct etc. And it is not just about compliance and control; it is also about a framework of principles that facilitate the organisation's ability to achieve its long-term objectives efficiently and effectively. It is also about maintaining specific performance over the long-term and it is about assurance that all these activities are done in an ethical environment" (Provincial Treasury, 2008, p. 8).

For South Africa "governance in the public sector implies that the Government is entrusted by the public to deliver service for the benefit of/or on behalf of the public, that would meet their needs and ensure the vesting of the rights imbedded in the Constitution" (Provincial Treasury, 2008). For the report governance becomes a major aspect of the implementation, as the success of governments policies depend on public service. Governance, particularly good governance, in South Africa is centered around the batho pele belief rooted in the legislative frameworks. Batho pele is an initiative that was launched in 1997 to transform public service at all levels (Akwasi, 2020). The initiative was launched because the South Africa government inherited a public system that lacked the necessary skills and attitudes needed to meet and address all developmental challenges that the country was facing (Akwasi, 2020). Batho pele is based on the following eight principles: 1. Consultation, 2. Service standards, 3. Redress, 4. Access, 5. Courtesy, 6. Information, 7. Openness and transparency, and 8. Value for money (Akwasi, 2020). These principles of good governance are required for the implementation of the NHI policy as it seeks to transform healthcare service delivery. The biggest component of transformation is public participation to hold public service accountable for the quality of service provided.

2.5.3. The National Health Insurance (NHI) Debates

The debate between entities around the NHI has largely lacked transparency to the public. As seen with the government official releases, typically after a decision has been made it is then open to public for participation and opinion. Thus far discussion from the public has happened within hearings at pilot districts. This related to the fact that many are worried about the issues raised in 2018 draft not being addressed in the 2019 version raise concern for the future and success of the bill.

The debate taking place amongst experts is of importance as different arguments and possibilities arise between the different divisions and interests. For one the issue of corruption is a central concern for all entities, however, "there is a split between those who believe corruption is so bad as to make NHI unimplementable, and those who are concerned with corruption, but who believe the risks can be managed" (Low, 2019). This specifically aims to acknowledge that apart from financial cost there has been a number of incidents such as state capture, corruption and mismanagement that have destroyed public service deliver particularly the public healthcare system over the last decade or two (Low, 2019).

Related to the issue of corruption is the concern of lack of accountability mechanism and governance structure. This issue at hand is the amount of power given to the minister of health, where "apart from placing NHI at risk of capture through future health ministers, this arrangement sends a signal that political control over NHI and the NHI Fund is preferred to the establishment of a technocratic institution accountable to the people through parliament" (Low, 2019). This component in relation to accountability mechanism speaks to the current centralised governance structure. The opposing camp is questing why the government didn't go with a more decentralised system of governance and that too much power is given to one entity. This concern has been particularly raised in relation to the District Health Management offices that in the bill have been defined as 'national government components'. Here the issue is that "This arrangement might well make it more difficult for healthcare under NHI to be adaptable to local needs. It might also reduce the sense of ownership people feel

over NHI and mean there are fewer people to hold accountable at a local level when things go wrong." (Low, 2019). Ultimately what is being questioned here is state capacity.

Interestingly the debates that have been taking place both for and against the NHI have largely been taking place politically. Since its announcement and its introduction to parliament the Democratic Alliance (DA) and the Institute for Race Relations have come out against the NHI, whereas on the other hand there has been unconditional support from the Congress of South African Trade Unions (COSATU) (Low, 2019). It is therefore a fair assessment to make that being on different ends of the NHI is informed by distinct political agendas. Through this question around the underpinning principles of the NHI have come into question as "there is a group of people who oppose NHI on mainly ideological grounds – particularly naysayers with a free market fundamentalist bent" (Low, 2019). Here what is happening is that there are those who are ideologically opposed to the NHI and those who are in support of the NHI but are just against the current plan.

Another issue taking place is concern around the state's ability to successfully implement the NHI. Currently "a distinction can be made between those who say that the state cannot possibly implement NHI and therefore we shouldn't even try, and those who have concerns about the state's ability to implement, but who believe that it may nevertheless be worth trying" (Low, 2019). What has come of these two opposing sides is that perhaps government can divert from the current plan and implement the NHI at a much slower pace and careful manner. This issue of successful implementation has also led to the questioning of the quality of service it will provide.

The issue of the private versus public entities has come to the forefront of the debates. As it stands the private medical scheme providers are against this shift in that it will limit their role in the healthcare system as they will only able to provide what is not covered by the national health insurance (Discovery, 2019). It is from this that the question around the use of a multi-layered system is also being debated, in that states that offer schemes such as the NHI usually allow for private medical schemes to provide the same coverage as the state insurance (Discovery, 2019). This is vital

as the private sector plays a large role in the health sector both monetarily as well as for the minority it caters for and if it is being removed in the sense that their functions and services will limited, their future sustainability and longevity in South Africa is one of uncertainty.

Finally another issue that is being taken up is the importance of the details of this bill. Here the issue of legislation versus the vision of the NHI is brought up, in that it is said that the only one who care about legislation are the lawyers everyone else is focused on the vision and idea of universal health care (Stevenson, 2019). The problem here is that "the vision, if it is not built into the defining systems and structures, is no more than a mirage" (Stevenson, 2019). These two camps are both dedicated to making the NHI successful, however on the one side are those who feel it is necessary to go beyond just support and speeches that the only way of achieving a funding system capable of furthering health for all is to engage with the details. On the other hand are those who believe through unconditional support the vision will be reached, it not so much how but when.

Chapter Three: Research Methodology

3.1. Introduction

The study into the National Health Insurance policy in South Africa and how government is proposing to address the health inequalities experienced by citizens was conducted through a qualitative research methods approach. The research developed a case study through the use of desktop research, namely reports, newspapers and public hearings, to look into the successes and failures of the early stages of the NHI implementation.

The focus of the research report into the OR Tambo pilot project was done for a number of reasons. First being that it touches on a gap that is not prominent in the literature, which looks at the policy's feasibility against its progress in the first phase implementation stage. The second is that not only is OR Tambo site the only pilot project in the Eastern Cape but also the most underperforming in comparison to the nine other districts across the country yet there are talks about establishing a second pilot project in the Eastern Cape. The underdevelopment of the OR Tambo speaks directly to debates surrounding governments ability to successfully implement the NHI, given the failure of the first phase implementation in this region arguments raised that the NHI should be introduced at a slower pace becomes one to consider. This coupled with worries about the possibility of corruption and lack of accountability mechanisms in its structure highlight the debates against the NHI and it being politically driven. The argument against the NHI does not speak to the opposition of the NHI itself but rather the opposition of the current plan, the lack of progress exhibited in the OR Tambo thus far begs the question of the feasibility of the NHI. Lastly the focus on one of the worst performing rural sites allows room for broader issues and ideas to be thoroughly examined against the current state of function of the NHI in this district. When looking into the feasibility of the NHI in South Africa it is important to look closely at shortcoming while still in the early phases of implementation as if issues can be identified early enough there is chance for correction and success.

3.2. Research Design

The research question was aimed at 1. looking into how the NHI in its first phase implementation matches the rural settings of South Africa in terms of improving healthcare and the overall health outcomes in these areas; and 2. How the structure of the NHI and it governance translate in the implementation of the first phase in a rural area. The report will be looking at "1. Accountability trough effective leadership and governance which requires collaboration between sectors to address social determinants of health; 2. The prioritisation of health promotion, protection and the prevention, treatment as well as rehabilitation of the conditions that make up South Africa's burden of disease; 3. Its 'people centred approach' which requires community participation in order to attain good health; and 4. The achievement of an equitable healthcare system through resource allocation and distribution of resources to ensure quality healthcare service delivery" ((DOH), 2011) in terms of the implementation of the pilot project in the OR Tambo district.

The specific qualitative approached utilised in the research was the case study method. The reason for use of a case study was that the case study approach allows for the exploration and understanding of the policy and a more in-depth investigation into the early phases of implementation. The exploratory nature of the research called for a document study which was reliant on a combination of official documents, mass media and government releases . A document study was chosen in particular as one is able to gather information from both primary and secondary sources. Essentially the report was designed through a conceptual study as research was conducted through observing and analysing of the already present information on the NHI given that the policy has not yet been implemented.

3.3. Site Selection

The case study is located in a rural area in one of South Africa's poorest provinces the Eastern Cape. The pilot project site met a particular criteria that was vital and useful in answering the research questions. Although the area is a pilot site its outcomes were drastically different from the other pilot

projects which highlighted great unevenness in the implementation progress across the country as well as between urban and rural settings. The pilot site highlights an important aspect of the proposed health reform in that nationally the NHI's success is measured by the effectiveness of the districts so failure of the districts if failure at National level. Essentially the districts are the ones that hold the NHI system together, thus at national level there is no NHI without the districts. It speaks to the interdependence between the local districts and national level.

The significance of the case study to the research is to investigate how the infrastructural dysfunctionalities at local level threaten the success of the NHI, the pilot site's failure is being ignored by politicians for the push of the NHI. The case provides the study with the angle that rural areas need specific policy adjustments that deal with their underdeveloped nature as financial access to healthcare is only one of the issues being experienced in rural areas when it comes to access health. The pilot site's failure also sheds light on the fact that results are being ignored which questions the success of the NHI.

3.4. Methods

Desktop Research:

A document study was utilised as both the literature and data gathering source. The reason for the use of this method is that the NHI policy under review has not yet been implemented in South Africa and the pilot projects are the first point of implementation. The sources used to gather data ranged from government media releases, official documents, news reports, visual media and journal articles. In answering the research question it was vital to look at the various government policy papers released on the NHI to develop an understanding of its aims and the communities it aimed to reach. The public hearings were also important to watch and analyse as it was the first public community participation offered by the NHI, especially in communities that have active pilot projects. This was important to look at against the backdrop of government statements as well as media outlets statements in attempts

to understand what the missing link was between what government aims where and what was actually being achieved on the ground.

The data gathered focused around two core themes: 1. The first phase implementation in rural areas as opposed to the rest of the pilot projects in the country as well as the results that were being produced during this period; and 2. The structures of the NHI and the relationship between the tiers of government throughout the implementation stage that led to either failure or success. After the data was collected and separated in these two categories, it was further analysed in the following themes that came out of the literature: 'rural', 'urban', 'public participation', 'local and national levels of government', 'first phase implementation', 'NHI successes' and 'NHI failures'. Other themes emerged from this specifically; 'public opinion', relationship between government structures, governance structures and the community'. This meant that success of the pilot projects was based on the improved access to healthcare services overall.

3.4.1. Data Analysis

The approach used to analyse data for the purpose of the research report was a content analysis approach. This method was selected as data was reviewed with regard to its relevance to the study into the NHI. This approached centred around the need for intervention by government in the health sector. Looking at it broadly there are many aspects to take into consideration, however policy making and current infrastructure are most vital. The research aimed at presenting a perspective around government's policy in terms of its understanding of the needs at ground level. It also analysed the challenges of the rural-urban health inequalities that exist in the current health system even with the first phase implementation of the NHI as well as the NHI governance structures and how it effects the first phase implementation of the NHI in a rural context.

3.5. Ethical Consideration

The desktop nature of the research centres ethics around the issue of copy write. Thus the duty is to ensure that there is no plagiarism given the use of; news reports, journal articles, government's releases and reports and visual media. This was done through ensuring the correct referencing of all direct quotes, paraphrasing, and citing of any ideas that were not mine.

3.6. Limitations

The qualitative nature of the research required the validity and reliability of the sources used to conduct the research. Given the document study approach sources had to be investigated on whether the information was influenced and biased in relation to its relevance to the study. The long period of time between when the documents were published and the progress that has been made since then proved difficult for the study to be specific to a certain period.

3.7. Conclusion

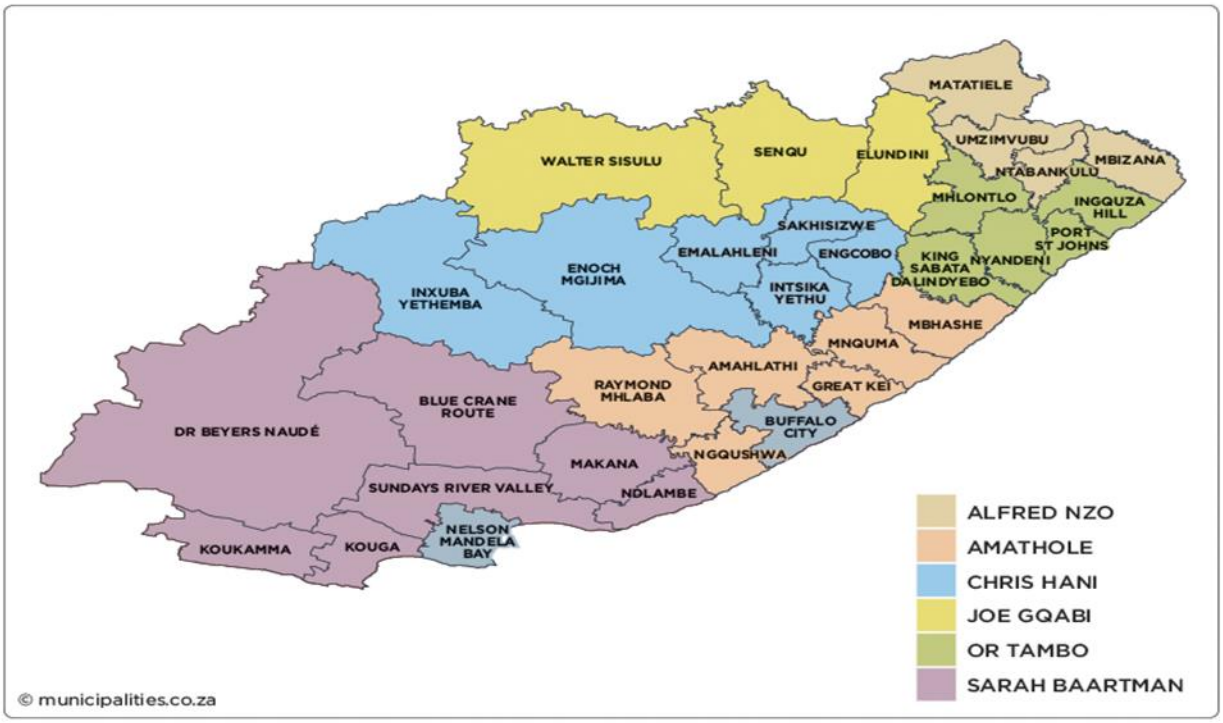
When looking at the NHI it is clear that government intervention is needed due to the historical injustices that have continued to persist in democratic South Africa. Given that at the core of the proposed NHI is majority of the population that cannot afford private health it is necessary to look at how the NHI will address the unique health sector problems in rural areas of South Africa. The research design and methodology of the report were adopted in relation to the question of the study. The next chapter provides a case study into the pilot site selected for the research.

Section Two: Findings and Discussion

Chapter Four: The OR Tambo District NHI Pilot Project Case Study

4.1. Introduction

The Eastern Cape is located on the on the east coast of South Africa. The province is the second-largest in the country with a population of 6 996 976 ranking it the third largest population (Municipalities of South Africa, n.d). The Eastern Cape is one of the poorest provinces in the country made up of large areas of former homelands, and continues to be characterised by its high levels of poverty, underdeveloped infrastructure as well as unemployment. The province "is divided into two metropolitan municipalities (Buffalo City Metropolitan Municipality and Nelson Mandela Bay Metropolitan Municipality) and six district municipalities, which are further subdivided into 31 local municipalities" (Municipalities of South Africa, n.d).



The Eastern Cape is a province where the urban/rural disparities were intensified by the injustices of the Apartheid system that restricted people from different race groups to certain areas and forcefully

removed those considered undesirable to the 'apartheid homelands'. The bantustans (homelands) were essentially racial reserves for majority of the black population established by the apartheid government to prevent them from living in the urban areas. This has consequently resulted in rural areas traditionally being overlooked when it comes to development planning and as such rural areas continue to be sites of marginalisation given the lack of resources, skills and infrastructure. The OR Tambo Municipality which was selected as a pilot site for the NHI has been chosen as a case study for this report as it continues to underperform and remains largely underdeveloped and rural.

4.2. The State of the Healthcare System in the Eastern Cape

The healthcare system in the Eastern Cape has for over a decade been on the brink of a collapse. Over the years the province has had the most poor performance in the country, "the causes of the Eastern Cape health crisis are well known: the provincial health department's chronic inability to manage its resources and the historical underfunding of rural health has brought the provincial health system to its knees" (Rural Health Advocacy Project, 2013). When refering to the lack of healthcare provison in the province its said that its generally hindered by a number of issues that includes but is not limited to the insufficent human resource management, poor planning, budget cuts, poor attitudes from healthcare workers, lack of medicines, poor policy implementation as well as policies that fail to address the rural context (Versteeg-Mojanaga, 2017). This generalisation is not to say that the issues only occur at ground level, but rather from top-down (national down to local) which ultimatley affects the overall poor health outcomes and poor levels of service provision.

The healthcare problems in the province are entrenched in the structures as well as its governance structures, which in turn affects all components of its healthcare system. A critical moment in understanding the healthcare service delivery was in 2013 when the Eastern Cape Health Crisis Action Coalition (ECHCAC) released a report on the issues affecting lack of healthcare delivery in the province. This report was conducted through ongoing monitoring of the health system in the province. In the report they highlighted that urgent attention needs to be placed on the fixing of "the

crumbling infrastructure, the availability of medication, supplies and supply chain management, human resources, the management of hospitals, emergency medical services and patient transport" (Mpulo, 2020). The issues identified in this report from the ECHCAC spoke directly to the issues impacting delivery of healthcare on the ground in terms of people physically receiving care. Following this report in 2018 there was a follow up assessment by the Treatment Action Campaign (TAC) who had found that nothing had improved since the ECHCAC report 2013 (Mpulo, 2020). The TAC report revealed that a major issue the province continues to have is the lack of human resources. Here "they argued that ensuring access to quality healthcare services and ensuring everyone had access to treatment and care, depended largely on having enough qualified and committed staff" (Mpulo, 2020). This report stresses the imperativeness for the analysis of the 2013 and 2018 reports on the state of healthcare in the Eastern Cape to trace the process of improvement and advancement or lack thereof. In other words, this analysis explores and evaluates the achievements of the healthcare system during this period in order to determine the level of transformation within the system.

The challenges experienced in the public healthcare in the Eastern Cape have a direct link to the vital role of leadership. According to Schneider (2020), "if we are to reimagine a future of access, equity and justice in health and health care in the Eastern Cape, we need bottom-up institutional-building involving civil society and not just top-down legislative, budgetary and other reforms" (Schneider, 2020). Thus coordination, cooperation and communication is needed from all sectors directly and indirectly affecting overall poor health comes in order for the NHI to work. That is to say, for instance, when members of the public, health workers and users and political party members had the opportunity to give their versions and express their dissatisfactions about the healthcare system. Dating back to the report from ECHCAC in 2013 and the follow up report in 2018 it was highlighted that "there was no proper management in the province's department of health. As a result, areas like contract management for food and laundry were neglected, the department failed to appoint or pay clinical staff on time causing chronic understaffing, facilities fell into disrepair, equipment were not

repaired and new equipment could not be obtained, and staff were left without leadership" (Mpulo, 2020). The Eastern Cape sees a crisis in its healthcare system where the lack of coordination between the national and provincial levels of government worsens the health issues in the province. It is clear that the two spheres of government in the province along with the lack civil engagement raise concern around the prioritisation of the delivery of healthcare.

For the report the top-down nature of the proposed NHI reform makes it important to investigate how it can result in a comprehensive turn around in such a setting. The problem this brings is that when looking at the NHI bill in its first phase implementation in the OR Tambo district against the backdrop of the failing health system in the Eastern Cape there is question around how the NHI will resolve a dysfunctional system when there is a lack of political and administrative will as well as capacity. The lack of coherence between the national department of health and the Eastern Cape department of health could pose a huge threat to the achievements and aims of the NHI policy as well as their obligation to realise the right to health under Chapter 3 of the constitution.

4.3. The OR Tambo District Municipality

The OR Tambo District Municipality is located in an area previously known as the Transkei. The Transkei was one of the ten former homelands that were systematically underfunded by the health department (Massyn, et al. 2017). The former Transkei area is one of Apartheid's legacies as it remains both underfunded and marginalised with little infrastructure or communications, and services collapsing. Since 1994 government has slowly discovered the extent to which the district has suffered from the lack of development since that period. The district remains largely rural with facilities that cannot be properly used because of the lack of human resources along with challenges of basic infrastructure such as water and electricity (Gaede & Versteeg, 2011). "The OR Tambo district is one of the largest districts in the Province, with a population of 1 382 399 meaning that 20% of the population in the Eastern Cape resides in the OR Tambo District Municipality" (DOH, 2020, p. 6). The topographical nature of the OR Tambo District directly challenges accessibility to health care

services in the communities, as a rural district it is characterised by poor infrastructure, poor road system as well as health systems (DOH, 2020, p. 6). The social determinates of health such as the "poor portable water supply and sanitation, low levels of education, unsafe disposal of domestic waste as well as high unemployment rates are predisposing factors to the high burden of diseases" (DOH, 2020, p. 6) in this district.

The OR Tambo is highly burden by "high maternal, neonatal and child mortality rate, high burden of HIV & AIDS and TB epidemic and high incidence of Non-communicable diseases" (DOH, 2020, p. 6). Although there have been efforts made in the ensuring of the provision of health services, the OR Tambo district is still faced with a number of challenges that hinder service delivery. The lack of access to health facilities remains a challenge as of 146 Municipal Wards 34 do not have health facilities, which in turn means that for certain communities long distances have to be travelled to what would be considered the nearest health facilities (DOH, 2020, p. 6). This is coupled with the difficulties to reach areas in the district where the health providers walk long distance to health consumers who cannot be reached by vehicles. It should also be noted that "the (10) available Community Health Centres (CHC) are few and serve populations that are higher than expected WHO norm of 60 000 people per CHC in rural areas whilst the only CHC in the peri-urban area serves more than 144 000 population" (DOH, 2020, p. 6).

Some of the hospitals in OR Tambo district are relevantly functional in that they appear dilapidated with exposed electricity cables, damaged plumbing and paint peeling off the walls. While in other areas of the district some of the healthcare buildings need to be replaced as they were built from mud and clay decades ago (Mehlwana, 2020). During a press briefing in 2020 the Eastern Cape Premier made note of the poor conditions of the healthcare facilities in the province, he said: "For far too long the rural masses of our people in particular have been receiving healthcare service in facilities that were not conducive for the provision of quality healthcare. Even worse, our healthcare workers had to endure working in shabby healthcare facilities. I have seen some of these health facilities with my

own eyes. It still boggles my mind how they maintained their status as healthcare facilities with their horrible state of infrastructure decay" (Mehlwana, 2020). The healthcare system deals with the collapsing facilities, human resource and management issues coupled with complaints from both healthcare users and workers. The state of the healthcare system in the OR Tambo district is in desperate need of the long-promised government intervention in terms of development which is dependent on the department of health.

4.3.1. How and Why the OR Tambo District Municipality was located for a NHI pilot project

2012 saw the roll out of the national health insurance (NHI) pilot interventions. The districts selected were chosen "to reflect criteria relating to location, burden of disease, performance and other key indicators relevant to describe the population currently accessing public sector" (NDOH, 2019, p. 23). The pilots selected focused on areas considered the most vulnerable sections of the society in the country. This was done in the hopes of strengthening the functioning of the district health systems as well as assessing if the health service package, the primary health care teams and strengthened referral systems, will improve the accessibility to quality health care services, particularly in the rural and previously disadvantaged areas (Bodibe, 2012).

The OR Tambo district was one of the selected sites to launch a NHI pilot project as the district was in need of infrastructure overhaul. The need for development in this region is dire as "important infrastructure, such as sewerage, buildings, electricity connections, and equipment, need replacement or are non-existent" (SAPA, 2013). The pilot project was launched in April of 2012 in the district public health facilities and was aimed at reducing the burden of disease and congestion in the hospitals in the district. The selection process of this district was based on a number of factors, "including socio-economic data, such as income levels, access to private medical aid and access to water, sanitation and electricity" (Bodibe, 2012). The selection criteria utilised were, "firstly, the demographic data in terms of population numbers from various studies, the socio-economic

conditions, health service performance in that district, district management capacity and, of course, the burden of disease'€ ¦ in that district, how much of HIV/AIDS and TB and all the other burden of disease that affect the country'¦ how much is it in that particular district?" (Bodibe, 2012).

In the assessing of the site the Health Minister expressed that the district was in desperate need of a health infrastructure remodel and that the most vital "infrastructure such as sewerage, buildings, electricity connections, and equipment, need replacement or are non-existent" (SAPA, 2013). The district fit the criteria for the health strengthening system initiative of the first phase implementation which set out to develop the healthcare provision within OR Tambo district so that when the NHI is implemented the healthcare system in the district would be able to provide quality care and access to healthcare services that meet the national standards of care delivery. The OR Tambo public hearing on the NHI in 2019 saw the public push for the speedy implementation of the NHI as they view it as a mechanism that will improve the health system not only in the district but in the province as well. What was of concern to the community was whether the NHI would be implemented with the current failing and poor infrastructure of the district (NHI Bill - Eastern Cape Public Hearing, 02 December 2019, 2019). This is to say that the public in the OR Tambo district are in full support of the NHI and want its implementation as it provides hope for the improvement of the level of healthcare received in the district. The governments selection of the OR Tambo as a pilot site was on the basis that the district was in crisis and in order for the NHI implementation to be successful the OR Tambo would need a series of development in order to achieve the objectives of achieving access to equitable and quality healthcare

The overall aim and objective of the pilot project in OR Tambo district was for the Department of Health (DOH) to evaluate the administrative and service delivery reforms proposed in the NHI and considered necessary to implement an NHI. It also sought to identify both barriers to efficient healthcare planning as well as budgeting and management lessons (Eager & Madonko, 2013). This meant that municipality would need to establish a coordinated implementation strategy in terms of

the district administrators, facility managers, healthcare workers and cummunity participation in order for the municipality to develop its healthcare system in order to meet national standards when the NHI comes into play.

4.3.2. The first phase Implementation and results

The first phase of the NHI pilot systems ran from 2012 to 2017 and focused on piloting a number of health systems strengthening (HSS) interventions directed at the primary healthcare (PHC) level. The main focus of the first phase was the implementation of specific interventions in the district in order to improve and strengthen the health system before the introduction of the NHI Fund. The PHC interventions comprised of the following components: "1. Ward-based Primary Healthcare Teams (WBPHCOTs), responsible for the provision of promotive and preventative healthcare to households; 2. Integrated School Health Programme (ISHP), aimed at providing various health promotion and preventive services to school-going children at their schools; 3. General practitioner (GP) contracting, focused on increasing the number of GPs at primary healthcare facilities to improve the quality and acceptability of care; 4. Ideal Clinic Realisation and Maintenance (ICRM) model, aimed at increasing the quality of services through the establishment of minimum standards; 5. District Clinical Specialist Teams (DCSTs), responsible for supporting clinical governance and undertaking clinical work, research and training; 6.Centralised Chronic Medicine Dispensing and Distribution (CCMDD) system, aimed at improving the distribution of medicines to patients through the providing of chronic medication at designated pick-up points (PUPs) closer to the communities in the pilot district; 7. Heath Patient Registration System (HPRS), began the capturing of patient data and the generation of electronic files but aimed at eventually achieving a fully electronic patient record-keeping system; 8. Stock Visibility System (SVS), aimed at improving oversight of stock with the use of an electronic stock monitoring system; 9. Infrastructure projects, implemented to improve health infrastructure; and 10, Workload Indicator for Staffing Need (WISN), a WHO planning tool used to facility managers make more efficient staffing decisions" (NDoH, 2019, p. 11). For the purpose of the report

from the abovementioned aims special focus will be placed on the contracting of practitioners, quality improvement and infrastructural projects in its discussion of the NHI in the OR Tambo district.

Overall the implementation of the first phase pilot projects shows significant challenges and lack of improvement in the OR Tambo district. There are a number of organisational problems being experienced on the ground in the district making progress difficult, as the primary healthcare facilities in the OR Tambo district showed that only 2% were able to provide the full package of primary healthcare services (Eagar, 2013). Human resource capacity in the district is also proved to be a challenge during this phase as OR Tambo saw only 60% of doctors posts in hospitals while nursing posts saw 51% at hospital and 37% at primary care level filled (Eagar, 2013). Another weakness found at the pilot site was the clinic committees and hospital boards, while all hospitals had boards their functionally was an issue, this is highly problematic as this speaks directly to the quality of structure intended to facilitate public participation (Eagar, 2013). The district's overall underperformance has been said to be a result of a lack of coordination and communication between the National Department of Health (NDoH) and the Department of Public Works

4.3.3. The OR Tambo District Community Participation in NHI Hearing

The first phase implementation of the NHI was accompanied by public hearings in order for government to offer a level of public participation. All eleven districts were provided public hearings, however in the Eastern Cape there were a total of five public hearings, which took place in Port Elizabeth, Queenstown, King Williams Town and Mthatha. The NHI public hearing for the OR Tambo district was held by Parliament's Portfolio Committee on Health at a Town Hall in Mthatha to engage with the community in the district, "the hearing was attended by local councillors, doctors, religious groups, health workers, regular community members and representatives from civil society" (Mehlwana, 2019). This hearing was an opportunity for the people in the community to voice their needs as well as represent a sort of consensus between the residents, which ultimately identifies the significant needs for better and equitable access to healthcare.

Residents raised concerns about the state of public health systems in rural areas, as facilities are far and few in between, while those in close range have poor infrastructure accompanied by a shortage of staff and medication. This was directly linked to the fear expressed by some women regarding their long distant travels for basic healthcare (NHI Bill - Eastern Cape Public Hearing, 02 December 2019, 2019). Here the danger of traveling through rivers and remote and bushy velds (bushy and abandoned fields) where they are vulnerable to rape and muggings were highlighted. Community members also mentioned that they were not aware that the NHI has been in play since 2012 and there has been little to no improvement, but it makes them hopeful in that they feel as if the NHI is a sign that government is hearing their cries (Mehlwana, 2019). These concerns tie into one of the problem areas for implementation as proximity and availability of healthcare institutions determine the NHI's success, meaning that with the implementation of the NHI the OR Tambo district is already at a disadvantage in terms of 'access' which underpins the motivation for the NHI. Accessibility in this regard sheds light on what the community is experiencing in terms of its barriers to these institutions.

The hearing was also attended by various healthcare workers, one of which was a Doctor who spoke on behalf of the South African Medical Association (SAMA). During his presentation he mentioned that SAMA in the Eastern Cape is in full support of the NHI and that it is important for the NHI to be achieved not only because of the sustainable development goals but also because the price of healthcare in South Africa is unsustainable for both the poor and rich (Mehlwana, 2019). Another Doctor who was trained in Cuba was in attendance and highlighted that it's important to remember that South Africa needs to prioritise healthcare specifically primary healthcare which is the most fundamental basis in that it is a developing country. He also went on to mention that in rural areas the elderly are forced to wait in queues the entire day for assistance and medication at the clinics due to the shortage of nurses (Mehlwana, 2019). Service availability is highly dependent on the work force, which the pilot project set out to improve as one consistent issue with the public healthcare system especially in rural areas was shortage of staff which is still persistent in this region. The first phase implementation is aimed at the development of the current structures which is vital to the

success of the NHI as it is being incorporated to the existing system that is not meeting the needs of the people evenly. Thus the highlighting of the persistent issue of the work force needs to be addressed adequately in that it presents a barrier to the implementation of the national medical scheme. The comments made about South Africa being a developmental state is important to note as it is directly linked to BRCS goal of achieving universal health coverage.

There was a general fear of corruption amongst the community, and one of the attending community members voiced that there should not be any plans of outsourcing the NHI project as it could lead to corruption as seen with other state-owned enterprises and that failure of the NHI project only sets rural communities such as theirs further back (NHI Bill - Eastern Cape Public Hearing, 02 December 2019, 2019). An important question was raised by the community, who asked if traditional healers would be a part of the NHI at primary level of healthcare. They expressed how important it is for traditional healers to be included as they form a large part of not only the health system in South Africa but also communities' particularly in rural areas and that government should not leave them behind in development (NHI Bill - Eastern Cape Public Hearing, 02 December 2019, 2019). The concerns surrounding the fear of corruption are legitimate in the sense that broader debates have been taking place in relation to the NHI governance structures and its lack of accountability mechanisms. The current structure of the board, CEO and Minister of Health has been in question in that little has been given in relation to accountability, public participation and how it ties into the principles of good governance. The limited knowledge on the NHI and its structures calls for its feasibility to be further investigated.

For the purposes of the report, the NHI public hearing in the OR Tambo district was vital is determining the level of public participation in the first phase implementation. The hearing was also key in highlighting the level of achieving the following elements of the policy that the report focuses on: 1. accountability through effective leadership and governance which requires collaboration of all sectors to address the social determinants of health; and 2. Its people centred approach that requires

community participation for the attainment of good health. Through the hearing it's clear that in the first phase of implementation, public (community) participation was limited in that, the pilot project began in 2012 but the hearing was only held in 2019. This means that for the entirety of the first phase of implementation the community was only consulted once in a period of six years, which indicates that government for the most part is implementing the NHI in a top-down manner which questions its people centred approach as well as its structures of good governance. Good governance in this sense speaks to transparency and accountability which is linked to the second element of focus. Here the lack of progress in regards to the level of impact the presence of a pilot project had in the district is alarming. This is cause for concern as the community is still facing many issues accessing health as well as the lack of awareness in the community of the pilot project. From this stand point governance needs to be questioned as it threatens the overall successful implementation of the NHI.

Conclusion:

Overall at the public hearing in Mthatha the residents expressed support for the proposed NHI Bill, however, still had concerns about how the bill would solve the collapsing health system in the Eastern Cape, and particularly in the rural areas. The general consensus was that the NHI should be implemented sooner rather than later as the current system is failing them; however, the existing health infrastructure should be fixed first. For the report the data on OR Tambo pilot project highlights the difficulties being experienced by a rural area in the implementing of the NHI and how the policy implementation translates at local level in a rural setting. The first phase implementation in the OR Tambo has shown a number of misses in achieving its goal of equal and equitable access to health for all, in that the public hearing demonstrates not only missed opportunity for further public engagement, but also the needs that are required to be heard and attended to if the NHI is to imagine an even successful implementation across the country.

Chapter Five: The Governance and the Implementation of the National Health Insurance(NHI)

5.1. Chapter Introduction

The proposed NHI in South Africa aims to reform the public health system with emphasis being placed on primary healthcare, which brings the question of governance to the forefront. The policy set to bring about this transformation refers to the following principles: accountability through effective leadership and governance; and equitable access through the allocation and distribution of resources to achieve quality health service delivery. The reason for governance being questioned is the scepticism surrounding effective policy and policy implementation. Healthcare governance in South Africa typically speaks to the way in which the state interacts with society in such a manner that allows for policy development that leads to bridging of the health disparities (Braun and Stanton, 2015). This is done through the public sector agencies in national, provincial and local level. Healthcare reform in terms of inclusive development has been a part of South Africa since the end of Apartheid. The purpose of this chapter is to see how the NHI fits into South Africa's principles of good governance and how the proposed structures of the NHI works with governments efforts in achieving equitable access to healthcare for all, particularly in a rural area with a NHI pilot project.

5.2. Good Governance

Kaufman et al. (1999) described governance as "traditions and institutions by which authority in a country is exercised for [the] common good". This includes "the process by which governments are selected and replaced; the capacity of the government to formulate and implement sound policies effectively; and the respect of citizens for the institutions that govern economic and social interactions among them" (Pillay, 2004, p. 587). Good governance according to Kofi Annan speaks to "ensuring respect for human rights and the rule of law, strengthening democratization and promoting transparency and capability in public administration" (Annan, 1998). We view it as also a way,

strategy, for ensuring sustainability for the future. “The content of the concept of good governance largely depends on the aims for which it is used; financial institutions tend to focus more on economic reforms, whereas for the more political organisations the content of the concept finds its angle in human rights law” (de la Harpe, 2008, p. 3). In South Africa, “in October 1997 the White Paper on Transforming Public Service Delivery (the Batho Pele White Paper) was introduced to put into effect the commitment of the Government to extend services to all citizens, not merely a privileged few. This commitment was first expressed in the RDP programmes and is enshrined in our Constitution and Bill of Rights” (Job Mokgoro Consulting cc, 2003, p. 5). This proposes that the South African departments of governments adapt a model or a set of principles of how client-centred organizations are run and what makes them successful with the chief aim of efficiently delivering services to the public. During this time South Africa’s commitments held special significance for its citizens as, “these commitments were to address poverty, promote social integration, create an enabling environment for social development, promote full employment, and mobilise resources for social development. Democracy, good governance, and the respect for human dignity were said to form part of the very nature and culture of Africans (Zuma, 2001)” (Pillay, 2004, p. 588). The idea for the principles of good governance has thus always been to create and sustain a secure and stable environment for democracy. Good governance in this sense is a ‘pillar’ for sustainable development in South Africa. “According to Paragon Regional Governance Programme (1999), governance strengthens the enabling environment for sustainable development” (Pillay, 2004, p. 588).

For sustainable development to happen, government capacity is clearly not enough (de la Harpe, 2008), and therefore cannot hold monopoly of resources and expertise, and must depend on the cooperation and coordination of other institutions and actors from within and outside government. In this sense, Hyden, Court, and Mease (2004) identify six fundamental principles that are widely accepted by researchers and governance stakeholders in developing and transitional societies around the world, 1) participation - the degree of involvement by affected stakeholders, 2) fairness - the degree to which rules apply equally to everyone in society, 3) decency - the degree to which the

formation and stewardship of the rules is undertaken without humiliating or harming people, 4) accountability – the extent to which political actors are responsible to society for what they say and do, 5) transparency - the degree of clarity and openness with which decisions are made, and 7) efficiency - the extent to which limited human and financial resources are applied without unnecessary waste, delay or corruption" (Braun and Stanton, 2015, p. 18). The IMF (2005: 1) suggests that good governance ensures the rule of law, improves the efficiency and accountability of the public sector, and tackles corruption. The UNDP (2005: 12) characterises good governance as participatory, transparent, accountable, effective and equitable. It promotes the rule of law and ensures political, social and economic priorities are based on consensus in society and that the voices of the poorest and most vulnerable are heard in decision-making" (Braun and Stanton, 2015, p. 18). Whilst it is not easy to offer a simple definition of good governance it is non-ambiguous on the fundamental elements which are transparency and accountability, and thus the concerns about the structure of the NHI. The report was able to notice that these play out at OR Tambo where for instance public participation has been limited and the public hearings which were held in MthaMtha demonstrated the reluctance of the release of the NHI pilot sites reports to the public. From a good governance stand point the lack of public participation as well as the reluctance of the release of the pilot site repots directly opposes the fundamental elements of transparency and accountability. As it stands without these reports, the level of good governance upheld in the first phase implementation in the OR Tambo district cannot be accurately measured overall. However, what the report draws from this is that the OR Tambo district has illustrated lack of good governance, in that the underperformance of the pilot project which has been linked to management capacity issues as well as the lack of bulk infrastructure in the district, is not being addressed with transparency and accountability. The public has no full knowledge of the direct causes within the implementation that has resulted in the pilot project failure, nor do the public know if the issues expressed through performance and limited public participation are being addressed. The lack of good governance in the district questions governments capacity to respond to the needs of the people.

5.3. Governance and the Implementation of the National Health Insurance (NHI)

Government has introduced a number of developments and programmes to improve health care, efficiency, safety and quality of delivery and access for all citizens, since it is a constitutional obligation in South Africa to deliver quality health care, which has seen transformation in health policy and legislation intended to ensure compliance in the delivery of quality health care (Maphumulo and Bhengu, 2019, p. 1). Dr Manto-Tshabalala-Msimang (Department of Health 2000) claimed that since 1994, the post-apartheid government and the Department of Health have developed and implemented a number of policies and pieces of legislation that impact directly and indirectly on the delivery of health services" (Braun and Stanton, 2015, p. 17). Notwithstanding the advancements made by the health sector in terms of improved quality of service delivery in healthcare, evidence has demonstrated that there is dissatisfaction for the standards of services in public health institutions, that is public health institutions are failing to meet basic standards of health care and patient expectations and communities. Maphumulo and Bhengu trace public health challenges back to the period of apartheid, the fragmentation and discrimination, in particular rural impoverishment, which they argue: "led to deterioration in health system delivery because of lack of resources, and poor communities were especially affected" (Maphumulo and Bhengu, 2019, p. 1). For Braun and Stanton, "South Africa has some of the world's best policies, yet sometimes struggle with their implementation" (Braun and Stanton, 2015, p. 17). The report argues that these are both accurate, therefore, in this section, the report explores how the NHI's efforts assist those of government in improving the quality of healthcare delivery since apartheid ended. In other words, whether the issues raised by the public regarding public health institutions are resolved in some ways by the introduction of the NHI, such as: "prolonged waiting time because of shortage of human resources, adverse events, poor hygiene and poor infection control measures, increased litigation because of avoidable errors, shortage of resources in medicine and equipment and poor recordkeeping" (Maphumulo and Bhengu, 2019, p. 2), this is of course among other serious issues as, decaying and ageing infrastructure, far distance and proximity between institutions and communities, facility shortages, etc.

The NHI rollout intends to apply and employ the principles of good governance in its processes, with strong intentions to enforce accountability and dispatch a strong anti-corruption team to prevent the risk of corruption, as well as to administer advanced monitoring and evaluation strategies. “Concerns about the governance of public entities are not only to safeguard against inefficient use of resources and corruption, it is also because good governance speaks to transparency and accountability” (Mafuma, 2019). It is through good governance that the improvement of the quality of life of all citizens and the optimisation of the potential of each can be achieved. “The White Paper on Transforming Public Service Delivery (Batho Pele White Paper, number 1459 of 1997) provided a policy framework and implementation strategy for the transformation of public service delivery, which included the delivery of health services” (Du Toit and Khoza, 2011, p. 8). The report refers good governance to the ‘Batho Pele’ principles, which means ‘people first’, as per the South African standards of good governance, and how it links to the public health sector.

The NHI faces serious challenges to its good governance, namely, extensive powers of the executive, lack of transparency, and lack of room for public participation, and as it stands it arguably, the fund does not meet Annan’s definition of good governance. The current structure of the NHI creates a challenge for public participation and transparency: “the NHI Fund board, made up of not more than 12 people, is appointed by the minister, and is accountable to the minister. The only references in the bill to public participation in the board appointment are through public nomination of candidates for the board in Section 13(2) and public interviews to be conducted in Section 13(3)(a)” (Mafuma, 2019). According to Mafuma, “it is not clear whether by public nomination the Bill anticipates that the names of the nominated candidates and their nominators will be made public, or if it simply means members of the public are invited to nominate candidates” (Mafuma, 2019). The assumption then becomes that the public are mere spectators, and therefore might not be able to make representations, and this of course brings about serious issues of transparency and accountability.

Enormous powers are vested upon the minister to make all appointments, and such centrality affects the credibility of the NHI. “In terms of Section 13 of the bill, the minister will be vested with enormous power to appoint board members. Following the nomination process for board member appointments, the minister must appoint an ad hoc advisory body to conduct public interviews of the shortlisted candidates and forward its recommendations to the minister for approval” (Mafuma, 2019). In this way, the public is not made aware of the criteria for selecting these members or who prepares the shortlisting of candidates. It is critical for the principles of good governance that appointments for board members and executives be done in a transparent fashion that inspires public confidence. Also cause for concern is the role of the minister in the appointment of the NHI fund CEO and the ministerial advisory committee that determines ultimately the pricing and benefits package, as well as the alarming ambiguity of the NHI policy framework, for instance, “although the board is involved in the appointment of the CEO, Section 15(4)(d) strangely states that the board must inform the minister of any advice it gives to the CEO” (Mafuma, 2019). In contrasting addition, “the role of Parliament in the appointment of both board members and the CEO is limited. The extent of its involvement is that the minister must notify it of the appointment of the CEO” (Mafuma, 2019).

Bad implementation of policy is a major obstacle to progress in South Africa despite government insisting that the policy framework is well-defined and is transparent, unfortunately, transforming policy in to practice is far more complex than that. According to Braun and Stanton, “critical concerns regarding issues about how policy can be effectively implemented and who should be responsible for implementing policy is one of major concern” (Braun and Stanton, 2015, p. 17). Moreover, “Ham and Hawkins (2003: 86) claim that the implementation of policies as a means of improving services in the health sector will vary depending on the degree of consistency between the values embedded in these policies and those held by actors in the system” (Braun and Stanton, 2015, p. 17).

5.4. Observation and Recommendations

The NHI implementation faces an institutional challenge with management capacity. This is an issue of management capacity as it deals directly with human resource development and appointment. The NHI governance structures propose both a centralised and decentralised functions of authority in that the fund has centralised authority through its board, CEO and Minster of Health, while the decentralisation comes into play with the new district and primary care level structures. Here "a strong system of health management and leadership will be needed to run the district health authorities and meet the new demands of a restructured primary health care system and a system of referrals to secondary and tertiary services" (Surender, 2014, p. 16). As seen in the current structure the department of health has exposed cracks in all levels if the healthcare sector as currently there are a number of failures with management capacity in terms of understaffing, lack of capacity to implement policy, lack of facilities, demotivated professionals as well as lack of medicines available (Surender, 2014). Given these issues the relationship between the national and provincial poses a threat and challenges to the implementation of the NHI, "as indicated in section 3, the separation of national level policy making from provincial level implementation, accompanied by federalist budgeting arrangements means that the central government has little leverage to ensure national policy priorities are uniformly implemented at provincial level" (Surender, 2014, p. 16). The first phase of implementation at the OR Tambo of the NHI shows the continuation of management capacity issues in that, one of the first reports released on the progress of the NHI demonstrated that the district in comparison to other pilot projects overwhelmingly underperformed. In the report it is highlighted that with human resource capacity the Eden and uMgungundlovu districts managed to fill 90% of their doctors posts while the OR Tambo district only managed to fill 60%; and with the nursing posts the OR Tambo district filled 37% while both the Eden and uMgungundlovu districts managed to fill 95% of the posts (Eagar, 2013). The report also goes onto detail the availability of full primary healthcare packages at health facilities, the OR Tambo only managed to get 2% of its facilities to offer the full primary healthcare package while the Eden district managed 80% and uMgungundlovu district 76% (Eagar, 2013). This is to say that the lack of coordination and communication between

provincial and national highlights inequalities between provinces which will ultimately affect the uniform equitable and quality provision of care at a national level. The unevenness of the results show that healthcare users will not be provided the same quality of care due to their geographical locations, " it would seem that many provinces do not possess the capability to spend even their current health budgets, a prerequisite for the implementation of a universal system of provision" (Surender, 2014). The OR Tambo pilot project in comparison to the of the Eden and uMgungundlovu is rural in nature and requires a more contextual approach to the implementation of the NHI.

For the report if the NHI would imagine a successful implementation in a rural area such as the OR Tambo it would have to account for the factors that shape a rural area which includes socio-economic dynamics, burden of disease, level of access and the inefficient structures in place. The NHI emphasises 'access for all' which is largely dependent on the retainment of healthcare professionals in the rural district. This however has been difficult in the OR Tambo as seen with the abovementioned statics. It has been suggested that the NHI will face difficulties with the retaining of private general practitioners who are predominantly active in the private primary care sector, the main concerns around this is the "remuneration, resistance to local state control, increased workload, clinical autonomy, and concern about blame for diminished quality of care" (Surender, 2014). The management capacity issues can only be resolved through the coordination and communication between the provincial and local levels of government, the failure of the OR Tambo district to some extent lies in its structures. The public participation in the district only took place in 2019 after the roll out in 2012. This has had a negative impact on the performance on the district overall as the community was only given the opportunity to participate after the fact. The lack of development from the pilot project was highlighted in the hearing where members made mention of either not being aware that the pilot project was taking place or being in favour of improving the current state of health then implementing the NHI following that (NHI Bill - Eastern Cape Public Hearing, 02 December 2019, 2019). The failure in the OR Tambo district questions the governance structures that resulted in its poor performance, as the good governance principles in South Africa speak to accountability,

transparency and public participation which has lacked in the district throughout the first phase implementation. The NHI in this sense has taken a top-down approach to addressing the issues of healthcare provision in this district, which was an attempt to develop the healthcare system in place through the first phase health strengthening systems initiative, and has done little in that effect. What is called into question from this is the people centred approach the NHI claims to have in its policy.

While the local and national structures contribute to health policy formulation and implementation, the role of provincial government under the NHI is unclear. What is particularly concerning in regards to the provincial governments functions, is that the implementation of the NHI limits the power of the provincial government to provide quality and affordable healthcare. It has been outlined that the roles of the provincial governments under the NHI include; "emergency medical services and forensic pathology services; environmental and pollution control services; health and medical services during provincial disasters" (PMG, 2019). What this means is that, under the NHI central hospitals report directly to the National DoH and the NHI Fund directly contracts health service providers such as regional hospitals, district management teams, private providers e.t.c. (PMG, 2019). Thus, the proposed centralisation of financing, governance as well as decision making of the NHI Fund, along with the access to services and payment of providers at national level in some ways duplicate the role of provincial government and its functions.

5.4. Chapter Conclusion

"The NHI Fund will receive substantial amounts of public funding and will be responsible for the healthcare services provided to millions of people in South Africa. It is vitally important that appropriate, efficient and effective governance structures are created to support it" (Mafuma, 2019). This chapter argued that the main reasons for why policies do not yield the results that are expected is because of implementation failure, that is to say, policies are drawn up which are good however, are not implemented. The NHI policy design is good in writing for the nature of the healthcare system in South Africa, with the health inequalities its aims have the potential for redress. The problem that

comes from this is that the policy at national level is not reaching its goals of implementation at local level, which the OR Tambo pilot project has demonstrated. The report finds that, the batho pele principles of good governance which are embedded in the policy design do not translate in the implementation processes at local level. The fundamental principles such as consultation, standards of service, access, information and transparency are not upheld during the first phase implementation, thus, it can be said that the OR Tambo pilot project demonstrated the lack of good governance structures in the NHI. These elements are particularly highlighted in the following findings from the OR Tambo pilot project: 1. limited public participation, 2. lack of service delivery improvement with the presence of the pilot project, 3. lack of awareness of the NHI or pilot project in the district, and, 3. the reluctance to release the reports detailing the underperformance. This undermines capacity of government to respond to the needs of the people through effective policy implementation. The NHI is still a work in progress and government is still establishing an understanding of what it is and why it should be implemented, and it requires continued discussions and dialogue by all stakeholders in society.

Chapter Six: The National Health Insurance (NHI) in Rural Areas

6.1. Chapter Introduction

The lack of communication and coordination has led to infrastructural issues that hinder the delivery of healthcare services, however the context of rurality in South Africa offers barriers that go beyond these structures. The relationship between healthcare, poverty and the poor health outcomes that result from that combination need to be further investigated as it has the potential to negatively affect the performance and implementation of the NHI as a whole on both national and local levels. These dynamics speak to the following core principles of the NHI policy: its people centred approach that requires community participation; and the prioritisation of health promotion, protection and the prevention, treatment and rehabilitation of the burden of disease. The NHI emphases access to healthcare for all and aims to achieve justice based on need, which the NHI has based on financial access. Thus it is imperative for the report to investigate the notion of access as it carries different meanings for the different contexts of the South African population. This chapter seeks to show how a national policy such as the National Health Insurance (NHI) was implemented local level into the rural setting of South Africa.

6.2. The Lack of Access to Efficient Healthcare Services in Rural Areas

The curative nature of the health system is highly burdened by the "high and inequitable spending, along with the country facing a quadruple disease burden (consisting of HIV & AIDS and tuberculosis (TB), chronic diseases, injuries, and maternal and child mortality), and the continued poor health outcomes in these areas" (Couper, du Toit, et al. 2013, p. 119). Rural areas remain the most disadvantaged when it comes to accessing quality healthcare which means that the aim of the rehabilitation of the burden of disease is not being taken into consideration when it comes to these settings. Accessing healthcare according to the WHO compromises of three components: financial, population and service coverage. In terms of South Africa the financial coverage speaks to the

protection against the financial and socio-economic burdens of accessing healthcare while the population coverage is impacted by the distances to health facilities and the service coverage includes not only the quality of care provided but also the services offered at the different levels (Gaede & Versteeg, 2011, p. 101).

Although there have been strides towards social security by the governments through the grant system there are still barriers to accessing healthcare in rural areas based on the financial constraints in getting to a point of access. The traveling aspect of gaining access to healthcare plays a large role in rural areas; usually people need to travel long distances due to the few facilities available within rural areas. There are not only distance, time and cost constraints to accessing what would be the considered nearest healthcare facility but also lack emergency transport and roads to facilitate access (Gaede & Versteeg, 2011). Another aspect to this is the healthcare facilities themselves, many clinics have been built since 1994 but there still remains "large differences …. in the numbers of facilities per population, utilisation rates and staffing levels across provinces, reflecting under-provisioning in rural areas" (Gaede & Versteeg, 2011, p. 102). Consequently the new facilities are being placed in areas where they are not able to be adequately utilised given lack of human resources and infrastructural challenges such as electricity and water. This has impacted both the quality of service delivery through failure of basic function such as emergency call out as well as human and infrastructural capacity. These facilities such as clinics and hospital in rural areas form part larger referral system entrenched in historical factors such as location and availability of services. The quality of services speaks to the quality of care received in rural areas, the main concerns have been raised around "shortages of staff, bad staff attitudes, large distances to health facilities and services, insufficient medication, lack of monitoring and evaluation, patient transport and shortage of ambulance services as major areas of concern" (Gaede & Versteeg, 2011, p. 102).

A report from the select committee on social services on an oversight visit to the OR Tambo District found that the district was one of the worst performing in the country. The reason for the visit was

to assess the progress of the NHI implementation in the district, here healthcare facilities were visited and progress was assessed through focussing on the following elements of the NHI: infrastructure and development, human resource planning, development and management, quality of health services, the re-engineering of primary health care system, the contracting of general practitioners and other health professionals and lastly the strengthening of hospital performance (Parliamentary Monitoring Group, 2014). The report revealed that some of the hospitals in the district had dilapidated building that are in need of reconstruction, staff had a negative attitude, there were budgetary constraints, shortage of pharmacists, inadequate equipment, there is a need for transport facilities, hospitals are not easily accessible and in some instances there are no visible health facilities" (Parliamentary Monitoring Group, 2014). The report in its concluding remarks highlighted that in order to strengthen the health system in the district the following would be crucial: "upgrading and/or rebuilding of health care facilities; addressing the challenges caused by the rationalization process, including creation and finalisation of organisational structures for institutions/health care facilities; filling of critical clinical and non-clinical posts; installing and/or improving supply chain management systems to better enable provision of quality health care and services; improving emergency medical services; provision of support and capacity building to personnel as per required; and comprehensive monitoring and reporting progress" (Parliamentary Monitoring Group, 2014).

The OR Tambo district is a rural area with the only NHI pilot project in the Eastern Cape, shows the infrastructural issues experienced on the ground. Even with the early implementation of the NHI, there are still infrastructural issues and lack of improvement in terms of the provision of healthcare services. Majority of the population in the district relies heavily on public healthcare and encounter barriers to accessing health daily. Given that in South Africa "a vast burden of disease is carried by our rural citizens, a legacy of the 'homeland' system of division and deprivation perpetrated by the previous government, and compounded by the poverty and unemployment endemic in these areas" (Reid, 2006, p. 676).

6.3. The Level of Healthcare Service Delivery in Rural versus Urban Areas

The first phase of implementation of the NHI has shown the persistence of disparities between urban and rural areas. Typically the package of services in terms of primary healthcare in district hospitals is limited in rural settings, given that the public sector is the only health service in the area the options offered are limited to the patients (Gaede & Versteeg, 2011, p. 102). The urban-rural disparities in healthcare delivery presents a barrier to development. South Africa has committed itself to ensuring equitable access not only in its Constitution but also with the introducion of the National Health Insurance (NHI). Healthcare reform in South Africa has long revolved around decentralisation with focus on the creation of district health systems. The idea behind making local government responsible for the provision of basic services (primary healthcare services) is because local government operates closest to the ground and interacts closest with users of public health (Booysen, 2003, p. 660). Even with these structures in place there are still disparities between urban and rural municipalities in their provision of healthcare services.

Rural areas in comparison to urban areas are typically seen as disadvantaged when it comes to access, availability and provision of healthcare services. Unlike urban areas when looking at healthcare in rural areas the following factors need to be taken into consideration “the higher burden of poverty; the social determinants of health have a more direct influence on health; the cost of accessing health services is higher; management capacity is relatively weak; and there is a relative paucity of private practitioners and specialists” (Rural Health Advocacy Project, 2016, p. 3). There is a blanket nature of the NHI that does not take these disparities into account when it comes to the redressing of the past. In South Africa the understanding of health disparities across provinces has been on the basis that historically, provinces that have the least developed health systems have received the least amount of funding from government. This not say that disparities are only inter-provincial, it is often times experienced more intra-provincially as seen within the Eastern Cape, Buffalo City and the Nelson Mandela Bay that are the more developed districts in the province have primary healthcare

expenditure that is significantly higher than the OR Tambo district which is extremely underdeveloped and one of the most rural districts in the country (Rural Health Advocacy Project, 2016, p. 12). This has been referred to as the 'infrastructure inequality trap' which describes the process of provinces and areas with relatively developed health system (infrastructure and human resources) receive larger funding from the available government resources (Rural Health Advocacy Project, 2016).

According to the rural health advocacy project "the relationship between poverty, poor health, and healthcare outcomes has been well established; not only do poor people experience higher burdens of disease because of various social determinants, they also have less access to care" (Rural Health Advocacy Project, 2016, p. 8). The aim of the NHI is in not only to provide financial risk protection but also to improve access to healthcare, this needs to be applied to rural and urban respectively as there are many inequalities. One of the biggest inequalities being lack of human resources, there is a concentration of healthcare professionals in urban areas which in turn becomes a barrier to accessing health in rural areas and speaks to an unequal distribution of human resources in the public sector (Rural Health Advocacy Project, 2016). This along infrastructural issues set rural areas back in terms of the implementation of the NHI which "as we have seen with some NHI pilot sites, private health professionals are not readily available in rural villages and remote communities and targeted strategies are required to address the human resource needs of such areas" (Rural Health Advocacy Project, 2016). The infrastructure such as collapsing buildings and lack of human resources hinder the improvement of healthcare in rural areas through the proposed NHI as it does not deal with the infrastructural inequalities of the urban-rural spaces.

There has been no special focus placed on rural health in terms of health policy which is problematic given the disparities in access and health outcome between the rural and urban areas in the country. The issue with rural areas is that they require policy adjustments due to their unique characteristics and need policy to reflect their needs in order to gain equal access to public health services. The

blanket nature of policy meaning the lack differentiating between rural and urban areas allows room to leave out interests and needs of certain groups. What this has shown us is a lack of lobbying for the needs of rural areas when it comes to policy and as such changes would require special policy decision making as well as in depth deliberation when it comes to budget allocating. “The Rural Health Advocacy Project said in its submission that without due consideration of factors such as geography (distance and topography), demographic characteristics, epidemiological profiles, high levels of socio-economic deprivation and inequities in the resourcing of care, the NHI will simply duplicate historical and structural neglect that continues to define much of rural health” (MedicalBrief, 2016).

What this means is that healthcare happens to people in rural areas as subjects, as opposed to them affecting the change for their needs. The different contexts of rural and urban areas shows the proximity to developmental assistance from government, for rural areas the proximity to central government is large terms of disparities in that they do not experience any difference in health service delivery from the NHI pilot districts, whereas urban areas will demonstrate positive results given their close proximity to governmental assistance. It’s important to note municipalities in rural areas are not the only level of government responsible for the development, rural municipalities are reliant on government policy for the development of rural areas.

6.4. Does Universal Health Coverage through the National Health Insurance (NHI) Reduce Inequalities ?

Health equity speaks to the fair distribution of health resources and outcomes, which includes equity between citizens as well as regions (inter-regional) (Coovadia & Friedman, 2015, p. 2). In this sense health inequality can be defined as “differences in health status or in the distribution of health determinants between different population groups” (Coovadia & Friedman, 2015, p. 2). In attempt to assess whether the NHI reduces health inequalities, the report focuses on the policy’s aims of equity of access and financial risk protection. The development of a pooling of funds system is meant to not

only improve access to the appropriate quality of care without the financial burden, but also offer the most vulnerable the same standard of care as the privileged. The early stages of the NHI has seen some improvements such as "the introduction of community health workers, improvements to monitoring the health of children and decongesting clinics by new modes of chronic illness medication distribution" (Eyles & Fusheini, 2016, p. 8). While UHC covers financial risk protection, the health inequalities exceed this aspect as inequalities in healthcare provision are deeply rooted in the unavailability (?) and location of facilities, ability to provide services, the equitable distribution of human resources across as well as within districts, the overall health outcomes of populations within areas, as well as the state of the health system (Eyles & Fusheini, 2016, p. 9). Although financial risk protection is a central and transformative component of reducing health inequality, the abovementioned aspects require the NHI within their UHC approach to go beyond the financing.

The NHI's ability to reduce health inequalities cannot be determined as yet due to the mixed results from the phase one pilot project intervention across the pilot districts. The first phase was assessed in accordance to the health strengthening (HSS) mechanisms in the primary healthcare facilities. These results showed that where successful the pilot projects had the following main structures in place "strong political will, adequate human and financial resources for implementation, good coordination and communication, and good monitoring systems put in place at the time of implementation" (Businesstech, 2019). Whereas for the districts that overwhelming unperformed, they had the following elements that hindered success "inadequate planning, lack of resources, inconsistent communication, a lack of coordination where necessary and insufficient mechanisms to monitor progress to ensure course correction" (Businesstech, 2019). According to Eyles & Fusheini "human resource distribution across the districts is perhaps the outstanding constraint… Even with the availability of facilities, UHC might not ensure equity in healthcare access without the required health professionals to deliver services" (Eyles & Fusheini, 2016, p. 8).

The report finds that the uneven progress of the pilot projects demonstrates these inequalities are a result from the different context of urban and rural areas. The disparities across the districts in context of "disease burden, human resources, financing and investment, administration and management capacity, service readiness and availability" (Eyles & Fusheini, 2016, p. 9) is a direct reflects of an area's health outcome. The improvement of the health inequalities between rural and urban areas should rest in the addressing of the social determinants and healthcare infrastructure. The NHI focus on financial risk protection overlooks the other reasons for the poor performance of the public health sector, by disregarding these elements the assessment of how problems surrounding health inequality can be overcome is ultimately affected.

6.5. Observation and Recommendations

"Poor infrastructure, a shortage of critical health care personnel and the unreliable supply of basic medicines continue to prevent nearly 40% of South Africa's population who live in rural areas from having full access to good quality health care" (Rural Health Adocacy Project, 2014). The government is aweare of the issues on the ground as seen with the various reform policies that are aimed at improving access to quality healthcare, but the policies are not developed in such a manner that speaks to the different infrastructural settings of the different areas in the country. The NHI objective is equitable and quality access for all, which is being carried out through the pilot project inititaives that are aimed at primary healthcare strengthenthing. The issue here is that the NHI will "only benefit rural communities if factors such as geographic inaccessibility, under resourcing and systemic neglect that continue to characterise the rural health context are not explicitly targeted in health policy, planning, resourcing and service delivery" (Rural Health Advocay Project, 2014). This is to say that South Africa needs to establish a clear definition of rural in order for policy to target these settings in such a manner that allows for development and succesful implementation. Generally the department of health does not use a typology or definition rather they treat rural areas as deprived

and underserved which in turn does not deal directly with the rural service derlivery environoment (Rural Health Advocacy Project, 2014).

The NHI policy stresses that ‘access’ to healthcare is hindered by financial risk, however, when matched to the barriers of access to health in rural areas there is a mismatch in policy. Thus for the report it is imperative to define ‘access’ on a contextual basis in that rural areas need to take the following aspects in to account: “geographic accessibility: high average distances to facilities and a lack of/ expensive transport to and from facilities. Availability of healthcare: inequitable distribution of healthcare workers between rural and urban areas and a shortage of health care facilities and supporting infrastructure such as roads, piped water and electricity. Acceptability: services are often not of an acceptable quality or acceptable based on social and cultural norms of the people accessing them” (Rural Health Advocacy Project, 2014). The NHI is a large state endeavour that requires all district to perform at national standards of healthcare provision for it to be successful, thus the lack of performance in rural areas put the success of the NHI at national level in jeopardy. The report proposes that typology for rural health policy reform be put in place in order to guide the development of policy and set aims and objectives specific to rural areas. The OR Tambo district being the only pilot project in the Eastern Cape has resulted in the province once again lagging behind in healthcare delivery, which ultimately means that the eastern cape department of health and the national department of health have failed in regards to the provision of access to quality healthcare under the banner of the NHI. Although under the NHI district level will be responsible for the purchasing and management of primary healthcare service provision, there seems to be no difference in the level of health provided even with the changing structures and principles of good governance. The disconnect would be the national policy at local level particularly in a rural setting as the OR Tambo pilot project suggests that the local level management built on the idea of local accountability and community participation are in need of effective oversight as the people’s needs are still not being met even with the presence of the NHI.

6.6. Chapter Conclusion

There have been significant changes and development in the South African healthcare system since 1994, however there has been uneven progress in development which has led to the lack of access to affordable, good quality and comprehensive health care remaining a serious challenge for many particularly those in rural areas. The developments since 1994 have made significant improvements in the accessing of primary healthcare services for all, however rural areas continue to encounter barriers to access. Given the evidence of past inequalities and the continuous transitioning of the health system along with the policy attempts for reform, it is clear that the rural areas are not protected and their needs are not necessarily dealt with. When it comes to the NHI, while people will be financially protected the facilities available to people in rural areas are still in need of an infrastructural overhaul. For the report, when looking at the difficulties that rural areas are most likely to experience when implementing the NHI, policy adjustments becomes a big aspect. As such the report found that policy adjustments for rural areas need to be taken into consideration for the NHI as financial barriers are not the only form of exclusion in rural areas. Despite the expansions made to healthcare, access to quality services remain uneven. When looking at what could potentially determine the difficulties with implementation of the NHI, the disparities become the biggest component. These disparities are according to Brauns and Stanton a "result from apartheid spatial and governance systems, compounded by institutional weakness in some provinces and municipalities. In short, the state's capacity is weakest where socioeconomic pressures are the greatest" (Brauns & Stanton, 2015, p. 173). Thus we find that focus on affordability does not in fact improve access to healthcare in rural areas rather it prevents further development and leaves those areas with lack of access.

Chapter Seven: Conclusion

During Apartheid the delivery of healthcare was inequitable and racially fragmented as "separate health departments were established in each of the homelands and became responsible for administering health care provision" (Surender, 2014, p. 2). The healthcare system under apartheid not only allowed for underfunding 'black areas' that left the former homelands severely underdeveloped but also restructured the system in such a manner that allowed for coloureds, whites and blacks to have their own administration of affairs. This meant that "the administrative fragmentation of health delivery into several racialized departments reinforced inequities of funding allocations and service delivery. Access to public health care was now subject to the vagaries of new poorly organized, geographically isolated and under-resourced, racially-constituted health administrations" (Surender, 2014, p. 2). Government's objectives in terms of health reform have been to reintegrate the health system and make it accessible to all especially those previously denied access. This however has only worked to certain degree as there are still health disparities that persist today that are rooted in the apartheid system. The proposed NHI is government's latest response to the continued inequality in the healthcare system.

The National Health Insurance (NHI) is not a new concept to South Africa, it has been on governments agenda since the attainment of democracy. The process and progress of the NHI has happened over a number of years with the release of the government Green Paper in 2011 that was open to public opinion, followed by the rollout of the NHI pilot projects which took place between 2012 till 2017. During this period of the pilot projects government went onto release a White Paper on the NHI in 2015 and a Further White Paper in 2017. Finally in 2018 a draft of the National Health Insurance Bill was released and in 2019 there was an introduction of the bill to parliament. The NHI falls part of governments push for the establishment of a single healthcare system that ensures equitably accessible to all citizens. The past twenty-six years of democracy has seen South Africa try

deal with the legacy of apartheid in the health system through the development of various policies aimed at the equitable access to healthcare especially for the previously disadvantaged.

The NHI aims to achieve equity, access, rights and participation which are also core elements of health justice. The policy presents an opportunity for government to improve and achieve health justice across the country, but the policy design appears to fall short in two crucial areas; how the NHI policy fits into the existing healthcare systems in rural areas as well as how its governance structure fits in these context. For the research the NHI aims to achieve its objects through social and distributive justice, which are both rooted in the right to good quality healthcare services on the basis of human dignity and equality. Government intends to implement the policy through applying principles of good governance, however, in the context of rural areas particularly the O.R Tambo district pilot project, the NHI in its implementation thus far falls short. The governance structures have allowed for a centralised system with a powerful executive, lack of transparency and accountability, as well as a lack of space for public participation. The limitation the structure of the policy poses to the ability for citizens to participate in decision making and well as oversight procedures in the implementation of the NHI defeats the aims and objects of health justice. Social justice from this stand point speaks to the role of the state taking positive measures in its provision of healthcare as a primary good.

The policy in its final form, tends to neglect the contexts of rural areas. This is to say that, the policy's focus on financial accessibility to quality healthcare services neglects the urban-rural health disparities, which in turn does not speak to the additional infrastructural barriers to healthcare services such as transport, roads, income and health facility developments required to improve the quality of health outcomes in rural areas. If both rural and urban contexts are taken into account and the NHI is implemented successfully, the policy could immensely contribute to social and health justice by equitably distributing quality healthcare services to all areas of South Africa, while also decreasing out-of-pocket expenditure of health. From Rawl's just system perspective, it morally and politically

unjust to continue or contribute to a system of exclusionary healthcare. There is no blueprint for how to create just, fair and equal NHI system for South Africa, however, what is clear is that for health justice to be achieved there needs to be an equal distribution of social primary goods, in this case healthcare services. In other words it is the state's duty to guarantee a level of healthcare from all its citizens and also ensure that the conditions people live in do not harm their right to healthcare, but rather promotes and fulfils this right.

Chapter five looked at the governance and implementation of the NHI and how these structures translate in the implementation of the NHI. The report found that there is a gap between the people centred approach of the NHI and the ways in which the NHI is being implemented. The aim of the NHI is to achieve equitable and quality access to healthcare for all and thus its structures need to help fix the health inequalities experienced on the ground. One of the aims of the report was to establish how the NHI at national level can be implemented at local level in rural settings. In doing so it established that the top-down approach, sort of ripple effect approach of the NHI has not demonstrated an effective response to the inequality of access to healthcare. The notion of good governance carriers a set of principles and of these public participation, accountability and transparency are seen as the most important. Thus far the top-down approach has neglected the participation of rural economies and areas, in that it takes the approach where rural communities have little to no say and only benefit to a certain extent as seen with the pilot project. While implementation started in 2013 the public hearings only took place in 2019, the community expressed the everyday barriers to accessing healthcare in a rural area as well as the lack of awareness of the presence of an NHI pilot project in the district. There has been no improvement in service delivery and the process of implementing the pilot project in the OR Tambo, highlighted a lack of good governance structures in the NHI as none of the principles embedded in the policy were upheld.

Chapter six of this report sought to demonstrate how the NHI policy does not take into account the urban/rural divide which hinders the successful implementation of the policy. In answering the

research question, the report established that the NHI above everything offers financial risk protection in the form of insurance to the people but does not directly deal with barriers other than financial constraints to accessing healthcare especially in rural areas. The blanket nature of the policy does not take into account the different rural-urban contexts which shows that the collapsing state of healthcare in rural areas not only hinders NHI implementation in these areas, but also that the NHI does not have the intended impact as they still remain underdeveloped and have a number of social determinants that impact health and access to healthcare. The lack of bulk infrastructure in the OR Tambo district made up the majority of difficulties most likely experienced by rural areas when implementing the NHI. The setting is extremely underdeveloped and does not accommodate an advanced policy such as the NHI, with management capacity issues it is clear that the issues are not only at ground level but also in the structures of government.

Recommendations and a further analysis are offered throughout the research report. These sections aimed to highlight where the report finds short comings of the NHI and its ability to bridge the health inequality gap as well as its governance structure that might hinder the successful implementation of the NHI. The report views the OR Tambo pilot project as a learning curve for the NHI in terms of offering government a rural perspective of how such a policy should improve rural health systems in order to ensure equitable access across the country. Whist there is significant literature on the NHI and its adoption in South Africa there is a grey area where the urban-rural health inequality gap is concerned. This speaks to elements of the NHI policy as well as it governance in terms of communication and coordination between levels of governance that allow for shortcoming in the oversight.

The investigation in to how the NHI fits into the rural settings of South Africa and its difficulties with policy implementation in these settings, meant that the report is not to say whether the NHI will succeed or fail, but perhaps to suggest how it can better speak to the needs of the people it needs to service. The use of the OR Tambo pilot project was used to show the extent to which rural

communities often time remain underdeveloped even with the implementation of policies as policies tend to overlook the elements that affect the performance of the public health sector in rural areas the most. Although a number of mechanisms have been implemented in the OR Tambo district it still remains largely rural and was the worst performing district in the country. The structure of the NHI is limiting in the sense of good governance. The structure of the NHI as it stands is too centralised, the government is not capacitated enough and therefore has to rely of outsourcing and procuring of healthcare services rather than having centralised monopoly on NHI Funds and resources. There is more risk of lack of accountability and transparency along with bad implementation and governance when the structure is centralised. For instance, Brauns and Stanton argue that "the state can no longer assume a monopoly of expertise or of the resources to govern, but must rely on a plurality of interdependent institutions and actors drawn from within and beyond government" (Brauns & Stanton, 2015, p. 18). Overall the report aimed to highlight that proximity to healthcare institutions and their adequate functionality are the most vital components of the NHI. This to say that the current plan does not take this into account, it rather has introduced a new policy which has the potential to continue the very cycles of health disparities it aims to rectify. If government does not take the various contexts of rurality versus urban into consideration it runs the risk of failure.

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