

**THE POLITICS OF HEALTH CARE REFORM: A COMPARATIVE ANALYSIS
OF SOUTH AFRICA, SWEDEN AND CANADA**

BY

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Abstract

South Africa is currently in the process health care reform as the Government has undertaken the task of providing universal health care to all South Africans through the implementation of the National Health Insurance Scheme (NHI). This study took an in-depth look at the history and progression of the post-1994 South African health care policy, and applied the Power Resources Theory to the political economy of the current health care reform process in South Africa. Through a comparative study of the pivotal elements in the phases of health reform in Canada and Sweden this study drew lessons for the design and implementation of universal public health care provision in South Africa. This study found that a strong culture of care, strong political will, active civil society participation and a focus on equality as opposed to poverty in the creation of policy is essential to a successful implementation of universal health care.

Key Terms

Health care Reform, Universal Health care, Solidarity, Equality, Power Resources, Political Will, Civil Society, Quality of Government, Welfare State, National Health Insurance.

Declaration

I Kimberley Usher declare that “The Politics of Health Care Reform: A Comparative Analysis of South Africa, Sweden and Canada” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

Kimberley Usher

Date

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Glossary of Abbreviations

AIDS - Acquired Immune Deficiency Syndrome
ANC – African National Congress
CCF - Cooperative Commonwealth Federation
CMA – Council for Medical Schemes
COSATU – Congress of South African Trade Unions
DoH – Department of Health
DoME - Department of Medical Economics
FC – Finance Canada
GDP – Gross Domestic Product
GEAR - Growth, Employment and Redistribution
GEMS – Government Employees Medical Scheme
GMP - Gross Medical Product
GMS - Group Medical Services
HC – Health Canada
HIV - Human Immunodeficiency Virus
HSF - The Helen Suzman Foundation
IMF – International Monetary Fund
KOD - Keep Our Doctors Committee
MDGs -Millennium Development Goals
MSI -Medical Services Incorporated
NDP - New Democratic Party
NEHAWU – National Education Health and Allied Workers Union
NHI – National Health Insurance
NHIL - The National Health Insurance Law of 1947 (Law No.1 enacted 3 January 1947)
NHS National Health Service/System
NUMSA - National Union of Metalworkers of South Africa
OECD - Organisation for Economic Co-operation and Development
PHC – Primary Health Care
PRT - Power Resources Theory
QoG - Quality of Government,
RSA – The Republic of South Africa
SACTU - South African Congress of Trade Unions
SAP - Swedish Social Democratic Party
SAPPF – South African Private Practitioners Forum
SARS – South African Revenue Service
SHI – Social Health Insurance
SMA - Swedish Medical Association
TB - Tuberculosis
UHC – Universal Health Care
UPFS - Uniform Patient Fee Schedule Policy
WHO – World Health Organisation

CHAPTER 1

INTRODUCTION

The Alma-Ata Declaration (1978) defines health as a state of complete physical, mental and social wellbeing and not merely an absence of disease and infirmity. Access to basic health care is described as a fundamental human right, the attainment of which is an important global social goal whose realization requires the action of not only public health departments but many other social and economic sectors (Alma-Ata, 1978). The Primary Health Care (PHC) approach was unanimously adopted as the best means of providing comprehensive, universal, equitable and affordable health at the Alma-Ata by all WHO member countries. PHC was envisaged as “essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development... It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (Alma-Ata, 1978).

The Alma-Ata declaration called for “an acceptable level of health for all people of the world by the year 2000 (Alma-Ata, 1978). However by 2000 this had not been realized by many developing countries. Political and economic changes in the 1980’s and 1990’s led to structural adjustment reforms that reduced government intervention and promoted privatization affecting the health sector drastically (Hall & Taylor, 2003:17). Governments had to contend with a highly inequitable health systems with the public health sector facing major resource challenges. As such, health care reform and research into health care reform has been on the rise in developing countries over the past decade. The Millennium Summit in 2000 established Millennium Development Goals (MDG’s) (2000) as set targets for eradicating poverty. Included in the MDG’s was provision of adequate health services to reduce child mortality, improve maternal health and combat HIV/AIDS, malaria and other diseases (WHO, 2008). Since the millennium development goals the governments of many third world countries have put health care reform on their

agenda and have dedicated substantial percentages of their national budgets to researching, initiating and implementing health care reform.

In an effort to achieve sustainable universal health care South Africa has had ongoing health reform initiatives since 1994, from the Reconstruction and Development Program to the National Health Insurance Scheme (NHI). This study will investigate the history and progression of the post-1994 health care policy but will specifically focus on the implementation of the current reform initiative, the NHI, in an attempt to understand the context, the philosophical, and structural bases of the current health care reform in South Africa. This study is a macro investigation that examines the health reform in South Africa while making a comparison to the Swedish and Canadian reform processes. Using the Canadian and Swedish experiences of health reform for comparative analysis, this study applies Power Resources Theory to understand the nature of health reform as South Africa, like Sweden and Canada, transitions to universal health care.

This study will begin in Chapter 2 with a literature review of health systems and health care reform. Chapter 3 will discuss the Power Resources Theory as the theoretical framework of this study. Chapter 4 will discuss the research design and methods adopted in this study as well as the challenges faced. Chapter 5 will provide a discussion of the Canadian experience of health reform, paying particular attention to the Saskatchewan reform during the period of 1955 to 1964, which spear-headed the national reform to universal coverage and Medicare. Chapter 6 is a discussion of the Swedish experience of health care reform, over a longer time line because the Swedish health system saw a number of small reforms over a longer period of time. These two chapters will discuss the nature of health care reform, in each country, outlining what led to it, what challenges the government faced and how those challenges were overcome to bring about the successful universal health coverage it has implemented. Chapter 7 will discuss the South African context. This chapter will be a broad discussion of the history and nature of health reform policies within post-1994 South Africa. Chapter 8 will be a discussion of the challenges and challengers to the NHI. It will discuss the arguments put forward by the main stakeholder's within the health sector either in favour or in opposition to the NHI policy articulated in the Green Paper. Chapter 9 will conclude with the lessons South

Africa can learn from the Canadian and Swedish experiences as we move forward with health reform process in the implementation of the NHI.

CHAPTER 2

LITERATURE REVIEW

HEALTH SYSTEMS AND HEALTH REFORM

A health care system, according to Berg (1980), is a highly heterogeneous system that “encompasses all health oriented activities performed by those other than the ill person himself” (Berg, 1980:17). Health systems are inherently complex and are embedded in the unique social, economic and political environments that determine the organizational and resource management strategies of each country. They are “strongly influenced by the underlying norms and values of the broader society within which they function” (Saltman *et.al.*, 1998:2). Health systems mirror the deeply rooted societal normative beliefs of the nature of health care itself. Depending on those normative beliefs health care can either be viewed as a collective good from which all members of society should benefit, or it can be viewed as a commodity to be bought and sold for profit on the open market (Saltman *et.al.*, 1998:2). Although the concept of health care as a commodity was popular in the 1980s and 1990s it has been increasingly replaced by the idea of health care as a collective good.

The World Health Report (2000) identifies that the three fundamental goals of a health system are to improve health, to be responsive to the legitimate demands of the population, and to ensure that no one is at the risk of serious financial losses because of ill health. According to WHO a health system includes “all the activities whose primary purpose is to promote, restore or maintain health” (2000:5). Van Rensburg (2004:3), in accordance with the WHO concern that most information on health systems refers only to the provision of or investment in health services, suggests that health systems must be understood in four dimensions. Firstly a health system must be understood “not only in terms of its component elements or parts (human resources, finances, hospitals, clinics, technologies etc) but also in terms of their interrelatedness.” Secondly, in understanding a health system, we should consider not only the supply-side but also the population who are not only beneficiaries, but are also taxpaying citizens who contribute as co-producers of health. Third, we must understand the health system in terms of its goals; for example,

the main goal of health systems in many developing countries is equality. And finally the health system must be understood in terms of its functions including but not limited to provision of health services, stewardship, financing and generating resources (Van Rensburg, 2004).

Within a health system exist both the Public and Private sectors. Public entitlement of access to quality health care falls within the ambit of the Public Health Sector while the Private sector functions along market principles on a for-profit-basis. As the steward for the public's health needs, the Public health sector must function on a basis of universality and comprehensiveness. Van Rensburg (2004:5-6) identifies five components to a public health system:

- (i) Human Resources – consisting of the workforce who are critical to the functioning of any health system.
- (ii) Cultural – consisting of the knowledge, beliefs, ideologies, superstitions, perceptions, procedures and ethics that motivate the health culture.
- (iii) Political Administrative – concerned with the structure, regulation and organization of the health system including administration and legislation.
- (iv) Financial-economic - consisting of financial and economic matters regarding payment systems and funding of the health system.
- (v) Care – which is the gross medical product (GMP) comprising of prevention, diagnosis, treatment, rehabilitation, custody and health education.

The public health system must deal with each of the above mentioned components individually and interrelatedly in order to ensure an effective, efficient and sustainable management of the public health sector. The population however, as co-producers of health also need to be involved in effective health management. Although not in the employ of the public health sector the population must take steps to ensure healthy lifestyles so as not to over burden the health sector with problems arising from ill health. However it is the mandate of the public health sector to work with the public in educating them on healthy living and healthy lifestyles. WHO (2007) noted that it is everyone's business to strengthen the health system and identified six building blocks of a well-functioning health system namely; good health service, efficient health workforce, proficient health information system, equitable access to essential medical products; a good financing system and sound leadership (WHO, 2007). A breakdown in any of these six dimensions has the potential to derail a well-functioning health system. (Van Rensburg, 2012:36). It is therefore the prerogative of every health system to provide

quality service by an efficient health force with a reliable information system using quality medical products within a fair and sustainable financing system.

Functions of a health system

The chief purpose of a public health system is to provide “access to care with financial risk protection to the population” (Kutzin, 2001:172). In order to do this the health system must have systems in place for risk pooling, purchasing and for social solidarity (Hussey & Anderson 2003: 216). The pooling of revenues in any health system is essential to its effectiveness and essential in insuring the population against the financial risks of ill health (Schieber & Madea, 1997). It allows for risks to be spread across a broad pool of individuals thereby reducing the financial burden of healthcare and preventing catastrophic expenditures that come with unexpected health incidents (Lagomarisino *et.al.*, 2012:935). Risk pooling effectively enables cross subsidies from the rich to the poor and the healthy to the less healthy by spreading the cost of health across households with different health and economic profiles.

The manner in which a country collects revenue for health care determines the degree to which the health system is financed either progressively or regressively. Progressive financing of the health system occurs when the proportion of contribution rises with one’s income level, resulting in the wealthier members of the population contributing more than the poorer members. Conversely, regressive financing occurs when the contribution is a predetermined set rate, regardless of income, the result of which is that poorer members of society contribute a larger proportion of their income than the wealthy do. Regressive financing leads to greater inequalities between the various economic groups in society. The organization of the insurance system can influence how efficiently the revenues are collected, the aggregate amount of revenue that can be raised, and how equitably this task is carried out (Schieber & Madea, 1997; Preker, 2005; Hauck, Smith & Goddard, 2005; Smith & Witter 2005).

Health systems are broadly classified as either single-payer or multi-payer health systems. Within a single-payer health system, the government acts as the sole payer bearing the cost of health care to the public. Typically the Public health sector provides health care to the population that is either free or inexpensive at the point of care. In this

system, the government provides universal health care by combining revenue generated from general taxes into a single risk pool covering the entire population. Taxes in this system are issued at a standard rate so that the percentage taxed from income represents the same proportion regardless of the income level (Hussey & Anderson, 2003; Preker, 2005). Single payer systems are considered progressive systems as they allow for greater subsidization of the costs of healthcare by higher income individuals for lower-income individuals (Wagstaff & van Doorslaer, 1992). The governments of countries with single payer health systems essentially have total control over aggregate expenditure which is determined through an annual budgeting process. Policymakers in this system therefore face the challenge of raising revenue to fund the health sector in an equitable and sustainable manner. Health care institutions such as hospitals and clinics are primarily 'owned' by the government or are under government employ. The majority of health care workers are government employees, and those in the private sector (which is usually smaller than and largely influenced by the public sector) collect their fees from the government. The Government, as the sole payer, exercises control over the market and has a big hand in determining the costs associated with care and health care purchasing arrangements (Ensor, 2001; Hussey & Anderson, 2003; Normand & Thomas, 2009). Comparatively, far more countries successfully operate the single payer model than any other model. Examples of such countries include Canada and Australia with Medicare, The United Kingdom with the National Health Service (NHS), and Taiwan with its NHI, all generally understood to provide Universal Health Care to their population (Ferreira, 1999; Gakidou & King 2000; Houtepen, 2000; Ensor, 2001; Kornai & Eggleston, 2001).

Multi-payer health insurance systems are characterized by multiple private health insurance carriers competing in the market and the public sector providing a minimal "essential services" package such as the PHC package. Within this system health insurance agencies offer multiple benefit packages that cover different health services to their members who pay a regular contribution to the scheme for health coverage. Consumers are thus afforded a choice of insurer, and a choice of benefit packages. Multi-payer systems operate with multiple pools of risk, depending on health conditions, health risks and income (Hussey & Anderson, 2003; Preker, 2005). This type of health system, however, benefits those who can afford it. Individuals are classified on a scale of high to

low risk: high risk being those that are less healthy and thus more likely to opt for more comprehensive and consequently more expensive health insurance packages. The majority of the population in most developing countries cannot afford the exorbitant price of health insurance, and therefore are left to rely on out of pocket payments for health care not provided within the public health care essential services packages (Ensor, 2001). The price of health services and medication in such a system is uncontrolled and generally higher when compared to the single payer model of insurance. Costs of care are driven up by competition and profit, leaving masses of the population un-catered for. This type of system exists predominantly in low income developing countries where the government lacks the resources to provide comprehensive health care to the entire population. However the same can be said about the health care system in United States of America for those outside of Medicare or Medicaid (Adler & Newman, 2002). Characteristic of this type of the multi-payer system is an affluent minority with separate arrangements for better private care, and a marginalized majority who stand to suffer economic hardship if they seek any health care outside of the essential packages provided within the public sector (Bennett, 1991; Kanji & Manji, 1991; Kanji & Jazdowska, 1993; Sen & Koivusalo, 1998).

It is important to note that many developing countries in sub-Saharan Africa that operate the multi-payer model used to operate the single payer model before Structural Adjustment reforms imposed by the World Bank (1987, 1993) changed the organizational and service delivery structuring of the health sector to facilitate a rapidly expanding role for private health care practitioners (Sen & Koivusalo, 1998: 200). The multi-payer system supports a re-emergence of colonial structures of health care in which the greatest gains are to be made by the private sector and its minority clientele, often at the expense of the public sector catering to the majority (Qadeer and Sen, 1998). The disparities in income and consequent disparities in quality and access to health care that exist in this type of system thus present challenges for social solidarity (Hussey and Anderson, 2003:223). Three models of health system financing have been developed in an effort to tackle the social solidarity challenges in the health sector. The Beveridgean Model, the Bismarckian Model, which are more traditional models of health system, as well as the more modern National Health Insurance model all attempt to provide health care to the public using methods aimed at balancing the inequitable distribution of health

care services (Ferreira, 1999; Gakidou & King 2000; Houtepen, 2000; Ensor, 2001; Kornai & Eggleston, 2001; Hussey & Anderson, 2003). Health reform generally occurs when a government moves from one of these health systems to another.

The Beveridge and Bismarck Models of Health Care

The Beveridge Model is based on the recommendations of the 'Report of the Inter-Departmental Committee on Social Insurance and Allied Services' more commonly known as 'The Beveridge Report of 1942'. The Beveridge report inspired the Act of 1946 that created the National Health Service (NHS) in the United Kingdom. William Beveridge, who served as Director of the London School of Economics from 1919-1937, was a firm believer in the Welfare State; he believed that adequate healthcare was necessary to protect people's capacity to work and contribute to the economy (Musgrove, 2000:845). The Beveridge model considers medical care as a public service; as such, the majority of medical practitioners are employees of the government. The Beveridge model is a good illustration of socialized medicine in practice. The NHS is regarded as the prime example of a tax-funded public health insurance Beveridge Model (Beveridge, 1943; Cousins, 2005; Orme *et.al.*, 2007; Ham, 2009; Or *et.al.* 2010; Stuckler *et.al.* 2010; Blank, 2013).

The Bismarck model, named after the Prussian Chancellor Otto von Bismarck who enacted legislation in Germany to insure workers against serious risks including health risks, is a Social Health Insurance system utilizing "sickness funds" (Saltman and Figueras,1998; Kutzin, 2001; Dixon *et.al.*, 2002; Saltman *et.al.*, 2004; Kutzin *et.al.*, 2009). The sickness funds are financed jointly by employers and employees through compulsory payroll deductions. Medical insurance companies are private entities but are, however, required to be non-profit and have to conform to heavily regulated schedules regarding fees and medical services. Hospitals and medical services are largely private and patients are required to pay a surcharge for health services. Within this system it is beneficial to purchase secondary insurance cover in order to cover more specialist medical problems and procedures. This model is therefore considered a multi-payer system of health care (Cremer & Pestieau 2003; Borowitz & Atun, 2007; Kutzin *et.al.* ,2009).

Often compared, the Beveridge and Bismarck models differ in three fundamental ways. Firstly the Beveridge model covers the entire population with universal health insurance,

whereas the insurance provided by the sickness funds under the Bismarck model cover only those members of the population who are gainfully employed (Franke, 2004). Secondly, the health sector adopting the Beveridge approach is largely centralized, while the health sector adopting the Bismarck approach is more decentralized. The Bismarck approach is characterized by a two tiered health system incorporating both public and private health providers into one system. The sickness funds provide a limited range of health services requiring the public to make out of pocket payments or purchase private health insurance to cover more specialized treatment. The private health sector in the Bismarck approach has the authority to exert control over the cost of medical services, determined by market forces. The Beveridge model on the other hand offers a more centralized approach to financing and purchasing of health care services. Since most hospitals are government owned, and most health workers are government employed, the government controls the cost and pricing of health services allowing for provision of medical attention to the population at minimal to no cost. The third fundamental differential is seen as a consequence of the first and second. The Beveridge model clearly provides for a redistribution of resources to cover the entire population whereas the Bismarck model offers no real redistribution between the various income groups (Kolmar 2007; Cremer & Pestieau 2003). Financing under the Beveridge model is primarily from the state budget, whereas financing under the Bismarck model is via contributions from workers income the amount of which is determined by one's wages or salary (Franke, 2004). Advocates of the Bismarck model are of the opinions that in low income developing countries insurance coverage will eventually expand from the formal sector to the entire population exemplified by the Japanese and South Korean experience (Shaw & Griffin, 1995; Engelen-Keffe, 2007; Holst & Brandrup- Lunkanow, 2007). However critics of this system argue that in low-income developing countries, with large informal sectors, this approach runs the risk of widening existing disparities in access to care and financial protection (Lloyd- Sherlock, 2006; Kutzin *et.al*, 2009;).

The National Health Insurance Model

The "National Health Insurance" model of health system adopts elements of both the Beveridge and Bismarck systems of health insurance. Similar to the Beveridge approach, the government as the single payer pools funding for universal health care from general taxes into a national health insurance fund. However this model differs from the

Beveridge model in that it makes use of private-sector health care providers who although not employed by the government receive payment for health services by the government. Although the government is the main purchaser the NHI model allows for private practitioners to still operate albeit under strict government regulations (Cremer & Pestieau, 2003; Klomar, 2007). Since the government as the single payer maintains significant control over the market to negotiate for low prices, this system eliminates competition amongst providers that push up prices. Canada for example has a health care system in which the cost of medication is significantly lower than other countries due to rigorous negotiation with pharmaceutical companies (Feinsilver, 1993; Fooks & Lewis, 2002). National Health Insurance systems further cut costs by providing a basket of medical services to the population, and providing a time frame within which patients wait to be treated (Blanpain, Delesie & Nys, 1978; Collins, Green & Hunter, 1999; Maynard & Bloor, 1995; Cremer & Pestieau, 2003; Klomar, 2007). A typical example of the NHI system is found in Canada.

The health care system of each country is determined by its “historical experience, culture, economy, political ideology, social organization, level of education, standard of living and attitudes towards welfare and the role of the state” (Cockerman, 2010:286). It must be noted that no pure ideal type of health system exists in reality as health systems are highly dynamic entities sensitive to socio-economic-political changes (Van Rensburg, 2012:11). Reforming a health system is a complicated process as balance amongst the pressures associated with the historical, social, economic and political contexts is sought (Freeman, 1998:395). The unique nature of a health system can only be understood by understanding the historical context from whence it developed. Similarly a country’s economic position, its mode of production and consumption, distribution of wealth and resources has a profound effect on the health sector. This study looks at the social and economic pressures affecting health reform, but will also use the Power Resources Theory to focus on the political determinants affecting the health sector. The government systems, political ideologies, policies, pressure groups, political pursuits and power distribution have significant effects on the health sector as this is where its structure and governing is established (De Miguel, 1975:19).

Health care reform

Health care reform has been defined as “the sustained process of fundamental change in national health policy and institutional arrangements, guided by government and designed to improve the functioning and performance of the health system and ultimately the health status of the population” (Lambo and Sambo, 2003:1). Health care reform “involves a significant purposeful effort to improve the performance of the health care system” (Roberts *et.al.*, 2008). It occurs when governments initiate major policy changes affecting health care services and delivery thereby transforming the health system of their country for the benefit of the population. For much of the last three decades health policy makers have been concerned with the performance of their health systems and many countries have introduced reforms aimed at improving their performance (WHO, 2000; Maynard & Bloor 1995, Collins & Hunter, 1999; OECD, 1996 ;Mills *et.al.* 2001; Berman 1995). Some of the main reasons for change in health systems worldwide are changing disease patterns, aging populations, technological and scientific developments, growing public demand, need for greater efficiency and equity, responsiveness to public expectation, health rights and public consciousness and rising costs of health (Benatar, 1998; Benatar & Brock, 2011; Berman 1995; WHO, 1998; Bhat, 2005; Altenstetter & Bjorkman, 1997; Stevens, 2010; Van Rensburg, 2012; Cockerham, 2014). The main objective of health reform in developing countries has been to alter an inefficient, inequitable health sector for the purposes of providing sustainable health care based on equitable provision of quality service to all members of the public. Inequalities in health among groups of various socioeconomic status as measured by education, occupation, and income constitute one of the main challenges for public health (Mackenbach, *et.al.*, 2012:2468).

Most sub-Saharan countries in Africa were subjected to structural adjustment programmes in the early 1980's as a requirement to qualify for World Bank and IMF loans with the intention of rescuing weak African economies. The effect however led to “greater social and economic deprivation” (Colgan 2001:4) which affected welfare sectors including health. By introducing cut-backs in public expenditure and promoting privatization the structural adjustment programmes led to the development of a highly inequitable health sector with a strong largely unaffordable private sector and a struggling public sector. Present health sector reforms are generally aimed at righting

this wrong through “universal access to care, cost containment, enhanced quality of care, increased patient choice and patient satisfaction and securing public accountability as well as public participation [and] increasing emphasis on health promotion and healthy lifestyles” (Van Rensburg, 2012:17).

In order to combat the challenges of an inequitable health system, WHO has identified Universal Health Coverage as the single most powerful tool that public health care has to offer (Van Rensburg, 2012: 47. The universal health care package, delivered through the public health care system is ideally characterized by economic and organizational features promoting equity, improving care and efficiency through better service, and preventing unchecked expansion of health expenditures that can adversely affect the economy (Cherichovsky & Chinitz, 1995; WHO, 2010). The success of the public health care sector at achieving this depends on the commitment of redistributively minded policy makers to welfare and the commitment of the welfare state to ensure that access to health care as a human right is provided.

Challenges to health care reform

Asvall (1998:x) describes the process of health reform as a “long learning cycle” requiring several years from implementation to assessing its impact. He argues that policy makers are often placed in uncomfortable positions to adopt expensive reforms that have only recently been implemented in other countries without seeing the hard evidence of their efficacy yet. Figueras *et al* (1998:15) states that while much focus is made on the development of the content of health reform policies, the actual process of reform and difficulties in its implementation is often neglected. Reforms are more difficult and much slower in implementation than expected and can have inadvertent outcomes (Chernichovsky & Chinitz, 1995; Cooper 1994; De Leeuw & Polman, 1995; Golinowska& Tymowska, 1995; James 1995). According to Saltman “a review of the evidence shows that reform failures often have little to do with the relative merits of the reform programme but rather reflect inadequate understanding of the process of reform implementation and of the management of the change” (Figueras *et al*, 1998: 15).

The implementation of health reform is influenced by the socio-economic and political environments prevalent in each country. This includes the “system of government and

distribution of authority” as well as various stakeholders who have influence on policy change. Political challenges are typical of health reform process. Rogers’s *et.al.* (2008) identify four factors that affect the nature, content and implication of health reform policy. These are Players, Power, Position and Perception. The players are the various stakeholders within the health system as a whole. These stakeholders, according to Walt (1998: 373) “can broadly be categorized as government actors (e.g. politicians, civil servants, bureaucrats) non-governmental actors (e.g. professional bodies, trade unions); pressure or interest groups (e.g. pharmaceutical industry, [medical aid groups]); international actors (eg multi and bilateral international agencies, multinational corporations) and others such as the media, academic institutions etc.” Citizens and civil society also may be included as stakeholders as their views are often represented through public opinion in media or by their own action through interest groups (Walt, 1998: 374). Power refers to the relative power that each of the stakeholders wields.

In many developing countries the interest groups with large stakes in the private health system such as private doctors, private hospital groups and medical aid schemes have more power and resources to effect policy than the beneficiaries of the public health system (Banfield and Wilson 1972). The position each player holds either in support or opposition of the policy and their commitment either for or against the policy is imperative to the actions they take. Each of the stakeholders depending on their position could present challenges to the implementation of policy and the reform process. Conflicts in politics, anxiety over economic implications and social concerns felt by stakeholders, combined with resources to oppose change, can lead to national debate which in turn leads to delays in implementation of health policy (Roberts, *et.al.* 2008). The Perception factor relates to the public and how they perceive the policy. This includes public understanding of the problems within the health sector that the policy intends to redress and the basic tenets of the policy and its implications for them (Rogers *et.al.*, 2008). All these factors can be influenced through the political strategies adopted by the policy makers and political protagonists. Political commitment and effective political strategy are essential for the health reform process and the implementation of health policy (Roberts *et.al.*, 2008).

One of the biggest reasons for health reform has been the increasing role and power of the private sector in terms of both health care service provision and funding (Figueras *et.al.*, 1998:5). The private sector run by market forces on a for-profit-basis have a role in the incidence of inequalities within the health sector as a whole. Unsurprisingly the power and reach of private sector therefore present one of the biggest challenges of health care reform. Governments in developing new policy have had to re-examine the place of market mechanisms within the health system in the public interest (Figueras *et.al.*, 1998: 4). This places the state against the private interest view made up of dominant classes, self-seeking bureaucrats and politicians (Mackintosh, 1992).

Scarcity of resources within the public sector present policy makers with the challenge of developing new strategies to fund the health system. Often times this involves the shifting of funds from other areas of public expenditure leading to competition amongst government welfare interests over resources within a limited national budget. The most common option adopted by governments has been to increase taxation or social insurance contributions. However “the redistributive aspects of health reform will especially be at risk, as business interests and groups of more privileged citizens press for lower taxes, looser regulations and reduced subsidies for low income people” (Skocpol, 2010). Health expenses can either be controlled from a demand side or supply side, and policy makers have to consider both to find the most suitable formula for financing the health system. Demand side measures “seek to reduce demand by shifting a portion of health care costs on to the individual” (Figueras, *et.al.* 1998:7) through taxation for example. The challenge of this type of measure is that depending on the tax method used it could be seen as regressive because not everyone can afford to contribute. Supply side measures on the other hand are “based on a more efficient allocation of resources” (Figueras *et.al.* 1998: 7). These measures involve reducing costs within the industry. For example, reducing wages or reducing the price of pharmaceuticals, budget cutting for hospitals and clinics etc. However the social implications of cutting down on already scarce resources could also be seen as regressive. Countries which choose universal coverage, such as those adopting the Beveridge model predominantly use tax-funded systems that affect policy change more on the demand-side. Literature has shown that in such countries (UK, Spain, Italy, Portugal, and Greece) the public has bought in to

the public sector as the main provider of health care and thus accept increased taxes as a means of ensuring universal access to health on an equitable basis (Ferrera, 2005).

Literature also shows that political leadership and political will is essential to successful management and direction of the health care reform and policy implementation (Chernichovsky & Chinitz, 1995; Gilson & Mills, 1995). Political will has been defined as the “demonstrated credible intent of political actors” (Stapenhurst *et.al.* 2006: 41). Brinkerhoff (2000: 242) defines it as “the commitment of political leaders and bureaucrats to undertake actions to achieve a set of objectives to sustain the costs of those actions over time.” What is emphasized however is that political will reflects a multifaceted set of underlying factors and is a complex phenomenon that cannot easily be defined or analyzed (Malena, 2009:18). Malena chooses rather to describe lack of political will as conditions where political actors do not follow through on public declarations or promises, fails to give priority to reforms or implement policies and fails to allocate adequate resources for government initiatives. Strong political will can lead to successful health reform despite vociferous opposition such as in the UK and New Zealand (Gladstone and Goldsmith, 1995; Saltman *et.al.* 1998). Introducing health reforms can be difficult when there political will is lacking or when there is an unstable political environment (Jonczyk, 1993). According to Rathwell (1998: 397) “the combination of strategic alliances coupled with political will do seem to be the major driving force behind the implementation of many reforms.”

Each of the stakeholders within the health system endeavors to push for their interests to be represented in health care reform policies. Although the central debate in health reform is between public interest and private interest, other stakeholders also represent significant interest and as such demonstrate varying powers of influence over policy (Mackintosh, 1992). The state, as a steward of the people must promote public interest, however politicians and political parties are themselves bearers of interests and ideological orientations that reflect particular group and class interests in society (Walt, 1998: 367). The process of health reform requires that the state consider the views of interest groups, in as far as it can, and weigh those views with the competing interests of providing equitable, sustainable and reliable universal health care to its people. In doing this the state has to contend with the lobbying powers of opposition stakeholders and

policy analysts must consider this dynamic and its implications for policy development. The following chapter outlines the Power Resources Theory as the most suitable theoretical approach to understanding the powers of stakeholders and their influence and role in social policy implementation.

CHAPTER 3

THEORETICAL FRAMEWORK

POWER RESOURCES THEORY

This study is located within the field of Social Policy, which literature on comparative public policy analysis has shown can be studied in a number of ways. According to Titmuss, social policies should be primarily about equality, freedom and social integration (1976:116). Comparative research on social policy has thus primarily been focused on the relationships between the welfare state and socio-economic inequalities (Ferrarini and Nelson, 2003). The welfare state has been defined as “the collection of state programs, regulations and actions that are intended to directly fulfil a states declared commitment to the welfare of its citizens” (Orenstien and Haas, 2004:131). According to Wilensky (1975) the “essence of the welfare state is government-protected minimum standards of income, nutrition, health, housing and education, assured to every citizen as a political right” (1975:1). Public health policy and a state mandate to provide universal health care on the basis of equality falls well within the obligation of the welfare state. Of the many theories that have been used to study the welfare state, this study will utilize the Power Resources Theory (PRT) advocated by Swedish sociologist Walter Korpi (1983).

The PRT brings the classic sociological concepts of class and power into the analysis of policy formation and conceptualization of the welfare state. This approach provides for a micro-macro analysis of public policy paying particular attention to the power resources deployed in the policy making process in the welfare state (Korpi, 1998: ix). This means that the Power Resources approach provides a conceptual framework for the understanding of the relationships of power to conflict, exchange and inequality which will be an essential focus when analysing policy development, implementation and reform. According to Korpi, the welfare state should be viewed in terms equality/inequality measures, central to which are not only distributive processes but also the ways in which they are influenced by political and other factors (Korpi, 1983:186). The PRT focusses on the distribution and utilization of power resources by

the different classes, effectively shaping the policy process and its outputs (Kelly, 2005:866). The welfare state is seen as the instrument through which the working class fights market influence on the distribution of wealth (Korpi, 1983:195). The development of the welfare state is explained in terms of conflicting class interests where the balance of power between labour and capital is seen as a major determinant in the extent of public welfare provisioning (Korpi, 1983; 2006).

Where capital can use wealth and influence as a powerful resource, labour can use its capacity and willingness to organize and protest as a powerful resource to effect government policy. However, in order for the collective voice of the working class to influence policy, the working class must organize. The PRT basically posits that working-class mobilization is essential to the extent to which the welfare state enacts policies along redistributive and equality lines (Pontusson and Kwon, 2006). Within the economic sphere the working class is organized through unions. The PRT emphasizes that working class mobilization through Unions is the most effective means of asserting workers interests in politics (Korpi, 1983; O'Connor and Olsen 1998; Kelly, 2005). Within the political sphere the power of working class organization is made evident by the strength of leftist parties in government. The PRT explains the welfare state as a function of the historical strength of the political left, mediated by alliances with the middle classes (Korpi 1983, 1989; Esping-Andersen 1990; Huber and Stephens 2001). Through the strength of labour unions aligned with left-party control in government, the working class, which generally favours egalitarian outcomes, can effect positive distributional outcomes on government policy (Korpi, 1989; Palme, 1990; Kangas, 1991; Myles and Quadagno, 2002; Kelly, 2005).

According to Korpi, there are two basic types of power resources—control over the means of production and the organization of wage-earners into unions and political parties. Korpi believes that variations between these power resources are of major significance in distributive processes in capitalist societies and consequently affect the extent of inequality (1983:186). He maintains that the differences in power resources between labour and business interests, along with their allied groups can influence the distributive processes in society, the social consciousness of the citizens, the levels and patterns of conflicts in the society, and the shaping and functioning of social institutions

(1983: 18). Korpi's hypothesis states that "the distribution of power resources between the main collectives or classes in a country affects the form and direction of public interventions in the distributive processes and thereby the extent of inequality in a country" (1983:195). In other words, the distribution of power resources is assumed to have a direct effect on the distributive processes (Korpi, 1983:16, 187). However power resources, through political influence can indirectly affect distributive processes as well as the scope and direction of state intervention in the distributive processes (Korpi, 1983:187). Korpi believes that the relative position of the working class (or related social collectives) in terms of collective power resources affects the degree of inequality in capitalist democracies (Korpi, 1983: 198). Korpi found that countries with a highly mobilized working class and long term control over governmental power appear to have less income inequalities and relatively small proportions of persons living in poverty. He notes that for these countries unemployment levels appear to be relatively low, and that redistributive effects of taxation are highest. These countries also appear to have relatively high redistributive effects of governmental budgets (1983:197). Korpi thus assumes that the distribution of power resources influences the outcomes of exchange processes and consequently the degree of inequality in society (1983: 18).

The Power Resources approach comes close to the perspective of Marx in that structural change is seen as the result of people, through cooperation or conflict, seeking solutions to what they define as important social problems (Korpi, 1983:20). Korpi's general hypothesis is that the presence of reformist socialist parties in government can bring public policies closer to the interest of wage-earners. He argues that within the tripartite societal bargaining between the state, labour and capital, the distribution of power resources and the political composition of the government can affect the pattern of coalition formation within this triad as well as the outcomes of bargaining (1983:25). The Power Resources model thus contends that the smaller the disadvantage in power resources of the labour movement and the stronger the left party hold over the government, the more likely are state representatives to side with labour in the tripartite bargaining, and the more equitable the distribution of resources within society will be (Korpi, 1983; Western, 1997; Rothstein *et al.*, 2012).

In a study by Rothstein *et al* (2012) they agree with the tenets of the PRT, however they believe that an additional component should be included in the power resources approach. According to them Quality of Government (QoG), which they describe as a “composite of the rule of law, control of corruption and government effectiveness” (Rothstein *et al.*, 2012:9) is an important factor in mobilizing social classes to support government policies. They argue that “in order for wage earners and their representatives to turn to the state to respond to their demand for protection against social risks and for redistribution, they have to have a high degree of confidence in ‘their’ state” (Rothstein *et al.*, 2012: 4). They explain that the Nordic countries which best exemplify the welfare state and are the countries from where the PRT was developed, were “historically less corrupt, less clientelistic and less prone to use violence against their citizens and more open to popular influence” than other European countries and that “high levels of distrust in government authorities are rare in the Nordic countries.” (Rothstien *et al.*, 2012: 4). They argue that this is not true for many countries, particularly developing countries where high levels of corruption, clientelism, patronage and consequently distrust in the government exist. The distrust in the QoG experienced in developing countries has the effect of hampering the government’s efforts to collect taxes and deliver necessary services to the population (Kornai *et al.*, 2004; Rothstein and Uslaner, 2005; Adesina, 2007; Riesco and Draibe, 2007; Brautigam *et al.*, 2008; Sorj and Martuccelli, 2008; Holmberg *et al.*, 2009; Pasotti, 2010; Rothstien *et al.*, 2012).

Rothstein *et al.* (2012) argue that citizens, political representatives and collective bargaining institutions have to consider three things in deciding to support a social policy. Firstly they must consider the normative aspect of the policy – is it a good thing? Second and most important for the middle class is the question of how much it will cost them in terms of contributions and taxes. Third, they have to trust that when someone needs care, the system will deliver (Rothstein *et al.*, 2012:9). Rothstein *et al* noted that “if citizens perceive the level of corruption in their society as high, this has a significant negative impact on their generalized trust [and] conversely, when individuals perceive that government institutions are fair and unbiased, this has a positive impact on their social trust” (Rothstein *et al.*, 2012:9; Rothstein and Uslander, 2005; Uslander, 2008; Dinensen, 2011). The study conducted by Rothstein *et al.*, (2012) on 18 OECD countries tested their hypothesis that “without a reasonably high level of QoG, political mobilization

for welfare state policies in the way that PRT has outlined is unlikely to have broad appeal” and concluded with results showing “both political mobilization according to PRT and a high level of QoG are necessary, but are not on their own sufficient for creating an encompassing, universal, and thereby more redistributive welfare state.”

For purposes of this study it is believed that the most suitable approach for analysis of social policy, and specifically public health policy and health reform is the PRT. This study makes use of the QoG theory as complementary to and encompassed in the PRT to analyse the reform process in South Africa. The PRT approach will be used to interrogate the NHI policy and the consequent politics of health reform that arise from the tripartite bargaining between the state, labour and capital, and policy contestations within the party itself. The PRT was also applied in the discussion of the Swedish and Canadian experience of health reform process and implementation so as to provide a comparative analysis for the purpose of ascertaining lessons South Africa can draw from their experiences.

CHAPTER 4

METHODS AND DESIGN CHALLENGES

Research Framework

This study was guided by a qualitative inquiry into the historical development and implementation of the health care policies and the health reform experiences of South Africa, Sweden and Canada. The comparative historical approach was found most suitable for the objectives of the study as it is especially significant to social science research and its endeavour to understand the dynamics and interrelationships of social transformations, political development, and contentious politics (Mahoney and Reuschemeyer, 2003:409). The underlying goal of comparative research is to search for similarities and variances. This involves identifying general patterns and isolating regularities from different contexts (Mills, et al, 2006:621). Comparative research involves the systematic, explicit comparison of data from two or more societies or the comparison of data from more than one point in time in the history of a single society (Marsh, 1967). The use of comparative research method allowed me to address the experiences of these three countries while historical research situated the study within the relevant historical context of each country (Lijpart, 1971; Amenta, 2003:94-95).

The use of comparative historical analysis allows researchers to derive lessons from past experiences that speak to the concerns of the present through the use of systematic and contextualized comparison of data (Mahoney and Rueschemeyer, 2003:9). According to Amenta (2003:91) a comparative-historical approach provides the best method for the study of social policy. It allows the researcher to take a broad perspective in interpretation and understanding of the social structures, which largely shape the course of our lives (Mahoney and Rueschemeyer, 2003: 424). In applying it specifically to sociological research, Øyen (1990: 4) points out that “for most sociologists, the very nature of sociological research is considered comparative and thinking in comparative terms is inherent in sociology.” Even Durkheim (1938: 139) posited that “comparative sociology is not a particular branch of sociology; it is sociology itself, in so far as it ceases to be purely descriptive and aspires to account for facts.” Cross-national studies are understood to be studies that utilize systematically comparable data from two or more

nations (Kohn 1989: 20). Cross national research provides an especially useful method both for further development of sociological theory and for establishing the generality of findings and the validity of interpretations derived from studies of single nations (Kohn, 1989b:77). Cross national comparisons are useful political instruments in that they increase the understanding of national events and form the basis for the major part of decision making (Øyen, 1990: 2). Rather than testing theory, the goal of comparative research when studying social policies is to identify lessons to be learnt, the reason for this being that countries tend to 'borrow' attractive policies from one another (Teune, 1973).

Research Methods

The comparative historical approach lends itself to a wide range of methods within qualitative research (Mahoney, 2003:337). York (1998) states that qualitative studies make use of three types of data collection, namely: content analysis, observation and interviews. These methods are often woven together in a single study to provide a more in-depth and rounded investigation of the research question (Patton, 1990). This particular study made use of content analysis for information on past reform processes and their outcomes in Canada and Sweden, as well as content analysis of policy documents from the ANC, government, and those contesting the space on NHI in South Africa. This study will also make use of in-depth interviews for information on the on-going health reform process in South Africa.

1. Content analysis

The data discussed in this study pertaining to Sweden and Canada was from secondary sources providing a clear understanding of the history and process of health reform, health policy, and health services. A study done by Sundin and Wilner entitled "Social change and health in Sweden: 250 years of politics and practice" provides a comprehensive discussion on the history and nature of the Swedish health care system and its relationship with the welfare state over a period of 250 years. This study therefore predominantly used the information from this paper for the discussion on Sweden, as the study according to its authors is expected to be utilized "first and foremost [by] students on an advanced academic level looking for comparative perspectives on their own geographical arena both in Europe and in economically less developed parts of the world"

(Sundin and Wilner, 2007:18). Secondary resources on Canada however were more readily available and thus multiple sources were used to gather information on the history of the Canadian experience. Historical research in most instances relies on secondary sources and does not necessarily have to employ data created by the researcher (Miriamowski & Hughes 1978; Lustick 199; Abbot, 1992; Abbot et al 1992; Griffin, 1992). The use of pre-existing data, already collected, tested for reliability and peer reviewed saved valuable time and significantly reduced the cost of collecting the same data using primary research methods (Stewart and Kamins, 1993:5). Archival research has been found to be very effective, particularly for development studies. It is described in methodology literature as the locating, evaluating and systematic interpretation and analysis of sources found in archives (Elder, 1993; Hill 1993).

Information was derived from data collected by and presented in existing peer reviewed and published studies and articles, information from various websites, books, journals and newspapers that provided pertinent insight into the health reform process in Canada, Sweden and South Africa. Other useful secondary sources utilized included various databases and websites dedicated to providing the public with information pertaining to the political, economic, demographic, geographic and social conditions in the various countries. Government websites, for example, store large amounts of data on bills, statutes and acts of government as well as a myriad of statistical information collected on the country that is made readily available to the public. These national archives proved advantageous for this research because they provided comprehensive, organized, data of various kinds, already tested for validity and reliability, made easily retrievable in a central location (Øyen, 1990:190).

2. In-depth interviews

The investigation of health reform issues in South Africa involved in-depth interviews of key informants, within South Africa, who are well versed in past and ongoing health reform issues within the country. Semi-structured in-depth interviews were chosen for this study because the participants of this study covered a wide range of vocations with varying expertise within the health sector. Compiling one interview schedule would not have sufficed. The interviews required individual preparation of an interview schedule for each participant specifically designed to interrogate their area of expertise. A semi-

structured approach allowed for more open ended and flexible line of questioning depending on the domains of experience of the participants. It also allows for more probing and deeper inquiry into and elaboration of issues brought up in the interviews (Leik, 1972; Taylor & Bogdan, 1998; Lune et al, 2010; Hennick, et al, 2011; Giddens et al., 2013; Seidman, 2013).

Sampling techniques

Initially this study intended to draw participants from the Ministerial advisory team on the NHI, and top management executives of stakeholders within the health sector. However I ran into much difficulty securing interviews with many of the prospective participants. Many were not interested in participating, others did not have the time available to interview and some who agreed rescheduled over a period of months before declining. I therefore made use of respondent driven sampling, which will combined snowball sampling with purposive sampling. Purposive sampling also described as expert sampling makes use of the key informant technique where key individuals are selected on the basis of their expertise and their willingness to share their knowledge (Seidler 1974, Tremblay 1957; Campbell 1955; Bernard 2002; Gustad et al. 2004). The main objective of this sampling method is to select a pool of experts in the particular field of study, who can provide specialist knowledge on the research topic (Paton, 1990; Bernard 2002). Once the participants agree to be interviewed, snowball sampling came into play by means of chain-referral. Snowball sampling is used in qualitative research as a means of non-probability sampling for identifying hard-to-reach candidates (Hesse-Biber & Leavy, 2011: 47). Snowball sampling takes advantage of the social networks of identified respondents, which can be used to provide a researcher with an escalating set of potential contacts (Atkinson & Flint, 2004). Snowball sampling begins with a convenience sample of initial participants - in this instance recruited through purposive sampling method - who then served as seeds through which the next wave of participants were suggested and selected.

Participants

Securing interviews with prospective participants in government departments was particularly challenging. However with the help of my supervisor I managed to secure interviews with two participants working closely on the NHI policy. Although the

projected number of participants was 20, I only managed to secure 9 interviews. These participants however covered stakeholder representatives from the South African Private Practitioners Forum, The Department of Health, The Treasury, The MediClinic hospital group, and Professors from the HSRC, Rhodes University, University of Cape Town and The University of the Witwatersrand, specialising in public health and health economics. I believe that the very learned participants provided adequate coverage of issues relevant to the study across a broad range of stakeholder groups. All the participants consented to having the interview digitally recorded and transcribed, and each elected to not have their real names used in this study.

Materials and Instruments

Each interview was recorded using a digital tape recorder and then transcribed. Two of the nine interviews were conducted in person at the offices of the participants, while the other seven participants elected to be interviewed telephonically. Other instruments used in this study were secondary resources from books, journals, articles, documentaries and websites providing information about the health reforms in Canada, Sweden and South Africa.

CHAPTER 5

THE CANADIAN EXPERIENCE

Introduction

Canada has historically been a federal state with strong separation of powers between provinces and the federal government. The Constitution Act of 1867 clearly outlines that the responsibility for law-making rests with the federal government, three territories and ten provinces. This effectively means that the provinces are responsible for laws governing their jurisdiction provided they are in line with the federal laws. The laws surrounding health care for example, were different for each province, depending on the political economy of each of the separate provinces. The Canadian health reform discussed in this chapter will focus on the reform that occurred in the province of Saskatchewan. Saskatchewan was the first province in Canada to drastically reform its health care policy. It went through a very contentious reform experience, which upon its success created the blueprint for the federally imposed Canadian health insurance system known as Medicare. Medicare is based on five essential principles outlined in section 7 of the Canada Health Act of 1984; care must be universal, portable, comprehensive, accessible, and publicly administered. Although Medicare itself has seen a number of reforms, this study will focus on the health reform that took place around the inception of Medicare between 1962 and 1966.

Health care historically

The health care system in Canada has a long history that has evolved over more than five decades into the present Medicare system of health insurance. Before Confederation in 1867 there was little or no organized health care. Local communities however had the autonomy to establish health boards in response to epidemics such as the cholera outbreak in 1832. Public health became a major issue in the 19th and early 20th Century as the poor health typical of the industrial revolution lowered health standards. Canada followed the lead of the British in establishing health reform measures to combat public health issues, particularly those affecting children. This resulted in sanitation reforms, particularly provision of clean water and milk to prevent TB as well vaccination

campaigns against smallpox and diphtheria in the late 19th Century. The Constitution Act of 1867 divided health between the federal and provincial governments and charging hospital responsibilities to the provincial domain (HC, 2012).

The Great Depression had a devastating impact on the health system in Canada. The Federal government could not afford the health care that was needed, thus the onus for financing the health system fell on the provinces, local municipalities and philanthropic organizations. This left an inequitable provision of health services in Canada with some provinces faring better than others. WWII brought with it the renewed interest in public health experienced in Europe. Proposals for a national health insurance program foundered in favour of health grants. The government, in line with the post WWII ideology in Europe, adopted the belief that governments owe their citizens a reasonable standard of living including access to basic services. The Federal government began creating the foundations of the Canadian welfare state. The general principles of Medicare in Canada were established by the social democratic party, the Cooperative Commonwealth Federation (CCF) (predecessor to the New Democratic Party) led by Premier Tommy Douglas in the province of Saskatchewan in 1947. It was through the efforts of Tommy Douglas, now known as the Father of Medicare and the CCF that Saskatchewan led Canada through a tumultuous health reform process.

Tommy Douglas

Tommy Clement Douglas, born in Failkirk Scotland in 1904 emigrated with his family to Winnipeg Canada in 1911 shortly after which he was diagnosed osteomyelitis, a serious bone infection in his right leg. His family could not afford the best and most immediate treatment resulting in delayed treatment which almost cost Douglas his leg. This experience marked the beginning of Douglas's quest for universal, public health care. By the time he was 18 Douglas set his sights on a career as a clergy. By 1929 he was ordained as a Minister at Calvary Baptist Church in Weyburn, Saskatchewan. It was the harsh unemployment and poverty facing Weyburn that transformed Douglas from a clergyman into a social activist. Douglas was one of the founders and the first president of the Independent Labour Party in Weyburn, Saskatchewan, which evolved into the Farmer Labour Party who believed in, and came to offer, hospital care for everyone on an equitable basis.

By July 1932 the four western provinces formed an alliance under the name Cooperative Commonwealth Federation (CCF) which became Canada's first national socialist party. In 1935 at the age of 31 Douglas was elected into parliament under the CCF which with only five seats did not have much political influence. However, with the end of WWII, Douglas and the CCF drove the socialist solution for Canadian economic problems. In one of his radio broadcasts Douglas said "Surely, if we can produce in such abundance in order to destroy our enemies, we can produce in equal abundance in order to provide food, clothing, and shelter for our children" (Douglas in McLoed & McLoed, 1987:42) In 1944 the CCF under Douglas won the Saskatchewan provincial election with the slogan "Humanity First" and became the first socialist government in North America. The CCF government planned to spend 70% of its budget on social services. Douglas emphasized socialism based on political and economic democracy. The CCF from its onset showed commitment to provision of health care for all, and after being elected as the Saskatchewan provincial government in 1944 became the first province in Canada to produce universal hospital insurance by introducing a public hospital insurance plan in the province by 1947 (Bernard, 1993; HC, 2011, 1).

Within Tommy Douglas' first term as Premier of Saskatchewan under the CCF government, in addition to the hospital plan, an old age pension plan was implemented including medical, hospital and dental services, the education system underwent radical change with the establishment of larger schools and medical school for the University of Saskatchewan, the provincial debt was paid off, roads were paved and electricity and sewage pipes were provided to the common man (McLoed & McLoed, 1987). Douglas was re-elected for three more terms and served as Premier of Saskatchewan for 17 years under the CCF. Upon realizing the benefit of the public hospital insurance, the Federal Government, a decade later, passed the Hospital Insurance and Diagnostic Services Act of 1957 offering a 50-50 cost sharing arrangement with the provinces to establish a comprehensive universal access to hospital plan covering hospital care (WHO, 1996; HC, 2011; HC, 2012). For Saskatchewan this provided some fiscal relief and freed up provincial funds for undertaking further health care reform in the province (Johnson 2004; Bernard, 1993). In 1961 the CCF together with the Canadian Labour Congress and the main labour federation in Canada joined to create the New Democratic Party (NDP). Tommy Douglas retired as Premier of Saskatchewan to lead the NDP. Under his

leadership the NDP gained momentum and attracted supporters of the movement for democratic socialism.

The Hall Commission

In the Federal sphere Prime Minister John Diefenbaker in December of 1961 formed The Royal Commission on Health Services, more commonly be known as the Hall Commission, with the Hon. Emmett M. Hall as its Chair. The mandate of the Commission, under Part I of the Inquiries Act was to “inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians” (HC, 2015). Seven commissioners¹ were appointed and tasked with providing a comprehensive report of the Health Services including projected costs of care services, methods of financing the health system, requirements for personnel and training and methods of improving health care services altogether. The commission, after holding 67 days of public hearings in all provinces, studying health systems in other countries, receiving various submissions from delegates of 406 organizations and after commissioning 26 research studies, released their report three years later. Two reports were issued, namely Royal Commission on Health Services: 1964: Volume I, tabled in the House of Commons on June 19, 1964, and the Royal Commission on Health Services: 1965: Volume II, issued on December 7, 1964. The Hall Commission recommended a national health policy and comprehensive health care program for health services, health personnel facilities and research and financing priorities (HC, 2015). Meanwhile in Saskatchewan Premier Douglas in 1959 announced his intention to introduce a province wide medical care insurance program. The fallout of his announcement and consequent debate over his plan took centre stage over the federal health care inquiries which were temporarily pushed aside.

Saskatchewan Reform

In Saskatchewan Douglas formed an advisory committee inclusive of three members of the medical profession and the College of Physicians and Surgeons, Dr Estathios Barootes,

¹ Mr. Justice Emmett M. Hall , Ms. Alice Girard, RN, Dr. David M. Baltzan, Professor O.J. Firestone, Dr. C.L. Strachan, Dr. Arthur F. Van Wart, and Mr. M. Wallace McCutcheon

Dr Clarence Houston and the previous president of the CMA Dr Jack Anderson, as well as three provincial government representatives and three members of the general public (Thompson, 2000). Douglas pushed for the report to be expedited to which the three medical professionals protested but eventually had to concede. The interim report came in 3 parts, two minority and one majority report. One of the minority reports from the members of the College of Physicians and Surgeons kept in line with the CMA policy and recommended that government support pre-existing programs and provide a subsidy for low income earners. The CCF ignored this report and announced that the Medicare plan would come into effect in 1962.

The College of Physicians and Surgeons in 1961 at its annual meeting passed the motion saying "The College of Physicians and Surgeons of Saskatchewan and the Saskatchewan Division of the CMA reiterate their refusal to accept a government-controlled medical scheme as outlined in the legislative draft sent to members by the Minister of Health and declares they cannot cooperate in such a plan" (Bennet, 1996). The CCF's Medicare came under fierce attack by the North American Medical Establishment in Saskatchewan. The private doctors protested against socialized health care and the province became a battleground culminating in the Doctors Strike of 1962 (Lovick, 1975; Swerhone, 1980; Thomas, 1982; Whelan and Whelan, 1990).

The Doctors strike of 1962

During elections of 1960 the CCF, in line with Douglas dream for universal health care, campaigned for the introduction of a comprehensive health care system for the Saskatchewan province. This system would be characterized by universal coverage of medical services, affordable premiums subsidized by general revenues; promotion of prevention treatment as well as medical research and education emphasizing the value of human life and would ensure a more equitable distribution of doctors throughout the province (Bernard, 1993). Tommy Douglas is often quoted as saying "Surely the time has come in Saskatchewan... for us to take this next great forward step and set up in the province of Saskatchewan a pre-paid medical care program" (Douglas 1962).

This new reform was met with considerable opposition from private practitioners, particularly from the College of Physicians and Surgeons who supported a huge campaign

in opposition of the reform. The College, being the most vocal against the reform argued in line with the minority report recommendations that those who could afford health care should purchase it from private insurance providers such as Group Medical Services (GMS) and Medical Services Incorporated (MSI), and those who could not afford the premiums should be assisted with payment of those premiums by the government. MSI and GMS paid 85% of the unofficial fee schedule and the CCF indicated and reiterated its intention to make the same payment under the Medicare reform. The College met with the Saskatchewan Cabinet three times in April 1962 stating and restating its intention to not practice under the proposed Act. In response to this, the Cabinet introduced new amendments prohibiting patients to “opt-out” of the plan, and effectively prohibiting the doctor to practice outside of the plan (Thompson, 1996; DoME, 1962). The College then began an aggressive campaign against Medicare, arguing for the freedom of their profession (Blakeney, 2008: 49).

The College, being the licensing body which determined who could practice medicine, was the only economic group representing the doctors and thus held tremendous power within the health sector. As a result doctors who supported Medicare found themselves ostracized by the hierarchy of the profession. The College amassed a hefty \$100,000 for propaganda purposes against the CCF campaign. This amount was much more than any party would spend in a Saskatchewan provincial election. Every household received pamphlets while advertisements saturated the radio and newspapers. Articles were published in medical journals against the reform. Public meetings addressed by prominent doctors and supporters were held province-wide (Brown & Taylor, 2012).

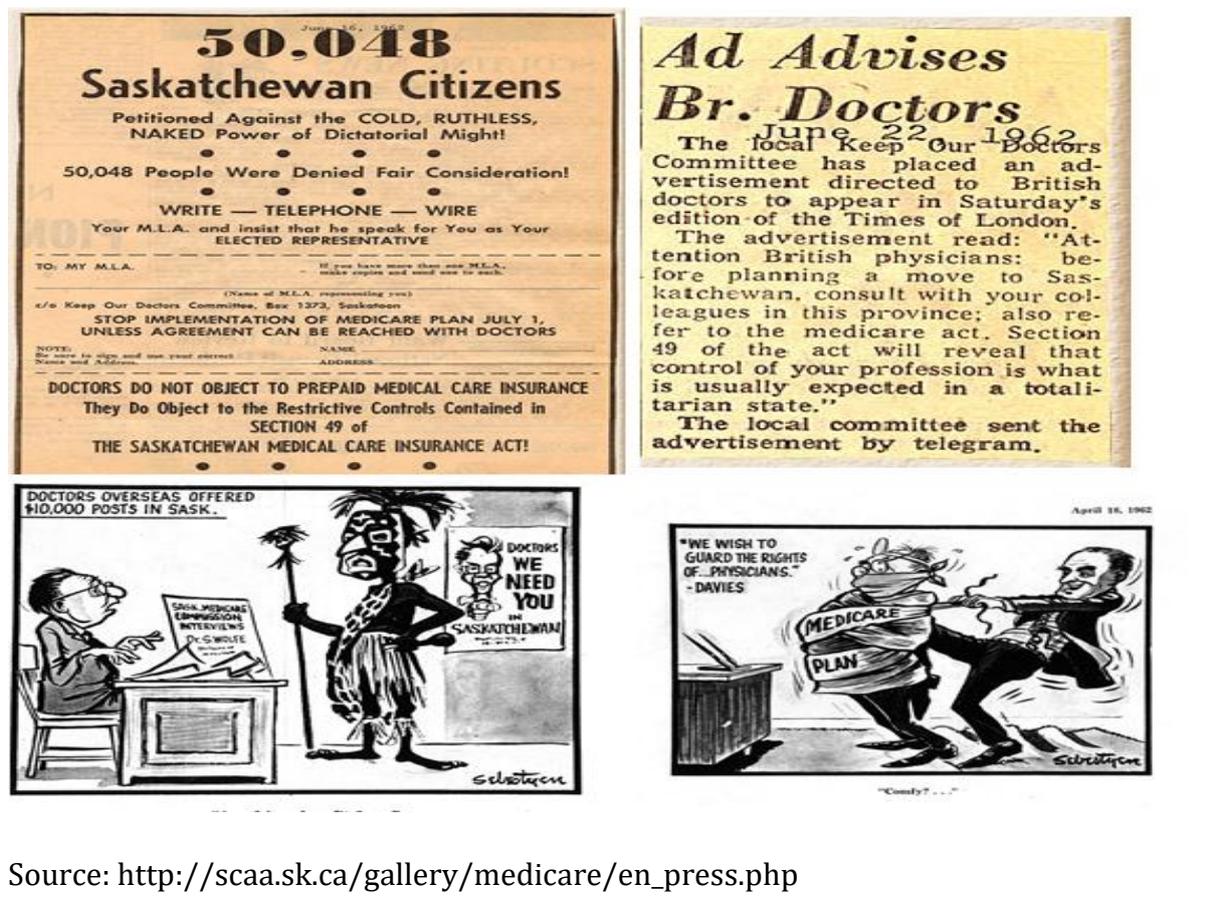
A review of the propaganda within the media at the time showed warnings against the evils of social medicine and against compulsion which was explained as people having no choice in doctors, and having to submit to a controlling government that could implement compulsory abortions and admit people into mental hospitals at will. While the local doctors asserted their intentions to never work under such a system, the government assured the population that more doctors were coming from other provinces and from Europe who were contracted to work in Saskatchewan. This sparked a huge campaign against foreign doctors, branding them as inferior. Norman Ward, a prominent political scientist at the time, is often quoted in the literature surrounding these events as saying

“They’ll have to fill up the profession with the garbage of Europe. Some of the European doctors who come out here are so bad we wonder if they have ever practiced medicine” (Brown & Taylor, 2012:1).

Despite the vociferous opposition the CCF won the 1960 election and proceeded with its plan resulting in the passing of the Saskatchewan Medical Care Insurance Act of 1961 in November 1961. The private practitioners in Saskatchewan continued their protest against socialized medicine accusing the CCF of communism and of imposing ‘compulsory state medicine’ upon what should be considered a free profession. The CCF was accused of interfering with the doctors professional rights to practice medicine in an attempt to force them to be salaried government employees. Many threatened to leave the province rather than submit to such a system. Doctors in Saskatchewan became more militant and advised the CCF government on May the 3rd, 1962, of their intention to withdraw their services if the Medicare Act was implemented as planned on the 1st of July.

The heated dispute over Medicare consumed public discourse in Saskatchewan, and the government began to plan for the eventuality of a doctors strike (Blakeney, 2008:53). The CCF concentrated efforts on recruiting doctors from Ireland and Britain by running multiple ads in British journals and publications; they conducted interviews at Saskatchewan House in London; arranged for teams of doctors from Detroit and Pittsburg to be on standby in the event of a strike (Blakeney, 2008:54). This effort was met with more propaganda against foreign doctors. Fig 5.1. below shows some examples of clippings from newspapers in 1962 in an effort to mobilize the public through all media outlets. The anti-Medicare campaign gave rise to a right-wing movement known as the Keep Our Doctors (KOD) Committee with a right-wing political agenda led by the Liberal Party whose mandate was not only stopping “socialized medicine” but in ridding the province of “socialism.” “(Brown and Taylor, 2012). The KOD committees were aggressive in their campaign, organizing public meetings and flooding the airways with slogans such as “you are going to lose your doctor” (Blakeney, 2008:56).

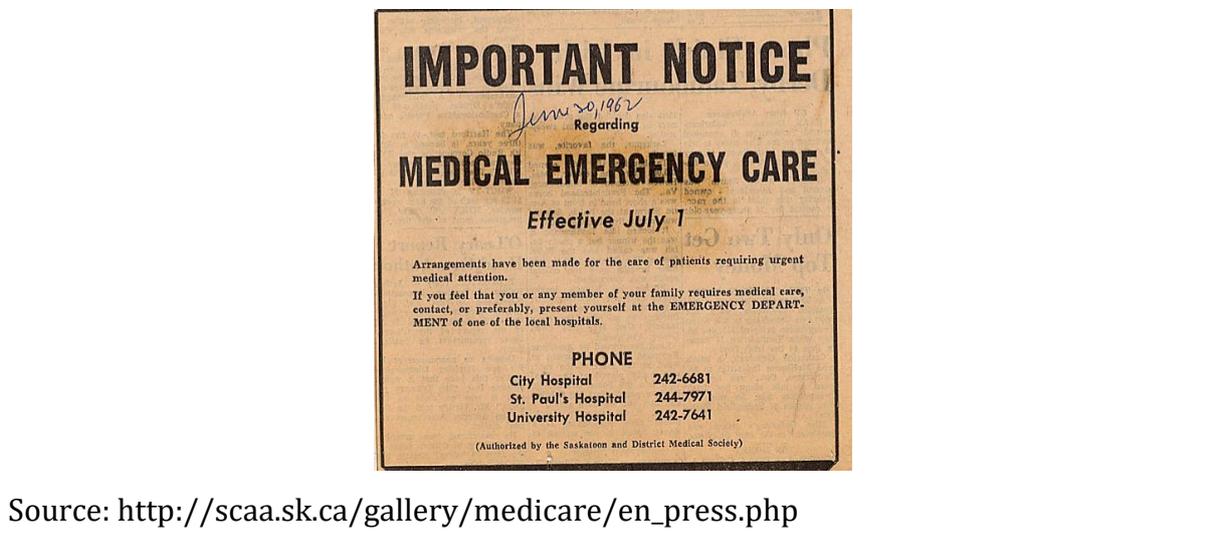
Fig 5.1. Propaganda seen in newspapers in 1962



Source: http://scaa.sk.ca/gallery/medicare/en_press.php

The government of Saskatchewan also took up space in local newspapers encouraging the people of Saskatchewan to support the plan and assuring them that they were prepared for what was to come with such statements as seen below in Fig 5.2 appearing in newspapers in 1962:

Fig 5.2 Government notice in Saskatchewan newspaper



Source: http://scaa.sk.ca/gallery/medicare/en_press.php

On the 1st of July, the first day the Saskatchewan Medical Care Insurance Act of 1961 came into effect, in an effort to coerce the CCF to back down on the health care legislation, 90% of the doctors in the province went on strike effectively withdrawing their services. The only provisions made were emergency services in the form of 200 doctors operating at 40 different hospital centres. Provincial hospitals with reduced staff remained open while the vast majority of private practitioners closed their offices. (Thompson, 2000). Signs such as the one seen below in Fig 5.3. were seen all over doctors rooms on the 1st of July 1962.

The Doctors Strike of 1962 has been described as the most polarized Saskatchewan battle of the 20th century which divided the population into warring camps which brought the province to the brink of a civil war. It even went so far as violence and threats of violence by those in support of the KOD's. One of the most infamous statements often quoted in the literature was one made by the right-wing priest Athol Murray to an anti-Medicare rally broadcasted on radio: "This thing may break into violence and bloodshed any day now, and God help us if it doesn't." In response to his statement, the Catholic Church ordered him out of Saskatchewan for the duration of the hostility (Blackeny, 2008; Brown and Taylor, 2012). The atmosphere was rife with tension and in an effort to negotiate terms three day long discussions took place between Cabinet and the Council of the Saskatchewan College of Physicians and Surgeons in June 1962 (Thompson, 2003). The Cabinet offered to make amendments to the plan allowing for a refund system to be put in place, effectively allowing physicians to practice outside the plan. The College Council disagreed. Ironically it was fundamentally this same concession made by the Cabinet four weeks later that brought an end to the doctors strike (Thompson, 2003).

Fig. 5.3. Sign on the door of the Prince Albert Clinic to notify patients that the doctors were going on strike on July 1, 1962



Source: Saskatchewan Archives Board, George and Tillie Taylor Fonds, A998-496.

The strike lasted 23 days and gained international media attention. Most of the national and the international media condemned the doctor's protests but the local Saskatchewan media supported the strike and called for the CCF to back down on the health reform. The wide media coverage heavily criticized the CCF and socialized medicine created a very heated climate in Saskatchewan. At this point Douglas was elected leader of the NDP and was replaced by Woodrow Lloyd Premier of Saskatchewan. "The Lloyd government held firm despite tremendous pressure, and stared down the North America medical-industrial complex for 23 anxious days. This was made possible by the dedication of CCF rank and file activists and a dedicated core of socialists, trade unionists, agrarian radicals, and of a small minority of courageous doctors who defied the ostracism of their colleagues. They built community clinics with the initial aim of employing doctors who defied the strike. Their long-range aim was to provide a consumer-controlled alternative to entrepreneurial fee-for-service medicine. It was the possibility that the community clinics might become really widespread and popular that really frightened the medical establishment. The same people who organized the community clinics also organized such groups as Citizens in Defense of Medicare and Citizens for a Free Press to counter the anti-Medicare propaganda." (Brown and Taylor, 2012). "Public opinion swung against the anti-Medicare lobby partly due to the work of the pro-Medicare committees with much help from the Saskatchewan Farmers' Union and the trade union movement, and

partly because of a popular backlash against the excesses of the KOD (Bernard, 1993). People in Saskatchewan began to withdraw their support for the strike. Local communities began to recruit doctors from other parts of Canada who were willing to work under the new health reform and British doctors began to set up practices in the voids left by the striking doctors. This response to the protest quickly diminished the striking doctors resolve. The College of Physicians and Surgeons was forced to call off the strike after an arrangement with the government, known as the Saskatoon Agreement negotiated by Lord Taylor between the doctors and the CCF, was made on July 23, 1962 effectively leaving the Saskatchewan Medical Care Insurance Act of 1961 relatively intact, with the same concessions offered to the College Council by the Cabinet in the 3 day long talks being made (Naylor 1986; Ostry 1995; Bernard, 1993; Ostry 2001; Blakeney: 2008). The main point of the agreement, known as the Saskatoon Agreement, was that medical insurance would remain government-controlled, compulsory, universal and reasonably comprehensive (Brown and Taylor, 2012).

Despite the contentious start to the 1961 health reform program it proved to be a success creating great strides for health reform in Canada. The Medicare plan fast became the prototype for the other Canadian provinces. The Federal Government in 1966 passed the Medical Care Act of 1966 (Medicare) establishing the guidelines for a national health care system. By 1971 every province had a universal, single payer, and comprehensive health care plan in place. And by 1972 the provinces had extended their insurance plans to include physician services, actively guaranteeing all Canadians access to essential medical services regardless of employment, income, or health under the Medicare program (Pollard, 2002, 2005; HC, 2011, Kraker, 2002; WHO, 1996, Bernard, 1993).

The Canada Health Act

The implementation of Medicare in the other provinces although not as contentious as the action in Saskatchewan was met with some resistance from the provincial medical associations. As in Saskatchewan the medical associations' feared socialized medicine, state medicine and government employ rendering them civil servants. However these tensions were effectively resolved between the provincial governments and the medical associations without the drastic action experienced in Saskatchewan. A report in 1979 ranked Canadian health care services among the best in the world, but revealed that user

fees levied by hospitals and extra billing by doctors who chose to opt out of the Medicare system created a two-tiered system that threatened universal access to care (Pollard, 2002; HC, 2011; Klatt, 2000). This report generated national debate calling for the banning of extra billing and user fees, and led to the enactment of the Canada Health Act in 1984. The Canada Health Act is the official health insurance legislation of the federal government. Although the right to healthcare is not explicitly mentioned in the Constitution of Canada, the rights afforded to its people and the obligations of the government and provinces are clearly outlined in the Canada Health Act. Section 3 of the Canada Health Act declares that “the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (Canada Health Act, 1984).

The PRT can be applied to the Canadian and particularly the Saskatchewan experience directly. The CCF which was a socialist party from its onset showed commitment to social policies based on equality and redistribution. Within the first three years in power the CCF had successfully incorporated traditionally leftist policies such as the hospital plan, pension plan and education plan into legislation. The CCF was highly motivated and aligned with strong labour movements from its foundation when it started out as the Independent Labour party which then became the Farmer labour party and later when it joined with the Canadian Labour Congress to form the NDP. The CCF maintained strong relations with labour unions who in alliance with the CCF represented interests of the workers, and interests of the broader society. Through the strong relationship between the union movement and the leftist party, the government of Saskatchewan overcame the challenges posed against them by movements opposing Medicare and successfully implemented UHC.

CHAPTER 6

THE SWEDISH EXPERIENCE

Introduction

Sweden has been described as a social-democratic welfare state that has over the years distinguished itself with high degrees of social inclusion and reintegration through the provision of many universal social benefits (Guogis, 2012). Sweden boasts the leading macro-social indicators and social achievements in the world, one of which is the most desirable public health care service delivery programs. As one of the older welfare states it has provided a myriad of literature on social democracy and the success of the welfare state. Many researchers agree that Sweden “is the site of the longest and fullest expression of social-democratic politics in practice” (Milner, 1990:8). Sweden has been described as a representation of the real-world expression of the principles underlying social democracy (Milner 1990:213), the values of which are equality, freedom, democracy, solidarity, security and efficiency (Furness and Tilton, 1979:38). Research has shown that the influence of social democratic thinking extends not only to political ideology but to the very nature of Swedish culture (Milner, 1990; Kesselman et al., 1967: 529). The Swedish health system is “primarily a form of social insurance designed to offset the consequences to living conditions of disease, disablement, or unemployment for medical reasons” (Board, 1970: 233).

A remarkable study by Sundin and Wilner (2007) on the history and nature of the Swedish health care system over a period of 250 years show how the influence and culture of social democracy has permeated Swedish politics and policies. This is demonstrated by the current Swedish public health care system in which the population enjoys a fairly inexpensive, high quality, curative public health care delivery, with those under the age of twenty receiving all health care services for free (Wang and Aspalter, 2007:63). This chapter will make use of a number of resources on the Swedish experience particularly on a study put together by Sundin and Wilner written, according to the authors, for the intention of being used by students “on an advanced academic level looking for comparative perspectives on their own geographical arena” (Sundin and

Wilner, 2007:18). This chapter will begin by outlining the characteristics of Sweden as a social democracy, and will then go on to discuss the history of the Swedish health system, its values, politics and policies.

History

Public health service has a fairly long history in Sweden dating back to the 17th Century where the first collective public health interventions were implemented to combat the plague. The 18th century produced one of the most significant steps in aid of public health. In 1749 an organization called *Tabellverket*, (the precursor of the modern-day Statistics Sweden) was founded to collect national population statistics. *Tabellverket* collected vital statistics on mortality and causes of death across Sweden and thus facilitated steps towards improving the health of the overall population (Sundin and Milner, 2007). Most other European countries began collecting such vital statistics much later in the 19th century. The data collected from the Swedish population registers as early as 1749 thus allows researchers a unique opportunity to follow health trends in Sweden over a considerable historical period.

During the early 19th Century Sweden saw a marked decline in mortality, which was attributed to “peace, vaccine and potatoes”. Peace - on account of the peaceful period after the Napoleonic wars (1803-1815); vaccine - accredited to the introduction of comprehensive smallpox vaccination; and potatoes - a metaphor for the increase in farm productivity and the agricultural revolution (Sundin and Wilner, 2007:20). Public health campaigns introduced by the government, mainly for immunization and the advantages of breast feeding were effected with little resistance from the general population resulting in a healthier generation of children. Sundin and Wilner (2007) point out that although the leading advocates of vaccinations were medical doctors, their encouragement alone did not result in the success of the vaccination program. The general population had to accept ‘the message’ and this was only accomplished through the influence of local administrations, the most influential of these being the local parish. During this time the local priest was a key figure, acting as a mediator between the central state and the common people (Sundin and Wilner, 2007:223). Making use of this established and trusted organizational framework allowed for the smooth implementation of the vaccination program. Other public health initiatives such as the

benefit of hygiene were not as readily accepted, but the introduction of publically trained midwives to the various conservative locales eventually gained acceptance and influence within the communities, consequently improving health and hygiene (Sundin and Wilner, 2007: 223).

At the beginning of the 19th century, the predominantly agrarian Swedish population was just over two million, with 9 out of 10 people living in rural areas, and the rest inhabiting small peasant towns (Sundin and Wilner, 2007:82). Within seventy years the social structure of Sweden changed. The population almost doubled, leading to dramatic increased commercial pressure on agriculture, in turn creating a fast-growing rural proletariat. This period, sometimes referred to as the “agrarian revolution” transformed Swedish economy from predominant importers of cereal and grain, to exporters of most of their cereal and grain. The state adopted a mercantilist ideology all about unifying the state, increasing its power and its monetary wealth. There was a growing interest to keep the population strong and physically fit, as health became recognized as an economic asset not only for families, but the nation as well (Sundin and Wilner, 2007:77).

Industrialisation in the latter years of the 19th century saw Sweden experience an economic boom. An increase in real wages for industrial and agricultural workers led to an improvement in the standard of living of the general population. However industrialisation according to Sundin and Wilner (2007:117) “also had a darker side” with long working hours, unhealthy and hazardous work environments, and poor housing conditions. Social differences amongst classes saw the working class living under poorer unsanitary conditions. Sundin and Wilner (2007:117) explain that “the working-class districts were characterized by open, stinking drainage ditches, poor public cleansing and water supply and severe overcrowding.” This posed a challenge to the healthcare institutions in Sweden as the mortality rate began to rise. The bourgeoisie “influenced by the Victorian repugnance of disorder and uncleanness” were appalled by the unhygienic conditions of the cities and as such made contributions to “improving the populations health and public welfare through enlightened reforms” (Sundin and Wilner, 2007: 136). The outbreak of cholera first in 1834 and again the 1850s and in 1866 played an important role in introducing simultaneous sanitary reforms in the developing urban areas. The construction of effective sewerage systems and the supply of fresh drinking

water contributed significantly to the increased life expectancy and general health of the Swedish population (Sundin and Wilner, 2007:21). Making use of the influence of local parishes, the local authorities pushed various health messages propagating sanitary living, which led to what was later referred to as the “century of hygienism” in Sweden (Sundin and Wilner, 2007:2195). The century of hygienism was characterized by a general increase in standards of living contributed in part to the ideology of “orderliness” in society. Excessive alcohol consumption for example, was considered not only a major deterrent of “orderliness” in society but a detriment to the health of the population and consequently damaging to the fiscal interests of the country. In order to reduce the health problems connected to excessive drinking the monarchy introduced reforms such as *Brännvinsförordning* (Decree on Spirits) of 1855 and *Tillverkningsförordning* (Decree on Production) of 1860 to restrict the manufacture and sale of alcohol (Kruzer, 2001; Sundin and Wilner, 2007).

Industrialisation and urbanisation in the 19th century resulted in, among other things, the formation of a political system in which the majority of citizens had no formal say. Remonstrations against this system triggered the rise of philanthropic associations, voluntary associations, trade unions and workers organizations, the development of which fostered a culture of helping those in need. Sundin and Wilner assert that “helping brothers and sisters in need became one of the imperatives of religious associations and welfare arrangements, just as social security benefits for the unemployed and the sick were started by the workers themselves” (2007:225). It was upon initiatives such as these that the democratic welfare state was built on after World War I.

Folkhemmet

Under the leadership of the Swedish Social Democratic Party (*Sveriges socialdemokratiska arbetareparti*) (SAP) in 1928, the political concept of *Folkhemmet*, the “People’s Home” was introduced. Citizens were encouraged to see Sweden as a good home (Rojas, 2005). The following description represents the basic philosophy of *Folkhemmet*:

The foundations of the home are community and the sense of belonging together. The good home knows no privileged and disadvantaged, no favourites and no stepchildren. None there looks down on any other, none tries to gain an advantage at the expense of others, the strong does not

oppress and plunder the weak. In the good home, equality, consideration, cooperation, helpfulness prevail. Applied to the great home of the people [Sweden] and citizenry, this would signify the breaking down of all social and economic barriers which now divide citizens into privileged and disadvantaged, rulers and dependents, rich and poor, propertied and impoverished, exploiters and exploited" (Hansson 1982: 227 cited in Rojas, 2005: 23).

Folkhemmet was based on Functionalist theory, where society was viewed as an organism in which all parts worked together harmoniously for the benefit of the whole. The *Folkhemmet* model of social democracy used social solidarity and equality principles to govern the markets. This political system was sustained through a unique balance of socialism and capitalism in Sweden. The government adopted many of the initiatives taken on by philanthropic associations into the scope of central and local governments. The "people's home" became "the ideal for a welfare state with neither privileged groups nor stepchildren" (Sundin and Wilner, 2007:173).

The SAP and Social Democracy

Preserving a relatively stable government since 1932, the SAP maintained active involvement in health insurance issues and demonstrated a commitment in socialized medicine. High on the SAP agenda, from years preceding WWII, were plans to reform the health care system in order to expand health coverage. During the war the Swedish government maintained its plans to extend the welfare state in order to guarantee equal living standards for all. This principle follows the general Scandinavian belief of the duty of a welfare state. The main objective of the Scandinavian system is to provide an adequate standard of living for all members of the population whereas the Liberal Protection system is concerned predominantly with the fight against poverty and the Conservative Corporatist system seeks to maintain worker revenue levels (Sundin & Wilner, 2007: 191). During the war, Sweden remained neutral, allowing it to emerge relatively unscathed in terms of housing and industrial capacity (Hicks, 2009:20). This placed Sweden in a much better economic position than the other European countries who had been more involved in the war and as it was able to produce the much needed wood, steel and engineering products in great demand for the reconstruction efforts after the war (Sundin & Wilner, 2007 :190). After the war the SAP with a fairly stable economy, strong social democratic tenets, and a vision of enlarging social citizenship, established

the basic elements of the internationally renowned Swedish welfare state (Immergut, 1992:192).

In 1944, a report published by The Social Welfare Committee, proposed a bill for compulsory health insurance which led to The National Health Insurance Law of 1947 (Law No.1 enacted 3 January 1947) (NHIL) (Heidenheimer and Elvander, 1980:63). In 1931 national networks were developed for the coordination of the Sickness Funds Laws of 1931. The Swedish sickness funds were characterized better as income maintenance insurance in the event of illness rather than as health insurance. The sickness funds covered only those employed persons who contributed to the sickness funds from their wage. Medical care was provided on a fee-for-service basis, and those covered by sickness funds were refunded in cash by the sickness funds in their municipalities. Medical benefits were not offered in kind, as such there was no control over the quality of medical care provided to determine if those insured received adequate medical attention (Ito,, 1980:53). The networks developed for the sickness funds set the foundation for the development of the health insurance system under the NHIL which sought to remedy the flawed sickness funds system (Immergut, 1992:201).

The NHIL effectively transformed the health system from a voluntary health insurance system to a compulsory health insurance system. A voluntary health system, which is the type of system that existed in Sweden before the NHIL, is a system in which health insurance is taken up and paid for at the discretion of individuals or employers on behalf of individuals" (Mossialos & Thompson, 2002). Voluntary health insurance is therefore analogous to private health insurance; as such it is available only to those who can afford it. Compulsory health insurance on the other hand, is a system in which health insurance is supported by contributions from the employees' pay, the employers' payroll as well as a contribution from the state (Lenroot, 1939:75). This type of insurance is structured so that it covers the larger portion of the population, financed by those who can afford it.

The transition from voluntary to compulsory health insurance in 1947 was relatively smooth. The limited reaction by the medical profession was attributed mostly to the strength of the public authorities over the relatively small private sector. The low number of private practitioners in Sweden was attributed to the size and economic conditions of

the market. A relatively small and sparse population made private practice in Sweden desirable only in the modest urban areas because the potential for growth elsewhere was limited. The lack of fiscal incentive made private practice in Sweden undesirable. These unfavourable conditions made it imperative for the government to finance medical officers to cater to the health needs of Sweden. This resulted in most of the medical practitioners in Sweden at the time being public employees. Being in government employ was more advantageous at this time because it guaranteed security in terms of a regular wage and more significantly a pension as a civil servant. For this reason the private practice in Sweden was relatively small, too small in fact to combat SAP in health policy initiatives (Ito, 1980:53-54).

The SAP used their political influence to pass The National Health Insurance Law of 1947. This piece of legislation was supported not only by the SAP and its interests groups, but was passed almost unanimously by all the political parties. Minority interests such as doctor and employer groups expressed reservations about the law but due to lack of veto powers had no choice but to accept it and cooperate (Immergut, 1992:204). Dag Knutson, appointed chairman of the Swedish Medical Association (SMA) in 1946, was one of the first physicians to vocalize the challenges of socialized medicine. Under the leadership of Dag Knutson, the private sector began to develop a consciousness of itself as a free profession. This led to a reorganization of the SMA which continued to grow in strength in opposition to socialized medicine and most significantly to the Höjer reform in 1948 (Ito, 1980)

The Höjer reform

In 1943 J Axel Höjer, an outspoken advocate for socialized medicine, was appointed the Director of the National Board of Health (Lindvall and Rothstein, 2006) and was designated as chair of a commission tasked to “investigate how best to pursue a reorganisation and expansion of the health system” (Hicks, 2009:19). After extensive research over two years, the Höjer report was presented in 1948 as a proposal for national health care service. It provided a comprehensive discussion of the health sector and detailed recommendations for the total reorganisation of health services in Sweden (Immergut, 1992:205). According to the Höjer report:

All medical care services needed by the individual should be offered free of charge at the time of treatment. It should be the duty of the community to deliver this by means of an extended and (comprehensively) regulated organization, including and coordinating public health, hospital care, preventative medicine on an individual basis and ambulatory medical care. Especially ambulatory medical care which has largely been left to medical doctors private initiative...should be extended and regulated by public provision. This will pursue the general line of development of Swedish social medicine.

(Höjer, 1948 cited in Heidenheimer and Elvander, 1980: 101).

The recommendations included in the Höjer report all fell in line with the commitments enshrined in the above passage. The Höjer report (1948 cited in Heidenheimer and Elvander, 1980: 102) included such recommendations as:

1. County Councils assuming the responsibility for outpatient care at the hospitals. Implicit in this charge, was a contractual obligation on the part of hospital doctors to perform this service.
2. Increasing the number of district medical officers still under state auspices
3. Establishing a fixed schedule for doctors' fees
4. Drawing up formal provisions for accepting Scandinavian physicians into the Swedish service
5. Increasing the number of students at medical facilities
6. Creating new educational facilities and reformation of medical school curricula
7. Decentralizing administrative power from the National Board of Health to regional boards.

The most controversial of the above-mentioned recommendations was the first one. This recommendation called for the provision of a national health service consolidating both in-patient and out-patient care into one system under the patronage of the County Councils. This meant that not only hospital in-patient care, but all forms of outpatient care performed by public and private doctors alike, be provided to the public under a health insurance system administered by the County Councils at a minimal cost to the public (Immergut, 1992:205; Hicks, 2009:19). This recommendation would effectively and eventually eliminate the private fees from private patients that doctors in hospitals as well as in private surgeries depended up on, thereby subjecting all doctors to a government paid salary (Immergut, 192:206). This particular recommendation incited massive protest from private doctors represented by the SMA as debate arose concerning payment and professional freedom. Upon the publishing of the Höjer report, the SMA launched a public campaign against Höjer and the Höjer reforms in the press. The report

was depicted as “a doctrinaire call for the immediate socialization of medicine and the downgrading of doctors from free professionals to state civil servants” (Immergut, 1992: 206). Few, particularly the Social Democrats, supported the report and criticized those opposing it for placing guild interests above public health in reform matters. The SMA, however, garnered support from newspapers and media as well as other significant groups such as The Conservative Party and the Swedish Employers' Association, who rallied around the protection of free market competition amongst doctors; and the main trade union federation *Landsorganisationen* (LO) whose primary objections were on the grounds of cost (Immergut, 1992: 206-7). Even the Federation of County Councils strongly opposed the Höjer's recommendations upon the belief that “ousting” private practice, would lead to staffing shortages as doctors would undoubtedly flee the system (Immergut, 1992, 207). In the face of such strong opposition and an election campaign in 1948, in which socialism and the welfare state values were attacked by non-socialist parties demonizing socialized medicine, the Höjer report was rejected (Immergut, 1992: 209).

Doctors would not be paid a state salary but would be paid on a fee-for-service basis by patients and the existing insurance funds. Immergut argues that “the abandonment of the Höjer reform was related to a general retrenchment on the part of the Social Democratic Party when faced with political opposition to its more controversial policies” (1992:209). However the need for health reform was still apparent. Better provision of healthcare to all sections of society was paramount as the inequalities that persisted left too many without access to sufficient health care.

The National Health Insurance Act 1953

Amidst the debate around the Höjer reforms, the Government forged ahead with plans to introduce legislation providing for compulsory health insurance. The National Health Insurance Act was introduced in 1953 but due to financial and staffing shortages its enactment was delayed until 1955 (Sermer, 1980:103). Doctors were consulted extensively during the formation of the provisions of the Act, so when time came for it to be passed, it did so without any of the controversy experienced with the Höjer reform (Hicks, 2009; Blanpain, Delesie and Nys, 1978: 73). The 1955 National Health Insurance Act provided for a compulsory health insurance system “essentially an extension of the

prevailing voluntary insurance system” (Hicks, 2009:36). This system was characterized by compulsory insurance for employees with fee-for-service at its core. Government paid salaries were not a part of the system thereby allowing private doctors the autonomy they desired for their free profession (Hicks, 2009:36). The National Health Insurance Law (1955) allowed for various forms of private medical practice for doctors whose fees were covered by the national insurance. For instance, senior doctors in public hospitals could receive private patients in private hospital beds (Immergut, 1992:211). At this point, patients were required to pay the full fee for health services and be reimbursed 75% of that cost by health insurance. The government had formulated an official fee schedule for health services, and would reimburse patients 75% of the officially determined cost of services as indicated on the schedule. The reimbursement schedule served as a guideline for the cost of particular services, but practitioners were not legally obligated to adhere to those prices (Sermer, 1980, 103-104).

It was not too long, however, before the autonomy of doctors was threatened once again. The SAP gradually introduced legislation transforming the health system and eliminating opportunities for private practitioners (Immergut, 1992:210). One of the objectives of the SAP was to reduce the market power of doctors. They planned on doing this by increasing the number of doctors while reducing the scope of private practice (Immergut, 1992:211). In order to achieve this objective, the government followed some of the recommendations included in the Höjer report. The government initiated plans to import doctors from Austria, build three new medical schools and provided incentives for increased class sizes in the already existing ones. The result was an increase in the doctors licensed each year “by a factor of 7 between 1947 and 1972” (Immergut, 1992:2110). In contrast to their opposition of the Höjer reform, the *LO* and the Federation of County councils showed strong support for the reform (Immergut, 1992: 218). The SMA however maintained opposition to the new laws, but was not strong enough to effect much change in the new policies being implemented. Their authority was further eroded when in 1960 the government took over the accreditation process from the SMA, further increasing the number of doctors. According to Immergut, “the fact that the government could oppose the SMA so soon after the defeat of the Höjer reform lends further support to the thesis that the profession triumphed in 1948 because political opportunities for

opposition to government policies presented themselves rather than because the profession could, by itself, threaten to sabotage the health care system" (1992:212).

The liberties of private practice were further limited with the 1959 Hospital Law. The Hospital law of 1959 enforced direct restrictions upon private practice within hospitals. It eliminated private beds and private in-patient services thereby eliminating private services and private fees within hospitals. The Hospital law also required that hospitals provide out patient care, effectively limiting the private hours of hospital doctors as well as services of private practitioners (Immergut, 199:212). As a result, "hospital outpatient visits increased from 7.4 million in 1952 to 18.4 million in 1963, or more than 40% of medical consultations" (Immergut, 1992:212). The Hospital Law of 1959 was the first of a number of laws designed to increase the scope of practice of public practitioners and limit that of private practitioners. Although this was successful in threatening the autonomy of the private sector, the most imposing threat came in 1969, with the introduction of the seven crowns reform.

The seven crowns reform

The introduction of the "seven crowns" reform in 1969 provided the "most dramatic threat to the private sector" (Immergut, 1992:212). This reform "eliminated private practice from public hospitals entirely and replaced fee-for-service payments to hospital doctors with full time salaries" (Immergut, 1992: 212). The reimbursement system of the National Health Insurance Act proved to be problematic for insurance authorities. Since private doctors and public doctors, during their private hours, were not obliged to stick to the amounts indicated in the reimbursement schedule, they tended to charge more than the official rates. This effectively reduced the amount the public was reimbursed by health insurance and called for a revision of the reimbursement schedule. However, revision of the reimbursement schedule could not keep up with the fees the doctors were charging, leaving the health insurance authorities "faced with a choice between patient dissatisfaction at being reimbursed at less than the promised rate of 75% or the prospect of maintaining the 75% rate by continually raising the reimbursement schedule to match doctors' fees" (Immergut, 1992:215). Both options were not desirable, and the latter proved impractical. This predicament, perpetuated by the trend of overcharging by

private practitioners, was a significant motivator for the seven crowns reform (Immergut, 1992:293).

The seven crowns reform changed the payment mechanism of hospital out-patient services. Patients would no longer have to pay doctors directly and wait for reimbursement of that payment from the health insurance, but would now be required to pay a flat rate for each visit (Immergut, 1992:213). The government's intention was to cover a significant majority of the cost of a doctor's visit. After extensive research into the matter it was found that the average cost of a visit to the doctor was 70 crowns. The fee that patients were liable to pay for each visit was therefore set at 10% of that cost, being 7 crowns, hence the name of the reform (Blanpain, Delesie & Nys, 1978: 175). This reduced the burden of cost for public health care services and provided more economic incentive for the public to make use of public health services such as hospital out-patient clinics, as opposed to the more expensive private health services (Immergut, 1992:214). The seven crown reform introduced a number of restrictions upon private practice. For instance, private practice and fee-for-service payments were no longer permitted in public hospitals, and doctors in public hospitals were to be considered full-time salaried employees of the government (Immergut, 1992:212). The SMA, although critical of the seven crown reform, conceded to the government demands, choosing the more practical option of negotiating with the Federation of County Councils for fair salaries for the doctors rather than protesting a reform they were unlikely to win.

The seven crowns reform not only wounded the private practitioners, but also closed off an exit option for disgruntled hospital doctors who would no longer find it lucrative to flee to the private sector. By eliminating and replacing the reimbursement system with a salaried system, the seven crowns reform resulted in more equal incomes for doctors in both urban and rural settings, thereby removing the deterrent of rural practice and consequently removing geographical inequalities. The consequences of this reform for private practice were devastating. The private sector experienced great difficulty in competing with the public sector because private practices were less attractive to patients who could make use of virtually free public services. Soon after the enactment of the seven crowns reform a vast majority of the doctors in Sweden worked as salaried employees of the government. Blanpain *et al* contend that "overnight, 90 percent of

Sweden's doctors became full-time salaried employees of the state" (1978, 175). In 1975, the government afforded private practitioners the opportunity to be incorporated into the government scheme (Immergut, 1992:220-1). This required that private doctors register with the insurance fund and adhere to a strict fee schedule. Fee-for-service still remained, but at significantly lower rates (Hicks, 2009:39). Those doctors who did not register would not be covered by health insurance, making it virtually impossible for them to receive patients who would have to pay the full cost of health services with no reimbursement (Immergut, 1992:221). The seven crowns reform effectively introduced several of the Höjer recommendations, the most significant being those reforms which rendered the medical profession a "salaried civil service corps" with its bargaining strength limited to maintaining wage levels in the public service (Hicks,2009:39).

The *Folkhemmet* philosophy was the dominant ideology during the period from 1932 to 1976 when the SAP ruled. Up until the end of the twentieth century, was considered the ideal society; more and more public resources were allocated in order to provide citizens with education, security and healthcare from the cradle to the grave (Sundin & Wilner, 2007: 225). High quality health care services in Sweden are provided for all residents, regardless of nationality and irrespective of their income level or location. Health care is funded by county council and municipal taxes and are provided through a social insurance system which is organized by the Swedish Social Insurance Agency and governed by the National Insurance Act of 1962 (*Lag om allmän försäkring*). The responsibility for providing health care services is shared between the central government and the 290 municipalities and 20 county councils within the four regions; Gotland, Halland, Skåne and Western Götaland. The organization of health care in Sweden occurs on three independent government levels, the National, County (provincial) and Municipal levels. Sweden's health care system can therefore be described as decentralized, with each level having designated responsibilities in the structure of the health system. Sweden allocates almost 10 per cent of its GDP to health and health care (SI, 2012) boasting an aggressive and fair distribution of health care and health services "including health-relevant programs of housing, nutrition, health education, and child care" (Wilensky, 1995:102). Thus the system effectively draws the income floor of everyone higher and more uniformly, assuring the least privileged of its

population a higher standard of living (Wilensky, 1975:102). It is for this reason that the Swedish people boast superior health care and that Swedish model shines.

Walter Korpi developed the PRT as a political theory to understand the welfare state. Sweden is one of the few countries that epitomises the welfare state and has for many years. The PRT explains both the initial failure of the Höjer reforms and the later success of the 7 Crowns reform. Both reform policies were presented by the SAP as a socialist party with strong leftist ideology. The Höjer Reform was however opposed by the LO and the Federation of County Councils in 1948 primarily due to objections to the finance proposals. Immergut (1992) argues that during this time the SAP faced strong political opposition to many of its socialist policies and as such withdrew the Höjer reform policy for political reasons. However, the LO and the Federation of County Councils, who represented the interests of labour in sharp contrast offered support for the 7 Crowns Reform which, even in the face of opposition by the private sector interests, was implemented swiftly and without much controversy. The Swedish experience of reform doubly iterates the tenets of the PRT as it clearly demonstrates how the link between the power of labour unions in opposition and in alliance with the left party in government resulted in the failure and success of health reform policy respectively.

CHAPTER 7

SOUTH AFRICA - POST 1994

Introduction

South Africa under apartheid was governed by undemocratic laws and policies that sanctioned segregation along racial lines. The Population Registration Act of 1950 classified people into four distinct categories: Bantu, Coloured, Asian and White. Legislation throughout the 1950's was based on a separate development for each of the races, for example the Group Areas Act of 1950, and the Land Act of 1954 and 1955 allocated separate residential and business areas to each of the racial groups. These laws restricted the already limited right of black Africans to own land, thereby entrenching the white minority's control of over 80% of South African land. Other laws prohibited most social contacts between the races; enforced the segregation of public facilities and the separation of educational and health care services; created race-specific jobs and employment opportunities; restricted the powers of African, Indian and Coloured unions; and restrained African, Indian and Coloured participation in government. This effectively meant that African, Indian and Coloured South Africans were denied many economic, political and social rights including rights to adequate health. The majority of health service resources were allocated to the white minority who enjoyed the provision of curative, high technology, hospital based health services; whilst the health services for the majority of the African, Indian and Coloured population was provided by a fragmented public health sector rife with geographical and racial inequalities (Cooper *et al.*, 2004:70).

RDP and Health Plan

In 1994, the new democratic government inherited a fragmented and inequitable health system. However the advent of democracy provided the opportunity for new laws and policies in line with the recognition of human rights to be created. The new direction for post-1994 health policy was originally outlined in the Reconstruction and Development Programme (RDP) (ANC,1994a) and the National Health Plan for South Africa (ANC, 1994b) which together outlined the framework for both societal and health reforms. The

intent of the RDP was “to mobilise our people and our countries resources toward the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future” (ANC, 1994a). The mandate for the newly elected ANC was to “address the disempowerment, discrimination, and underdevelopment that over centuries had weakened the health system” (Coovadia *et. al.*, 2009:828). Under the leadership of the ANC a health commission was established which set out a health plan aimed at unifying the fragmented health system by transforming the health sector into a single, comprehensive and integrated system with an equitable distribution of resources and expanded service delivery extending access to an improved health system (Cooper *et. al.*, 2004:70, Van Rensburg and Engelbrecht, 2012: 123). In order to achieve this a reform strategy had to “rectify the suffocating undemocratic culture of dominance and exclusion under apartheid” (Van Rensburg and Engelbrecht 2012:122). This meant adopting a more unitary and integrated health system dealing with the multiple fragmentation within the health sector along:

- (i) Sectoral lines - addressing the deeply imbedded inequalities between public and private sectors, including the market oriented nature of health services;
- (ii) Racial lines – caused by the apartheid legislation that largely benefitted the white minority;
- (iii) Geographical lines – in which the urban areas received more resources leaving the rural and peri-urban areas severely under serviced and neglected;
- (iv) Structural and functional lines – caused by maldistribution, mismanagement and severe shortages; and
- (v) Health status lines – addressing the poor health status suffered by large proportions of the population due to harsh working conditions and impoverished living conditions caused by discriminatory policies.
(Van Rensburg and Engelbrecht,2012:122).

The National Health Plan for South Africa (ANC, 1994b) as an extension of the RDP outlined the plan for the South African system. The National Health Plan was drafted with the principles that everyone has a right to achieve optimal health and to be treated with dignity and respect and that the state should be responsible for providing the conditions to secure health for the people (ANC, 1994b). Similar to the Alma Ata declaration, with an emphasis on health as a human right, the National Health Plan adopted the PHC philosophy, committing to attend to the health needs of the most vulnerable groups in society based on the comprehensive, promotive, preventative, rehabilitative and curative care with priority attention to rural and impoverished urban areas. According to the National Health Plan this could be met through a decentralised district health system

(DHS), essential to which was full community participation in planning, provision, control and monitoring of services under democratically elected representatives. Also essential to an integrated health system was a closer collaboration between government departments in related sectors such as education, employment, water and sanitation which were all recognised as determinants of health. The National Health Plan emphasised the need for training and reorientation of existing health care workers and the training of new health care workers to staff the newly integrated health system. It was within the National Health Plan that the government foresaw a single comprehensive, equitable, tax funded health system organized at a central, provincial and district level in the form of a NHS (ANC, 1994b; Van Rensburg, 2012) .

The National Health Plan for South Africa offered free health care for women in the form of pre and post-natal care, as well as for children under the age of 6, and free PHC services for all who utilize public clinics. It offered free hospital services to children below the age of 14, pregnant women, pensioners, the formally unemployed and people on social grants. Also offered was free TB services, HIV counselling and testing, prevention of mother to child transmission of HIV, cervical screening and medico legal services for sexual assault survivors (Van Rensburg, 2012:128). Greater access to health care was increasingly provided for people living in rural areas and informal settlements with the introduction of the free health care policies as more and more people made use of these public services (Rispel *et al.*, 2009). However the extent to which the public would depend on the public sector was not adequately planned for resulting in severe shortages of essential supplies, overcrowding, poor working conditions, poor health worker morale, deteriorating quality of care and abuse of scarce resources (Van Rensburg, 2012:128). The public health sector could not, and still struggles to meet up with the overwhelming demand particularly due to high prevalence of HIV/AIDS and related diseases.

Contrary to the RDP policy the government showed tacit support for the commercialisation of health as evidenced by reduced expenditure on public health and deregulation of the private sector allowing for the establishment of private hospitals and promoting the growth of medical aid schemes and private forms of service provision (Ruiters *et al.*, 2012:37). The government focus moved away from RDP ideology to a more market-led policy framework which undermined the RDP progression. As a result the

RDP program faced great criticism for not meeting its objectives and became symbolic of the ANC's inability and incapacity to deliver on election promises. Amongst the many issues with the RDP was the discouraging records of spending, delivery and absorption capacity, underspending on projects, mismanagement and corruption, huge bureaucratic bottlenecks and red tape, ideological battles within the ANC alliance over social and economic policy and lack of interdepartmental collaboration. The RDP was criticised as being a naïve "wish list" or mere "pre-election shopping list" by some, while others preferred to look at it not as a direction for policy but as an inspirational framework for change (Atkinson, 1996; Blumenfeld, 1996; Deng & Tjønneland, 1996; Le Roux, 1996; Tjønneland, 1996; Van Rensburg and Engelbrecht in Van Rensburg, 2012: 123).

GEAR

In 1996 the Department of Finance released the Growth, Employment and Redistribution Strategy (GEAR) (DoF, 1996) based on the advice from the World Bank and IMF. GEAR was essentially a neoliberal, macroeconomic strategy aimed at reducing poverty and inequality through economic growth. GEAR as a home grown structural adjustment programme prioritised export-led growth and reduced national spending (Naidoo, 2005). Simply put GEAR encouraged aggressive privatisation and reduction in government spending with the intention of meeting social needs through a trickle-down effect from increased economic growth (Bond, 2007:112). GEAR represented "a significant ideological shift in development thinking, as explicated in its being essentially growth inspired and market oriented" (Van Rensburg, 2012: 131). The labour movement, and one third member of the tripartite alliance, the Congress of South African Trade Unions (COSATU) was firmly against the implementation of GEAR and argued that the policy was not in line with the ANC's Freedom Charter (Nel *et. al.*, 2005:28; Naidoo, 2005; Bond, 2007; Valodia, 2000:7). Despite organised protests against GEAR and demonstrating opposition to the ANC's fervent endorsement of the policy, COSATU failed to reverse the neoliberal trajectory and GEAR was implemented. GEAR was heavily criticised by leftist organisations for limiting one's ability to make a living and significantly reducing access to basic social needs such as health care (Naidoo, 2005). According to Dr. Floyd a health economist and participant of this study, GEAR caused more damage than reparation to the health sector. She said when asked about the failure of the health sector:

“..As far as I’m concerned the damage was done during the period of GEAR when the real per capita spending in the public health sector declined and I mean we lost a decade. So in 2005 I think we had got back to the level of real per capita expenditure that we were at in 1996. So the GEAR policy had a massive impact. I mean government had to restrict its expenditure etc. and the social sectors got hit, especially the health sector”

The focus on GEAR has been cited as one of the major reasons for the growth in income inequality during the late 1990’s and early 2000’s, because it fostered growth and not redistribution (Coovadia *et. al.*, 2009:284). The growth experienced in the economy “almost exclusively benefited the white population” (Coovadia *et. al.*, 2009:284). Coovadia *et. al.* (2009:817) emphasise that policies such as GEAR that promote economic growth alone “are insufficient; an economic architecture should allow the development of programmes that reduce poverty, unemployment and inequalities.” Social development programs are therefore essential for solidarity. But much of the social solidarity principles espoused in the RDP were contradicted and thus compromised by GEAR (Van Rensburg, 2012:131). Barker (2010:81) says that GEAR’s “neoliberal basis, tight fiscal policy and minimal-state ideology became the overwhelming priority of the ANC government which made achievement of the redistribution and equity goals of the RDP and National Health Plan almost impossible.” By curtailing government expenditure and putting social development on the back seat GEAR has consequently been criticized for not being in the interests of the poor (Van Rensburg, 2012: 131). As a policy it represented a step back in the health reform agenda and development agenda as a whole.

The National Health Act

The Department of Health in 1997 published “The White Paper for the Transformation of the Health System in South Africa.” A key objective of the White Paper was to reduce the disparities of the past with an emphasis on redressing inequalities and providing adequate health care to the previously disadvantaged and vulnerable members of society. The Department of Health set out to develop a “unified health system capable of delivering quality health care to all citizens efficiently and in a caring environment” (Dlamini-Zuma: preface of white paper, 1997: 3). Seven key goals set out by the White Paper were to:

1. Unify fragmented health services at all levels into a comprehensive integrated National Health System (NHS);
2. Promote equity, accessibility and utilization of health services;

3. Extend the availability and ensure the appropriateness of health services;
4. Develop health promotion activities;
5. Develop the human resources available to the health sector;
6. Foster community participation across the health sector; and
7. Improve health sector planning and the monitoring of health status and services.
(RSA: 1997:12-15)

In accordance with the Reconstruction and Development Programme (RDP) the White paper outlined five key strategies for restructuring the health sector. These are:

- a) The health sector must play its part in promoting equity by developing a single, unified health system.
- b) The health system will focus on districts as the major locus of implementation, and emphasize the primary health care (PHC) approach.
- c) The three spheres of government, NGOs and the private sector will unite in the promotion of common goals.
- d) The national, provincial and district levels will play distinct and complementary roles.
- e) An integrated package of essential PHC services will be available to the entire population at the first point of contact.
(RSA, 1997:12).

The White paper effectively converted the National Health Plan into a formal policy which led to the National Health Bill, which in turn led to the National Health Act 61 of 2003 (Pillay *et. al.* 2002; Van Rensburg, 2012:132). The Act set out “to provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regards to health services; and to provide for matters connected therewith” (RSA, 2003:2). The Act set out to “regulate national health and to provide uniformity in respect of health services” (Van Rensburg, 2012:135) through (i) the establishment a National Health System encompassing both public and private health care services which will provide the people with affordable, quality health services; (ii) Outlining the duties of health providers, health workers, health institutions and the beneficiaries of health care; and (iii) by protecting, promoting and fulfilling the rights of the population as set out in the Constitution (RSA,2003; Gray *et. al.*,2005; Pillay *et. al.* 2002; Van Rensburg, 2012).

The Department of Health adopted the Primary Health Care (PHC) framework as the philosophical and structural basis of the South African health care system. The health sector mission statement as set out in the White paper (1997:13) was “to provide

leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary health care approach." The PHC framework placed a strong emphasis on equity and a "commitment to universal access to integrated, comprehensive primary care services" (McIntyre and Klugman, 2003:108).

A key objective of the PHC was decentralization of health services aimed at improving local health needs and community involvement through a municipal based, DHS (Cooper *et. al.*, 2004:72). This involved a restructuring of the health services in accordance with the proposal outlined in the RDP and assigning distinct functions to the national, the provincial, the district and community levels of government (RDP, 1994: 43). In accordance with the RDP plan that the health system be based on the DHS as the vehicle for the delivery of primary health care according to the PHC approach a policy for the development of a DHS was established in 1995. The DHS has been advocated as the most suitable system for primary health care and set out the following goals for the effectiveness of the PHC approach at district level:

1. There will be a unitary national health service based on the DHS that allows access for everybody, to improve their health;
2. The country will be divided into geographically coherent, functional health districts;
3. There will be a single health service and health management team for each health district;
4. The health team in each health district will be accountable to a single authority within a provincial and national framework;
5. Ideally, in the long term, district health systems should be part of Local Government, where the boundaries of a health district coincide or are coterminous with those of a local authority;
6. A single authority will be the employer of the district health team;
7. Uniform salary and service conditions will be phased in for all public sector health personnel.
8. The health team will be responsible for providing comprehensive health services throughout the district up to and including District Hospital level;
9. The provincial Health Authority will be responsible for monitoring, evaluating and supporting district health services;
10. Services rendered by private (independent) and traditional practitioners, NGOs, and provincially-aided hospital services will be seen as integral to the health district.

(ANC: 1995:2)

The White Paper highlighted that the restructuring of health service "requires that the new structures be staffed by skilled people, to ensure efficiency and effectiveness in

management and administration” (RSA, 1997:15). Human resource development was identified as a “critical factor in the implementation of health and social development” (RSA, 1997:41). A framework for the training and development of health personnel was set out with emphasis on the optimal use of skills and experience of all health personnel to ensure maximum cost effectiveness and equitable distribution of health personnel throughout the country (RSA, 1997; 42-45). Chapter 4 also discussed caring as an ethos for the health care system based on the principle that “the experience of people using the health system should be one of caring and compassion” (RSA, 1997:49).

The ANC government was criticized for the delay in the implementation of the Act. Some sections were only enacted in 2005, which allowed GEAR policies more time to negatively affect the health sector and development within it. The National Health Act has been amended a number of times and it has been argued is still in need of more amendment to keep pace with international and local developments (Rispel and Moorman, 2010). However, since the Act has been enforced a number of significant organisational structures beneficial to the health sector have arisen including: *The National Consultative Health Forum* launched in 2006, established to “promote and facilitate interaction, communication and the sharing of information on national health issues” (RSA, 2003:32). The Forum meets once a year for the purpose of strengthening dialogue amongst all partners and role-players in the health sector (Tshabalala-Msimang, 2006); *The Market Inquiry into the Private Healthcare Sector* conducted by the Competition Commission whose mandate is to investigate and implement measures to increase market transparency within the private sector (RSA,1998); as well as the establishment of the *Ministerial Advisory Committee for the NHI*, comprising of 25 members appointed by Health Minister Aaron Mokoaleli Mofokeng to advise the Minister on matters relating to the NHI policy (DoH, 2009).

In December 2007, at its national policy conference in Polokwane, the ANC reaffirmed its commitment to left-of-centre policy orientation after many of its members criticised the compromises struck at constitutional negotiations in 1993 and the slow pace of social development (Ruiters et al, 2012:1). The ANC at Polokwane prioritised education and health and in an effort to realise better health services and reduce inequalities in the health sector introduced the National Health Insurance plan (NHI). The ANC

acknowledged “that the South African health system has challenges that can only be addressed through a comprehensive transformation of the system” (Ruiters, et al, 2012:3). The proposed NHI system would provide for all South Africans, regardless of socio economic status, with access to good quality, efficient and affordable health (DoH, 2011). The NHI represented the next reform step in transforming the South African health sector. However before discussing the NHI it is important to first discuss the current problems within the Health Sector. Following is a discussion of the problems and challenges within the health sector derived from secondary sources and from information gathered from participants in this study.

Problems within the Health Sector

One of the things all the participants in this study agreed on was that there are problems within the health sector. Dr Mabena, a representative of the DoH, explained “there are many problems in the health system, we have a fragmented health system, we have human resource shortages [and] we have challenges with quality so they are multifaceted.” Dr Molefe, a health economist summarises the main problem within the health sector as inequality. Inequalities in terms of good quality to health care, quality of care and underfunding within the public sector and inequalities between public and private sectors. In agreement with this assessment, Dr Floyd, an economist specialising in health inequalities said the “biggest problem is inequity between two separate parallel systems, the private and public sectors, each with their own problems.” However before discussing the inequalities plaguing the health system, it is pertinent to discuss decentralisation as one of the drivers of inequality.

Decentralization

In most developing countries health reform has occurred under the context of structural adjustment programmes and has involved a combination of altering the role of the state, decentralisation and an emphasis on primary health care (Bach, 2001:2). The national vision for health care services in South Africa is the PHC through a decentralised, municipal based DHS. The Constitution of the Republic of South Africa, 1996, clearly states that the government is divided into national, provincial and local spheres. The provincial sphere consists of nine different provinces and the local sphere is made up of 8 metropolitan municipalities, 44 district municipalities and 226 local municipalities

(Yes! Media, 2015). The White Paper set out the responsibilities of each sphere of government regarding health care, and emphasized the need to work together coherently to enable the achievement of the PHC goals through equitable and efficient service delivery (Hall *et. al.*, 2000: 28).

Decentralisation policies are often criticised because of their effects on equity, even in instances where there appears to be an increase in efficiency (Bossert & Beauvias, 2002: 26). Other countries have shown that decentralisation of health services it is a complex, fragile process and great care must be taken to prevent perpetuating inequality and fragmentation (Collins, 1996: 163). Decentralisation in health sectors has been seen to lead to inequitable distribution of both financial and human resources, as well as inequitable quality of service delivery (Bossert & Beauvias, 2002: 26). Research found that when the health system is not nationally unified “district health professionals no longer [have] the same geographic mobility and access to promotion, making it significantly more difficult for poorer, rural districts to attract qualified personnel” (Bossert & Beauvias, 2002:26). Variation in the resources allocated to districts, and the priority that each district places on health care delivery lead to a lack of uniformity in training as well as in the capacity of health care workers as the wealthier districts provide better resources and opportunities for health workers compared to the poorer districts (Okuonzi & Lubanga, 1995).

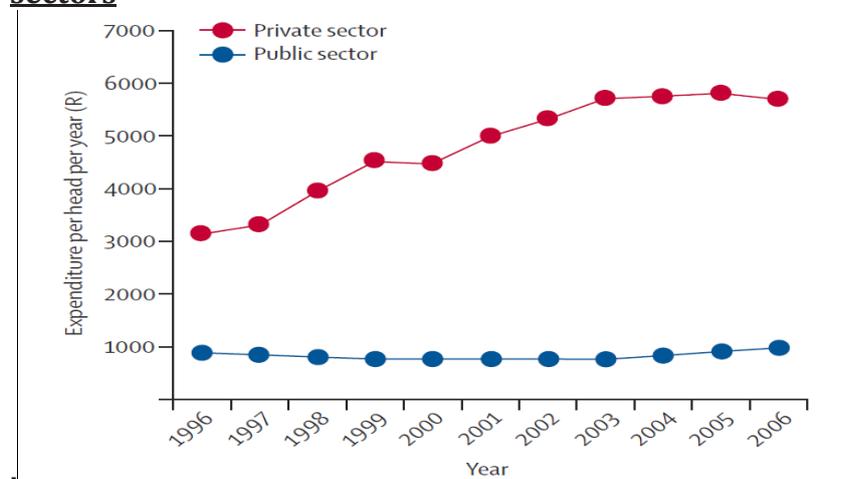
Research on South Africa’s implementation of the PHC through decentralisation has confirmed the international picture that decentralisation leads to inequalities within the health system (McIntyre, 1997; Ntuli *et. al.*, 2001; McIntyre *et. al.*, 1995; Thomas and Muirhead, 2000; Thomas *et. al.*, 2003; McIntyre and Klugman, 2003). The implementation of the PHC approach was criticised as being problematic and lacking in coherent strategy (Kautzky and Tollman 2008: 23). For example, poor co-ordination amongst the provincial and local spheres, and delays in implementing the DHS created uncertainty in the organisational structure and governance of the health system with regard to HIV/AIDS treatment (Blaauw *et. al.*, 2003: 37). Geographical inequalities in the allocation of resources continued to persist perpetuating gross inequalities in the distribution of human resources and infrastructure amongst and within provinces (Coovadia *et. al.*, 2009). Budgetary allocations between municipalities were inequitable leaving those

with the greatest needs (as measured by populations weighted by deprivation) with least funding (Gilson, 2004:64). Decentralisation of the health sector is a sensitive process that is influenced by the socio-economic and political context of a country (Atkinson *et al.*, 2000). The prevailing international experience shows that unless appropriate measures are taken to ensure equalization in distribution of resources and adequate management put in place to enforce it, inequalities prevalent in decentralisation will persist (Kolehmainen-Aitken, 2004).

Inequalities in the South African Health System

The PHC approach was meant to provide health services on an equitable basis to all in accordance with the Constitution. A study in 2004 showed evidence of inequalities between the private and the public health care service. It showed that in 2004, 20% of the South African population had access to private health care while consuming nearly 60% of all health care resources (Cooper *et al.*, 2004: 73). The private sector absorbed an estimated 62% of national health expenditure providing medical care to approximately seven million people, while the public sector absorbed only 38% while providing for an estimated 35 million people (Kautzky and Tollman 2008: 24). A later study in 2008 showed that 17% of the population were covered by medical aid or medical insurance—which used private health care, whilst the remaining 83% relied on the public health care facilities (CMS, 2009). Resources allocated to the public sector have remained relatively stagnant since 1994 while the private sector boasts substantial increase in expenditure, as demonstrated in Fig 7.1 below.

Fig 7.1. Health-care expenditure per head in South Africa's public and private sectors



Source (Coovadia, Jewkes, Barron, Sanders & McIntyre: 2009:12)

The increases in private expenditure shown above is as a result of cost escalation due to the commodification of health services adopted by the private sector rather than changes in the health services provided or investment in new technology (Coovadia *et. al.*, 2009:12). According to Prof Schoeman, a professor of social policy specialising in inequality and participant of this study, the commodified nature of health care in South Africa has led to a focus on the “bio-medical” tertiary levels of health care provision at the cost of the primary levels of health care provision that should be taking place at community levels. Speaking on this issue Prof Schoeman says:

“Big hospitals like Groote Schuur hospital and so forth drain up to 60-65% of provincial health budgets, that’s a fantastic draining of resources into this bio-medical forms of health care provision, the third level of care provision. That’s a problem [with] the institutional structure between primary care, secondary care and tertiary care. One is not arguing within that for the displacement of tertiary levels of care but for a more appropriate form of health care provision at the level it is needed. At the moment the real need is at community based level. So that level needs to be strengthened, it needs to be better resourced, and of course the benefits of that is building in a PHC approach at the local community level means that you will have less patients presenting at secondary and tertiary levels if you can deal with the problem effectively at a primary level.” (Interviewed 1 September 2015).

The ANC acknowledged that “the current command of health resources by the private health sector, which serves a minority section of the population has been to the detriment of the public sector on which the vast majority of South Africans depend” and that government expenditure on health care per person dependent on the public health sector has not kept up with the rate of inflation (ANC, 2010: 06). WHO recommends that a minimum 5% of a country’s GDP be spent on health care. Research shows that high income countries spend an average of 7.7 % of GDP on health while most middle income countries spend 5.8% and low income countries spent 4.7 % of their GDP on health (Schieber, *et. al.* 2006 cited in DoH, 2011). South Africa currently spends 8.9% of its GDP on health care, which in light of the recommendation from WHO is significantly higher than what should be adequate (WHO, 2015). However, compared to similar middle-income countries, South Africa’s has a poor health outcome, due in large part to the inequalities between the public and private sectors (DoH, 2011).

Dr Burton, a participant of this study and a representative of the Private Practitioners Forum, described the split between public and private sectors spending of the percentage

of GDP spent on health (currently 8.9%) as “4.3% of GDP is spent by the private sector on 8 and a half million people, 16% of the population and 4.4% or whatever it is today, is spent on the other 84%” (Interviewed 26 November 2014). Dr Floyd, notes that within South Africa, “there’s a problem in relation to having half of your financial resources within medical schemes serving 16% of the population and the other half of your money in a tax funded system that about 80% of the population is heavily dependent upon, particularly in relation to hospital and specialist care.” This demonstrates a stark inequality between the public and private sectors on the nation’s health spending. Dr Molefe similarly noted:

“When you talk about expenditure for health South Africa, which is almost about 8.6/8.6 per cent of GDP, half of that is private...Now if you look at the amount of money that we spend in the private sector, it’s almost as much as we are spending in the public sector. Now that in itself might not be a problem because there are many countries that have got private sector providers in all sorts of forms that are contributing to equitable access. The problem is that there is only a few proportion that have access to private service” (Interviewed 31 August 2015).

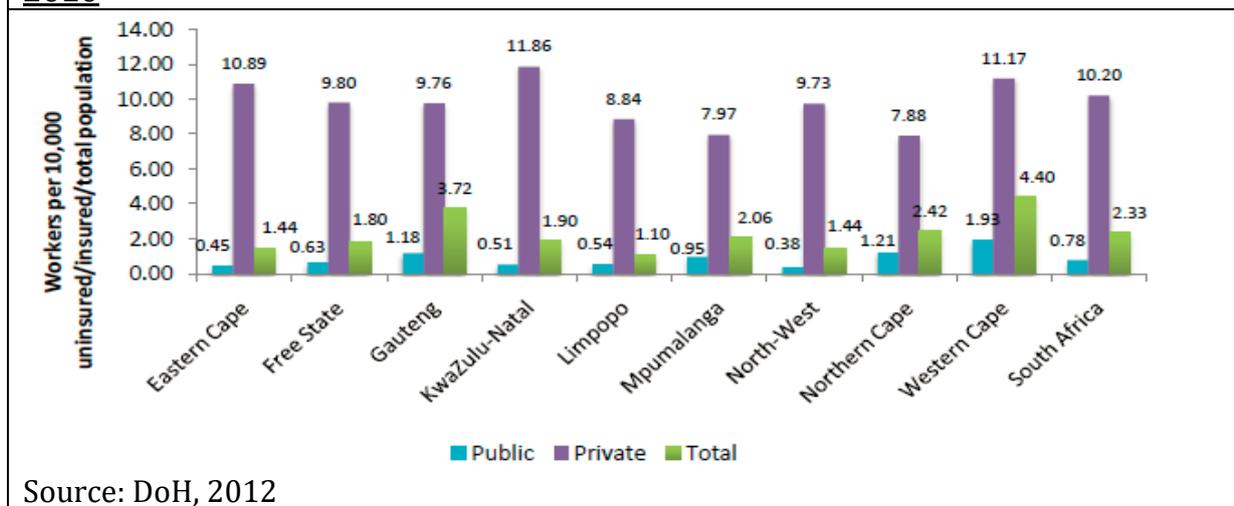
Prof. Schoeman notes that “65% of total health monies only go to service 16% of the population and the majority part of the population they are dependent on a poorly served system of health care which structurally and institutionally is constructed in a way that reproduces the inequality” (Interviewed 1 September 2015). He argues that there is fiscal inequality within the very structure of the health system that reproduce the schism between public and private forms of care. He justifies this by saying:

“the government incentivises employers with 2/3^{rds} tax deductions to enrol their staff onto medical aid schemes but those medical aid schemes are arrangements within the private healthcare system. So the government actually incentivises private health care. So the professional classes use the medical aid schemes to access health care, but it’s in the private system. So the funding flow goes to private health care through this incentivised scheme through the tax subsidy schemes and where the money should be located which is in the public system the funds don’t actually reach the public system because of the way the system is structured, so I would argue it is the systemic inequality in the way that health care is constructed that we see the scale of inequality” (Interviewed 1 September 2015).

Prof Schoemans argument is that the government seems to promote use of private medical schemes. According to SARS in 2015 a tax credit of is R270 per month is awarded to the tax payer who paid the medical scheme contributions with an additional R270 per month for the first dependant, and R181 per month for each additional dependant

(SARS:2015). Pof Schoeman believes that the government should go back to the PHC model declared by the Alma-ata, and effectively use it to systematically deal with the socio-economic determinants of poor health and other forms of inequality within communities at a local level. However inequalities persist. The distribution of pharmacists between the public and the private sectors as demonstrated in Fig 7.2 below is a shocking example of the extent of inequality between the public and private sectors.

Fig 7.2. Number of pharmacists per 10,000 population in each sector, by province, 2010



Source: DoH, 2012

What is made abundantly clear is that the private sector comparatively has more finances and therefore more resources within the health care system. This dynamic gives rise to more inequalities in resources allocated between sectors as well as the skewed allocation of health care workers. It also explains the inequalities between classes in terms of access to health and quality of health care. The rich, who can afford private care are afforded more access and better services while the poor who rely on the public sector, have less access and lower quality of service. Dr Molefe asserts that the problem of inequality in access to good care is demonstrated by the fact that “we still have many areas where people travel long distances” to access health care services but questions the standard of care because “the quality of care in the public system is as you know very questionable, particularly because of shortages of human resources, attitudes, [and] performance productivity.”

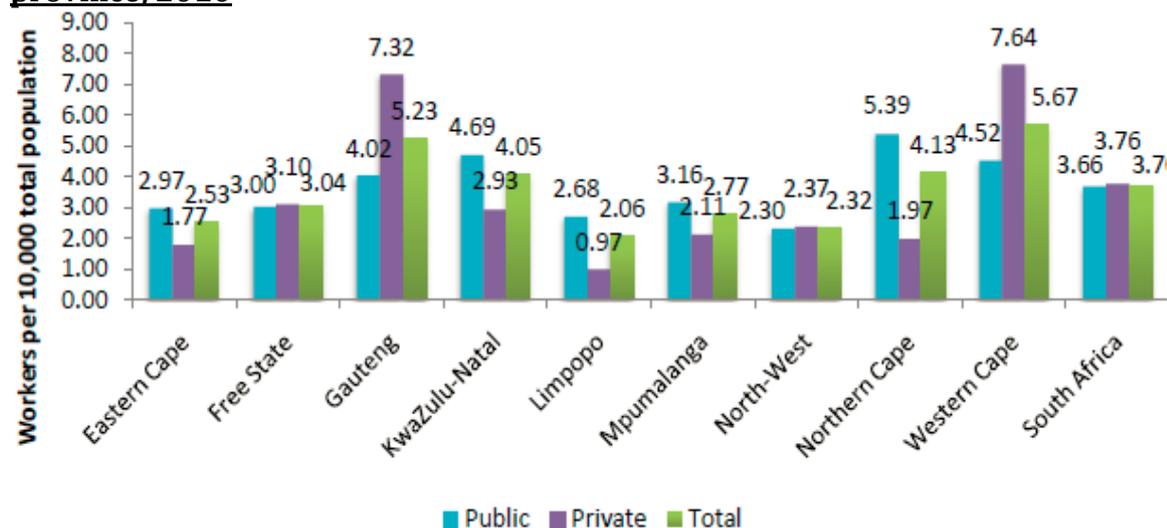
Commodification

Prof Schoeman states that the problem of inequality between public and private as a consequence of the commodification of health care. He argues that health workers do not have incentive to work in the public sector, whose focus is on community based forms of health care provision but opt to work in the private sector with a more marketable bio-medical focus. According to Prof Schoeman:

“Within a commodified health system, as we have at the moment, the orientation of those doctors is to work in the private sector because it’s a commodity driven form of health care provision. So that’s another part of the problem, the fact that the system is commodified and that’s not just in terms of the fiscal flows but also in terms of the consciousness that’s imparted to doctors and other health care personnel in the process of their training... It’s a problem with human resourcing, that’s a key issue, and the consciousness that accompanies the training of doctors and where they come to be deployed between the public and the private sector, and it’s mainly in the private sector” (Interviewed 1 September 2015).

The shortage of health workers within the health system as a whole makes the inequalities between sectors even more dire as most health workers prefer the incentive of working in the private sector over the public sector. All the participants in this study agreed that there is an urgent need for more health workers and more resources as a whole within the public sector as that is where the real need is.

In addition to inequalities in the public and private health sectors, research done by The Local Government and Health Consortium in April 2004, on the various districts in South Africa, has shown geographical inequalities where financial resources are highly concentrated in certain provinces and health districts. KwaZulu Natal, Gauteng and Western Cape were found to account for 60% of resources but only 43% of the population. The five best-funded health districts claim 43% of national funding for primary health care activities which are provided outside of hospitals, although they are home to only 28% of the population (The Local government and Health Consortium, 2004:19). An example of the number of medical practitioners per province and per sector is shown in Fig 3 below for the year 2010.

Fig 7.3. Number of medical practitioners per 10,000 population in each sector, by province, 2010

Source: DoH, 2012

Shortage of workers in the health sector

Another major problem within the health sector as a whole is the shortage of health care workers. Adequate staffing of the health sector is a key ingredient to equitable and efficient service delivery. The white paper identified the grave need for skilled workers to insure “efficiency and effectiveness in management and administration” (RSA, 1997:8). It outlined a national framework for the training and development of health personnel whose experience and expertise should be used optimally to ensure maximum efficiency and cost effectiveness. This included the equitable distribution of such personnel throughout the country. However, critical shortage of trained health personnel as a result of international emigration has undermined quality of care particularly in the public sector. District health care centres and clinics bear the brunt of the inequitable distribution of human resources as a result of health worker shortages, thus undermining health system development “at the most critical point of care” (Kautzky and Tollman 2008: 25). The ANC NHI discussion paper points out that 60% of nurses and 40% of doctors serve 85% of the population (ANC, 2010: 10). The vacancy rate of nurses grew from 31.5% in 2006 to 36% in 2007, while the OECD estimated in 2001 that almost 9000 South African doctors were in its countries (ANC, 2010: 10). The staff shortfall of public health workers was close to 80 000 in 2007/8 indicating a severe shortage of not only nurses but all health care workers.

Public health services such as clinics have become inundated as the population becomes increasingly reliant on the State for all basic services and necessities, as was accorded to them by the PHC (Kautzky and Tollman 2008: 23). The lack of sufficient resources for public sector health care delivery has been a common justification of the failings of the health sector as it is argued it “occurs within a context of competing needs for resource allocation for housing, education and job creation, and by the continued skewed allocation of health resources towards the private health sector” (Cooper *et. al.*, 2004:73). Therefore the sector has to operate within a limited focus in that priority has to be given to certain services above others. This resulted in the movement of resources from secondary and tertiary levels to the primary level. The effect of this is that although more primary services are made readily available, specialized services, particularly hospital based services, are less available to the poor because of budgetary constraints.

WHO suggests a minimum of 200 nurses per 100 000 population, which works out to a ratio of 500:1. It would appear from Fig 4 that South Africa falls favourably with a ratio 434:1 in 2010 and 428:1 in to 2011. However it must be emphasised that these figures, although showing a healthy sufficiency of nurses in the workforce, disguises the disparities in provincial and especially public/private distribution. These figures do not show that the private sector has more nurses, but serves less of the population. The NHI discussion paper (ANC, 2010) states that 60% of nurses serve 85% of the population, in the public sector, while 15% of the population is served by 40% of the nursing workforce, in the private sector. Using the SANC data above for the year 2011, this means that the public sector serves at a ratio of 605:1 while the private sector serves at 160:1.

Fig 7.4. Distribution of population vs nurses in provinces 2010 and 2011

Province	Population 2010	Registered nurses 2010	Ratio 2010	Population 2011	Registered nurses 2011	Ratio 2011
Limpopo	5 439 600	9 025	603:1	5 554 657	9404	591:1
North West	3 200 900	7 775	412:1	3 253 390	7978	408:1
Mpumalanga	3 617 600	5 714	633:1	3 657 181	5927	617:1
Gauteng	11 191 700	30 063	372:1	11 328 03	30770	368:1
Free state	2 824 500	7 550	374:1	2 759 644	7623	362:1
KwaZuluNatal	10 645 400	24 360	437:1	10 819 130	25440	425:1
NorthernCape	1 103 900	2 146	514:1	1 096 731	2202	498:1
Western Cape	5 223 900	14 626	357:1	5 287 863	14800	357:1
Eastern cape	6 743 800	13 985	482:1	6 829 958	14118	484:1
TOTAL	49 991 300	115 244	434:1	50 586 757	118262	428:1

Source: SANC 2011

According to a study done by Wildschut and Mqolozana (2008) on the shortage of nurses in South Africa, they found that South African nurses are not happy. They found this to be especially true for nurses in the public sector who complain about having to function in an environment characterized by shortages of personnel and necessary equipment. The health system continues to haemorrhage nurses who are driven away by working conditions, thus increasing the pressure on those who remain (Wildschut & Mqolozana, 2008:49). James Buchain (in Du Bois, Mckee & Nolte, 2006) conducted research on the reasons South African health workers emigrate to Europe. He found that the 'push factors' that encourage emigration include low pay, poor working conditions, lack of resources to work effectively, limited career opportunities, limited education opportunities, the impact of HIV/AIDS, unstable or dangerous working environments and economic instability. Among the 'pull factors' that encourage immigration into Europe are higher salaries and opportunities or remittances, better working conditions, better resourced health systems, career opportunities, provision of post-basic education, travel opportunities and aid work (Du Bois, *et. al.*, 2006).

The DoH noted in 2012 that "education and training system for the health sector in South Africa has not grown sufficiently to meet health needs and health system requirements. This is in part due to a lack of integrated planning between the health and education sectors on the development of health professionals in relation to healthcare needs, and inadequate financing mechanisms for health professional development" (DoH,2012:44). Strikes within the nurse workforce stress the plight of healthcare workers and "illuminate the human resources crisis in health care as caused by poor conditions, increased workloads and failure to develop and implement a reasonable human resource plan for health (Wildschut & Mqolozana, 2008:49). Although the Minister for Public Service and Administration and Minister of Health condemned health workers for their actions and accused them of behaving in a manner "discordant to their vows to put the lives of patients above everything else" trade union organisations have supported the nurses right to protest poor working conditions, remuneration and discontent with the health sector (Wildschut & Mqolozana, 2008:49).

The Minister of Health in 2010, after a visit to Brazil where he observed their health system, returned with a vision to re-engineer the PHC system in South Africa (Pillay &

Brown, 2011). This demonstrated the DoH's renewed commitment to the PHC approach as the philosophical basis for the NHI. However the DoH acknowledges the need for strengthening the PHC approach. According to Dr Mabena the DoH is proceeding with PHC re-engineering. She acknowledges that "we need to go back to a PHC approach where we need to put more emphasis on services that are produced at community levels, PHC levels, so that you prevent people from presenting in your facilities when they have complications." It is the re-engineered, strengthened PHC approach that is the basis of the proposed NHI (DoH, 2011).

The NHI

In an effort to realise better health services and reduce inequalities in the health system, the government is in the process of implementing the National Health Insurance System (NHI). Following the Discussion Paper in 2010, the Department of health released the National Health Insurance Policy Paper in February 2012, but embargoed it until 5am on the 12th of August 2012. According to the DoH, the NHI "will be publicly funded and administered and will provide the right of all to access quality health care which will be free at the point of service" (ANC, 2010: 5).

The NHI policy paper identifies the fragmented nature of the South African health system prior to 1994 and the failure of health reform attempts to bring about an equitable health care system (DoH, 2011). The two-tiered nature of the South African health care system, the public and private sectors, are criticized as being "unsustainable, destructive, very costly, and highly curative or hospi-centric" (DoH, 2011:6). The rationale for introducing the NHI is "to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes. National Health Insurance will improve access to quality healthcare services and provide financial risk protection against health-related catastrophic expenditures for the whole population" (DoH, 2011:15).

The objectives of the NHI are centred around providing universal coverage which according to WHO is "the progressive development of a health system including its financing mechanisms into one that ensures that everyone has access to quality, needed health services and where everyone is accorded protection from financial hardships

linked to accessing these health services” (cited in DoH, 2011:18). Based on principles of the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency (DoH, 2011:16), the objectives of the NHI set out in the policy paper are:

- a) To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not.
- b) To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund.
- c) To act as the strategic purchaser in the health sector.
- d) To strengthen the under-resourced and strained public sector so as to improve health systems performance
(DoH, 2011:19)

The NHI will cover the South African population affording people the right to “a defined comprehensive package of health services at all levels of care namely: primary, secondary, tertiary and quaternary with guaranteed continuity of healthcare benefits” (DoH, 2011:25). However, foreign students, tourists and visitors “will be required to obtain compulsory travel insurance and must produce evidence of this upon entry into South Africa” (DoH, 2011:24). The Department of Health anticipate that the NHI will provide socio-economic benefits that will affect social development and economic productivity of the country. This is based on the belief that a healthier workforce works more efficiently and is thus more productive, which contributes to the economic development in the long run, attracting more investment into South Africa (RSA, 2012:20).

Since the NHI will be based on a re-engineering of the PHC approach its main focus will be community outreach services, health promotion and preventative care, using the DHS system. The NHI policy paper clearly states that PHC will be “population orientated with extensive community outreach and home based services, and in which community health workers form an essential part.” Because health districts under the previous health system lacked specialist resources to support PHC services, the NHI provides that an integrated team of specialists be based in each district, comprising primarily of a “principal obstetrician and gynaecologist; a principal paediatrician; a principal family physician; a principal anaesthetist; a principal midwife and a principal primary health care professional nurse” with others being added on an as needed basis (RSA,2012:25).

NHI as it applies to the South African context is a misnomer. According to Ruiters, Van Niekerk and McIntyre, the “NHI scheme is more than just a proposal for creating an integrated fund for financing health care for all...It has far wider transformative objectives and may in fact be more akin to a national health service” (Ruiters et al, 2012: 13). Prof Schoeman emphasises this point and explains that the NHI that is being argued for is actually more akin to the NHS of the United Kingdom because it’s not an insurance based system of care but a tax funded system of care. He explains the reason that it continues to be called NHI as a result “of an early proposal of the ANC about 10 years ago where it had traction. The ANC was arguing for reform of the health care system along the lines of the NHI. They kept to the language of the NHI because of the political traction of that term within the ANC in terms of the political discourse element.” Therefore it is important to understand the NHI as is presented by the ANC and the DoH is a misapplication of the term, it is NHI in name but is actually in effect a NHS.

Implementation of NHI

The NHI was set to be phased in over 14 years, according to a 10-point plan beginning with pilots in selected 11 districts² from April 2012 (DoH, 2011:1). The criteria for selecting the pilot districts are socio-economic indicators, millennium development goal proxy indicators, health service management indicators and financial and resource management (DoH, 2011:4-6). Upon completion of a country-wide audit of all healthcare facilities based on the above mentioned indicators, as well as basic infrastructure, compliance with standards and appropriate management levels, the Department of Health selected the 11 pilot districts (DoH, 2011:4). The DoH is now in the process of determining additional districts for inclusion in the roll out will occur annually. The pilots will be used as a foundation phase to build an enabling environment and to strengthen the health system and demonstrate the key administrative and technical aspects of implementing the NHI to ensure a smooth roll out (DoH, 2011:3).

² Pilot districts include Oliver Tambo District in the Eastern Cape, Thabo Mofutsanyana District in the Free State, Tshwane District in Gauteng, Umzinyathi District, Umugungundluouvu District, and Amajuba District in Kwa Zulu Natal, Vhembe District in Limpopo, Gert Sibande District in Mpumalanga, KK Kaunda District in the North West, Pixley ka Seme District in the Northern Cape and Eden District in the Western Cape.

Cost of NHI

The NHI policy paper provides preliminary estimates on the cost of the NHI and emphasises that the figures given merely “provide a good indication of the likely magnitude of resource requirements and more importantly allow for the implications of key National Health Insurance design elements to be assessed” (DoH, 2011:36). The model used to calculate the costs propose that the resources to implement the NHI should “increase from R125billion in 2012 to R214billion in 2020 and R225billion in 2025 if implemented gradually over a 14-year period” (RSA,2012:37). The policy paper states that the funding for the NHI is best achieved through a pre-payment health financing mechanism that is achieved through a pooling of funds from a combination of sources such as the fiscus, employers and individuals. This would require payments for health care in advance and a pooling of those payments to be used to fund the health care needs of the population (DoH, 2011:35). The money earned by the ‘fiscus,’ or government, ultimately is derived from individuals through taxes, therefore the primary mechanism of funding for the NHI is expected to be through taxes. South African economists such as Kevin Lings (of Stanlib) and Mike Schussler (of economists.co.za) have within the media expressed concern with the NHI budget claiming that the NHI scheme could push the economy into a recession (Govender, 2011). According to Bateman (2010) Tony Twine (of Econometrix) particularly questions the assumption that South Africa will achieve an economic growth rate of over 7% per annum for the next 13years consecutively when a growth of 3.5%-4.5% is more realistic. It has been argued that the health expenditure in such an instance will consume 22- 28% of government spending by 2025 and as such would cause friction with other high-priority government targets such as education, housing and infrastructure. Further arguments from economists suggest that increasing the general tax load, as has been proposed, would weigh on the economy and limit growth and job creation (Bateman, 2010: 792). The policy paper points out that the cost of the NHI is “the subject of continuing technical work and will be further clarified in the next 6 months parallel to the public consultation” (DoH, 2011: 35). However it has been 3 years since the Green paper and we are yet to receive any clarification on the financing of the proposed NHI.

Finance Minister Pravin Gordhan, when delivering the Budget Speech to Parliament on the 22nd of February 2012, announced an allocation of R121billion for the 2012/2013

health budget “aimed at improving hospitals and strengthening public health ahead of the scheme’s introduction. Gordhan (2012) announced that R1billion has been allocated to NHI pilot projects, while R450million has been dedicated to upgrade up to 30 nursing colleges and R426million allocated for the refurbishment of five major tertiary hospitals (the Nelson Mandela Hospital in the Eastern Cape, the Chris Hani Academic Hospital in Johannesburg, the Dr George Mukhari Hospital in the North West province, the Limpopo Academic Hospital in Limpopo and King Edward VII Hospital in Durban).

Dr Mabena is encouraged by the progress made within the first phase of the NHI. She describes some of the progress thus: “We have demerged Limpopo from Medunsa. So we’ve got two Universities now. We have approached all the other existing medical schools and health sciences faculties to increase their training capacity, they are receiving additional funding. But we are also training outside of the country. We have got the Cuban doctor programme that is part of expanding the production.” She describes the NHI as not merely as a reform but as a transformation of the health system the goal of which is to “ensure that all South Africans irrespective of their socioeconomic status have access to quality health.” She maintains however that “the most important thing is to make sure that the steps you take towards that really really are grounded and they make sure that you take everyone who is in this country into account when you are planning your health services.”

Much of the NHI objectives are similar to that of the RDP, however one significant difference is that of developing an NHI Fund that will act as a strategic purchaser. Purchasing is the process by which funds are allocated to healthcare providers to obtain services on behalf of identified groups, which in this instance is the entire population (Kutzin, 2001; RESYST, 2014). A World Health Report on universal health coverage noted that raising sufficient money for health and removing financial risk through pooling, although imperative is not enough to ensure universal coverage. A final requirement is ensuring that the resources are used efficiently (WHO, 2010). This highlights the importance of the purchasing function of health financing which is “the critical link between resources mobilised for universal coverage and the effective delivery of quality services” (RESYST, 2014). According to the NHI policy plan the strategic purchaser will be the semi-autonomous NHI Fund (DoH, 2011). Strategic purchasing will require the

NHI Fund to engage actively with government, health care providers and citizens. The role of the NHI Fund as the strategic purchaser will involve identifying services to be purchased considering population needs, choosing providers based on quality and equity, and contracting providers for services on behalf of the population (WHO, 200; Figueras, Robinson and Jakubowski, 2005; RESYST, 2014). Dr Floyd and Dr Breyer both contend that the current purchasing arrangements within the public sector are inefficient. Dr Breyer states that with this reform comes what is known in the international health insurance environment as the “purchaser provider split where you separate the purchasing body from the provider body and the arrangements are much more contractual and reimbursement and bound” (Interviewed 15 April 2015). Dr Floyd emphasises the main advantage of the NHI Fund as a strategic is that it “would hold all the purse strings, they can dictate about price... if you have a single purchaser, basically providers can say look I don’t want to accept that price and they can say fine, I won’t purchase services from you. You’re a price maker if you’re a strategic purchaser rather than a price taker” (Interviewed 29 June 2015). She states that the strategic purchasing arrangement is “ a mechanism for insuring that the quality of services is good, it’s also a mechanism for making sure that resources go where they are needed.” The NHI fund can use its powerful position as a strategic purchaser to promote efficiency, equity and quality of service. RESYST (2014) states for example that “purchasers can offer higher payment rates for services provided in under-served areas” thereby improving equitable distribution of health workers and finances across geographical areas by “promoting the availability of well-staffed, equipped and supplied health services across the country.” According to Dr Breyer Treasury believes “we are now at the point where we can form the fund” and that South Africa can indeed afford the NHI. Treasury, however cannot disclose its plans contained in its Finance Paper until the DoH releases the White Paper.

The delay in release of the White Paper has been a major cause of concern for not only the public but for all stakeholders involved in the health sector. Dr Mabane however is encouraged by the progress of the NHI within its first phase and assures regarding the publication of the White Paper that “when we have completed all the processes that we have to follow in terms of policy development, consultation, government processes, then it will come out. We are close to its finalisation.” The opinions, positions and powers of stakeholders are essential to the reform process. Stakeholders within the health sector

have been outspoken either in support or opposition of the implementation of the NHI. Similar to the Canadian and Swedish experiences, health reform has met with many challenges as stakeholders lobby for or against the implementation of the NHI. The following chapter will discuss the debates and contentions between the various stakeholders as South Africa currently goes through the process of health reform and moves towards implementation of the NHI.

CHAPTER 8

SOUTH AFRICA – STAKEHOLDERS CONTRIBUTIONS TO REFORM

Introduction

The DoH released the NHI Green Paper on the 12 of August 2011 for public comment. It originally stated that comments must be submitted within two months from the publication of the Green Paper, however the DoH extended the submission deadline to the end of December 2011. Within this time period representatives of various stakeholders within the health sector made submissions on publically accessible forums. Amongst the respondents were academics such as Prof Alex Van de Heever, the Chair of Social Security Systems Administration and Management Studies at the University of the Witwatersrand, medical funding groups such as Discovery, private providers represented by the South African Private Practitioners Forum (SAPPF), the South African Medical Association (SAMA), trade unions such as National Education Health & Allied Workers Union (NEHAWU), and other interest groups such as the Helen Suzman Foundation. Although many of the submissions and comments were not in full support of the NHI, one thing that they all agreed on was the failure of the current health system in meeting the health needs of the population. This chapter will discuss the opinions of the stakeholders, the representations in media and the positions of government as debate ensues around the implementation of the NHI.

As seen with the Canadian and Swedish reform processes, stakeholders representing powerful interest groups who are not in support of reform are able to campaign and lobby around preventing reform from happening. As is the case with most health reform, the private sector show the most opposition to universal health care provision when the public sector is envisaged as the dominant provider. For the private sector, which is made up of providers and funders, who act upon market principles and are the “winners” in the current health sector environment, health reform presents a challenge to their ‘way of life.’ The private sector however is used by those who can afford it, mainly being the professional middle class and the wealthy. These classes, although not the majority represent strong interests within the broader economic, social and political arena’s and as such wield significant power over policy. It is this power and influence that is weighed

against the power and influence of the poorer majority, whose interests according to PRT are represented by strong trade union movements and leftist government representation. Within South Africa it is the interests of these two groups that are most represented in public debate around implementation of the NHI as seen in the comments on the NHI and massive media campaigns. The biggest areas of debate are concerns around the delay of the White Paper, the capacity of Government to meet the challenge of the NHI and how much the NHI will cost the government and the tax paying public.

The Role of the Private sector

Within their NHI submission document, the SAPPF acknowledges the health sector faces significant challenges demonstrate their support of a “pragmatic approach to health care reform” but remain sceptical of “any proposal which seeks a radical overhaul of the health care system” (SAPPF, 2011:1). The SAPPF question whether the proposals presented in the NHI are the best means of achieving its equitable goals. The biggest concern permeating the SAPPF submission document however is the role of the private sector within the new NHI dispensation. Their submission demands more clarification of the role of the private sector, details of the proposed benefit package, details about the cost and reimbursement mechanisms, information on the intended public-private partnerships and the role of the DoH and provincial departments in the regulation and implementation of the NHI (SAPPF, 2011). SAPPF state in their submission “while we acknowledge that the standards of care are far superior in the private sector to that experienced in the public sector, it will not help to discourage investment in the private sector and to encourage more persons to make use of public sector facilities. This would only serve to further over-burden the public sector at a time when the real issue that requires urgent redress is the poor standard of care within that sector” (2011:9). They reject the characterisation of the private provider costs being inappropriately high and submit that the private sector is not overpriced or unsustainable as suggested in the Green paper. Their argument is that the DoH’s agenda “to simply criticise the private sector distracts attention from the most pressing concern facing the health sector: the dire state of public health” (SAPPF, 2011: 3).

The SAPPF (2011) reading of the Green Paper finds that the DoH seeks to rid the health sector of the private sector and argue that “private health sector is a national asset that

should be nurtured.” Dr Burton a representative of the SAPPF reiterated this view. He stated that the private sector “is not something that should be closed down in favour of developing a universal system such as the NHI, it rather should be used to complement and supplement the services of the state and we should find mechanisms for making the private sector more accessible to more people” (Interviewed 26 November 2014).

According to Dr Burton one of the roles that the private sector serves it that it “saves the state from providing health care services to those people who can afford to pay for themselves.” He maintains that it’s financed by private money which costs the state nothing but a subsidy in the form of a rebate. Dr Burton challenges the statistics that show that the private sector has more human resources in terms of doctors and nurses than the public sector. He argues that

there are far more GP’s for example, working in the public sector than in the private sector, and there are far more nurses employed in the public sector than there are in the private sector. There are more specialists in the private sector, but the reason for that is Governments policy which prioritized primary health care over tertiary health care and therefore closed wards and stopped young specialists from finding employment within the public sector. And if it wasn’t for the existence of the private sector, a lot of these young specialists would have had no option but to emigrate. (Interviewed 26 November 2014).

Dr Burton believes that because the public sector offers them no jobs the private sector is the only option for specialists within the South African health system and in effect acts as a safety net for keeping specialists within the country. He argues that most doctors would prefer working in the public sector because comparatively they earn more. He maintains that:

“If I earned at the end of a day what a public doctor earns I’d be quite happy. Because I mean a person in my position in the public sector at the moment is earning quite a lot, quite a good salary, and he has no costs. I’ve got to employ staff, I’ve got to pay rent, I’ve got to pay for my ultra sound machine and laptops and the cost of running an average private practice today is close to a million rand. Find me a job in the public sector. There are no specialist posts. That’s why young specialists come out into the private sector. Because there are no jobs and they don’t want to work there. Not because of the salary, it’s because of the conditions of employment” (Interviewed 26 November 2014).

In a research interview Dr Burton’s argument was posed to Dr Moloeffe, a health economist. His response was:

We have a huge shortage of doctors. Unless he had some sort of a cognitive dissonance. You can’t be saying that. We have a huge shortage of doctors

in the public sector. A doctor can find a job anytime today. It's just because they choose where they want to work. They want to work in urban settings... Nobody denies that if you set up a GP practice it's an investment. Of course. You have to at least break even or even make a normal profit. They are not making a normal profit, they are making a supernormal profit. Is that good for society, I mean it's not. For themselves its good. They're not gods. They just spend a little bit more time studying, one thing. But they are not gods. So it's understandable that they have to recover their costs. ...But I understand that they have a right to do business....But if all of them are going to be in Pretoria, the reason that they end up not making enough money is because you have a GP here a GP there a GP there a GP there, I mean, it's just, there's no business acumen. I would never set my GP in a context where there is a very small catchment population. You'll be out competed. Unfortunately that's how the market works on their side. But they are making enough money (Interviewed 31 August 2015).

Dr Molefe agrees that private practitioners have a place within the health system and a partnership between the public and private sectors should be encouraged. He states that private providers can improve access if they are located in places where they are most needed and if their services are affordable. But "they must be willing to go to the furthest part of Umtata rural area and set up a surgery and be able to say government look, I've invested my money here, the community is like this, can you help? That's what we're saying. Those are the public/private partnerships that work." Discovery contends that "the NHI reform framework should explicitly allow for both private and public sector healthcare access in South Africa... [and that] these two sectors should ideally co-exist in a way that optimises the interfaces between them, and avoids either causing harm to the other" (Discovery 2011). Dr Burton states the SAPPF recognizes the opportunities for the private sector to improve access to healthcare "if it's allowed to involve itself in public private partnerships with the state." The key according to him lies within the governments' willingness to work with the private providers. According to Dr Burton:

There's a lot of antipathy in the DoH towards the private sector, and I believe there's a lot of willingness on behalf of private doctors to make a contribution. But we need to change the environment; we need to get closer together with the public sector and say look we need to cooperate, don't try and close us down, rather talk and say how we can cooperate to actually provide better health care for more people. That's what the approach should be. But because the private sector per say is seen as a monster all they want to do is close it down, they don't want to have anything to do with it. And they're missing an opportunity" (Interviewed 26.11.14)

Constitutionality of NHI

Many of the private sector stakeholders question the constitutionality of the NHI in their submissions. (SAPPF, 2011, MediClinic, 2011, HSF, 2011). The main arguments are that establishment of the NHI diminishes the powers of the provinces, infringes on private citizens right to join medical schemes and infringes upon service providers rights to profession, property and freedom of trade. According to Mr Swart the private sector does not cause any threat to solidarity. He believes that that argument is based on “fear blinded by some very obscure thinking” within the ANC caucuses that the private sector is a threat to the NHI. His argument is “if everyone has paid his dues in taxation, and we are confident that those who earn most aren’t taking more out of the public sector system than anyone else, in fact they should be taking less, then it shouldn’t be an issue at all what I do with my money after that.” According to him:

“The fear works off the principal that we think that as a private individual who has money spare at the end of the month, I shouldn’t be able to buy health care and that I think is really unsound. It’s a model applied in Canada, where they try and force providers not to charge private patients. But it takes away my right. And I really think there’s something fundamentally wrong with that thinking. If I feel that I would want my knee fixed up tomorrow as opposed to waiting two years and I have the money for it then no reasonable argument can be made that I shouldn’t have it done. There’s some sort of strange thinking in this arena that’s says it’s unfair if someone, just because he’s got money can have his knees fixed up before anyone else. And I find that absolutely unbelievable. If you earn the money and you’ve paid your dues then what you choose to spend it on And the fact is if I choose to have that health care and I want it done by a doctor, then I think we should have the right (Interviewed 15 January 2015).

Mr Swart, as a representative of MediClinic as well as Mr Burton from SAPPF, in line with arguments presented by Discovery, the HSF and Alex Van den Heever in their NHI submissions all argue the point of the right to choice of either private or public sector services, doctors, hospitals and medication for the individual along the lines of market principles that dictate if one can afford it and is willing to pay, then one should be exercise their constitutional freedom to do so.

Duality of the Health System

Dr Burton was visibly concerned about the arguments put forward in the Green Paper. According to him the DoH is wrong in their assertion that “the cause of all their problems was the existence of the two tier system of health care” and their description of the private sector as an “iniquitous” system is unfounded. He argues that just because more doctors and nurses are attracted to the private sector and “because private individuals were prepared to spend their own private money on their own health care, you shouldn’t conflate that with what the state was prepared to spend of the nation’s taxes on health care for South Africans.” He maintains that according to the SAPPF “the role of the private sector is not to service the vast majority of South Africans.” He argues that historically the private sector developed because the government paid no attention to private individuals but rather took on the responsibility to provide for the indigent. As a result the private sector was developed to fulfil a need not being met by the state, that of creating a space for those who can afford to pay their own health care to do so. He states that the private sector grew phenomenally over the years because of deregulation. Essentially implying that the government allowed and through lack of regulation, encouraged the private sector to develop and flourish.

Discovery (2011) believe that the DoH has not and needs to take into account the duality of the health system and the NHI policy needs to reflect the reality of private access to health care beyond public health care provision. They believe the NHI is based on an assumption that the duality of the health system will disappear and warn that if the NHI does not consider the duality of the health system “there is significant risk of multiple unintended consequences, which may impact negatively on the realisation of the objectives of the NHI policy” (Discovery, 2011). According to Van der Heever (2014) developing countries “face the inevitability of multiple, or plural, financing mechanisms, and mixed public and private service-deliver” therefore the “seductive simplicity of one-size-fits-all financing approaches faces serious practical implementation problems in developing countries, which, if attempted, are likely to prove counterproductive” (Van der Heever, 2014: 1). The HSF believes that it is “the strengthening and re-orientation of the current institutional framework, and not the creation of policy that should be the focus of attention and first port of call for all involved in the health care system” (HSF, 2011). They believe that a health care system rendered by the state is unsustainable in

the South African context due to its “demographic heterogeneity, strong rural-urban divide and high level of social inequality” (HSF, 2011).

Dr Mabena of the DoH however says:

“Currently the way the system is structured is such that the majority of the population is served in the public system. But in terms of resourcing the resources are skewed. So we want to create a unified health system where both public and private sector provision is aimed at ensuring that everyone in the population can access those services. We are not saying that the public sector must go or the private sector must go. They both have a role to play but they must be directed at one goal... They [the private sector] will have a role to play because it’s a resource for the country and it must be kept and utilised for the benefit of all...services are going to be accessed through both public and private providers. So we want to ensure that those especially those who have the greatest need can access services equitably from all the resources that the country has” (Interviewed 24 March 2015).

Dr Kruger believes that “even with the NHI we still going to end up with a two tier system” because people are still going to make use of private forms of provision. He predicts that the public sector will simply be unable to offer what they initially promised, which will cause the public to further doubt the public sector as a practical option for health care provision. He believes that a better way of bringing about solidarity is by acknowledging that the 2-tier system is inevitable and using it. He imagines the best option involves incorporating more people into the private sector by making it more attractive to lower income individuals or alternatively increasing the efficiency of the public sector to enhance competition and bring about more efficiency gains in the health sector as a whole.

Dr Burton of the SAPPF suggested that a one tier approach could work in the South African context only if the private sector provides health care services in a deregulated market. According to Burton:

Regulations determine to a large extent how private practice is practiced in this country and if we deregulate the industry or we make it possible for doctors to join in large partnerships and large group practices, we believe we’ll be able to make it more affordable. Because there will be economies of scale that will be established as a result of those arrangements that will make it more accessible (Interviewed 26 November 2014).

Burton believes that deregulation will give hospitals more autonomy which will result in a more efficient running of health facilities in the day to day. This in his opinion will rid the health sector of mismanagement and bottleneck problems. Burton suggests:

If health care was privatized and the government used the money that its spending on public services to fund the indigent patients use of the private facility, I think that would work far better. So all the money that the government has at the moment, they should use it to pay for the health care services of the people who cannot afford to pay themselves. Providing we can get the government to pay for the services for the people that it's taking care of (Interviewed 26 November 2014).

In a research interview, this option was posed to Dr Molefe who has been working closely with the DoH on the NHI policy. Upon asking him about the feasibility of this option for South Africa he said vehemently:

With due respect to that person but I don't know on which planet that person lives. Who talks about privatisation? Because there is no evidence anywhere in the world where the private sector has improved the quality of life of people. I mean it's just the antithesis of it, health is a public good. I'm not saying it because our minister says it. It's not something that you can literally sell and buy (Interviewed 31 August 2015).

He refers to Minister Motsoaledi's statement that in the process of health care reform one should realise that health is a public good and not a commodity (Motsoaledi, 2011) in as much as it helps to deepen social cohesion and give substance to the democratic process (Ruiters et al, 2012:4). Molefe believes that because of the nature of health as a public good, health markets that commodify it fail.

They fail because you can't apply market principals to it. Private providers work well in a private market. If you can afford it you can access it, you can get whatever you want. But in our markets people fall ill, they don't choose to get ill, they don't all have enough money to access services, so what happens if they fall ill and cant access services? I mean quality of life, they die. I don't know, I don't know where that evidence comes from. I'm afraid I might sound biased but even looking at the evidence there's nothing like that (Interviewed 31 August 2015).

Molefe argues that the SAPPF represent private practitioners so their interest is to protect their sector. According to him the private practitioners, particularly the specialists, agenda is clear. Profit, unreasonable profit, while taking advantage of a weak public sector. Considering the studies on health systems, a one tier system in which the

private sector wholly provide services is not feasible for equity and solidarity. This system would therefore not work for South Africa.

Dr Mabena divides the private sector role players into winners and losers. The winners she describes as those who will gain from the NHI. These are the general practitioners “at the bottom of the food chain in terms of who makes what money,” and the pharmaceutical industry who are “ambivalent [and] don’t have a strong position, as long as they make their money.” The winners therefore have nothing to fear from the NHI and in most instances support it. The losers however, are very sceptical. These she describes as the specialists, private hospitals and the medical schemes, because “they are the biggest beneficiaries of the current system [and] if we come with a single payer system their role will be diminished.” She described how the ‘losers’ in the past have been very vociferous in their opposition by hosting “symposiums and seminars where they have tried to convince everyone that the approach that we are taking is wrong.” She does believe however that even now they “covertly probably they have other tactics that they are using to try and influence the process.” The DoH is even prepared to be taken to court by them. The DoH is expecting “challenges from scheme administrators and schemes because their role is going to be diminished significantly. And they are just intermediaries currently, they are not offering any value, they are middle men. And they are taking a significant proportion of the health rand yet they are just middle men.” Regarding specialists Dr Mabena anticipates “they are going to fight, we anticipate that the fight might even be very bitter.” They also anticipate challenges from “some of the more right wing research institutions such as the F W De Klerk Foundation and Hellen Suzeman Foundation and those types of institutions.” The DoH has already seen many of their arguments about the constitutionality of “reducing their cake” but Mabena’s response is “we are not saying that they must not operate, we are just saying they must be more transparent with how they price themselves.” She reiterates that the DoH’s believe that they have a role in the health sector: “we have indicated that they’ll have to find a niche for themselves within a single payer system. That’s all that I can say. They’re innovators they can innovate.”

Dr Mabena believes that whoever argues South Africa is not ready for universal health care is wrong. She argues that not only can South Africa afford it, but:

If you don't have a universal health system it means you still have an apartheid health system that is fragmented and divided and you are disadvantaging those that do not have the means. And if anyone can sleep at night with that thought then they can say that we are not ready for a universal health system. But if you believe in equity and fairness and justice, you can never say that we are not ready for a universal health system (Interviewed 24.03.2015).

For those who argue that waiting lists are a major problem in universal health care systems, and as such are inefficient, Dr Mabena in full disagreement argues that if within the health sector you have a waiting lists:

Well I think that that is very good because at least you understand the need. When a need is hidden and people die at home because we don't know that they have a need then it's absolutely atrocious. So rather know your lists and understand what your demand is out of society and find innovative ways of addressing those needs than not to know. Because what is happening in this country currently is that old gogo from a rural area who needs a hip replacement cannot even be in a queue because we do not even have a system that would allow her to be in a queue. Whereas in the UK when you have a need for a hip replacement you get into a queue and we know you're there. So we must expose our needs than to hide them and say that we don't want to know that we have long waiting lists. I don't think we can say that we'll overcome them because even the most advanced economies like the UK still have waiting lists but the idea is to find innovative ways of addressing those waiting lists. And over and above that you need to find a way of ensuring that you prioritise those with the greatest need (Interviewed 24.03.2015).

For those who argue that the private sector provides a better standard of service than the public sector, and as such should be the main service provider within the health sector, Dr Mabena responds:

In the private sector they don't provide preventative services, health promotion, they wait for you to get sick and then you are supposed to be cured. Whereas the public system offers all the services but with a focus specifically on ensuring that we pick up the conditions before they complicate or prevent them from even becoming problems (Interviewed 24 March 2015).

This highlights the importance of the public sector as the more appropriate tool for providing universal health care on a comprehensive basis to the entire population, rich or poor. The public sector provides services that cater for the healthy living needs of the population, not merely the sick needs of the already ill. Dr Mabena notes that when looking at the political economy of implementing the NHI you will see that South Africa is a capitalist country "the doctrine that is being propagated is that of market fundamentalism, liberalise, privatise, reduce government, reduce social spending,

increase consumption etc. And that type of thinking is not very aligned to a social democratic or democratic socialist type of thinking that favours policies like NHI which are more redistributive, more equalising between those that have and those that do not have.” Policy makers therefore find themselves in an environment where many don’t want to participate in social solidarity policies. She maintains that the South African “environment is not really receptive at this point and time in the country. She points out that “when you look at who is supportive of the policy you will find that it is the workers, it’s the poor, because they understand that there has to be some redistributive mechanism within this capitalist environment that we are operating in.” She states that “if you don’t have a deliberate decisiveness of saying that yes we are operating in this environment but health, education, are special social goods that cannot be subjected to the market fundamentalism, then you are not going to advance.” She argues with the market fundamentalist believe that the best way of implementing a policy like NHI is through economic growth. Using Thailand as an example of a country that implemented reforms at the peak of an economic crisis, she argues that even if South Africa is not seeing economic growth, evidence from other countries shows that economic development is not a precursor to equitable universalist policies such as the NHI. In fact studies have shown that “by taking up universal health policies those countries have ended up with healthier populations that can be the drivers of economic development.” Mabena notes that in the South African context “the ones in the more affluent bracket of society are going to be most opposed to this type of reform because they can look after themselves, whereas the majority who are the poorest are going to support this policy because they have got the most to benefit.”

Government accountability

Poor management of the public sector, lack of accountability and poor governance were also cited as a major cause for concern in the envisioned system. The private sector stakeholders argue that these problems should first be tackled within the public sector before considering a move towards the NHI. The HSF states that “systemic issues in the health system relating to lack of accountability and governance, poor management and inefficiencies need to be recognised as the primary reason for South Africa’s ineffective and inefficient health system” (2011:6). Stakeholders within the private sector argue that government has not enforced a number of laws and policies put in place for solidarity measures and therefore cannot be trusted to enforce the NHI. Two examples cited by

participants of this study were the Risk Equalisation Fund and Mandatory membership. According to Mr Swart, if the Risk Equalization Fund was enforced it would effectively reduce medical aid premiums by 20%. Dr Burton points out that there are many gaps within the regulations in the private health sector “that in most cases have been imposed or put there by government inaction.” Private sector stakeholders (Discovery, SAPPF, MediClinic) agreed with Dr Burton's belief that “there's a lot of things that can be done to make private health care more affordable, and most of the things that need to be done unfortunately involve government taking action. And at the moment they don't seem to be doing much in any direction.” The biggest and most used example of government inaction regarding health care has been the delay in the release of the White Paper. However Dr Mabane said when asked about the delay in the release of the White Paper that it will be released “when we have completed all the processes that we have to follow in terms of policy development, consultation, and government processes, then it will come out. We are close to its finalisation, finalisation of the processes.”

Private sector stakeholders also argue that the government should be held accountable for implementing policy that contributes to inequality in the health sector. The SAPPF state that DOH's Uniform Patient Fee Schedule (UPFS) Policy of 2006 states that the subsidies in the public health service are structured in such a way that those earning above a certain threshold must pay in full or in part for public services so as “to encourage those individuals to take out medical aid” (SAPPF, 2011:17). They argue that this in fact contributes to inequality as those members of the public, who cannot afford private medical schemes, but fall within that threshold face the real risk of financial hardship.

8.6 Government as Payer

Regarding faith in the government to pay providers for services, Dr Burton says “the government has not shown itself to be a very reliable payer. I would hate to have to rely on the South African government to pay my salary. I mean, it just doesn't work. No I'd far rather take my chances with the medical aid.” He cited poor service delivery within the public sector as the reason for his lack of faith in the government as a reliable payer. He maintains that the government

“have got to sort the public sector out, prove that they can run a health care service, and then maybe we'd say okay, well, let's look at joining forces and how we can run one system efficiently. But they mustn't come and tell us that

they're going to close the private sector when the public sector is in such complete disarray. It doesn't give anyone any confidence that they can do anything. They haven't got a chance in.., they will never ever be able to emulate Discovery Health and the sophistication of that system. And they would need the system to be 20 times the size of Discovery and they would need to be able to run it with the same efficiency. There is no chance of that happening, not in my grandchild's lifetime" (Interviewed 26 November 2014).

However, Mr Swart has a more optimistic view. He maintains that "it's a question of if you write the right contract and they're serious about it you know you can't always keep pointing fingers back at peoples mistakes in the past. The fact is you have to set up an agreement, you have to define the terms of the agreement, and then if one party doesn't deliver you obviously have the right to stop and so on. I think we must look for the good in people." Dr Molefe states that according to "the institutional arrangement that is being proposed by NHI there's no way that it will be a slow payer." He explains:

The reason why government as they're currently structured, and they're slow payers is because 1. There is very poor management, and those guys who are responsible for paying there's a lot of corruption unfortunately. That's why. There's poor planning. You cannot engage a provider when you cannot pay. The funds must be there, so you can easily pay within 30/60 days. Treasury has all of these regulations. It's just poor capacity. So if their concern is about capacity of government, it's a legitimate concern. But NHI is proposing to make sure that there is that capacity to make sure that they engage in a better purchasing arrangement...I mean, it's always a concern that you would want a government that's able to provide and pay you on time, but they've been paid on time. We have examples of doctors who do private sessions in government and they get paid (Interviewed 31 August 2015).

About corruption Dr Mabena notes "corruption is a practice that is pervasive throughout society here in South Africa." She however maintains that this as a major problem is being addressed:

That's why we have seen in the past 2, 3 years there have been interventions that have been taken through findings of the auditor general, through section 100 to try and nip in the bud some of the leakages that are happening in the system. So there have been areas that have been identified. There have been government departments, provincial departments where we have found that there are leakages (Interviewed 24 March 2015).

Dr Mabena emphasised that corruption exists in the broader society in general and not just within government. She said:

Don't forget that corruption is not just by public servants. It's the corrupter and the corruptee. And for me the most critical area of corruption arises as a result of the outsourcing and the tender system. And it's not government

officials only...it [takes] two parties to tango. If its according to me there shouldn't be any tenders. There should be capacity building inside the fund for example, so that there is no need for services to be sourced from external role players. Because that's where the problem is." (Interviewed 24 March 2015).

According to Dr Kruger the broad issue is poor quality of human capital and how accountable are people for what they're supposed to deliver. Dr Mabena along the same lines stated

You have to have an accountable leadership, you have to have commitment, you have to have decisiveness. But you have to care for the people whose lives you are trying to better. Accountability is very very important. Accountability is not just at a leadership level of a minister or a director general or officials in the department, its leadership at all levels of care and leadership that is accountable (Interviewed 24.03.2015).

Dr Mabena says its for these reasons that the DoH gave 14 years for NHI implementation. She said "The 14 year figure is a figure that would allow us to undertake certain interventions that would be preparing the health system so that by the time we get to the 14 years there is a confidence in the health system"

NHI Financing

The SAPPF (2011) in their submission argue that the NHI policy as seen in the Green Paper is untested and therefore unproven and will not only be a massive expense but will threaten the continued viability of private health care in this country. They argue that the NHI funding mechanism, even if it succeeded in other countries, does not take into account the South African context and is not mindful of the particular needs unique to South Africa. The SAPPF are "doubtful whether the current South African tax-paying base is big enough to pay for such a complex and expensive restructuring of not only our health services but the manner in which those services are funded" (SAPPF, 2011). Their argument is that "current levels of taxation are already very high and the imposition of an additional tax (whether taking the form of income tax or a mandatory contribution to NHI) may thus have negative unintended consequences for the economy due to shrinking disposable income" (SAPPF, 2011). Dr Kruger says "it is very difficult to warrant that level of expenditure on health compared to other sectors like education and grants etc. etc." According to Mr Swart says as South Africans we are fairly high taxed anyway...the working force is small...we have 50 million people that live here but the actual tax base is

actually only 5 or 6 or 7 million people, so to pretend that you can tax everything that you need out of the 4 or 5 or 6 million people is not real.”

In their submission, Econex estimated figures will require massive increases in national spending on health. They argue that many people will choose to continue paying private medical insurance, therefore the reduction in GDP spent on healthcare estimated in the Green Paper is misleading (Econex, 2011). SAPPF warn against the government embarking on “such an ambitious and costly project” without having demonstrated in the Green Paper that the NHI is affordable. Their concern is that a single payer model will not be effective in addressing the current concerns facing access to health care as it will incur crippling costs that South Africa can ill afford given the pressing demands on already limited resources.” They all argue for economic growth that leads to more jobs because what South Africa needs are more tax payers to support the system. Mr Swart sums it thus:

So I think a very important part of this is you want the economy to grow, you want more jobs, you want to have a lower unemployed work force rate, you want people to have money to be able to afford health care, to be able to afford to buy it, to get that whole ball park rolling. In our case in SA we’ve gone backwards in terms of economic growth because for a long time we were sitting at 3.5 but we’ve now gone back to 2.8, 2.2 and so on and we haven’t really done much in terms of the enablement part for a system change (Interviewed 15 January 2015).

KPMG however conducted research on the financing of the NHI and found that the economic benefit of investing in health care outweighed the cost of increased taxes needed to fund the NHI (KPMG, 2011). They “discovered that implementing the NHI could improve the health of the population, which, in turn, can increase productivity, expand the GDP and make the country more prosperous – even after taking into account the cost of funding it” (KPMG, 2011). Based on the estimates from the NHI Green Paper “KPMG calculated that the rollout of the NHI will cost an average of R10.4 billion every year, above what is currently spent on public healthcare, amounting to a total of R145 billion in real terms over the next 14 years.” They estimate the average increase in taxes to fund the NHI will be 1.1% for personal income tax (from 21.8% to 22.9%) 0.8% for VAT (from 14%-14.8%) and for sin taxes a bottle of wine would increase by 80c, port by R1.47, spirits by R12.82 and a box of cigarettes (20) by R4.47 (KPMG:2011). Although tax increases are never good news they believe that these increases are fair and are “more

accessible than first imagined” (KPMG, 2011). KPMG argues that there are significant economic benefits to a healthier population as they found “that other countries that have implemented a form of national health insurance benefited economically from a healthier population” (KPMG, 2011). Dr Mabena of the DoH also stated that “experience has shown that in countries that have implemented a single payer system, they operate more efficiently.”

KPMG does however note that “the positive impact on South Africa would depend on the speed of implementation and the capacity of the healthcare service to remove the bottlenecks in provision and access to care” (KPMG, 2011). KPMG warns against falling into the trap of considering health care expenditure as only a cost to the economy, they assert that it is a long term investment in the human capital of the country, one which could see “South African citizens getting a little richer, increasing our per capita GDP between R2 210 and R1 470 in real terms, depending on the tax scenario used” (KPMG, 2011). According to Sven Byl, the KPMG Head of Healthcare for Africa and South Africa, the results of their study imply that if South Africa is successful in improving the health of the labour force through the implementation of NHI and this leads to productivity gains of only 10% between 2012 and 2020, half of the improvement in productivity seen in other countries, the economic benefits could outweigh the economic costs of implementing NHI” (KPMG, 2011).

Dr Mabena maintains that the DoH does not envisage increased tax burden. She argues that those who are presently on medical aid will be required to pay into the NHI much less than what the medical schemes currently charge. She states that “all NHI is doing is to redirect our contributions from the multiple pools into a single pool, so those that are currently contributing which is the 8.5million or 8.7 million into the schemes will simply now redirect their contributions into the NHI.” She explains “what you currently contribute, you will be mandated by law to redirect it into the NHI and depending on the role that medical aid schemes are going to play in the future, if you choose after that that you still want to have a medical aid then you can do that.” (Interviewed 24 March 2015).

Government Stakeholders on NHI Policy

One of the main contentions during the health reform process in South Africa has been the relationship between the DoH and the Treasury. Dr Mabane stated that there have

been challenges with other government departments and mentions that the DoH and Treasury have not had a common vision regarding the health sector. Although she does not clarify but says instead that it is a common occurrence even in other countries for the Health department and Treasury to be at odds regarding policy. She says Treasury

Does not have a problem with the policy, they just want to understand the implementation. They want to make sure that the controls are in place to ensure that there is no wastage and leakage of funding. That's the role of Treasury, Treasury must be in that role at all times (Interviewed 24.03.2015).

Dr Breyer a representative of Treasury, and Dr Molefe who works closely with the DoH were however more forthcoming with the antagonistic relationship between the DoH and Treasury. Dr Breyer stated that the Treasury is ready to go ahead with plans for the NHI but is waiting on the DoH to release the White Paper. Treasury has drafted a paper outlining the details of the NHI funding mechanism but cannot release it until the White Paper has been released. Breyer suggests that maybe "some of the reasons for the delays may be around the difficulty in confronting some quite difficult policy choices around some powerful stakeholders." Dr Breyer confirms that "there have been some residual differences between the departments in some details of the policy, but I actually don't understand fully why the paper has not been released. It's very frustrating for me personally as one of the key authors of the Treasury paper in as far as inputs into the health paper, or trying to input should I say. I don't know if the Treasury comments have been that welcomed." Treasury believe that the DoH have "taken the view that the only Treasury role in health financing is raising the money. Treasury must just raise money, everything else is on their side. Treasury is not comfortable with that position." Treasury expects to "to be much more intimately involved in the design and in the aspects of the pooling and purchasing arrangements, but has largely felt excluded from that. Treasury has largely felt that its views on the matter have not been very seriously considered."

Breyer believes that the DoH has not been flexible in their position and "not really prepared to listen seriously to the extent of changing their policy as to what Treasury is saying." Treasury believes the DoH has been very slow in many of the practical aspects of the NHI implementation. According to Dr Breyer "Treasury tends to be more involved in market type issues and also deals more with tax payers so I think we would like to see more involvement of a mixed public and private delivery options, constructive role for medical schemes through the transitional process." Treasury believes the DoH although

rightfully focussed on strengthening the public sector, has neglected the private sector completely. Breyer states the Treasury's concern that "with the move to NHI that in a sense there's been a gap within the regulatory reform within the medical schemes. You know there's just been this idea that medical schemes will disappear and we move to NHI so we don't think about them very much." He says that this is one of the points of difference between the DoH and the Treasury. Treasury believes in the market principles and competition of the private sector and believe that the NHI would unnecessarily cause "a revolution amongst the 8million medical scheme beneficiaries" whom Treasury believe will not buy in to the NHI. Treasury positions themselves as the protectors of the tax-payer's interests. It believes that there must be "be some kind of match between what people pay and what they receive." Treasury believes that the tax payers will only be happy paying additional taxes if the services from the public sector can match their needs. But according to Treasury the NHI Fund would essentially be a monopoly on purchasing and Treasury is not confident in South African monopolies. According to Breyer:

The Treasury view is South Africa's monopolies haven't been very good, because they become uncompetitive monopolies, if you look at Eskom for example. On paper it sounds great, you have the one organisation which is the sole purchaser, the sole this the sole that which can leverage maximally but in reality now its an unchallenged monopoly and it doesn't deliver (Interviewed 15.04.2015).

Breyer stated that "initially the Treasury was not convinced there was a place for a national insurance fund" however they have made "a lot of compromises" the NHI Fund being one. Treasury does believe that private medical care is very expensive and that economies of scale are necessary to bring down the cost of health care, and the NHI Fund if run "properly" could benefit both the public and the private sectors. Treasury believes however that the DoH is ignoring the private sector in its policy framework and by doing so will not convince the public to buy in to the NHI. Dr Breyer warns that:

By not engaging with the private sector in a very positive way, I don't think that they have created the trust with the general public that they're serious about bringing them into the system (Interviewed 15.04.2015).

Treasury understands however that the first phase of the NHI framework is to strengthen the public sector, so that may be why there is little mention of the private sector. Breyer argues however that "the problem is firstly that improving the public sector is very difficult, and now after 3-5 years of doing that am not sure that the general public is convinced how the public sector is working right." Breyer indicated the Treasury's

frustration with the DoH by talking to the two conditional grants that Treasury gave the DoH, but which they squandered. He explains:

We offered for example, when we started with the NHI, before the green paper 5 years ago, why we don't contract a thousand GP's in the first year, in their practices. Take it up by a thousand a year so that by year five we'll have [five] thousand GP's contracted to the public sector and we'll raise money for that, we'll find money for that. No they didn't like it, eventually they decided okay we'll use this grant. We've given them 2 NHI grants, conditional grants. So eventually they decide through the conditional grants they will do a bit of contracting with GP's, but no we can't contract with GP's in their rooms, that's no good at the moment, we can't do that, the GP's have got to come do some sessions in the clinic. First they said no completely then they said only in the clinics, and now we have a R500million conditional grant, a NHI grant to contract these GP's in the clinics. In 2-3 years they've contracted 160 GP's. And of R500million is only spent R50million, and the rest comes back to us. Because the GPs don't want to come work in the clinics, the rates don't suit them, the negotiations haven't gone well, etc. etc....We think we could bring a lot of the private sector into good arrangements and that's key to what NHI is about, and the notion that you arguing that it could bring the prices down. But we're not seeing it, we're not seeing it in what the DoH is doing. They've been doing very little work with the private sector (Interviewed 15 April 2015).

Breyer argues that the DoH refuses not only to comply with the conditions set by the conditional grants, but that eventually when they do, they don't do it efficiently and in fact are very slow in implementation. Of the second grant he describes:

The other thing that is also a bit frustrating for us is that the DoH has been very slow in many of the practical aspects of this. For example, 3 or 5 years ago we started giving them money to develop a new way of paying hospitals, which would be suitable both for public hospitals and for private hospitals. We started giving them money to develop what's called a system of diagnosis related groups, DRG's is a way of paying hospitals. They are still, 3-5 years later, at the beginning stages of it. And they couldn't do it themselves. now they're spending R30-R50million asking PwC to help them to do it, and it's in a very early phase and it's not clear that they're going to get to the end of it. So they're very very slow. They're full of politics and full of promises but the actual delivery of the hard things we often find they don't deliver, they're too slow in the delivery. Health is very quick on certain things but on a lot of these things they're very slow. And it depends on some individuals. There's some managers individually in the DoH who deliver very quickly on things. So there's some sections in the DoH that work very well and quickly, and there's other sections that just take years and things are very slow (Interviewed 15 April 2015).

Breyer's frustration with the DoH was clear as he paced up and down his office describing the contentious relationship between the departments. He made very clear that Treasury is getting frustrated, "talk has been going on for too long, not enough doing." He insists

that “to move from the talking to the doing we have to be able to reach these national social compromises between the key groups” (the public and the private sectors). Breyer says of Treasury “ideally we would have probably wanted to see maybe some competitive arrangement between the public fund and the medical aids.” He admits:

I think the Treasury would like to see more competition, greater freedom of choice. I do think that we need some sort of private regulation in the current private environment because the current absence of any type of pricing schedule is expecting every party to compete in the market on pricing which is not good. The private sector should bring in more products to cater for a wider range of people. We would like to see more people using the private sector but at lower tariffs (Interviewed 15 April 2015).

It is clear that the Treasury’s view is one based on market fundamentalism in which the private sector’s role does not change, but the public sector’s role must improve. The DoH on the other hand has a more socialist viewpoint with the public sector being the main service provider where health care is not commodified but seen rather as a public good. Dr Molefe spoke to most of what Dr Breyer said regarding the relationship between the DoH and the Treasury. However his position on the matters were very different. Dr Molefe believes that the Treasury in giving the conditional NHI grants, from the onset set to sabotage the process. He says:

Now, in this country we also have a Treasury that has the resources and that is supposed to fund the reforms, let’s say the pilot’s right now. But it is the very same Treasury that makes sure that those funds cannot be absorbed as quickly as possible. Because I am one of those, we knew from day one, that when the DoH was given was it R250million, so that it moves to five hundred and then to a billion, that the idea was that they were going to create a situation where there was a return of money. So, processes of getting the money to the department, processes of them moving the money down to where it is needed took a long time. You know how governments function, from the province to the district and who is in charge, who has power. So they knew that very well. We knew that even ourselves, some of us. We knew when 6 months down the road things didn’t seem to be moving. You need to build capacity... So we knew. The idea was to begin to generate the evidence to then say that money cannot be absorbed. And indeed that’s what happened. So instead of moving to the 500 million they said Oh, we gave you the money you didn’t spend it, it sounds legitimate... From a technical point of view I gave you money, you didn’t spend it, so why should I give you more? That’s what it looks like from anybody who doesn’t have insight. But to tell you the truth, it’s not like that (Interviewed 31 08. 2015).

Dr Molefe argued that as a government department, Treasury knows how the government departments run and that processes take time. He does not believe that

Treasury gave the DoH enough time to establish the capacity to absorb the full grant as a means to set up the DoH for failure, to then refuse to increase the grants. He argued that Treasury has been acting outside of its mandate regarding the NHI. Molefe speaks to the role of Treasury:

Their role is to say is what the ministry of health saying within the capacity of government to afford, and is it for the benefit of people. If we have enough fiscal space to provide for it, it's not their job to challenge the policy position. It's their job to say this option is expensive, this option is not expensive, or we can't afford this at this moment. That kind of thing. But not to begin to say no, we will not fund this if you do not change the policy in this or that way. Because that is what is happening. That is not their job. The Treasury function is, I'm coming here, I want to have a program on building houses, I want to use an example that has nothing to with health. So they would do a cost benefit analysis, that's their role, they need to look at the fiscal space, in other words the capacity of government to do this, and context of other programs because it's not just health. It's affordable, we can do it but we want you to put this and this in place to make sure the money is not misused. That's their job. It is not their job to say that the houses you are building are too big, the houses are too small. Who are they? They are not specialists in health policy. That's my own understanding, they are not specialists in health policy. They are specialists in assessing programs that come to them, are they affordable or not, will they benefit the people or not, what are the implications in terms of the macroeconomics of the country, or not, what would be the implications of moving money from here to there, that kind of thing, and maybe suggest you might want to do this thing in phases, something like that. But not the real content and design of the policy. But they tend to from my experience in the health sector, they just tend to go beyond their remit. Treasury by definition, their role is a Treasury function. We pay taxes, some revenue fund, they must respond to government policy and then say how we allocate this money. That's it. (Interviewed 31.08. 2015).

It is abundantly clear that the ideological differences between the DoH and the Treasury are causing contestation in the health reform process. Treasury and the DoH have different interpretations of the role of Treasury, where Treasury wants to and believes it should be more intimately involved in the specifics of the policy and the DoH believes that health is their mandate, money is the Treasury's mandate and provided South Africa can afford the NHI the DoH proposes, Treasury's only position should be to oblige. Prof Schoeman believes:

Treasury have an ideological view that in fact the monetary flows in health care should be to prop up public forms of provision and they should leave largely untouched the private forms of provision. What they're really saying is leave the private sector alone, at least its working, at least its providing health care for the middle class. Lets

focus on the very poorly provided for public system of care. Let's improve that, let's put our energy into that. And the DoH hasn't been able to shift that politics. They've not been strong enough to shift that politics. (Interviewed 1.09.2015).

The difference in ideology within the two government departments needs to be resolved in order to see progress in the implementation of the NHI. The very opposing standpoints, accusations of incompetence and sabotage, and general disagreement on departmental mandates needs to be addressed swiftly for the benefit of the South African population. Many of the participants of this study believe that the ideology of the DoH is more fitting with the redistributive principles of the NHI, and the Treasury seems more aligned with private sector market fundamentalism. Many also believe that the DoH lacks the strength to oppose Treasury in a meaningful way, and this is why there are delays in the release of the White Paper. This speaks to the lobbying power and the strength of the stakeholders opposing the NHI.

Media Influence on NHI Policy

South African media has devoted a lot of attention to the NHI over the past few years. It has been used both by those in support of the NHI and those in opposition to it. The Minister of Health Aaron Motsoaledi has on many occasions taken to the media to support the NHI and defend the NHI against private sector lobbyists. He has relayed statistics from the Green Paper such as the unjustifiable expenses of the private sector catering to only 16% of the population leaving the remaining 84% with second rate care. He has on each occasion in the media expressed that South Africa needs the NHI for a more equitable health system that considers the public's right to access affordable good quality health care regardless of income. In a letter to the M&G Dr Chris Archer said of the Minister has declared war against the private sector and "is being disingenuous – he is painting a picture and creating an aura of hope that simply cannot be, unless, that is, one ignores and disregards the realities of South Africa's budgetary and human-resource constraints" (Archer, 2014). In his response Minister Motsoaledi says:

My very first reaction was to ignore this letter, because it comes from an individual who pretends to be supporting universal access to health care, yet is rubbishing it. But I realised that there are many myths and serious misconceptions in Archer's letter that could mislead readers. I therefore deemed it important to put things in perspective. First and foremost, I have no war to wage against the private healthcare sector, as Archer is suggesting. I do, however, have every right to wage war against exorbitant fees in the

healthcare system. Any health minister worth their salt would not sit back and watch when healthcare becomes unaffordable. After all, it's my duty to protect South Africa's citizens and I will speak out loudly against any practice that may threaten their health and wellbeing (Motsoaledi, 2014).

It has been the Minister who has been the most vocal against the criticism of the NHI within the media, and thus has also been the target of many attacks. The Minister however holds fast and continues to assure the public that the NHI is in the public interest and will be implemented despite unfair criticism. Diane McIntyre in a study notes that "recent media coverage on the proposed NHI has illustrated that some members of the public, particularly those who currently have privileged access to health care will strenuously oppose the NHI" (2010:35). Newspapers, both paper and online, along with magazines, blogs, twitter and you-tube channels have been used as tools to get stakeholder messages out. For example, a blogger notes:

Looking at recent responses to the green paper on National Health Insurance (NHI), one is reminded of the saying "Hell hath no fury like a woman scorned". Except here the woman is the medical schemes and private healthcare providers, aided and abetted by their various supporters. If they are to be believed, South Africa is facing potentially disastrous times, with not just hell but damnation awaiting the architects of the insurance scheme and those who might try to implement it.

The media has had hundreds of articles about the NHI demonstrating the strong opposition that many have against it. In Fig 8.1 below are examples of just some of the titles of the newspaper articles. From the examples below one can see a very disdainful theme towards the DoH and government for attempting to introduce the NHI. Much of the criticism in the media has been that the DoH and the Minister have not held public debates on the NHI. Instead they chose to consider only submissions or comments on the Green Paper. This however has not stopped stakeholders from holding their own debates and discussion panels. Examples of panel discussions available on YouTube are the South African Civil Society Information Service and the Friedrich Ebert Foundation South Africa Office panel discussion on the theme, "Making the National Health Insurance Scheme (NHI) Work for All South Africans - Can It Be Achieved?" as well as the more popular and highly critical Panel Discussion on NHI by Jeremy Mansfield and various guests. In these panel discussions, as with most of the online debate, most agree that the public sector is in need of strengthening, most agree that universal health care is needed, but many do

not agree that the NHI is the way because of high costs and the fear of losing quality in the private sector to inferiority in the public sector.

Fig 8.1. Cut-outs of Newspaper article titles about the NHI



According to Dr Molefe stakeholder engagement is a very necessary part of a reform process. He argues however that some of what has been portrayed in the media shows a lack of understanding of the basic tenets of the NHI. He says that the DoH and policy

makers were “massacred in the newspapers” and insulted for not knowing what they are doing. He states about media criticism:

We couldn't respond because you can't respond. We are not official spokes persons for government or anything. But there were a lot of those who were very vocal, claiming to be the only ones who can understand these things. And we were in the background thinking we also went to school, we also studied these things. These people who are making noise, these are hired guns who probably don't know what they are talking about, but you can't engage them. So the media also played a role. There were a few people who were also very vocal, misleading people. Oh this fool and that fool. This doesn't make sense...You run to some newspaper and start crying this rubbish this rubbish that, while the government is there to run the health system, including those very same people. Because the major shareholder in the health system is not providers, it's the citizens. So if the government is trying to do something that will help the citizens, you can cry all you want because it's the citizens who are the shareholder. You are an important stakeholder... But literally they've been successful in lobbying now. Even Obama. He's a good example. Obama, they're even threatening the Obamacare that they will repeal it. Some of the stakeholders are trying to use the American style of lobbying to either delay the implementation of the policy or to stop it, so that it naturally sort of dies. This is not the first time NHI, it started a long time ago. Every process that starts, it stalls because there are strategists that are busy working. They are hired guns. Even if the white paper was to come now I can tell you there are papers ready, to go to the constitutional court and god knows where. I'm telling you. I am 100% sure (Interviewed 31 .08. 2015).

Dr Mabane from the DoH when asked about the mass media critique of the Green paper simply said that much of the input seen in the media don't seem to understand what a green paper is. They seem to think that the green paper must provide a comprehensive and detailed overview of policy, but this is not true. She says:

A green paper is a broad policy direction. It tells you that this is the direction the country is moving towards, so you may not find all the detail that you want. Even in the white paper, you may not find the minutest detail, because that will come in the implementation plan. So the fact of the matter is people are anxious about how things are going to be shaping up in future but those details will come as the policy process and the legislative process evolves. So it's the direction that the country is moving towards and some details will come out in other documents (Interviewed 24 March 2015).

Dr Mabane points out that the entire point of the NHI is about social solidarity and equity. She maintains that only if you do not understand the need for its redistributive mandate will you argue so vociferously against it. She says that:

You see we have moved from 1994. We have liberalised, we have subscribed to market fundamentalism and we are in this situation where our health system is not performing the way it is supposed to perform...The goals of the NHI are to ensure that all South Africans irrespective of their socioeconomic status have access to quality health. So that is what NHI is aiming for and if you are clear about your goal, the most important thing is to make sure that the steps you take towards that really really are grounded and they make sure that you take everyone who is in this country into account when you are planning your health services (Interviewed 24 .03. 2015).

Civil Society

What is lacking in the media however is a strong voice of civil society movements in favour of the NHI. For purposes of this study civil society is considered in a broad sense to comprise of those non-governmental organisations that represent the interests of members of society including organisations such as church groups and trade unions. Civil society has a very powerful voice in reaching the public and as such is a valuable tool in the reform process. Within South Africa the civil society movements have been largely inactive regarding the NHI. Although COSATU, NEHAWU and People's Health Movement and various other organisations have expressed support for the NHI, not much social action has been undertaken regarding its implementation. Regarding civil society in South Africa Dr Molefe said:

Ideally in other countries you have civil society that will understand the agenda and therefore will advocate for achieving that agenda. But you also have a type of civil society in this country that have their own agendas, but they will masquerade as if they are fighting for this agenda when they are fighting for the other. They know some, depending on who is funding them they will sing their hymn. So that's the problem, but, all civil society should be playing a greater role and being involved...Because if you have a civil society movement understanding what the issues are, they will speak for the people and it works, in other countries.

What is pervasive within the South African trade union movement is the high levels of politicisation. Dr Molefe describes that initially the Trade Unions were involved in some design structures surrounding the NHI but only to a certain extent. He believes that the crossover of many trade unionists into government results in over politicisation of labour movements and causes one to question who will call the government to order. He states that the union officials rather than develop and push their agenda of labour are less concerned with ideological commitment and are more disposed towards personal advancement.

Dr Schoeman agrees that the Trade union movement within South Africa has been absent in terms of engaging with the NHI. He admits that dominant trade union like COSATU and SACTU although having shown policy commitment to supporting the NHI, have not engaged in the debate in a determined way. He makes the point however that one must consider the structure of the dominant unions. He states:

if you look at the structure of COSATU and the dominant unions, one of them in SACTU, comprising mainly of teachers, teachers are professional civil servants and therefore are eligible to GEMS. So you find SACTU are accessing private medical schemes. Even in the radical unions like NUMSA which is the radical alternative, or at least positioning themselves as the radical alternatives, their members also have got access to private medical aid schemes. So if you take a crude view of it, its not in the class interests of the union movement to be organising for a NHS because that means they may potentially lose the minimum benefits that they have (Interviewed 01.09.2015)

Dr Schoeman makes the point that trade unions face the dilemma of losing the minimum benefits of private health care provision afforded to their members and their families through GEM's by campaigning for the NHI. He argues that unions are not aggressively mobilising in support of the NHI "because of the uneven benefits that are provided for workers through the current labour market structure that allow some workers to access private forms of medical aid." He believes however that the DoH should make an argument to those workers that "the cost structure provided through GEMS could be better provided through the NHS and in terms of your interest as a member of COSATU in creating a more equal society for all workers that is much better served by you campaigning and fighting for a NHS than doing it through GEMS."

Dr Schoeman compares the campaign around the NHI with that around the basic income grant. He noticed that "there was a lot of civil society mobilisation around that." Schoeman believes that civil society will act depending on whether social problems are identified as worthy of issues from around which the middle class should be mobilized. Most of the civil society organisations are situated within the middle class and therefore more often than not represent middle class interests. He contends that if you look at the proposal around the NHI it "unequivocally calls into question in the role of the middle class in relation to the establishment of a national health system." Schoeman believes however that:

it's a failure on the part of civil society activists to not mobilise within the middle class and demonstrate how a publically provided single national health care service will absolutely be in their interests because its proven for e.g. in the Eastern Cape that providing the same care of service as is provided in the commodified private health care system will be 25% of the cost if adequately provided in the public system (Interviewed 01.09.2015).

The consciousness of the middle class therefore needs to be addressed but this would require the state to make an argument that the public forms of provision envisioned within the NHI policy will not only be in the interests of the middle class but will be lead to solidarity and a more stable society. The NHI however has caused pause within the middle class due to uncertainty about its financing. Private sector stakeholders have flooded the media with propaganda on increased taxes and unaffordability. The design of the NHI implies that the middle class will have to give up the tax credit that the state provides them to access private forms of health provision. Dr Schoeman states that even though the NHI policy aims to transform the condition of the poor, which the middle class can get behind, resistance comes when the middle class are called to give up something. Dr Schoeman explains that "the middle class voice is cohered around securing the best form of health benefit that they can derive from their medical aid schemes." In other words their focus is on fighting for a better package from their medical aids. The government has not given the middle class enough incentive to make use of the public forms of health care provision. As a result, the middle class attention is on the private sector and reducing costs within it rather than improving the public sector.

Dr Molefe states that the government is there to serve the population and its constitutional role is to implement policies for the benefit of the people. This resounds with Minister Motsoaledi countless statements assuring those both for and against the NHI that it is happening and that it will succeed in South Africa. Stakeholders have submitted their inputs, rallied their lobbyists and made every effort to gather support against the NHI. Their lobbying powers have been mentioned as very powerful by all the participants of the study. Ruiters *et al* (2012:38) warn that the hegemonic power of the private health sector in South Africa should not be underestimated in the rollout of the NHI. Some would say that their efforts are succeeding because of the delay in releasing the White Paper but the DoH assures of its imminent release.

CHAPTER 9

CONCLUSION

LESSONS FOR SOUTH AFRICA

Introduction

This chapter will consider the Canadian and Swedish experiences of reform and rather than compare the vast differences in the social, political and economic contexts of the countries, will consider the similarities in the reform processes with what South Africa is presently experiencing in an effort to understand how the Canadian and Swedish governments overcame the same reform challenges. In order to do this, this study broadly categorised the stakeholders within the South African health sector into three groups in accordance with Korpi's PRT theory. Firstly those with a market fundamentalist approach to health care provision and who represent the interests of the wealthy, or the winners of the current fragmented health system. Secondly those with a social solidarity ideology representing the interests of the poor who are the losers of the current system. Third, those representing the sceptical middle class, who are although are beneficiaries of the system, could stand to gain more from the NHI. Each of these stakeholder groups represent class interests with different power resources within the South African socio-economic and political context. From studying Canada and Sweden, this study will pose three reasons for the conquering of their reform challenges. These are Culture of Care, Political Will and Pro-equity Ideology. It is the finding of this study, from examining the experiences of these two countries and from the information gathered from the learned participants of this study, that these are the three lessons that South Africa can learn from Canada and Sweden in order to successfully implement universal health care through the NHI.

Culture of care

At the time of the Canadian and Swedish health reform, the countries were both recovering from war and going through industrialisation and as such were not the high income, developed countries they are today. It was during a particularly difficult economic period that both Canada and Sweden implemented significant social reforms that formed the basis of their social democracies now. According to Dr Mabena of the

DoH, a country does not have to be in a period of economic growth to implement reform.

She says:

When you have an economic crunch the most vulnerable people who are going to feel the effect of the economic crunch are the poorest and if you do not come up with a mechanism that will ensure that they are protected in terms of their access to health services from the ravages of the economic crunch, then you are going to find that they are the ones who are going to be the biggest victims of the economic crunch. And that's why even WHO is saying that when the economy is bad, make sure that you protect the most vulnerable against the ravages of economic crisis by ensuring that you implement universal health systems that protect the poorest.

Principles of solidarity are therefore crucial in establishing social reforms such as universal health coverage and essential to social solidarity policies is the culture of care. In Sweden after WWI, when the country was going through economic turmoil, the SAP built on the philanthropic culture of civil society organisations such as churches, workers unions and voluntary organisations to campaign for the idea of *Folkhemmet*, the "People's Home." This idea became a central philosophy to the political and social ideology of Sweden. The government saw the need to embed a culture of brotherhood within society in order to more effectively enact welfare state policies based on social democracy. *Folkhemmet* was a social construction based on principles of solidarity and equality. Once it became a part of the culture of society, the chances of social reforms in line with the principles of *Folkhemmet* being rejected were greatly reduced. This, I believe is one of the reasons that the SMA did not hold much political clout in contesting the health reform of the SAP. Health reforms were in the interest of the people, many of whom could not afford private health care, and as such were in line with the culture of *Folkhemmet*.

Tommy Douglas, who has become known as the Father of Medicare was a Baptist minister turned social democrat, who as the Premier of Saskatchewan Province and leader of the CCF party drove for socialist reforms. The CCF was the first socialist party to hold power in northern America and was founded on values of solidarity and equality. After WWII, Canada also fell upon difficult economic times and capitalism was fast enveloping the political economy of the country. However the CCF under the leadership of Tommy Douglas and similarly minded politicians campaigned for a new way. Within Saskatchewan they gained political power and there implemented social reforms that convinced the people of Saskatchewan that socialism is in their best interests. Their

success kept the CCF in power for over 20 years, allowing the culture of socialism to soak into the social culture. When the College protested against Medicare, the public indeed got caught up in the remonstrations, but as the strike went on, and the CCF continued to explain that Medicare was in their best interests, the public shifted support and now the whole of Canada boasts about Medicare.

Within South Africa, although we have the Freedom Charter and the Constitution which provide the basic tenets that should guide our culture and policy, the country is dominated pervasively by the capitalist system. Market fundamentalism has seeped into the very core of political agendas, so much so that Treasury itself sides with the market over solidarity. As discussed in the previous chapter, civil society within South Africa, particularly trade unions are not engaging with the debate around the NHI in the same way they did in Sweden and Canada. The reason being for much of the apathy towards advocating for the NHI policy is that many of the people represented by trade unions benefit from the current labour structure that provides them with private sector health provision through the government subsidised health insurance program GEMS. The Trade Unions, who traditionally are meant to defend the working class interests, appear to have aligned with the interests of the middle class who are more focussed on securing the best forms of health benefits from their private medical schemes.

The middle class holds significant power in influencing the direction of policy but at present in South Africa the middle class are not incentivised to support the NHI. The middle class within the Swedish and Canadian reforms were aligned through a culture of care to universal health provision based on solidarity and equity. Within South Africa however, the middle class is not invested in public forms of provision. Dr Schoeman notes “for social cohesion to occur the middle class must be willing to give up something in return, and part of this means that you start to increasingly invest in public forms of provision.” He also notes that when the middle class are called to give up something you find that actually there’s this hesitancy. This is in part due to the self-interest motives of the middle class. They are more concerned with keeping the quality of service they receive in the private sector, and lack of faith that the general public has in the quality of services within the public sector. The position the middle class takes is therefore one of a neo-liberal or market ideology which asserts that individuals know best and should

be given the opportunity to choose their goods and services in a competitive market (Ruiters et al, 2012:22). It is a far cry from the *Folkehmmet* ideology of Sweden and the solidarity principles governing Canada where the culture of care motivated the broader civil society to align with working class, redistributive interests.

Political will

The culture of care within a society however will not permeate policy unless the politicians have the political will to create, implement and enforce policies that demonstrate the values of equality and solidarity. Within the Canadian and Swedish contexts both the CCF and the SAP demonstrated strong political will to push through the health policies they believed would benefit the public. Through the stakeholder lobbying and protests the politicians stood their ground and negotiated only as much as did not affect the underlying principles of the universal access to health care for all. Throughout the stakeholder engagement period, the politicians demonstrated a commitment to their policy and backed it with the political will and the capacity to ensure its successful implementation.

Dr Molefe who has worked closely with the NHI policy makers stated that “if you want to make this system work you are not going to tinker on the edges the concept, the idea is right, but what is happening is a lot of tinkering around the whole thing.” According to Molefe the ANC have not demonstrated the capacity to steward the health system. The government has allowed the private sector to take advantage of the struggling health system for profit, and they have been successful in doing so. He admits that “they’ve got enough power, in a broad sense, political power you can even say, to influence policies.” Molefe believes that the private sector has been so successful because of weak governance and weak stewardship functions.” He gave an example of a case study conducted in Umtata where an investigation was made into why GP’s were not taking up the contracts offered by the DoH. The investigation found that the reason boiled down to poor communication from the DoH as to what the contract entailed. Once the doctors understood what the contracts were about they were willing to participate in the pilots because it actually benefitted them. Molefe said “its one thing to have policy and it’s another to communicate it and how it gets down to the ground level...But you need policy champions.” He explains that without knowledge people are vulnerable to the extreme

lobbying from stakeholders, so governments must stick to their position, focus on the real objectives and demonstrate strong leadership when engaging with stakeholders. He states that:

There's one thing to talk about something and there is another to do something. We don't have a shortage of policies in this country, in all areas. We have a problem of implementation. We don't have a problem of talking; no people are making careers in talking. That's how I see it. But they don't make a career in implementation...this is why I said we need policy champions. Because if they are interested they will implement it... If the political will is there and it's coming from the highest office possible, things will get done. So you need political will. You need a leader who has public interest, not self-interest. Because if you have self-interest the first thing you ask is what are the political consequences of doing this.

Dr Schoeman also stated that as "we have appropriate policy, but the problem is the lack of political will to implement those policies." He states that Minister Motsoaledi does not have the political clout to challenge the stakeholder and the opposing politicians in cabinet, and this is why the health system is failing. Dr Floyd agrees that the success of the NHI depends on the government's willingness to challenge the stakeholders that represent only the interests of the wealthy. She maintains "it depends on whether the government is prepared to actually take them on and say sorry we are doing this, it's in the interests of people and of the country." Although the ANC in 2007 reaffirmed their commitment to health reform based on solidarity and equality, the government is seemingly procrastinating implementation. The DoH has presented NHI policies to cabinet, but the lack of support from the executive in pushing the agenda of the NHI with urgency, and the strong influence of Treasury against the DoH proposals stifles any progress towards the release of the White Paper and the implementation of the NHI. Prof Schoeman is of the view that the presidency is "imbedded with capital" which causes one to question the scale of the executive's commitment to transformative social policies such as the NHI. Treasury has clearly taken a market fundamentalist stance, in protection of the status quo that allows the wealthy private health sector to continue to operate in an open market. Considering that Treasury 'holds the purse strings' and has such opposing views to the DoH, it would appear that they are able to 'hold the DoH hostage' to their policies by vehemently arguing against the fiscal efficacy of the NHI in parliament. Minister Motsoaledi needs support and endorsement by fellow politicians however it

would appear that political will is lacking from the ANC government and particularly from the executive branch of government.

Ideology – anti poverty or equality

The ideology of the policy agenda, politician's agenda, civil society and stakeholder agendas are imperative to a policy reform, particularly whether the agenda is directed at poverty or at equality. Policies that are directed specifically at the poor, such as social grants, represent policies with a poverty aligned objective. Policies that are focussed on the whole population, regardless of socio-economic position are more aligned with equality. The ideology dominant within the Swedish and Canadian cultures is the latter. Both countries developed policies targeted at universal coverage on an equitable basis to all members of the population. This too is the ideology that permeates the South African NHI and is certainly the objective that the DoH wishes to achieve. However the DoH is not the only stakeholder within the health sector with powers to influence change and it is the ideology of other interest groups that require adjustment and that could learn from the Canadian and Swedish experiences. According to Dr Schoeman what would be ideal for South Africa is the creation of:

A system where both poor people, impoverished people, working people, middle class people can share in the same system based on a set of values cohered around social solidarity. So those who are better off and who are healthier support those who are less better off and less healthier; a process of cross subsidisation built into your value of social solidarity.

This falls in line with Titmus belief that social policy should be universal because “services for the poor will always be poor services.” But within South Africa the majority of policies have been focussed on the poverty and the poor. The NHI however “promises to be the ANC's most universalist policy yet, signalling a shift towards a politics of solidarity that does not separate the poor from the rich” (Ruiters and Van Niekerk, 2012:5). The NHI offers a shift in focus from the poverty alleviation goals of previous policies such as the MDG's, which treat the poor as a residual problem, towards a more inclusive approach. However stakeholders within the private sector, Treasury and civil society in general hold the view that the government should focus its efforts on providing for the indigent as a separate group, while those who can afford private medical should be left to pay for their own private health care. The DoH on the other hand firmly believes that policies targeted at the poor have not been found to be redistributive. However it has

struggled to drive its ideology within politics. According to Dr Schoeman, due to “the monetary dimension of the debate, how it’s going to be afforded and costed, you find that there’s a retreat on the part of the DoH. They no longer stressing that element of establishing an equitable health care provision based on solidarity which will be a single system of provision.” Due to the strength of the Treasury argument within the political arena, and the gatekeeping function Treasury holds over the fiscal concerns of government, the DoH have not been able to match the political strength of Treasury and contest the poverty ideology in cabinet, which has effectively weakened their resolution. However, a household survey conducted in 2008 revealed that more than 70% of medical scheme members agreed that they would join a publically supported health insurance scheme if their monthly contribution was less than the amount they pay for private medical aid schemes (Ruiters et al, 2012:36). This then causes one to believe that if the DoH were to run a campaign targeted at the middle class about the benefits of the NHI to their pocket, they may transfer the power resources of the middle class into alignment with the redistributive policy of the DoH. Prof Schoeman believes that the state should make an argument to the middle class that not only will public forms of provision under the NHI cost 25% of present private health sector services, but the NHI will also lead to a more socially stable society. In order to create solidarity within society through social policies based on equality, the state must first develop a culture of care, strong political will to implement policy and must develop the capacity to convince civil society groups to buy in to the equality ideology.

Conclusion

The PRT explains the unique position South Africa is in regarding the health reform process. The NHI has been on the governments agenda since 1994 but unlike other countries has not seemed to take off. According to PRT three things are necessary that do not seem to occur in sufficient form in the South African context. Firstly, working class mobilisation is essential to the extent to which the state implements redistributive policies. However the shift in representation of Trade Unions from the working class interests to the middle class interests effectively transfers the power resources of the working class to the market aligned middle-class. If a condition of successful implementation of social policies is the power of the working class alliances, the lack thereof in the South African context explains the passivity to the DoH initiative, the apathy

of the executive and the success of the neo-liberalist private sector and Treasury in delaying the implementation of the redistributive NHI policy. The middle class according to PRT will align with welfare state redistributive policies if the benefits are seen to outweigh the costs and if they have faith in the QoG. The results of this study demonstrate the middleclass does not have faith in the QoG and are not convinced by about the redistributive aspects of the NHI policy in as far as it affects their status quo. However I believe addressing the consciousness of the middle class while improving the quality of the public health sector will likely improve middle class opinion on QoG and result in a transfer of their power resources in alignment with redistributive policies.

Secondly according to PRT a strong leftist party in government is essential to representing working class interests towards solidarity and redistributive policies. However this requirement is also lacking in the South African context and thus explains the policy imbroglio on the NHI. The ANC has prided itself on social democracy but has not shown the political will within its departments to enforce the implementation of the NHI against the strong lobbying powers of the private stakeholders. The executive branch of government, as a powerful stakeholder, has not demonstrated a commitment to the redistributive nature of the NHI policy, and Treasury, the gatekeeper of fiscal resources has aligned with market principles to encourage neo-liberal policies. Finally, the QoG within the ANC and the contentious relationship between government departments with different ideologies has caused a hiatus in progression of the NHI. However it is the hope that with the release of the White paper we will see a much improved reform process following the footsteps of Canada and Sweden.

This study has shown that Canada and Sweden provide South Africa with good examples on how the strength of government with the right ideology and support from civil society can effectively overcome the challenges associated with health care reform and enact universal health service provision even in the midst of economic hardship. From the Canadian and Swedish experiences this study has found that appropriate lessons that could be applied to South Africa. Firstly, it is necessary to establish a culture of care within the broader society to garner support from civil society in the interests of social cohesion and solidarity. Secondly, in order for redistributive policies to be implemented government representatives and government departments must demonstrate strong

political will and a commitment to policies that are in line with equality and solidarity in order to improve QoG. These qualities are essential to combating the opposition from strong stakeholder groups, and successfully implementing a universal health care system.

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INTERVIEW SCHEDULE

Interviews conducted in the course of this study were semi-structured in-depth interviews. This allowed for a fluid line of questioning depending on the responses given by participants. The in-depth interview process required that the interviewer developed a good sense of the prospective participants/key informants. For this study, the researcher read up on the things that each of the prospective participants have said or written about the NHI and explored the issues that they had raised within the interview in an effort to dig deeper into, and test their arguments. Below is a broad framework of prospective interview questions that could be asked to the broad array of participants. However, it must be emphasized that the line of questioning was be predominantly respondent driven and thus open to explore specific issues raised by each participant within the interview process.

	Prompt Questions	Probing Questions
1.	Please explain the nature of your role in health care issues in South Africa.	How familiar are you with the NHI?
2.	What health care problems, if any, can you identify within the South African health system?	What do you believe the causes of these problems are? What /who is responsible for these problems? (<i>Institutional, Structural</i>)
3.	Do you believe that reform is necessary within the health system?	If so, what problems would reform resolve? If not, what in your opinion makes the health system so successful?
4.	In your opinion, is the NHI a solution to South Africa's health problems	How so? If not, what is?
5.	What has your involvement been within the NHI task team/ ministerial committee/ opposing parties?	Depending on involvement (whether for or against NHI) ask probing questions specific to nature of involvement, motivation for involvement, extent of involvement, reach of involvement, support for belief, opposition to belief, concerns arising from involvement, consequences of involvement, challenges of involvement, perceived outcome of involvement.
6.	Do you believe that the NHI will/can be successful?	If so, what do you believe is necessary / will be responsible for its success? If not, why not? What do you anticipate will be responsible for its failure? Explore arguments. Depending on responses, ask probing questions into nature of equity within health context (health system, delivery of services, availability of resources, private/public mix/ sustainability)

7.	Do you have any knowledge of how the NHI will be financed?	<p>In your opinion is this feasible/equitable/practical/efficient/ sustainable?</p> <p>Depending on answers, ask probing questions regarding risk pooling, revenue collection and purchasing. Ask questions pertaining to financial cost to different groups of people and effects of costs on solidarity and equity. Ask opinions on how the South African population is expected to react to financial costs to them.</p>
8.	<p>What challenges do you believe the NHI poses for the private health care industry?</p> <p>What challenges do you believe private health care industry poses for the NHI?</p>	<p>Is there common ground to be reached? Is bargaining a possibility? What would the process of bargaining involve? Cause? Result in in your opinion?</p> <p>What in your opinion would it take overcome these challenges?</p>
9.	Are you familiar with health reform in other countries?	If so, what lessons do you believe South Africa could learn from the nature of those health systems and health reform?
10.	<i>Any other pertinent questions that arise within interview process.</i>	