Wits student perceptions and attitudes of the South African National Health Insurance (NHI) policy reform

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by

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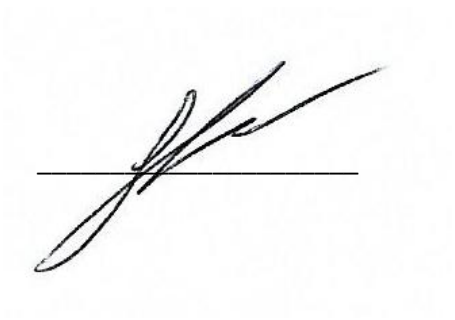
Declaration

I, Dr Alessandra Kim Heggenstaller, hereby declare this research report is submitted in partial requirements for the degree of Master's in Management: Governance Public and Development Sector Monitoring & Evaluation at the Wits School of Governance, University of the Witwatersrand, Johannesburg, South Africa. Apart from where recognised, this research is my own work, and has not been formerly submitted for any degree to another university.



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Abstract

South African healthcare is practiced within a two-tier system. This sees the public sector as run by government and the private sector which is supported in relation to an individual's ability to contribute to a medical scheme—which is the main form of health insurance. Due to the absence of adequate coverage for many people in the developing world the World Health Organisation (WHO) has advocated the elimination of these gaps with the ultimate objective being Universal Health Coverage (UHC). This global initiative has been used to frame the rationale for a reconsideration of the South African health system. Their proposed systemic overhaul is broadly referred to as an attempt to achieve a single-payer National Health Insurance (NHI) policy reform (the White Paper, 2017). The primary goal of this policy is to ensure healthcare equity within an ethos of equality is provided to all South Africans.

Functioning dynamics associated current South African political structures and agendas have put into question the reasonableness and rationale of NHI. This is particularly the case when reviewing the successes and shortcomings associated the nationalisation of private entities. State-owned Enterprises (SoE) have brought to light numerous limitations in how government maintains national infrastructure and delivers public services. Highlighted features of concern are bureaucratic maladministration, fraudulent and corrupt practices. It is from this point of view that questions are raised regarding the viability of the proposals. The policy proposals involve what appear to be extraordinarily complex interventions which raise questions about their appropriateness in context. Policy deliberations and technical appraisals are largely absent with very few people understanding both the proposals and the policy alternatives.

It is within this context that this research seeks to examine how well members of the public understand the proposals—focusing on a relatively well-informed sub-group of university students.

The research, therefore, seeks to examine if a relationship exists between tertiary students' perceptions and attitudes in relation to their sense of knowledgeability in supporting, or even dismissing, the proposed NHI policy reform.

Focus is given to students enrolled for the 2021 academic year at the University of Witwatersrand (Wits), Johannesburg, South Africa. The project was ethically approved by the Wits Human Research Ethics Committee (Non-Medical). To establish if a correlation exists between the student's subjective/intersubjective opinions and his/her/their knowledge base, a mixed methods research design was used. A total of 211 online research survey responses were recorded and a total of 4 semi-structured face-to-face interviews were conducted.

The results indicate that knowledge transfer influenced how the students perceived and accepted the NHI proposals as well as the healthcare policy reform. Moreover, the terminology used to describe the technical processes related to the NHI Bill impact on how openly the students embraced the health systems change. In broad summary, the students expressed a lack of confidence in governments' ability to improve the current healthcare sector.

Keywords

Universal Health Coverage (UHC)

South Africa

National Health Insurance (NHI)

Two-tier healthcare system

Policy reform

Non-incremental change

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List of acronyms

ANC	African National Congress
B-BBEE	Broad-Based Black Economic Empowerment
BRICS	Brazil, Russia, India, China, and South Africa
DA	Democratic Alliance
DoH	Department of Health
GDP	Gross Domestic Product
GEAR	Growth, Employment and Redistribution
GNI	Gross National Income
HMI	Health Market Inquiry
IRR	Institute of Race Relations
KZN	KwaZulu Natal
NHI	National Health Insurance
NHIB	National Health Insurance Bill
NHIP	National Health Insurance Policy
RDP	Reconstruction & Development Programme
SoE	State-owned Enterprise
UHC	Universal Health Coverage
UN	United Nations
WBG	World Bank Group
WHO	World Health Organisation
Wits	University of the Witwatersrand
WSG	Wits School of Governance

Chapter 1: The proposal

Introduction

The National Health Insurance (NHI) policy proposals have proven to be controversial and have aroused much discussion and debate within the South African healthcare context. The concept of Universal Health Coverage (UHC), which is related to but distinct from the South African NHI proposals (Fusheini & Eyles, 2016, p. 2), has also become a global topic. Coovadia and Friedman (2015, p. 1-2) are of the opinion that: "…the health of a population is fundamentally dependent on fair access to social goods and processes within the society, health equity and social justice are interlinked". However, it is also understood that health systems are not solely responsible for improving health outcomes generally (Kruk et al., 2018, p. e1196; World Health Organization, 2021). Social determinants like education, physical environment, and support networks as well as economic factors are known to play a role in the collective health status of a population (Artiga & Hinton, 2018, p. 1-2).

Agencies like the World Health Organisation (WHO) and the World Bank Group (WBG) have also made concerted efforts to renegotiate health-based standards, and therewith rectify associated inequalities, in a bid to provide quality care to all people. In short, implement a standardised healthcare framework that overlooks features related to gender, demographic location, socio-economic status, or racial/ethnic classification. This equality-driven approach has resulted in developed countries like Canada and the United Kingdom independently adopting strong, but quite differently organised, universal coverage systems; these models are supported by both government and citizen alike (Wellings, 2017; Martin et al., 2018, p. 1718).

Successes related to UHC in the developed world have motivated developing countries like South Africa to re-evaluate their healthcare agenda(s). Currently, the South African healthcare system is characterised by large public and private sectors forming what some argue is a two-tier framework. Weaknesses with the public part of the health system are argued to be "…indicative of institutionalised mismanagement resulting from system-wide governance failures" (van den Heever, 2019a, p. 1).

Politically these healthcare failures are blamed on "…migrants; insufficient funds; insufficient staff; medical schemes; lawyers suing them [provincial health departments] for medical negligence; the existence of two tiers and even the middle class" (van den Heever, 2019a, p. 1). However, little culpability is placed on political performance, financial mismanagement, and weak leadership capabilities when addressing the declining public healthcare sector and the overall "poor-quality service delivery" (Siddle, 2011, p. 6; Jeffery, 2018, p. 4; Maphumulo & Bhengu, 2019, p. 7).

The private healthcare system is also not void of problems; shortcomings are just framed differently. This is particularly evident when engaging with the Health Market Inquiry (HMI) which summarises various market related failures and oversights in accountability (Health Market Inquiry, 2019, p. 30).

Irrespective of who is held accountable for regulating the South African healthcare system it is commonly accepted that public state-run institutions are lacking and inferior in relation to the private healthcare sector (National Department of Health, 2012, p. 4; Maphumulo & Bhengu, 2019, p. 1). And, thus, it is widely agreed upon that most government-run healthcare facilities need an overhaul—from infrastructure to administrative practices (Rispel, 2018, p. 1; Health Market Inquiry, 2019).

NHI is effectively regarded as *the* solution to the systemic failures of both the public and private systems and aims to institutionalise the pooling of various revenue sources into a single fund. This is achieved by dissolving private (and costly) medical aid schemes and increasing taxation by a minimum of 3% of the country's Gross Domestic Product (GDP).

The underlying goal is to promote healthcare equality, in practice and treatment, by redistributing funds. The affluent middle-to-upper class person(s) will contribute to the fund; enabling the underprivileged and socio-economically burdened equal access to quality healthcare. In addition, the private healthcare sector as well as practitioner will be absorbed into the public sphere to allow for governments proposed goal of providing equal access to all healthcare needs (Kahn, 2019).

This introductory overview is undoubtedly needed in a democratic society. However, critical examination of the proposals raises a range of technical questions. These arise from the NHI proposal, which is the vehicle for transforming the current healthcare system while engaging the vagueness with which complex issues are being addressed. Especially, given the envisaged three-phase implementation process[1] seen together with the commencement date of 2026.

Public concern(s) with the missing detail(s) and information typically results in government officials reassuring the public that key understandings, information, and approaches will be addressed timeously (Molokomme et al., 2018; Health-e News, 2019; Free Market Foundation, 2019; Donnelly, 2019).

[1] Phase 1 (2012-2017) – "…piloting health system strengthening initiatives; the establishing of the NHI Fund and key institutions; and the central hospitals to the national sphere" (The Citizen, 2019).
Phase 2 (2017-2022) – "…ensuring the NHI Fund is fully functional and has the required management and governance structures so that the purchase of services and population registration can begin" (The Citizen, 2019).
Phase 3 (2022-2026) – "…the introduction of mandatory prepayment and the contracting of accredited private hospital and specialist services as well as the finalisation of the Medical Schemes Amendment Act" (The Citizen, 2019).

Government representatives publicly emphasise (via broadcasting networks, conferences, televised discussions) the all-encompassing successes associated with the NHI scheme (Gerber, 2019). These reassuring statements contribute to the public's awareness of and willingness to adopt the specific NHI proposals as the response to their healthcare needs; however, there is a growing sentiment that the public should be more critical and engaged in the rationale behind NHI (Banderker, 2019).

Public engagement appears important in addressing the underlying value judgements shaping government's *rationale* for the policy reform, together with the *reasonableness* of features of the proposed reform. In other words, how the policy framework is systematically positioned (rationale) and if this "course of action or inaction" (Leggon & McNeely cited in Didion et al., 2012, p. 109) is justified as "not extreme or excessive" (Garrett, 2017, p. 69) and, thus, sound in judgement (reasonable).

The study aims to explore tertiary students' perceptions and attitudes towards the current healthcare agenda(s) and the NHIB. Emphasis is given to the transparency of complex information by the government as to how *knowledge*, or lack thereof, influences public perceptions and support. In other words, how do students *understand* the NHI as a healthcare reform and what impact does the external stakeholder's *choice(s)* have on the overall support of the policy. It should be noted that within the context of this study, the term *external stakeholder* refers to individuals not directly involved with the NHI policy reform but affected by the successes or shortcomings of the scheme. This positions the public as the majority external stakeholder in relation to the proposed healthcare reform.

Background

Since the inception of apartheid (1948-1993), health-related considerations were positioned in a practice of inequality and exclusion. Segregation was established and reinforced in the Bantustan territories whereby healthcare systems were predominantly supported by "…non-profit, missionary-run hospitals" (Coovadia et al., 2009, p. 826). "Racial[2]" classifications influenced an individual's healthcare access—with designated whites privileged in relation to other group classifications. This division was reinforced by the Public Health Amendment Act of 1897 which supported the notion of "…fragmentation, both within the public health sector and between the public and private sectors" (Coovadia et al., 2009, p. 825). However, in 1994 democracy was introduced.

[2] According to Renn (cited in Wijeyesinghe & Jackson III, 2012, p. 11) "race is a social construction based on physical appearance (skin color, hair color and texture, facial features), ancestry, nationality, and culture. It is used for identification". It should be note that this study does not accept discriminatory classifications based on the socially constructed premise of 'race'. The study also does not endorse or intend to promote the notion of 'Otherness' and, therefore, the forthcoming discussions will engage the notion of race as a person/people identifying as part of a group membership within the context of a *population group*.

All people, irrespective of their group identity, are seen as equal and deserving of autonomy and respect. Even with everyday apartheid practices being abolished, the South African healthcare system operates with a two-tier framework with the public and private sectors serving discrete populations distinguished by income adequacy. This practice of separateness is not maintained in relation to an individual's racial affiliation, but rather in respect to his/her/their socio-economic status.

As a developing country, South African healthcare services are either privately purchased (via medical aid schemes) or subsidised by the state through the provision of free services for people falling below a means test. However, the discrepancy shaping public service deliverability is influenced by governmental mismanagement, corruption, and financial misconduct to wasteful expenditure and the underreporting of comprehensive data and health-related outcomes (Treatment Action Campaign, 2018, p. 1; Health Market Inquiry, 2019, p.204; GENESIS, 2019, p. 15-16). This reveals that a health systems intervention is needed.

Even as South Africa aims to renegotiate its healthcare system, a driving narrative behind the proposed policy reform is that it seeks to address the ills of the past; "…NHI will help undo the legacy of disparity" (Williams, 2019, p. 1).

Reference is given to sensitivities instilled by apartheid-based segregation and fragmentation. However, Benatar et al. (2017) argue that various developing and developed countries who have not experienced an apartheid system also rely on and function within a multi-tier healthcare system; for example: United States of America, Germany, Ireland, Argentina, Morocco, and Mexico.

This unfolding discussion reveals that aspects of the healthcare system are prioritised and shaped in relation to a government's political agenda. Mayosi and Benatar (2014, p. 1350) are in agreement and state: "…trends in disparities in health…in part reflect the outcome of policies adopted by successive governments".

To briefly contextualise the unfolding political policies in South Africa's democratic era; Nelson Mandela looked to renegotiating racial inequality, via the "social determinants of health—poverty, inequality, inadequate housing and poor education", and the redistribution of financial wealth accumulated by apartheid elites (Mooney & McIntyre, 2008, p. 637).

These reformation objectives were pursued via the Reconstruction and Development Programme (RDP) and Growth, Employment and Redistribution (GEAR) initiative. In short, these policy agendas aimed to empower and grow the Black African middle-income bracket (van Vuuren, 2013, p. 38; Mayosi & Benatar, 2014, p. 1350).

Thabo Mbeki's administration focused more on neo-liberalism[3] and capital dualism (Mooney & McIntyre, 2008, p. 637). Traditional African leaders and part of the ANC felt Mbeki's approach was "…morally unjust, dysfunctional, and also unsustainable" (Mooney & McIntyre, 2008, p. 637; Gumede, 2007); prompting ex-President Jacob Zuma's pursuit to realign the party in favour of a more "traditional style of governance" (Gumede, 2017).

> [It] has [been] described, Zuma's presidential style as that of a traditional African "chief", in that he has used the office of the presidency to distribute state patronage to allies, friends and family. On this view, the president, as head of state, is everybody's chief, including the country's several kings (Gumede, 2017, p. 1).

Here focus was given to economic growth in the form of nationalising key infrastructure(s)[4] over job creation while unemployment rates grew (Padayachee, 2018, p. 17-18; Mayosi & Benatar 2014, p. 1350-1351).

This political overview prompts a more focused discussion into patronage politics. According to Oliveros (2021, p. 5) patronage politics is where a "good is exchanged in a public sector job". Focus is not so much on the exchange itself but rather that the patron delivers upon the agreed support or benefit (Oliveros, 2021, p. 5).

From a South African perspective, patronage politics is thought to be positioned in a

> …hybrid form of political system in which significant elements of patron-client politics survive and thrive…[here] political leaders are said to derive support and legitimacy by distributing patronage through informal, deeply personalized patron-client networks built upon mutual expectations or reciprocity (Beresford, 2015, p. 227).

Beresford's (2015) understanding sheds additional light on the above democratic leadership discussion insofar as the changing dynamics attributed the ANC government's leadership style. Though Nelson Mandela envisioned South Africa within the rainbow nation ideal, preceding leaders adapted the party dynamics to include a more practical practice within the patron-client ideology. This party evolution reveals a stronger pull towards a modern African value system (addition emphasis is

[3] Neoliberalism – "a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade…State interventions in markets…must be kept to a bare minimum" (Harvey, 2007, p. 2).

[4] Nationalisation – "…is the direct opposite of privatisation, and can be defined as the "confiscation" with or without compensation, of privately owned enterprises by government…the belief that government is more competent than the private sector to make decisions about public needs…nationalisation argues that the efficient production of all goods and services in society can be accomplished only when the means of production (land, labour and machinery) are owned and controlled by the State" (Moeti, et al., 2007, p. 112).

given in Chapter 2: Public policy as a science and how the different theories influences public policy directives as well as how the concept of power shapes civic engagement from the South African context).

This change in party dynamics is said to encompass elements of "neo-patrimonialism and corruption" that has resulted in "gatekeeper politics" (Beresford, 2015, p. 228).

> Gatekeeping is a term commonly used within ANC circles and the term gatekeeper politics is employed here to refer to how political leaders in positions of authority within the ruling party or in public office control access to resources and opportunities in order to forward their own political and economic ends (Beresford, 2015, p. 228).

It should be noted that gatekeeper politics is not synonymous with corruption but in some case is a by-product of it (Beresford, 2015, p. 229). The benefits of gatekeeping, thus, emphasises "political and social structures through which authority and power are cultivated, disseminated, and contested" (Beresford, 2015, p. 229).

To date, the South African healthcare system is argued to be in *crisis* (Dhai & Mohamed 2018, p. 8; Dentlinger, 2019, p. 1; Maphumulo & Bhengu, 2019, p. 6). Because of the weaknesses in the health system and wider social concerns, the NHI proposals have gained prominence as a populist policy (Roodt, 2018).

By inequalities and shortcomings, one must accord an all-encompassing gaze towards health care services and facilities, particularly state-run institutions. Government facilities are known to emphasise themes of poor governance, maladministration, mismanagement, and corruption; a lack of consumables and medical treatments; as well as shortages in staff and qualified medical personnel (Nt'sekhe, 2018).

Some argue that South Africa's public healthcare system is on the verge of collapse. Take for example: Dr Imran Keeka KwaZulu Natal (KZN) shadow MEC for the Democratic Alliance (DA) states:

> There's a shortage of chronic medication and the minister [of Health] denies this, a shortage of vaccines and broken equipment. KZN has vacancies for staff amounting to over 8000…[and more distressing]…rats were seen feeding on a corpse at one of the hospitals (Reporter, 2018, p. 1).

A lack of transparency is also felt when engaging the government (Kahn, 2019). Many commentators and researchers (Michel et al., 2020, p. 4; Cameron, 2020b, p. 1) have raised concerns that there is no financial appraisal of the NHI; as "…National Treasury has yet to make any costings public [and] the

2011 Green Paper on the NHI projected general tax increases would need to equal roughly 3% of the country's gross domestic product" (Gonzalez, 2019, p. 1).

The former Minister of Health (Dr Aaron Motsoaledi) added weight to these concerns by stating that: "a total cost of the system is impossible to calculate and it is up to National Treasury to fund it" (Roodt, 2018, p. 1).

The only reliable reference made to the financial running of the NHI schemes is the centralisation of healthcare purchasing via "the NHI Fund" (the White Paper, 2017, p. 54). However, little information is given to the purchasing scheme when a more advanced medical treatment or intervention is needed (see Novelty shaping NHI for additional context).

When engaging the topic of UHC, government promotes its desired outcome via public assurances and promises but is often hesitant to discuss healthcare particulars (Maphumulo & Bhengu, 2019, p. 9). Moreover, since introducing the concept of NHI in May 2008; to date (2021), government is still to produce a *policy appraisal* and account for the rationality or reasonableness of NHI (IMSA, 2009, p. 6; Maphumulo & Bhengu, 2019, p. 9; Malakoane et al., 2020, p. 12).

This is confirmed in a report by GENESIS (2019), in relation to findings of the 11 NHI pilot districts; "…inadequate planning, lack of resources, inconsistent communication, a lack of coordination where necessary and insufficient mechanisms to monitor progress to ensure course correction" (GENESIS, 2019, p. 14).

Under these circumstances, many commentators and researchers are concerned that despite government's positioning, the NHI is potentially the first step to South Africa's downfall—in quality healthcare (in part through a mass exodus of qualified medical specialists—estimated at 60% (de Lange, 2020, p. 1)), economic implications (additional taxes, loss of private healthcare sector), and autonomy (infringement of medical choice and rights if not NHI approved). Thus, with the implementation date set for 2026, additional clarity is sorely needed.

Problem statement

Due to a lack of open and consistent government dialogue, notions related to current healthcare reform(s) and the NHI scheme are perceived unfavourably; "…it is unclear how the NHI will improve public healthcare, and…that government appears unable to say how much it will cost" (de Lange, 2020a, p. 1). Statements such as these are becoming commonplace, raising additional concerns. To fully comprehend the impact NHI will have on the country's economy, public's experience of healthcare and its medical personnel; various surveys, polls, and studies have been conducted. Findings, thus far, are not optimistic; with an average of over 60% of healthcare professionals claiming

to leave the country should the NHI scheme be implemented (de Lange, 2020a, p. 1). Minister of Health, Dr Zweli Mkhize, countered these findings by claiming "response bias" (de Lange, 2020b, p. 1). He believes these figures are used to instil a sense of fear and uncertainty amongst the South African population.

To critically engage contrasting views, a purposefully designed online research survey and interview schedule is used to assess and evaluate perceptions, attitudes, and behaviours of tertiary students, registered at the University of Witwatersrand, South Africa. The undergraduate 1st-to-3rd year humanities student are purposefully sought to obtain a broader and more complex perspective to their sense of knowledge with regards to the NHI policy and proposed healthcare reform. Particularly, how proactive young intellectuals and potential future leaders embrace/dismiss the concept of NHI as well as what role these students play in shaping the healthcare system in relation to older and more experienced WSG master's students.

In short, focus is given to two cohorts of Wits student's *knowledgeability.* The research looks to understand how the construction of knowledge in relation to the technical information associated the South African healthcare reform and the NHI proposals is perceived, understood, and accepted/dismissed.

Due to the complex nature of the NHI and the healthcare reform, this research aims to contribute to the identified knowledge gap; namely, to ascertain the extent to which the informed public can understand and express a view on the policy proposals. It should, thus, be explored if a generally informed member of the public, or a proxy thereof, is able to properly engage with the area of strategic health reform. In this research the proxy used are students in a tertiary institution.

Purpose statement

The purpose of the research is to review and evaluate the *knowledgeability* of students in relation to the NHI proposals. The study seeks to engage student perceptions, attitudes, and behaviours related to governmental agendas, current healthcare systems and practices, universal health coverage, and the NHI as a policy reform.

The research intends to contribute to our knowledge of the external stakeholder's role in competently supporting/disputing NHI as a reform. This will be achieved by monitoring and comparing two randomly selected research groups—$\overline{X}_1$ (Wits humanities undergraduates) and $\overline{X}_2$ (WSG master's students). Simply put, how do the middle-income citizens (undergraduate and master's students) perceive and understand the complexity associated with NHI proposals; particularly, in relation to government assurances/promises/predicted success(es) thereof.

Research question and sub-questions

What impact does knowledgeability of NHI, during 2021 academic year, have on University of Witwatersrand students' perceptions, attitudes, and behaviours in supporting the ANC government complex policy reform agenda?

1. What does the external stakeholder (Wits student) really know about NHI?
2. Does the Wits student think enough information is presented to make an informed decision to support/oppose the NHI policy reform?
3. How informed is a Wits tertiary student concerning the merits/demerits of the NHI policy?
4. How is support/opposition affected by a tertiary level understanding (of the proposal)?
5. Has the reform been sufficiently clarified for the Wits student population to understand their advantages and disadvantages thereof?
6. What features of the debate influence support/opposition for the proposal?

Conclusion

NHI has become a controversial topic in South Africa. Irrespective of the government's desired objective(s) in establishing UHC, a critical gaze must be placed on the viability of this project within the South African context. This will not only allow one to logically deduce certain successes but more importantly its shortcomings.

Public participation and understanding are plausibly important features in major health system reforms in a democratic society. If government positions itself as superior to its people, major reforms will not be embraced. Success is only found in transparency and achieved via transfer of technical knowledge, thus, empowering the public to make informed decisions in relation to their healthcare needs and to contribute important information so that policy processes can learn.

The discussion so far reveals that many commentators and researchers are seeking further clarity from government. Particularly, how government intends to improve public healthcare and what approaches are used to fund, manage, and maintain NHI. The preliminary literature reveals a gap in dialogue and technical knowledge transfer between government and the external stakeholder.

It is, therefore, imperative that additional research is done in relation to NHI and what the public understands about this, and any, complex policy reform. Is the government presenting enough information in a way that allows people to participate meaningfully in the policy process? This research explores this knowledge gap and intends to contribute to our understanding of public opinion (using Wits students as a proxy) insofar as the consequences associated a lack of inclusion of knowledge transfer and choice.

Chapter 2: Theory

Introduction

The contextualisation of any research undertaking is important. By outlining and discussing how an investigation is philosophically approached and what methodological steps are taken; shapes the credibility of the research as well as the generalisability of its findings. In short, "…philosophical assumptions inform our choice of theories that guide our research" (Creswell & Poth, 2018, p. 47). This process also influences what knowledge and/or information is used to contribute to a given discipline or field of study.

As this investigation is positioned in a mixed methods research design, I begin the chapter by discussing how the research is philosophically framed in relation to a critical realist worldview. Focus is given to the real and observable world insofar as the impact policies and reforms have on an individual's lifeworld and society. Various policy evaluation theories are also explored—elite theory, political systems theory, institutional theory, rational choice theory, incremental theory, and network theory. Key concepts, themes, understandings, as well as contexts associated with these original theories may be used and/or renegotiated to develop a more nuanced policy evaluation approach. The aim of this chapter is to put forth a framed synthesis to guide the data analysis.

Philosophical assumptions of mixed methods

Mixed methods, as a research design, engages both qualitative and quantitative principles. Meaning that a constructivist and a post-positivist understanding is used when investigating perceptions and attitudes related to the research inquiry. A qualitative research design looks to understand how an individual perceives, interprets, and experiences his/her/their everyday lifeworld (Flick et al., 2004). Emphasis is given to concepts of "subjectivity" and "meaningfulness" (Flick et al., 2004, p. 70).

Whereas a quantitative research design aims "…to answer research questions or test hypotheses" via measurements, thus, simplifying large data sets and present findings numerically (Allen, 2017, p. 1318). By exploring both the interpretive as well as the numerical values associated the data, this study aims to put forth additional insight to the phenomenon of UHC as well as what methods and means are used in meeting given political agendas.

To engage a mixed methods design, I begin with a clarification of how the study is conceptualised. It should be noted that the terms *worldview* and *paradigm* are used interchangeably in the forthcoming discussion(s). A worldview or paradigm is a philosophical perspective that frames how a study is perceived and approached. According to Ritzer (1981, p. 3), it "…is a fundamental image of the subject matter within a science…and serves to differentiate one scientific community (or sub-community)

from another. It subsumes, defines, and interrelates the exemplars, theories and methods and instruments that exist within it". Thus, a researcher purposefully selects a paradigm view to guide the investigative process.

A critical realist worldview is a paradigm situated between positivist and constructivist thinking. It is a philosophy concerned with ontology, or more simply put, the nature of being (Bhaskar, 2008). It assumes that our everyday world is real and functions independently from human awareness, knowledge, or the conception thereof. It frames our understanding of the world as consisting of multiple objective realities; these structured realities are approached and engaged independently but in relation to an individual's historical, social, and cultural contexts. This influences how we perceive and accept knowledge as it is shaped and expressed from a subjective point of view.

It is from this frame of reference that the study unfolds, to explore notions related to UHC and South Africa's political drive to renegotiate the current two-tier healthcare system via the NHI proposals.

Philosophical assumptions structure how a study unfolds. In other words, producing a theoretical foundation to approach the research. Key assumptions to acknowledge and discuss when developing a study are ontology, epistemology, axiology, rhetoric, and methodology (Creswell, 2003).

These elements serve to inform the reader of: the procedural steps taken (methodology); how the respondent perceives reality (ontology); what constitutes knowledge as well as how stock of knowledge influences lifeworld perceptions (epistemology); what values are attributed a given event and context (axiology); and how experiences are communicated and represented via written texts (rhetoric).

I continue this section by giving additional context to each philosophical element in relation to its influence on the study.

Ontology

Ontology is concerned with "the nature of reality" (Creswell & Poth, 2018, p. 54). A social constructivist acknowledges the interpretive nature of multiple realities (Creswell & Poth, 2018, p. 54) whereas the positivist context looks at reality as measurable and independent of social actors (Memon et al., 2017, p. 34). Mediating between these two extremes is the critical realist's worldview: positioning the natural world as *real* while existing and functioning independently of our subjective beliefs and social constructions. Roy Bhaskar (1975) expands:

> Critical realism distinguishes not only between the world and our experience of it, but between the real, the actual and the empirical…[and] seek to identify both necessity

> and possibility or potential in the world – what things must go together, and what could happen, given the nature of the objects (cited in Sayer, 2000, p. 11).

In short, critical realists see the world as "intransitive" (Bhaskar, 2008, p. 52). To simplify this understanding, critical realists approach ontology as "emergent" but within a "stratified" manner (Sayer, 2000, p. 12). Emphasis is given to our conscious ability to strategically interpret daily happenings in relation to the countless natural elements and social constructs that define our everyday environment, while still actively participating in and distinguishing between varying intersubjective ideological contexts and cultural norms associated with socialisation. Thus, the concept of *agency* and *social structure* are not approached separately but rather as an interplay between the other (Bhaskar, 2008, p. 187).

As the study explores perceptions and attitudes related to policy reforms within the South African healthcare sector, emphasis is given to notions of "agency" and "structures" (Bhaskar, 2008, p. 187). Particularly, with the mind being an emergent part to matter, and reasons as causally efficacious in producing actions. By engaging the world and our experience of it as part of "the real, the actual and the empirical" (Bhaskar, 2008, p. 177), additional insight is ascribed the phenomenon of universal healthcare—how social structures and political powers influence an individual's sense of agency; and in turn, how an individual's perceptions and lifeworld experiences impact governments policy making behaviours and agendas.

Axiology

Axiology looks to understand how values are ascribed. The main premise of this philosophical assumption is to unwrap what "value-stance" an investigator takes in relation to the research context (Creswell & Poth, 2018, p. 418). Discussions related to this philosophical element are usually approached from within a qualitative design, due to the value laden nature of the data.

This puts focus on the concept of bias; particularly, how a researcher's subjective interpretation and decisions can influence the way a study is presented and framed.

To overcome this limitation, I, as the researcher, rely on the process of reflexivity. I openly recognise and discuss my individuality insofar as how my motives, personal interests, and experiences shape and influence the research undertaking (Gough, 2003, p. 23). This approach does not only allow me to reflect on my personal biases, but also contributes an additional sense of trustworthiness to the study via transparency.

From a critical realist point of view, axiology is a "moral positioning" that is procedurally structured within an emancipatory approach (Walsh & Evans, 2014, p. e4). According to Bhaskar (2008) the

primary ontological dimensions within critical realism are positioned as *the actual* and *the empirical.* These dimensions influence how an individual's sense of agency is shaped (the actual) as well as governed via socially accepted behaviours and norms (the empirical).

Haigh et al. (2019, p. 4) elaborates the emancipatory worldview: "…when phenomena are under investigation it may be possible to identify how these features may be influenced…in order to ameliorate harmful effects or to enhance beneficial effects".

Thus, critical realists intend their investigative projects to contribute to the betterment of a given situation (Haigh et al., 2019, p. 4).

This research is not designed to monitor the effects of a government-based initiative or community intervention (as popularised in action research); rather it aims to explore subjective perceptions and understandings in relation to the casual functioning of the real world.

Particular attention is given to the inquiry of how NHI will impact (for the intended betterment) the South African healthcare system. Findings are framed within a predictive context and can be used as a broad guide informing officials and/or policymakers to student opinions as well as what is perceived to happen should government fail to deliver on current ideals, supportive assurances, and popularised promises.

Rhetoric

This philosophical assumption looks at how a concept is negotiated within the research process and put forth via written text.

From a qualitative perspective, rhetoric emphasises how a researcher positions him/her/their self in the study as well as how the researcher frames a participant's experience. According to Creswell and Poth (2018, p. 317) rhetoric focuses on the "essence" of an experience and how the subjective is contextually framed via the researcher's personal voice.

In this study, the researcher adopts a first-person presence within her writing style. This will allow for a more nuanced discussion to develop while engaging the data collection, analysis, and findings process of the investigation. First-person pronouns will be used within a reflexive context to aid the researcher in renegotiating the complex into simple but insightful conclusions.

In other words, highlighting key insights to given statistical frequencies (quantitative) as well as illuminating the depth and meaningfulness associated a given narrative perspective and/or lifeworld experience (qualitative).

The researcher does not use this investigative undertaking to express her personal views but rather gives voice to the Wits student cohort.

Methodology

Methodology is concerned with the procedural steps undertaken in conducting a study. This assumption looks to broadly discuss the life cycle of a research project; from the conceptualisation of the theoretical frameworks to how data is collected and analysed.

Tashakkori and Teddlie (2009, p. 27) elaborate:

> A research methodology is a broad approach to scientific inquiry specifying how research questions should be asked and answered…includes worldview considerations, general preferences for designs, sampling logic, data collection and analytical strategies, guidelines for making inferences, and the criteria for assessing and improving quality.

From a qualitative perspective, emphasis is placed on the concept of emergence within the research process (Creswell & Poth, 2018, p. 55). Focus is on inductive reasoning and the steps taken in collecting and analysing the data leading to additional insight(s) of the topic and contributing to the development of knowledge within the field of study (Creswell & Poth, 2018, p. 56).

A quantitative approach relies on pre-established research frameworks to test a given hypothesis via "numerical data and statistical analyses" (Tashakkori & Teddlie, 2009, p. 29). This methodological perspective engages deductive reasoning to guide the investigation.

As this study is positioned within a mixed methods design, both deductive and inductive logic is used.

> This inductive-deductive research cycle may be seen as moving from grounded results (observations, facts) through inductive inference to general inferences (theory, conceptual framework, model), then from those general inferences through deductive inference to predictions to the particular (a priori [original] hypotheses) (Tashakkori & Teddlie, 2009, p. 31).

By relying on a mixed methods design, I believe additional depth and meaning is attributed to tertiary students' perceptions and overviews related the South African healthcare system. This is achieved by obtaining and analysing a large quantitative data set; establishing a baseline to generalised views and understandings.

Randomly selected participants from the initial sample population will be interviewed and asked a set of open-ended questions.

The aim of this approach is to gain additional insights of NHI, and how political agendas are perceived to motivate policy reforms. Emphasis is placed on the co-construction of meaningfulness within the interview process and how subjective experiences are interpreted, and later, how these narratives are presented within the research context.

As a critical realist, attention is given to the role of the real world insofar as how the unobservable world influences events within an individual's social world. It is a delicate interplay between pre-established power structures and how they are subjectively experienced.

From this line of thought, focus is placed on governance practices as used by the government in relation to how the Wits students perceive and experience the public healthcare system. In other words, are current policy reforms altruistically designed to address current health systems shortcoming and benefit the social wellbeing of the broader public or are these systemic overhauls used for Machiavellian[5] agendas to advantage the government.

I continue this chapter by exploring political theories that are commonly used to shape governance. Each theoretical framework is analysed with the intention of gaining additional insight to its structural outline and prescribed objective in shaping administrative leadership. By reviewing the complexity associated each theory further context is given the policy development agenda.

Public policy as a science

Undesired or negatively shared ecological social conditions are broadly classified as public problems; usually encompassing elements related to basic human rights insofar as "environmental degradation, insufficient access to health care services, or…consumer safety" among other factors (Kraft & Furlong, 2018, p. 37).

When public issues are experienced as unacceptable or socially problematic, citizens rely on government to intervene. These interventions are framed in *policy*; "…a standing decision characterized by behavioural consistency and repetitiveness on the part of both those who make it and those who abide by it" (Eulau & Prewitt, 1973, p. 465).

Simply put: *public policy* is when government proactively engages with public problems; with the intention of improving or bettering people's lives.

[5] Machiavellian "…motivation as one of cold selfishness or pure instrumentality. Rather than having a unique set of goals, individuals high in Machiavellianism…were assumed to have typical intrinsic motives…[pursued] in duplicitous ways" (Jones & Paulhus cited in Leary & Hoyle, 2009, p. 93).

Should a policy initiative already be in place, an amendment might be sought to improve the intervention guiding social law. Any changes made to pre-existing public policy are categorised as either incremental or non-incremental reforms.

An incremental policy reform is positioned in the understanding: "…adjustments [are] made at the margins of existing policies through minor amendments or the gradual extension of a program's mandate or the groups it serves" (Kraft & Furlong, 2018, p. 93).

Non-incremental policy reform is, rather, defined within the context of: "…extended stasis punctuated by abrupt transformation" (Jacobs cited in Mahoney & Thelen, 2010, p. 96).

Extreme changes to existing rules are generally not favoured when renegotiating public policy; as such a radical shift prompts the adherents to experience a sense of displacement (Mahoney & Thelen, 2010, p. 16). According to Schulman (1975, p. 1362), non-incremental policy as a reform is "…devoid of middle ground between self-generating states of growth and decay".

In short, it is a political framework that relies on an all-or-nothing approach to antecedent rules. Due to the envisioned systemic overhaul accorded the South African healthcare system, the NHI scheme is strategically designed within the constructs of a non-incremental policy reform.

After a policy is developed/amended and later put into practice, government must assess the policy cycle to establish its success as well as its shortcomings. Policy evaluation focuses on what achievement were met from the development phase; namely, projected outputs and objectives. The underlying goal of any policy evaluation is to determine if a change occurred; particularly, for the betterment of a community and society as a whole.

However, to adequately assess if the policy process was successful, attention needs to be given to the adopted theoretical lens used to guide the governance approach. Political theories are traditionally structured within the theoretical framework of elite theory, political systems theory, institutional theory, rational choice theory, incremental theory, and network theory.

I continue this chapter by briefly exploring each theoretical context; while emphasising key feature and/or associated themes that may hold relevance to this project. A key concept that is explored in the forthcoming discussion is the role of *power.* Particularly, that power is a central theme that shapes political theory.

The underlying purpose of this discussion is that by contributing a deeper appreciation to these traditional political theories, further clarity is given to the paradigm lens framing how data is analysed and the mode in which findings are presented.

Elite theory

Elite theory focuses on a small group of influential individuals holding powerful and/or top executive positions within the social strata (Pakulski, 2018, p. 9).

These distinguished individuals have the ability to persuade and motivate their cause, irrespective the consequences or impact, as experienced by non-elites. Their exclusive networks are strategically stratified as *above* the everyday citizen and generally comprising of political figures, business tycoons, media moguls, among others.

Elite members are perceived to work in conjunction with each other to fulfil shared interests—being it to grow self-wealth or to establish greater social authority, power, and influence (López, 2013, p. 4). It is an oligarchic approach in leadership whereby a few govern a country.

The framework can best be depicted in relation to the South African apartheid government. This form of political governing saw all people categorised according to race and demographically stratified. The population was racially segregated and ruled in an authoritarian manner.

Autonomy and agency were seen as insignificant, resulting in insurmountable human rights violations against peoples deemed *other*[6]. Thus, when a country is run in an oligarchical manner, the concept of democracy and personal liberty are null and void.

John Higley agrees and states:

> Elite theory has no place for idealized visions of democracy or social revolution, nor does it have a place for the spread of new values that dispose human beings toward a consistent and thorough altruism…elites are the central actors in politics, but the theory that centers on them is unlikely to have many enthusiastic adherents (Higley, 2008, p. 17).

The underlying principle to elite theory is: "…elites may come from anywhere, as long as they find the necessary tools to exercise power" (López, 2013, p. 3).

These *tools* or rather personality traits include but are not limited to ambition, cognitive capacity, skill set, consciousness (scrupulousness); while still taking into consideration the individual's education, financial affluence and social affiliations. Each of these traits lends itself to the enforcement of certain outcomes via the means of position and power.

[6] Other or "Otherness may be defined in biological or cultural terms and expressed in inferiorisation or insurmountable difference, or both" (Clarke, 2003, p. 41).

This understanding is reaffirmed by C. Wright Mills, who states:

> …men [and women] whose positions enable them to transcend the ordinary environments of ordinary men and women…for they are in command of the major hierarchies and organizations of modern society (Wright Mills, 1956[2000], p. 3-4).

For this study, the concept of *power* will be critically reviewed, and where applicable, renegotiated and integrated into a more nuanced framework.

The purpose of developing a synthesised approach is to present a more contextualised view to South African policy development as well as to systematically explore the reliability and viability of how the NHI proposals are theoretically framed and publicly perceived.

Particular focus is placed on current ruling elites' behaviours insofar as how their governance and leadership style(s) have shaped, impacted on, and transformed South African healthcare while still achieving their political agendas.

Political systems theory

As a framework, political systems theory is positioned similarly to that of general systems thinking. This unfolding process looks at the interrelations of elements, institutions, natural laws, as well as systemic structures and how each system influences, and at times changes, the procedural functioning of the other.

Kenneth Boulding defines general systems theory as:

> A phenomenon of almost universal significance for all disciplines is that of the interaction of an 'individual' of some kind with its environment. Each discipline studies some kind of "individual" – electron, atom, molecule, crystal, virus, cell, man, family, corporation, and so on. Each of these individuals exhibits 'behavior', action or change, and this behavior is considered to be related in some way to the environment of the individual – that is, with other individuals with which it comes into contact or into some relationship (cited in Dolfsma & Kesting, 2013, p. 25).

From a political perspective, the theory engages the broader "social, economic, and cultural context in which political decisions and policy choices are made" (Kraft & Furlong, 2018, p. 152).

Particular focus is given to the concept of *demands*. The demands are usually constructed via public opinion and social movement groups.

Depending on government's response, certain policies can be developed to overcome the identified problem. The purpose of this approach is to establish if a *change* occurred; irrespective if the change was deemed beneficial or not. Take for example, the 1960s and 1970s feminist movement for gender equality and women's rights. The struggle for gender equality saw a milestone breakthrough in March 1972 when the United States Congress passed the Equal Rights Amendment Bill whereby "Equality of rights under the law shall not be denied or abridge by the United States or by any State on account of sex" (Imbornoni, 2017, p. 1). In short, women were treated as equal or fairly in relation to men in the workplace.

Political systems theory is a framework focused on a bottom-up approach whereby the public (individuals or groups) identifies and advocates for a cause (demand), with the intention of bettering the lives of people or the population as a whole (policy development and change). Key aspects of the theory are: "…input, demands, support, policy outputs, policy outcomes, and feedback" (Kraft & Furlong, 2018, p. 152).

For this study, attention is given to the students' voice. This is particularly important to the democratic cause-effect dynamic between public perceptions/experiences of state-run healthcare and governance structures/policy objectives of the government. Simply put, how does the Wits student engage government over their quality of healthcare needs and the inequalities of health-related practices and services. In turn, what policies are developed and initiatives implemented to address these student concerns.

Institutional theory

Institutional theory explores the complex structural aspects framing organisational practices (Kraft & Furlong, 2018, p. 149). Emphasis is placed on the legal powers and ethical procedures used by institutions to govern their people. Thus, attention is given to the constructs of "functionalism and limited rationality, external environments, attenuated consciousness, and the symbolic life of organizations" (Lammers & Garcia, 2017, p. 196).

Institutional theory as an approach is authoritative in nature. From a political perspective, it aids leaders to develop, establish, and implement procedural practices as well as policies, resulting in a socially accepted stratification of norms and behaviours.

Socially agreed upon behaviours are beneficial in understanding the unique power dynamic between an organisation and its populace.

When engaging the concept of health and UHC, focus is given to formal rules and laws used by all levels of government when revising and implementing the NHI policy reform. In other words, how will

institutional powers be employed while taking into consideration faction groups and opposition—what information will be made available, how will advocacy groups and public outcries be approached, as well as acknowledging political interests and agendas while monitoring bureaucratic authority.

The key point to emphasise here is: South Africa is established as a democratic nation and, therefore, the government is obligated by the Constitution to empower its people through open and transparent dialogue in all decision-making and policy-development agendas.

This reveals that *all* voices are heard and taken into consideration before any drastic initiatives and systemic reforms are implemented into the South African healthcare sector.

Rational choice theory

This framework is reliant on various socio-economic factors and how these conditions influence an individual's cognitive process. It is a theory that "…assumes that in making decisions, individuals are rational actors who seek to attain their preferences or further their self-interests" (Kraft & Furlong, 2018, p. 757).

As this theory is focused on public interest(s), it is popular when developing and evaluating policies.

When analysing the unfolding process, a deductive logic is attributed to the approach insofar as people are rational actors in pursuit of self-interest. This, thus, enables key decision makers, lobbyists, political officials, and legislators a platform when modelling behavioural norms; predictively guiding what public policy is favoured (Kraft & Furlong, 2018, p. 150).

A main criticism to rational choice theory is directed to the understanding of the cognitive abilities, attainment of information, and the product of rational thought.

In other words, how does an individual behave (or assume behaviour) when pertinent information is lacking or withheld. Moreover, can one really accord a sense of logic or accuracy to the produced behaviour or outcome; particularly, when the information was problematic to begin with.

This theory is best explained in a presidential election—various data sets are analysed to give additional insight to public opinion on policy initiatives and agendas. This inadvertently allows key party members to realign their political objectives to obtain voter favour. The more voters, the higher the chances of winning the presidential race.

Once the new president takes office, he/she/they hold the power to implement what agendas are met; irrespective of what assurances and declarations were made to gain initial voter favour. It is a clever theoretical design modelled to predict (and even persuade/manipulate) a desired outcome within the institutional or political sphere.

In this study, rational choice theory is explored in relation to the power of political promises and public declarations made by the government and their accorded officials. Focus is placed on current health-related information, and what level of transparency and simplification is associated the motivated information, to gain public favour and support for the NHI policy.

Emphasis is also given to opposition groups and what impact their agenda has on public perceptions; particularly, when exposing unacknowledged but credible shortcomings or missing information.

The overall aim of this approach is to predict how the public will react, should misleading assurances not be fulfilled or meet perceived healthcare expectations.

Incremental theory

Incremental theory emphasises how small amendments are made to the policy frameworks over time (Kraft & Furlong, 2018, p. 93). These amendments are implemented slowly and over time, with the underlying goal being to effectively meet long-term policy objectives.

Miller and McTavish state:

> …incrementalism assumes that policy makers…are pragmatic and search for solutions that satisfy the various and diverse interests and values of policy actors (Miller & McTavish, 2014, p. 36).

A criticism of this theory is the conservative manner in which existing policies are approached in meeting pre-established goals.

When engaging this theory, focus needs to be given the successes of UHC as an overall policy reform. Consideration needs to be placed on how other developing countries renegotiated and implemented universal healthcare insofar as what impact has the reform had on their economy, governance strategies, and given populations level of health.

When looking past the principle of: Human Rights and the dignity to equal healthcare; as a critical analyst, I need to be open to explore the unpopular thought: what impact does NHI have as a non-incremental policy reform in relation to the South African reality.

Network theory

The key premise of this theory is positioned within the concept of mutual associations.

Friedman (cited in Moran et al., 2006, p. 485) defines a network as "…set of relationships among the multiple organizations involved in a program". These mutual systems are common within government;

due to “inter-agency efforts” to aid and/or meet in the deliverability of shared goals, objectives, and/or policy programmes (Moran et al., 2006, p. 485).

What is taken from this process is that key individuals have the means and authority to motivate certain agendas, via incentives, and meet sought-after goals.

Focus needs to be given to the concept of *accountability* insofar as how influential people use and manage their presence within the networking process.

Network accountability covers both a vertical and horizontal gaze. Vertical accountability is traditionally positioned in a top-down authoritative manner; revealing a delegated or chain of command approach to achieving set objectives (Uhr cited in Bovens et al., 2014, p. 235). Horizontal accountability is seen as mutually inclusive; emphasising a diagonal emergence that incorporates multiple influences from various institutions to reach a desired outcome (Uhr cited in Bovens et al., 2014, p. 236).

Governance as a political system is seen to practice a blended leadership style, relying both on a hierarchical power structure as well as the deliberation of debate through democracy; thus, blurring the line of accountability.

To overcome this limitation and to adequately measure what impact administrative directives, policy agendas, and government-based initiatives have had; the researcher looks to “public judgement” (Uhr cited in Bovens et al., 2014, p. 237). This bottom-up approach focuses on: “…empirical evidence of the public sustainability of the outcomes (including procedural outcomes) arising from the governance process” (Uhr cited in Bovens et al., 2014, p. 237).

This theoretical outline will play a necessary role within this study. Particularly, when engaging the concept of government and accountability—professional/ministerial position in relation to personal agendas; i.e., power dynamics, policy preferences, financial motivations, and nepotism.

In short, how will the government promote the concept of NHI and what methods or means are used to achieving their desired objective (political affiliation as well as personal motive) in association to the healthcare reform.

This theory explores various sensitive themes that may unearth some unwelcome truths and views.

A synthesised approach

When reviewing the above discussed theories in relations to the research focus, a more nuanced framework can be produced.

Due to the diverse and complex nature of South Africa, this research study actively explores various policy-based theoretical frameworks to purposefully renegotiated key ideas and concepts to produce a *best fit* approach to aid the data analysis process.

According to David Easton a best fit approach

> …consists of a set of interrelated propositions that are designed to synthesize the data contained in an unorganized body of singular generalizations (Seaton & Claessen, 2012, p. 33).

In other words, the synthesised approach puts forth a strategically designed framework that takes into consideration the various subjective and intersubjective political elements that influence the social functioning of South African society.

By unwrapping the original theories and illuminating the baseline premise/objective/goal; a fuller and more comprehensive understanding is attributed political leadership styles as well as policy motives and agendas.

In summarising commonalities associated the original frameworks, a re-emerging theme is found; namely, the concept of *power*.

In its simplest form, power is defined as "…an agent's ability to have an effect on other agents' actions or on their dispositions to act" (Menge, 2018, p. 23).

From a political perspective, power is broadly understood to be in "…control of resources" (Kurtz, 2001, p. 22). This is achieved by controlling "the material and the ideational domains"—being resources related to the: "human" (supporters/allies), "tangible" (culturally defined goods/money), "ideology" (ideas/beliefs), "symbols" (meaningfulness via text/objects), and "information" (contextualising/transferring meaning) (Kurtz, 2001, p. 31).

Thus, public administration and policy decisions are seen to originate through a desire to influence, and at times manipulate and control, the broader populace.

Power and how it is used politically will be the guiding principle in this research study.

What ideational measures are taken by political powers when recognising current shortcomings and their promotional assurances/promises to the public (benefit through change); in turn, is administrative transparency of information and practice empowering the external stakeholder and reassuring him/her/them that government has his/her/their best interest at heart.

Is the policy reform rationale and plausible within the needs of the given social context or are leaders promoting self-interest and nepotism via an illogical modus operandi and, thus, through elite status lacking in accountability.

In short, is the government promoting an open and democratic society whilst renegotiating the two-tier health system or is the NHI policy reform a strategic manoeuvre to nationalise healthcare—redirecting decision-making powers to a select group of people[7]. Building on this scenario, emphasis is also placed on how the broader public is predicted to react should a misuse of political power or a Machiavellian agenda be discovered (see discussion on: nationalising key infrastructurenationalising key infrastructure).

To obtain a better understanding to this inquiry, I look to the Wits tertiary population; particularly, 1st-to-3rd year undergraduate humanities students and Wits School of Governance (WSG) master's student.

This target population is purposefully sought to gain a deeper appreciation of what cognitively aware individual's think about the proposed healthcare reform. Specific focus is given the students knowledgeability of NHI and their perception of South Africa's current political leadership approach to inclusivity via information transparency.

The main premise to this investigation is to bring additional clarity to the question: Do Wits students feel they are making an informed decision in supporting/dismissing the proposed NHI healthcare reform?

Conclusion

This study looks to contribute to the understanding insofar as what the role of communication and social buy-in plays when dealing with a complex reform.

To appreciate this inquiry, a critical realist point of view is adopted. Meaning that consideration is given to the worldview dynamics of "the real, the actual and the empirical" (Bhaskar, 2008, p. 177) in relation to the governments political rule—encompassing features related to their leadership style, decision-making motives and bureaucratic agendas, governance in practice, as well as policy-based development, implementations, and reforms.

To competently engage tertiary students' perceptions and attitudes about UHC and the government's ability to deliver the proposed NHI White Paper policy reform, various political theories were

[7] Previously nationalised institutions in South Africa include: South African Reserve Bank, Eskom, Passenger Rail Agency of South Africa (PRASA), South African Airways (SAA), Road Accident Fund (RAF), among others.

approached. These include elite theory, political systems theory, institutional theory, rational choice theory, incremental theory, and network theory.

Each theoretical framework was briefly unpacked and analysed with the intention of identifying key elements associated the modus operandi, adding additional insight and depth to the research investigation.

However, due to the uniqueness of South Africa, a best fit approach was negotiated. This saw the merging of relevant ideas, themes, and understandings from the original theory and synthesised into a more nuanced approach.

By engaging the concept of political power within the resource-controlled domains of *material* and *ideational* (Kurtz, 2001, p. 31), further structure and insight is attributed the analytical process.

Allowing findings to be presented holistically whereby acknowledging both the generalisability of the numerical data set as well as giving voice and meaning to the narrated accounts.

Chapter 3: Literature review

Introduction

For this research emphasis is given to the role of informed public choice in the design and implementation of a complex policy reform (see Critically engaging how respondents were negotiated).

Focus is placed on the themes of: UHC and NHI; the NHI process needed for societal buy-in with a complex reform, does the concept of societal buy-in exist in the NHI process, what are the implications for the success of the health reform as well as a general overview of an alternative proposals aimed at improving the current healthcare system.

Understanding universal health coverage

Health autonomy is a fundamental human right and the maintenance thereof is considered a "social investment" (Barlow, 2016).

The World Health Organisation (WHO) suggests that "…half of [the] world's population do[es] not have access to the health care they need" (World Health Organization 2020a, p. 1). This has prompted various humanitarian organisations to actively address and engage this ever-growing social demand.

To overcome this identified problem, UHC is the favoured concept aimed at addressing this shortcoming by looking at three key objectives: access, quality, and financial protection (World Health Organization, 2020a, p. 1). According to the WHO, UHC is framed within the principle of:

> …ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship (World Health Organization, 2020b, p. 1).

The WHO is an agency that operates within the United Nations (UN) to identify, coordinate, address, and re-direct various health-related crisis(es) to the benefit of humankind.

Due to numerous healthcare shortages (from infrastructure to consumables), the WHO has advocated for an all-inclusive health systems agenda to be globally negotiated and, in time, adopted.

UHC is the favoured solution to renegotiating health inequality by providing essential services within four predetermined categories—"reproductive, maternal, newborn and childcare"; "infectious diseases"; "noncommunicable diseases"; and "service capacity and access" (World Health Organization, 2019a, p. 1).

Concerted efforts are being made for universal cover to be accepted globally by the year 2030.

Universally accessible healthcare, as an agenda, intends to promote the understanding: *equity for all*. This is particularly the case for developing countries, like South Africa, where vast socio-economic disparities indicate what healthcare access and treatment trajectory an individual will receive within the medical system.

In other words, UHC is aimed at empowering the vulnerable population in seeking medical care without suffering the financial consequences thereof. It is, further, believed that good health is a key determinant in reducing poverty and promoting "economic and social development" (see: OECD, 2003, p. 9; ODPHP, 2020, p. 1; World Health Organization, 2020b, p. 1).

This understanding is expanded on in a 2016 report by KPMG:

> A KPMG economic analysis of NHI suggests that if the NHI improves the health of the labour force resulting in productivity gains of 10% between 2012 and 2020 (half of the improvement in productivity seen in other countries), the economic benefits would outweigh the economic costs of implementing NHI (cited in Davis Tax Committee, 2017, p. 30).

These merging ideals have prompted the South African government to question the current two-tier healthcare framework; namely, the private and public systems.

Purposeful efforts are made to analyse the social and economic viability of a non-incremental policy reform, whilst meeting the WHO's 2030 agenda of providing universal cover to the vulnerable population.

Having purportedly explored features related to the workability of the public services model as adopted by the United Kingdom—the National Health Service (NHS)—South African officials have proposed the NHI scheme to address current health-related shortcomings and bureaucratic inadequacies.

NHI is, therefore, designed in accordance with a public service approach, as it is predominately funded through "direct taxes"—having "a pro-poor income redistributive effect" (Ataguba, 2021, p. 730).

This policy reform repositions the South African two-tier system, from a mixed social security-based[8] and out of pocket[9] model design, to a centralised state-controlled funding mechanism (Ataguba, 2021). In short, public monies and taxes are centrally pooled and used via a purchaser-provider split framework to make available essential healthcare services to the vulnerable South African population.

National Health Insurance (NHI)

Over 4% of GDP is allocated to a fully subsidised public service for those without adequate incomes. Higher income groups take out insurance for their coverage, and are not fully subsidised. Simply said, an individual's purchases his/her/their healthcare. This is achieved either through medical scheme cover or through out-of-pocket purchases.

Public healthcare functions within 3 spheres—primary, secondary, and tertiary facilities (Mahlathi & Dlamini, 2015, p. 3). These facilities are financially subsidised through legislature (general taxes) and run-in accordance to The Health Professions Council of South Africa (HPCSA) (National Treasury, 2019, p. 309).

Even as state-run institutions are openly accessible and financially subsided from the fiscus to all who seek medical assistance, growing mismanagement has led to various public concerns—shortages in healthcare personnel (specialists and nurses), lack of crucial health-based consumables and medical treatments, deteriorating equipment and infrastructure, incompetence in managerial skills and budgeting—all requiring immediate address for improvement (Moyimane et al., 2017; South African Lancet National Commission, 2019; Maphumulo & Bhengu, 2019; Zikali, 2019).

This understanding is summarised as follows:

> In South Africa, public doctors have been found dissatisfied by pay, as well as non-financial factors including: 'lack of equipment, drugs…unsupportive management systems'…in addition, lack of beds, and regular power cuts…and lack of a career structure (Ashmore, 2013, p. 3).

The private sector ethically abides by the National Ministry of Health and HPCSA (HPCSA, 2020). Private healthcare is financed through medical aid schemes. Due to the vast difference in how the medical experience is perceived and understood in relation to state-run and private institutions, most

[8] Social security model "…sometimes referred to as "mixed" models since both public and private providers can be used, and funding are also more flexible" (Econex, 2011, p. 2).

[9] Out of pocket model "…patients pay in cash (or by whatever means they have available) …to receive medical care" (Econex, 2011, p. 3).

higher-income households contribute to regulated health insurance in the form of medical schemes to access healthcare services. These households do not have access to free public hospital services.

Most developing countries as well as the countries forming part of BRICS have multi-tier health systems (Thomas et al., 2013). And according to a study conducted by the World Bank Group, most middle-income countries, including South Africa, are in the process of renegotiating their healthcare systems (Cotlear et al., 2015, p. 24).

A primary motivation for reform is the need to provide essential services to the poor and/or vulnerable populace. This encompasses the notion that a healthy population positively impacts on the social and economic functioning and growth of society (Bloom et al. cited in Clift, 2004, p. 10; Lustig, 2004, p. 15; Atun & Fitzpatrick, 2005, p. 20).

Or as Ngcaweni and Khumalo (2019, p. 1) state: "We cannot build a prosperous and economically thriving nation if a small minority of our workforce is healthy while the majority is vulnerable to ill-health and disease".

As each country is unique, a one-size fits all approach to global coverage does not appear feasible, with each country system designed in accordance with the given social context. Interestingly, Cotlear et al. (2015, p. 28) found that the concept *inequality* was a defining denominator in motivating the process of renegotiating the given healthcare system and, therefore, provides a plausible starting point for constructing a rationale, while still emphasising key motives behind the reasonability of UHC.

Within the South African context, the guiding principles of NHI are (the White Paper, 2017, p. 9):

i. Right to access health care;
ii. Social solidarity;
iii. Equity;
iv. Health care as a Public Good;
v. Affordability;
vi. Efficiency;
vii. Effectiveness; and
viii. Appropriateness.

When drawing these principles together, NHI is publicly defined as:

> …a health financing system that is designed to pool funds and actively purchases services with these funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their

> socio-economic status. NHI will be implemented through the creation of a single fund that is publicly financed and publicly administered. The health services covered by NHI will be provided free at the point of care. NHI will provide a mechanism for improving cross-subsidisation in the overall health system. NHI benefits will be in line with an individual's need for health care. Implementation of NHI is based on the need to address structural imbalances in the health system and to reduce the burden of disease (Motsoaledi cited in the White Paper, 2017, p. 8).

It is the government's express interest to address current shortcomings in healthcare ideals, practices, and services.

Or as Dr Zweli Mkhize (2019) echoed in a live briefing on eNCA:

> …we tend to think that what people wish in term of a…I want to see a specialist! I want to get an MRI! Isn't really how it works! It's the family practitioner [GP], at that level are the ones who will tend to guide, refer and then move you to a higher level. They specialist in the field of general practitioner…uhm…practice and they will be a very important source at that level…At a primary healthcare level, to screen, to say where people will be referred further. It is a function of a specialist system (Mkhize, 8 August 2019, 2.36:25).

The NHI policy reform as proposed would be phased in, with the scheme intended to be fully operational by 2026. However, no specifics have been provided on the feasibility of the original timeline, with or without the COVID-19 pandemic.

The underlying goal of NHI is to pool the available finances to allow all to seek healthcare.

According to the White Paper, key features framing NHI are a *mandatory prepayment* scheme to access universal healthcare (financed by further tax increases); these accumulated funds are pooled into a *single entity* to streamline the *strategic purchasing* in accordance with public need (medical consumables and buying services of healthcare specialists) (the White Paper, 2017, p. 8).

Little information is available regarding the additional costs the South African public has to incur (Larkan, 2019; Baxter, 2019). Clearly the public should be aware of the implications of alternative governance approaches. This would include the wider institutional framework as well as the "corporate governance" elements (Sanders & Reynolds, 2018; Mafuma, 2019). In short, is there an adequate separation of power? How is the system to be held to account?

It is argued that such vital information should, however, form part of public engagement, allowing for informed and active debate (Zikali, 2019).

By engaging the populace in relation to the NHI policy reform's objectives and outcomes, political leaders are not only empowering the people to speak out and voice their concerns but also enabling them to negotiate vested long-term community interests. Or as Mabalane Mfundisi of the South African National Aids Council (SANAC) states:

> As a society, we'll debate this Bill to ensure it reflects our views of what universal health coverage should be in line with Section 27 of the South African Constitution (cited in Zikali, 2019, p. 1).

Novelty shaping NHI

This section looks at the uniqueness and distinctions of the NHI funding mechanism, the idea of subsidisation and taxation for healthcare, and an understanding of the benefits package. By further unpacking these concepts, additional emphasis is given to the importance of civic buy-in over in-principle support for UHC.

NHI is based on the premise of "…a single-payer and single-purchaser responsible for the pooling of funds and the purchasing of personal health services on behalf of the entire population" (the White Paper, 2017, p. 49). Various sources are explored but the main mechanism used to fund the NHI are personal income tax, value-added tax, and corporate tax (the White Paper, 2017, p. 44). Moreover, an addition surcharge tax may be used to subsidise any financial shortcoming.

The main point of this financial arrangement is:

> Economic growth is needed to ensure an expansion of the tax base, and if tax revenue is re-channelled into the economy in the form of productive public expenditure, it will support and stimulate growth. An efficient and cost-effective health sector will lead to improved health outcomes that will improve productivity and enhance economic growth. Crucially, in order for taxes to play a role in promoting economic growth, revenues need to be collected, allocated and spent in an efficient manner (the White Paper, 2017, p. 44).

The NHI fund is positioned as publicly administered and established through legislation as an autonomous public entity (the White Paper, 2017, p. 50). A unique feature accorded this funding approach is that members comprising the NHI board are not part of a stakeholder representative body, but rather mandated to ensure the fund is "…functional, effective and

accountable" (the White Paper, 2017, p. 50). In other words, this funding approach looks to reduce patronage and gatekeeping politics; limiting corruption and maladministrative practices.

Much is unknown when exploring the idea of subsidisation and taxation for healthcare. The White Paper (2017) presents a comprehensive discussion in relation to funding the NHI through taxation but these discussions are not based on projections and cost estimates.

When exploring these projections and estimates, focus was placed on demographic trends. Here initial findings show that public spending on healthcare would need to rise to 6.2% of the current GDP to support the NHI by 2025/26 (the White Paper, 2017, p. 40). To offset the burden of rising general tax, the White Paper (2017, p. 43) suggests the implementation of a "tax mix". Here a broad focus is given to direct taxes (personal income tax, corporate income tax) or indirect taxes (consumption expenditure) (the White Paper, 2017, p. 44).

Also, to maintain the needed revenue to fund NHI, it is suggested that payroll taxes are used as mandatory membership contributions, a surcharge tax on personal income of up to 45% is implemented, as well as an increase in value-added tax of 14% (the White Paper, 2017, p. 45). Other tax options are being explored—alcohol and tobacco products, non-essential goods and services, wealth and property, securities transfer tax, and carbon tax—but to date, these revenue sources have not been integrated into the NHI funding mechanism (the White Paper, 2017, p. 46-47).

The benefits behind the increase in the various sources of taxation are that primary healthcare, specialised secondary care, and highly specialised tertiary level of care are all-inclusive to the NHI package. It is from this perspective that civic buy-in is maintained. As motivated in the White Paper (2017), these fundamental components structuring UHC are not only publically supported in-principle but also embraced in practicality.

The central point is that the financial viability of the NHI proposals are a key element for informed public engagement. But there has been no formal evaluation of this aspect release to the public (Blecher et al., 2019).

Internal stakeholders

According to Freeman and Reed (1983, p. 91) the concept of a stakeholder encompasses the understanding: "…any identifiable group or individual who can affect the achievement of an organization's objectives or who is affected by the achievement of an organization's objectives".

This broad overview is further defined as: "…any identifiable group or individual on which the organization is dependent for its continued survival" (Freeman & Reed, 1983, p. 91). This survival is commonly positioned within the context of organisational success insofar as ensuring future corporate financial sustainability and growth.

In the case of UHC, it is a policy goal that looks to address health systems, but it can also contribute to broader goals related to the social, the political, and the economic functioning of a country (McKee et al., 2013, p. S39). Thus, UHC is framed as a global policy restructuring, that looks "…to renew political commitments to primary health care" as acknowledged in the 2018 *Declaration of Astana* (World Health Organisation, 2019b).

The United Nations, the World Health Organisation, and the World Bank Group are the primary endorsers of UHC (Tichenor & Sridhar, 2017, p. 2).

These agencies, among others, are encouraging a universal humanitarian shift in healthcare services and practices. This approach poses various challenges; particularly, in developing countries where socio-economic disparities are an ever-growing concern (World Health Organization, 2019c).

This understanding was a leading agenda item in the UN High-Level Meeting (HLM) on Universal Health Coverage in September 2019, where the World Bank and the WHO pointed out that for UHC to become a working reality, a minimum of 5% of a country's GDP must be invested into its public health sector (Wright & Boldosser-Boesch, 2019).

Later in this discussion, it was acknowledged that this blanket target of "…5% will be harder and slower for the poorest countries [to achieve] and that interim targets may be needed for different types of countries" (Wright & Boldosser-Boesch, 2019, p. 1). However, in closing it was surmised that though 5% of the GDP would make a substantial difference in low-income and developing country healthcare systems, it would still not be enough to support the envisioned UHC framework (Wright & Boldosser-Boesch, 2019, p. 1).

In short, lower income and developing countries would need to increase their GDP contribution by at least another 1% to fund the concept of universal cover.

This increase would be near impossible for struggling countries to carry, so it was suggested that donor governments should consider investing the additional 1% of their Gross National Income (GNI) as part of Official Development Assistance (ODA) towards UHC (Wright & Boldosser-Boesch, 2019).

This dilemma was already a topic of concern in 2012 when Navarro and Lievens developed a paper for the Collaborative African Budget Reform Initiative (CABRI) dialogue where they stated that: Sub-

Saharan Africa is "…largely aid dependent; [and] external assistance plays a significant role in health sector financing in all the African sub-regions" (Navarro & Lievens, 2012, p. 19).

What can be taken from this discussion is that national as well as international discussions highlight the financial challenges that lower income and developing countries face when financing healthcare services, this even prior to the Covid pandemic.

Building on this broad discussion, focus now needs to be placed on how South Africa will manage to meet any predetermined healthcare objectives and reforms post-pandemic—financially and in relation to public confidence.

From within a South African context, the government is positioned as the majority internal stakeholder in relation to the proposed healthcare reform. Internationally, the government appears to be loosely aligning itself with globally set UHC objectives. However, as a developing country, little attention is given to the actual fiscal impact NHI will have on the people of South Africa.

To date, government relies on broad projections and estimations when addressing the NHI financing requirements, with any financial deficits (as address in the White Paper) being accounted for by increases in taxation (Davis Tax Committee, 2017, p. 42).

Taxes as a potential revenue source are seen to include: a surcharge on income tax, value added tax increase, increases in duties on alcohol and tobacco products, securities transfer tax, estate duty tax, carbon tax, and additional employer contributions tax (Davis Tax Committee, 2017, p. 34-35).

Even as NHI is framed to benefit the people of South Africa, an uncomfortable conclusion starts to emerge with the rising costs of everyday living expenses coupled with the various surcharge taxes needed to support NHI, much is predicated on being able to raise taxes to finance the shortfall needed to cover the medical scheme members targeted for inclusion in the state system.

According to eNCA (2021, p. 1) the South African unemployment rates have risen to "32.5% in Q4 of 2020"; and with the burdened post-Covid economy, it is unlikely that the NHI policy reform will be openly embraced by the middle-to-upper socio-economic class.

The Davis Tax Committee (2017, p. 42) states that…

> …inadequate engagement at the early stages of NHI may well create resistance to change in the latter states of implementation…The voice of the person in the street, the patient, seems conspicuous by its absence in a policy domain dominated by experts.

Dialogical discourse and political promises

This section looks to give additional insight to how emotionally driven statements are publicly perceived and what impact strategic outlooks have in gaining support (Mbude, 2017).

Dialogical discourse refers to meaningful communication, emphasising "…social relationships of equal status, intellectual openness, and possibilities for critique and creative thought" (O'Connor & Michaels, 2007, p. 277).

This dialogical approach fits with the government's original ethos of participatory democracy whereby the people shall participate in governing (Buhlungu, 2005, p. 38). However, with the internal shift of party dynamics (particularly, in relation to hegemony and their contemporary patronage model), additional emphasis is placed on how statements are bureaucratically framed; particularly, within the concept of a promise.

The Merriam Webster Dictionary (2020, p. 1) defines a promise as: "a declaration that gives the person to whom it is made a right to expect or to claim the performance or forbearance of a specified act". Thus, before one can appreciate the effect of an unfulfilled promise, it is important to discuss how a promise is perceptually perceived and what it publicly represents.

A promise is traditionally presented as a rhetorical agreement/statement that is made with the specific intention of (re)assuring a person or group of people to a certain outcome associated a particular event or occurrence. Even as the medium of speaking words is done effortlessly, the verbal acknowledgement in stating the *promise* ensures meaningfulness in and instils an overall sense of trustworthiness to the (re)assurance.

This reveals that a promise, to some extent, is laden with emotionality. To establish a sense of trustworthiness in relation to political promises, this research looks to understand how dialogical discussions and rhetorical assurances made by the government influences the people's perception and understanding of the proposed healthcare reform.

To gain additional context, focus needs to be given to previous reforms and policy agendas, and what successes these transformative initiatives have achieved. These programmes and policy initiatives include: The Redistribution Development Programme (RDP), the Growth, Employment and Redistribution (GEAR) strategy, National School Nutrition Programme (NSNP), the Joint Initiative on Priority Skill Acquisition (JIPSA), New Growth Path (NGP), Shared Growth Initiative for South Africa (ASGISA), the Sector Education and Training Authorities (SETAS), to name but a few.

Each of these programmes, among others, have been monitored over the years to determine what impact they have had on the economic transformation, skills development, as well as the social

wellbeing of post-apartheid South Africa. Tragically, most of these policy-based interventions have cumulatively failed to redress the vast socio-economic inequalities as experienced by the South African people (Sharp, 2010; Fedderke cited in Bhorat et al., 2014; Bendile, 2015; Seekings, 2020; Amnesty International, 2020).

This understanding is reflected by the following excerpt:

> The ANC government faces popular discontent from the citizens of South Africa because of its failure to address the triple challenges of poverty, inequality and unemployment…illustrating that the ANC government has bound itself to neo-liberal economic policies, which has resulted in it not achieving many of its promised objectives (Mosala et al., 2017, p. 337).

Furthermore, the public is becoming more and more disillusioned by the common place rhetoric used by the government and its key political leaders. This can be seen with a growing number of reports[10]—online publications, print and broadcast media, opposition parties, as well as public forums and protest movements—all echoing similar sentiments as shared by DA's national spokesperson Solly Malatsi:

> After 107 years of existence and almost 25 years in government, it is now clear that the [ANC] party is a hollow version of its former self. By recycling the same old ideas or failed interventions, Ramaphosa has not convinced the nation that his ANC has what it takes to build a South Africa that is united and where the economic inequalities of the past are redressed. The party has broken our government with empty promises and corruption and it is clear that it will always put itself above the people (Malatsi, 2019, p. 1).

What can be taken from this discussion is that contemporary political leaders rely on key words and position phrases that incite an emotional need for *social cohesion* and *comradeship* when advocating change. However, this strategy seems to be wearing thin, revealing the public is growing tired of the "…promises that are habitually broken in practice and renewed rhetorically" (Mkhabela, 2020, p. 1).

What is brought to the fore from this discussion is that government's reliance on political promises should not be used casually to mitigate political shortcomings or failures. Particularly, when engaging policy reforms.

[10] See: Basson & du Toit, 2017; Tshishonga cited in Mugambwa & Katusiimeh, 2018, p. 125; Seitisho, 2019; Mkhabela, 2020; Williams, 2020.

As to date, commentators and researchers are particularly interested in seeing how government intends to implement and maintain NHI.

External stakeholders

The public, or external stakeholder, is openly encouraged to participate in the policy debate. Here the individual, student, community leader, or group representative can put forth various questions and concerns with regards to the proposed reform. This approach is important to ensure the principle of social solidarity is achieved (Ngcaweni & Khumalo, 2019).

In open debates, stakeholders are empowered to voice their concerns and even pose alternative ideas that can improve key areas in the current healthcare systems strategy.

In a democratic society, the voice of all the people (affluent to vulnerable) needs to be taken into consideration when proposing a change to the norm. In summary:

> Political acceptability is of key importance in designing the benefits package [associated NHI], especially among the people who are paying for the [health] insurance…If the government will fund a mandatory insurance scheme through general tax revenues, national health goals are likely to guide design of the benefits package. In addition, to sustain political support for the national scheme, the tax-paying population should perceive the benefits package as valuable. The priorities and political power of the paying population may be at odds with those of the nonpaying, poor population, requiring an incremental, consensus-building approach to expand insurance to nonpaying populations (Wang et al., 2012, p. 28).

For this study, the external stakeholder is proxied by Wits tertiary students enrolled for the 2021 academic year. The student's population emphasises two groups: undergraduate humanities (1st-to-3rd year) as well as master's.

These cohorts are purposefully sought due to their diverse outlooks—undergraduates renegotiating their identity as independent members of society whereas the postgraduate demographic having established a sense of independence through lifeworld experiences. The researcher feels a more inclusive yet diverse set of opinions are attained, adding complexity to the study inquiry.

Both population groups are invited to share their thoughts and attitudes about the South African healthcare system and how NHI as a policy reform could improve or compromise the current two-tier medical system.

The students' views should broaden our understanding and perspective in relation to how the government has/is approaching the proposed healthcare reform. The analytical findings should help clarify whether the technical information framing the NHI contributes to comprehension of the healthcare system by the public (using students as a proxy) as well as his/her/their sense of autonomy, belonging, and citizenry.

Public opinion and knowledge of NHI

The external stakeholder opinion is an important aspect for government to take into consideration and later consult when renegotiating any policy directives or initiatives.

To appreciate what the public knows and thinks about the South African healthcare system and the proposed NHI policy scheme, the current published literature and forums are used to position present understandings.

In starting this search, the researcher struggled to find reputable or published works in relation to the South African public's perception and attitude toward UHC or even the proposed NHI reform. This shortcoming was also experienced by Booysen and Hongoro (2018, p. 2): "Only a handful of studies have documented the awareness and/or perceptions of and support for national health insurance among healthcare users in South Africa".

This finding is interesting as part of the democratic constitution and defining feature of the RDP was established to encourage "community participation in government policy, planning, managing, delivery, monitoring and evaluation of health services" (Ngcaweni & Khumalo 2019, p. 1).

In 2019 the parliamentary portfolio committee on health opened a line of communication for the public, via written submissions, to voice their concerns about NHI as the desired health policy reform (Parliamentary Monitoring Group, 2019).

The primary focus here, was for communities to be given a "…chance to influence the direction of the NHI in a meaningful way" (Ngcaweni & Khumalo, 2019, p. 1). But even though an open line of communication has been established by government, groups like the People's Health Movement South Africa (PHM-SA), the Treatment Action Campaign (TAC), SECTION 27, Rural Health Advocacy Project (RHAP) and Lawyers for Human Rights (LHR) are of the opinion that government is not prioritising the people's voice and rather will use the policy reform for self-gains.

These groups have come together and established the People's NHI Campaign.

This advocacy campaign looks to *voice* a unified concern on behalf of 'the South African people' in relation to political agendas and motives associated amendments to the current healthcare system.

The People's NHI Campaign are of the opinion that the NHI policy reform, as proposed in the Green Paper and two White Papers, is structured to appease corporate interests: namely, favourably influencing the financial profitability of an elite few (People's Health Movement South Africa (PHM-SA), 2018).

So far, this discussion reveals two polarised views—from the South African government and the advocacy groups' perspective—and the tension framing the proposed healthcare reform. Ulriksen and Plagerson (2017, p. 15) believe that this is because: "In the absence of a universally trusted lead institution, processes of negotiation between stakeholders have struggled to overcome ideological, professional and technocratic differences".

Awoonor-Williams et al. (2016), Alhassan et al. (2016), Aboagye et al. (2017), Adomah-afari and Chandler (2018) are all in agreement that: "…a lack of community participation is a common phenomenon in Sub-Saharan Africa" when approaching policy reforms; particularly, UHC (Christmals & Aidam, 2020, p. 1898).

This should be addressed by government insofar as focus needs to be redirected to the people of South Africa and what they know about NHI. Knowledge holds a sense of power or as Sir Francis Bacon so aptly proclaimed "scientia potestas est" (Rodrígez García, 2001, p. 109).

In a study conducted by Setswe et al. (2015, p. 1), they found that of 748 respondents residing in Limpopo, KwaZulu Natal, and the Eastern Cape province: "…awareness of NHI was high...[yet] knowledge of what the NHI was all about was generally poor".

Booysen and Hongoro build on Setswe et al. (2015) findings and state that additional…

> …concerted efforts are required to develop a proper communication strategy to disseminate information on the country's national health insurance policy and its implementation to healthcare users, both in the private sector and in the public sectors (Booysen & Hongoro, 2018, p. 5).

This will allow the public to make an informed decision to support/dismiss the proposed healthcare reform. By keeping pertinent information from the external stakeholder can result in a fracture of trust between government officials and civil obedience.

Thus, depending on what the people know about UHC, will shape opinions and, in turn, influences how the public choose to embrace the NHI policy reform. Therefore, should government withhold technical information associated NHI or the transparency thereof, the researcher is led to ask if a sense of credibility can be accorded public choice?

Especially, that the literature shows growing support for this study's knowledge gap between public understanding and the proposed healthcare reform. This understanding is elegantly summarised by Ruth Passchier:

> Although political will is essential, it is necessary to involve all stakeholders when attempting any reform. Vision, collaboration and oversight of the NHI will require co-operation and input from multiple levels, getting community members, service users, health workers and politicians together from the start, to share their views about the system and to commit to working together to solve problems…Without [acknowledging] the vision and oversight of all those using and working in the health system, the NHI may face resistance from personnel at ground level (Passchier, 2017, p. 837).

Credibility of choice

Democracy, as part of the South African context, positions each person to the constitutional right of equality, freedom, and human dignity (Government of South Africa, 2021). It is from this democratic understanding that protest action is embraced.

Here the civilian population demonstrates their dissatisfaction and/or discontent to governmental shortcomings; these demonstrations can be enacted as a peaceful march to a predetermined location or resulting in frustration and ending in violence. Irrespective of the motive and outcome, an undeniable aspect associated South African democracy is the freedom to collectively express (verbally and in action) how an individual, or community, feels. Thus, an individual's autonomy, sense of freedom, and rationale to choose are fundamental components that shape a democratic society.

When reverting back and building on the discussion generated in the previous section (see: Public opinion and knowledge of NHI), how is UHC perceived; particularly, when it was established that a general lack of knowledgeably is associated the proposed NHI policy reform.

The literature shows that the government embraces, and even promotes, the practice of community engagement when addressing current social shortcoming or proposed interventions. However, in reality they are not overly transparent in transferring the technical information accorded the desired systemic shift (Mukwena & Manyisa, 2022, p. 2).

van den Heever (cited in Mazibuko, 2019, p. 354) is in agreement: "The Department of Health (DoH) has only produced superficial proposals, while National Treasury has published no financial analysis". This hesitancy in openly disclosing the complexity of the non-incremental healthcare reform could be attributed to current perceptions associated governance practices, highlighting political

maladministration and financial mismanagement. Thereby transparency is seen "…as an instrument to accountability" (Roelofs, 2019, p. 567).

In short, the more transparent government is, the more vulnerable political figures are to public scrutiny and, in turn, publicly accountable for their actions (Rose-Ackerman, 1996; Stiglitz, 1998). Thus, "…transparency might have clear limits to its utility as a method for deterring corruption and improving citizen satisfaction" (Park & Blenkinsopp, 2011, p. 271).

In relation to a recent study conducted by Tandwa and Dhai[11], findings correspond with the conclusions drawn by Setswe et al. (2015) and Booysen and Hongoro (2018), whereby public awareness of the NHI policy reform was noticeable. However, Tandwa and Dhai's investigation further found that the study cohorts…

> …were aware of their right to be involved in the policy making process of the NHI, in order for the right to be involved in policy making to be realised, there ought to be fair opportunity for patients to be involved in the policy making process, which the majority of the participant responded that they had not received (Tandwa & Dhai, 2020, p. 7).

Again, these findings are not supportive of South Africa's Ubuntu ideology. Therefore, additional emphasis needs to be given the notion of political trust, credibility of public choice, and blind acceptance in part to political loyalty.

Particularly, when the external stakeholder's health autonomy and his/her/their rationale thereof is constructed within the context of weak transparency in how government presents technical information associated the NHI proposals. Moreover, it should be asked: Can a sense of credibility or trustworthiness be associated the external stakeholder's final decision insofar as supporting or dismissing governments proposed non-incremental healthcare reform.

To emphasise this line of thought, attention needs to be given the elements of explanatory data analysis when reviewing and interpreting the findings. The primary objective is to contribute additional knowledge to the phenomenon of power and choice from the perspective of the external stakeholder.

By interpretively engaging the findings from both a descriptive as well as explanatory point of view, the researcher is afforded the opportunity to add additional context and depth to the results

[11] "Public engagement in the development of the National Health Insurance: a study involving patients from a central hospital in South Africa" (Tandwa & Dhai, 2020).

discussion. This will allow for key strengths and weaknesses to be highlighted when reviewing how the NHI proposals is perceived, understood, and accepted/dismissed by the external stakeholder.

Though acknowledging the NHI proposals strength is a valuable exercise, certain focus should be put on what is missing from the process of public engagement as well as the public's understanding, or lack thereof, of the NHI as the primary healthcare provider. Particularly, how civic perception and engagement is promoted within the procedural process of introducing NHI proposals to the final steps of implementing NHI as a healthcare service.

It is only when we actively acknowledge current shortcomings that we can begin to address statements like: "Most of the participants in this study were not aware of the NHI and therefore were not equipped with the necessary information to be involved in the policymaking process in a meaningful way" (Tandwa & Dhai, 2020, p. 8).

This somewhat critical approach will add valuable insights to how the external stakeholder experiences choice by accepting/dismissing the proposed healthcare policy as a complex policy reform. It also empowers the external stakeholder to voice his/her/their concerns. And by giving voice to the people a further sense of self autonomy is promoted when seeking healthcare services.

Constitutionally, it is "the citizenry's right to know" (Kaufmann & Bellver, 2005, p. 1) enabling the public to make consciously informed decisions to support or dismiss NHI. It is, therefore, imperative for policymakers to invite the South African community, from grass-roots level up, to not only learn more about the policy reform but to actively contribute their thoughts and feelings towards the proposed policy. This can be achieved through the promotion of scientific evidence in forums and community meetings and by educating the public through social media platforms as well as other national media outlets like radio and print. As ultimately, this policy decision affects all South Africans irrespective of gender, age, racial affiliation, or socio-economic status.

Towards a plausible alternative

Since 2007, little progress has been made in resolving key concerns associated NHI. These concerns can be framed in relation to government's lack of technical transparency of the procedural unfolding of NHI; motivating alternative approaches to be suggested.

These proposed approaches take into account and embrace the NHI's presumed fundamental values and objectives but also try to address perceived shortcomings. Particularly, how the NHI policy aims for a complete systemic overhaul, instead of incrementally reviewing and addressing problem areas within the current healthcare system. In short, enabling for reasonable adjustments to be made should systemic errors or social challenges arise.

In 2016, the Democratic Alliance (DA) had proposed a counter healthcare plan in the form of: Sizani Universal Healthcare (SUH) (Schütz, 2019). This plan as per their 2019 manifesto states:

> The first step to fixing our poor public health system is to address challenges in terms of primary Healthcare – in other words, to make our clinics work and build more where needed. South Africa has a ratio of 1 clinic to 16 971 people, as opposed to the guideline of 1:10 000. South Africa also has a ratio of 0.7 doctors to every 100 000 people, well below the average of OECD or BRICS nations (Mnikati, 2020, p. 98-99).

Here, the DA intends to "roll out universal healthcare to the people of South Africa…within the current budget envelope; without destroying the economy; without the increased opportunity for mass scale corruption and with the provision of quality healthcare" (Molelekwa & Seboholi, 2020, p. 1).

Though the SUH proposal is actively looking to counter the NHI's shortcomings; some feel the healthcare plan is a Trojan horse in relation to the equity-based ideology framing NHI.

Schütz (2019, p. 1) expands: SUH looks to "appeasing medical aid members and private sector actors" in relation to the NHI's intention of nationalising healthcare by redressing the public-private divide via the pooling of funds into a single entity.

Irrespective of how one approaches the proposed healthcare policy reform, it is agreed that the South African healthcare system is in need of an intervention.

> Whether the DA will get the chance to implement its plan nationally obviously depends on the voters. But whether South Africans support the NHI ideal, or the alternative offering from the opposition, what's clear is that the health system as it stands isn't working as it should, and that an overhaul is absolutely essential (Caelers 2016, p. 1).

Regardless of the position one takes in the debate for a socially inclusive healthcare system, much work still needs to be given to the practical requirements of universal coverage within the South African context.

This need has been emphasised by the Coronavirus pandemic. Various health-related shortcomings have been brought to the fore, revealing where interventions and improvements are sorely needed. This context should be seen in relation to the success/shortcomings associated how "the centralised procurement of vaccines" influenced the overall deliverability of essential healthcare services (Cleary, 2021, p. 1).

Especially, when healthcare practices and interventions are overshadowed with governance failures like the Personal Protective Equipment (PPE) scandal, highlighting "…how pre-existing provincial public healthcare systems are deeply corrupt across the board, which is cause for concern given the centralised structure of NHI" as well as the outcome when transparency is not prioritised (van den Heever cited in Cleary, 2021, p. 1).

Conclusion

This chapter shows that a distinct polarisation shapes the South African healthcare systems—private versus public healthcare. Though gaps and shortcomings can be found in both the private as well as in the public sphere, attention is given government's role in delivering current healthcare services.

The analysed literature has revealed that the current two-tier healthcare system is in need of improvement.

With reports of maladministration and corrupt practices associated the public healthcare sector, many external stakeholders worry that the NHI is just another policy proposal aimed at enriching an elite few over improving the current healthcare system.

It should be noted that the private sector is not void of problems, however, this study focuses on UHC and governments approach to implementing NHI.

To date, a lack of information is found on the technical processes associated the proposed NHI scheme.

Professor Alex van den Heever Chairs the Social Security Systems Administration and Management Studies at the Wits School of Governance, Johannesburg, South Africa. He says:

> The NHI proposals do not offer an answer to the failures of either the public or private health systems, while not actually demonstrating concretely that the key features of the system are in fact implementable. The draft bill offers no certainty that any aspect of the NHI will be operational in the foreseeable future. Even if the NHI were to be fully implemented, it still does not address the systemic weaknesses of the public and private health systems which have been identified to date in numerous inquiries and official processes (cited in Mazibuko, 2019, p. 377).

This literature review chapter identified a potential gap in knowledge between the government and society at large. The purpose of this research is to better understand the extent to which relevant information on a complex policy reform has been incorporated into the process of public engagement.

Chapter 4: The research method

Introduction

This chapter looks to describe what methods and techniques were used to conduct the study. By reflexively engaging the research process, additional insight was accorded the project.

The forthcoming discussion influences how the study was perceived insofar as its sense of trustworthiness and overall meaningfulness, whilst putting forward what steps were taken to account for the analytical findings.

By deconstructing the research process, acknowledgement was given to any shortcomings as well as emphasising concepts related to the reliability and validity of the investigation.

The purpose of the chapter is to describe how the research undertaking was conducted in relation to meeting predetermined study aims and ethical protocols.

Salmons is in agreement and states:

> The choice of methodology is important to the organization of the study and to choices made in other areas of the research design (Salmons cited in Hesse-Biber & Johnson, 2015, p. 540).

The unfolding discussion focused on the research structure, how respondents were negotiated, and the research ethics.

These themes were strategically negotiated to contextually frame the investigative process; thus, giving context to the research project.

Structuring the research

For this research undertaking, a mixed methods research design was used; namely, quantitative and qualitative.

In relation to the philosophical assumptions framing the study, this methodological approach was supported by Brown and Roberts (as cited in Edwards et al., 2014, p. 301) whereby mixed methods was positioned "…between extreme positivism (associated with quantitative methods) and extreme interpretivism (associated with qualitative methods)".

The quantitative method looked to simplify large data sets with the aim of giving summarised insights to certain inquires. Whereas the qualitative method intended to emphasise subjective perspectives, understandings, and opinions of around 1.5% of the sample population.

Sampling method

The study relied on non-probability sampling, focusing on the technique of purposive sampling.

This sampling method emphasised that respondents were purposefully identified in accordance with certain characteristics or variables that met the research objectives.

As the research was structured within a predefined criterion—the identified target population was at Wits and the sample frame consisted of humanities and master's students—the concept of "independent chance of selection" was not achieved (Kumar, 2011, p. 199).

However, to ensure the respondents were given an equal chance to participate, the researcher relied on randomisation within the selection process as defined within the target parameters.

Teddlie and Tashakkori (2009, p. 186) posit this unfolding progression was the logical fit when engaging a mixed method design, referring to this approach as "stratified purposive sampling".

The aim of *stratified purposive sampling* was to limit elements related to sampling error as well as enhancing the study's external validity and generalisability.

Data collection

Before any data was collected, the researcher pursued formal ethical clearance. As such, associated ethical considerations and implications are critically discussed in the following section of the chapter (see Ethical considerations).

The study did not intend to obtain data via concealment or deception, but rather through open and transparent methods. Raw data was collected under the assumption of voluntary participation. This section served as a general overview to the data collection instruments intended process, purpose, and design.

Mixed method research designs relied on both numerical and subjective/intersubjective data. Raw data was collected via a "between-strategies" approach; purposefully designed, but separate data collection instruments (Teddlie & Tashakkori, 2009, p. 191).

For this study, the measuring instruments included an online research survey (close-ended questionnaire) and an interview schedule (semi-structured open-ended questionnaire).

Moreover, in relation to the online research survey, key questions were formulated to test the respondent's knowledge and to establish if he/she/they were answering the question from an understanding of knowledgability or randomly choosing answers to complete the survey. These questions included figure 17; Private vs. public healthcare, question 8; Political confidence, question

10; and NHI knowledge, question 8 and were purposefully discussed and cross-referenced to either the study literature or previously reformulated survey questions. The aim of this approach was to establish if a knowledge gap was present between the student's comprehension of NHI and how the technical information that shaped the proposed healthcare reform was disseminated.

Data analysis

In this study, data was reviewed both statistically (quantitative) and thematically (qualitative).

The numerical data collected via the online questionnaire was analysed within a descriptive statistical framework, with the specific focus on item analysis. The aim of item analysis was to determine the frequency (percentage) of each structured close-ended question (Mentz & Botha as cited in Wagner et al., 2012, p. 177). Thus, allowing results to be determined. Research results were then presented graphically in the form of tables, thus, simplifying large data sets and conveying an overview of the findings. Broad summaries were used to guide each tabular representation.

The qualitative data was reviewed in accordance with thematic content analysis. Relevant narrated segments of the analysis (opinions and understandings) were included in the results chapter to enhance, or even oppose, findings associated the statistical results.

Critically engaging how respondents were negotiated

Before one can accurately discuss pivotal elements linked to the sample population, emphasis was given to the research parameters. Simply put, does the investigation explore variables associated a niche topic and/or relied on a unique demographic; thus, influencing procedures related to participant identification and selection.

In the case of this undertaking, the concept of NHI framed within the South African context was considered a niche segment within the global drive towards UHC.

As the study looked to deconstruct perceptions and attitudes of tertiary students enrolled at Wits, the primary objective of the research was to understand how the tertiary students perceived, understood, and contextualised features/concepts/statements associated the NHI proposals.

Focus was, thus, given to how information was transferred from government official to student and what level of transparency was used when sharing knowledge.

When acquiring this form of data, a non-probability (purposive and snowball) sampling technique was used. In addition, a typical case sampling category was assigned this sampling technique; as it "…involve[d] selecting those cases that are the most typical, normal, or representative of the group of cases under consideration" (Teddlie & Tashakkori, 2009, p. 156).

The non-probability technique under the typical case sampling category was incorporated into the study due to its adaptive framework; whilst still complimenting key features associated the mixed methods research design as:

> …representativeness is most often associated with probability sampling…there are also situations where the QUAL researcher is interested in the most typical or representative instances of a phenomenon of interest (Teddlie & Tashakkori, 2009, p. 156).

Non-probability sampling was a technique adopted to emphasise the understanding that participants were identified in relation to a predetermined set of characteristics and selection was not purely random.

Or as Daniel (2012, p. 66) states: "…does not give some elements in the population a chance to be in the sample" and, therefore, was not truly representative of the general population. Though the researcher did try to maintain a sense of reliability and trustworthiness to the selection process, it was acknowledged that purposive sampling as the main method to the participant selection criterion was seen as limiting.

To overcome this limitation, the researcher negotiated with a gatekeeper at the University of Witwatersrand Registrar's office to identify and randomly invite individual's (Wits students' who met the study's line of interest) to participate in the research undertaking. This approach was used to account for the primary investigator's selection bias as well as to maintain a participant's anonymity in the quantitative data collection process (expanded on below). Building on this, should the predetermined population sample size not be met, the researcher would rely on the snowball sampling technique. For Bell et al. (2015, p. 396):

> Snowball sampling is a sampling technique in which the researcher samples initially a small group of people relevant to the research questions, and these sampled participants propose other participants who have had the experience or characteristics relevant to the research. These participants will then suggest [or invite] others and so on [to join].

When exploring the technique further, a questionable feature associated purposive sampling was the sample size. As specific characteristics were used to define eligibility to participate in the study, the initial sample population was generally small. This was because "purposive sampling leads to greater depth of information from a smaller number of carefully selected cases…based on expert judgements" (Plano Clark & Creswell, 2008, p. 208).

However, as this investigation was positioned within a mixed methods research design, a "qualitative nested in quantitative strategy" was used to define the sampling parameters of the study (Leavy, 2017, p. 178). In other words, initially a large quantitative sample size was drawn and from this population group a smaller sample size was randomly selected to represent the qualitative perspective. This enabled the investigator to generalise findings to the broader population, while still giving voice to the individual's experience.

To obtain a more inclusive representation of the South African demographic, the researcher had negotiated that participant were drawn from the target population: 1st-to-3rd year undergraduate humanities as well as the master's student population.

It was believed that a broader and more diverse overview could be obtained—in: age, gender, political affiliation, knowledgeability, lifeworld experience, and forward thinking—by focusing on these two distinct tertiary groups.

It should be noted that this study looked to gain additional perspective to how the Wits student perceived and understood the role the NHI policy reform proposes to play in the South African healthcare system and, therefore, did not look to limit participatory inclusion in relation to diversity.

The only defined characteristics framing participation in this research study was tertiary enrolment at the University of the Witwatersrand for the 2021 academic year and the student being registered in either an undergraduate humanities course or in a master's course at WSG.

The researcher had negotiated a total of 300 tertiary students' participant in the online research survey (quantitative); and at the respondent's discretion (voluntarily providing an email address in the online survey, to be considered for a later face-to-face interview) randomised selection of the initial quantitative population resulted in a total of 4 individuals be interviewed (qualitative). The ethical procedures accorded this process are discussed below (section: Ethical considerations).

300 participants were negotiated in relation to diversity of opinion as well as having met a larger data set within a predetermined degree timeframe. The researcher felt that obtaining raw data of the Wits student population would add numerical insight to what the future working class generation thought about NHI and the proposed policy reform.

As this demographic sought additional knowledge in the form of a tertiary education, the researcher was also of the opinion that a certain level of knowledge about NHI as a policy reform would be more easily available. Especially that students had access to the library and computer labs, thus, being able to access key online and social media sources of information. In short, having the ability to inform oneself of the proposed healthcare reform. Also, as the researcher was a student at Wits it was

recommended that negotiating access via the Registrar's Office would enable her to complete the research project within the given degree timeframe.

Again, due to the time given to complete the degree the researcher was advised to keep participants who engaged the interview process small and it was agreed that a total of 4 interviews were sufficient for this study. Particularly, due to the added time needed to transcribe and thematically analysis the recorded interviews. As the study was not a purely quantitative or qualitative study but rather a mixed methods project it was thought the narrative segments could enhance key statistical findings in a more fluid and relatable manner. Thus, giving a relatable voice to relevant findings.

The online research survey was purposively disseminated to the student population on the 17th March 2021 (this date was determined by the Registrar's office on 09.11.2020) to a total of 3616 undergraduate humanities students and 1347 WSG master's students.

However, on Monday, 15th March 2021, most South African universities (including the University of the Witwatersrand) engaged in a nationwide shutdown within the higher education sector until 15 demands be addressed by government; predominantly focusing on clearing historical debt estimated at around "R13-billion" (Macupe, 2021; Moche, 2021; Nkanjeni, 2021; Ntshidi, 2021). This movement negatively impacted on student enrolment and the overall orientation for the 2021 academic year.

Due to the Student Representative Council (SRC) positing that: "Wits (and other universities) postpone the commencement of the academic year to March 30 2021" (Pijoos & Tshikalange, 2021, p. 1); I, as the primary investigator, had difficulty in obtaining participant responses. It is possible that the initial lack of responses could be due to the registered Wits students engaging their academic course work online whilst renegotiating the Covid-19 related lockdown measures as well as rolling blackouts lasting between 2 to 5 hours daily (Winkler, 2021).

These unforeseen nuisance variables and the *#FeesMustFall* protest resulted in the initial participatory request as sent by the Registrar's office producing less than satisfactory results—with a total of 51 responses.

The researcher proceeded to account for this shortcoming by emailing respondents, who had voluntarily consented to a potential face-to-face interview (totally 12 humanities students and 7 WSG master's students); requesting he/she/they forward the survey hyperlink to fellow peers/friends/student groups/colleagues who met the research criteria.

It was explicitly stated in the standardised email (see: Addendum G: Standardised email undergraduate cohort & Addendum H: Standardised email master's cohort) that their participation in this request would not influence the interview selection process but rather was done compassionately

to aid the investigator meet predetermined research deadlines in accordance to the degree time frame.

After 2 weeks the research obtained a total of 64 survey responses—30 undergraduate and 34 WSG master's.

Again, these results were not sufficient in supporting the study objectives. The researcher re-contacted the Wits Registrar's office and motivated her position. The Registrar's office agreed to disseminate a second round of requests of 1 April 2021.

Here a total of 6115 humanities students and 1462 WSG master's students were contacted and invited to participate in the online survey.

After 3 weeks, the researcher obtained a total of 141 responses in the undergraduate cohort and a total of 70 responses in the WSG master's cohort. The researcher acknowledged the shortcoming of not meeting her initial participant estimates and how the findings limit the overall generalisability of the study but due to the time restraints associated this research project and degree, she had to conclude the first phase of the data collection (survey) and begin the second phase; namely, the interviews.

Of the 141 undergraduate participants a total of 54 emails were obtained whereas of the 70 master's participants who engaged in the survey, a total of 14 emails were gathered. To maintain objectivity, the researcher contacted every 18th undergraduate and every 4th master's participant and invited them to a 30-minute face-to-face interview via Zoom.

This randomisation process produced only one consenting interview from the first-round invites in the undergraduate cohort and two from the master's group. Second round of invites were sent, resulting in one consenting undergraduate interview; enabling the researcher to achieve her desired 4 interviews.

Ethical considerations

This study was categorised as minimal risk. The study inquiry was focused on students' perceptions and attitudes towards the NHI policy reform.

Irrespective of the minimal ranking associated with the investigation, the researcher felt it important to not only align the study within accepted ethical guidelines but also obtain formal ethical clearance, ensuring the work conformed with the principles of *do no harm*.

Key areas included how participants were negotiated with and informed, the data collection process, how collected information was kept confidential and analysed, as well as the researcher's motive and procedural approach in engaging and presenting the study.

When approaching key principles associated this study, emphasis was given to Murphy and Dingwall's ethical theory framework. Specifically, the points: "non-maleficence" "beneficence", "autonomy/self-determination", and "justice" (Murphy & Dingwall cited in Atkinson et al., 2007, p. 399).

These points looked to guide the researcher insofar as "avoid harming participants", that the "research produces some positive and identifiable benefit", that "participants are respected", and that all "people are equal" and continually treated as such (Murphy & Dingwall cited in Atkinson et al., 2007, p. 399).

No vulnerable groups (children or cognitively impaired individual's) were sought, and the participating respondents were over the age of 18 years.

To warrant these principles were met, the researcher relied on transparency when obtaining informed consent.

This process ensured that:

- The consent was given by someone competent;
- The person given the consent was adequately informed;
- The consent was given voluntarily

  (Allmark, 2002, p. 13).

The notion of openness and transparency echoes throughout this research undertaking.

At no time did the researcher engage any form of deception or coercion[12] whist negotiating access to the sample population or throughout the data collection process. Focus was on the participants' wellbeing.

The researcher renegotiated her position to fit the respondent's level of comprehension and cognitive capacity (written and verbal language use), their everyday convenience (allowing timely access to the online survey as well as when negotiating the interview schedule) and being mindful of the power-relation (respondents were informed of the forthcoming investigative processes and their role whilst participating; especially, their right to withdraw or even ignore participatory requests). The primary

[12] Manipulating or persuading someone to do something that is not normally done by that person.

purpose was to empower the respondents and ensure their sense of autonomy and self-confidence was not brought into question or compromised in any way.

This study obtained ethical approval from the Human Research Ethics Committee (Non-Medical) at the University of the Witwatersrand, Johannesburg, South Africa. The protocol number H20/10/08 was issued on the 10 March 2021 (Addendum A: Ethical approval). The proposed research process as well as accompanying documentation was approved. These included: standardised introductory email and information sheet (Addendum B: Information sheet – online survey), the online questionnaire (Addendum C: Survey questions), the consent form (Addendum D: Information sheet – interview & Addendum E: Consent form – interview), and the interview schedule (Addendum F: Interview schedule).

After ethical approval was obtained, a request was made to the Registrar's office to be allowed access to the student population. In this email the drafted information sheet was attached. When approved by the appointed gatekeeper at the Registrar's office, an introductory email (including the information sheet and the consent process) invited the Wits student to participate in the online research survey.

The information sheet addressed relevant information, including what the study was about, the role of the researcher, the aim and objectives of the investigation, what was required when participating, the benefits and potential shortcomings of participation, and the respondent's rights; particularly, the voluntary nature of the participation and the right to withdraw at any time.

Contact details were provided; these included the primary investigator, the supervisor, and the Wits Human Research Ethics Committee should the participant require additional clarification, verification, or find the need to report a grievance.

Two forms of consent were obtained.

- First, a mean consent was recorded once the participant purposefully chose to 'submit' the online research survey.
- Second, a verbal consent was recorded for the participants who participated in the face-to-face interview.

Moreover, when negotiating the interview process, the researcher presented the participant an overview and purpose to the face-to-face discussion and purposefully asked consent to audio record the discussion.

Clarity was given to the purpose of the audio recordings (use of narrative segments in the study), the safeguarding of the raw data/transcribed materials as well as the length of maintaining the data (five

years) and how the data will be destroyed thereafter, the participant's narrative ownership, and right to withdraw without any adverse consequences.

The researcher aimed to create an open platform (acknowledging the power dynamic associated the interviewer/interviewee relationship) enabling the participant to feel comfortable to express his/her/their thoughts and feelings without judgement. In concluding the interviews, the researcher continued to encourage an open line of communication enabling the participant the opportunity to contribute additional thoughts or to withdraw from the study, should the desire arise.

As this study looks at experiences and attitudes associated the South African medical sphere, the researcher was conscious and sensitive to the participant's emotional cues. Particularly, in the case where an emotional response was experienced, the researcher would acknowledge the response, propose a break and/or offer that the session be continued at a later time.

Moreover, contact details of the Wits counselling helpline was referred to the participant. These services are free of charge and can be sought via email: info.ccdu@wits.ac.za. Alternatively, the tollfree number was made available: 0800 111 331.

It should be noted, that the questions used to shape the online survey and the interview schedule were not designed to probe or arouse feelings associated a past traumatic experience but explore perceptions related the proposed NHI policy reform.

This research undertaking followed the strict ethical guidelines as set out by the Human Research Ethics Committee (Non-Medical) at Wits University. In the case where unforeseen circumstances were experienced or are perceived to compromise aspects of the study, the primary investigator would seek the counsel of her supervisor. Emphasis was given to the dilemma/issue at hand whilst still ensuring anonymity (the participants personal/identifiable details remain confidential) and reputational integrity (safeguarding their character).

Conclusion

This chapter looked at the various processes associated the research undertaking. As the investigation engages Wits tertiary students' perceptions and attitudes in relation to the South African healthcare system and the proposed non-incremental policy reform, it is essential that an open and transparent approach was given to this study.

Only by openly acknowledging how the research was conducted can additional insight be given any limitations or shortcomings the inquiry or procedural unfolding. Transparency also contributed to the trustworthiness of the project.

This element of trustworthiness could affect how the findings are ultimately perceived and accepted. In other words, a further sense of meaningfulness was given the analytical discussion. Particularly, when engaging the narrative testimonies due the interpretive nature of the presented conclusion.

To safeguard against any subjective bias adversely shaping the study, the researcher was not only conscious of her role in the project but purposefully practiced reflexivity, accounting for how she engaged the participants, her preconceived views/interpretations of the data, as well as what the results and summary findings revealed.

The objective of this investigation was to put forth reliable insights and conclusions that could contribute to and address the potential knowledge gap: how does knowledge influence a student's support or dismissal of the government's complex policy reform agenda?

Chapter 5: Results

Introduction

After much discussion was given the conceptual and ethical structure of this investigation—in theory, literature, and methodology—this chapter presents the quantitative results.

The raw data was analysed to produce summary statistics.

The focus was on the univariant measure of frequencies (percentages) in relation to item analysis. Items are presented thematically in the tabular form and discussed in relation to the statistical observations. In short, informative summaries were used to describe key observations as produced by the analysed data in the table.

It should be noted that due to the statistical nature of this research study, some tables and insights were not included in the following discussion due to the results lending to inferences over sound analytical conclusion. These tables and associated insights can be found in Addendum I: Undiscussed results.

The results

The following discussion extrapolated results from the analysed data. These results are factually discussed in relation to the table item.

Each table represents a thematic summary of the online research survey (see Addendum C: Survey questions).

The data was represented in relation to frequencies. Namely, percentages.

To distinguish between the tabular representations of the two cohorts the researcher had assigned a colour code to distinguish between the humanities and master's group.

This is seen as:

- Colour code blue for the 1st-to-3rd year undergraduate humanities students.
  - Table in the left-hand column in the sections 'Introducing the Wits students' and 'Engaging the South African healthcare system'.
  - The first table represented in sections 'Exploring governance, leadership approaches, and public trust', 'What is really known about NHI' and 'Subjectivity taken into account'.
- Colour code purple for Wits School of Governance (WSG) master's students.

- Table in the right-hand column in the sections 'Introducing the Wits students' and 'Engaging the South African healthcare system'.
- The second table represented in sections 'Exploring governance, leadership approaches, and public trust', 'What is really known about NHI' and 'Subjectivity taken into account'.

Introducing the Wits students

This section looked at data in relation to the respondent's biographical information, associated registration at Wits, and how the students identified/aligned with South African politics.

In short, the following discussion contributed additional context to the analysed data.

Figure 1: Profiling the respondent's gender

1.	Gender
Female	72.5%
Male	26.8%
Prefer not to say	0.7%

1.	Gender
Female	44.3%
Male	55.7%
Prefer not to say	0%

From the 138 recorded humanities responses and the 70 master's responses, seemingly equal gender dispersion was recorded across the two cohorts.

Generally speaking, a more female perspective was represented in the humanities cohort whereas the master's results leaned slightly into the masculine perspective.

The data, however, showed a diverse dispersion was recorded across both groups.

Figure 2: Outlining the students ages

2.	Age
18 – 21	68.8%
22 – 25	10.1%
26 – 29	3.7%
30 – 35	8.7%
36 +	8.7%

2.	Age
18 – 21	0%
22 – 25	5.8%
26 – 29	15.7%
30 – 35	41.4%
36 +	37.1%

The frequency associated age dispersion aligned with socially constructed ideals.

A large proportion of the undergraduate cohort represented the 18- to 25-year-old demographic whereas the majority of the master's cohort were 26 years and older.

This broad distribution of age ranges positioned the data to encompass various perceptions, viewpoints, and attitudes in relation to different lifeworld experiences.

Figure 3: How the degrees represent the cohorts

3.	Degree registered for
Undergraduate first-year	69.6%
Undergraduate second-year	5.8%
Undergraduate third-year	10.1%
WSG master	14.5%

3.	Degree registered for
Undergraduate first-year	0%
Undergraduate second-year	0%
Undergraduate third-year	1.4%
WSG master	98.6%

The humanities cohort encompassed a diverse depiction of the undergraduate degree life-cycle. The majority of the respondents were recorded as 1st year students. Interestingly, a marginal aspect of responses were recorded as presenting master's level studies in the undergraduate group.

The master's cohort denoted a more inclusive representation in their degree trajectory. All registered for a postgraduate master's degree.

Figure 4: Registered time frame to complete the degree

4.	Form of registration
Full-time student	84.1%
Part-time student	15.9%

4.	Form of registration
Full-time student	38.6%
Part-time student	61.4%

Broadly speaking, the data was consistent with Figure 2 and Figure 3.

Most of the humanities cohort were enrolled as full-time students whereas a large proportion of the master's cohort represented part-time registration.

Engaging the South African healthcare system

The following discussion focused on the two-tier healthcare system, the Wits student's awareness in relation to the NHI proposals, and the technical information associated the healthcare reform.

Figure 6: Ensuring healthcare autonomy though a scheme

1.	Do you have private medical aid?
Yes	45.7%
No	52.9%
Not applicable	1.4%

1.	Do you have private medical aid?
Yes	70%
No	30%
Not applicable	0%

The analysed data showed that less than half the humanities cohort had private medical aid.

According to Respondent 2 this could be attributed to: *"Medical aid is like more than R7000 a month."*

When analysing the master's data, results revealed most of the respondents were privately insured.

Figure 7: Experiencing public healthcare practices

2.	Have you ever sought medical treatment at a state-run institution?
Yes	45.7%
No	53.6%
Other	0.7%

2.	Have you ever sought medical treatment at a state-run institution?
Yes	55.7%
No	37.1%
Other	7.1%

Less than half the respondents in the humanities cohort had sought medical care from government-run hospitals. On the other hand, over half the master's cohort had personal experiences in public healthcare. And a marginal few had relied on other means of treatment.

When taking Figure 6 into consideration, a broad conclusion could be made with regards to the undergraduate cohort's lack of sustainable income, thus, resulting in financial limitations to purchase private healthcare.

Figure 8: Feeling toward equitable healthcare

3.	Are you in support of Universal Health Coverage (UHC)?
Yes	55.8%
No	24.6%
Other	19.6%

3.	Are you in support of Universal Health Coverage (UHC)?
Yes	64.3%
No	32.9%
Other	2.8%

Both the humanities and master's cohorts were in general support of UHC. However, a third from both cohorts disagreed.

There were also a marginal few that remained neutral.

This according to Respondent 3 could be because:

> *On the policy side it is a good thing that government wants to do. But on the practical side of things, I doubt that it will be a good health system, once they introduce it. Because I don't think that they will be able to meet the basic minimum that will be required for it to be called a good national health insurance*.

Figure 9: Knowledgeability shaping support of the NHI proposals

4.	Do you FEEL you have enough information to make an informed choice to support National Health Insurance (NHI)?
Yes	14.5%
No	79.7%
Other	5.8%

4.	Do you FEEL you have enough information to make an informed choice to support National Health Insurance (NHI)?
Yes	34.3%
No	61.4%
Other	4.3%

The data revealed that more than half the respondents from both the undergraduate as well as the master's cohort did not have enough information to support the NHI proposals.

However, a third of the master's students felt enough information was provided to support the NHI scheme.

These figures dropped substantially for the humanities cohort. Perhaps lifeworld experience and/or employment played a role in where the dissemination of information took place, thus, influencing the respondent's knowledgeability to support the proposed policy reform.

Figure 10: The accuracy of technical information promoting NHI

5.	The NHI reform is implemented via 3 phases and set to be implemented in:
2025	23.9%
2026	18.1%
2030	10.1%
No date is set	47.8%

5.	The NHI reform is implemented via 3 phases and set to be implemented in:
2025	35.7%
2026	14.3%
2030	24.3%
No date is set	25.7%

Nearly half of the students in the humanities cohort in relation to a quarter of the master's cohort indicated that no date was set to the implementation of NHI (see page 30 for in-depth discussion).

The overall dispersion of the remaining results indicated uncertainty.

With less than a third of the humanities cohort knowing when NHI is set to start.

Surprisingly, the master's cohort seemed slightly less informed. This understanding is best expressed by Respondent 2:

> *I think its 2 years' time, right? Wait was it 2025! 2023 or 2025 it* [NHI] *wanted to be completely live.*

Only a marginal few in both cohorts correctly noted the start date of 2026.

Figure 11: The primary motive endorsing the healthcare reform

6.	The rationale for the healthcare reform should be weighted as follows:
Equity	23.9%
Efficient purchasing	3.6%
Governance reform	8.7%
Equality	35.5%
Not sure	28.3%

6.	The rationale for the healthcare reform should be weighted as follows:
Equity	30%
Efficient purchasing	14.3%
Governance reform	11.4%
Equality	38.6%
Not sure	5.7%

The data revealed that equality was the driving concept motivating the health systems change.

The humanities students were unsure of the rationale behind the policy reform in relation to the politically endorsed notion that NHI is used to promote equity within South African healthcare system.

Moreover, the data shaping the master's cohort findings revealed that nearly a third of the students felt that the rationale for NHI should be based on equitable healthcare.

Both cohorts marginally indicated that the foundational premise of NHI was to improve the efficiency of purchasing healthcare or for structural change within the political domain (see Novelty shaping NHI).

But to date, government has not sufficiently motivated the appropriateness for NHI as a policy reform in relation to current healthcare practices (see Chapter 3: Literature review).

Figure 12: Understanding how the NHI will work

7.	Do you know what a purchaser-provider split is?
Yes	16.7%
No	62.3%
Not sure	21%

7.	Do you know what a purchaser-provider split is?
Yes	30%
No	47.1%
Not sure	22.9%

Another primary concept related NHI was the purchaser-provider spilt.

More than half of the humanities students expressed that they did not know what the puchaser-provider split entailed.

More surprising is that nearly half of the master's cohort also did not know what the purchaser-provider split encompassed.

But a near equal dispersment of ambivalence was recorded across both groups.

The data shows that there was a definite gap in the students understanding of the functioning dynamics of NHI.

Figure 13: How students envision policy changes to occur

8.	I think small policy changes over time are better than a sudden big policy change?
Yes	79.7%
No	13%
Other	7.2%

8.	I think small policy changes over time are better than a sudden big policy change?
Yes	64.3%
No	24.3%
Other	11.4%

The results showed that the majority of the humanities students supported the idea that the proposed NHI policy framework should be implemented over time.

Few opposed the idea of incremental change, with even fewer respondents maintaining a stance of neutrality.

The master's group data also showed that more than half of the respondents were in agreement with the understanding that amendements and changes to the current healthcare system should be implemented incrementally over time.

However, results revealed that nearly a quarter of the master's cohort disagreed with this idea. There were also a periphiral few remaining neutral.

Figure 14: Students understanding of the funding approach shaping NHI

9.	Do you know what pooling refers to?
Yes	18.8%
No	57.2%
Not sure	23.9%

9.	Do you know what pooling refers to?
Yes	42.9%
No	38.6%
Not sure	18.6%

Initially, the data revealed that the humanities cohort were less informed than the master's cohort.

Only a small number of humanities students were knowledgeable with regards to NHI terminology and expressed a generalised understanding of what pooling aimed to achieve.

The master's cohort were more confident in their understanding of pooling. However, further analysis revealed that more than half the respondents accounted for 'not knowing' and 'not sure'.

This broadly suggested that Wits students from both cohorts lacked an understanding of how the NHI intended to approach its funding strategy.

Respondent 4 expands:

> *If I have a question, I'm not even sure 'where do I go?' I feel like there isn't that touch point.*

Figure 15: Students engaging the concept of pooling

10.	Pooling represents?
The merging of private and public healthcare systems	23.2%
The standardizing of medical treatments	8%
A single entity revenue fund	18.1%
Not sure	50.7%

10.	Pooling represents?
The merging of private and public healthcare systems	27.1%
The standardizing of medical treatments	15.7%
A single entity revenue fund	40%
Not sure	17.1%

When analysing how the respondents engaged with the concept of centralised purchasing of healthcare through the pooling of revenue, the results showed that half of the humanitites cohort were not aware of the process.

The master's cohort, on the other hand, were more knowledgeable to the NHI proposals revenue procedures.

Take for example Respondent 3 explanation:

> *What I understand now is that NHI involves the pulling together of resources. Let me just say funds in a big pot by government. And these are the funds that will be used in the provision of such* [healthcare] *services. To provide a structure*.

These result were supported by the finding in Figure 14 and congruent with the results from Figure 10 and Figure 12 that probed the respondents' percieved sense of knowledgeabiltiy in relation to the technical information shaping the NHI proposals. In summary, a knowledge gap was found.

Figure 16: How Wits students perceive health autonomy

11.	I agree that government should control every aspect of the healthcare sector?
Yes	23.9%
No	71%
Other	5.1%

11.	I agree that government should control every aspect of the healthcare sector?
Yes	34.3%
No	62.9%
Other	2.8%

By renegotiating the private versus public healthcare framework, the NHI is structured as purchaser-provider split and functions in relation to a General Practitioners (GP) recommendation and/or referral

to a state-approved healthcare facility within the individual's living radius; thus, influencing if/where a medical intervention would be received and/or if a treatment regimen is needed/approved in accordance to a preapproved system (see page 30 for additional clarity).

The data suggested that both cohorts supported the notion of health autonomy and liberty over government mandated and controlled healthcare.

Moreover, it was surmised that the undergraduate students favoured a more independent healthcare approach in relation to the NHI proposals.

Respondent 1 states:

> *They* [the government] *have to cover people for these* [standard] *things but if you want something over and above that, it will be a personal choice and* [expense] *or something like that…I think it is unfair to be given a list saying we will only help you with this, that is going against your human rights*.

The analysed results from the master's cohort echoed a similar tone to the humanities cohort, but a larger majority felt that government should be in more control of processes related to the South African healthcare system and individual healthcare needs.

Figure 17: Are students involved in the current affairs of NHI

12.	I feel confident in the NHI after the policy appraisal was conducted?
Yes	18.1%
No	28.3%
Not sure	53.6%

12.	I feel confident in the NHI after the policy appraisal was conducted?
Yes	28.6%
No	47.1%
Not sure	24.3%

The data indicated that more than half of the undergraduate students weren't confident in their understanding that a policy appraisal was conducted.

Whereas, only a quarter of the master's cohort lacked confidence in the notion that a policy appraisal was performed.

Interestingly, over a quarter of the master's group were reassured in the results produced from the policy appraisal. And nearly half were not confident in NHI after the policy appraisal.

To date, a NHI policy appraisal has not been conducted (see: policy appraisal on page 7).

These results continue to support the conclusion of a knowledge gap between the Wits students and government dialogue; particularly, with regards to transparency of key technical information about the NHI proposals and the governments role in the scheme.

Respondent 4 explains:

> *…even if you send them an email, we already know that they* [the government] *don't respond to such things or they take a while. So that's why I feel like, nah, it's* [NHI policy] *not open for us to engage*.

Figure 18: Pooling of revenue funds and limiting government maladministration

13.	I agree the pooling of funds will limit corrupt financial practices?
Yes	37%
No	31.2%
Other	31.9%

13.	I agree the pooling of funds will limit corrupt financial practices?
Yes	35.7%
No	55.7%
Other	8.6%

The humanities cohort revealed a nearly even dispersion of results. This saw just over a third of the respondents agreed that the pooling of funds would stop maladministration and/or corrupt practices in government, a third disagreed, and the remaining third stayed neutral.

Results associated the master's cohort presented a more critical stance. With over half the respondents dismissing the notion that the pooling of healthcare revenue would curb corruption and maladministration.

According to Respondent 4:

> *…with the public sector there is so much corruption and I think also in the private sector but then who will manage that* [fund]? *Because I feel like our health sector is in a lot of damages right now*.

Respondent 1 holds a strong stance when stating:

> *Look it just can't work! The maladministration! I just think it* [pooling of funds for the NHI] *can't work! I think the idea is good but the execution, not so much*.

A segmented third in the master's group were more optimistic and the data suggested that these students felt the pooling approach could have more positive results in the new governance framework.

A marginalised few stayed impartial to the question.

Figure 19: Open government dialogue and transparency of technical NHI information

14.	Technical information on the NHI proposal has been publicly motivated and is reasonable in rationale (its appropriateness in relation to alternative designs)?
Yes	18.8%
No	13.8%
Not sure	67.4%

14.	Technical information on the NHI proposal has been publicly motivated and is reasonable in rationale (its appropriateness in relation to alternative designs)?
Yes	32.9%
No	38.6%
Not sure	28.6%

When approaching the rationale behind NHI, the data showed all round hesitancy.

From the humanities cohort, nearly two thirds of the respondents were unsure. Taking a stance in supporting or dismissing the reasonableness of the NHI proposals saw marginal figures.

The master's group were more confident in expressing their views.

Nearly a third of the respondents felt that the NHI proposal was sufficiently motivated to the public.

However, just over a third of the master's students disagreed with the reasonableness in the rationale of NHI.

And while taking into consideration that a large segment of the master's responses remained neutral and overtly supportive notions were not recorded.

This stance is echoed in a sentiment by Respondent 4:

> *You know what; I would say I support NHI. I think it's a good idea with everybody having that access to healthcare. I think it's a good idea but I think my concerns are around the governance of it. And also, those funds! How will they be administered? I just have trust issues about it*.

Exploring governance, leadership approaches, and public trust

This section looked at the relationship between the government and the Wits students. Particularly, the unique interplay between social investment in the public domain and how political confidence was expressed by students.

In the forthcoming discussion, a broad overview was given the data table. This is due to the overall scope of the data collected. To keep discussions meaningful and relevant, the researcher only focused on the survey items that could be linked to or bring additional context to the research question and sub-questions (see page 9). Therefore, selected survey items were highlighted and discussed in

relation to the two cohorts in the summary analysis. This does not mean that the other survey questions and results did not hold relevance or meaningfulness but to avoid repetition or discussing topics that did not contribute the study's aims and objectives some survey items were not actively discussed. Moreover, some of the findings in Figure 20, Figure 21, and Figure 22 have already been analysed and discussed in the preceding results discussion.

Figure 20: Unwrapping Wits student's perceptions of government's motives

Political confidence						
Survey item	**Statement**	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Item 1.	The ANC is abolishing an apartheid system	11.6%	13%	44.2%	15.9%	15.2%
Item 2.	Government has given me enough information to understand the NHI policy reform	32.6%	38.4%	19.6%	6.5%	2.9%
Item 3.	The ANC ensures key political objectives are met for the public good (social investment)	24.6%	26.8%	32.6%	10.9%	5.1%
Item 4.	I am confident in government ability to improve the healthcare system	32.6%	18.8%	23.9%	14.5%	10.1%
Item 5.	Government has acknowledged their shortcoming(s) in the public health sector	17.4%	35.5%	23.9%	16.7%	6.5%
Item 6.	NHI single-purchaser strategy is designed to support the lower-income populace	3.6%	3.6%	42%	34.8%	15.9%
Item 7.	The BENEFITS of NHI are openly promoted	11.6%	18.8%	39.1%	21.7%	8.7%
Item 8.	The CHALLENGES of NHI are openly and publicly discussed	17.4%	26.1%	42.8%	10.1%	3.6%
Item 9.	Government officials simplify complex NHI information for the public	14.5%	23.2%	34.8%	20.3%	7.2%
Item 10.	The NHI Bill represents an incremental policy reform	3.6%	13%	55.8%	23.2%	4.3%

Political confidence						
Survey item	**Statement**	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Item 1.	The ANC is abolishing an apartheid system	17.1%	14.3%	24.3%	17.1%	27.1%

Item 2.	Government has given me enough information to understand the NHI policy reform	27.1%	18.6%	30%	14.3%	10%
Item 3.	The ANC ensures key political objectives are met for the public good (social investment)	21.4%	22.9%	30%	15.7%	10%
Item 4.	I am confident in government ability to improve the healthcare system	37.1%	24.3%	14.3%	17.1%	7.1%
Item 5.	Government has acknowledged their shortcoming(s) in the public health sector	24.3%	21.4%	28.6%	17.1%	8.6%
Item 6.	NHI single-purchaser strategy is designed to support the lower-income populace	5.7%	10%	31.4%	37.1%	15.7%
Item 7.	The BENEFITS of NHI are openly promoted	11.4%	22.9%	25.7%	28.6%	11.4%
Item 8.	The CHALLENGES of NHI are openly and publicly discussed	25.7%	31.4%	14.3%	20%	8.6%
Item 9.	Government officials simplify complex NHI information for the public	15.7%	30%	22.9%	21.4%	10%
Item 10.	The NHI Bill represents an incremental policy reform	18.6%	18.6%	31.4%	22.9%	8.6%

Some policymakers have indicated that NHI was a framework used to abolish the previous apartheid health system.

When analysing survey Item 1. the data indicated that nearly half of the undergraduate cohort were unsure that the narrative 'removing the previous apartheid system' was the primary motive. An almost equal dispersion was found between the respondents agreeing/disagreeing with the statement.

However, the more experienced master's cohort were more varied in their responses. The majority agreed with the idea that NHI was to reform the previous apartheid system. But there was a material proportion of students that disagreed with the statement.

With a quarter of the master's group remaining undecided when deducing the underlying motive for the policy reform.

Survey Item 3. asked if the governments political objectives as set in the NHI proposals could be actualised within the South African context (see page 29 for addition context). The extrapolated data showed that the respondents weren't optimistic.

More than half of the humanities cohort disagreed with the statement. A third remained neutral.

A slightly higher level of optimism was recorded in the master's group.

These results emphasised an understanding associated with public mistrust.

This lack of public trust is, therefore, linked with the current political agenda promoting NHI. However, this notion of mistrust is not positioned within an extreme tone. Indicating the public's awareness that NHI was designed to improve the current system. Furthermore, this finding suggested that government was not blind to the present two-tier healthcare systems shortcomings.

From a critical stance, it could be asked if these statistical outcomes were reliable. Particularly, in relation to the emotive nature of the responses and how previous health-related experiences could influence the respondents' perceptions and/or if the government's lack of transparency and knowledge transfer was done purposefully to motivate a response of political faith from the public.

What the findings showed was that a majority in both cohorts disagreed with the idea that NHI is a policy employed solely for public good (see Figure 20, survey Item 3.).

This understanding even had some of the respondents doubting the Bill's authenticity and credibility.

> *When you see what is happening in the government and in the government hospitals and that sort of stuff; before they roll out the NHI completely, they going to have to up-skill and fix-up those* [public] *hospitals first. And with everything that is going on with Eskom* [electricity provider] *and all of that* [rolling blackouts]*, I just don't think it is really an option for them* [government]. (Respondent 1)

> *It's all the promises and all the bells but actually, because there is so much unknown around it* [NHI] *and all so incredibly vague. It's like they just decided: it's a headliner. They just decided to pump up the machine. They have no real data or what it's gonna look like or how to do it. So, it just doesn't even feel real. It feels like a big fluffy promise; like Santa.* (Respondent 2)

What could be extrapolated from the above discussion so far, students questioned the government's ability to improve the current healthcare system. This understanding was constructed in relation to government's historical conduct insofar as tender irregularities and the misappropriation of funds are concerned (additional insights can be found on page 6).

This point of view was expanded on by Respondent 1:

> *I think if they* [political officials] c*ould stop stealing. They have to start putting the people first! There is corruption in every single country in the entire world but I mean if you are going to steal a billion Rand, just give the people something.*

Findings from Figure 20, survey Item 4. showed that only a marginal few from the undergraduate group as well as in the master's cohort strongly agreed with government's ability to improve the healthcare system.

The majority of the students felt that NHI as a policy was rightly designed to improve the quality of healthcare for the lower-income populace but with governments lack of acknowledgement in relation to current health systems shortcomings, with on average half of the respondents from both cohort's data sets indicating that they were unaware of how the NHI scheme would benefit their personal needs (see survey Item 7.).

Respondent 2 states: "*I feel like it is a political ploy to get votes actually*."

What is really known about NHI

This section explored the Wits student's comprehension of the two-tier healthcare system as well as the proposed NHI scheme.

Focus was given to the respondent's sense of knowledgeability.

Figure 21: Perceptions and understanding of the South African healthcare systems

NHI knowledge						
Survey item	**Statement**	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Item 1.	Enough information is presented on NHI	23.2%	28.3%	31.2%	13.8%	3.6%
Item 2.	The redistribution of medical aid funds leads to equity in healthcare services	9.4%	13%	30.4%	32.6%	14.5%
Item 3.	The purchaser-provider split will improve healthcare services	5.1%	12.3%	52.2%	20.3%	10.1%
Item 4.	Nationalising the medical system will strengthen health practices	18.8%	8%	31.2%	23.9%	18.1%
Item 5.	The pooling of funds for universal coverage will stop corruption	23.9%	22.5%	34.8%	10.9%	8%
Item 6.	An additional public tax should be enforced to support the social objectives of the NHI	25.4%	22.5%	26.8%	14.5%	10.9%
Item 7.	The healthcare system needs a strategic overhaul	0%	2.9%	26.1%	31.2%	39.9%
Item 8.	A non-incremental policy reform will benefit the healthcare system	5.1%	8.7%	55.8%	19.6%	10.9%

NHI knowledge						
Survey item	**Statement**	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Item 1.	Enough information is presented on NHI	20%	24.3%	22.9%	17.1%	15.7%
Item 2.	The redistribution of medical aid funds leads to equity in healthcare services	14.3%	11.4%	30%	31.4%	12.9%
Item 3.	The purchaser-provider split will improve healthcare services	10%	15.7%	35.7%	24.3%	14.3%
Item 4.	Nationalising the medical system will strengthen health practices	21.4%	18.6%	24.3%	25.7%	10%
Item 5.	The pooling of funds for universal coverage will stop corruption	31.4%	21.4%	12.9%	22.9%	11.4%
Item 6.	An additional public tax should be enforced to support the social objectives of the NHI	42.9%	12.9%	18.6%	20%	5.7%
Item 7.	The healthcare system needs a strategic overhaul	7.1%	7.1%	8.6%	35.7%	41.4%
Item 8.	A non-incremental policy reform will benefit the healthcare system	12.9%	14.3%	32.9%	27.1%	12.9%

Three questions were purposefully formulated and strategically integrated into the online survey (Addendum C: Survey questions: Private vs. public healthcare, question 8; Political confidence, question 10; and NHI knowledge, question 8).

These questions were cross-referenced and used to establish if a knowledge gap was present between the Wits student's comprehension of NHI and governments dissemination of technical information shaping the healthcare reform.

The summary results showed that from an undergraduate perspective, the students broadly revealed an understanding in how they would like to experience a restructuring of the current healthcare system but are unaware of the finer aspects associated the NHI scheme, in particular its implementation.

Only a marginal few from the humanities cohort knew that the healthcare policy reform was designed to encompass a sudden non-incremental change (see Figure 20: survey Item 10.), but when inquiring if a non-incremental reform would benefit the South African healthcare system, less than a third agreed (see Figure 21, survey Item 8.).

When simplifying this inquiry, a large majority indicated that they preferred small changes to occur over time in relation to a sudden big policy change (see Figure 13).

In summary, the results suggested that the undergraduate cohort was not confident in how they perceptually supported or dismissed the proposed NHI reform.

When exploring the data from the master's group, it was found that lifeworld experience did play a role in how the policy reform was negotiated and accepted.

Just over a third of the respondents could distinguish between an incremental and a non-incremental approach, while many remained neutral (see Figure 20: survey Item 10.).

Building on this analysis, nearly half of the master's cohort felt that a systematic overhaul was the right approach for the South African healthcare sector (see Figure 21, survey Item 8.).

These figures were further supported in Figure 13 with a quarter of the master's group disagreeing with the idea that institutional change should be applied slowly over time

Therefore, the results suggested that the master's students were more informed about political rhetoric and governance approaches. Also, that the master's cohort were more in favour of the proposed non-incremental policy reform.

Even with a relatively relatable overview associated the government's UHC strategy, Figure 21, survey Item 1. revealed that both the humanities as well as the master's cohort still wanted additional information about NHI.

As a primary process to the functionality of NHI, the purchaser-provider split is explored. This approach is simply motivated via the purchasing of health services in relation to public need.

As touched on in Figure 12, the majority of the respondents in both cohorts did not know what the purchaser-provider split[13] entailed. This result was reaffirmed in Figure 21, survey Item 2. where more than half of the humanities students and just over a third of the master's cohort remained neutral.

When inquiring if the purchaser-provider split would positively improve the healthcare system, the data from Figure 21, survey Item 3. revealed an equal dispersion of neutrality was recorded.

[13] "The NHI Fund will be the single, strategic purchaser of personal health services for the populations. As a strategic purchaser, the Fund will contract directly with accredited public and private facilities at the relevant level of care, including emergency medical services through selective contracting arrangements" (the White Paper, 2017, p. 54).

These finding should be interpreted in relation to a lack of technical knowledgeability. As when rephrasing the processes, a more favourable view was obtained.

Thus, an interesting feature was found when engaging the notion of jargon and/or word choice. Nearly half the respondents from both cohorts favoured the purchaser-provider split when presented with the term *equity* (Figure 21, survey Item 2.).

This reveals that language and word choice framing the technical information is vital when introducing a policy reform.

> *Sometimes I feel like I'm stuck in the middle. Who do I believe* [government or institutions]? *Because this one says this and these people are saying that. So, that transparency, that information is just not there.* (Respondent 4)

The analysed data endorsed the finding that current terminology used to describe the NHI's rationale and reasonability as well as its implementation process is too complex. Also, due to the value-laden nature of the questions the researcher has determined that the results do not contribute further meaningfulness to the overall inquiry. Thus, a neutral stance was taken when engaging the students' general understanding when engaging the various themes of NHI.

Subjectivity taken into account

The concept of choice and autonomy is positioned as a fundamental component to an individual's sense of self and impacts how they interact subjectively and intersubjectively. It also positions how the individual accepts and engages his/her/their every day.

The notion of choice and autonomy is linked to knowledgeability.

Figure 22: Are the student's voice and choice heard by government

Choice and Health Autonomy						
Survey item	**Statement**	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Item 1.	NHI benefits my personal needs	13%	15.9%	42.8%	21%	7.2%
Item 2.	Choosing my healthcare provider and funder is empowering	2.2%	5.8%	23.2%	25.4%	43.5%
Item 3.	The removal of choice over my funder and service provider is the only way to achieved equity and efficiency objectives	20.3%	22.5%	32.6%	17.4%	7.2%

Item 4.	I am confident in my understanding of NHI and the alternative healthcare proposals	18.1%	26.1%	38.4%	12.3%	5.1%
Item 5.	The ANC has my healthcare interest at heart in their policy objectives	31.2%	19.6%	32.6%	10.9%	5.8%
Item 6.	I support the NHI reform	5.8%	8%	50%	21%	15.2%
Item 7.	My choice and voice are taken into account by government	30.4%	30.4%	25.4%	9.4%	4.3%
Item 8.	Opposing or supporting the healthcare reform is a democratic right	2.9%	2.9%	17.4%	26.8%	50%
Item 9.	There are more reasonable ways to improve the health system than the proposed NHI	1.4%	10.1%	42.8%	24.6%	21%

Choice and Health Autonomy						
Survey item	**Statement**	**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Item 1.	NHI benefits my personal needs	30%	14.3%	15.7%	20%	20%
Item 2.	Choosing my healthcare provider and funder is empowering	10%	2.9%	15.7%	34.3%	37.1%
Item 3.	The removal of choice over my funder and service provider is the only way to achieved equity and efficiency objectives	28.6%	21.4%	25.7%	15.7%	8.6%
Item 4.	I am confident in my understanding of NHI and the alternative healthcare proposals	12.9%	18.6%	28.6%	31.4%	8.6%
Item 5.	The ANC has my healthcare interest at heart in their policy objectives	34.3%	17.1%	18.6%	22.9%	7.1%
Item 6.	I support the NHI reform	20%	11.4%	15.7%	25.7%	27.1%
Item 7.	My choice and voice are taken into account by government	31.4%	18.6%	24.3%	17.1%	8.6%
Item 8.	Opposing or supporting the healthcare reform is a democratic right	5.7%	1.4%	8.6%	32.9%	51.4%
Item 9.	There are more reasonable ways to improve the health system than the proposed NHI	14.3%	11.4%	21.4%	25.7%	27.1%

The concept of choice was a critical component to the introduction and implementation of the NHI. Particularly that choice could be positioned in and constructed from misinformation and thereby result in rejection (stemming from a lack of information and understanding) or consciously be negotiated and purposefully embraced.

For informed choice to be made, transparency of information is needed.

The unfolding process of informed decision-making engaged the understanding that information and propositions are evaluated in relation to past experiences and their outcomes.

With South Africa's widely publicised bureaucratic shortcomings; themes related fraud, corruption, maladministration, and a skills shortage are undeniably influential elements shaping public perceptions.

It is from this context that UHC is positioned and NHI is proposed to the South African public. Admittedly, this is not a promising start for the NHI Bill. When presenting this dilemma to the respondents, just over a third from both cohorts felt that the pooling of funds would limit corrupt financial practices (Figure 18)

However, the undergraduate cohort were more optimistic in their outlook with just shy of a third remaining neutral (Figure 18).

This indicated that the sample demographic was more open to negotiating their current perceptions and attitudes towards governance shortcomings.

It is rather the older generation that saw little change happening to current political practices. Here over half of the master's cohort disagreed with the notion that the NHI policy framework would minimise political corruption and fraudulent practices (Figure 18).

As South Africa functions as a democracy, the concept of choice and autonomy was accepted as a form of empowerment. The data analysis supported this understanding.

According to Figure 22, survey Item 2. a large majority from both cohorts agreed that choosing a healthcare provide was empowering.

These results contrast governments approach as stipulated in the NHI proposals. Here the government aims to determine the public's healthcare needs and right to health autonomy (see a quote express by Dr Zweli Mkhize on page 30). This would be achieved by renegotiating the current two-tier structure into a state-controlled and run system.

Respondent 3 is of the opinion:

> *It has been established in economics that government is not a good manager of things. Not just in South Africa but in most countries…And government in South Africa have demonstrated they cannot manage State-owned Enterprises.*

Moreover, the students felt that an alternative way could be formulated to achieve the desired outcome of national healthcare equity.

According to the data shown in Figure 22 survey Item 3. less than a quarter of the humanities cohort as well as the master's cohort agreed to the premise that the removal of choice in determining one's medical funder and healthcare service provider would ensure free and fair healthcare for all.

Respondent 4 believes that UHC would take away his/her/their independent choice, especially if NHI as the predominant scheme does not deliver a certain level of quality care.

> *I always feel like the private sector – if I'm not happy with the public sector, there is that option to go private. Will I have that option with NHI to say that: 'they* [the government's] *not providing the services' where do I go? I'm not sure if it will cater for such needs*.

This narrative segment reaffirmed the analysed finding in Figure 22, survey Item 3. that self-autonomy and choice were fundamental characteristics to how the Wits student's population perceived and constructed their sense of identity within South African society.

The data also showed that subjective choice and voice was not high on the political agenda. With more than half of the respondents from both cohorts believing that their voices or choice were not taken into consideration by government.

Respondent 2 sarcastically retorts:

> *That is a complete nightmare and the most ridiculous level of control: 'we* [the government] *not going to give you proper healthcare but we not going to let you access your own'. That is catastrophic for the country, honestly!*

As seen in Figure 22, survey Item 8. an overwhelming majority of the undergraduate cohort as well as the master's cohort indicated that irrespective of their subjective stance towards the proposed policy reform, voicing one's opinion was a democratic right.

When engaging the notion of an alternative approach to improving the current healthcare system, many of the participants from both cohorts were broadly in favour of UHC as an ideal.

However, nearly half of the undergraduate population maintained a neutral position (see Figure 22, survey Item 9.).

From an interpretive point of view, it is asked: could this finding be indicative of a lack of choice or rather due to a limited understanding of what the NHI encompasses; particularly, with undergraduates being more open to debate and, thus, persuadable.

Respondent 1 felt South African politics holds little weight and exclaims:

> *I will no longer be voting for the DA because of everything that has happened. So personally, I wouldn't even pay much attention to what the DA or politics has to say!*

On further analysis, this narrative shows that little attention is given to the opposition and this limits choice. And as the data presently reflects, the NHI as a policy framework in conjunction with government rhetoric was perceived as lacking.

Respondent 2 states:

> *I feel like if this country or any country got it* [UHC] *right, no one would spend money on private healthcare services. But when healthcare system is not right and it's failing and it's corrupt and it's broken; who is going to put their health at risk because the government say: 'Oh no, we got this' when they clearly they don't!*

According to the results produced by the master's cohort, seen in Figure 22, survey Item 9. there were more reasonable/favourable ways to improve the health system than relying solely on the proposed NHI policy reform.

Conclusion

In concluding this chapter, findings showed that the current political approach used to renegotiate the two-tier healthcare system to embrace key concepts of UHC were not ideal.

This had motivated an understanding that the Wits student population were not in full support of the NHI policy reform—from the perceptual framework and design to its unfolding functionality and sustainability.

It was found that the NHI scheme would privilege the lower socio-economic demographic whilst putting additional financial burden on the middle-to-upper tax paying populace.

Moreover, it was expressed that the NHI as a policy would reposition political members and associated cadre allies in an elitist position. This understanding was particularly problematic when exploring the

purchaser-provider slit and political accountability towards the pooled monies used to buy healthcare services.

Chapter 6: Discussion of results

Introduction

This chapter presents the researcher's interpretation of the results. A summary overview is given in relation to the results chapter. This analytical approach intends to add contrast and complexity to the findings.

When beginning the investigative process, the researcher negotiated key questions to help guide as well as give structure to the study.

A principal research question was used within the context of a hypothesis. And six sub-questions were designed to guide the researcher in comprehensively answering the main research question.

This section looks to bring forth insightful summaries with the express intention of answering the primary research question: what impact does knowledgeability of NHI, during the 2021 academic year, have on Wits students' perceptions, attitudes, and behaviours in supporting the governments complex policy reform agenda?

Engaging the research sub-questions

Before a dedicated discussion could be given to the main research question, focus was placed on the sub-questions. By answering each of these questions, additional context was given the primary question that shaped this study process and overall investigative gaze.

1. What does the external stakeholder really know about NHI?

The analysed data revealed that the external stakeholder, as represented by the Wits tertiary student, was consciously aware of UHC and South Africa's political drive to reform the current two-tier healthcare system. But when probing for more specific information, both the humanities cohort as well as the master's cohort lacked confidence in stating common place knowledge in relation to NHI (see Figure 21). From when the scheme is set to be implemented and fully functional; encompassing the various phases associated the procedural process of seeking medical care. Also features related the practicality of the purchaser-provider split—how healthcare services will be negotiated and brought forward for public wellbeing.

As concluded in Figure 21, a high percentage of the respondents were unsure about the finer details associated the NHI proposals and policy reform. The researcher acknowledged that the value-laden nature of the questions used in this section of the online research survey could have influenced this outcome but when reviewing the findings in relation to the previously discussed literature a theme was found.

A knowledge gap does exist between how the Wits students understand and engage the technical information shaping the NHI policy. However, by further investigating this theme in relation to published literature in Chapter 3 (see External stakeholders, Public opinion and knowledge of NHI, Credibility of choice) the researcher found that other investigations drew a similar conclusion (see Setswe et al. Booysen and Hongoro (2018); Tandwa & Dhai (2020)).

The narrated testimonies supported the statistical findings insofar as the technical knowledge framing the NHI healthcare system is not easily accessible by the public (see Respondent 4). Again this is supported by a summary conclusion made by the Davis Tax Committee . Also the respondents were unsure of where to inquire to obtain more information on the NHI proposals and policy reform. This revealed a shortcoming in the use of media-based technology to transfer key information to the broader public (see page 42).

However, in the case where the respondent knew where to direct his/her/their inquiry; it was, thereafter, expressed that a valid, reliable, or timeous official response would not be obtained. From Figure 20 findings showed that the respondents felt that officials were unresponsiveness in forwarding technical information with regards to the NHI proposals. These findings are supported by Mukwena and Manyisa (2022, p. 2):

> …this wonderful [NHI] proposal is fraught with difficulties, as the healthcare system is fragmented and in need of repair as suggested in the Phase 1 of the NHI pilot project evaluation report in South Africa, which revealed that the implementation of the pilot intervention had mixed feelings across the pilot districts. These include the lack of strong political will, inadequate human and financial resources for implementation, poor/lack of coordination and communication, and a lack of monitoring systems put in place at the time of implementation.

Though the concept of UHC was widely accepted by the sample population (see Figure 8), the majority of the respondents felt that additional information was needed with regards to the NHI policy reform (see Figure 9) and how the systemic change would affect their healthcare needs and wellbeing (see Figure 16).

2. Does the Wits student think enough information is presented to make an informed decision to support/oppose the NHI policy reform?

When this research was undertaken, findings revealed that the students did not have enough technical information to actively support but neither dismiss the proposed NHI policy reform (see Figure 9). This understanding is further emphasised by Figure 10—when is the NHI implemented (see introductory

overview as well as page 30 in support of the findings that showed a knowledge gap is evident in relation to common place technical information framing the NHI).

The respondents were of the view that a more transparent and open line of communication was needed from government officials and policymakers (see Figure 10).

Primary emphasis was placed on the premise of choice (see Figure 22). This finding is supported by Ruth Passchier (2017) which echoes the importance of civic engagement in the policy reform process. Thus, if technical information is not adequately put forth by official sources a gap in knowledge ultimately establishes the basis by which public decisions are made. This indirectly influences an individual's credibility of choice (see further discussion on page 40).

Figure 11;Figure 11 Figure 20; and Figure 21 support the understanding that without a meaningful knowledge transfer the respondents felt that they could not adequately choose to support or oppose the policy and thereby removing their right to take a proactive position in the healthcare debate.Figure 11

Due to the limited dialogue from government, the students felt that their voice was ultimately overlooked. This prompted some to question the political motives promoting the non-incremental healthcare reform. The concept of a non-incremental policy approach is expanded on page 16 but engages the concept of sudden change over small corrective measures made over time. Though the NHI proponents now argue that they will implement the policy incrementally, it is still not an incremental approach due to the radical nature of the proposed institutional approach.

According to the Minister of Health, Dr Joe Phaahla:

> NHI is not going to be something that happens at a go, at full blast…Medical schemes will continue to cover those aspects that NHI is not covering at the introductory level (in Kahn, 2022, p. 1).

Said in another way, both the humanities as well as the master's cohort were of the opinion that by limiting key information, government could implement the NHI scheme for manipulation to serve elite interests (see the theoretical discussion on Elite theory and further explanatory thoughts on page 36).

3. How informed is a Wits student concerning the merits/demerits of the NHI policy?

Due to the fragmented past shaping South African history, the concept of human rights is a sensitive topic; particularly when these rights are infringed upon. The concept of democracy within the South African context was discussed in Chapter 1: Background and further engaged in Dialogical discourse and political promises as well as in Credibility of choice.

As universities promotes freedom of speech and an individual's sense of autonomy, the notion of democracy is a driving component to the social construction of South African reality and the student's lifeworld experiences therewith. Moreover, how students perceive democracy influences how they social construct themselves as an individual as well as being part of the broader community. In other words, giving an individual a sense of belonging and citizenry (see External stakeholders).

When reviewing the data, it was found that the Wits tertiary students were aware of his/her/their democratic rights as a South African citizen. This understanding was supported overall by Figure 22 particularly Item 8. Here it could be seen that the students believed that their civic right to democratic debate is upheld. This finding is in line with the South African constitution; discussed at length in the literature—see bookmarks to: Governance participatory democracy and Democracy.

From a democratic point of view, the respondents felt that their voice was important within the healthcare debate. However, current knowledge related the NHI proposals seemed to be lacking. According to Figure 12, Figure 14, Figure 15 and Figure 18 the results showed that knowledge about the technical details of the NHI was not confidently approached.

Each of these survey questions engaged concepts related to the proposed financial management—the purchaser-provider split and the pooling of healthcare funds—of the NHI as a healthcare service. These findings are in line with the current literature debate of Kahn, 2019; Michel et al., 2020; Cameron, 2020b; Gonzalez, 2019; and Roodt, 2018 (see page 6).

Again, the concept of UHC was encouraged (Figure 8). But when probed further, Respondent 4 and Respondent 2 echoed an understanding that though the current private versus public healthcare systems revealed an unequal and potentially broken system; little faith is placed in the NHI reform (see page 76).

This could be due to the identified knowledge gap; the lack of technical knowledge shaping the NHI (expanded on in the literature page 31). This inadvertently influenced an understanding of pessimism in health service deliverability and sustainability, thus, putting into question the long-term merits of NHI (see Respondent 2 statement).

4. How is support/opposition affected by a tertiary level understanding (of the proposal)?

Tertiary level comprehension and appreciation does not seem to play any significant role in understanding the complexities associated the NHI proposals or the policy reform.

This could be due to the limited transparency in relation to the transferal of technical information. As seen in Figure 9 the students openly stated their lack of knowledgeability towards the NHI. This finding

in relation to Figure 22 Item 7.—where the students felt that their voice and opinion are taken into account by government—does present opposing views.

This could be due to a limited engagement in the use of current technological mediums like social media and radio. In short, the identified knowledge gap could be attributed to a lack of open dialogue from government to the public.

By reviewing government dialogue, attention needs to be given the use of terminology and the explanation therewith. As Figure 14 and Figure 15 have shown, current understandings associated the key financial mechanism of the NHI scheme is vague. Here funds and an additional surcharge tax are pooled into a singular fund used to purchase healthcare services for the public (see mandatory prepayment scheme on page 30 for additional context).

When complex terms were simplified or clarified in the online research survey or within the face-to-face interview discussion, the respondents seemed to engage the topic at hand with more enthusiasm. Moreover, subjective opinions were shared, enabling the researcher to obtain additional insight to the Wits students' attitudes and perceptions on NHI, political engagements and governance protocols, as well as the public's receptiveness of this systemic healthcare change (see analysis section Engaging the South African healthcare system, Exploring governance, leadership approaches, and public trust, What is really known about NHI, as well as Subjectivity taken into account).

The key focus was placed on the students' voice and ability to express his/her/their feelings towards the two-tier healthcare system and what impact the NHI Bill would have on addressing current health-related shortcomings.

Figure 22 and the interview discussion produced various points of views. However, once analysed a generalised view determined that as far as current healthcare practices are concerned, improvements are needed. This is particularly concerning insofar as taking into account an individual's sense of health autonomy. According to Figure 16 and Figure 22 Item 2. the respondents felt that their health autonomy should be determined subjectively.

The notion of UHC (see Understanding universal health coverage in the literature review) was openly embraced and seen as procedurally correct in ensuring equity is given to the people (see Figure 8). But it was from a South African governance perspective that the students had their reservations. This is expressed by Respondent 1 and Respondent 2 who believe that the current motivation behind the NHI policy are somewhat hollow and before the scheme could be implemented government should focus on fixing up and rectify the current shortcomings of the two-tier healthcare system.

This finding could be attributed to a lack of open dialogue between government officials and the students' whereby prompting a sense of hesitancy to the NHI scheme. In conjunction with Figure 9 and Figure 17, the literature highlighted criticism towards the policy design and overall framework, administrative bureaucracy and skills, safety protocols deterring fraudulent activities, the authoritative approach to healthcare protocols from government, deliverability of medical consumables and adequate healthcare services, as well as the maintenance of hospital infrastructure (Treatment Action Campaign, 2018, p. 1; Health Market Inquiry, 2019, p.204; GENESIS, 2019, p. 15-16; Nt'sekhe, 2018).

5. Has the reform been sufficiently clarified for the Wits student population to understand their advantages and disadvantages thereof?

According to the statistical as well as the interpretive data, the results indicated that information related the NHI proposals and policy reform was not perceived as inclusive, explanatory, or enlightening to the Wits student population.

This above statement is supported in the understanding that the respondents did lack knowledge with regards to the NHI policy proposals (see Figure 13, Figure 19, Figure 20 Item 8. and Figure 21 Item 1.) and, therefore, could not openly agree with the envisioned healthcare strategy.

Furthermore, Figure 22 Item 7. reveals that the respondents felt that their voices were overlooked by government.

Though some participants knew where to inquire for additional information, a lack of government response was disheartening for these respondents. This resulted in the participants questioning: 'what the point was in their quest to obtain more information' as their inquiry was deemed unimportant to government and/or their representatives. Respondent 4 echoed an overall understanding insofar as the public's voice and overall concern was meaningless within the healthcare policy reform process.

It was, therefore, surmised that transparency of technical information from government officials to the Wits student cohort needed redress. This understanding was supported by the literature (discussed in Chapter 1: Introduction and Background) and analysed findings that the respondents were despondent to the NHI proposals (see Figure 9 and Figure 17). As summarised by Respondent 4, the respondents did not feel comfortable making an actual decision to support or dismiss the healthcare reform.

As seen in the findings shaping Figure 12, Figure 14 and Figure 15, the technical terminology framing the NHI proposal lacked satisfactory comprehension. Interestingly, the master's cohort did reveal a somewhat more confident approach to funding strategy namely, "pooling". However, the statistical

values were only marginally better than the undergraduate cohorts. Also, at times in the interview session, the respondents prompted the researcher to clarify broad technical terms associated with and used to motive NHI; this requested clarification of technical information was used to make a more informed decision to contribute the interview discussion.

This reveals that the policy reform has not been sufficiently discussed with the external stakeholder. Particularly, questions that clarify and/or build additional context to the NHI scheme and governments role in the deliverability of and/or the short- to long-term sustainability of the healthcare system. This understanding was of primary concern for Respondent 3 who reflected on both the policy agenda as well as the practical implications needed to improve the current two-tier healthcare system.

6. What features of the debate influence support/opposition for the proposal?

The findings indicated strong support for the notion of UHC (see Figure 8). The majority of the participants believed that the ethos that drives the idea of equity in healthcare was vital to a democratic society as well as keeping with the global consensus ensuring healthcare equality to all (see Figure 22 Item 6.).

When unwrapping UHC within the South African context, the responses showed that the idea behind the UHC concept is embraced, especially when reflecting on the lifeworlds of the lower economic income bracket populace (Kruk et al., 2018, p. e1196; World Health Organization, 2021).

As discussed in the section Credibility of choice, the respondents were also concerned at how the government is renegotiating the two-tier healthcare system in favour of NHI. This understanding was informed by the experiences shaping State controlled enterprises; namely, maladministration and the misappropriation of funds in SAA, Eskom, PRASA, SA Post Office, and so forth (see Winkler, 2021 and the statement made by Respondent 3). Respondent 1 summarise this understanding with the view that government should focus on fixing the current system in favour to a systemic overhaul of the current healthcare system.

In reviewing the NHI as the favoured healthcare policy reform, resulted in a sense of hesitancy among the respondents. This could be due to the respondents age (Figure 2), ability to afford medical aid (Figure 7), and government's lack of open dialogue (Figure 20 Item 5.) in expanding on the technical information used in the scheme.

From the interviews, a key theme was found; namely, information on NHI is limited. This finding is in line with a statement made by Alex van den Heever in Mazibuko, 2019. Furthermore, when the student sought additional information in relation to the proposed healthcare reform, the governance

structures shaping the scheme as well as its perceived functionality; many students from both cohorts felt perplexed that their inquiries and voice was so easily overlooked (see Figure 22 Item 7.).

The statistical as well as the interpretive analysis found that the respondents were hesitant in blindly accepting government's political rhetoric; this was particularly due to the infringement of a student's rights to voice their concerns. Figure 17 emphasises this understanding when reviewing the notion of the NHI policy appraisal. Nearly half of the undergraduate cohort where unsure if a policy appraisal was conducted and 47% of the master's cohort were not confident in the findings.

Interestingly, to date, a NHI policy appraisal has not been conducted (IMSA, 2009, p. 6; Maphumulo & Bhengu, 2019, p. 9; Malakoane et al., 2020, p. 12; see additional discussion on the policy appraisal on page 7).

Thus, a lack of open dialogue between political officials and government with the Wits student population has created a sense of hesitancy to openly embracing the NHI policy reform. This understanding should also be generalised to the broader South African population insofar as how will the various socio-economic class embrace and even benefit from this healthcare scheme.

Discussing the research question

The discussions and summaries related to the above sub-questions have allowed the researcher to draw the following conclusion with regards to the main research question: What impact does knowledgeability of NHI, during 2021 academic year, have on Wits students' perceptions, attitudes, and behaviours in supporting the government's complex policy reform agenda?

This study found that the concept as well as the applicability of knowledge was, and is, a relevant feature associated the healthcare policy reform process. The respondents were aware of the global initiative and drive for UHC. But probing further resulted in knowledge gaps. These findings are reaffirmed in a 2015 study by Setswe et al. as well as a 2018 study by Booysen and Hongoro (see page 39 for additional context).

Technical information framing the NHI proposals as well as the process for adopting the proposed policy reform was lacking. So much so, that the data revealed that even rudimentary information associated the NHI start date was missing. This finding is supported in Figure 9 and Figure 10.

Respondents felt that the healthcare system, especially from a private practice perspective, is a vital component to the South African reality and one's wellbeing. Though none of the interviewed participants openly claimed to be diagnosed with a chronic illness, it was echoed that health autonomy should not be overlooked (Respondent 1 expands this understanding when reviewing the data for Figure 16). This understanding was reaffirmed in the quantitative data; with a majority of the

undergraduate cohort as well as the master's cohort (see Figure 16 and Figure 22, survey Item 2.) supported the view that choosing their healthcare provider is a critical component to their everyday lifeworld reality. It also influences their sense of self-empowerment.

The study found the government lacking in relation to their openness in presenting technical healthcare reform information to the Wits student. This is in support with the literature review (see further discussion on a lack of transparency on page 6). And the tertiary population did echo worrying sentiments in how government will negotiate the current two-tier healthcare system to incorporate NHI as well as its long-term sustainability (Kahn, 2019; Michel et al., 2020, p. 4; Cameron, 2020b, p. 1; Gonzalez, 2019, p. 1).

Moreover, this line of thought roused additional concerns when reviewing the financial implications; particularly, when exploring the complexities that define the South African socio-economic landscape. According to Gonzalez (2019, p. 1) the Green Paper stipulates that an additional 3% tax increase is needed to support the NHI. Simply put, with government's agenda in delivering equitable healthcare, the tax paying bracket in South African need to renegotiate their financial contribution via surcharge taxes.

To date, these additional monetary implications have not been accurately discussed or presented the public. This is reaffirmed by the Minister of Health Dr Aaron Motsoaledi who stated "a total cost of the system is impossible to calculate and it is up to National Treasury to fund it" (Roodt, 2018, p. 1). Rather broad overviews and generalised remarks have been publicly made whereby ensuring more definitive strategies will be presented the public in time. A more contextualised discussion is presented in Chapter 1: Background.

Again, these ambiguous remarks have prompted the respondents to question the reform and some have inquired for further information. As summarised by rRespondent 4 these inquiries resulted in disappointment.

In concluding, the 2021 academic Wits cohort were not overly optimistic towards the proposed healthcare reform and government's strategy in implementing UHC. This can be summarised in a statement made by Respondent 2 :

> *That is a complete nightmare and the most ridiculous level of control: 'we* [the government] *not going to give you proper healthcare but we not going to let you access your own'. That is catastrophic for the country, honestly!*

Respondent 2 testimony was negotiated within the context of past experiences of governments' ability to supply quality services in relation to systemic change; namely, the functionality and

deliverability of previously nationalised entities. Further context on nationalisation can be gained on page 5.

As interpretively concluded by the researcher: the concept of UHC was openly and enthusiastically embraced by the students but due to their limited understanding and knowledgeability of the technical aspects shaping the proposed South African healthcare system, an attitude of confusion and element of distrust were recorded. Additional emphasis should be given to how political leaders convey key technical information to the external stakeholder, and public at large.

Thereby sharing technical information is a key construct and feature to knowledge production. And as the Wits tertiary student population is a demographic that thirsts for information and actively questions socially constructed norms, it is only rational to assume that the concept of knowledgeability would play an important role in how these individuals negotiate primary features to support and/or oppose the healthcare policy reform.

What the study found

In drawing the data results and interpretive discussion to a close, four primary findings were extrapolated from this research undertaking.

These findings are:

- A knowledge gap was found between the Wits students and government. Especially in how pertinent health-related information is disseminated by government and, in turn, obtained and understood by students,
- Language use and key terminology played a role in how messages are perceived, thus, putting into question the students right to choice,
- From the student's perspective, confidence was lacking in the NHI Bill as well as government's willingness to change bureaucratic practices to improve the current healthcare system,
- Ultimately, this lack of confidence impacted on the student's sense of health autonomy.

Conclusion

These interpretive conclusions shaping this chapter are intended to provide additional context and insight to identified shortcoming associated the current healthcare system as well as the proposed NHI Bill.

To ensure the success and sustainability of NHI in South Africa, emphasis should be given to how technical information is framed as well as the mode used to disseminate this information.

Broadly speaking, the analysed data indicated that the public is more likely to resist the healthcare reform due to limited information and a perceived lack of knowledgeability. Rather, by openly informing the public, the government is indirectly empowering the people to embrace the forthcoming healthcare changes.

To reflexively evaluate this research undertaking, the following chapter acknowledges the study limitations and shortcomings. Also, relevant recommendations are put forth to aid future investigations.

Chapter 7: Concluding insights

Introduction

This study explored various theoretical themes, statistical data, and subjective perceptions to determine if enough technical information about the NHI Bill was given to the Wits student to support or dismiss the planned healthcare reform.

As the concept of UHC is a global initiative, additional complexity is accorded the proposed systemic change.

The researchers remark

To renegotiate any functioning healthcare structure is challenging, yet alone within the South African healthcare system which comprises of the public sector (primary, secondary, and tertiary) and private institutions.

It has been widely reported on that the public sector which currently operates within the two-tier structure, is lacking (see: Coovadia et al., 2009; Rispel et al., 2016; Maphumulo & Bhengu, 2019; Aikman, 2019; Rozani, 2021). This is not to say that the private sector is not without its shortcomings and faults, but little is left to desire when reviewing health-related service deliveries as provided by the majority of state-run institutions.

Failures encompassing the public healthcare sector are seen on most levels; including but not limited to an inadequacy of skills and corporate maladministration to the shortage of medical consumables and an overall dissatisfactory deliverability of key medical services. It is from this understanding that the government is expecting the students as well as the broader South African public to trust that the NHI scheme will rectify present problems and that the future of the healthcare system will not succumb to these currently experienced shortcomings.

In short, political leaders are promoting the understanding that NHI will be run effectively and efficiently whist delivering quality healthcare from the ethos of equity for all. But history and previous lifeworld experience has taught the external stakeholder that it is important to question systemic weaknesses and politically motivated reforms that result in State controlled enterprises, especially when framed within the context of public faith.

But public faith only goes so far.

This health systems reform cannot fall short and later be overcome through justifications linked to the eradication of the previous apartheid system, skills shortage, bureaucratic oversights, or a lack of

financial viability due to the misappropriation of funds. These go to rationalisations will not suffice when human life is at stake.

It is, therefore, vital that the public's voice is heard.

Additional clarity can be achieved by exploring the concluded results of the research questions, as discussed in Chapter 5: Results and Chapter 6: Discussion of results.

These summary insights can contribute to our understanding. Particularly, the public's attitudes towards NHI, how people perceive the governments modus operandi when approaching the reform, and if/where/what technical information is given and/or identified as lacking, thus, shaping the overall level of public support or dismissal of the policy as part of future legislation.

Shortcomings and limitations

Acknowledging the shortcomings and limitations of this study is important; especially when emphasising the concept of research validity, reliability, and trustworthiness.

Due to the repetitive nature of questions, the term "government" and "ANC" were used interchangeably. By using these terms interchangeably acknowledgement must be given to the complex or even confusing nature that could have caused the high percentage of indecisiveness in the online research survey. This, thus, could be the reason the respondents lacked confidence in taking a stronger stance in their answers.

In this study a primary limitation is accorded the research population. As focus was only given the Wits student population, the researcher acknowledges that the student sample does not accurately represent the public at large. Particularly, in relation to grass-root and community level discussions.

As discussed previously (in the section titled Critically engaging how respondents were negotiated) the study did not meet its initial target population. It was negotiated that a total of 150 undergraduate humanities students and 150 WSG master's students enrolled at the University of Witwatersrand, Johannesburg, South Africa, would participate in the online research survey.

In reality, only 141 undergraduate and 70 master's students' responses were recorded. Of this sample demographic, the researcher met her desired qualitative predetermined sample; totally 4 face-to-face semi-structured interviews.

From a critical point of view, the researcher assumes that not meeting the initial response criteria is attributed to three external nuisance variables.

These include: confusion around registration processes for the 2021 academic year due to coronavirus restrictions; the student protest conflicting with the predetermined survey release date; and the rolling blackouts resulting from the South Africa's failing power grid.

Each of these variables are perceived as disruptive, but irrespective, key features shaping the everyday reality that defines a student's lifeworld and academic experiences. The researcher was, therefore, grateful to have obtained the current recorded responses. As a large majority participated in the study, the researcher was not adversely affected or hindered in her ability to generalise relevant results and findings to encompass aspects of the broader South African population.

Building on this shortcoming, the researcher is of the opinion that the study timeframe did play a role in limiting student participation. Whereby, additional focus could have been given to the snowball sampling technique.

The researcher could have motivated her stance to the tertiary population who volunteered their email addresses in the online survey; with the primary intention of rousing additional quantitative responses. However, this process could not be fully implemented due the strict timeframe shaping the master's degree (2-year course).

From an analytical review, the researcher acknowledged that questions from Figure 21 were value-based and at times leading. As a high percentage of the responses indicated a neutral stance, thematically the inquiry lacks a sense of meaningfulness. The researcher also recognises that her prior knowledge about the NHI, budgetary spending, surcharge taxes, and the redistribution of funds leading to equitable healthcare; did not contribute additional depth nor insight to the inquiry of what is really known about the NHI. Moreover, as the questions were established, and from a methodological point of view could not be changed, a lack of clarity frames the thematic interpretation of the findings. Thus, the results obtained from Figure 21 are positioned as neutral.

The researcher's role in the qualitative practice can be seen as a limitation. This is due to the interpretive and descriptive nature of the study. Particularly, due to the subjective stance of the researcher aspects associated the interpretation, analysing and writing-up of the data could result in research bias.

Throughout this study, the researcher was conscious of her role in the investigative undertaking. She purposefully engaged her subjective perceptions via reflexively accounting for her feelings and attitudes towards this study. Her primary goal was to present the research work in a critical manner that contributes the identified knowledge gap; namely, if the students felt that the government was missing the mark when engaging the external stakeholder.

Moreover, due to the lack of transparency on pertinent technical healthcare information, the students did not feel confident in supporting and/or opposing the proposed NHI Bill. It was, however, agreed that a systemic change is needed within the South African healthcare sector and UHC as an ethos should be the desired outcome.

Future recommendations

In reviewing the study topic, design, and procedure, the following recommendations are made for future researchers:

- Negotiate a larger sample population with a more national scope (engage more universities);
- Allow for more time for data collection, analysis, and write-up;
- Conduct and/or participate in grass root community discussions;
- Explore the viability of educational programmes (aid communities understanding of NHI and the health systems change);

To contextualise the above, the researcher found that elements associated these points can benefit future investigations or academic research project.

Due to the volatile nature of the academic sphere (protests, online classes due to Coronavirus restrictions, rolling blackouts), the researcher is of the opinion that a larger target population (inclusive of more tertiary institutions across South Africa) would add additional contrast and depth to a study. To adequately approach the data collection and analysis phase of a larger sample cohort, additional time needs to be factored into this process.

It would benefit the research if focus is given to grass root discussions and how lower income communities perceive and engage the proposed healthcare reform and NHI Bill. Contrasting views can reveal issues and dilemmas that this study overlooked.

From logical deduction, the researcher perceives the concept of knowledgeability as related to education as a foreseeable problem. Therefore, emphasis can be place on educational programmes that can aid the external stakeholder and communities competently engage government and policy-developers in addressing everyday problems.

In other words, simplify the technical information surrounding concepts related to: what the healthcare reform is or how a process related to the NHI scheme will benefit an individual seeking medical services. Educate the people about what NHI is, what the scheme intends to deliver, and how the policy is sustained economically and within the South African context.

Conclusion

There seems much is left to question. Particularly, how government is approaching the rollout of the Covid vaccination programme during the third wave lockdown; due to the Delta variant.

Furthermore, whilst bring this research undertaking to a close, South Africa experienced its worst public unrest to date. Sparked by the arrest and jailing of the former President Jacob Zuma, on the 12th of July 2021, thousands of his public supporters gathered to loot and destroy shops, malls, and warehouses in the KwaZulu Natal and Gauteng provinces of South Africa (see: Burke, 2021; Chothia, 2021). It was even reported that hospitals and residential homes in the areas of Phoenix, Chatsworth, and Pietermaritzburg were violently targeted and attacked in the unrest (see: Ntuli, 2021; Singh, 2021).

Economically, the country has been brought to its knees as the public rallies to save what little infrastructure is left while battling food, fuel, and medical shortages (see: Evans, 2021; Ward & Sishi, 2021).

Ultimately, this #UnrestSA sees billions of Rands worth of damages to the South African economy, infrastructure, and peoples' livelihoods; with the knock of effect of a compromised perception in any future international investor confidence. And according to Wood Turner (2021, p. 1): "South Africa is drifting off into a mix of crime, economic hardship and political hopelessness".

Thus, how this devastation as well as the pandemic will impact the proposed NHI health systems reform, the researcher cannot critically predict. However, this unprecedented instability has put South Africa in a questionable position both nationally and internationally.

However, in closing, the researcher is of the opinion that the NHI as a healthcare system is a viable option despite the challenges and shortcomings as discussed in Chapter 6: Discussion of results.

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Addendum A: Ethical approval

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

OFFICE OF THE DEPUTY REGISTRAR

10 March 2021

Dr Alessandra Heggenstaller
Staff/Student number (2325733)
Master of Management: Gov (Pub&Dev Sect Monit&Eval)
Wits School of Governance

TO WHOM IT MAY CONCERN

"Wits student perceptions and attitudes of the South African National Health Insurance (NHI) policy reform"

This letter serves to confirm that the above project has received permission to be conducted on University premises, and/or involving staff and/or students of the University as research participants. In undertaking this research, you agree to abide by all University regulations for conducting research on campus and to respect participants' rights to withdraw from participation at any time.

If you are conducting research on certain student cohorts, year groups or courses within specific Schools and within the teaching term, permission must be sought from Heads of School or individual academics.

Ethical clearance has been obtained. (Protocol number: **H20/10/08**)

Research Commencement: (17 March 2021)

Potgieter

Nicoleen Potgieter
University Deputy Registrar

Addendum B: Information sheet – online survey

Dear Madam/Sir

My name is Dr Alessandra Kim Heggenstaller and I am a Master of Management student in the field of Governance: Monitoring & Evaluation, at the University of Witwatersrand School of Governance (WSG) in Johannesburg. As part of my studies, I have to undertake a research project and, thus, am investigating the South African healthcare system and what impact National Health Insurance (Universal Health Coverage) will have on public perception.

The study titled: *South African Healthcare: Perceptions and Attitudes on the National Health Insurance (NHI) Policy Reform* has the support and backing of the University of Witwatersrand, Johannesburg's Human Research Ethics Committee (Non-Medical) and holds formal ethical clearance: H20/10/08.

The research project aims to explore tertiary students' perceptions and attitudes towards the current healthcare system and the envisioned success of the National Health Insurance (NHI) policy reform. Particular emphasis is given to the transparency of technical information by the government cohort and key individuals within the Health Department insofar as how knowledge, or lack thereof, influences public perceptions and support. In other words, how do you understand NHI as a health reform and what impact does public choice(s) have on the overall support of the policy.

As part of this project, I would formally like to invite you to participate in answering an *online questionnaire*. This activity involves you reading a total of 46 questions and according to your understanding, picking or rating, the most appropriate answer. The questionnaire should take no longer than *35 minutes* to complete. Please note that you may withdraw at any time by closing the browser. Furthermore, by completing and submitting the survey, you acknowledge to mean consent. In other words, when formally finalising and submitting your online survey, you cannot withdraw your response from the data collection process of this research or the Google Cloud where your data is stored.

An option will be made available in the online survey for your email address. This option is presented within the context of voluntarily consenting to a potential 30-minute face-to-face interview. Your email address is kept in the utmost confidence on a password protect digital Cloud and is delete once the research report is completed and passed.

Please note that providing your email address, I, as the researcher, cannot ensure total anonymity. However, I will be the only person to have access to the cloud that contains your email information and I will be the only person contacting you; thus, practicing strict ethical protocols in keeping your information as confidential as possible. Should you have any questions in relation to the interview

process and/or any ethical concerns, please feel free to contact me on the detail provided below. Ethical considerations related to the interview process will be discussed in-depth after being randomly selected.

When engaging the online survey, please note that by finalising and submitting the questionnaire, you are unable to retract your answers from the Cloud. Your answers are ensured anonymity due to the numerical nature of the survey design. This means that no identifying personal information will be reveal from your participation – excluding the opinion where you consent to include your email address (for a potential face-to-face interview with the primary researcher).

The benefit of partaking in the study, you will be helping me in completing my Master of Management Degree as well as contributing to existing knowledge related to South African healthcare system, Universal Health Coverage/National Health Insurance, transferability of technical information related to policy reforms, and perceptions in accordance to public choice.

As participation is strictly *voluntary,* you will NOT receive any direct benefits from taking part in this study; there are no disadvantages or penalties for not participating as well as not inserting your email address.

If you have any questions about this research, please feel free to contact me on the details listed below. This study will be written up as a research dissertation which will be available online through the Wits university library website. Findings may also result in the publishing of a peer-reviewed article.

If you have any queries, concerns, or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone: 011 717 1408 or email: hrecnon-medical@wits.ac.za

Should you like to learn more about the National Health Insurance Bill, please see the documents:

- The White Paper Policy (http://www.health.gov.za/index.php/national-health-insurance-right-menu?download=2133:white-paper-nhi-2017);
- Health Market Inquiry (https://www.hfassociation.co.za/images/docs/Health-Market-Inquiry-Report.pdf);
- GENESIS: Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa (https://www.hst.org.za/publications/NonHST%20Publications/nhi_evaluation_report_final_14%2007%202019.pdf);
- National Health Insurance Policy Bill Review (https://docs.mymembership.co.za/docmanager/1e9aea2c-b58d-4aed-b5a2-96187d705aee/00146348.pdf).

Yours sincerely,

Alessandra

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011 717 3944

Addendum C: Survey questions

1. Biographical Data

1. Gender

Female ☐

Male ☐

Non-binary ☐

2. Age

18 – 21 ☐

22 – 25 ☐

26 – 29 ☐

30 – 35 ☐

36+ ☐

3. Degree registered for

Undergraduate first-year ☐

Undergraduate second-year ☐

Undergraduate third-year ☐

WSG Master ☐

4. Form of registration

Full-time ☐

Part-time ☐

5. Political affiliation

ANC ☐

EFF ☐

DA ☐

BLF ☐

IFP ☐

FF+ ☐

COPE ☐

Other ☐

Not Applicable ☐

2. Private vs Public Healthcare

1. **Do you have private medical aid?**

Yes ☐

No ☐

Not Applicable ☐

2. **Have you ever sought medical treatment at a state-run institution?**

Yes ☐

No ☐

Other ☐

3. **Are you in support of Universal Health Coverage?**

Yes ☐

No ☐

Other ☐

4. **Do you feel you have enough information to make an informed choice to support NHI?**

Yes ☐

No ☐

Other ☐

5. **The NHI reform is implemented via 3 phases and set to be implemented in:**

2025 ☐

2026 ☐

2030 ☐

No date is set ☐

6. **The rationale for the healthcare reform should be weighted as follows:**

Equity ☐

Efficient purchasing ☐

Governance reform ☐

Equality ☐

Not sure ☐

7. **Do you know what a purchaser-provider split is?**

Yes ☐

No ☐

Not sure ☐

8. **I think small policy changes over time are better than a sudden big policy change?**

Yes ☐

No ☐

Other ☐

9. **Do you know what pooling refers to?**

Yes ☐

No ☐

Not sure ☐

10. **Pooling represents?**

The merging private and public healthcare systems ☐

The standardising of medical treatments ☐

A single entity revenue fund ☐

Not sure ☐

11. **I agree that government should control every aspect of the healthcare sector?**

Yes ☐

No ☐

Other ☐

12. **I feel confident in the NHI after the policy appraisal was conducted?**

Yes ☐

No ☐

Not sure ☐

13. **I agree the pooling of funds will limit corrupt financial practices?**

Yes ☐

No ☐

Other ☐

14. **Technical information on the NHI proposal has been publicly motivated and is reasonable in rationale (its appropriateness in relation to alternative designs)?**

Yes ☐

No ☐

Not sure ☐

3. Political Confidence

Strong Disagree, Disagree, Neutral, Agree, Strongly Agree

	Strong Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The ANC is abolishing an apartheid system with NHI					
2. Government has given me enough information to understand the NHI policy reform					
3. The ANC ensures key political objectives are met for the public good (social investment)					
4. I am confident in governments ability to improve the healthcare system					
5. Government has acknowledged their shortcoming(s) in the public health sector					
6. NHI single-purchaser strategy is designed to support the lower-income populace (redistribute health benefits to the unemployed/poor)					
7. The benefits of NHI are openly promoted					
8. The challenges of NHI are openly and publicly discussed					
9. Government officials simplify complex NHI information for the public					
10. The NHI Bill represents an incremental policy reform					

4. NHI Knowledge

Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. Enough information is presented on NHI					
2. The redistribution of medical aid funds leads to equity in healthcare services					

3. The purchaser-provider split will improve healthcare services					
4. Nationalising the medical system will strengthen health practices					
5. The pooling of funds for universal coverage will stop corruption					
6. An additional public tax should be enforced to support the social objectives of the NHI					
7. The healthcare system needs a strategic overhaul					
8. A non-incremental policy reform will benefit the healthcare system					

5. Choice

Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. NHI benefits my personal needs					
2. Choosing my healthcare provider and funder is empowering					
3. The removal of choice over my funder and service provider is the only way to achieved equity and efficiency objectives					
4. I am confident in my understanding of NHI and the alternatives					
5. The ANC has my healthcare interest at heart in their policy objectives					
6. I support the NHI policy reform					
7. My choice and voice are taken into account by government					
8. Opposing or supporting the healthcare reform is a democratic right					
9. There are more reasonable ways to improve the health system than the proposed NHI					

From more information relating to the National Health Insurance Policy Bill please see:

- The White Paper Policy (http://www.health.gov.za/index.php/national-health-insurance-right-menu?download=2133:white-paper-nhi-2017);
- Health Market Inquiry (https://www.hfassociation.co.za/images/docs/Health-Market-Inquiry-Report.pdf);
- GENESIS: Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa

(https://www.hst.org.za/publications/NonHST%20Publications/nhi_evaluation_report_final_14%2007%202019.pdf);

- National Health Insurance Policy Bill Review (https://docs.mymembership.co.za/docmanager/1e9aea2c-b58d-4aed-b5a2-96187d705aee/00146348.pdf).

Once you have submitted your responses, you will be unable to retract your participation in this online survey. To finalize the process: please click "FINISH" below to record your response or close the browser to exit the survey.

Thank you for your participation.

FINISH

Addendum D: Information sheet – interview

Dear Madam/Sir

Thank you for your participation in the interview phase of the data collection process. As previously discussed, I am a Master of Management student in the field of Governance: Monitoring & Evaluation, at the University of Witwatersrand School of Governance (WSG) in Johannesburg. As part of my studies, I have to undertake a research project and am investigating the South African healthcare system and what impact National Health Insurance (Universal Health Coverage) will have on public perception.

The study titled: *Wits student perceptions and attitudes of the South African National Health Insurance (NHI) policy reform* has the support and backing of the WSG and holds formal ethical clearance: (H20/10/08).

The research project aims to explore tertiary students' perceptions and attitudes towards the current healthcare system and the envisioned success of the National Health Insurance (NHI) policy reform. Particular emphasis is given to the transparency of technical information by the ANC government cohort and key individuals within the Health Department insofar as how knowledge, or lack thereof, influences public perceptions and support. In other words, how do you understand NHI as a health reform and what impact does public choice(s) have on the overall support of the policy.

The interview will take no longer than *30 minutes*. The interview is guided by strict ethical protocols and formally requests that the interview is audio recorded. Audio recordings will be transcribed by the researcher and email back to you to ensure that the document is authentic to our discussion and accurately projects your voice and thoughts. As I am in direct contact with you and am privileged to your email address, I cannot ensure complete anonymity. However, to overcome any identifying information, I will be using a pseudonym (false name) to represent your participation, in my final research report. This strategy is used to maintain, as much as possible, your anonymity. Furthermore, I will not be asking for any identifying information, and the information you give to me will be held securely, within the context of confidentiality, and not disclosed to anyone else. If you experience any distress or discomfort, we can stop the interview or resume at another time.

Participation in this study is strictly *voluntary* and all information will be held in the utmost confidence. You have the freedom to withdraw from the study at any time, as a result of feeling emotionally vulnerable or uncomfortable in talking about the South African healthcare system, the NHI policy reform, or political governance. Should you feel you would like to withdraw from the study; no further

contact will be made, your details and any collected information/materials will be delete/destroyed with immediate effect, and no adverse feelings of prejudice will be held against you. Your sense of surety and emotional comfort are the researcher's primary concern within the data collection process.

The results of the information collected will be treated with the highest level of respect. Before analysing the transcribed materials, I will email a copy of the transcript to you, verifying that your words are authentic and have been represented accurately.

The benefit of partaking in the study, you will be helping me in completing my Master of Management Degree as well as contributing to existing knowledge related to South African healthcare system, Universal Health Coverage/National Health Insurance, transferability of technical information related to policy reforms, and perceptions in accordance to public choice.

For more information in relation to the National Health Insurance Bill, please see:

- The White Paper Policy (http://www.health.gov.za/index.php/national-health-insurance-right-menu?download=2133:white-paper-nhi-2017);
- Health Market Inquiry (https://www.hfassociation.co.za/images/docs/Health-Market-Inquiry-Report.pdf);
- GENESIS: Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa (https://www.hst.org.za/publications/NonHST%20Publications/nhi_evaluation_report_final_14%2007%202019.pdf);
- National Health Insurance Policy Bill Review (https://docs.mymembership.co.za/docmanager/1e9aea2c-b58d-4aed-b5a2-96187d705aee/00146348.pdf).

As participation is strictly *voluntary,* you will NOT receive any direct benefits from taking part in this study; there are no disadvantages or penalties for not participating. Due to the rising costs of Data and the financial limits associated a tertiary student's budget; I am favourable to negotiating a token of appreciation in the form of a data bundle to the value of no more than R100,00 per interview.

If you have any questions about this research, please feel free to contact me on the details listed below. This study will be written up as a research dissertation which will be available online through the Wits university library website. Findings may also result in the publishing of a peer-reviewed article. If you wish to receive a summary of this report, I will be happy to send it to you upon request. If you have any queries, concerns, or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (non-medical), telephone: 011 717 1408 or email: hrecnon-medical@wits.ac.za

Yours sincerely,

Alessandra

Researcher: Dr Alessandra Kim Heggenstaller

2325733@student.wits.ac.za

082 563 8243

Supervisor: Prof. Alex van den Heever

Alex.vandenheever@wits.ac.za

011 717 3944

Addendum E: Consent form – interview

Title of project: Wits student perceptions and attitudes of the South African National Health Insurance (NHI) policy reform

Name of researcher: Dr Alessandra Kim Heggenstaller

I, ……., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree to the voluntary nature of this study	YES NO
I agree that my participation will remain confidential	YES NO
I understand that the consent from can guarantee anonymity in the reporting. This is achieved via the allocation of pseudonyms when engaging materials accorded your participation	YES NO
I agree that the researcher may use anonymous quotes in her research report by assigning pseudonyms to the extract	YES NO
I agree that the interview may be audio recorded	YES NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by the researcher, and other researchers, subject to their own ethics clearance being obtained	YES NO
I understand that total anonymity and cannot be ensured due to the face-to-face nature of the data collection process	YES NO
I understand my rights; particularly, that I can withdraw my participation from this study at any time without any prejudice	YES NO

…… (signature)
…… (name of participant)
…… (date)

Addendum F: Interview schedule

1. Can you tell me about what you know about Universal Health Coverage?
2. Do you have enough technical information about the National Health Insurance to make an informed decision to support the healthcare reform? Please expand
    a. So, are you confident in your choice to support/dismiss the NHI policy?
3. Can you tell me about the NHI formulary list?
4. Do you think people are blindly accepting government decisions?
    a. Yes, do you think it is based on political allegiance?
    b. No, how are people questioning current decisions?
5. How do you think NHI will work in South Africa?
    a. Why?
    b. What about the bureaucratic mismanagement and corruption?
6. Do you think there are alternative ways to improve South Africa's healthcare system?
    a. Please expand

Addendum G: Standardised email undergraduate cohort

Dear Madam/Sir,

Formally, I would like to thank you for participating in my survey about the NHI policy reform and your willingness to be considered for a potential interview. I have securely recorded your email address and should you be randomly selected; I look forward to our additional communication. Unless specified otherwise – the study is voluntary and you are welcome to withdraw at any time. However, I do need your help.

Due to current protests and institutional disruptions in tertiary learning, would you be willing to forward the below hyperlink to fellow friends/peers/student groups (anyone enrolled in 1st-to-3rd year humanities) who would voluntarily consider participating in this survey. These individuals are also welcome to forward the link on to others.

- The hyperlink:

https://docs.google.com/forms/d/e/1FAIpQLSe8_YviX9fJ6EnF71vKKHVV0o5-7P991QUSOW7JIWq_uxeZKw/viewform?usp=sf_link

PLEASE NOTE: You hold NO obligation to meet this request nor will it influence your chances of being selected/not selected for the interview. You would just be helping me meet strict deadlines.

If you have any questions, please feel free to reply to this email.

Sincerely,

Alessandra

Addendum H: Standardised email master's cohort

Dear Madam/Sir,

Formally, I would like to thank you for participating in my survey about the NHI policy reform and your willingness to be considered for a potential interview. I have securely recorded your email address and should you be randomly selected; I look forward to our additional communication. Unless specified otherwise – the study is voluntary and you are welcome to withdraw at any time. However, I do need your help.

Due to current protests and institutional disruptions in tertiary learning, coupled with our work commitments, would you be willing to forward the below hyperlink to fellow friends/peers/colleagues (anyone enrolled in a WSG master's programme) who would voluntarily consider participating in this survey. These individuals are also welcome to forward the link on to others.

- The hyperlink:

https://docs.google.com/forms/d/e/1FAIpQLSeQQHvlcnc4KpvEhrdQpmjP4y_hyFLcnsHtmgTmf8PH1Rc3kA/viewform?usp=sf_link

PLEASE NOTE: You hold NO obligation to meet this request nor will it influence your chances of being selected/not selected for the interview. You would just be helping me meet strict deadlines.

If you have any questions, please feel free to reply to this email.

Sincerely,

Alessandra

Addendum I: Undiscussed results

Introduction

This section looked to acknowledge findings that did not contribute viable insights to the results chapter. In short, these results can be seen to promote an assumption over statistical fact.

Figure 5: How Wits students identifying politically

5.	Political affiliation
ANC	18.1%
EFF	8.7%
DA	8.7%
BLF	0%
IFP	0%
FF+	0.7%
COPE	0%
Other	5.1%
Not applicable	58.7%

5.	Political affiliation
ANC	18.6%
EFF	11.4%
DA	8.6%
BLF	7.1%
IFP	2.9%
FF+	0%
COPE	1.4%
Other	5.7%
Not applicable	44.3%

From a political point of view, a nearly even data dispersion was found between the two cohort. Particularly, within the leading political parties shaping South African politics; namely, the ANC and the DA.

An interesting result was brought to the fore when exploring student's political affiliation to both the EFF and the BLF. Broadly speaking, both these political parties were positioned as young, vibrant, and energetic in their agendas and both seeking non-incremental reforms to benefit the previously disadvantaged populace.

With the study having engaged the younger tertiary demographic, it was deduced—from the media and political rhetoric—that a large percentage of the respondents were aligned with either the EFF or BLF.

However, the data showed otherwise. With a significant majority of the humanities cohort as well as the master's cohort remaining neutral.

Addendum J: Turn-it-in report

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Submission ID:	1688336417

Prof Alex van den Heever

Wits student perceptions and attitudes of the South African National Health Insurance (NHI) policy reform

by

Dr. Alessandra Kim Heggenstaller

(2325733)

Submitted in Partial Fulfilment of the Requirements for the Degree of Master in Management: Governance Public and Development Sector Monitoring & Evaluation

at

Wits School of Governance (WSG)

University of Witwatersrand

Johannesburg, South Africa

Supervisor: Professor Alex van den Heever

October 2021

Match Overview

6%