A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

by

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DECLARATION

A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

I, Kate Mamokgati Kgasi, student number 3245-916-5, declare that the above thesis 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 submitted the thesis to originality-checking software and that it falls within the accepted requirements for originality.

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

_____   July 2022
SIGNATURE   DATE

ACKNOWLEDGEMENTS

I can do all things through Christ who strengthens me.

(Philippians 4:13)

I thank God the Almighty for enabling me to go through this journey. It all began with a thought and a step. It has been a journey of discovery, and understanding what can really be achieved, if one is given the opportunity. It took certain individuals to see the potential and allow me the opportunity to realise my dream.

I wish to express my sincere gratitude to the following institutions and individuals for their immense support, which made it possible for me to complete this study:

DEDICATION

To the husband of my youth, Tlotlo, I thank you for your constant love, support and encouragement.

My son, Kamano, and daughter, Phenyo, I appreciate your unconditional love and understanding in all that I do.

My late parents, Levi and Mildred Mashiane, I thank you deeply for the good seed you planted in my life.

Last, but not least, my siblings that I love dearly, Mrs Sophie Masipa, Mrs Salome Malefo and Mr Edward Mashiane; thank you for your unconditional support and for always believing in me.

Morwedi wa Mashiane, setlogolo sa Mokone

(Translated as Mashiane's daughter, Mokone's grandchild)

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SUMMARY

Health systems are pivotal to ensure that individuals have access to affordable, equitable, quality and sustainable healthcare services. South Africa is reforming its health system to achieve Universal Health Coverage (UHC) to improve population healthcare access while ensuring financial risk protection. Despite policies to realise UHC, there are leadership and governance weaknesses across the health system, and poor quality healthcare. There are also reports of inadequate stakeholder engagements about the envisaged health reform.

The goal of the study was to conceptualise a multi-dimensional framework for implementing health system reform in South Africa. A case study research strategy was used to explore and describe the complexities within the health system by analysing, multi-dimensionally, the role of leadership and governance in health system reform; how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities; and the role of stakeholders and their influence in the health reform process.

The participants consisted of stakeholders within the health system, namely, National Department of Health, regulators, medical schemes, medical scheme administrator, healthcare facilities, funder association, labour unions, and an independent medical practitioner. The sample comprised of 26 participants. Face-to-face interviews were conducted with the selected participants.

The findings revealed that there are several governance challenges in both the public and private sectors, and boards have been non-existent at various levels of the public sector. Poor service delivery is due to limited government funding, ailing infrastructure and lack of Information and Communications Technology (ICT) systems to support work processes. Stakeholders, mainly in the private sector, believed that they were not engaged about the health reform process. The process has been politically driven and ordinary citizens were not engaged from the start.

The dimensions of theories (leadership and governance; service delivery; and stakeholders) and the study findings, informed by the analysed multi-dimensionality of the phenomenon, have been integrated to develop a conceptual framework on how health system reform may be implemented. The conceptual framework is a tool to bridge the identified gaps in literature, and to guide policymakers to implement health system reform effectively.

Key Terms

National health insurance, stakeholder management, health system

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CHAPTER 1: ORIENTATION TO THE STUDY

Chapter 1 is structured as follows: introduction; background and context of the research; problem statement; the goal, objectives and research questions of the study; theoretical framework; and research methodology. Finally, the envisaged contributions to the study are discussed.

1.1 Introduction

The South African government is currently experiencing unprecedented challenges in the health system, which is hampering its ability to provide quality healthcare. There is a leadership and governance crisis, and the strategies adopted by government to improve healthcare delivery are not being implemented appropriately (Barron & Padarath, 2017; Maphumulo & Bhengu, 2019; Rispel, 2016). Both the public and private sectors face challenges related to poor-quality healthcare and hospi-centrism (Department of Health South Africa, 2017). The challenges are aggravated by the country's two-tier system because competition for privately funded healthcare resources negatively affects the quality of healthcare in the public sector (Ramjee & Vieyra, 2014; Rowe & Moodley, 2015).

Considering the stated challenges, the researcher draws from the contingency theory of leadership; the Donabedian model of quality health service delivery; the health system governance framework; and stakeholder theory to discuss the paradigm perspective of this research. Firstly, based on the contingency theory, organisational performance is dependent on organisational characteristics, namely structure, strategy and environment (Blanton, Watson & Moody, 1992; Donaldson, 2001). As the contingency theory prescribes, government's approach to reform should focus on dimensions covered in the theory. Secondly, a framework to assess governance of health systems in low-income countries was considered suitable for the study (Baez-Camargo & Jacobs, 2011; Pyone, Smith & van den Broek, 2017). Based on the health systems governance framework, the governance dimensions (inputs, processes and outcomes) are categorised against the backdrop of human resources, medicines and technology, financing, information and delivery of health services) (Baez-Camargo & Jacobs, 2011). The State needs to consider the elements in this framework to improve health system performance. Thirdly, an integrative stakeholder theory (Hörisch, Freeman & Schaltegger, 2014) was adopted in this study. According to Donaldson and Preston (1995), stakeholder theory states that organisations are comprised of various stakeholder

groups with different interests; appropriate management of stakeholder interests is important to contribute positively to the organisational objectives; and organisations need to be ethical and objective when dealing with stakeholders' interests. The Department of Health is expected to engage with stakeholders regarding the planned reform, as stakeholder theory prescribes this.

Although health system reform has been contemplated at a high level by government, in-depth research has not been conducted to determine the leadership required to effect the reform, considering the structure, strategy and environment which might affect organisational performance. Most leadership studies have been conducted in developed countries and in areas outside healthcare, and only very few in the healthcare domain and developing countries (Figueroa, Harrison, Chauhan & Meyer, 2019; Ghiasipour, Mosadeghrad, Arab & Jaafaripooyan, 2017; Saroja & Reddy, 2018). The lack of healthcare leadership studies necessitates similar studies in developing countries (Ghiasipour *et al*., 2017; Peus, Braun & Frey, 2013). In addition, the literature on governance of the health system is not sufficient, despite the growing discourse on governance (Barbazza & Tello, 2014; Kaufmann & Kraay, 2007; Siddiqi, Masud, Nishtar, Peters, Sabri, Bile & Jama, 2008). Conceptually and practically, governance is open to various interpretations regarding its role, and how to address its weaknesses (Barbazza & Tello, 2014; Brinkerhoff & Bossert, 2013). No extensive research has been conducted into the governance inputs, processes and outcomes required to improve health system performance. Furthermore, although stakeholders need to express their opinion to provide input into decisions about matters that affect them, and to hold decision-makers accountable, public officials often perceive stakeholder participation as time-consuming and unhelpful, and accountability as an unwelcome limitation of their discretionary power (Sidiqqi *et al*., 2008). Stakeholder identification, legitimacy, roles and management need to be addressed in the context of this study.

It is argued that improved efficiency of the public health system is urgently needed to reach UHC in South Africa (Malakoane, Heunis, Chikobvu, Kigozi & Kruger, 2020). To address this, the country is currently in a process of reforming the health system to improve health system performance and access to quality healthcare. Health system researchers acknowledge that for countries to have well-performing health systems, leaders need to set appropriate goals and strategies; enhance commitment and compliance with organisational objectives, and productivity; promote a culture of teamwork and dynamicity in organisations; and create commitment across

the health sector to address identified priorities for improved healthcare delivery (Figueroa *et al*., 2019; Ghiasipour *et al*., 2017; Saroja & Reddy, 2018). Effective governance is needed as a key contributor to socioeconomic development, which is a crucial aspect of managing the care provided, and an important factor in health system performance (Brinkerhoff & Bossert, 2013; Siddiqi *et al*., 2008; Saroja & Reddy, 2018). In strengthening the health sector, national health systems stewards need to ensure alignment, and coherence of policies and priorities among different stakeholders; and manage and coordinate partnerships, and expectations (Senkubuge, Modisenyane & Bishaw, 2014). Stakeholders are affected by, and affect policy (Long, Foster & Arnold, 2019). In the quest to achieve UHC, the World Health Organization (2018) states that UHC should not be discussed and planned, let alone implemented, without a focus on the quality of healthcare because poor-quality care wastes time and money.

Considering the challenges in the health system, the researcher is of the view that the country needs to adopt approaches to effectively implementing the planned reform. A framework is, therefore, required to guide the implementation of the envisaged health system reform. To address the issues that have not been addressed, the contingency theory was applied to analyse the role of leadership in health system reform and how leadership may influence service delivery; a framework to assess governance of health systems in low-income countries was used to analyse the role of governance in health system reform; and the Donabedian model was adopted to explore and describe quality-of-care improvement concepts in health service delivery, necessary for health system reform. Stakeholder theory was applied to analyse the role and influence of stakeholders in implementing health system reform.

The research makes five significant contributions to implementing health system reform. Firstly, the contingencies, namely the organisational structure, strategy and environment, influence organisational performance in the leadership dimension. Secondly, the governance dimension is affected by the inputs, processes and outcomes. Thirdly, leadership impacts service delivery. Fourthly, in health system reform, it is vital to identify stakeholders and determine their roles; understand their interests, needs and powers; and engage and manage them to establish their influence on health system reform. Lastly, a framework for implementing health system reform in South Africa is conceptualised.

1.2 Background and Context of the Research

This section gives the background to the field being studied; that is, it gives a brief overview of the literature, in the areas constituting the research topic, and provides the context of the study, which is South Africa and the health system reform.

1.2.1 Background to the field of study

In South Africa, the provision of healthcare is a constitutional and human rights issue. The right to access healthcare, in its preventive and curative forms, is enshrined in the Constitution of the country (Council for Medical Schemes, 2014). The Constitution of South Africa, 1996 (Act No 108 of 1996), section 27 (2) states that the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the rights of people to have access to healthcare services (South Africa, 2003).

Additionally, the provision of universal, equitable, efficient and quality healthcare is mandated as a goal in the country's National Development Plan (NDP) (Gordon, Booysen & Mbonigaba, 2020). "By 2030, the health system should provide quality care to all, free at the point of service, or paid for by publicly provided or privately funded insurance" (National Development Plan, 2015:51).

The World Health Organization (WHO) further endorses that all people must have access to healthcare services without a financial burden, when and where those services are needed (Abiiro & De Allegri, 2015:2; Michel, Tediosi, Egger, Barnighausen, McIntyre, Tanner & Evans, 2020). To make health for all a reality, the World Health Organization supports the goals of UHC (Abiiro & De Allegri, 2015). UHC is a priority goal of most countries' health systems and is within the mandate of the right and access to healthcare for all (Holmes, 2014; Abiiro & De Allegri, 2015).

According to the researcher, despite the constitutional and policy obligations for South Africa to make healthcare accessible to the country's citizens, the country has been experiencing health system challenges that hamper the realisation of this objective. South Africa has a healthcare system which is classified as a free-market system characterised by both private and public systems of healthcare services (Katuu, 2018; Van Rensburg, 2004).

According to the researcher, the existing health system arrangements have contributed to disparate healthcare access. Affordability and ability to pay are the key drivers of inequalities in healthcare access and utilisation in the country (Gordon *et al.*, 2020; Maphumulo & Bhengu, 2019; Mhlanga & Garidzirai, 2020). The researcher is also of the view that the country's health system arrangement poses a challenge to realising the envisaged reform to achieve UHC because some individuals and organisations that have been benefitting from the current status quo may resist the health system reform. Fusheini and Eyles (2016) indicate that South Africa's path to UHC is not only complicated by the country's history, but also by the size of the private healthcare sector.

1.2.2 Context of the research

South Africa as the location of the study is described first, followed by the South African health system, after which the identified existing knowledge gaps are given.

1.2.2.1 Context and location of the study

A study exploring and describing the implementation of health system reform of the NHI was conducted in South Africa. The country has nine provinces depicted in the next diagram.
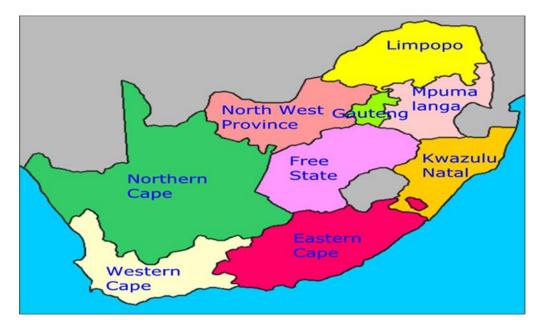
Figure 1.1: Map of South Africa (**Source:** https://www.southafrica.to/provinces/provinces.htm)

Figure 1.1 shows South Africa and the country's provincial demarcations. In 2021, the country had a mid-year population estimated at 60.14 million (Statistics South Africa, 2021). Figure 1.2 depicts the estimated population sizes per province.
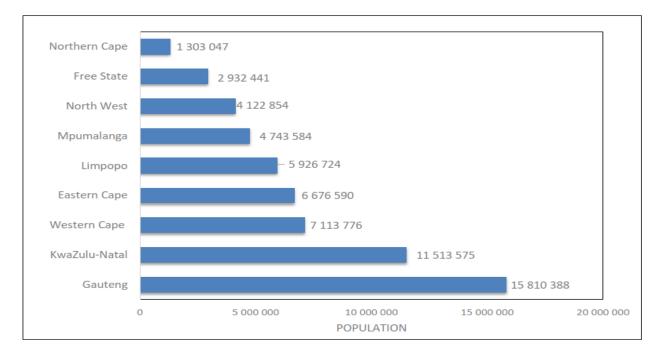
Figure 1.2: Mid-year population estimates for South Africa by province, 2021 (**Source:** Statistics South Africa, 2021)

Statistics South Africa (2021) indicates that some 15.81 million people (26,3%) live in Gauteng province. KwaZulu-Natal is the second largest populous province, with an estimated 11.5 million people (19,1%). The Northern Cape remains the province with the smallest population, with around 1.3 million people (2,2%). Statistics South Africa (2019) states that Free State province had the second smallest share of the country's population estimated at 2.9 million (4,9%). Migration, fertility and mortality rates shape the distribution and age structure of the provincial population.

According to Statistics South Africa (2021), almost 17.04 million (28,3%) of the country's population is younger than 15 years of age, and resides mainly in Gauteng (21,8%) and KwaZulu-Natal (21,2%). An estimated 5.51 million (9,2%) of the population is 60 years or older and this proportion of the population has been increasing. In 2019, the highest numbers of elderly persons (aged 60 years and above) were found in the Eastern Cape (11,3%), the Northern Cape (10,2%) and the Western Cape (10,0%) (Statistics South Africa, 2019).

Fertility rates among women in South Africa have been declining over time and women currently have an average of 2.6 children (National Department of Health, Statistics South Africa, South African Medical Research Council and ICF, 2018). Fertility rates vary by residence and province, reflecting that women in urban areas have fewer children (an average of 2,4), compared to 3,1 children among women in rural areas. In addition, fertility decreases with the increase of both education and household wealth (Ibid., 2018).

The more rural provinces such as the Eastern Cape and Limpopo have higher fertility rates, whereas the urbanised provinces such as Gauteng and the Western Cape have lower fertility levels (Statistics South Africa, 2019). The Western Cape has consistently experienced the highest life expectancy at birth for both males and females over time, while the Free State has experienced the lowest life expectancy at birth (Ibid., 2019).

- **South Africa as a developing country**

South Africa is considered a developing country and has a dual economy with one of the highest inequality rates in the world (World Bank, 2018). The country has a long history of racial segregation, but enjoyed a peaceful political transition to democracy in 1994 (Butler, 2017). Steady progress towards improving the wellbeing of the country's citizens has been noted since the democratic era. The majority of the population, however, still struggle to access the needed resources in a highly unequal society. The legacy of racial segregation still obstructs efforts to create a coherent and inclusive social order (Ibid., 2017).

- **South African spheres of government**

South Africa has three spheres of government as stipulated in the Constitution of the country (Department of Provincial and Local Government, 2007). The Constitution of South Africa, 1996 (Act No 108 of 1996), Section 40 (1) states that "in the Republic, government is constituted as National, Provincial and Local spheres of government which are distinctive, interdependent and interrelated". The spheres of government are autonomous, but are required to function as a single system of co-operative government (Department of Provincial and Local Government, 2007).

1.2.2.2 The South African health system

South Africa's health system is two-tiered, comprising the public and private sectors (Deloitte, 2015; Van Rensburg, 2004). The National Ministry of Health is responsible for overall policy development and coordination (Mahlathi & Dlamini, 2015). There are nine provincial health departments which are government-funded to provide healthcare services to the people utilising the public sector (Ibid., 2015).

The private sector provides healthcare services which are funded mainly through medical schemes, thereby encouraging private healthcare for people who can pay for those services (Mahlathi & Dlamini, 2015; Van Rensburg, 2004). Even so, in the current medical schemes environment, members are, at times, denied access to needed services in the private sector, if the benefits are depleted (Department of Health South Africa, 2015).

South Africa is a developing country, but the country's Gross Domestic Product (GDP) spent on healthcare is on par with developed countries such as the United Kingdom (UK) at 8,8%, and half the spending of the United States (US) GDP at 17,1% (Deloitte, 2015).

Department of Health, South Africa (2015); Gordon *et al*. (2020) indicate that 4,1% of the country's GDP was spent on 84% of the population, utilising the public health sector. Some 4,4% of the GDP was spent on only 16% of the population accessing healthcare services in the private sector. However, the proportion of beneficiaries covered by medical schemes in the country has declined since 2000, from 16% to 14,78% in 2020 (Council for Medical Schemes, 2021). This trend is attributed to the negative economic impact of the COVID-19 pandemic on households (Ibid., 2021). The country's unemployment rate increased in the fourth quarter of 2020 to 32,5%, compared to 29,1% in the fourth quarter of 2019, before COVID-19 (Statistics South Africa, 2021).

Many South Africans view the private sector as better resourced, providing high-quality healthcare, personal attention to patients and 'state-of-the art' facilities (Gordon *et al*., 2020; Maphumulo & Bhengu, 2019; Section 27, 2010). In contrast, the public sector is perceived as overburdened, overcrowded, offering substandard healthcare, and plagued by leadership and governance failures (Gordon *et al*., 2020; Maphumulo & Bhengu, 2019; Mhlanga & Garidzirai, 2020; Rispel, 2016; Section 27, 2010).

Although this view might be understandable, the perception is not totally correct (Section 27, 2010). Private healthcare is expensive and is not always of high quality. Although the public sector is underfunded, public health policies are more rational, and the employees are more community-focused (Ibid., 2010).

1.2.3 Challenges in the healthcare system

Department of Health (2017) acknowledges that the challenges facing the country's health system are related to the inability to effectively implement the six health system building blocks proposed by the World Health Organization to effectively strengthen the health system, namely *leadership and governance*; *financing*; *information*; *medical products and technologies; health workforce and service delivery*.

As the six building blocks are interconnected, the study focuses on *leadership and governance* as a dimension because of its bearing on the other dimensions. The study also focuses on *service delivery*, which reflects the health system outputs. *Stakeholder* aspects are discussed as a lagging addition to the building blocks, as the stakeholders affect and will be affected by the reform.

1.2.3.1 Leadership and governance issues

The South African health system has seen relatively poor performance, despite the country's significant spending on healthcare (Barron & Padarath, 2017). There are systemic leadership and governance failures, with a general lack of accountability at various levels of the public sector entities which negatively impact the country's ability to provide quality healthcare (Rispel, 2016).

Leadership and governance challenges continue to prevail at various levels of the public sector, despite the government's efforts to instil a culture of good leadership and governance (Department of Health South Africa, 2017). Long-standing problems experienced also relate to a disconnection between progressive policies and their implementation (Barron & Padarath, 2017).

Additionally, the suboptimal performance of the South African health system is attributed to some management decisions that are not based on objective evidence and information (Harvard Medical School, 2015). Leadership incompetence is perceived to be a reflection of leadership culture (Michel *et al*., 2020).

In the analysis of factors causing overspending in provincial government health departments, the reasons provided were linked to serious management flaws and leadership gaps, especially in relation to the core business of service delivery and the quality of service delivery (Michel *et al*., 2020). The private sector also has weak systems of leadership and governance, thus remaining poorly regulated and less accountable, in terms of quality and costs (Department of Health South Africa, 2017). Governance failure in the private sector is attributed to lack of transparency, and lack of accountability to the members of medical schemes (South African Lancet National Commission, 2019).

The South African government has been labelled as corrupt and lacking stewardship (Conmy, 2018). Corruption and fraud are major threats to equitable access to quality healthcare (South African Lancet National Commission, 2019). The lack of organised healthcare structure and cohesive politics fails to address the source of the problem (Conmy, 2018).

Notwithstanding the enabling Constitution, strong health legislation and numerous health policies that express government's commitment to a high-quality health system, gaps in ethical leadership, management and governance contribute to the poor quality of care (South African Lancet National Commission, 2019). These gaps are exacerbated by evidence of mismanagement, inefficiencies and incompetence at various levels of the health system (Ibid., 2019).

In addition, there are governance weaknesses in the Health Professions Council of South Africa and the South African Nursing Council, which are the regulators of most healthcare professionals in the country (South African Lancet National Commission, 2019).

1.2.3.2 Service delivery inadequacies

According to the researcher, the provision of quality healthcare remains a complex health system challenge. Both the public and the private sectors face challenges related to poor-quality healthcare and hospi-centrism (Department of Health South Africa, 2017). There have been reports of

fragmented health service planning in the public sector which was often not related to financial and human resource requirements (Michel *et al*., 2020). This was coupled with poor health programme linkages, coordination and integration within the national health department, and between national and provincial health departments (Ibid., 2020).

Budgetary cuts also affect the operational efficiencies because organisations are expected to deliver quality care at minimal cost (Figueroa *et al*., 2019). Assessments of public sector facilities continued to reveal quality problems in the areas that were identified as the six ministerial or priority quality areas, namely *cleanliness, drug stock-outs, infection control, staff attitudes, waiting times, and safety and security of patients and personnel* (Harvard Medical School, 2015; Madisha, 2015; Maphumulo & Bhengu, 2019; Michel *et al*., 2020).

There have been media reports of medicine shortages in healthcare facilities (Barron & Padarath, 2017). The reasons cited were varied and ranged from shortage of personnel to the lack of communication between suppliers, depots, and health facilities (Ibid., 2017). Department of Health South Africa (2017) acknowledges that there were inadequacies in the pharmaceutical supply chain, and the annual inventory procurement costs. Expired medication and trade deficits on unaccounted stock were also common.

Increased patient loads and utilisation in the public sector have compromised the quality of healthcare provided in this setting (Department of Health South Africa, 2017; Maphumulo & Bhengu, 2019). The unhappiness of the public regarding the quality of services in both the public and the private sectors has been noted (Department of Health South Africa, 2017). The dissatisfaction has led to increased medico-legal claims which put enormous strain on the fiscus and the healthcare professionals (Ibid., 2017). Corruption and lack of leadership skills continue to delay the achievement of quality healthcare delivery in the country (Maphumulo & Bhengu, 2019).

Irrespective of the service delivery challenges, communities are willing to tolerate public sector healthcare service characteristics such as long waiting times, the lack of direct access to doctors, and poor staff attitudes, if they receive access to a thorough examination, a clear explanation of the diagnosis and prescribed treatment from other health professionals, and are being provided with the needed medicines (Honda, Ryan, van Niekerk & McIntyre, 2015).

1.2.3.3 Stakeholder engagement obstacles

South Africa is planning to implement a health system reform under the banner of the NHI, which is a financing system to address the challenges that are fundamentally hampering access to quality healthcare (Department of Health South Africa, 2017; Fusheini & Eyles, 2016). According to McIntyre, Goudge, Harris, Nxumalo and Nkosi (2009), there have been inadequate stakeholder engagement and awareness about the NHI. This is very concerning, as the public is the beneficiary and the contributor that will be directly affected by the NHI, and will also affect its implementation.

Medical schemes funding private healthcare in the country are some of the major stakeholders, but have been reported as standing in the way of the government's proposed NHI (Michel *et al.*, 2020). During the NHI pilot process, the challenge of recruiting and retaining GPs in private practice to increase patient access to Primary Health Care (PHC) was identified (Harvard Medical School, 2015). There has been a low uptake of national contracts among these practitioners, which is attributed to the lack of effective communication and consultation from national government, thereby creating mistrust and uneasiness among local private doctors (Hongoro, Funani, Chitha & Godlimpi, 2015).

Gaps have been identified in the NDoH's stakeholder identification and prioritisation strategy regarding the NHI (Vena & Nhlabatsi, 2018). The approach used was biased and only prioritised those that were closer to the decision-makers, and the ruling party (Ibid., 2018).

There are several barriers to effective community participation, which may influence stakeholder accountability (South African Lancet National Commission, 2019). In the case of a heterogeneous and multi-cultural society, the challenge might be how to derive strength in diversity (Sindane, 2011).

1.2.4 Identified knowledge gaps

"If the main goal of UHC is to ensure good quality care for all then universal access to services is a precondition to achieving universal coverage" (Fusheini & Eyles, 2016:7). However, little guidance is provided on how to achieve UHC and how to design a system accordingly (Giedion, Alfonso & Díaz, 2013). Governments and leaders in Africa acknowledge that those that lead and manage health systems are not sufficiently equipped to succeed in their leadership roles (Afegbua & Adejuwon, 2012; Mitchel *et al.*, 2020).

In this study, a reformed health system infers that there will be UHC, which means having equal access to quality healthcare without any hindrance. Having a reformed health system, notably the provision of UHC, means formulating and implementing policies, guidelines and strategies to effect reform.

This study focuses on the gaps identified in relation to *leadership and governance*; *service delivery*; and *stakeholder aspects* within the health system. The researcher is of the view that South Africa requires a framework that can guide the country in implementing health system reform, considering the identified gaps. The researcher envisages that the framework will be a useful tool in guiding South Africa in effectively implementing health system reform. This study is, therefore, intended to bridge the knowledge gaps with a multi-dimensional framework that will address the *leadership and governance*; *service delivery*; and *stakeholder aspects* necessary for health system reform.

1.2.4.1 Leadership and governance

Firstly, one of the key interventions proposed for the South African health system reform is radical changes in administration and management (Jobson, 2015). Secondly, leadership and governance are integral to *overall policy* and *regulation* in the health system (World Health Organization, 2010). Leadership and governance take into consideration that strategic policy frameworks exist, in combination with the provision of appropriate regulations and incentives, attention to the design of the system and accountability, effective oversight and coalition-building (World Health Organization, 2007).

Leadership reforms are needed to transform health systems, in order to deal with a variety of existing health challenges (Gilson & Daire, 2011). However, there have been limited discussions on the nature of leadership required across the health system (Ibid., 2011). There is also a need to strengthen leadership and governance in the health system, if UHC policy implementation is to succeed (Michel *et al*., 2020).

The identified knowledge gaps, in relation to *leadership and governance* gaps are*:*

- *Management processes and procedures:* There was a lack of clarity on how the management processes and procedures would affect the health system reform. The study intended to bridge the identified gap by unravelling the processes and procedures necessary for health system reform in a developing country.
- *Governance strategy and policies:* There was a lack of available information on governance measures required for the health system reform. Strategy and policies are articulated in the study.

1.2.4.2 Service delivery

Firstly, service delivery reflects on the immediate outputs of the health system, which are the *availability* and *distribution of care* (World Health Organization, 2010). Secondly, one of the key interventions for NHI implementation is the complete transformation of how the healthcare services will be provided and delivered (Jobson, 2015).

Although much has been done to restructure the country's healthcare system over time to improve the quality of care, millions of South Africans still suffer the negative effects of being unable to access quality healthcare (Maphumulo & Bhengu, 2019; Mhlanga & Garidzirai, 2020).

On the other hand, changes in health policies and regulations compound the challenges faced by healthcare leaders to deliver high-quality care because transformation may necessitate changes in values, structures, processes and systems that can constrain how leaders align their organisations to new agendas (Figueroa *at al*., 2019). There is still much that needs to be done by government and society to address the issues of poor-quality service delivery (Maphumulo & Bhengu, 2019). *Service delivery knowledge gaps* are:

- *Structure measures:* There was no clear guideline on the context-specific inputs required for the planned health system reform. The study intended to discover how this could be articulated.
- *Process measures:* How the process would be measured was not articulated clearly. This is analysed in the study.
- *Outcomes measures:* There was no specific tool to determine how service delivery would be measured, in relation to health system reform. This is analysed in the study.

1.2.4.3 Stakeholder engagement

Stakeholder attributes are dynamic and require continuous analysis, and stakeholder concerns should be continuously addressed (Vena & Nhlabatsi, 2018). There has been limited stakeholder engagement regarding the NHI implementation in the country (McIntyre *et al*., 2009). In this study, it is argued that there is a need to identify, manage and engage various stakeholders.

Stakeholder knowledge gaps are:

- *Types and roles:* The types of stakeholders and their roles in implementing health system reform were limited in the literature, especially in the context of a developing country. The study intended to find out how the stakeholders were identified, classified and managed, and how their roles were described.

- *Interests and powers:* In practice and in theory, the interests and powers of stakeholders in the context of a developing country were inadequate. The study intended to bridge this gap.

- *Needs and viewpoints:* The literature and practice did not provide clarity on the needs and viewpoints of the stakeholders necessary for the reform. The study intended to explore the needs and viewpoints of stakeholders in implementing health system reform in a developing country.

1.3 Problem Statement

South Africa is striving for reform in the health system to improve access to quality healthcare. Major health system challenges need to be addressed, such as long waiting times, unclean facilities, negative staff attitudes, medicine stock-outs, and compromised safety and security of both staff, and patients (Malakoane *et al*., 2020). Although several changes in health policy and legislation have been made to improve the quality of healthcare, services in public sector health institutions are still failing to meet basic standards of care and patient expectations (Maphumulo & Bhengu, 2019; Stuckler, Basu & McKee 2011).

Research in Gauteng, which is the mostly populated province in South Africa, showed that almost 75% of randomly selected respondents were not utilising the public sector, owing to the perceived diminished quality of healthcare services (Abaerei, Ncayiyana & Levin, 2017; Malakoane *et al*., 2020). Weak leadership and fragmentation of services resulted in poor quality of care in the public sector (Malakoane *et al*., 2020).

Despite government's intention to reform the health system, no framework was, to the best of the researcher's knowledge, presented that addressed the multi-dimensionality of implementing health system reform of UHC to address the challenges identified in the preceding sections. In addition, there was inadequate literature and a lack of research to inform the desired *leadership* and *governance*, *service delivery* and *stakeholder* aspects required to successfully implement health system reform, especially in the context of a developing country. Existing literature provided the 'know what', but not the 'know-how' of implementing health system reform. In other words, there was no empirically informed way of implementing health system reform in a developing country such as South Africa. This meant, therefore, that there was a dire need for a study such as this one to expand the body of knowledge that would subsequently inform the health system reform process.

The research results might bridge the identified gaps by providing: empirical evidence of the *leadership* and *governance* elements necessary for the implementation of health system reform in a developing country such as South Africa; a pragmatic view of *service delivery,* with specific emphasis on the structure, process and outcome measures vital for delivery of quality healthcare; and insight into the *stakeholders* necessary for desired health system reform – the types, their roles, power, interests, needs and viewpoints.

1.4 Goal of the Study

The goal of the study was, therefore, to conceptualise a multi-dimensional framework for implementing health system reform in South Africa.

1.4.1 Objectives of the study

The objectives of the study were:

- To analyse the role of leadership and governance in health system reform
- To analyse how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities
- To analyse the role and influence of stakeholders in implementing health system reform
- To determine how health system reform may be implemented, informed by the analysed multi-dimensionality of the phenomenon.

1.5 Research Questions

1.5.1 Primary research question

How should health system reform be implemented in South Africa?

1.5.2 The secondary research questions that directed the study were:

- What is the role of leadership and governance, and how leadership and governance influence health system reform?
- How does leadership influence service delivery and what are the service delivery challenges in South African healthcare facilities?
- What is the role of stakeholders in implementing health system reform?
- How do stakeholders influence the implementation of the health system reform?
- How should the implementation of health system reform be conceptualised in South Africa?

1.6 Theoretical Frameworks

A theoretical framework refers to the use of a theory in a study and serves as a lens for how the study will process new knowledge (Collins & Stockton, 2018). The theoretical framework is regarded as the foundation from which all knowledge for the study is constructed (Grant & Osanloo, 2014). In addition, the theoretical framework serves as the structure and support for the basis of the study, the problem statement, the purpose, the significance and the research questions. The framework also provides a grounding base for the literature review, research methods and data analysis (Ibid., 2014). The theoretical frameworks that were used to discuss the paradigm perspective of this study were as follows:

- Contingency theory of leadership
- The health system governance framework
- Donabedian model of quality in health service delivery
- Stakeholder theory.

A literature review of these concepts enabled the researcher to develop research questions, analyse data, generate themes and formulate a conceptual framework for implementing health system reform in South Africa.

1.6.1 Contingency theory of leadership

A review of literature on leadership reveals that there is no one leadership style that is correct for every manager, under all circumstances (Bolden, Gosling, Marturano & Dennison, 2003; Yukl, 2013). Contingency theory was developed to show that the style of leadership is dependent on factors such as the people, the task, the situation, the organisation and the environment (Bolden *et al.*, 2003). Contingency theories suggest that there is no universal best way to design an organisation to achieve the desired outcomes (Cummings & Worley, 2009).

Contingency infers that the structures and practices of an organisational system depend on the environment or situation relevant to the system (Cummings & Worley, 2009; Longenecker & Pringle, 1978). Situational variables refer to outcomes of the interaction that exists among environmental variables such as culture, education, technology, suppliers and competitors (Longenecker & Pringle, 1978).

Contingency theory of leadership was applied in this study to explore and describe the *organisational structures and practices* necessary to successfully implement health system reform. This was done in relation to the leadership gaps identified, that is, how the management processes and procedures would affect the health system reform. The objective was to analyse the role of leadership in health system reform.

1.6.2 Health system governance framework

Health system governance refers to the institutions that define and regulate the processes through which human resources are managed, medicines and technologies are acquired and distributed, information is generated and disseminated, and financing means for healthcare are provided to the population (Baez-Camargo & Jacobs, 2011). Health systems governance concerns the actions and means adopted by society to promote and protect population health (Sidiqqi *et al*., 2008). Governance, therefore, influences all other health system functions, thereby leading to improved performance of the health system and, ultimately, to better health outcomes (Barbazza & Tello, 2014; Sidiqqi *et al*., 2008).

As the objective of the study was to analyse the role of governance in health system reform, a framework to assess governance of health systems in low income countries, proposed by Baez-Camargo and Jacobs (2011), was adopted to explore and describe the *strategy and policies* necessary for the health system reform. The rationale for adopting this framework is that the health system in South Africa requires a governance analysis that considers socio-political aspects because these elements have a bearing on health system performance.

Baez-Camargo and Jacobs (2011) state that this framework provides an approach that considers power and influence in formal and informal decision-making, and accounts for how different forms of political administrations and legitimation modes can have an impact on observed governance performance of health systems.

The framework involves assessing health policies and strategic institutional design (governance inputs), and performing an accountability evaluation (governance processes) at critical institutional connections, with an emphasis on understanding both the formal and informal determinants underpinning the quality of governance (Baez-Camargo & Jacobs, 2011). The aim is to generate insights into possible ways of improving health systems outcomes such as responsiveness, equity and efficiency (Ibid., 2011).

1.6.3 The Donabedian model of quality in health service delivery

The Donabedian model is used for quality assessment and monitoring of systems in health service delivery, and links the structure, processes and outcomes (Ameh, Gómez-Olivé, Kahn, Tollman & Klipstein-Grobusch, 2017; Donabedian, 1997; Handler, Issel & Turnock, 2001). Donabedian postulates that there is a unidirectional relationship between the *structure, processes and outcome* concepts based on the notion that good structure promotes good process, and good process results in good outcome (Ameh *et al*., 2017; Donabedian, 1997). As the objective of the study was to analyse how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities, the Donabedian model was adopted to explore and describe quality of care improvement concepts in health service delivery, necessary for health system reform.

1.6.4 Stakeholder theory

"Stakeholder theory" is essentially about how a business works fully and how the entity could work (Freeman, Harrison, Wicks, Parmar & de Colle, 2010). This theory is descriptive, instrumental and prescriptive (Freeman *et al.*, 2010). Stakeholder theory is about creating value and managing a business effectively (Ibid., 2010). The table below provides a summary of several forms of stakeholder theories.

Table 1.1: Different types of stakeholder theories (**Source**: Hörisch *et al.*, 2014)

Descriptive/empirical stakeholder theory	Description of how companies are managed; identification of relevant stakeholders
Instrumental stakeholder theory	Effects of stakeholder management on the achievement of corporate objectives
Normative stakeholder theory	Discussion of the purpose of business; moral justifications of stakeholder theory
Integrative stakeholder theory	Considers the descriptive, instrumental and normative aspects of stakeholder theory to be inextricably linked

Considering Table 1.1 above, the integrative version of stakeholder theory was employed in this study. According to the integrative stakeholder theory, descriptive, instrumental and normative aspects of stakeholder theories cannot be separated (Hörisch *et al.*, 2014).

The all-inclusive view helped the researcher to analyse the role, and influence of stakeholders in implementing health system reform. In this study, stakeholder concepts were analysed focusing on stakeholder *identification, legitimacy, roles and management.* This was done taking into consideration the stakeholder knowledge gaps that were identified, namely the *types and roles*; *interests and powers*; *needs and viewpoints*.

1.7 Research Methodology

Research methodology refers to the methods used to conduct research, procedures, steps and strategies to gather, and analyse data (Polit & Beck, 2004). There are two types of research methodologies, namely qualitative and quantitative. The background to the study, research problem, identified knowledge gaps, research purpose and objectives of the study necessitated that the researcher uses qualitative research methodology.

Qualitative research is a methodical, subjective approach used to describe life events and give the experiences meaning (Burns & Grove, 2005). In this chapter, the research design (unit of analysis, context, population and sampling; data collection and analysis), including trustworthiness and ethical considerations, is briefly discussed. The research methodology is explained in detail in Chapter 4.

1.7.1 Research design

In the study, health system is argued to be a complex, multi-dimensional phenomenon. Consequently, in order to profoundly understand the phenomenon, there was a need to explore and describe each dimension, in the context in which it happened. An exploratory and descriptive research design was used, as it was considered suitable for the study. Exploratory research design involves non-numeric concepts, where little is known of the phenomenon or the problem (Wegner, 2000). Descriptive research evaluates the situation as it stands without modifying the situation being investigated (Leedy & Ormond, 2010).

1.7.2   Unit of analysis, context, population and sampling
Unit of analysis

> The unit of analysis describes the level at which the study is conducted, and the objects being studied (Lewis-Beck, Bryman & Liao, 2004). The unit of analysis for this study was South Africa (health system) as a developing country.

Research setting

> Refers to the selection of a location where specific events are expected to occur, and information is expected to be gathered (Van Dyk, 2016). As the study is multi-level, the study was conducted at macro, meso and micro levels.

Population

> Refers to the group from which the researcher wants to gather information and make conclusions (Polit & Beck, 2004). The population is comprised of an entire set of individuals which has some common characteristics (Ibid., 2004).

As the study was multi-dimensional and multi-level, the participants comprised of stakeholders such as Department of Health, regulators, medical schemes, healthcare facilities, funder association, and labour unions.

Sampling

Refers to the selected group of people or elements for inclusion in the study (Burns & Grove, 2005). In this study, the sampling was within the health system stakeholders. Purposive sampling was used to identify the participants. Purposive sampling refers to selective sampling where the researcher intentionally chooses the participants to include in the study (Burns & Grove, 2011). Therefore, purposive sampling was used to identify participants from each stakeholder within the health system. Subsequently, the actual study participants were purposively selected based on their positions and roles:

- Each position had a role that is defined in terms of knowledge, skills, competencies and experience, with respect to the health system.

1.7.3 Data collection methods and procedures

Data collection refers to the collection of all the information that is relevant to the research questions (Stommel & Wills, 2004). Semi-structured focus group and individual interviews were conducted to allow the participants the opportunity to communicate their experiences, thoughts and views. The interviews were conducted until saturation was reached. Observations were also done.

Focus group interview

A focus group interview was conducted with health workers in a district hospital. Focus groups are designed to obtain participants' views about a specific area, in a setting that is permissive and non-threatening (Burns & Grove, 2005). Interviews were conducted until saturation was reached. Burns and Grove (2011) explained that the focus of qualitative research is on the quality of information, rather than the size of the sample.

Individual interviews

Individual interviews involve talking to one person at a time, provide more time to discuss a topic in detail and the participant is given full attention; the researcher may adjust the interview style according to the participant's needs; and there are no group dynamics expected with focus groups (Ennis & Chen, 2012).

Individual interviews were conducted to collect data from the stakeholders, namely NDoH, regulators, health facilities, medical schemes, independent medical practitioner, funder association, and labour unions.

Observations and documents

Participant observation was done to enable the researcher to develop mutual trust with the participants, take notes and discover context-specific information. Acts, Bills, White Papers, annual reports, policy and other relevant documents were reviewed.

1.7.4 Data analysis

In this study, content analysis and thematic analysis were the techniques used to analyse the data collected. Data analysis is conducted to condense, organise and give meaning to data (Polit & Beck, 2004). The data analysis methods employed were content analysis of documents and thematic analysis. Thematic analysis and coding of qualitative data were performed. Thematic analysis was performed on data collected from the interviews. Analysis of the Acts, Bills, White Papers, annual reports, policy and other relevant documents was also conducted.

1.7.5 Measures to ensure trustworthiness

Trustworthiness ensures that qualitative research is credible and defensible (Van Dyk, 2016). Criteria for data quality were explained based on the principles of credibility, transferability, dependability, confirmability and authenticity (Guba & Lincoln, 1994).

Credibility

Refers to "the confidence that can be placed in the truth of the research findings" (Korstjens & Moser, 2018:121). In-depth interviews with the participants, engagement with the participants during the interviews, observations and audit trails ensured credibility of the findings.

Transferability

This is the extent to which the findings can be generalised to other situations and target populations (Stommel & Wills, 2004). Transferability was attained through conducting interviews until saturation was reached. The behaviour and experiences of participants, and the context were described to make the interpretation meaningful.

Confirmability

Confirmability assessment is used to determine whether two or more researchers can agree on the process, steps and decisions about the type of data to collect, and how to interpret the data (Stommel & Wills, 2004). Confirmability was achieved through describing the research steps taken, and providing the interpretations and conclusions from the interviews conducted.

Authenticity

Authenticity requires the researcher to ensure that both the conduct and evaluation of research are genuine, and credible, not only in terms of participants' lived experiences, but also in relation to the wider political and social implications of research (Given, 2008).

The researcher analysed statements provided by the participants and left audit trails that documented the participants' consciousness and understanding of the world. Data was critically interpreted to reflect the participants' views and emotions as they occurred.

1.7.6 Ethical considerations

Ethical rigour requires the researcher to acknowledge and discuss the ethical implications related to the conduct of a study (Burns & Grove, 2005). Approval to conduct the study was sought from the Department of Health, regulators, health facilities, medical schemes, funder association, and labour unions. Permission to conduct the study was also sought from the selected participants in the specified organisations. Ethical considerations are discussed in detail in chapter 4.

1.8 The Scope of the Study

The study was confined to the South African health system. The participants were comprised of stakeholders, namely Department of Health, regulators, health facilities, medical schemes, funder association and labour unions.

1.9 Limitations of the Study

Depth of information provided by the participants might have varied, depending on their knowledge, and understanding of the UHC and the NHI, their perceived expectations, and their understanding of leadership and governance, service delivery, the role of stakeholders and how the health system functions. The study results may also have been influenced by varied organisational structures, processes and systems. The external environment might also have had a bearing on the performance of organisations.

1.10 Delimitations

These are the things that the study did not focus on. Firstly, the study did not focus on health system reform in a developed country. Secondly, the study did not include patient advocacy groups as stakeholders.

1.11 Envisaged Contributions

This section explains the contributions that were expected from the study.

Theoretical

In reviewing the existing body of knowledge, with respect to health systems and health system reforms, there were identified knowledge gaps which needed to be addressed. The study intended to bridge these gaps by giving a profound analysis and understanding of how health system reform might be implemented in a specific context.

The theoretical contribution constituted providing the theory on 'how to' implement health system reform in a developing country such as South Africa. This theory and the 'how to' are in the form of a multi-dimensional framework.

Methodological

An exploratory and descriptive qualitative study was conducted to provide the 'know-how' and 'how' to implement health system reform in a developing country.

Practical

The framework provides practitioners with the 'know-how' on the implementation of health system reform in a developing country such as South Africa.

Contextual

A contextual gap was bridged, as this study provides the 'know-how' and 'how' to implement health system reform in a developing country such as South Africa. The country had the vision to implement the NHI, but lacked the 'know-how' and the 'how' to implement the reform.

1.12 Envisaged Outline of the Thesis

Chapter 1: Orientation to the study

This chapter provides an overall orientation to the study.

Chapter 2: Literature review

The chapter focuses on the extensive literature reviewed on health systems, health system reforms and UHC. The paradigmatic and conceptual foundations of health systems, health system reforms and UHC are discussed. A comparative analysis of other countries' health systems and reforms is also given. Finally, South Africa's health system transition is discussed.

Chapter 3: Theoretical frameworks

In this chapter, contingency theory of leadership, health system governance framework, Donabedian model of quality, and stakeholder theory are discussed as theoretical frameworks of the study. Concepts relating to these theories are also explained.

Chapter 4: Research methodology

This chapter describes the research methodology. Epistemology, ontology, research paradigm, research approach, research strategy and research design are also discussed.

Chapter 5, 6, 7 and 8: Research findings

These chapters give an analysis and interpretation of the findings on dimensions of the study, which are leadership and governance, service delivery and stakeholders. The results are presented in narratives, themes, subthemes, categories, and subcategories for convenient and practical interpretation.

Chapter 9: A multi-dimensional framework for implementing health system reform – research contribution

This chapter conceptualises how health system reform may be implemented in South Africa. The conceptualisation is informed by the literature reviewed, the theories underpinning the study and an interpretation of findings.

Chapter 10: Conclusions, limitations and recommendations

This chapter focuses on the conclusions and limitations based on the study findings. Linkages are made with the literature review conducted and theoretical frameworks of the study. Recommendations are also made on the relevance of the findings and possibilities for further research.

CHAPTER 2: EXTENSIVE LITERATURE REVIEW

This chapter focuses on the extensive literature reviewed on health systems, health systems reform and UHC, and serves as the first phase of the literature reviewed. The paradigmatic and conceptual foundations of health systems, health system reforms and UHC are discussed, while comparative analyses of other countries' health systems and reforms are considered. Finally, South Africa's health system in transition is explained.

2.1 Health Systems

An exposition of health system definitions and descriptions by various authors follows.

Table 2.1 Health system definitions and descriptions

Author	Definition and Descriptions
Roemer (1993)	A health system refers to the combination of resources, organisation, financing and management for healthcare service delivery to the population. The five main components in a health system are *economic support, resources, organisation, management* and *delivery of services*, and these characteristics allow for differentiation of national health systems.
World Health Organization (2000)	A health system refers to all activities where the primary purpose is to promote, restore and maintain health.
Van Rensburg (2004)	A health system comprises three components, namely a *healthcare system* – the total health service delivery or supply system; *environment* – the wider context within which the healthcare system is embedded; and *clientele or target population* – the people served by the healthcare system. These components are continuously interacting with each other.
Giaimo (2016:23)	The healthcare system in any nation "has institutionalised rules and practices, and a particular settlement among the State, healthcare providers, payers and patients, about their respective roles, powers and jurisdictions in healthcare".
World Bank (2007)	There are interconnected parts within a health system, and the interconnections are reflected in the functions played by those parts.
World Health Organization (2010)	The actions of the health system should demonstrate responsiveness to the population's needs and be financially fair, while treating people with respect.
Mills (2014)	A health system encompasses the institutions, organisations and resources (physical, financial and human) assembled to deliver healthcare services that meet population needs.

The history, political ideology and economic status of a country determine the funding mechanisms, types and characteristics of health systems (Green, 1999; Roemer, 1993). The organisation of health systems notably includes the private healthcare sector, aimed at promoting, maintaining and restoring health (Roemer, 1993; USAID, 2015). The society's healthcare system is directly and indirectly influenced by the environment, and the clientele are also embedded in the same larger environment and influenced by the environment (Van Rensburg, 2004). The next diagram depicts how a health system is conceptualised by the World Health Organization.
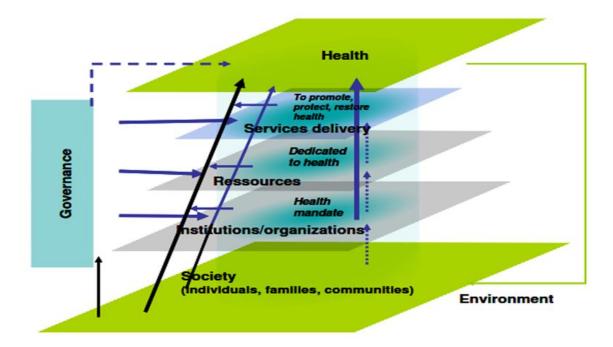
Figure 2.1: Conceptual framework of the boundaries of public health and the health system **(Source:** World Health Organization, 2011)

The above diagram (Figure 2.1) depicts the fact that in a health system, the society, environment and governance, including the platforms which are institutions or organisations with a health mandate, the resources dedicated to health, and the services delivered to promote, protect and restore health have an impact on health (World Health Organization, 2011). According to Frenk (2010), the health system focus should be on the interrelations of essential elements such as human resources, financing, healthcare facilities and technologies. The other focus should be on the population and not only on the institutional or supply side of the health system.

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In this study, a health system is a social activity comprised of people, health workforce, technological tools, healthcare facilities, processes, procedures and policies, with the aim to promote, restore or maintain health. A health system includes all the resources and institutions that are made available to promote access to affordable quality healthcare, considering the legislative and governance mandates of a country to improve health outcomes.

2.1.1 Levels of the health system

There are three levels of the health system, namely macro, meso and micro levels (Samuels, Amaya, Pose & Balabanova, 2014).

Figure 2.2: Health system levels **(Source:** Aroni, 2012:13)

Macro level

Macro level is broadly defined as the level of national policies and strategies at which decisions about priorities are taken, policies and interventions designed, and resources allocated for their implementation (Samuels *et al*., 2014). The policies, regulations and strategies are implemented by the overall government and under the leadership of the national health authority for achieving national health goals (Aroni, 2012). The macro level focuses on the overall dimensions of the health sector, namely the total size, shape and functioning of the health sector (Hsiao, 2003).

Meso level

> The policies are operationalised and implemented as specific programmes and are affected by the organisational context, the strength of competing interests at this level, and the ability to forge alliances among multiple institutions to achieve the same goal (Samuels *et al*., 2014). The meso level refers to the management of health services and facilities, and is responsible for the provision of people-centred services based on population needs, expectations and preferences (Aroni, 2012).

Micro or service delivery level

> This level represents the interface of health systems and users or communities (Samuels *et al*., 2014). The micro level explores behaviour and dynamics of individual firms and households (Hsiao, 2003); and encompasses the direct provision of clinical care (Aroni, 2012).

The functions of each level are not static and are likely to differ across contexts (Samuels *et al*., 2014). In some settings, institutions at the meso level may have more significant power to design interventions and allocate funding than at the macro level (Ibid., 2014).

2.1.2 Functions of a health system and dimensions for measuring performance

This subsection discusses the functions followed by the goals of a health system. This is followed by the health system strengthening, and the dimensions for measuring health system performance, respectively.

2.1.2.1 Health system functions

Health systems must direct provision of healthcare services, and a functioning health system is central to the achievement of universal healthcare, which has been the focus of recent statements by advocacy groups and other organisations around the world, including a declaration by the United Nations, in 2012 (Malik, 2014; Van Rensburg, 2004).

Financing
Revenue collection
Fund pooling
Purchasing

Provision
personal health services
Non-personal health services

STEWARDSHIP

RESOURCE GENERATION
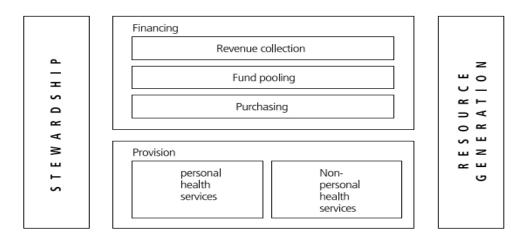
Figure 2.3: Functions of health systems (**Source:** Murray & Frenk, 2000:724)

According to Figure 2.3, health system functions include *financing*, which is the process through which revenue is collected, and funds are pooled and allocated to provide healthcare activities; *provision of healthcare services*, which refers to the combination of inputs required for healthcare delivery; and *resource generation*, which is not limited to institutions that finance the services, but also includes human resources, physical resources such as facilities and equipment, and knowledge (Murray & Frenk, 2000).

Health systems must perform the enabling functions of stewardship (Murray & Frenk, 2000; Van Rensburg, 2004). Stewardship "involves three key aspects, which are setting, implementing and monitoring the rules for the health system; assuring a level playing field for all actors in the system (particularly purchasers, providers and patients); and defining strategic directions for the health system as a whole" (Murray & Frenk, 2000:726).

Internationally, there is an increasing understanding that sustaining progress in health depends on strong and effective health systems which can deliver essential healthcare services to the population (Samuels *et al.*, 2014). An effective health system is perceived as capable of delivering optimal models of healthcare for the changing burdens of disease, while at the same time achieving good long-term health and broader societal outcomes through, among others, a healthier and more productive workforce (Samuels *et al.*, 2014).

Well-functioning health systems provide social protection, contribute to economic growth, and underpin UHC (Atun, de Andrade, Almeida, Cotlear, Dmytraczenko, Frenz, Garcia, Gómez-Dantés, Knaul, Muntaner, de Paula, Rígoli, Serrate & Wagstaf, 2015).

There are challenges within health systems which may be attributed to the difficulty in prioritising the allocation of resources, reducing healthcare costs, and improving overall performance of the health system (World Health Organization, 2011). Due to these challenges, healthcare in most low and middle-income countries (LMICs) was characterised by a deteriorating public healthcare sector, poor infrastructure and declining morale among health workers by the turn of the millennium (Sengupta, 2013).

2.1.2.2 Health System Goals

Frenk, 2010; Murray and Frenk (2000); and World Health Organization (2000) explain that there are three main health system goals:
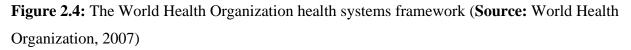
- *Good health:* improving the health of the population served throughout the course of life
- *Responsiveness* (respect of persons and client orientation): responding to people's legitimate expectations
- *Fairness in financial contribution*: ensuring that finances are distributed in an equitable manner to provide financial protection against the costs of ill health. Households must not suffer financial hardship as a result of needed healthcare services.

Specifying the goals provides guidance in assessing health system performance by measuring how well each of the goals has been achieved, considering the level of healthcare expenditure and the social determinants of health (Frenk, 2010). According to the World Health Organization (2007), the achievement of these goals depends on proper leadership and governance systems; finances that are allocated according to need; health workers and other key resources that are developed and sustained; and healthcare services that are provided based on the population needs.

2.1.2.3 Health system strengthening

Firstly, the public health service needs to be strengthened to achieve an effective system of NHI (Mayosi, Lawn, van Niekerk, Bradshaw, Abdool Karim & Coovadia, 2012). The World Health Organization (2007) proposes a framework which indicates that there are six building blocks that must be addressed to effectively strengthen the health system for effective healthcare delivery (Rwabukwisi, Bawah, Gimbel, Phillips, Mutale & Drobac, 2017). The World Health Organization health system framework is depicted in the next diagram.

Figure 2.4: The World Health Organization health systems framework (**Source:** World Health Organization, 2007)
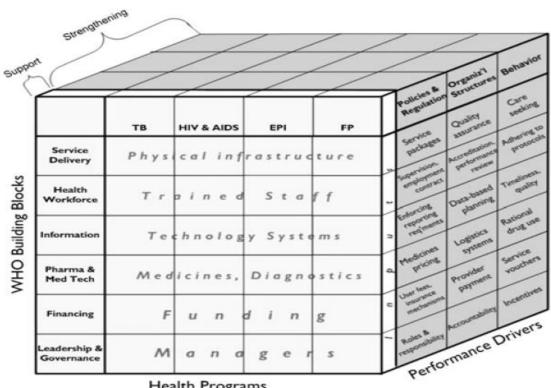
According to the World Health Organization (2010), the six building blocks reflected in Figure 2.4 contribute to the strengthening of health systems in the following ways:

- Firstly, *leadership* and *governance,* and *information* are cross-cutting components because these building blocks provide the basis for overall policy and regulation.
- Secondly, *financing* and *health workforce* are the main input components in a health system.
- Thirdly, *medical products* and *technologies,* and *service delivery* reflect on the availability and distribution of healthcare services, which are the direct outputs of the health system.

The limitation of this health systems framework is that the substantial and dynamic links, and interactions which exist across each component are not considered (World Health Organization, 2010). On the other hand, the health system is viewed as a cube with activities to support and strengthen the system (Chee, Pielemeier, Lion & Connor, 2013).

Figure 2.5: The health system cube (**Source:** Chee *et al.*, 2013:89).

According to this cube (Figure 2.5), the following applies:

- The left vertical axis shows the World Health Organization's *six building blocks* (service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance) (World Health Organization, 2007).

- The horizontal axis illustrates the *disease-specific programmes* for the delivery of critical services such as Family Planning (FP) and the Extended Programme on Immunisation (EPI) (Chee *et al*., 2013).

- According to Chee *et al*. (2013), *performance drivers* are:
  - *Inputs,* including managers; funding; medicines and diagnostics; technology systems; trained staff; and physical infrastructure
  - *Policies and regulations,* incorporating service packages; supervision and employment contracts; enforcing reporting requirements; medicine pricing; user fees and insurance mechanisms; roles and responsibility

- *Organisational structures,* referring to data-based planning; logistics systems; accreditation and performance review; provider payment; quality assurance; and accountability
- *Behaviours,* referring to healthcare seeking; timelines and quality; adhering to protocols; rational drug use; service vouchers; and incentives
- The sets of *performance drivers* affect how well the inputs are used to produce outcomes.

- *Strengthening* the health system, which focuses on performance drivers, is vital and can be accomplished by more inclusive changes in policies and regulations, organisational structures, and relationships across the health system building blocks to enable the effective use of resources, in order to improve healthcare services (Chee *et al*., 2013).
    - Health system strengthening includes the strategies, responses and activities that are designed to improve the country's health system performance in a sustainable manner (USAID, 2015).
    - Health system strengthening calls for improving interactions between the six health system building blocks, and managing their interactions; and sustainable improvements across health services and health outcomes (Chee *et al*., 2013; World Health Organization, 2007).
    - The multiple relationships and interactions among the blocks affect and influence the others, and the blocks are, in turn, affected by one another, thereby converting these blocks into a system (Chee *et al*., 2013).

- Chee *et al*. (2013) explain that the cube allows for appreciation of the depth of each building block. For example, although the production of trained workers (workforce input) is a clear driver of workforce performance, it is not the sole driver of performance. The distribution, compensation, performance monitoring, and behaviour of employees also contribute to a well-performing health workforce. However, in practice, training may not be supported by policies and practices to ensure the application of new skills, retain skilled workers, or motivate high performance.

There is currently a clear acknowledgement that weak health systems hinder the delivery of health services, and waste valuable economic and human resources, and that addressing the health system's inadequacies may be beneficial to the country (Samuels *et al*., 2014).

The processes in the health system may be inefficient for two distinct, but related reasons (Cylus, Papanicolas & Smith, 2016). *Firstly* – the health system inputs such as expenditure or other resources may be directed at outputs which are not a national priority. *Secondly* – there could be a misuse of inputs in the process of producing valued health system outputs, which is a wasteful use of resources for priority needs (Cylus *et al*., 2016).

Cylus *et al*. (2016) indicate that the inefficient use of health system resources poses serious concerns, as that leads to the following:

- Denying health gains to patients because the patients will not receive the best possible care available within the health system's resource limits
- Possible hampering of opportunities in other sectors of the economy
- Possible reduction of the society's willingness to contribute to the funding of healthcare services, thereby weakening social solidarity, health system performance and societal welfare.

It is, therefore, necessary to look at several levels and sectors of the health system to determine the nature and extent of the inefficiencies (Cylus *et al*., 2016). Tackling inefficiencies has an important accountability value, which is to reassure payers that their money is being spent wisely, and lets the general population know that their claims on the health system are being treated fairly and consistently (Ibid., 2016).

2.1.2.4 Dimensions of health system performance

Various countries have differing key objectives and priorities at national level (Papanicolas & Cylus, 2015). However, it is possible to identify the broad areas of health system performance that are valued and compared internationally (Ibid, 2015). An alternative, and possibly the main approach to measuring health system performance currently, is to quantify "healthy life expectancy" or the average amount of time the average person at a given age can expect to live in good health (Beckfield, Olafsdottir & Sosnaud, 2013). Health system performance is defined by achieving the intended results (Frenk, 2010).

The health system framework developed by Murray and Frenk (2000) attempts to provide a clear conceptualisation of health system performance, in terms of health system functions and goals (Papanicolas & Smith, 2013).
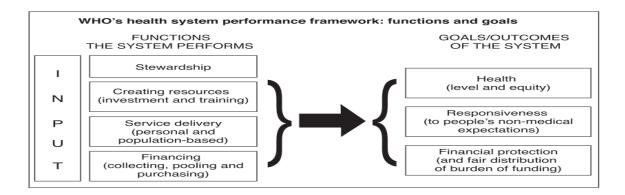
Figure 2.6: WHO's health system performance framework **(Source:** World Health Organization, 2000)

The implementation of this framework in Figure 2.6, for assessing health system performance, lays the foundation for a shift from ideological discourse in health policy to a more empirical approach (Murray & Frenk, 2000). Over time, pragmatic answers should be provided to questions such as the relationship between the organisation of health financing and the level, and distribution of health and responsiveness (Ibid., 2000).

Based on this framework, the line of work should make it possible to establish, for example, the extent to which competition among purchasers or providers enhances responsiveness (Murray & Frenk, 2000). Various countries recognise that not measuring health system performance makes it difficult to identify good and bad service delivery practices; protect patients and funders of healthcare; motivate for investment in healthcare; and design health system reforms (Papanicolas & Smith, 2013).

Benchmarking performance against other countries is, therefore, considered central to securing accountability for health system actions and outcomes to citizens, patients and payers (Papanicolas & Smith, 2013). Several determinants which include leadership, institutions, quality healthcare delivery, and technologies need to be addressed to improve health system performance (Frenk, 2010).

2.1.3 Macro organisation for healthcare delivery

There are four fundamental decisions regarding the macro organisation of healthcare provision, namely 1) competition; 2) decentralisation; 3) integration; 4) and ownership (Hsiao, 2003).

Public monopoly versus competition

The most important decision is whether to rely on public monopoly, that is, publicly funded government facilities, or on competition among public and private providers to provide healthcare services (Hsiao, 2003). Monopoly is characterised by only one supplier and seller, dictating the price and setting outputs (McPake, Kumaranayake & Normand, 2002). A pure monopoly industry has no substitutes and the barriers to entry prevent other firms from entering the industry as competitors (Case, Fair & Oster, 2014).

The limitations of public monopolies based on international experience indicate that politics often interferes, and distracts organisations from pursuing the general public interest (Hsiao, 2003). Additionally, public monopolies often lack adequate external checks and balances. The monopolies may, over time, put the interest of staff before the priorities of citizens (Ibid., 2003).

On the other hand, competition may be encouraged to organise health services providers (Hsiao, 2003). Competitive industry is comprised of many firms, each one being relatively small to the industry (Case *et al.*, 2014). The firms produce similar products and their outputs are similar. Prices are set by the interaction of supply and demand (Ibid., 2014).

Economic theorists have suggested that competition induced by government contracting services should increase efficiency and organisations' responsiveness to patient demands (Hsiao, 2003). Avoiding market failures requires the maintenance of effective competition (Ibid., 2003).

Decentralisation

Decentralisation holds a strong political element, as it deals with the balance of power between the centre and the periphery to provide more effective, efficient, equitable and responsive government (Van Rensburg, 2004).

Hsiao (2003) indicates that when a nation chooses to rely on a public monopoly to provide healthcare, a decision must be made regarding which level of government will be responsible and accountable for managing performance at central, regional or district level.

Some theorists suggest that public power, responsibility and accountability should be delegated to the lowest level, where voters have the most direct knowledge and information about public healthcare services' efficiency and quality (Hsiao, 2003). However, there is a concern that local governments often lack the capacity and human resources to manage public healthcare services (Ibid., 2003).

Vertical integration

Vertical integration refers to the firm's or organisation's ownership of related vertical activities (Grant, 2013). This type of integration can be upstream into the suppliers' activities or downstream into the customers' activities (Ibid., 2013). Hsiao (2003) states that the integration of preventive, primary, secondary and tertiary level of care services is desirable. A decision needs to be made on whether health services should be provided by separate and independent clinics and hospitals, or by integrated networks of healthcare service providers with clear referral guidelines.

This macro organisation decision has an influence on the quality and efficiency of healthcare (Hsiao, 2003). When healthcare services are fragmented, services are often duplicated at various levels, as other levels may not know what the patient has already received. As a result, patients may suffer from gaps in service or treatment delays and errors (Ibid., 2003).

Ownership

According to Hsiao (2003), ownership determines to whom and for what the organisation is accountable. There are three types of ownership, namely public, for-profit and private non-profit. Each behaves somewhat differently. Profit entities are profit-driven and will deny services to those who are not able to pay. Public and non-profit institutions often have multiple and ambivalent objectives such as serving community interests while maintaining financial solvency. Ownership decisions significantly impact the efficiency and quality of healthcare services, and affect health status and public satisfaction.

2.1.4 Comparison of health systems in developed countries

The following subsection provides an overview of how health systems in certain developed countries are organised.

Table 2.2: Organisation and governance

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Organisation and governance	1. There are six states and two territories (hereafter all referred to as states). Each of the states retains its own government and the responsibility for public health and healthcare. 2. The national government, the Commonwealth of Australia, holds the major revenue-raising powers. 3. Universal, tax-financed comprehensive health insurance, the Australian Medicare, has been relatively stable for three decades. Performance of Medicare is attributed to the interplay between public and private financing, public and private service provision, and a division of responsibilities between the federal and state governments. The states rely on financial transfers to provide services. 4. The Commonwealth has the duty to pay for benefits through Medicare for out-of-hospital medical care and in-hospital private medical services. 5. The Commonwealth is also responsible for the Pharmaceutical Benefits Scheme which covers most of the prescribed drugs. However, funding arrangements for other services often involve both levels of government.	1. Ministry of Health, Welfare and Sport develops policies and measures to promote the health and well-being of the Dutch population and to safeguard access to a high-quality system of healthcare. 2. The balance of responsibilities in the Dutch healthcare sector has shifted repeatedly over time. The principles of decentralisation and regionalisation where necessary were applied. 3. Before 2006, the health system was a hybrid system based on social insurance, combined with private insurance covering the better-off. 4. Until 2006, the focus of healthcare reform was mainly on the supply side, with rationalisation of provision and strengthening of primary care. 5. The 2006 reform introduced a single healthcare insurance scheme and managed competition aimed to promote efficiency, reduce central governance and improve access at acceptable societal costs. 6. The 2006 reforms shifted the focus to the demand side, introducing three managed markets for a defined universal health insurance package, plus healthcare purchasing and provision. 7. Both insurers and providers have been consolidating, in part to strengthen their position within the market. Currently, four insurer groups have 90% of the insurance market.	1. There is a decentralised regulatory framework that is influenced by democracy. There are three levels of government which are the federal level, the cantons, and for social services the municipalities. 2. Civil society organisations such as associations of health insurers and health care providers are recognised in influencing policy and healthcare service delivery. The Swiss people have the right to veto or demand reform through public referenda. 3. The federal level regulates the financing of the system (mandatory health insurance (MHI) and other social insurances); the quality and safety of pharmaceuticals and medical devices; public health (control of infectious diseases, food safety, some areas of health promotion); and research and training (tertiary education, training of non-physician health professionals). 4. Cantons are responsible for securing the provision of healthcare for their populations. However, the cantons may also include hospitals from other regions on their lists of providers, and finance about half of hospitalisation care. 5. Associations of MHI companies and providers such as physicians and hospitals play an important role in the health system. They are responsible for determining reimbursement tariffs for the services, negotiating contracts and overseeing their members at the cantonal

Table 2.2 shows that the Ministry of Health is generally responsible for the organisation and governance, and raising of funds for healthcare provision. The countries have decentralised systems, where regions and local municipalities play a role in promoting access to health services. A mixture of public and private financing, and service provision exists. This includes setting of tariffs; contracts; and overseeing providers.

Table 2.3: Healthcare financing

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Financing	1. Total health expenditure (THE) reporterted in 2015 was 9.1% of Gross Domestic Product (GDP). 2. The country has had several approaches to health care financing consisting of private insurance with public subsidies. At certain times, the country implemented publicly financed national universal health insurance. Since 2013, publicly financed national universal health insurance through Medicare with meanstesting for private insurance subsidies was implemented. 3. The rationale for government subsidies for private insurers alongside a public universal insurance scheme is not clear. However, this is seen as a compromise in a system with various conflict of interests. 4. Public sources of funding covers 66.9% of the healthcare costs. Out-of-pocket payments are averaged at 56%.	1. The Netherlands is among the five wealthiest countries in the Eurozone nad the Dutch health system is among the most expensive in Europe. As a result of the 2006 reform, and with the abolition of the private insurance scheme for the better-off, the balance of expenditure has shifted substantially from private to public expenditure, which has increased from 64.7% of the total in 2005 to 79.8% in 2013. The Ministry of Finance has the responsibility to collect levies for social health insurance contributions though employers. The Ministry also pays out the healthcare allowance which is a tax subsidy introduced with the 2006 reform, to compensate lower-income groups for an excessive premium burden for basic health insurance. 2. Adults pay a community-rated premium to their insurer and the government contributes the premium for children. 3. Seventy-two percent of healthcare is mainly financed through the compulsory health insurance contributions from citizens. Thirteen percent of funding comes from general taxation.	1. Total health expenditure (THE) in 2013 was 11.5% of Gross Domestic Product (GDP), and was one of the highest shares in Europe and well above the European Union (EU) which has an average of 9.5%. 2. The country spends US$ 6187 when measured in purchasing power parities, approaching double the EU average of US$ 3379. 3. Financial flows are fragmented and split between different government levels and different social insurance schemes. 4. Revenue is raised through means such as the federal and cantonal taxes, and the Mandatory Health Insurances (MHIs). 5. MHI companies operate and compete in a highly regulated environment by offering differentpolicies for a standard benefits package which all residents have to purchase. MHI companies are not allowed to turn down applications from persons who want to purchase insurance and they may not make profits (nor losses) from providing MHI. Excess earnings have to be reinvested in the company and must benefit the insured. 6. The share of public spending is relatively low at 66% of THE compared to the EU average of 76%. On the other hand, the share of out-of-pocket (OOP) payments is exceptionally high at 26% of THE, compared to the EU average of 16%.

Table 2.3 provides a summary of the financing mechanisms in the selected countries. Comprehensive tax-financed insurance, social health insurance and private insurance are the financing mechanisms. Funding for healthcare is mainly from compulsory health insurance contributions from citizens. Out-of-pocket payments vary, depending on the extent of coverage from mandatory health insurances.

Table 2.4: Market structure and developments, and risk adjustment mechanisms

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Market structure and developments	1. Medicare provides a set amount towards medical fees for provision of healthcare. 2. Private insurance, if the member has one, contributes partially to in-hospital medical fees and the hospital charges, depending on the policy and the insurer's agreements with the hospital and the other provider's of healthcare. This results in a lot of out-of-pocket payments that the members do not have control over. 2. The states fund public hospitals and emergency services in full.	1. The 2006 Health Insurance Act and the Health Care Market Regulation Act introduced the concepts of managed competition among actors as a new driving mechanism in healthcare. This implied a role change for the government from that of direct control of volumes and prices, to rule-setting and overseeing a proper functioning of the markets. 2. Most healthcare providers use some form of electronic patient record system. All general practitioners (GPs) use an electronic patient record system, including the electronic prescription system. The national roll-out of an electronic patient record system has however mainly due to reasons of privacy. A more limited system is being implemented.	1. The citizens have a lot of choice of MHI companies and MHI plans despite a considerable reduction in the number of companies over the past few years. In 2013, there were 61 MHI companies operating in the country with each company offering several plans. 2. The size of the federal contribution for premium subsidies is fixed at 7.5% of the estimated MHI (gross) costs in a given year, i.e. the sum of total MHI premiums and the cost-sharing payments of the insured. 3. The federal contribution is distributed to individual cantons on the basis of population size. There are also premium differences across cantons and this variation has led to a total of 287 000 different insurance premiums in the country. 4. For children less than 18 years of age and those below 25 years who are in training, their premium subsidies have been standardised. Cantons are mandated by law to reduce premiums for both groups by 50% for lower- and middle-income households. 5. Finally, a small number of MHI companies offer bonus insurance, where individuals who do not make a claim in a particular year can obtain a premium reduction in the following year.
Risk adjustment	There are no risk adjustment methods reported.	Adults pay an income-dependent premium into a central fund that is redistributed amongst insurers on a risk-adjusted basis.	1. MHI premiums are community-rated within cantons. However, the old and sick have higher costs than the young and healthy. 2. Risk adjustment is necessary in order to compensate MHI companies for differences in the costs they face from the varying risk profiles of the insured members. 3. MHI companies with relatively healthier and younger members must pay into a common pool managed by the Common Institution under the Federal Health Insurance Law. The Common Institution redistributes funds to MHI companies according to the risk structure of their insured population.

Table 2.4 – Funding for healthcare is determined based on the financing mechanisms in place. Individuals have freedom to choose a setting where care is provided. However, funding of such services is based on the contracts in place. Shortfalls may be funded by means of out-of-pocket payments. Risk adjustment mechanisms exist to compensate insurers for various risk profiles of their members.

Table 2.5: Purchaser-provider relations, and reimbursement methods

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Purchaser-provider relations	1. Medicare funds GP services at 100% of the agreed schedule of fees. Specialists are paid up to 85% of the fee schedules. 2. More than 80% of all GP consultations are paid for by government when the providers send claims directly to Medicare for payment. When this is done, there are no out-of-pocket costs for patients. However, the medical practitioners that charge patients directly require full payment.	1. Health insurers and providers negotiate on price and quality of care. However, competition on quality is starting. For care where negotiations are not feasible, such as emergency care or organ transplantation where there are very few skilled providers, the Dutch Healthcare Authority establishes maximum prices to be funded. 2. Health insurers are responsible for purchasing and remunerating all curative health services covered by basic health insurance. 3 Healthcare providers are independent and not supposed to make profit.	MHI companies are by far the most important purchasers of healthcare services and goods.The second important group of actors on the purchaser side is the cantons. MHI companies and the cantons are however passive purchasers, mostly reimbursing the bills of health care providers. 2. Collective contracts dominate the relationship between purchasers and providers. MHI companies are obliged to reimburse bills of all authorised providers. Approved providers are all those that fulfil the basic regulatory requirements for providing MHI billable services. 3. Direct competition between providers for contracts from MHI companies is therefore limited. MHI companies can engage in selective contracting with physicians only in the case of managed care arrangements. 4. Conditions of reimbursement are specified in the contracts negotiated between associations of insurers and providers, and tariffs have to be agreed upon by MHI companies and providers.
Reimbursement methods	The states operate public hospitals and provide emergency department visits without charge. Medicare provides funding for out-of-hospital care and private hospital services. However, Medicare provides a set amount towards medical fees. Private insurance, if available, contributes partially depending on the policy and the insurer's agreements with the hospital. Citizens incur out-of-pocket payments for services that are not covered by Medicare and their private insurance.	Hospitals are paid through an adapted type of diagnosis-related group (DRG) system relating to Diagnosis Treatment Combinations. GPs are paid by a combination of fee-for-service, capitation, bundled payments for integrated care, and pay-for-performance, focused on issues such as accessibility and referral patterns.	Fee-for-service (FFS) is the dominant method of provider payment. DRGs have replaced per diems as the most important payment mechanism for inpatient care. For long-term care, a system of care-level adjusted per diem payments exists. Public health activities are mostly paid for on the basis of lump sum contracts or FFS.

Table 2.5 – Both the Ministry of Health and insurers play a role in the purchasing of healthcare. There are collective contracts that determine the relationship between purchasers and providers. These contracts also specify the fees to be paid to providers. Various reimbursements methods are used such as Fee-for-service (FFS), Diagnosis-Related Groups (DRGs) and out-of-pocket payments.

Table 2.6: Patient empowerment

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Patient empowerment	1. Patients have the right to choose to access care in a public or private institution. 2. The level of care provided between private and public facilities may differ depending on availability of skilled or specialist recources.	1. The government provides a web site to help patients choose healthcare providers; other independent web sites are also available. Nevertheless, opportunities to make choices during the care process are limited, as is the extent to which patients exercise their notional choice. 2. When patients are referred for secondary level of care, they can choose the hospital they want to be treated in. However, payment for healthcare may depend on the existing health policies. Benefits-in-kind policies are unlikely to reimburse full costs for care from a provider that does not have a contract with that insurer. Although funding policies allow freer choice of providers, what is perceived as 'reasonable' cost will be paid.	1. Most people still regard their family physician, family members and friends, as their primary sources of information on personal health and the health care system. 2. A growing number of information materials and counselling services are being made available free of charge by the various stakeholders of the system. 3. Individual patient rights are enshrined in a range of cantonal laws and federal legislation, and they are included in private law, public law and penal law.

Table 2.6 indicates that patients have the right to access healthcare in the public and private sectors. However, benefits are unlikely to be funded in full, if the services are provided by non-contracted providers. Nonetheless, a reasonable fee will be paid. The rights of patients are protected through various laws and policies. Various platforms to empower patients are available to enable them to make informed decisions. Nevertheless, opportunities to make choices during the care process are minimal.

Table 2.7: Public participation

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Public participation	The level of public participation is not clear. Decisions to provide and fund healthcare rest with the states and the Austrial Commonwealth.	The government still has an important role in health policy development and implementation. Advisory bodies and research institutes play an intermediate role. Different actors in the healthcare system can commission reports either on the state of knowledge in certain policy areas or to clarify the consequences of different policy options. Such information can be used in the debates among stakeholders. Consultation and consensus between the government and the many lobbies are typical in the complex process of healthcare decision-making. Patients are able to make formal representation in councils and other bodies.	Public participation is ensured through various democratic processes. *Firstly,* citizens have the right to decide on almost all health-related legislation through (mandatory or optional) referenda. *Secondly,* key features of health service provision are organised by the cantons, where direct democracy allows local populations to be involved in decision-making and to vote on most issues of concern. *Thirdly,* the legislative process includes a formal consultation process in the early stages of drafting new laws, where all relevant stakeholders (academia, insurers, patients, providers) can make their opinions known to the government. *Fourthly,* the health system offers formal public participation in several important institutions.

Table 2.7 provides information on the level of public participation in these countries. It is evident that democracy is central to the involvement in consultative processes, decision-making and public involvement in health-related legislation. Consultation and consensus between government and stakeholders are important.

Table 2.8: Assessment of the health system

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Assessment of the health system	1. The average life expectancy at birth is 82 years. 2. Primary care physicians which are mainly general practitioners (GPs) play a central role as gatekeepers to the rest of the system. All specialist care requires a GP referral. Although the gate-keeping system would seem to place primary care in a strong position to coordinate and manage care, such coordination has not been achieved. 3. General Practitioners (GPs) work mainly in private practice, receiving fee-for-service payments. These payment method is an incentive to maximise volume rather than continuity and integration of care. 4. Patients receiving government welfare payments, children, low-income groups, and people living in urban areas where there are no GP shortages are "bulk billed". 5. There are regional variations in the provision of evidence-based medicine. Healthcare is not sufficiently integrated for smooth transitions from hospital and specialist care in one state, to primary and specialty care in another.	1. Life expectancy is 81.8 years in comparison to 80.9 for the European Union (EU) as a whole. 2. There are inequalities in health, in particular by socio-economic status, with a six-year gap in life expectancy between the low and high educational attainment population groups. 3. Mental disorders represent both the greatest burden of disease and one of the only groups of conditions with rising mortality rates in recent decades. 4. The gatekeeping principle is one of the main characteristics of the Dutch system. Therefore, hospital care and specialist care (except emergency care) require referral from a GP or some other primary care practitioners, such as midwives or dentists. 5. Primary care in the Netherlands is strong in comparison with primary care in many other European countries, and Dutch GPs have broad service profiles compared to GPs in many other countries. Around 93% of all patient contacts with a GP are handled within primary care; only 7% of the contacts result in a referral to secondary care. 6. The Dutch government has three main goals for the healthcare system which are: (1) quality of care (effective, safe and patient-centred; (2) accessibility to care (reasonable costs for individuals, travel distance and waiting times); (3) and affordability of care (overall cost control).	1. Life expectancy at birth in 2013 was 80.7 years for men and 84.9 years for women, with average life expectancy of 82.8 being the second highest in the European Region (after Iceland). 2. Patients are highly satisfied with the health system, perceive quality to be good or very good, and there are virtually no waiting times. 3. Financial protection of households from the costs of medical care is good, and is seen as better than in many European countries when all forms of social protection are taken into account. 4. However, the very high share of OOP payments – related to the exclusion of certain services from coverage, notably dental care, and to the relatively high user charges – means that financial protection is more limited than in countries such as Austria, Germany and the Netherlands. 5. Almost 3% of the poorest income quintile have unmet needs for treatment due to costs. This percentage is considerably higher than in Austria, Germany or the Netherlands. Low-income households tend to contribute a greater share of their income to the financing the health system than higher-income households. ital investments and fragmentation of provision of healthcare. 6. There are variations in expenditures across cantons and this is at least partially related to supplier-induced demand, resulting from flawed incentives due to fee-for-service reimbursement, subsidised hospital investments and fragmentation of provision of healthcare.

Table 2.8: Assessment of the health system (continued)

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Assessment of the health system		7. Accessibility to healthcare is good. Essential healthcare services are within easy reach for almost the entire population, and waiting times for most services have been decreasing and in most cases meet national standars for reasonable waiting times.The system protects Dutch citizens against catastrophic spending and out-of-pocket payments remain low compared to most other European countries, and well below both the EU and OECD averages. 8. To enable patients and consumers to make choices between insurers and providers, the availability of relevant information is essential. Transparency has been high on the political agenda for several years. 9. Key concerns are the lack of reliable quality indicators that are available to citizens and the fragmentation, inadequacy, inaccessibility and lack of clarity of record systems. 10. Future health challenges are attributed to demographic changes resulting in more chronic disease. One of the environmental health challenges is air pollution in a densely populated country.	7. There is limited use of independent health technology assessments (HTA) to inform coverage decisions and to limit expenditures on existing and new services of uncertain benefit. 8. The use of medical guidelines could be strengthened to help professionals "choose wisely" when examining and treating patients. 9. Prices of pharmaceuticals remain higher than in Austria, the Netherlands or France, while the share of generics remains relatively small. 10. Efficiency and quality could be increased by systematically improving coordination of care and addressing patient safety issues.

Table 2.8 – Life expectancy in these countries is generally above 80 years. General practitioners and other primary care providers are the gatekeepers of the rest of the system. That is, patients can only access specialist care on referral by primary care providers. Access to essential healthcare is good and patients are generally satisfied with the health system. In Australia, there are concerns regarding poorly integrated healthcare and fee-for-service funding that encourages volume, rather than continuity and integration of care. There are also regional variations of evidence-based care in that country. In the Netherlands, there is concern regarding the lack of reliable quality indicators, while Switzerland experiences limited use of health technology assessment to inform coverage decisions. Out-of-pocket payments are also higher for low-income families in Switzerland.

2.2 Health System Reform

This subsection provides a review of literature on health system reform, systems thinking in health reforms and typology of reforms.

2.2.1 Conceptual foundations of health system reform

Health reform refers to the sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector, aimed at greater efficiency, fairness and responsiveness to the expectations of people served by healthcare systems (Gwatkin, 2001; Van Rensburg 2004). Health sector reforms are aimed at correcting system-wide problems (Sama & Nguyen, 2008).

Health systems, like other socioeconomic systems, evolve in unique historic, cultural and political contexts to serve societal needs (Hsiao, 2003). Politics, vested interests, corruption, public pressure or advocacy can influence decisions at the macro level (Samuels *et al*., 2014).

Health systems have experienced various forms of reform in the past 100 years, including the funding of national health systems and the extension of social insurance schemes (World Health Organization, 2000). This was later followed by the promotion of primary healthcare as a path to achieving affordable universal coverage, with the goal of health for all (Ibid., 2000).

Subsequently, there was a gradual shift of vision towards 'new universalism' (World Health Organization, 2000). The movement implied that, rather than offering possible care for everyone, there should be an explicit choice of priorities among healthcare interventions, and efficient rationing of services to all population groups (Ibid., 2000).

Every nation must make difficult trade-offs to achieve multiple objectives with limited resources (Hsiao, 2003). The trade-offs must be made between health-system goals (that is, improving the health status of the population) and other political, economic and social goals (such as providing education for all children) (Ibid., 2003).

Consequently, financial risk protection, consumer satisfaction, and the level and distribution of health status depend in part on the nation's economic resources (Hsiao, 2003). On the other hand, it is important to note that historical processes and fundamental social values can create implicit boundaries for trading off different objectives, thereby limiting the range of available reform options (Ibid., 2003).

Considerable attention has been paid to the cost of healthcare, and controls over such costs are a crucial aspect of health policy (Van Rensburg, 2004). This poses a challenge to the existing structures of healthcare services and their traditional ways of functioning (Aroni, 2012). Preventive medical services are also receiving increasing emphasis as more attempts are being made to keep people healthy (Van Rensburg, 2004). Efforts are also being made to design more effective administration, often resulting in decentralisation or regionalisation (Ibid., 2004).

Health reforms have cycles, which include problem definition, diagnosis, policy development, political decision, implementation and evaluation, and the process is iterative (Roberts, Hsiao, Berman & Reich, 2002). Politics must be embraced, and it needs to be decided that reforms will take into consideration the political environment and the possible consequences (Shewade & Aggarwal, 2012).

There are three major ethical perspectives which may be used as tools for making decisions about healthcare reform (Roberts *et al.*, 2002). Understanding the larger ethical perspectives which lie behind debates on health reform can help policy analysts and policymakers to do their jobs more effectively, and to better explain and defend their own positions (Ibid., 2002).

Utilitarianism

> The principle of utilitarianism is a consequential principle (Carrol & Buchholtz, 2009). Utilitarianism asserts that we should always act to produce the greatest ratio of good to evil for everyone. One should take that course of action that represents the "greatest good for the greatest number" (Ibid., 2009).

> Utilitarianism evaluates consequences by examining the effects of a decision on the sum of individual wellbeing in a society, indicating that policy should be judged by its consequences (Roberts *et al.*, 2002). This perspective motivates many health reform efforts around the world (Ibid., 2002).

Liberalism

Liberalism refers to the fact that liberty is very important, and the State needs strong justification for infringing upon it (Rajczi, 2008). It focuses on rights and opportunities, on where people start, not on where they end up (Robert *et al*., 2002). This view also plays an important role in health sector reform debates. The frequent claim that citizens have rights to healthcare, or even to health itself, reflects the concerns of liberals (Ibid., 2002).

Communitarianism

Communitarianism is a social philosophy that emphasises the importance of society in articulating the good (Etzioni, 2015). Communitarianism is often contrasted with liberalism, as communitarians examine the ways in which shared origins of the good are formed, transmitted, justified and enforced (Ibid., 2015).

Communitarianism can conflict with both consequence-based and rights-based thinking, since inculcating virtue can involve actions that do not maximise wellbeing, or that constrain individual liberty (Roberts *et al.*, 2002).

2.2.2 Comparison of developed country reforms

The next table provides an overview of health reforms in developed countries, which include Australia, the Netherlands and Switzerland.

Table 2.9: Principal health reforms

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Principal health reforms	1. The National Health Reform Agreement has been signed by all states and the Commonwealth in 2011. 2. A new basis for the Commonwealth's contribution to public hospital funding, based on organisations' case mix and known as activity-based funding was established. 3. A new independent authority was established to determine the National Efficient Price for each case type, deriving prices from detailed cost reports from public hospitals in all states. 4. The agreement also attempted to strengthen primary care by establishing 61 new entities called Medicare Locals. These entities were however replaced by new agenciese to facilitate access to allied health care, identify underserved groups in their community (particularly those with chronic diseases), and ease the transitions between hospital and community. 5. Funding consisted of core grants for assessment of population needs and planning, and program grants for initiatives with such goals as improving after-hours care and mental health services.	1. Long-term care was reformed in 2015 in order to contain costs. Care at home, preferably by informal carers, is now given greater priority over institutional care, which was seen as having become over-used. Long-term care is principally the responsibility of municipalities, on the assumption that locally organised care is more efficient. 2. Long-term care at home for patients who do not need 24-hour supervision is assessed and coordinated by the district nurse. Assessments of needs for domestic care and social support are mostly carried out by employees of the municipality or social district teams that are coordinated by municipalities. 3. Health insurers took over the responsibility for home nursing, with district nurses playing a key role in integrating different aspects of care and support. 4. Extra attention is now being paid to integrated care for chronic diseases and care for people with multiple health condition, shifting care to lower levels of specialisation, that is from hospital care to GP care, to practice nurse to self-care.	1. Several reforms were made to optimise the MHI system, change the financing of hospitals, improve regulations in the area of pharmaceuticals, strengthen the control of epidemics, and harmonise regulation of human resources across the country. 2. Future areas of reform are focused on these areas (1) improving the use of information; (2) improving planning of ambulatory care; and (3) improving health care provision for people with specific needs.

Table 2.9: Principal health reforms (continued)

Topic	Australia: Australian Health Care — The Challenge of Reform in a Fragmented System. Hall (2015).	Netherlands: Health system in transition. Kroneman, Boerma, van den Berg, Groenewegen, de Jong, van Ginneken (2016).	Switzerland: Health Systems in Transition. De Pietro, Camenzind, Sturny, Crivelli, Edwards-Garavoglia, Spranger, Wittenbecher & Quentin (2015).
Principal health reforms	6. Although this funding gave Medicare Locals some leverage, the bulk of primary care funding continued to support fee-for-service visits and did not flow through the new organisations, which therefore gained little traction for improving care integration. 7. In 2015, Medicare Locals were disbanded and replaced by Primary Health Networks. The eligibility of various organisations, including private health insurance funds, as contractors was emphasised. The networks may yet develop the potential to become purchasers and thereby provide impetus for integrated care. 8. The new government has also reversed the agreement that provided additional Commonwealth funding to public hospitals on the basis of efficient cost increases and volume growth. 9. A new agreement with the retail pharmacy sector suggests that pharmacists will begin playing a greater role in primary care, including chronic disease management. 10. The Commonwealth's additional contributions will be based only on population growth and inflation. This approach may limit funding of other programs such as education and transportation, and in developing innovative health programs that might improve care integration and coordination as this is currently weak.	5. The 2006 healthcare reform has not led to sustainable cost-containment, which became an even more pressing issue after the 2008 financial crisis. 6. Quality is not yet a leading principle in the purchasing processes; the focus is mostly on price and volume. However, quality is becoming more important due to the introduction of quality indicators and the development of professional guidelines.	

Table 2.9 - Health system reforms are implemented to decentralise health service provision; minimise regional differences; ration care; promote care coordination, efficiency and quality healthcare; and optimise healthcare delivery. The reforms are aimed at improving health and health financing, and responsiveness of the system to the people's needs.

2.2.3 Health sector reforms in Africa

This subsection deals with issues and reforms in Kenya, in East Africa, followed by Cameroon, in West Africa.

2.2.3.1 Health sector reforms in Kenya

The reforms were introduced to improve healthcare delivery because of the challenges that faced the country, which included financial constraints; inefficiencies and inequities; poor management and inappropriate pricing of services; dilapidated medical infrastructure; poorly maintained equipment; and financial hardships, especially among the poor (Okech & Lelegwe, 2016; Sama & Nguyen, 2008).

According to Okech and Lelegwe (2016); Sama and Nguyen (2008), Kenya's health reform policy and achieving UHC were designed to achieve the following objectives:

- Increase coverage and accessibility of preventive, promotive and curative health services, especially in rural areas
- Improve equity and the provision of quality healthcare, and remove user fees to prevent catastrophic spending by households, especially the poor and vulnerable groups
- Strengthen the Ministry of Health's management capabilities, with district-level emphasis to improve management in areas such as drug supply, transport and equipment management
- Improve inter-sectoral collaboration between the Ministry of Health and other ministries
- Increase investment in healthcare by considering mechanisms that encourage social solidarity; improve efficiency in allocation and utilisation of funds; and review and harmonise services across regions.

Kenya's health system comprises a public sector, and a for-profit private sector (Sama & Nguyen, 2008). Missions and religious groups provide curative services, but at a lower price than what the private sector charges. Parastatals and private companies are allowed to provide curative services for their staff. The Ministry of Health is the main funder and provider of healthcare in the country (Ibid. 2008). In 2018, life expectancy in Kenya was 67 years (World Life Expectancy, 2018).

2.2.3.2 Health sector reforms in Cameroon

The country's health system was previously designed to serve the colonial masters, and was characterised by the irrational distribution of health infrastructure (Sama & Nguyen, 2008). Hospitals were concentrated in urban areas, depriving those that lived in remote areas of access to care. The movement from colonial rule to independence in 1960 paved the way for health sector reforms (Ibid., 2008).

The country experienced challenges which included a high level of out-of-pocket payments for healthcare services; poor-quality healthcare; difficulty in regulating the growing private sector; an insufficient number of qualified human resources; and corruption and lack of accountability (Sieleunou, Turcotte-Tremblay, Fotso, Tamga, Yumo, Kouokam & Ridde, 2017).

In terms of the reform to address health system challenges, services were organised to provide healthcare at three subsystems, namely *local health centres* which provide preventive and basic curative care, and are usually staffed by certified nurses; *district and departmental hospitals* which serve as the first referral hospitals from the local centres, and have at least one physician; and *provincial and central-level hospitals* which provide specialised services (Sama & Nguyen, 2008).

Funding for health services is mainly provided from the national budget, revenues generated from authorities from cost recovery at local level through user fees, and external donors (Sama & Nguyen, 2008). Cameroon's health system comprises the public and private sectors, and the services in the private sector are generally more expensive than those in the public sector. UHC has not been achieved (Ibid., 2008). However, there is the political will to ensure accountability in dealing with corruption and effecting health system reform (Sieleunou *et al*., 2017). In 2018, life expectancy in Cameroon was 58 years (World Life Expectancy, 2018).

2.3 Universal Health Coverage (UHC)

In this subsection, UHC as health system reform is discussed. This includes guiding considerations for UHC; determinants of UHC; themes of UHC; major thrusts towards UHC; pooled health spending to improve population health; factors influencing health service coverage; raising revenues, risk pooling, and purchasing services; public participation; public accountability; and monitoring and evaluation.

2.3.1 The concept and evolution of UHC

UHC refers to all people receiving quality and effective healthcare services that meet their needs without exposure to financial hardship in paying for the services (Fusheini & Eyles, 2016; World Health Organization, 2014). UHC as health system reform may be traced back to the emergence of organised healthcare in the 19th century, in response to labour requests for the implementation of social security systems (Abiiro & Allegri, 2015).

This concept first started in Germany, under the leadership of Otto von Bismarck, and later spread to other parts of Europe such as Britain, France and Sweden (Abiiro & Allegri, 2015). The global movement of UHC follows two other great transitions in health (Rodin & de Ferranti, 2012). The first was the demographic transition that began in the late 18th century and changed the world in the 20th century through public health improvements, such as basic sewerage and sanitation, which helped to significantly reduce premature death (Ibid., 2012).

The second was the epidemiological transition that began in the 20th century (Rodin & de Ferranti, 2012). Communicable/infectious diseases such as smallpox and poliomyelitis were controlled. Currently, a third great transition, which is UHC, is a global phenomenon that is changing how healthcare is financed and how health systems are organised (Ibid., 2012).

In 1948, UHC was implicitly enshrined in the World Health Organization's Constitution, recognising that human beings must be afforded the basic right to attain the highest standard of health, regardless of race, religion, economic or social status, and political belief (Abiiro & Allegri, 2015). This essential human right was later endorsed by the World Health Organization in the "Health for all" declaration of the Alma Ata conference on primary healthcare (PHC), in 1978 (Ibid., 2015).

In 2005, the concept of UHC was again acknowledged and endorsed by the World Health Assembly, and countries were urged to develop context-specific health-financing systems to guarantee access to healthcare while ensuring financial risk protection (World Health Organization, 2005). Three dimensions of UHC, depicted in the next diagram, were subsequently proposed, which include *population coverage*, *package of services* and *financial protection* (World Health Organization, 2010).
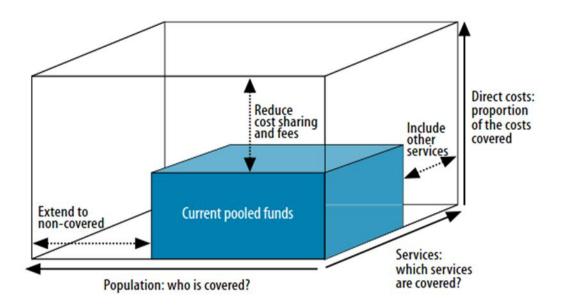
Figure 2.7: The UHC cube **(Source:** World Health Organization, 2010)

According to the UHC cube in Figure 2.7, UHC is considered to be a system that will gradually move towards providing healthcare coverage for the whole *population*; providing a defined *package of services,* according to need; and *pooling funds* to reduce co-payments, when individuals require healthcare services (World Health Organization, 2010). To achieve UHC, countries are urged to advance in *expanding priority services*, *including more people*, and *reducing out-of-pocket payments* (World Health Organization, 2014).

Countries are, however, faced with challenges concerning which services to expand first, whom to include first, and how to shift from out-of-pocket payment (World Health Organization, 2014). Commitment to fairness and concern for equity, and commitment to respecting the rights of individuals to healthcare must guide countries in decision-making (Ibid., 2014).

In 2015, the United Nations endorsed 17 Sustainable Development Goals (SDGs), which are a far-reaching and people-centred set of universal, and transformative goals and targets (United Nations, 2015). When these SDGs were reported, all 193 United Nations (UN) member states committed to defining their own strategies to achieve these universal and ambitious goals (Capacity4dev.eu, 2018).

Countries agreed to achieve sustainable development in a balanced and integrated manner, focusing on social, economic and environmental matters, by 2030 (United Nations, 2015). The attainment of UHC falls under SDG 3: to "ensure healthy lives and promote wellbeing for all at all ages" (Ibid., 2015).

Governments are obliged to immediately and progressively move towards the full realisation of UHC, recognising the constraints imposed by limited available resources (Baltussen, Jansen, Bijlmakers, Tromp, Yamin, & Norheim, 2017). Political stability, committed leadership, sustained economic growth, and strong health systems are crucial to achieving UHC, which may be hindered by income inequalities (Atun *et al.*, 2015).

2.3.2 Features of UHC
Countries have reached UHC by different paths and with highly diverse health systems, and the trajectory towards UHC has three common features (Abiiro & De Allegri, 2015; Atun *et al*., 2015; Savedoff, de Ferranti, Smith & Fan, 2012), namely:

- *Firstly*, there is a political process driven by various societal forces to generalise access to healthcare. Countries have responded to these social forces by creating regulations or programmes to pool financial risks of care across populations, improve equity, and expand access to care.
- *Secondly*, growth in income is associated with the rise in healthcare spending. The increased spending enables the buying of more healthcare services and contributes to improved population health.
- *Thirdly*, an increase in the share of healthcare spending is pooled, rather than out-of-pocket payments made by individuals and families. This pooled share may be mobilised through taxes, or in the form of contributions to public insurance or mandatory private health insurance.

2.3.2.1 Does pooled health spending improve population health?

"Good access to healthcare that enables people to benefit fully from a healthcare system is widely recognised as an important facilitator of overall population health" (Tang, Chiu, Chiang, Su & Chan, 2017:126). However, progress towards UHC should be linked to a health-financing transition that is characterised by a *rising pooling of funds* and *increased healthcare funding* (Moreno-Serra & Smith, 2012). The following diagram shows the relationship that exists between the concepts, namely *pooled prepaid health funds, health coverage* and *health outcomes*.
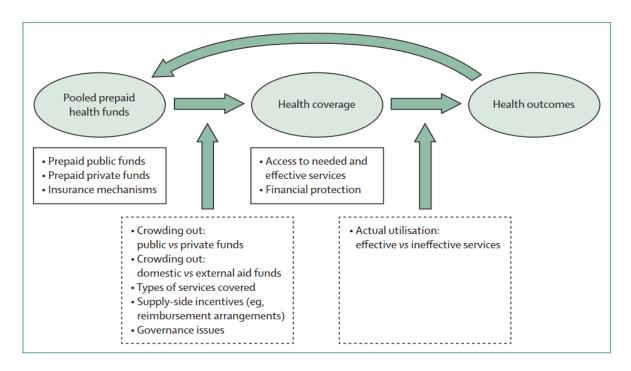
Figure 2.8: Causal pathway between pooled, prepaid health financing, health coverage and outcomes (**Source:** Moreno-Serra & Smith, 2012:919)

The above diagram (Figure 2.8) indicates that there is a causal relationship that exists between *prepaid health financing* (prepaid public funds, prepaid private funds, and insurance mechanisms); *health coverage* (access to needed and effective services, and financial protection); and *health outcomes*. Financial barriers are still a key limitation to accessing health services, especially in low and middle-income countries where out-of-pocket (OOP) payments contribute to a significant proportion of health expenditure (Asante, Price, Hayen, Jan & Wiseman, 2016).

2.3.2.2 Do insurance mechanisms improve population health?

Insurance mechanisms generally lead to improved coverage, in terms of access to care and financial protection, and improved health outcomes (Institute of Medicine (US) Committee on the Consequences of Uninsurance, 2002; Moreno-Serra & Smith, 2012). However, the scale of estimated gains differs greatly, depending on the context (Giedion *et al*., 2013; Moreno-Serra & Smith, 2012).

Analyses in middle-income and low-income countries demonstrate that coverage expansions through publicly or privately funded insurance mechanisms for outpatient and inpatient services raise service use (Moreno-Serra & Smith, 2012). Attaining the highest level of health is not possible without health-financing systems that guarantee financial risk protection, and health systems that function appropriately (Kieny & Evans, 2013). People can only access the health services they need when they have knowledge that they will not suffer financial hardship because of paying for those services (Ibid., 2013).

In practice, effective access to healthcare, and good outcomes depend strongly on the socioeconomic conditions of a country (Braveman & Gottlieb, 2014; Sachs, 2012). Improvements in access to care and financial risk protection from insurance coverage were specifically noted in high-income countries (Moreno-Serra & Smith, 2012). The empirical challenge is to assess the extent to which these observed relationships are causal (Ibid., 2012).

2.3.3 Guiding strategies and considerations for UHC

Kieny and Evans (2013) are of the view that countries should undertake a situation analysis of UHC, and identify the main obstacles and opportunities within the health system for moving closer to UHC; engage in inclusive policy dialogue with all stakeholders to assess policy options for moving closer to UHC, or maintaining existing gains; focus on the areas that are likely to have the biggest impact first; develop and implement holistic strategies and plans for health systems strengthening to move closer to UHC; and monitor, evaluate and adapt plans and strategies as necessary.

The World Health Organization (2014) provides the guiding considerations regarding the path to UHC and indicates that these must be balanced against each other, as well as against other concerns. The guiding principles must consider the following:

- *Fair distribution* – coverage and use of services should be based on needs. Priority should be given to policies which benefit the worst-off population.
- *Cost-effectiveness* – cost-effective policies must be prioritised.
- *Fair contribution* – contributions to the health system should be based on ability to pay, and not the need for more healthcare services.

2.3.4 Themes of UHC

According to Stuckler *et al*. (2010), there are four themes of UHC, namely 1) access to care or insurance; 2) service coverage; 3) package of services; 4) rights-based approach of UHC; and 5) social and economic risk protection. These themes are discussed next.

2.3.4.1 Access to care or insurance

Access to care is related to the timely use of health services, according to need (Peters, Garg, Bloom, Walker, Brieger & Rahman, 2008). UHC is aimed at providing every citizen or resident access to insurance or a particular set of services (Stuckler *et al*., 2010).

Levesque, Harris and Russell (2013); Peters *et al*. (2008); Tang *et al*. (2017) explain that there are dimensions which affect healthcare access, including *geographic accessibility,* such as physical distance or travel time to the user from the service delivery point; *availability,* where the correct type of care and services is available at the right time to those in need; *financial accessibility,* looking at the relationship between the price of services, the willingness and ability of users to pay for those services, as well as protection from the economic effects of healthcare costs; and *acceptability,* where a match exists between health service providers' responsiveness to the social and cultural expectations of individual users and communities; *approachability*, which indicates that people who have health needs can actually identify that the services exist, can be reached, and that those services have an impact on individual health.

In terms of usage, everyone can obtain insurance, although not necessarily universal or comprehensive, as well as certain services, such as access to essential medicines and care with financial risk protection (Atun *et al*., 2015; Cotlear *et al*., 2015; Giedion, 2013; Stuckler *et al*., 2010). There is a concern that people may achieve the financial, geographic and legal means of access to health services and protection, but still face cultural or social barriers to care (Stuckler *et al*., 2010).

There are large disparities within low and middle-income countries, between the poor and better-off, concerning the types of services offered, and the region in which these services are provided (Peters *et al.*, 2008). An important factor in assessing accessibility is an understanding of how, when and where individuals access services (Tang *et al*., 2017). Success depends, in part, on gaining a local understanding of the dimensions and determinants of access to health services, along with purposeful attempts to improve services for the poor (Peters *et al.*, 2008).
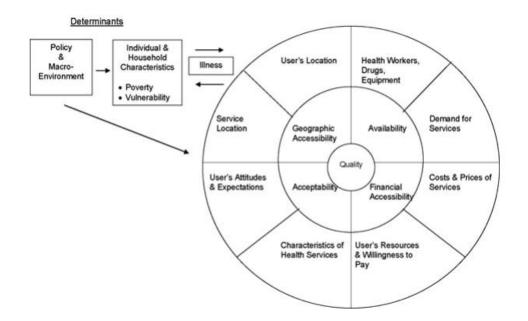
Figure 2.9: Framework for assessing access to health services (**Source:** Peters *et al*., 2008:162).

Firstly, Figure 2.9 indicates that access to health services is affected by determinants of health, namely policy and the macro environment. These, in turn, influence other determinants, such as individual and household characteristics. Individual and household characteristics affect, and are affected by illness.

Secondly, the framework shows that determinants of health, namely policy and macro environment, and individual and household characteristics, affect the dimensions of *geographic accessibility, availability, financial accessibility,* and *acceptability.* In addition, illness affects, and is affected by these four dimensions.

According to the framework, the dimensions of geographic accessibility, availability, financial accessibility, and acceptability are affected and effected by the following concepts:

- *Geographic accessibility* is affected by service location; and users' locations.
- A*vailability* is influenced by health workers, drugs and equipment; and the influence of demand for services.
- *Financial accessibility* is influenced by costs and prices of services; and users' resources and willingness to pay.
- *Acceptability* is affected by the characteristics of health services; and users' attitudes and expectations.

These four dimensions directly affect *quality,* which is central to access to healthcare services and is characterised by *effectiveness*, *patient safety*, and *responsiveness/people-centredness* (World Health Organization, 2017).

The World Health Organization (2017) indicates that *effectiveness* is defined as service coverage that results in desired health gains; *patient safety* is concerned with avoiding injuries to people who receive care; and *responsiveness/people-centredness* comprises patient experiences (care provided corresponds with individual preferences, needs and values), and integratedness (seamless, continuous and holistic care, tailored to the patient's needs).

Progress towards UHC means a lowering of the barriers to seeking and receiving needed care, namely out-of-pocket payments, distance, poorly equipped facilities and poorly trained health workers (Asante *et al*., 2016; World Health Organization, 2017).

People can only access the healthcare services they need when they have knowledge that they will not suffer financial hardships because of paying for those services (Kieny & Evans, 2013). Efforts should be made to have health systems that focus more on the poor and recognise that many poor people do not use health services at all, not even primary services (Asante *et al*., 2016). Therefore,

the financing mechanisms that are in place must enhance equity and improve efficiency (Ibid., 2016).

2.3.4.2 Service coverage

Coverage refers to 100 percent of the population having a comprehensive health coverage without incurring user fees (Stuckler *et al*., 2010). The goal of the service coverage dimension of UHC is that people in need of promotive, preventive, curative, rehabilitative or palliative health services receive them, and that the services received are of sufficient quality to achieve potential health gains (World Health Organization, 2017).

The indicators for service coverage are defined as the proportion that people in need of a service they are entitled to, receive, regardless of quality (Abiiro & De Allegri, 2015; World Health Organization, 2017). Health service coverage depends on the ability of people to interact with the system to benefit from that particular system (Tanahashi, 1978).

Another aspect, in terms of service coverage, is effective coverage (World Health Organization, 2017). Effective coverage refers to real access and utilisation of healthcare services, according to need (Abiiro & De Allegri, 2015). Indicators for effective coverage are less commonly measured than service coverage indicators (World Health Organization, 2017).

O'Connell and Sharkey (2013) provide a perspective to identify bottlenecks within the system, taking into consideration the six determinants of effective coverage based on the modified Tanahashi model. The determinants are depicted in the following diagram:

Figure 2.10: A modified Tanahashi model based on analysing determinants of effective coverage (**Source:** O'Connell & Sharkey, 2013)

The six determinants of effective coverage in Figure 2.10 are availability of essential health commodities; availability of human resources with a correct skills mix; accessibility – physical access of services; initial utilisation; continuous coverage; and effective coverage, which are explained next in a stepwise approach.

Availability of essential health commodities

The availability of critical health system inputs, such as medicines, vaccines and related commodities in sufficient quantities to cover the target population, is vital in providing quality healthcare and in affecting the utilisation thereof (Kerber, de Graft-Johnson, Bhutta, Okong, Starrs & Lawn, 2007; Gupta, Maliqi, França, Nyonator, Pate, Sanders, Belhadj & Daelmans, 2011).

Availability of human resources with a correct skills mix

The foundation to having a strong and effective health workforce is the ability to respond to 21st century priorities (World Health Organization, 2016). This requires countries to match the supply and skills of health workers to the population's current and future needs (Ibid., 2016).

The issue here is not simply having sufficient availability of human resources, but rather, having trained personnel to provide quality and effective interventions or services (O'Connell & Sharkey, 2013). Supervisory and incentive systems are needed to motivate and enforce compliance with global and national norms, and standards. There is increasing evidence which directly links increased availability of skilled health workers with improved health outcomes (Ibid., 2013).

There is a trend of under-investment in the education and training of health workers in certain countries. There is also a misalignment between health systems' education strategies and population needs. The mismatch results in continuous shortages of health workers (World Health Organization, 2016).

Department of Health South Africa (2011) indicates that a strategic policy framework was developed to guide to action the need to develop policies and programmes, make detailed staffing plans for new service strategies, manage the country's healthcare workforce in ways that motivate them to provide quality health care, and meet new services demands for the immediate, medium and long-term future.

Health workers that are competent, motivated, empowered, equitably distributed, accessible, and adequately supported by the health system are able to deliver quality healthcare that is appropriate and acceptable to the sociocultural expectations of the population (World Health Organization, 2016).

Accessibility – physical accessibility of services

Accessibility represents the conditions determining physical access to health services such as distance, travel time, or ease with which individuals can access a facility (O'Connell & Sharkey, 2013). Even if all the necessary resources are available, the service must be located within reasonable reach of the people (Ibid., 2013).

Initial utilisation

Initial utilisation represents the first use of, or contact with a facility for accessing healthcare services or interventions (O'Connell & Sharkey, 2013). There is a linear relationship between material resources and healthcare utilisation (Bakeera, Wamala, Galea, State, Peterson & Pariyo, 2009).

Utilisation is influenced by the need; the affordability of healthcare services, which depends largely on the individual's ability and willingness to pay; how well providers meet people's limitations and preferences; acceptability, reflecting the individual's comfort level with the provider and service delivered; as well as availability and accessibility to healthcare services (Bakeera *et al*., 2009; Levesque & Russel, 2013; O'Connell & Sharkey, 2013). Barriers that exist within the health system, such as poor healthcare worker attitudes and practices, need to be addressed to enhance healthcare utilisation, and improve the quality of services (Bakeera *et al*., 2009).

Continuous coverage

Continuous coverage refers to the extent to which the full course of contacts or interventions have been provided, according to need (O'Connell & Sharkey, 2013). The key consideration is whether the care received is appropriate (Ibid., 2013).

This aspect has two dimensions, namely appropriateness of the service and appropriateness of the setting in which the care is provided (O'Connell & Sharkey, 2013).

Effective coverage

Effective coverage refers to the number of people who have received satisfactory service, and reflects the measure of service output (Tanahashi, 1978). Effective coverage encompasses three components, namely need, utilisation, and quality of healthcare service (Jannati, Sadeghi, Imania & Saadati, 2018). The quality of service that is provided is critical, and considers the technical and interpersonal aspects (O'Connell & Sharkey, 2013).

Effective service coverage indicators are used to capture the country's efforts to meet people's needs for quality health services, and these are preferred indicators for monitoring the service coverage dimension of UHC (World Health Organization, 2017).

The World Health Organization (2017) posits that there are three key challenges associated with monitoring effective service coverage.

- The first challenge is the accurate measurement of the population in need of service because administrative records often provide unreliable information, as those who do not have access to healthcare services remain undiagnosed.
- The second challenge is determining effectiveness of service coverage, that is, the degree to which services result in health improvement.
  The third key challenge is to monitor equity in access to quality health services.

Jannati *et al*. (2018) argue that weak systems in low-income settings may not have developed data systems and the capacity critical to monitoring effective coverage.

2.3.4.3 Package of services

A basket of services was defined as consisting of the basic medicines and services set out by the World Health Organization (WHO) for healthcare delivery (Stuckler *et al.*, 2010). This approach seeks to identify a universal package of guaranteed benefits or entitlements which comprises a set of essential services for the population (Ibid., 2010). The aim of the essential health package is to ensure that scarce resources are concentrated on interventions which provide the best value for money (World Health Organization, 2008). This enables improved efficiency; equity; effective healthcare provision; political empowerment; and accountability (Ibid., 2008).

Drummond, Sculpher, Claxton, Stoddart and Torrance (2015); Cotlear *et al*. (2015) state that informing healthcare decisions requires consideration of cost and benefits. Economic evaluation is, therefore, required to determine the cost regarding what must be given up, and the overall expected benefit. Economic evaluation is also concerned about choices because the resources are limited.

2.3.4.4 Rights-based approach of UHC

The rights-based approach starts from the position that health is a human right (Stuckler *et al*., 2010). The right to the highest attainable standard of health is the cornerstone of both an effective health system, and human rights (Backman, Hunt, Khosla, Jaramillo-Strouss, Fikre, Rumble, Pevalin, Páez, Pineda, Frisancho, Tarco, Motlagh, Farcasanu & Vladescu, 2008). The State has the responsibility to ensure that there are legislated social provisions aimed at guaranteeing economic welfare and security for every citizen, and that the standard of those provisions correspond with the prevailing standards in the society (Stuckler *et al.*, 2010).

2.3.4.5 Social and economic risk protection

Social and economic risk protection refers to effective access to affordable healthcare of acceptable quality, while providing financial protection, in case of illness (Stuckler *et al.*, 2010). UHC efforts focus on two issues which affect socioeconomic risk protection, namely "catastrophic spending on health" and "impoverishing spending on health" (World Health Organization, 2017).

Catastrophic spending on health refers to out-of-pocket medical spending which exceeds the household's ability to pay without reimbursement by a third party (Choi, Kim, Jang, Jang, Kim & Park, 2016; World Health Organization, 2017). The incidence of catastrophic spending on health is reported based on out-of-pocket expenditure exceeding 10% and 25% of total household income or consumption (World Health Organization, 2017). The trend of incurring catastrophic health expenses is more prevalent in low-income families (Choi *et al*., 2016).

Impoverishing spending on health occurs when a household is forced by an adverse health event to divert its non-medical budget for items such as food, shelter and clothing, to such an extent that the spending on these items is reduced below the poverty line (World Health Organization, 2017).

The World Health Organization (2017) indicates that, in 2010, Asia and Africa had the highest rates of impoverishment at the $1.90-a-day poverty line. These two regions account for 97% of the world's population impoverished by out-of-pocket health spending at the $1.90-a-day poverty line.

There is a strong and widely observed association between health indicators and measures of individuals' socioeconomic resources or social position (Braveman & Gottlieb, 2014). In high-income countries with high inequality of income and status, the socially deprived individuals fare much worse than the rich (Sachs, 2012). Being a member of an ethnic minority or indigenous population can also lead to a lack of access to healthcare, and adverse health outcomes (Ibid., 2012).

2.3.5 Major thrusts towards UHC

There are four recommended elements for attaining the goal of UHC (Sambo & Kirigia, 2014), namely 1) strengthening public health infrastructure capacity; 2) raising sufficient resources to strengthen health systems; 3) promoting efficiency in national health services to optimise resource use and maximise results; and 4) removing financial risks, and barriers to care and service access.

Strengthening public health infrastructure capacity

Health infrastructure refers to essential resources such as human resources, technologies and facilities that are needed for the delivery of healthcare (Sambo & Kirigia, 2014).

According to the World Health Organization (2013), the Road Map to Expand Human Resources for Improved Health Service Delivery in the African Region 2012-2025 proposes six focus areas to countries, namely enhancing regulatory capacity; strengthening leadership and governance; improving the generation of information to support evidence-based decision-making; scaling up education and training; optimising the deployment, retention and performance of available personnel; and strengthening partnership and dialogue.

Sambo and Kirigia (2014) posit that essential health technologies are needed to enable health workers to apply their knowledge and skills to solve specific health problems. Acquisition of health technology should take into consideration the available related infrastructure components. Each country should have a national health technology policy as an integral part of the overall national health policy legislation.

Raising sufficient resources to strengthen health systems

Countries are required to increase domestic resources through improved efficiencies in tax revenue collection and prioritisation of government budgets to meet the 15% requirement defined by the Abuja commitment (Sambo & Kirigia, 2014; World Health Organization, 2010).

Attaining UHC goals depends not only on the collection of revenue, but also on how other functions such as risk pooling, purchasing of goods and services, and service delivery are performed (Giedion *et al*., 2013).

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Public financing can be sourced through earmarked revenues such as payroll taxes, general revenues or donor-supported incomes (Sachs, 2012). Once government has raised sufficient revenues and decided on how to risk pool, resources should be used in these pools to finance services of high quality that are effective and accessible (Lagomarsino *et al.*, 2012).

Promoting efficiency in national health services to optimise resource use and maximise results

Sambo and Kirigia (2014) indicate that, in an attempt to promote efficiency to optimise outcomes, several tools such as the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa exist to address health resource gaps. According to the World Health Organization (2008), the framework highlights the following points:

- Use priority health interventions as an entry point to strengthen national health systems based on the Primary Health Care approach, including referral systems; speed up decentralisation by focusing on local health system development to improve access, equity and quality of health services

- Promote intersectoral collaboration and public-private partnership, including civil society and communities, with a view to improving the use of health services and taking appropriate action on the economic, social, demographic, cultural and environmental determinants of health, including climate change

- Implement strategies to address the human-resources-for-health needs by improved planning, strengthening of the capacity of health training institutions, management, motivation and retention to enhance the coverage and quality of healthcare

- Set up sustainable mechanisms to increase availability, affordability and accessibility of essential medicines, services, appropriate technologies and infrastructure through provision of adequate resources

- Strengthen health information and surveillance systems, and promote operational research on health systems for evidence-based decisions

- Develop and implement strategic health-financing policies and plans, integrated into the overall national development framework, which protect the poor and vulnerable, in particular, women and children, while ensuring equitable and sustainable allocation of resources by level of care

- Implement the Abuja Declaration to incrementally allocate at least 15% of the overall national budget to health; allocate at least 2% of the health budget to reinforcing national health research systems; and create centres of excellence in Africa.

Removing financial risks and barriers to care, and service access

Compulsory prepayment into a fund for health services before the need arises is recommended as a way of removing financial risks and barriers to accessing healthcare services (Sambo & Kirigia, 2014). Prepayments may be organised through general taxes or compulsory contributions for health insurance or both. In instances where multiple funds exist, cross-subsidisation is encouraged (Ibid., 2014). Removing financial obstacles related to prices charged by healthcare providers lead to increased utilisation of healthcare services (Levesque *et al*., 2013). This may, however, not be impactful in communities that cannot travel to healthcare facilities because of not having the means to do so (Bakeera *et al*., 2009; Cotlear, 2015; Levesque *et al*., 2013; Sachs, 2012).

2.3.6 Public participation and accountability
Public participation

Public participation is the practice of involving members of the public in the agenda-setting, decision-making and policy-forming activities of the institutions responsible for policy development (World Health Organization, 2014). Public participation involves interaction and dialogue, and goes beyond situations where institutions simply provide information to the public, or simply obtain information from the public (Ibid., 2014).

Public policies are often developed by politicians and government institutions, and then implemented for the country and its citizens (Antonini, Hogg, Mannetti, Barbieri & Wagoner, 2015). Although governments generally formulate policies, the public has the ability to decide on whether or not a policy is implementable (Antonini *et al.*, 2015).

In 1948, the World Health Organization developed a constitution indicating that informed opinion and active co-operation by the public are very important in improving the population's health (World Health Organization, 2014). The 1978 Declaration of Alma-Ata states that "the people have the right and duty to participate individually and collectively in the planning and implementation of their healthcare" (World Health

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Organization, 2014:42). The citizens should not only be on the receiving end, but should be actively involved in shaping the system to be effective and sustainable (Nyawo, 2017).

Although governments promote public participation in policymaking, direct involvement of citizens is avoided, at times (Antonini *et al*., 2015). On the other hand, individuals participate in policymaking processes, if justification exists that policies will improve the quality of governmental decisions, and maximise community benefits. In certain instances, people do not participate, if they feel that their voices are not being heard, and that participation will not bring changes to improve the community's wellbeing (Ibid., 2015).

People who perceive authority as oppressive, unfair or untrustworthy may opt for protesting against the government's inconsideration, inequity and oppression (Antonini *et al*., 2015). This may be challenging in cases where governments often encourage their citizens to participate in policymaking. Nevertheless, motivating citizens to participate in policymaking remains a challenge (Ibid., 2015). Governments and other relevant institutions are accountable to ensure that proper participatory processes are in place (World Health Organization, 2014).

Accountability

Public participation and accountability are related to, and partly overlap with important aspects such as transparency, voice, inclusion, empowerment and responsiveness (World Health Organization, 2014). Public participation and accountability are inseparable when dealing with service delivery issues (Nyawo, 2017).

Accountability is one of the important requirements for preventing abuse of power and misuse of public resources, as well as ensuring responsiveness, efficiency, effectiveness, and transparency in public service (Nyawo, 2017). Governments are urged to share the relevant information widely and strategically to promote public participation, and accountability (Nyawo, 2017; Owe Chi & Namara, 2012). Democratic governments should strengthen public participation in policymaking, in order to increase transparency in public processes and hold officials accountable (Kyohairwe, 2014).

All the stakeholders that influence the health system and the pursuit of UHC are expected to be accountable to the public in a meaningful way (World Health Organization, 2014). In

addition, the public should have the opportunity to monitor and evaluate the performance of government, and demand accountability from representatives (Nyawo, 2017; World Health Organization, 2014).

The participatory process helps with strengthening accountability and improving outcomes (Nyawo, 2017). Public officials, including politicians, are required to display honesty to achieve a high and sustained standard of public service delivery (Ibid., 2017).

2.3.7 Monitoring and evaluation

All aspects of the health system require monitoring and evaluation of the implementation stage, and the effects of the approved policies (World Health Organization, 2014). Health sector efficiency and related issues, such as cost-effectiveness and value for money, are some of the most discussed dimensions of health system performance (Cylus *et al.*, 2016). Fair and progressive realisation of UHC requires monitoring and evaluation of resources, coverage and health outcomes based on defined indicators (World Health Organization, 2014).

"The core set of indicators and targets should be based on a country demographic and epidemiological profile, health systems, the level of socioeconomic development, and people's needs and expectations, and, as a minimum, include a small set of globally recommended tracer indicators" (Boerma, Eozenou, Evans, Evans, Kieny & Wagstaff, 2014:7).

Resources

Resources for health services should be monitored based on how funds are generated and how they are used (World Health Organization, 2014). It is necessary for public institutions to address issues of mismanagement of resources and poor quality reporting, as these affect policy implementation and desired outcomes (Nyawo, 2017). Information about current affairs and changes over time is needed to facilitate comparison to stated policy, and inform public debate and future policymaking (Ibid., 2017). Countries should track and report on aggregate resource indicators (World Health Organization, 2014).

Coverage

Monitoring and evaluation of service coverage are essential to accountability, and participation in the specific context of UHC and the pursuit of UHC, in general (Boerma *et al.*, 2014; World Health Organization, 2014). The use of a comprehensive set of indicators is needed to enable the public to hold decision-makers accountable for taking the right steps toward UHC (World Health Organization, 2014).

Indicators of service coverage and financial risk protection are needed, and the selection of specific indicators is important (World Health Organization, 2014). Therefore, not only average levels, but also the distribution across relevant groups must be measured and reported (Ibid., 2014).

Health outcomes

Health outcomes result from many complex factors inside and outside the health system (Sachs, 2012). The effects of poverty, which are characterised by poor nutritional adequacy, lack of a safe home environment, poor quality of water and sanitation, environmental exposure to toxic substances, limitations of knowledge about health-seeking behaviours, due to a lack of literacy and schooling, physiological stress and poor psychosocial wellbeing, affect health outcomes (Ibid., 2012).

Among the main motivations for UHC are the improvement of population health and the promotion of a fair distribution of health in society (World Health Organization, 2014). Decision-makers should be held accountable for health outcomes, and accountability in this area should be strengthened through monitoring and evaluation of the relevant outcomes (Ibid., 2014).

The average levels and distribution of health inequalities across socioeconomic groups, or geographic areas across relevant groups, must be measured and reported (World Health Organization, 2014). These can form the basis for civil society pressure for reform. Therefore, information on health outcomes constitutes a critical input to policy formulation (Ibid., 2014).

2.3.8 Comparison of country reforms to achieve UHC

In this subsection, studies related to countries that are reforming their health systems to achieve UHC were reviewed. The intention was to understand the progress, obstacles, and areas that need improvement. The table below provides a summary of the findings.

Table 2.10: Comparison of countries that are reforming their health systems to achieve UHC

Author (year)	Topic of study	Context of study and location	Findings	What was not concluded
Gedion, Alfonso & Díaz, 2013	The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence	Universal Health Coverage Studies Series (UNICO Study Series) was aimed at developing knowledge and operational tools to help countries tackle implementation challenges in ways that are fiscally sustainable, enhancing equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyse different issues related to the challenges of UHC policy implementation. Complete list of country papers reviewed are Afghanistan, Bangladesh, Brazil, Bulgaria, Burkina Faso, Cambodia, Colombia, Costa Rica, Ecuador, Egypt, Ethiopia, Georgia, Ghana, India, Indonesia, Jordan, Mali, Mexico, Namibia, Nicaragua, Nigeria, Pakistan, Peru, Phillipines, Rwanda, Senegal, Thailand, Uganda, Vietnam and Zambia.	1. UHC referred to several coexisting schemes that were meant to complement one other. Most schemes had some form of risk pooling but the design and implementation varied substantially. Schemes defined explicit benefits packages, but the content and design varied considerably across schemes, and countries. 2. Access to health care, utilisation and financial protection from catastrophic health expenditure were to an extent influenced by the Scheme design and other health determinants such as living close to the health facility, and socio-economic status. Insurance scheme should thus consider the disease profile and the population's health expenditure pattern, to be effective in protecting the population from medical impoverishment. 3. Targeting the poor and vulnerable groups was a common feature in most of the countries. The delivery of health care was mostly organised with a mix of public, and private providers. 4. Firstly, improvements in affordability did not always translate into improvements in access. Secondly, when targeting the poor, also keep an eye on the nonpoor. The common UHC scheme designs are less effective for the nonpoor, when extending coverage to the nonpoor. Thirdly, benefits should be closely linked to target populations' needs. Fourthly, highly focused interventions can be a useful initial step toward UHC. 5. Measure of financial protection frequently does not include other health-seeking related costs beyond direct payments, such as transportation costs or informal payments; do not capture other strategies to cope with costs of illness such as reduced household consumption of other goods and services or increasing debt to finance health expenses; do not include indirect costs such as income loss due to illness.	Evidence on the impact of specific UHC design features and their intended outcomes is inconclusive and limited. UHC schemes and available evidence highlight some implications for both policy and future UHC research. 2. There are major data and methodological limitations that need to be tackled to provide a better understanding of the link between coverage and health outcomes, and the specific factors driving the effectiveness (or the lack of it) of UHC.

Table 2.10: Comparison of countries that are reforming their health systems to achieve UHC (continued)

Author (year)	Topic of study	Context of study and location	Findings	What was not concluded
Cotlear, Nagpal, Smith, Tandon & Cortez, 2015	Going universal: How 24 countries are implementing universal health coverage from the bottom up.	Analysis of policy decisions at country level was done to shed light on how UHC programs are implemented. 24 developing countries that have embarked on the journey towards UHC were included in the study. The countries are Ghana, Nigeria, Ethipia, Kenya, South Africa, Tunisia, Argentina, Brazil, Columbia, Chile, Peru, Jamaica, Costa Rica, Guatemala, Mexico, Indonesia, Phillipines, Thailand, Vietnam, India, China, Kyrgyz Republic, Georgia and Turkey.	1. The UHC programs are not just about adding more resources to the system, but rather involve an attempt to introduce a new way of doing business that is more complex and requires new technical skills. 2. The bottom-up approach is a viable option for developing countries. Prioritising the poor and vulnerable groups may require identification and targeting capacities to be developed. 3. Mechanisms to ensure quality of services contribute to patient safety and accountability, and should be integral to UHC program design and not presented as an afterthought. 4. Gatekeeping and referral mechanisms are complex, and most countries struggle to get them right, but should perseverance is needed. 5. Very few UHC programs systematically measure program impact on key objectives such as better health outcomes and financial protection. 6. Answers are needed on how to establish a culture of evidence-based policy making that draws on the new information, by mainly applying well-developed monitoring and evaluation expertise, and how to empower citizens to hold politicians, policy makers, and providers to account for UHC implementation.	1. More operational research is needed to guide policy makers in their efforts to cover people, manage money, expand benefits, improve health care provision, and strengthen accountability. 2. More research is needed on the extent to which out of pocket expenditure reflects inadequate financing for UHC and the poor supply-side readiness.

Table 2.10: Comparison of countries that are reforming their health systems to achieve UHC (continued)

Author (year)	Topic of study	Context of study and location	Findings	What was not concluded
Atun, Odorico, de Andrade, Almeida, Cotlear, Dmytraczenko, Frenz, Garcia, Gómez-Dantés, Knaul, Muntaner, de Paula, Rígoli, Serrate & Wagstaff, 2015	UHC implementation in Latin America	The study was based on distinguishing features of health-system strengthening for universal health coverage and lessons from the Latin American experience relevant for countries advancing universal health coverage. Countries included in the study are Brazil, Costa Rica, Cuba, Uruguay and Venezuela.	1. In all the study countries, health has been established as a legal or constitutional right, with mechanisms to enforce citizens' rights to health or the protection of health. 2. Except for Cuba, the countries retained a public-private mix in financing and service provision, but have strengthened the public sector. 3. An important feature of the health system reforms was the strong cooperation amongst countries to	Research is needed to document systematically the positive and negative effects of transfer of human resources on the recipient and originating countries.

From Table 2.10, it can be inferred that UHC refers to several schemes that coexist, with varying designs and implementation. Most countries have public and private sectors; consequently, their health systems financing streams happen to come from both these sectors. Preceding studies also show that access to healthcare and its utilisation is, to a large extent, influenced by the design of schemes. Given the reliance of health sector programmes on the State, it has been recommended that resource allocation be channelled according to need, and that the services be tailored to ensure financial sustainability. Countries are urged to design their healthcare packages according to country-specific needs. Healthcare benefits must be explicitly defined while ensuring that services are targeted at the poor and vulnerable groups, but do not overlook those that are not poor. When countries embark on changing their healthcare benefits, the impact of the cost to providers and financiers should be assessed. However, financial risk protection of citizens should not be overlooked. Studies also report that several countries experienced challenges with gatekeeping and referral mechanisms, and, therefore, struggled to implement them. It was found that there was no best practice model identified in effecting UHC. It is, however, important to ensure that the mechanisms which safeguard patient safety, provision of quality healthcare, accountability and sustainability are in place. Countries are encouraged to co-operate with each other to achieve health equity.

2.4 South African Health System Transition

In this subsection, the history, state and reform of South Africa's health system is discussed.

2.4.1 History of South Africa's health system

There are different phases of history based primarily on developments related to health policy, legislation, and reforms (Katuu, 2018; Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). Seven attempts were previously made to introduce a health scheme with progressive features to address the country's health system challenges (Mayosi *et al*., 2012).

> *Phase 1* – during the period before 1919, the first health legislation was promulgated for the Union of South Africa (Katuu, 2018). According to Coovadia *et al*. (2009), hospital care was provided by Christian missions, colonial governments, and the Dutch East India Company in the 17th and 18th centuries. The first health legislation was promulgated in 1807, and the Union of South Africa was established in 1910 and had four provinces which were characterised by fragmented health services.
>
> *Phase 2* – the period between 1919 and 1940 saw the introduction of South Africa's first health legislation that had national jurisdiction (Katuu, 2018). In 1919, the first Union-wide public health department was established through the Health Act (Coovadia *et al*., 2009). The Commission on Old Age Pension and National Insurance was established in 1928 to cover medical, maternity and death benefits for low income formal sector employees in urban areas (Department of Health, 2011; Mayosi *et al*., 2012). In 1935, a Committee of Enquiry into the NHI recommended similar proposals to those made in 1928, but recommendations by the two committees were ignored (Department of Health, 2011).
>
> *Phase 3* – the period between 1940 and 1950 was a phase characterised by progressive and forward-thinking activities within the health sector (Katuu, 2018). In the period 1942 to 1944, a singular national health service was advocated by the Gluckman Commission, and several community health centres were set up in 1945, after Gluckman became Minister of Health in 1945 (Coovadia *et al*., 2009). The Gluckman

Commission recommended a tax for the funding of health services (Mayosi *et al*., 2012). The gains were reversed in 1948 (Department of Health, 2011).

Phase 4 – during the period between 1950 and 1990, apartheid had its greatest impact on the country (Katuu, 2018). In 1952, a segregated medical school for black students was established in Durban, and the State took over missionary hospitals, which were the backbone of the *bantustan* health services (Coovadia *et al*., 2009). In 1977, the National Health Act perpetuated the fragmentation of curative services. The Alma-Ata Declaration of 1978 failed to have an effect on South Africa, which was isolated, owing to the laws of racial segregation. The Tricameral Parliament, established in 1983, further fragmented the country's health services based on colour (Ibid., 2009).

Phase 5 – the period between 1990 and 1994 was a transitional period as the apartheid regime declined, eventually leading to democratic elections (Katuu, 2018).

Phase 6 – the period between 1994 and 2003 saw the most fundamental change in South Africa, in 1994 (Katuu, 2018). This is a critical point because the nation's post-Apartheid health sector has fundamentally different constitutional imperatives. The country's new Constitution established inalienable rights to health for all South Africans, regardless of race. In addition, the most recent National Health Act (South Africa, 2003) was promulgated (Ibid., 2018). In 1994, the African National Congress (ANC) Health Plan was crafted based on the principles of primary healthcare (Coovadia *et al*., 2009). In the same year, the Healthcare Finance Committee recommended that all individuals that were formally employed, including their dependents, should be part of a social health insurance membership arrangement, with the aim of expanding coverage to other groups (Department of Health, 2011). The suggestion of a multi-funder (or multi-payer) system was also made, and that medical schemes should act as financial intermediaries for channelling funds to healthcare providers (Ibid., 2011).

Phase 7 – the period from 2003 to the current era envisaged UHC (Katuu, 2018). In 2004, the national health system was legislated through the National Health Act to incorporate public and private sectors, and the provision of equitable healthcare

services (Coovadia *et al*., 2009). The establishment of the district health system was also legislated for the implementation of primary healthcare throughout the country (Ibid., 2009).

Given the country's history, reforming the health system has been hampered by the lack of political will over the years. South Africa's history and policy are inextricably connected (Van Rensburg, 2012). The challenges facing South Africa are more than medical (Department of Health South Africa, 2015). The health system functions may determine the success in the treatment of disorders, and the longevity and quality of life of the population (Ibid., 2015). In 2018, life expectancy at birth was 64 years (Statistics South Africa, 2018). Life expectancy across Africa was 63 years, in 2018 (Statista, 2018). The global average life expectancy in the same year was 70 years (Ibid., 2018). However, life expectancy has decreased, owing to the COVID-19 pandemic (Statistics South Africa, 2021).

2.4.2 The state of South Africa's health system

South Africa has a progressive Constitution which protects human rights and access to healthcare, but struggles with providing equitable access to quality healthcare (Maphumulo & Bhengu, 2018). According to the Department of Health South Africa (2015), the performance of the country's health system has been poor, since 1994, despite good and progressive policies, and relatively high spending as a proportion of GDP.

In the first years of democracy, the democratic government formulated policies to transform the health system into an integrated, comprehensive national health system (Department of Health South Africa, 2015). However, there was a misguided effort to change everything at once, whereas many aspects of the system were not faulty (Ibid., 2015).

Management of the health system is centralised and top-down (Department of Health South Africa, 2015). Centralised control has not worked because health personnel lack discipline; perform inappropriate functions and are not held accountable; do not adhere to policies; and are inadequately overseen (Ibid., 2015).

In addition, the institutional links between the different levels of service are weak (Department of Health South Africa, 2015). The health system is, therefore, characterised by poor authority, weak accountability, the marginalisation of clinicians, and low staff morale. Services are fragmented between the public and private sectors, and the express needs of communities are not always valued and respected (Ibid., 2015).

The public health sector is served by about 30% of the doctors, despite providing healthcare for the majority of the country's population (Mayosi & Benatar, 2014). Most of the government hospitals are in a state of crisis, and the public healthcare infrastructure is run down and dysfunctional because of mismanagement, neglect and underfunding (Ibid., 2014).

The public sector is experiencing service delivery challenges characterised by prolonged waiting times, owing to personnel shortages, lack of cleanliness, poor infection control measures, adverse events, increased litigation because of avoidable medical errors, shortage of medicines and equipment, and poor record-keeping (Maphumulo & Bhengu, 2018; Mhlanga & Garidzirai, 2020).

The main challenge for the current administration is to reduce health inequities, in other words, differences in access to healthcare and related services across provinces, and between rural and urban areas, which are attributed to the legacy of segregation (Coovadia *et al*., 2009; Mhlanga & Garidzirai, 2020). In South Africa, extreme poverty affects a large proportion of the population and leads to an inability to access basic needs such as clean water, adequate nutrition and proper sanitation, which impact health (Mayosi & Benatar, 2014).

Health outcome reports in the country indicate a complete failure in public sector healthcare delivery (Maphumulo & Bhengu, 2018). Leadership crises may be traced back to the early days of democracy, following the government's implementation of policies aimed at improving the living conditions of poor households (Ibid., 2018).

2.4.3 Reform of South Africa's health system

The NDoH is committed to improving the quality of healthcare delivery (Maphumulo & Bhengu, 2018; Department of Health, 2015). The National Planning Commission was established in 2010 to develop a vision and strategic plan for South Africa to align the country's efforts with the goal of achieving UHC by 2030 (National Planning Commission, 2011).

According to the National Planning Commission (2011), public health system reform should focus on improved management, particularly at institutional level; more and better trained healthcare professionals, combined with effective accountability; and better patient information systems which support more decentralised and home-based care (HBC) models

Complete health system reform will mean that the health system is revitalised and integrated; public and private health delivery systems are evidence-based; there is clear separation of policymaking from oversight and operations; authority is decentralised to the lowest levels; clinical processes are rationalised; there is a greater use of ICT, and systematic use of data at all levels; and the infrastructure backlog is cleared (National Planning Commission, 2011).

Meaningful public-private partnerships are needed in the context of the NHI (National Planning Commission, 2011). Best practice purchasing, provisioning, procurement, and sound financial management are important in these partnerships to improve access, equity, quality and innovation for efficient service (Ibid., 2011). The next diagram shows how public-private partnership is envisaged.
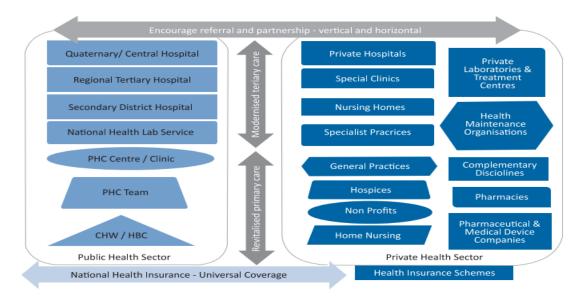
Figure 2.11: Integration between public and private sectors (**Source:** National Planning Commission, 2011:322)

Figure 2.11 shows how intersectoral collaboration and inter-ministerial collaboration are foreseen to encourage referrals and partnerships.

The Ministry of Health is embarking on massive reform, covering health systems, personnel and financing, among others (Department of Health South Africa, 2015). Health stakeholders are also called on to collaborate with each other and with government, to be open to new ways of doing things, and to put patients first (Ibid., 2015).

NHI is a policy shift that will contribute towards poverty reduction and addressing the inequalities inherited from the past (Department of Health South Africa, 2015). Implementation of NHI reflects the kind of society South Africans wish to live in: one based on the values of justice, fairness and social solidarity (Ibid., 2015).

Department of Health South Africa (2015) states that the NHI implementation is consistent with the worldwide vision that healthcare should be a social investment and, therefore, not subjected to market forces, where it is treated as a normal commodity of trade.

Department of Health South Africa (2015) further asserts that NHI will ensure a more responsive and accountable health system. A more responsive health system is likely to improve user satisfaction, and lead to a better quality of life of the citizens and improved health outcomes across all socioeconomic groups. This will contribute towards improved human capital, labour productivity, economic growth, social stability and social cohesion. As the NHI evolves, the tax treatment of medical expenses and medical scheme contributions will be reviewed. There is also an expectation that there will be a reduction in the need for medical scheme contributions and/or the level of coverage.

NHI will ensure that all South Africans have access to comprehensive quality healthcare services closest to where they live and at the appropriate level of care, delivered through certified and accredited public and private providers using the NHI Card (Department of Health South Africa, 2015).

2.4.3.1 NHI

NHI is defined as a health financing system that is designed to pool funds and purchase services to provide all South Africans access to quality and affordable healthcare, according to need, regardless of socioeconomic status (Department of Health South Africa, 2017).

The mandate of the NHI is derived from Section 27 of the Constitution of South Africa, which indicates that the State must take reasonable legislative and other measures, within the country's available resources, to achieve the progressive realisation of the right to healthcare (Department of Health South Africa, 2017). NHI will be implemented through the creation of a single fund that is publicly administered and financed (Ibid., 2017).

Department of Health South Africa (2015) states that the NHI will ensure that the State optimally utilises the available resources to benefit the country's population. The benefits will include the provision of post-retirement entitlements. In addition, financing and delivery of healthcare services in the private sector are expected to be aligned with the principles of access, affordability, effectiveness, efficiency, equity, health as a public good, and social solidarity.

South Africa has proposed a framework to support the roll-out of the NHI over a 14-year period, which started in 2012 (Harvard Medical School, 2015). Four key interventions which were identified as crucial to this health reform process are: (1) a total overhaul of the healthcare system; (2) radical changes in administration and management; (3) complete transformation of healthcare service provision and delivery; and (4) the provision of a comprehensive package of care, underpinned by re-engineered PHC (Department of Health South Africa, 2017; Jobson, 2015; Maphumulo & Bhengu, 2019).

According to Mayosi and Benatar (2014), the expectation that NHI will promote equity in healthcare delivery at the level close to the current private-sector standard is unrealistic, due to the disparities in funding between the public and private sectors. Kgasi (2016) reports the following research findings regarding the perceptions of managers within a medical scheme, of the NHI in South Africa:

Access to care or insurance

The participants were of the view that every citizen will have access to health insurance coverage and obtain access to healthcare, but timely access to healthcare may not be provided.

Package of services

The participants agreed that the basket of services will contain basic medicines and healthcare services. However, there were mixed perceptions on whether the service will be cost-effective, or cover the whole population.

Social and economic risk protection

The participants believed that access to affordable healthcare will be provided, but the healthcare will not be satisfactory to individuals. Participants, therefore, had mixed opinions on the fact that individuals will be protected from costs of treatment, due to ill health.

Removing financial risks and barriers to care, and service access

The participants had mixed opinions on whether: there should be cross-subsidisation where multiple medical funds exist; compulsory prepayment into a single fund for health services should be implemented; and prepayment arrangements should be organised through general taxation, compulsory contributions or both.

Purchasing services

The participants' perceptions indicated that there should be a split between the provision and purchasing of health services, and that there should be multiple purchasers of health services and no single purchaser.

2.4.3.2 NHI Bill

The NHI Bill was approved by Cabinet in July 2019. The document highlights the following legislative changes to the health system:

Access to healthcare services

The Fund, in consultation with the Minister of Health, must purchase healthcare services for the population; persons eligible to receive healthcare services through the Fund must register as users at an accredited healthcare service provider or health establishment; healthcare services purchased by the Fund will be provided within the State's available resources; in consultation with the Minister of Health, the Fund must purchase healthcare services that have been determined by the Benefits Advisory Committee; healthcare services will be provided free of charge by accredited healthcare service providers or health establishments, at the point of care (Republic of South Africa, 2019).

Advisory committees established by Minister

The Minister must, after consultation with the board, establish the Benefits Advisory Committee and Health Care Benefits Pricing Committee; and appoint a Stakeholder Advisory Committee comprised of representatives from the civil society organisations,

patient advocacy groups, organised labour, public health entities, statutory health professions councils, associations of health professionals and providers, in such a manner as may be prescribed (Republic of South Africa, 2019).

General provisions applicable to operation of the Fund

- The Fund must be an active and strategic purchaser of healthcare services on behalf of users according to need; establish an information platform to allow the Fund to make informed decisions on population health needs assessment, financing, purchasing, patient registration, service provider contracting and reimbursement, utilisation patterns, performance management, setting the parameters for the procurement of health goods, and fraud and risk management; determine the nature of provider payment mechanisms and adopt additional mechanisms; and contribute to the development and maintenance of the national health information system (Republic of South Africa, 2019).

- An Office of Health Products Procurement which sets parameters for the public procurement of health-related products must be established by the board, in consultation with the Minister (Republic of South Africa, 2019).

- Accredited healthcare service providers and health establishments must deliver to the users an appropriate level of healthcare services that have been purchased by the Fund, according to need and the benefits entitlements (Republic of South Africa, 2019).

- Once the NHI has been fully implemented, medical schemes may only offer complementary cover for services not funded by the Fund (Republic of South Africa, 2019).

Complaints and appeals

A user, healthcare service provider, health establishment or supplier, may lodge a complaint with the Fund, if aggrieved, according to the procedures determined by the Fund, in consultation with the Minister (Republic of South Africa, 2019). The Fund

must deal with such complaints lawfully and timeously. The aggrieved party may appeal the outcome of the investigation to the Appeal Tribunal (Ibid., 2019).

Financial matters

- According to the Republic of South Africa (2019), the Fund is entitled to money appropriated yearly by Parliament to achieve the purpose of the Act. Funding will be sourced from the *general tax revenue; reallocation of funding for medical scheme tax credits; payroll tax (employer and employee); and surcharge on personal income tax.*

- The Auditor General must annually audit the accounts and financial records of the Fund; the board must submit a report to the Minister and Parliament on the activities of the Fund during a financial year, as determined by the Public Finance Management Act; and the legislative reforms must be initiated to enable the introduction of NHI, including changes to the relevant Acts (Republic of South Africa, 2019).

2.5 Chapter Summary

The chapter discussed literature on health systems, health systems reform and UHC. Health systems are complex and, therefore, various countries need to employ context-specific funding models to promote access to quality healthcare, with the aim of improving health outcomes.

High-income countries have experienced increased life expectancy, good access to quality healthcare, and satisfaction with delivery of care. However, low and middle-income countries still grapple with poor-performing health systems attributed to poor organisation and governance, weak financing mechanisms, and insufficient human resources, to name a few.

Countries are urged to establish the means for pooling funds to ensure that effective health coverage is provided to the people in need. UHC is currently considered a crucial agenda to promote access to healthcare, while ensuring financial risk protection, irrespective of socioeconomic status. Quality healthcare is necessary, and the provision thereof should be affordable, accessible and acceptable to the population to improve health outcomes.

Health outcomes, which are an indirect measure of health coverage, reflect the structure and processes needed to produce the desired health effects. Strengthening public health infrastructure capacity; raising sufficient resources to strengthen health systems; promoting efficiency in national health services to optimise resource use and maximise results; removing financial risks and barriers to care; and service access are viewed as major focus areas for achieving UHC. Fair and progressive realisation of UHC requires monitoring and evaluation of resources, coverage and health outcomes based on clear indicators.

CHAPTER 3: THEORETICAL FRAMEWORKS

This chapter forms the second phase of the extensive literature review. Contingency theory of leadership, health system governance framework, Donabedian model of quality, and stakeholder theory are discussed as theoretical frameworks of this study. Concepts relating to these theories are also explained. This is done in relation to the envisaged health system reform of UHC through the NHI.

3.1 Contingency Theory of Leadership

Contingency leadership theory was considered relevant to this study. According to this theory, there is no single best way of organising or managing (Grant, 2013). The theory describes how aspects of the leadership situation may change the leader's influence and effectiveness (Yukl, 2013). The contingency approach recognises that every organisation, and even departments or units within an organisation are unique and exist with unique goals and personnel (Smit, Botha & Vrba, 2018).

A leader should be able to recognise a situation, make a diagnosis, identify the leadership style most suitable for the situation and then implement that leadership style (Arfeen, Aslam & Mothi, 2015). Leaders should change their leadership style based on the situational needs (Arfeen *et al.*, 2015). This will enable the leaders to develop appropriate objectives, make the right strategic choices to achieve the objectives, and implement effective plans to ensure that the resources are available to attain organisational objectives (Shriberg, Lloyd, Shriberg & Williamson, 1997).

In the process, leaders create organisational structure, facilitate activities and relationships in a group or organisation, and set standards to guide organisational culture and the results to be achieved (Franco & Almeida, 2011; Yukl, 2013; Shriberg *et al.*, 1997). Members are influenced to accept or commit to participation in courses that contribute to the effectiveness and achievement of the organisation's vision or goals (Smit *et al*., 2018; Robbins, Judge, Odendaal & Roodt, 2016).

The best way to design, manage and lead the organisation depends on the characteristics of the environment (Grant, 2013). The contingencies or characteristics of the situation that must be managed are the organisation's external environment; the firm's capabilities (strength and weaknesses); the size, values and goals; skills and attitudes of managers and workers; technology used by the organisation; and the nature of the work performed by the leader's unit or organisation (Brevis & Vrba, 2018; Olden, 2015; Smit *et al.*, 2018). Based on the contingency theory, organisational performance is dependent on the characteristics of the organisation such as the structure and the environment (Donaldson, 2001).
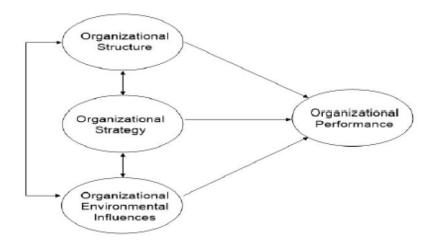
Figure 3.1: Contingency theory (**Source:** Blanton *et al*., 1992)

- Blanton *et al*. (1992) indicate that contingencies such as the structure, strategy and environment influence organisational performance as depicted in Figure 3.1. Contingency theory of leadership was applied in this study to explore and describe the *organisational structures and practices* necessary to successfully implement health system reform. This was done in relation to the following leadership gaps identified: *Management – processes and procedures:* There was a lack of clarity on how the management processes and procedures would affect health system reform. The study intended to bridge the identified gap by unravelling the processes and procedures necessary for health system reform in a developing country.

The contingencies relevant to this study in the theory proposed by Blanton *et al*. (1992), which are the structure, strategy and environment influencing organisational performance are explained next.

3.1.1 Organisational structure

Organisational structure refers to how tasks are formally divided, grouped and coordinated within an organisation (Ginter, Duncan & Swayne, 2013; Robbins & Judge, 2013; Robbins, Judge, Odendaal & Roodt, 2016). Organisational structure provides a framework for strategy implementation (Venter, 2018). Earlier organisational structures were regularly based on either product or function (Lunenburg, 2012). Later approaches examined the relationship between organisational strategy and structure (Ibid., 2012). The organisation's size and the environmental conditions also influence the firm's structure (Lunenburg, 2012).

Organisational structures vary, depending on the firm's vision, mission, purpose and strategy, and the structures are expected to facilitate overall strategy implementation (Ginter *et al*., 2013). Once the directional, market-entry, competitive and service delivery strategies have been developed, management must determine the structure suitable for the organisation (Ibid., 2013). Organisational structure needs to be supported by proper systems and a well-conceived culture (Maduenyi, Oke, Fadeyi & Ajagbe, 2015).

Steps in designing organisational structure include strategic planning (vision, mission, goals and strategies – generic and corporate strategies); outlining tasks and activities; designing jobs and assigning the tasks to employees; defining worker relationships; developing organisational design to support strategic, tactical and operational plans; and having an overarching control mechanism to attain an organisation's mission and goals (Brevis & Vrba, 2018).

3.1.2 Organisational strategy

Strategy is not a detailed plan or programme of instructions, but rather a unifying theme that provides direction and coherence to the actions, and decisions of individuals or organisations (Grant, 2013). "It is a means by which individuals or organisations achieve their objectives"

(Grant, 2013:13). Strategy serves as a link between the organisation and the external environment (Grant, 2013; Venter, 2018).

The organisation embodies three elements, namely the *goals and values*; *resources and capabilities*; and *structure and systems* (Grant, 2013). The external industry environment embodies the fourth element, which is the *competitive environment*, defined by how the organisation relates with customers, suppliers and competitors (Ibid., 2013).

Successful strategy requires alignment between the organisation's external environment (threats and opportunities), and internal environment (mission, goals, values, structure, systems, resources and capabilities) with the firm's strengths and weaknesses (Venter, 2018).

The main source of competitive advantage for organisations is the *tangible resources*, which are financial capital, physical capital, human capital and technological capital; and *intangible resources*, which include human resources, innovation, reputational resources and capabilities (Venter, 2018). Resources and capabilities enable organisations to differentiate themselves from competitors, and to develop a strategy that is beneficial to the organisation (Ibid., 2018).

3.1.3 Environmental factors

Macro-environmental factors and the healthcare industry's competitiveness analysis are discussed in this subsection.

3.1.3.1 Macro-environmental factors

Analysis of both domestic and global environmental forces, and trends is crucial because of the great impact these factors have on organisations (Venter, 2018). The macro environment focuses on the political, economic, social, technological and legal factors (PESTL) (Grant, 2013). These factors or conditions are always changing in the wider macro environment, are beyond the control of business and can change the industry's competitive structure (Ibid., 2013).

Political factors

Government is a major role-player in the macro environment, since the State influences organisations mainly as a regulating force (Brevis & Vrba, 2018; Smit *et al.*, 2018). Political factors include political proclamations, policies, laws and regulations (Thompson, Peteraf, Gamble & Strickland, 2012). Political pressures for change include decisions by local councils, national governments and other supra-national bodies (Pardey, 2007).

Section 36 of the Constitution of South Africa deals with the limitation of rights and sets clear criteria to be met when any right contained in the Bill of Rights is limited by law (Akazili & Ataguba, 2010). In addition, the South African government is committed to the establishment of the NHI system, mainly due to concerns about the challenges within the country's health system (Ibid., 2010).

The State reflected on growing concerns for the poor, who sometimes cannot utilise healthcare services, due to high costs and transport costs to access services (Akazili & Ataguba, 2010). Employees have also been complaining about escalating medical scheme contributions (Akazili & Ataguba, 2010; Minister of Health, 2017).

Economic factors

Economic factors include economic growth rate, inflation and interest rates, business cycles, trade deficits or surpluses, savings rates, per capita domestic products and unemployment rates (Brevis & Vrba, 2018; Thompson *et al.*, 2012). Poverty remains intractable in the country, with a demonstrable increase in vulnerability over a 10-year period from 2006 to 2015 (South African Lancet National Commission, 2019).

In 2015, some 55,5% of the country's population lived in poverty, or survived on less than R992 per month. The number of people in extreme poverty, or living on less than R441 per month, increased from 11 million in 2011 to 23.8 million in 2015 (South African Lancet National Commission, 2019).

Poverty trends are differentiated by race, thereby continuing the Apartheid legacy (South African Lancet National Commission, 2019). In 2015, poverty was low in the white population at 0,4%; Indians experienced a drop from 2,9% to 1,2%; Coloureds had an increase from 20,2% to 23,1%; and black Africans experienced an upsurge from 36,4% to 40%. The rates of unemployment and the rates of young people who are not in employment, education or training differ by race, age and gender (Ibid., 2019).

An estimated 72,2% of whites belong to medical schemes, compared to 49,5% of Asians, 19,7% of Coloureds, and 10,5% of black Africans (South African Lancet National Commission, 2019). Rural and peri-urban indigent women and their children are still mainly utilising the under-resourced public healthcare system (Ibid., 2019).

Social factors

Social factors refer to attitudes, cultural factors, lifestyle and societal values (Thompson *et al.*, 2012). Social pressures for change include changing demographic characteristics such as the ageing population, attitudes, behaviours and expectations (Pardey, 2007).

The country has many young people, aged 15 years and below, at 29,5%, and a small, but growing elderly population at 8,5% (South African Lancet National Commission, 2019; Statistics South Africa, 2019). The sex ratio of males is 95 for every 100 females, which is in line with the demographics of other countries of similar economic status (Ibid., 2019).

PricewaterhouseCoopers (2014) reports that medical schemes have identified the rise in pensioner ratio as the biggest threat to their strategy. This trend is consistent with the increase in life expectancy rates, which are related to unpredictable healthcare costs.

The distribution of illness across socioeconomic groups shows that socially determined illnesses and disability disproportionately affect poor people (South African Lancet National Commission, 2019).

In 2016, Tuberculosis and Human Immunodeficiency Virus (HIV) disease accounted for the leading causes for deaths among black Africans, while ischaemic heart diseases were the leading cause of deaths among whites (South African Lancet National Commission, 2019).

Technological factors

Technology is defined as the knowledge, actions, tools and techniques used to transform ideas, information, raw materials and components into finished products and services (Brevis & Vrba, 2018). Technology also encapsulates the physical elements of human innovation and invention (Ibid., 2018).

Technological factors include the rate at which change in technology and technical developments has a wide spectrum of impact on society (Thompson *et al.*, 2012). Technological pressures for change are critical in many organisations, affecting how goods and services are produced, and the types of goods and services that consumers may use (Pardey, 2007).

Effective management of innovation and technology can be a great source of competitive advantage (Brevis & Vrba, 2018). Technological astuteness offers great opportunities for the healthcare industry to address the most pressing global challenges of making healthcare more accessible, faster and better (PricewaterhouseCoopers, 2014).

Legal factors

Legal factors refer to the laws, regulations, policies and processes which affect an organisation's activities, including employment of individuals, design of processes, finance and governance, information, and the sale of goods and services (Pardey, 2007; Thompson *et al.*, 2012).

The ability of a health system to achieve optimal health outcomes is determined by the legislative framework, which is based on structures that give effect to the legal provisions (South African Lancet National Commission, 2019). South Africa's

enabling Constitution, strong health legislation and numerous health policies express Government's commitment to a high-quality health system (Ibid., 2019).

3.1.3.2 Healthcare industry's competitiveness analysis

The industry's competitiveness is analysed and described using Porter's five forces model. The analysis of the healthcare industry's competitiveness structure and market attractiveness is based on the threats of new entrants; bargaining power of customers; bargaining power of suppliers; threat of substitutes; and rivalry among competitors (Grant, 2013; Thompson *et al.*, 2012). Effective competition comes from organisations that are already operating in the market, firms that can readily enter the market and buyers that exercise effective disciplinary pressure on suppliers (Competition Commission South Africa, 2018).

Threat of new entrants

New entrants to the market bring new innovative production capacity, the desire to be established in the market, and sometimes substantial resources (Thompson *et al.*, 2012). Industry players are willing to defend their positions and make it hard for new entrants to enter the market (Ibid., 2012).

Barriers to entry include the high costs associated with purchasing equipment, general construction of facilities, the required licences to operate, strong brand preferences and a high degree of customer loyalty (DNA Economic, 2013; Thompson *et al.*, 2012).

The Competition Commission South Africa (2018) reports the following:

- Barriers applicable to healthcare facilities include substantial investments and sunk costs, licensing and other regulatory requirements, and contractual or informal relationships between existing healthcare facilities and practitioners.

- Barriers applicable to medical practitioners include rules and regulations promulgated by the Health Professions Council of South Africa and the NDoH, contractual arrangements between medical schemes or their

administrators and practitioners, and agreements and arrangements between facilities and practitioners.

These dynamics limit the number of industry players and may hamper new entrants (DNA Economic, 2013).

Bargaining power of customers

The strength of customers' buying power that organisations face depends on the extent to which buyers are price-sensitive and their relative bargaining power (Grant, 2013; Thomspon *et al.*, 2012).

Customers may have greater economic power and this power can be high, if the customers are few, or buy in bulk; the product or service being offered is similar, making it easier to switch to other suppliers; the value of the buyers' purchases is higher than the sellers' total income; and the buyers' ability to produce products and services (Venter, 2018).

DNA Economic (2013) states that patients generally have little bargaining power over prices; there is usually information asymmetry, as consumers are commonly less informed than their doctors regarding cost of healthcare and healthcare products.

The Competition Commission South Africa (2018) reports that the absence of appropriate market transparency in the private sector may harm competition and distort outcomes of healthcare markets.

Inadequate information in the healthcare sector leaves consumers exposed (Competition Commission South Africa, 2018). Patients may not be able to choose the most appropriate providers and treatments; members' choices of medical schemes may be compromised by an inability to make value-for-money decisions; and patients may lack information available to facilities or funders on whether certain treatments and technologies represent value-for-money (Ibid., 2018).

Bargaining power of suppliers

Grant (2013) provides an analysis of the relative power between the suppliers and the buyers. The key issues are the ease with which industry firms can switch between different suppliers and the relative bargaining power of each party (Ibid., 2013).

Supplier power is high when there are few providers, in relation to the industry served; suppliers in the industry are not the same, thereby making it difficult for customers to find alternatives; few or no substitute products or services exist; the suppliers can move forward into the value chain; and the value of the industry's purchases constitute a small portion of the suppliers' total income (Venter, 2018).

According to Ramjee and Vieyra (2014), medical schemes have been criticised for being passive, rather than strategic purchasers of services, especially in the way selective contracting and alternative re-imbursements are effected.

The Competition Commission South Africa (2018) states that another characteristic of the country's healthcare market is the preservation of solo practices in the private sector, with minimal, or a lack of, integrated healthcare. In most cases, there is a failure to explore multi-disciplinary models of healthcare.

The NHI White Paper has identified that contracting and purchasing in the public and private sectors is 'passive' (South African Lancet National Commission, 2019).

In the public sector, provincial and municipal health departments are contracted to provide services predominantly through global budget allocations not linked to healthcare outcomes or achievement of quality standards (South African Lancet National Commission, 2019).In the private sector, the contracting of providers can be linked to agreements to use specific treatment protocols, medicine formularies and other requirements related to the health insurance package of the patient, mainly with the aim to contain costs rather than promote quality (South African Lancet National Commission, 2019).

Threat of substitutes

The price the customer is willing to pay for a product or service depends, to an extent, on the availability of a substitute (Grant, 2013). Competitive pressures depend on the availability of substitutes; whether substitutes are well priced; and the cost of switching from one product to another (Thomspon *et al.*, 2012).

Product differences – according to the researcher, benefits offered by medical schemes are largely similar, in terms of cover for in or out-of-hospital expenses. Richer or more benefits are commonly offered to members on top plans.

Higher plans are more expensive than lower plans, and their membership is comprised of people who are generally sick, the elderly and those with chronic medical conditions requiring more healthcare cover.

Product offerings – regarding seeking a health service, the researcher has noted that the choice of healthcare providers by members is not easily differentiated. Members choose a healthcare provider based on a diagnosis, accessibility, ability to pay, contractual obligations with the healthcare funders, referrals by the primary physician and, in certain instances, word-of-mouth recommendations.

The Competition Commission South Africa (2018) states that the absence of appropriate market transparency in the private sector may harm competition and distort outcomes of healthcare markets. Healthcare funders may be unable to compare costs and quality of providers; and patients may lack information available to facilities or funders on whether certain treatments and technologies represent value-for-money.

Switching costs – the researcher has observed that members of medical schemes usually change from one medical scheme to another when they are not happy with the benefits offered or service rendered, especially when healthcare claims are not paid. There are no penalties applicable to members when they leave one medical scheme for another. The only deterrent might be the waiting periods that apply on joining a new medical scheme. The waiting period signifies that a member may not have medical cover on a

new medical scheme for certain medical conditions until the stipulated period expires. The timeframe may be from three months, or even up to 12 months after joining a new medical scheme.

Rivalry among existing competitors

The major determinant of the overall state of competition and the general level of profitability is competition among the firms within the industry (Grant, 2013). Active rivals may compete against one another by differentiating their products through offering better performance features, higher quality, improved customer service or a wider selection of products (Thompson *et al.*, 2012).

Industry growth – the number of medical schemes decreased from 144 in 2000 to 76 in 2020 (Council for Medical Schemes, 2021). The drivers of this trend are voluntary amalgamations and consolidations. There were 76 registered entities in 2020, comprising 18 open and 58 restricted medical schemes (Ibid., 2021).

There is currently one dominant open medical scheme, which is Discovery Health Medical Scheme (DHMS), owning 55% of the open medical scheme market share (Competition Commission South Africa, 2018). DHMS continues to grow progressively and there has been amalgamations with smaller restricted schemes. The Government Employees Medical Scheme (GEMS) is the largest restricted scheme and is second only to DHMS as measured by the number of beneficiaries (Ibid., 2018). The trend, in terms of market share, remains (Council for Medical Schemes, 2020).

The Council for Medical Schemes (2015) reports that Discovery Health (Pty) Ltd.'s share of the open schemes market increased to 53,4% (2013:52,4%); and its share of the restricted schemes market increased to 5,1% (2013:4,6 %). Medscheme Holdings (Pty) Ltd. has the second biggest share in both the open and restricted schemes administration market, at 16,5% (2013:16,6%) and 36,3% (2013: also 36.3%), respectively. Metropolitan Health Corporate (Pty) Ltd. has the biggest share of the restricted schemes market at 46,6% (2013:46,7%). Despite their medical schemes'

market dominance and inherent benefits of economies of scale, they do not appear to offer any cost advantages over their smaller rivals.

Netcare, Mediclinic and Life Healthcare hospitals have a combined 83% market share of the South African private healthcare facilities (Competition Commission of South Africa, 2018). The public hospital system does not provide a competitive constraint to private facilities (Ibid., 2018).

Diversity of competitors – in the private sector, facility groups compete to attract specialist practitioners (Competition Commission South Africa, 2018). There is little need for clear or formal collusive agreements; and there is alignment of interests between facility and practitioner, where both stand to benefit from higher treatment volumes and intensity (Ibid., 2018).

The uninformed patients assume that these arrangements are to their advantage and may not be concerned with the longer-term financial impact on medical scheme cover (Competition Commission South Africa, 2018).

3.1.4 Organisational performance

Organisational performance refers to the organisation's ability to achieve the set goals and objectives using the available resources in a structured manner (Ricardo & Wade, 2001). Organisational performance is viewed in terms of the actual outputs or results of an organisation against the desired goals and objectives (Short, Ketchen, Palmer & Hult, 2007), and organisations adopt different measurements and objectives for organisational performance (Hage, 1980; Maduenyi *et al*., 2015). Organisational performance reflects the state of an organisation or outcomes emanating from management decisions, and the implementation of those decisions by employees (Greenberg, 2011).

Performance is also regarded as a set of financial and non-financial indicators which offer information on the degree of achievement of objectives and results (Hodge & William, 2004; Short *et al*., 2007). However, if both operational and financial performance are used to measure

organisational performance, the aspects that need to be measured should be clearly defined (Gentry & Shen, 2010).

Profitability is deemed to be the best indicator of organisational performance (Sethibe, 2016). Return of equity (ROE) and return on assets, and profit margin are frequently used to measure performance (Galbraith & Scendel, 1983; Maduenyi *et al*., 2015; Sethibe, 2016).

The health system in South Africa is in transition and this may affect the performance of organisations within the system. Due to the change process towards UHC through NHI, organisational change and aspects relating to leadership effectiveness are discussed next. Achieving organisational performance depends mainly on how the organisation adapts to the external environmental changes (Venter, 2018; Grant, 2013).

3.1.4.1 Organisational change

Organisations are faced with external and internal sources of pressure which necessitate change (Rizescu & Tileaga, 2016). Change involves continuous adjustment to external conditions by organisations in the operating environment (Ibid., 2016). Organisations need to anticipate and adjust to demographic changes, global politics, competition, social trends, immigration, outsourcing and a multi-cultural environment, in order to survive (Brevis & Vrba, 2018; Robbins & Judge, 2013).

3.1.4.1.1 External sources of change

Hallinger and Snidvongs (2008); Thompson *et al.* (2012); Brevis and Vrba (2018) postulate that the external sources of organisational change include the following:

- Regulatory influences and changes in government policy
- Greater openness of political systems among nations, which allows greater access to global information and exchange of cross-border business
- Developments in information technology, which have fundamentally changed the way of doing business, allowing for efficient communication, and greater efficiencies in the production and management of goods and services

- The standard of competition in all sectors that provide goods and services, which has increased because of growth and integration of a global, increasingly free market economy
- Change in issues that affect society such as the level and quality of education; ethical, gender and race issues; people's attitudes and lifestyles
- Economic forces affecting consumer spending behaviour
- Ecological and physical forces such as climate change affecting the source of raw materials for production of goods.

3.1.4.1.2 Internal sources of change

The four categories of change within the organisation are strategic; structural; technological; and changes in people (Smit *et al.*, 2018; Szydlowska, 2016).

Strategic

These changes relate to the organisation's strategy, overall goals, purpose and mission (Szydlowska, 2016). A change in an organisation's strategic direction would inadvertently result in a change in structure, culture, technological issues and the balance of power (Brevis & Vrba, 2016).

The reasons for this type of change include the firm's outdated and irrelevant way of thinking, which puts the firm in a disadvantaged position relative to its competitors; a new vision for the future; and the introduction of improvements and new systems to support the enhancements (Szydlowska, 2016).

Structural

A change in strategy should ordinarily lead to a change in organisational structure (Smit *et al.*, 2016). The change may affect the hierarchy, management systems and administrative procedures, and may well include reducing the levels of management and span of control; merging departments or sections; and revising authority or decentralising decision-making (Smit *et al.*, 2018; Szydlowska, 2016).

Technological

Changes in technology require an adjustment to the techniques and equipment used in the firm (Szydlowska, 2016). Technological changes occur in areas where improvements are incorporated into technological devices to improve quality in operations (Ibid., 2016). Technological changes may involve replacing people with robots, changing equipment, or introducing new systems or processes of production (Smit *et al.*, 2018).

Changes in people

Changes in people describe changes in employees' attitudes, behaviour, expectations and perceptions (Szydlowska, 2016). The main purpose of these changes is to improve employees' performance, and enhance their efficiency towards the organisation, their relationships with managers and group co-operation (Ibid., 2016).

Change in strategy may require a change in job descriptions, the employees' mind-set, behaviour and corporate culture (Smit *et al.*, 2018).

3.1.4.2 Leading change

Leadership is an important component of processes that support organisational change (Aarons, Ehrhart, Farahnak & Sklar, 2014). Companies that went from good to great achieved success because of leadership, and not systems, strategies or structures alone (Meyer & Bonineli, 2004). The leaders that led organisations to superior performance and market penetration had qualities of personal will and humility (Ibid., 2004).

Leaders must predict forces that will cause change, identify opportunities that will require change, react to unforeseen events that make change urgent, and work with others to overcome resistance (Alkahtani, Abu-Jarad, Sulaiman & Nikbin, 2011). Leaders must also conserve the values and institutions that come under attack. It is also vital to know when to change and when to preserve (Alkahtani *et al.*, 2011). As in other countries, leadership matters to the current South African health system improvement and development initiatives for two reasons (Gilson & Daire, 2011):

- *Firstly*, new efforts to strengthen the health system, such as introducing NHI or improved quality assurance, must recognise the complexity of policy implementation and the required leadership.
- *Secondly*, leadership is needed to transform the existing organisational structures and culture of the public health system, in particular, and translate new policies into routine ways of doing business within the system.

Leading change is a significant part of the policy process (Alkahtani *et al.*, 2011). It is not enough to identify policy issues, develop potential solutions, and allocate the necessary resources. In order to implement policy in organisations, the community and society as a whole, leaders must learn how to initiate and plan for change, how to communicate the need for change, how to make a change appealing to gain support from others, and how to consolidate the results to ensure a sustainable change (Ibid., 2011). Leaders must communicate with people to inspire them to exceed their previous achievements (Shriberg *et al*., 1997).

Factors that positively influence the change process are driven by fostering agreement, active involvement, commitment and congruence of support at all levels of leadership (Aarons *et al.*, 2014).

At the work group level, the degree to which providers agree about the strategy or change being implemented predicts implementation success (Aarons *et al.*, 2014). Similarly, the collective of multiple levels of leadership predicts organisational outcomes as a function of strategic implementation efforts. Therefore, leadership congruence is effective because this aspect sends a clear message regarding the importance of change and facilitates a positive implementation climate among stakeholders (Ibid., 2014).

Both the perceptions and attitudes of employees are very important in any organisational change (Alkahtani *et al.*, 2011). Today's leaders share power, rather than keeping it to themselves; they find ways to increase an organisation's influence by making everyone in the organisation involved and committed (Ibid., 2011).

According to Alkahtani *et al.* (2011), for leaders to bring about change, they should be involved in their employees' activities and should not be aloof. On the other hand, it has been noted that the managers who use the autocratic leadership style tend to be open to experience, while those managers who are responsible, achievement-oriented, persistent and dependable tend to use an involvement leadership style. Therefore, organisations can apply these theoretical findings by involving managers in training that can enhance and develop their personality traits or leadership style for effective leadership.

There are six skill sets that have been found to positively influence the organisational success rate and have, therefore, been incorporated as targeted elements into numerous change models (Gilley, Dixon & Gilley, 2008).

Ability to coach

> According to Gilley *et al.* (2008), the primary role in coaching is that of an agent of change. The leaders who coach, help employees improve their renewal capacity and resilience, which positively influences organisational success. Coaching inspires individuals to remain future-oriented and optimistic, pursue beneficial partnerships and networks, and be their best.

Ability to reward

> Gilley *et al.* (2008) state that a compensation and reward philosophy should be based on rewarding employees for the 'right' performance. Organisations that encourage change and innovation do so by demonstrating their understanding that "the things that get rewarded get done". On the contrary, failure to reward the right behaviour leads to unsatisfactory performance and outcomes.

Ability to communicate

> Innovation requires leadership to move beyond the command-and-control mode of managing, which ultimately maintains the status quo (Gilley *et al.*, 2008).

Innovation needs a range of communication techniques such as communicating clearly to the organisation the risks of clinging to the status quo and the potential rewards of embracing a completely different future (Gilley *et al.*, 2008).

Ability to motivate

Motivating others requires skilled managers who can organise and foster a motivating environment, communicate effectively, address employees' questions, generate creative ideas, prioritise ideas, direct personnel practices, commit employees to action, and provide follow-up to overcome motivational problems (Gilley *et al.*, 2008).

Ability to involve and support others

Employee involvement and support have proven critical to successfully implementing change. Showing confidence in the employees' ability to be successful on the job and valuing contributions also demonstrates support (Gilley *et al.*, 2008).

The ability to connect with employees and offer a high level of support has been positively related to innovation and creativity (Gilley *et al.*, 2008). Therefore, those that can meaningfully participate in the change process are likely to be more committed to its success, as their relevant contributions are integrated into the change plan (Ibid., 2008).

Ability to promote teamwork and collaboration

The two leadership abilities critical for achieving organisational goals are: 1) to effectively manage teams; and 2) to structure workgroups to support collaboration (Gilley *et al.*, 2008).

Significant influence on change and innovation comes from teamwork and collaboration, in the form of work group design. Work groups can be designed so that members who have diverse skills and backgrounds can communicate, and interact in such a way that members are able to constructively challenge each other's ideas (Gilley *et al.*, 2008).

3.1.4.3 Leadership and management in the change process

In order to understand the managerial processes and procedures necessary for health system reform, it is important to distinguish between leadership and management to determine the leader or manager required to enhance organisational change.

Management

> Management is the process of getting things done with and through people to achieve organisational objectives (Brevis & Vrba, 2018; Olden, 2015). Managers believe that to have a successful organisation, things should be kept settled and stable, and that strict control is needed for organisations to function efficiently and effectively (Alkahtani *et al.*, 2011).

> The management process involves planning and budgeting; organising and staffing; controlling and problem-solving, and leading (Lunenburg, 2011). Management requires implementing the vision and direction provided by leaders, coordinating and staffing the organisation, and managing day-to-day problems (Ibid., 2011).

> Irrespective of the manager's title, level, designated role and type of organisation, management is comprised of four functions, namely planning, organising, controlling and leading (Brevis & Vrba, 2018; Lombardi & Schermerhorn, 2007).

Leadership

> Leadership is about coping with change by giving direction, and leaders believe that change is the appropriate means to success (Alkahtani *et al.*, 2011; Pardey, 2007). The leader is concerned with the mission and values (Pardey, 2007).

> Leadership process involves developing a vision for the organisation; aligning people with that vision through communication; and motivating people to action through empowerment and fulfilment of their basic needs (Lunenburg, 2011). This includes establishing clear channels of communication, and the arrangement and coordination of activities, for individuals and groups to implement plans (Brevis &Vrba, 2018; Lombardi & Schermerhorn, 2007). Leadership refers to the ability of managers to guide, influence, and motivate subordinates to contribute willingly toward the effective and successful achievement of organisational goals (Murry, 2010).

Leadership is part of management (Shriberg *et al*., 1997). Leadership and management provide two different, but complementary roles (Pardey, 2007). Murry (2010) views leadership and management holistically, and indicates that leadership and management concepts are comprised of the formal tasks that focus on achieving the specified organisational goals.

Not all managers can bring about or lead change (Alkahtani *et al.*, 2011) and not every manager is an effective leader (Murry, 2010). To lead change, managers should be self-confident in leading the change process (Alkahtani *et al*., 2011). Organisations that remain static lack effective leadership (Pardey, 2007). Purposeful change is driven by vision, goals and a clear sense of direction. Today's dynamic workplace requires leaders that can challenge the status quo, inspire and persuade organisations' members (Ibid., 2007).

3.1.4.4 Skills related to the advancement and effectiveness of leaders

- *Technical skills*, which include knowledge about processes, methods, procedures and techniques for executing an activity (Yukl, 2013).
- *Conceptual skills*, which involve logical thinking, analytical ability, concept formulation proficiency, and conceptualisation of complex and ambiguous relationships (Yukl, 2013).
- *Strong interpersonal skills*, which include the ability to understand the feelings, attitudes and motives of others; knowledge about human behaviour and group processes; and the ability to communicate clearly (Yukl, 2013). Interpersonal skills are essential for influencing people (Schermerhon, Hunt & Osborn, 2008).
- *Emotional intelligence*, which is the ability to recognise and understand one's emotions and those of others (Olden 2015).
- *Social intelligence,* which deals with determining the leadership requirements for a particular situation and selecting an appropriate response (Yukl, 2013). DuBrin (2007) states that leaders who are socially aware, go beyond sensing the emotions of others by showing that they care.

- *Systems thinking*, which is an understanding of how different parts of the organisation are interrelated, when making decisions, as complex problems usually have multiple causes (Olden 2015).
- A*bility to learn*, which involves analysing one's cognitive processes and obtaining ways to improve them (Yukl, 2013). A leader must be *teachable* and have the willingness to grow and learn (Ibid., 2013).

A manager who lacks the skills to be an effective leader will ruin the organisation within a short space of time. Even though effective leadership skills may take time to develop, they should not be overlooked (Murry, 2010).

3.2 A framework for health system governance

In the context of this study, namely to implement health system reform with the aim of improving health system performance, a framework to assess governance of health systems in low-income countries depicted below was considered suitable to address the identified governance gaps (Baez-Camargo & Jacobs, 2011).
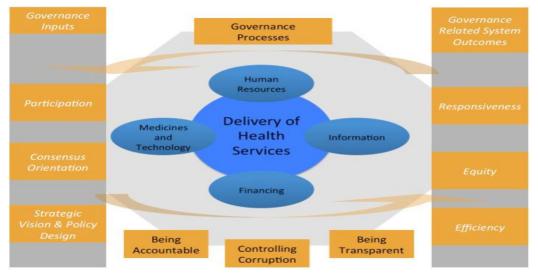
Figure 3.2: A framework to assess governance of health systems in low income countries (**Source**: Baez-Camargo & Jacobs, 2011:10)

Figure 3.2 shows how the governance dimensions (inputs, processes, and outcomes) are categorised against the backdrop of the interlinked World Health Organization's building blocks of the health system (human resources, medicines and technology, financing, information and delivery of health services) (Baez-Camargo & Jacobs, 2011). This framework proposes some important relationships and interactions in the governance of public health service delivery, which are discussed next (Ibid., 2011).

Governance inputs

This refers to how and by whom the institutions and rules governing the health system are constructed. An analysis of governance inputs helps with addressing aspects such as identifying the stakeholders involved in defining and designing health policy (*participation*); assessing the extent to which government and State officials co-operate with, or involve other stakeholders in goal-setting and policy design for public health decisions (*consensus orientation*); and setting up the health system institutions in a conducive manner to achieve health policy goals (*strategic vision and policy design*). Governance inputs cannot be overlooked because the best execution of flawed policies fails to deliver the desired benefits. Therefore, coherent policy design, supported by sound evidence, technical expertise, and co-operation or consultation with relevant stakeholders is essential for effective health system performance.

Governance processes

These are the basic attributes which characterise the implementation of rules and administrative procedures governing the health sector, and refer to the way in which operations and regulations are executed. Governance processes are crucial to the quality of health outcomes produced. The governance processes emphasised in this framework focus on three closely interrelated aspects, namely *accountability*, *transparency* and *control of corruption*. The supposition is that improved accountability fosters transparency and leads to reduced corruption.

Governance outcomes

This denotes the positive qualities that health system outputs should generate, once the rules and processes have been designed and implemented. The governance-associated health system outcomes that are emphasised in this framework are *responsiveness* of

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the health system to the needs of the population; *equitable* access of all the population groups to healthcare services; and *efficiency* in the use of resources. These elements can be used to assess the social desirability of health services, considering that the ultimate goal of health systems is to have a significant positive impact on the wellbeing of the population based on their health needs.

The rationale for adopting this framework is that South Africa's health system requires a governance analysis which considers the socio-political aspects because these elements have a bearing on health system performance. According to Baez-Camargo and Jacobs (2011), it is necessary to understand governance as a multi-dimensional concept, and to consider the linkages and trade-offs among the different dimensions. The focus should not only be on formal governance, but also on the informal institutions and stakeholder networks which affect public governance processes, especially in many low-income countries. Using this approach helped the researcher to analyse and describe the *strategy and policies* necessary to successfully implement health system reform. This was done in relation to the governance gaps identified, namely*:*

- *Governance strategy and policies:* There was a lack of available information on governance measures required for the health system reform. Strategy and policies are articulated in the study.

3.2.1 Principles of governance

Governance denotes an arrangement of different, but interconnected elements, which include policies and a regulatory framework; organisational, financial and programmatic structures; guidelines and institutional rules; resources; administrative rules and norms which enable or hinder performance; priorities; service production and service delivery processes (Siswana, 2007). Good governance refers to a process of public administration that maximises public interest (Keping, 2018). The process involves active and productive co-operation between the State and citizens. The success of good governance lies mainly in the powers participating in political administration (Ibid., 2018).

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The basic principles of governance are consistency, responsibility/responsiveness, accountability, equity, transparency, participation, effectiveness and adherence to the law (Keping, 2018; Toksöz, 2008). These principles constitute good governance (Toksöz, 2008). The principles of good governance are shown in the next diagram.
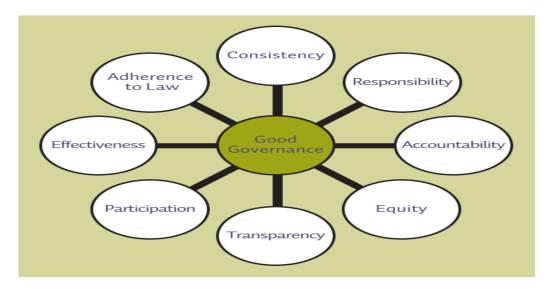
Figure 3.3: Principles of governance (**Source:** Toksöz, 2008:19)

Consistency

Consistency in decision-making ensures that policies and regulations promulgated by the State are predictable and that citizens can realise that their development will improve future investments in a reliable environment (Toksöz, 2008).

Responsibility or responsiveness

Good governance requires that institutions and processes serve all stakeholders within a reasonable timeframe (UNESCAP, 2009). The government is required to have the capacity and flexibility to respond rapidly to changes in society (Toksöz, 2008).

The State is expected to proactively seek advice from citizens, where necessary, explain their policies to them and answer their questions on a regular basis (Keping, 2018). An increased level of responsiveness improves governance (Ibid., 2018).

Accountability

Accountability means holding individuals accountable for their actions (Keping, 2018). Public officials are responsible for resources, budgeting, and reporting of those resources and their expenditures (Toksöz, 2008). The administrators and administrative bodies are expected to perform their roles, and obligations because failure to perform their duties constitutes dereliction of duty or lack of accountability (Keping, 2018). Good governance requires that ethics and the law be applied to enhance the accountability of individuals and institutions (Ibid., 2018).

Equity

The wellbeing of society depends on ensuring that all citizens feel that they are not excluded from the mainstream activities of society (UNESCAP, 2009). This means that all groups, especially the most vulnerable, have opportunities to improve or maintain their wellbeing (Ibid., 2009).

Transparency

All citizens are entitled to State policy information that is related to their own interests, including administrative budgets, public expenditures, legislative activities, legal provisions, policymaking, policy enforcement and other relevant political information (Keping, 2018).

Transparency requires that political information be properly communicated to citizens through various media platforms to enable the people to participate in public policymaking and supervise the process of public administration in an effective manner (Keping, 2018).

Transparency and openness in government procurement, subsidies, interventions and fiscal policies provide the public with information which may lead to successful political and economic reforms (North, Acemoglu, Fukuyama & Rodrik, 2008). Increased transparency improves the level of good governance (Keping, 2018).

Participation

The preparation, implementation and monitoring stages of the decision-making process should actively include the participation of civil society organisations and individuals (Toksöz, 2008). Individuals could participate directly, through legitimate representatives or through intermediate organisations (UNESCAP, 2009).

Participation needs to be informed and organised (UNESCAP, 2009). When public decisions are taken in an inclusive manner involving the affected stakeholders, the possibility of implementing the decisions increases (Toksöz, 2008).

Effectiveness

Effectiveness mainly refers to efficiency in management (Keping, 2018). When decisions are taken by government, there should be a reasonable correlation between the results to be achieved, the resources to be used and their impact (Toksöz, 2008). Good governance improves when administration is effective (Keping, 2018). Good governance means that processes and institutions produce the results that meet society's needs, using the available resources (UNESCAP, 2009).

Adherence to law or rule of law

The rule of law means that the law in public political administration is the supreme principle and should be observed by all government officials and citizens because everyone is equal before the law (Keping, 2018). The government is required to take decisions based on objective information within the rule of law and ensure that those pronouncements are supervised through legal channels (Toksöz, 2008). The rule of law is intended to regulate citizens' behaviour and maintain order in society (Keping, 2018). The goal is to protect human rights, particularly of the minority, including freedom and equality (Keping, 2018; UNESCAP, 2009).

3.2.2 Approaches to health system governance

The questions that policymakers continue to struggle with are, "What constitutes health governance and how should it be improved?" and, "How does it contribute to better health systems?" (Brinkerhoff & Bossert, 2013; Savedoff, 2011). Health system governance remains a complicated topic to define, assess and operationalise (Baez-Camargo & Jacobs, 2011; Barbazza & Tello, 2014). Therefore, new approaches are required to ensure a better understanding of the complex interplay between the various determinants of health, specifically the role of socioeconomic factors, and ways in which resources and influences are distributed across society (World Organization, 2011).

A key premise is that multiple determinants must be addressed using cross-societal and joint government approaches which involve multiple sectors and stakeholders (World Organization, 2011). Governments are urged to pursue inclusiveness by leveraging the information, ideas and resources held by all stakeholders, including citizens, civil society organisations and the private sector (Organisation for Economic Co-operation and Development, 2018). Although governance arrangements for public health differ between countries, broad governance principles, such as accountability and transparency, remain constant (World Health Organization, 2011).

According to the World Health Organization (2011), a framework for action requires several conditions, namely:

- Population health must be explicitly recognised as a key governance role of national government.
- National government must support the leading role of the Minister of Health, while promoting multi-sectoral collaboration.
- Health policy priorities and strategies should be revised based on an assessment of current health needs and inequalities in health, and inequitable access to preventive services should be reduced.
- Consistency in strategy and direction across different levels of organisation should be secured using systems for monitoring performance, and ensuring accountability.

- National and subnational governments should ensure that adequate resources are targeted to deliver essential public health services.

South Africa (2003) indicates that "public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles", which include:

- *Professional ethics* – a high standard of ethics must be promoted and maintained.
- *Resources* – efficient, economic and effective use of resources must be promoted.
- *Public administration* – must be development-oriented, accountable and broadly represent the South African people.
- *Services* – must be provided impartially, fairly, equitably and without bias.
- *People's needs* – must be responded to, and the public must be encouraged to participate in policymaking.
- *Transparency* – must be fostered by providing the public with timely, accessible and accurate information.
- *Maximise human potential* – good human resource management and career development practices must be cultivated.

The Companies Act 71 of 2008, Section 7b(iii), encourages transparency and high standards of corporate governance as appropriate, given the significant role of enterprises within the social and economic life of the nation (South Africa, 2011). Governance requires leaders to seek consensus in their activities, negotiate, and be transparent and responsive to the needs of society (Sindane, 2011). Accountability must not be compromised; environments that allow for transgressions must be minimised and discouraged. Appropriate sanctions must be imposed where ethical violations occur (Ibid., 2011).

The South African Lancet National Commission (2019) made the following recommendations *to enhance leadership and governance* for quality and equity:

1. For prevention of fraud and corruption:
   - Ethical and effective leadership should be inculcated based on the values of integrity, fairness, transparency, competence, responsibility and accountability.

- The regulators of healthcare professions must reiterate ethical codes and enforce ethical and professional behaviour of those under their jurisdiction.
- Both public and private healthcare authorities must communicate a message of no tolerance to fraud and corruption in the healthcare sector.
- Alleged transgressions should be timeously investigated and swift action must be taken against offenders.
- The NDoH must draw on the expertise of the National Prosecuting Authority, the Public Service Commission and civil society organisations for prevention, detection and disciplinary action, and possible prosecution of wrongdoers.
- The NDoH must also be provided with copies of the provincial health departments' prevention of fraud and corruption plans, which is a legislative requirement. The implementation plans must be monitored at the National Health Council.
- In addition, the NDoH should request provincial treasuries to monitor the implementation of plans on the prevention of fraud and corruption in health departments.
- Employers must ensure that employees have access to contact numbers to report fraud and/or corruption.

2. Embarking on national campaigns to educate patients and communities about their health rights and responsibilities (South African Lancet National Commission, 2019):

- The NDoH should lead national campaigns to increase public awareness regarding quality of care issues.
- NDoH should design campaigns with inputs, including partnerships with the Government Communication and Information Services, the Presidency, South African Human Rights Commission, Office of the Health Standards and Compliance (OHSC), and civil society organisations.
- The campaigns must include information on the importance of disease prevention, health promotion and protection, health outcomes, health system performance (including OHSC inspection reports) and mechanisms for correction and redress at different levels of the health system.

- The communication media should include mobile phones, radio, social media, print and television, and the utilisation of existing forums where the campaigns can reach large numbers of people (such as shopping centres, pension pay-outs, places of worship, and schools).

A well-governed health system should have clear goals which explain the degree of stakeholder participation, considering those from disadvantaged groups or those who are less influential (Mikkelsen-Lopez, Wyss & de Savigny, 2011). In addition, the policymaking process must be transparent, promote accountability and reduce the risk of corruption (Mikkelsen-Lopez *et al.*, 2011; United States Agency for International Development, 2008).

3.3 Donabedian model of quality in health service delivery

In a health system, the provision of quality healthcare service delivery is crucial. The Donabedian model recognises the existence of three essential factors in assessing the quality of healthcare, namely *structure* (resources and administration), *process* (culture and professional co-operation) and *outcome* (competence development and goal achievement) (Voyce, Gouveia, Medinas, Santos & Ferreira, 2015; Kunkel, Rosenqvist & Westerling, 2007).

Structure

The Donabedian model indicates that the *structure* refers to the places where medical care takes place, including the features of the system, the patients and the service provider (Voyce *et al.*, 2015). According to Donabedian, structure refers to the professional and organisational resources associated with the provision of healthcare such as availability of medicines and equipment, and staff training (Ameh *et al.*, 2017). However, the structural capacity depends on elements such as fiscal resources, human resources, and information (Handler *et al.*, 2001).

Process

Refers to the set of activities that take place between professionals, and between professionals and patients, including technical and interpersonal aspects (Voyce *et al.*,

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2015). Process also implies the things that are done to and for the patients, which help in identifying, prioritising and addressing health problems, and resources and outputs (Ameh *et al.*, 2017; Handler *et al.*, 2001).

Outcome

Refers to the consequences for the health and wellbeing of individuals and society, and includes clinical outcomes, quality of life, and satisfaction with the healthcare provided (Voyce *et al.*, 2015). An outcome reflects on the results of the healthcare provided and has an impact on individuals, families, communities and providers (Ameh *et al.*, 2017; Handler *et al.*, 2001).

There are two types of outcomes: i) technical outcomes, which refer to the physical and functional aspects of care, such as absence of complications and reduction in disease, disability and death; and ii) interpersonal outcomes, which include the patient's satisfaction with care, and the influence of care on the patient's quality of life as perceived by the patient (Ameh *et al.*, 2017; Donabedian, 1997).

According to the Donabedian model, the effect on the population over time is related to the interaction of the structural capacity and processes, and the macro environment (Donabedian, 1997; Handler *et al.*, 2001). The possibility of a causal relationship between structure, process and outcome, and how they influence each other should be considered in assessing quality of healthcare (Voyce *et al.*, 2015). The Donabedian model has proved to be valuable in examining the clinical processes and outcomes of healthcare (Carayon, Schoofs Hundt, Karsh, Gurses, Alvarado, Smith & Flatley Brennan, 2006). However, this model is limited in recognising the interactions and interdependencies among system components (Carayon *et al.*, 2006). Voyce *et al.* (2015), Rosenqvist and Westerling (2007) propose a model where outcome depends on both the structure and the process factors. At the same time, the model indicates that there is a direct and causal link between structure and outcome, with no involvement of process.
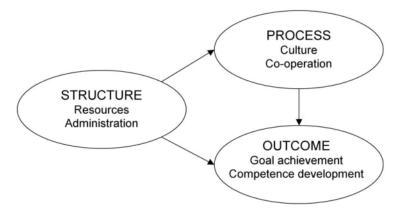
Figure 3.4: Donabedian model of quality in health service delivery (**Source:** Kunkel *et al.*, 2007:2; Voyce *et al.*, 2015:4).

Kunkel *et al.* (2007) conclude that the structure (resources and administration) may be improved by implementing guidelines for quality improvement. Process (culture and co-operation) may be enhanced by rewarding exemplary performance while refraining from using punitive measures when mistakes are reported. Outcome (evaluation of goal achievement and development of competence) may benefit from rapid feedback on which measures are effective and which are not.

Based on the analyses provided, the three factors, namely structure, process and outcome are essential for assessing quality of care, irrespective of the nature of the relationships among the factors. Quality of service delivery concepts are, therefore, analysed and described with a focus on the structure, process and outcome measures within a health system. *Service delivery knowledge gaps in this study were:*

- *Structure measures:* There was no clear guideline on the context-specific inputs required for the planned health system reform.
- *Process measures:* The way the process would be measured was not articulated clearly.
- *Outcomes measures:* There was no specific tool to determine how service delivery would be measured, in relation to health system reform.

3.3.1 Improving service delivery

Improving service delivery is an important goal of the public service transformation programme and calls for a shift away from inward-looking, bureaucratic systems, processes and attitudes, supporting a search for new ways of working which prioritise the public needs, and are better, faster and more responsive to citizens' needs (Department of Public Service and Administration, 1997). It also means a complete change in the way services are delivered (Ibid., 1997).

Public sector organisations are under increasing pressure to deliver an increasingly broad and complex range of services in a manner that is timely, efficient, economical, equitable, transparent and corruption-free (PricewaterhouseCoopers, 2007). Improving service delivery is a continuous, progressive process because, as standards are raised, the targets must also be set higher (Department of Public Service and Administration, 1997).

To ensure that service delivery is constantly improved, national and provincial departments are required to outline their specific short, medium and long-term goals for service provision (PricewaterhouseCoopers, 2007). They are also required to provide annual and five-yearly targets for the delivery of specific services, and report to their respective national and provincial legislatures on their achievements (Ibid., 2007).

Improving the effectiveness of service delivery is typically a highly complex responsibility which involves many transactions between service providers and customers (United Nations Development Programme, 2016). In South Africa, the White Paper on the Transformation of the Public Service (WPTPS) sets out transformation priorities, among which transforming service delivery is the key (Department of Public Service and Administration, 1997). The basis of the publication is that the transformed South African public service will be judged by its effectiveness in delivering services which meet the basic needs of all South African citizens (Ibid., 1997).

In line with constitutional principles, national and provincial departments are required to make service delivery a priority (Department of Public Service and Administration, 1997). A framework has also been provided to enable national and provincial departments to develop

departmental service delivery strategies to promote continuous improvements in the quantity, quality and equity of service provision (Ibid., 1997).

According to the Department of Public Service and Administration (1997), national and provincial departments are required to identify, among others:

- *A mission statement for service delivery*, together with service guarantees indicating the services being provided, target groups, and user fees; the principle of affordability; and the principle of redirecting resources to areas and groups previously under-resourced
- *Service standards, defined outputs and targets, and performance indicators*, benchmarked against comparable international standards; monitoring and evaluation mechanisms; and structures, designed to measure progress and introduce corrective action, where required
- *Plans for staffing, human resource development and organisational capacity-building*, specifically to service delivery needs
- *The redirection of human and other resources* from administrative tasks to service provision, mainly for disadvantaged populations and areas; financial plans linking budgets directly to service needs and personnel plans
- *Potential partnerships* with the private sector, non-governmental organisations and community-based organisations, which will provide more effective forms of service delivery
- *The development, particularly through training, of a customer care culture and approaches* to service delivery that are sensitive to issues of disability, gender and race.

Government process re-engineering is often needed to put in place improved, value-for-money processes that will reduce waste and duplication, producing an effective 'customer journey' (PricewaterhouseCoopers, 2007). "The importance of deploying a modern client-centric approach in public services is generally well accepted in the public sector and has become a goal" (PricewaterhouseCoopers, 2007:1). The challenges today reside in how you achieve that across all departments. It is also a continuous change process (Ibid., 2007).

According to PricewaterhouseCoopers (2007), the key pillars for building capacity to deliver customer-centric public services include strategy (policy making); organisational and political leadership; organisational and process design focusing on 'customer centricity' and 'connected government'; technology, which is an enabler of transformation; people and culture, with the aim of building internal capacity for transformation, talent management, training to respond to changing customer needs, and incentivising performance.

Service delivery monitoring is crucial and has a direct bearing on the management of healthcare services, which distinguishes this area from other health systems building blocks (World Health Organization, 2010). Shortage of medicines, uneven distribution of healthcare services, and the poor availability of equipment or guidelines must all be considered part of basic service management (Ibid., 2010).

According to PricewaterhouseCoopers (2007), improvements in customer experience and outcomes should focus on the *speed* to deliver the service correctly the first time; *responsiveness* to the customer needs; *integrated* service delivery models of care; the *choice*, which allows for multiple channels for service delivery, at different times; and cost-effective service delivery mechanisms and value-driven customer outcomes.

Citizen engagement initiatives, such as community development committees, citizen satisfaction surveys, public consultations, participatory planning, budget consultations and social audits, are encouraged (United Nations Development Programme, 2016). With these types of initiatives, citizens seek solutions to specific problems in the public sector by constructively engaging with public officials and political leadership (Ibid., 2016).

3.3.2 Service delivery reorientation

Public services in a civilised and democratic society are a legitimate expectation and not a privilege (Department of Public Service and Administration, 1997). The South African Constitution, through the Bill of Rights, gives citizens certain rights to act against the State, if they believe their constitutional rights have been infringed (Ibid., 1997).

Global trends such as rising customer expectations, budgetary constraints, global competition for investment, reform programmes and changing demographics have transformed the environment in which the public sector operates (PricewaterhouseCoopers, 2007). These changing expectations of customers require the public sector to redefine its role, strengthen customer focus and build integrated service delivery models (Ibid., 2007).

This means that government institutions must be reoriented to optimise citizens' access to the needed services within the context of fiscal constraints and the fulfilment of competing needs, considering that the objectives of service delivery include welfare, equity and efficiency (Department of Public Service and Administration, 1997).

The change models to realise the desired benefits must be based on meeting customer needs more efficiently and more effectively (Department of Public Service and Administration, 1997). Meaning that keeping the customers' needs must be at the core of every decision, from strategy formulation and design through to execution (Ibid., 2007).

"The President of the Republic of South Africa, Mr Matamela Cyril Ramaphosa conceived of the Presidential Health Compact, following a series of events highlighting the need to make a substantial intervention to improve the quality of healthcare" (South African Government, 2019:19). Nine areas (pillars) were identified as requiring intervention to prevent collapse of the country's health system, namely:

Human resources for health

> Critical interventions related to human resources for health are needed with a focus on human resources policy; governance, leadership and management; education, training, and development; and working with partners to ensure health workforce wellbeing and advocacy (South African Government, 2019). The plan proposes intervening through the design of the human resource development and management road map that includes forecasting, production, posting, retention, and continuous training and management improvement (Ibid., 2019).

Improving access to essential medicines, vaccines and medical products

South African Government (2019) proposed three interventions to improve the management of supply chain equipment and machinery:

1) Establish a centralised procurement system with a decentralised ordering and purchasing system

2) Develop a national policy on capital equipment purchasing

3) Ensure that skilled persons are involved in the development of specifications for tenders.

Execution of the infrastructure plan

The current infrastructure construction has either failed to meet the standards, or even costs far more than it should (South African Government, 2019). Maintenance of existing infrastructure, as well as new capital (whether upgrades or new sites), is not prioritised (Ibid., 2019).

The 10-year Health Infrastructure Plan was developed, but was never adopted by the National Health Council, nor shared with the private sector (South African Government, 2019). Therefore, execution of the infrastructure plan is needed to ensure that the health facilities are appropriately distributed and well maintained (Ibid., 2019).

Engaging the private sector in improving access, coverage, and quality of health services

The World Bank indicated in 2015 that the ratio of doctors to the general population in South Africa was 0,78 per 1 000 (South African Government, 2019). This figure is lower than the standard for a middle-income country. The international average is 1,5 per 1 000 (Ibid., 2019).

There are several engagement mechanisms between the public and private sector, but there are no formalised and legitimate structures between the two sectors (South African Government, 2019). To address the public sector crisis, a credible engagement

structure will be established between these sectors to provide a platform for raising concerns, contribution and collaboration (Ibid., 2019).

Improving the quality, safety and quantity of health services

South Africa needs to adopt the World Health Organization's Integrated People-Centred Health Services (IPCHS) framework (South African Government, 2019). The framework has two distinct components (Ibid., 2019):

1) People-centredness, which puts people and communities at the centre of a health system and empowers them to take responsibility for their health

2) Integrated health services (promotive, preventive, curative, rehabilitative and palliative services) that are organised, managed and delivered to ensure a continuum of care at various levels and sites within the health system.

Improving the efficiency of public sector financial management systems and processes

This is required to address capacity constraints and revenue-generation mechanisms that exist in the public sector; deal with fraud and corruption; and improve governance within institutions (South African Government, 2019).

Strengthen accountability mechanisms at national, provincial and institutional level within the current constitutional framework

The three levels of government, namely national, provincial with nine provinces, and municipal with 278 municipalities, are semi-autonomous and have different structures and capacities (South African Government, 2019). These arrangements make the standardised implementation of national health policies, norms and standards, and strategies difficult (Ibid., 2019).

The organisational structure of the NDoH should be reviewed to ensure a harmonised reporting system from the national to the provincial level (South African Government, 2019). The policies and processes should also be revised to ensure that competent and skilled incumbents are recruited in the health system (Ibid., 2019).

Engaging and empowering the community

Communities and populations are usually not consulted in the organisation of health services, concerning their needs and expectations from the health systems (South African Government, 2019). A patient charter and feedback system exists, but is not working optimally. There are challenges with the referral and outreach services, including poor road infrastructure and a shortage of fleets, which impact on the health and safety of communities (Ibid., 2019).

Focused community engagement and empowerment are needed to promote participation, and empower communities regarding issues that matter to them (South African Government, 2019). This pillar is important to ensure adequate and appropriate community-based care (Ibid., 2019).

Developing an information system that will guide the health system policies, strategies and investments

The current health information systems within the public and private health sectors, and between these sectors, are fragmented (South African Government, 2019).

Digital technologies provide concrete opportunities to tackle health system challenges and offer the potential to improve coverage, and quality of health practices and services (South African Government, 2019). The development and implementation of an integrated health information system is needed to focus on both the management of the system, and the efficiency, and efficacy gains and quality of the health system (Ibid., 2019).

3.4 Stakeholder theory

Stakeholder theory is about creating value and managing a business effectively, and is concerned with the relationship between the organisations and their stakeholders (Freeman *et al*., 2010; Fernando & Lawrence, 2014). "Stakeholder theory attempts to reframe managerial capitalism by replacing the belief that managers have a singular duty to shareholders with the notion that managers should create and sustain moral relationships, and fairly distribute the

harms and benefits of corporate activities among those who can affect or are affected by the corporation" (Dawkins, 2014:284).

Stakeholder theory states that individuals are entitled to participate in matters of the corporation that affect them (Dawkins, 2014). The corporation is an entity that exercises broad discretionary powers, and the organisation's accountability to affected parties cannot be completely fulfilled outside engagement that bears on distributive outcomes. Therefore, corporate leaders are morally obliged to address the interests of their stakeholders, and direct resources and activities to benefit the stakeholders (Ibid., 2014).

Freeman (2004), Donaldson and Preston (1995) argue that categories of stakeholder theories are descriptive, instrumental or normative:

- Descriptive theory simply illustrates that firms have stakeholders.
- Instrumental theory shows that firms with successful strategies consider their stakeholders.
- Normative theory describes why firms should consider their stakeholders.

Organisations need to consider stakeholders in their strategies; make decisions that protect and benefit all stakeholders as part of corporate governance; and understand "who and what really counts", using qualitative criteria of *power, legitimacy* and *urgency* in their corporate social responsibilities (Freeman, 2004). In this study, it is argued that there is a need to identify, engage and manage various stakeholders. *Stakeholder knowledge gaps* were:

- *Types and roles:* The types of stakeholders and their roles in implementing health system reform were limited in the literature, especially in the context of a developing country.
- *Interests and powers:* In practice and in theory, the interests and powers of stakeholders in the context of a developing country were inadequate.
- *Needs and viewpoints:* The literature and practice did not provide clarity on the needs and viewpoints of the stakeholders necessary for the reform.

The integrative stakeholder theory, which is comprised of descriptive, instrumental and normative aspects of stakeholder theories (Hörisch *et al.*, 2014), helped in *stakeholder identification, determining stakeholder legitimacy, roles* and *management.* This was done

taking into consideration the stakeholder knowledge gaps that were identified, namely the *types and roles*; *interests and powers*; and *needs and viewpoints*. Stakeholder identification, attributes, typologies and management are discussed next.

3.4.1 Stakeholder identification

A stakeholder is any individual, group or entity that may affect, or is affected by the organisation's activities and objectives (Freeman, 1984; Venter, 2018). Society is composed of numerous diverse, autonomous and semi-autonomous groups that might cause one to question whether people can realistically speak of a society in a definitive sense of having any generally agreed-upon meaning (Buchholtz & Carroll, 2012). Stakeholders are not equal and, therefore, the organisation is required to balance their different needs and claims (Venter, 2018). The next diagram shows various stakeholders that may affect and be affected by an organisation.
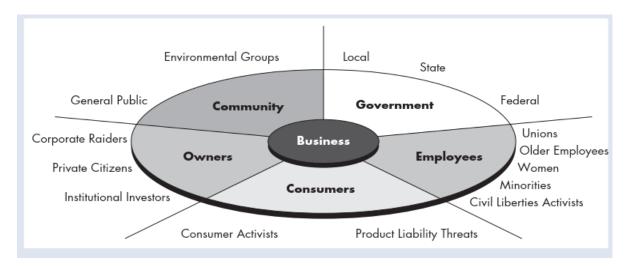
Figure 3.5: Business and selected stakeholder relationships (**Source:** Buchholtz & Carroll, 2012:10)

Figure 3.5 shows the interface between business and some of the multiple societies, systems, or stakeholders with which business interacts (Buchholtz & Carroll, 2012). If the total number of relationships is an indicator of complexity, the argument may be easily made that the firm's current relationships with different segments of society constitute a truly complex social environment (Ibid., 2012).

There are generally two broad groups of stakeholders, namely internal and external (Buchholtz & Carroll, 2012). Employees and business owners are considered internal stakeholders. External stakeholders include the government, consumers, the natural environment and community members (Ibid., 2012).

The government is important, as the State represents the public (Buchholtz & Carroll, 2012). It is crucial to understand the role and workings of government to best appreciate the business's relationships with other groups (Ibid., 2012).

Consumers may be the business's most important stakeholders (Buchholtz & Carroll, 2012). Members of the community are also crucial and may be concerned about a variety of issues. The natural environment is also important. All these issues have a direct effect on the public (Ibid., 2012).

Both the internal and external stakeholders have legitimate legal and moral claims on the organisation (Buchholtz & Carroll, 2012). Therefore, management's task is to address the stakeholder needs, and balance these needs against those of the firm and other stakeholder groups (Ibid., 2012). Board members need to consider individuals or groups that are beyond the legal owners (shareholders in for-profit or members in non-profit entities) because stakeholders are also entitled to some rights and interests, as they are important to the existence of any organisation (Ferkins & Shilbury, 2015).

Considering the large number of policy actors interested in the health system reform of UHC, it is necessary to identify and prioritise stakeholders (Gilson, Erasmus, Borghi, Macha, Kamuzora & Mtei, 2012). The approach that may be considered is to initially identify influential stakeholders, considering the in-depth knowledge of a particular context, including interactions with some policy actors (Gilson *et al*., 2012).

It is also necessary to consider stakeholders that are less visible or powerful, but still able to influence the views of others (Gilson *et al*., 2012). Stakeholders who may be affected by the issue, without having an obvious or vested interest in the matter, should also not be ignored. It will also be important to identify and track new actors that emerge as influential players (Ibid., 2012).

3.4.2 Stakeholder attributes

The three attributes of stakeholders central to determining stakeholder salience are *legitimacy, power* and *urgency* (Ferkins & Shilbury, 2015). These attributes are matched with a type of stakeholder who might be considered as latent, expectant and definitive. Each type of stakeholder possesses a combination of power, legitimacy and/or urgency (Ibid., 2015).

Power

Stakeholder power refers to the stakeholder's ability to affect the implementation of the health reform policy (Schmeer, 1999). According to Buchholtz and Carroll, (2012); Venter (2018), stakeholder power denotes the degree to which stakeholders have the ability to control the resources required by the organisation, and the capacity to produce an effect. Employees and unions have direct control over the organisation's human resources.

Irrespective of stakeholder power, all stakeholders have the right to be treated fairly by organisations (Fernando & Lawrence, 2014). Stakeholder analysis (SHA) may be conducted retrospectively to understand how the position of policy actors and their relative power influenced the process of policy change (Gilson *et al*., 2012; Varvasovszky & Brugha, 2000). SHA can also be done prospectively to generate knowledge that helps to inform the process of policy change. (Gilson *et al.*, 2012).

Legitimacy

Legitimacy refers to the extent to which stakeholders are affected by the decisions of the organisation (Venter, 2018). Legitimacy denotes the perceived validity or appropriateness of the stakeholder's claim to a stake (Buchholtz & Carroll, 2012). Business owners, employees and customers have a high degree of legitimacy with the organisation, due to the explicit, formal and direct relationships between these stakeholders and the organisation (Buchholtz & Carroll, 2012).

Urgency

"Urgency is determined by the time sensitivity of the stakeholder's claim" (Venter, 2018:55). It refers to the degree to which the stakeholder's claim on the business calls for the business's immediate response (Buchholtz & Carroll, 2012).

3.4.3 Typologies of stakeholders

Once the attributes of stakeholders have been identified, the organisation must identify and understand the stakeholders' threats and opportunities (Buchholtz & Carroll, 2012). Based on the attributes (power, legitimacy and urgency), a stakeholder may be classified as a *supportive stakeholder; a marginal stakeholder; a non-supportive stakeholder;* or *a mixed-blessing stakeholder* (Buchholtz & Carroll, 2012; Savage, Nix, Whitehead & Blair, 1991). The next diagram shows how stakeholders may be classified.
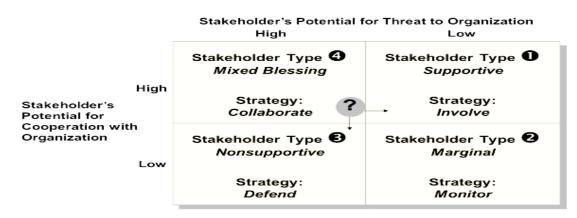
Figure 3.6: Diagnostic typology of organisational stakeholders (**Source:** Savage *et al.*, 1991:65)

Type 1 – supportive stakeholder

The supportive stakeholder supports the organisation's goals and actions (Buchholtz & Carroll, 2012). This type of stakeholder is high on potential for co-operation and low on potential for threat (Ibid., 2012). Generally, in well-managed organisations, these stakeholders may include parent organisations, boards of trustees, employees, loyal customers, service providers, suppliers and not-for-profit organisations (Buchholtz &

Carroll, 2012; Savage *et al.*, 1991). The strategy to manage these stakeholders is to maximally involve and encourage co-operation (Ibid., 2012; Ibid., 1991).

Type 2 – marginal stakeholder

The stakeholder is low on both the potential for threat and co-operation (Buchholtz & Carroll, 2012). These stakeholders are generally not concerned about the firm's issues (Savage *et al.*, 1991). For medium or large-sized organisations, the marginal stakeholder might include employees' professional associations and consumer interest groups (Buchholtz & Carroll, 2012; Savage *et al.*, 1991).

Management of these stakeholders requires careful monitoring to prevent problems (Buchholtz & Carroll, 2012). Managers can only involve these stakeholders in issues affecting them (Savage *et al.*, 1991).

Type 3 – non-supportive stakeholder

The non-supportive stakeholder is high on potential for threat, but low on potential for co-operation (Buchholtz & Carroll, 2012). These stakeholders can be very distressing to management and the organisation (Savage *et al.*, 1991). Examples of these stakeholders may include competing organisations, unions and government levels (national, provincial and local), and sometimes, the media (Buchholtz & Carroll, 2012; Savage *et al.*, 1991).

The strategy recommended in this instance is to defend the organisation (defensive strategy) against the non-supportive stakeholder (Buchholtz & Carroll, 2012; Savage *et al.*, 1991).

Type 4 – mixed-blessing stakeholder

The stakeholder is high on both potential for co-operation and threat (Buchholtz & Carroll, 2012). Examples may include employees who are in short supply, customers, or organisations providing complementary products or services (Buchholtz & Carroll, 2012; Savage *et al.*, 1991). Maximising collaboration with these stakeholders is recommended for the stakeholders to remain supportive (Buchholtz & Carroll, 2012). A variety of joint ventures and mergers may be considered (Savage *et al.*, 1991).

Responses of stakeholders to policy proposals are varied and complex because different dimensions of the same policy may have a contrary impact on stakeholders (Gilson *et al.*, 2012). In South Africa, the ANC-aligned trade unions are likely to support a reform that collects revenue through a public sector authority and pools this revenue in a central NHI Fund administered by a government-controlled body (Ibid., 2012).

Once the organisation has established the threats and opportunities, responsibilities for managing stakeholders must be identified (Buchholtz & Carroll, 2012). The organisation's responsibilities might be in terms of corporate social responsibility. The responsibilities could also be economic, legal, ethical and philanthropic. Managers may use the matrix below to determine the stakeholders and responsibilities towards them (Ibid., 2012).

Stakeholders	Economic	Legal	Ethical	Philanthropic
Owners				
Customers				
Employees				
Community				
Public at large				
Social Activists				
Other				

Figure 3.7: Stakeholder responsibility matrix (**Source:** Buchholtz & Carroll, 2012:78)

The matrix in Figure 3.7 can be used by managers to systematically analyse and determine the various organisational responsibilities towards stakeholders (Buchholtz & Carroll, 2012).

3.4.4 Stakeholder management

Once the organisation has determined the responsibilities towards stakeholders, strategies and actions must be developed to deal with stakeholders (Buchholtz & Carroll, 2012). Demands must be prioritised before an appropriate strategy is employed (Ibid., 2012).

Careful and thorough strategic thinking in the form of communication, degree of collaboration, development of policies and programmes, and resource allocation are important (Buchholtz & Carroll, 2012). Strategy development should be based on a classification of stakeholders' "potentials for co-operation and threat" (Ibid., 2012).

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Stakeholder management strategies should target stakeholders that are willing to initiate or lead an action for a new health policy, or those that may act, or convince others to oppose health reforms (Gilson *et al.*, 2012). Clarkson (1999) proposes seven principles of stakeholder management, namely:

1. *Acknowledge* and *actively monitor* the concerns of all the legitimate stakeholders, and take their interests into consideration when making decisions.

2. *Listen* and *communicate openly* with stakeholders about their concerns and contributions. Communication should also include the risks the stakeholders assume when they get involved with the organisation.

3. *Adopt processes* and *behaviours* that are sensitive to the concerns of stakeholders.

4. *Recognise the interdependence* of efforts and rewards among stakeholders, and attempt to achieve a fair distribution of the benefits and burdens of corporate activity among them, considering their risks and vulnerabilities.

5. *Work co-operatively* with other entities to ensure that risks and harms are minimised, and avoided, where possible.

6. *Avoid activities* that might *endanger* human life, or give rise to risks.

7. *Acknowledge the potential conflicts* between their role as stakeholders, and their legal and moral responsibilities towards stakeholder interests. Conflicts should be addressed through open communication, appropriate reporting, an incentive system and third-party review, where necessary.

The seven principles of stakeholder management are helpful in guiding managers towards more effective stakeholder thinking (Buchholtz & Carroll, 2012). Stakeholder management can still be complex and time-consuming. Successful steps in stakeholder management include making stakeholders part of the guiding philosophy, creating value statements, and developing measurement systems to monitor results (Ibid., 2012).

3.4.5 Substantive engagement in stakeholder theory

The purpose of the firm is to produce value for all stakeholders, and to make the case that good strategy essentially entails moral and ethical concerns (Dawkins, 2014). Stakeholder engagement is expected to provide stakeholders with mechanisms that impact outcomes, rather than simply making normative appeals for managers to protect their interests (Ibid., 2014).

In keeping with the pluralist perspective, the involved parties should rather engage directly and represent their interests within a framework of rules that restrict opportunism, and the processes of stakeholder engagement should be arranged to reduce the impact of power asymmetries (Dawkins, 2014).

Merryl (1994) proposes that in healthcare reforms, the process through which major policy decisions are made should be participatory, involving all the stakeholders in the deliberations. A nation must clearly define its needed healthcare benefits and determine how to fund those needs. Empowered members of society are knowledgeable and committed, and engage in constructive participation in the affairs of the public or an institution (Sindane, 2011).

According to Dawkins (2014), substantive stakeholder engagement is needed, and the process includes an inclusive and participative forum of interaction, such that neither party is dependent solely on the benevolence of the other; reduced power asymmetries, such that either side can prevail in a dispute; and has the capacity to impact distributive outcomes.

There is also a growing recognition that effective regulatory structures require partnerships between the State and other stakeholders, and that the formulation of evidence-based national health policy necessitates the wide participation of stakeholders, which provides long-term strategic vision (Sidiqqi *et al*., 2008). On the other hand, policymakers often encounter challenges in engaging different stakeholders in coherent, multi-dimensional public-governance reforms to solve complex, crosscutting policy challenges because stakeholders have heterogeneous preferences (Long *et al*., 2019; Organisation for Economic Co-operation and Development, 2018).

Therefore, a clear, crosscutting, government-wide guiding policy should exist on stakeholder engagements because including key stakeholders in the development of policy and strategy allows a comprehensive range of factors that promote good-quality health services to be addressed (Organisation for Economic Co-operation and Development, 2018; World Health Organization, 2018). Engaging stakeholders constitutes a key factor to avoiding policy capture during the policymaking process (Organisation for Economic Co-operation and Development, 2018).

3.5 Conceptual Framework for Implementing Health System Reform

A conceptual framework is defined as a network of interlinked concepts that serves as a blueprint to understand a specific phenomenon that can be modified over time when new knowledge becomes available (Jabareen, 2009).

A conceptual framework provides a visual picture of the study, resulting from a thorough literature review presented in a graphical form or schematic diagram showing the key concepts and their relationships (Jabareen, 2009; Marshall & Rossman, 2006; van der Waldt, 2020). This is to provide a comprehensive understanding of the phenomena (Jabareen, 2009). A conceptual framework is essentially required to identify key concepts, conceptualise the concepts, and indicate their interrelatedness (van der Waldt, 2020).

This subsection discusses how elements of theories (leadership and governance; service delivery; and stakeholders), covered in the preceding sections, have been contextualised for the purpose of this study.
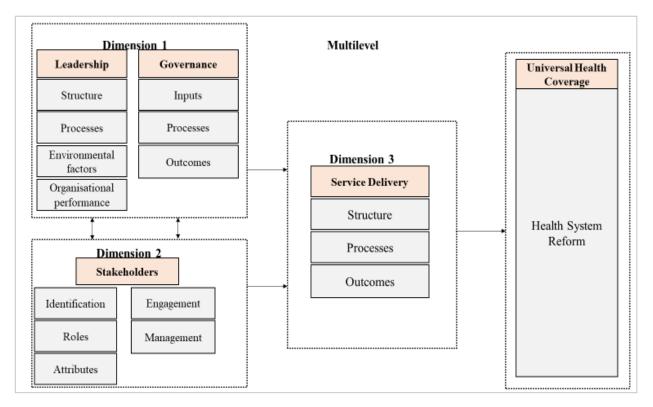
Figure 3.8: Conceptual framework for implementing health system reform

In this conceptual framework (Figure 3.8), there are three levels of the health system (multi-level), that is, *macro*, *meso* and *micro* levels. There are three dimensions, namely *leadership and governance*; *stakeholders* (stakeholders include Department of Health, healthcare facilities, regulators, medical schemes, funder association, and trade unions within the health system); and *service delivery*. The conceptual research framework is in line with the research arguments and served as a lens for the study in the following ways:

- This research framework shows how dimensions of leadership and governance, and the stakeholder dimension influence and effect service delivery as the other dimension.
- In this study, leadership has been looked at, considering the *organisational structures, processes, environmental factors,* and *organisational performance* concepts.
- In terms of governance, concepts relevant to this study are the *inputs* (participation, consensus orientation, strategies, and policies*); processes* (accountability,

transparency, and control of corruption); and *outcomes* (responsiveness, equitable access, and efficiency) in the context of health system reform.

- Service delivery, which reflects the health system outputs, was looked at, considering the *structure* (resources and administration); *processes* (culture and professional cooperation); and *outcomes* (satisfaction with services, that is, affordable, accessible and acceptable to the population).

- *Identification*, and *roles* of stakeholders; *stakeholder attributes* (legitimacy, power, and urgency); *engagement,* and *management* are important in the context of this study.

- In this study, health system reform is seen as the realisation of UHC through NHI coverage and access to all. When the policy of the NHI is implemented and service delivery has been effected, the result will be health system reform of UHC, characterised by *improved health, responsiveness, and financial protection*. This is envisaged to happen at the varied levels of the health system.

- The goal of the study was to conceptualise a multi-dimensional framework that will provide the 'know-how' to implement health system reform in a developing country, such as South Africa, cognisant of the preceding dimensions. That is, the framework will provide practitioners with the 'how' to implement health system reform in a developing country, addressing the dimensions of leadership and governance, stakeholders, and health system indicators.

3.6 Chapter Summary

This chapter provided the conceptual foundations relating to leadership and governance, service delivery and stakeholders. A theoretical analysis of the literature reviewed on leadership and governance, service delivery, and stakeholders was also provided, in relation to the envisaged health system reform of the NHI. From the literature reviewed, it is evident that no one leadership style is ideal for all circumstances. Contingency leadership theory, therefore, provides the basis for understanding that leadership is contingent on aspects such as the organisational strategy, structure, and environment.

Leaders operate within organisational structures that vary, depending on their mission, purpose and strategy, and the structures are expected to facilitate overall strategy implementation. Managers lead organisations at various organisational levels, and the decision-making hierarchy plays a critical role in organisational structure. Leadership involves leading change. However, not all managers can bring about, or lead change.

Organisations that remain static lack effective leadership. Therefore, the current dynamic workplace requires leaders that can lead in the change process. New approaches to health governance are also required to ensure a better understanding of the complex interplay between the organisational environment and the health system.

Public services are a legitimate expectation of society, and organisations are expected to improve service delivery, taking into consideration rising customer expectations. The public sector is required to redefine its role and re-engineer its business processes to build customer-centric, integrated service delivery models. Monitoring and evaluation are needed for continuous improvements and alignment with the needs of the population.

Stakeholders, both internal and external, have legitimate legal and moral claims on the organisation. It is, therefore, imperative for management to address the stakeholder needs and strike a balance between the organisational needs, and the needs of other stakeholder groups. Therefore, governance structures must enable stakeholder interests to be considered, not neglecting the interests of the shareholders. Substantive stakeholder engagements are encouraged to reduce power asymmetries, provide an inclusive and participative forum of interaction, and allow for integrative outcomes.

CHAPTER 4: RESEARCH METHODOLOGY

This chapter discusses the research methodology. Firstly, the research purpose, research philosophy, research approach and research strategy are explained. This is followed by an overview of the research design, which includes the context, population and sampling; data collection methods and procedures; tool construction; data analysis; and measures to ensure trustworthiness. Ethical considerations are discussed last.

4.1 Research Methodology

Research methodology refers to the methods used to conduct research, procedures, steps and strategies to gather, and analyse data (Polit & Beck, 2004). This study is qualitative in nature. Qualitative research is a systematic, subjective approach used to describe life experiences and give the experiences meaning (Burns & Grove, 2005).

"Qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning of individuals or groups ascribing to a social or human problem" (Creswell & Poth, 2018:8). Qualitative research is grounded epistemologically in social constructivist, symbolic interactionist, or other interpretive conceptual frameworks or perspectives (Cleary, Horsfall & Hayter, 2014). Qualitative groups tend to apply induction, multi-variate and process interactions, and context-specific methods (Lee, 2011).

This method allowed the researcher to systematically gather subjective data from the participants, considering the concepts derived from the conceptual framework; describe the participants' lived experiences systematically and objectively; analyse and present data logically from diverse stakeholders to generate knowledge on how a health system reform may be implemented in South Africa.

4.1.1 Research philosophy

Research philosophy refers to the belief relating to the ways in which data about a phenomenon should be collected, analysed and utilised (Bajpai, 2011). Philosophy provides the general principles of theoretical thinking and deals with the source, nature and development of knowledge (Bajpai, 2011; Moon & Blackman, 2014). Whether the researcher is aware of it or not, the researcher always brings certain beliefs and philosophical assumptions to the study (Creswell & Poth, 2018). Philosophy basically involves deliberations around epistemology and ontology (Singh, 2015). The epistemological and ontological perspectives of this study are discussed next.

4.1.1.1 Epistemology

Epistemology focuses on how reality can be known; the assumptions, characteristics and principles that guide the process of knowing, and the achievement of results; the relationship between the knower and what is known; and the likelihood of the process being shared and repeated by others to assess the quality of the research and the reliability of those findings (De Gialdino, 2009).

"Epistemology is concerned with all aspects of the validity, scope and methods of acquiring knowledge, such as what constitutes a knowledge claim; how knowledge can be produced or acquired; and how the extent of its applicability can be determined" (Moon & Blackman, 2015:5).

The epistemological perspective of the study was informed by existing research on the dimensions of *leadership and governance*; *stakeholders;* and *service delivery* necessary for the implementation of health system reform. A review of the literature was conducted based on the protocol proposed by Giedion, Alfonso and Díaz (2013), which comprises:

- Focused analytical questions based on the concepts encompassing the topic and the research area
- A specific search strategy focusing on health systems and reforms, UHC, NHI, leadership and governance, stakeholders, and service delivery concepts

- Literature informing the study, which was extracted electronically from the World Health Organization, the World Bank, Health Systems Trust, EBSCO, Elsevier, Oxford journals database, Science Direct, Springerlink and the University of South Africa Library
- A formal assessment of the quality of the literature and studies on it.

4.1.1.2 Ontology

Ontology deals with the nature of the phenomena, entities or social world that the researcher needs to investigate (Mason, 2018). The research is conducted with the intent to report, using multiple realities (Creswell & Poth, 2018).

The researcher's ontological assumption was that the role of leadership and governance in health system reform would be explored, and described through interactions with participants on the planned NHI. This was envisaged to happen at the varied levels of the health system.

The influence of leadership on service delivery and the service delivery challenges in South African healthcare facilities would be explored and described through the responses solicited from the participants. This was also expected to occur at the varied levels of the health system.

In addition, the researcher would explore, and describe the role and influence of stakeholders in this health reform process through interacting with the specified stakeholders. This was planned to happen at the various health system levels.

4.1.2 Research paradigm

Research paradigm may be defined as "a loose collection of logically related assumptions, concepts, or propositions that orient thinking and research or the philosophical intent or motivation for undertaking a study" (Mackenzie & Knipe, 2006:2). A research paradigm is an action of submitting to a view (Groenewald, 2004). The research paradigm is comprised of three elements, namely belief about the nature of knowledge; a methodology; and criteria for validity (Mackenzie & Knipe, 2006).

The choice of paradigm sets out the intent, motivation and expectations for the research (Mackenzie & Knipe, 2006). Without choosing a paradigm as the first step, there is no basis for subsequent selections about the methodology, methods, literature or research design (Ibid., 2006). An interpretivist paradigm was considered suitable for this study.

Interpretivist paradigm

The focus is on the subjective experiences of the world and is based on the ontological belief that reality is socially constructed (van der Berg, 2017). Interpretivist research poses an epistemological assumption that knowledge about the world is gained through social constructions such as consciousness, language and shared meanings (Cardoso & Ramos, 2012).

In interpretive research, there are no predefined dependent and independent variables, but the focus is on the complexity of human sense-making as the situation emerges (Klein & Myers 1999).

There are two schools of thought on interpretive research founded on the epistemological assumption (Cardoso & Ramos, 2012). One is based on language and its meaning; the other is related to phenomenology and hermeneutics (Ibid., 2012). According to Cardoso and Ramos (2012); Klein and Myers (1999), a set of principles for interpretive research are:

(1) The fundamental principle of the hermeneutic circle – all human understanding is achieved by iterating between the interdependent meaning of the parts, and the whole that they form. This principle should guide the application of the other principles.

(2) The principle of contextualisation – an explanation of the situation under investigation requires a critical understanding of the social and historical aspects.

(3) The principle of interaction between the researcher and the subjects – there should be critical reflection on how research materials were socially constructed through the interaction between researcher and participants.

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(4) The principle of abstraction and generalisation – the researcher should relate the idiographic details revealed by the data interpretation to theoretical and more general level concepts.

(5) The principle of dialogical reasoning – there should be sensitivity to possible contradictions between the theoretical framework guiding the research and the actual findings.

(6) The principle of multiple interpretations – sensitivity is required to possible differences in interpretation among the participants as is typically expressed in multiple narratives.

(7) The principle of suspicion – sensitivity to possible differences in interpretation of the events under study, among the participants, is underscored, and the principle of suspicion emanates from this, in that the researcher should also be sensible to possible bias and distortions in the narratives collected from the participants.

The *interpretivist paradigm* was adopted to unravel the complex multi-dimensional phenomenon of the health system:

- The complexities within the health system were explored and described by analysing, multi-dimensionally, the role of leadership and governance in health system reform; how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities; and the role of stakeholders and their influence in this health reform process.
- The researcher was, therefore, able to generate an in-depth, multi-faceted understanding of health system reform as a complex, multi-dimensional phenomenon, with a focus on the dimensions of *leadership and governance*, *stakeholders,* and *service delivery.*
- The in-depth understanding of this multi-dimensional phenomenon was gained through social interaction with the participants and the participants' interpretation of the context, using their language, consciousness and shared meanings.
- This also enabled the researcher to achieve the study objectives and ensure the trustworthiness of the study findings, and conclusions.

4.1.3 Research approach

This study is inductive in nature. The reasons for applying an inductive approach were: to condense raw data into a brief; to establish a clear association between the research objectives and the findings which are derived from the raw data; and to develop a framework of the underlying experiences and processes derived from the raw data (Thomas, 2006). The approach provides a set of procedures to systematically analyse qualitative data that can produce reliable and valid findings (Ibid., 2006).

Justification for going inductive

> An inductive approach was employed in this study to develop themes from the raw data; to determine if there was an association between the research objectives and the findings derived from the raw data, specifically in relation to the role of leadership and governance in health system reform; to assess how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities; and to evaluate the role of stakeholders and their influence in this health reform process. This also allowed the researcher to develop a framework based on the underlying experiences and processes derived from the raw data.

4.1.4 Research strategy

A case study strategy was adopted in this study. A case study is an empirical enquiry that investigates a contemporary phenomenon within its real-life setting (Yin, 2014). A case study explores a real-life, contemporary bounded system (a case), or multiple bounded systems (cases over time), through in-depth and detailed data collection which involves multiple information sources such as interviews, audio-visual material, observations, documents and reports (Creswell & Poth, 2018).

Case study enquiry relies on multiple sources of evidence, with data needing to converge in a triangulating fashion; and benefits from the prior development of theoretical propositions to guide data collection and analysis (Yin, 2014).

A case study allows for the study to retain the holistic and meaningful characteristics of real-life events such as individual lifecycles, organisational and managerial processes, and the maturation of industries (Yin, 1994), and permits for 'thick descriptions' of the phenomena under study (Yin, 2014). The researcher's goal is to expand and generalise theories (analytic generalisation), and not to make statistical generalisation (Ibid., 2014).

Health system reform as a case studied

In the study, the health system is argued to be a complex, multi-dimensional phenomenon, and the focus is at macro, meso and micro levels of the health system. The study also focuses on three dimensions based on the theoretical frameworks, namely *leadership and governance; stakeholders;* and *service delivery.*

In terms of whether or not a theory may be developed from a case study, any three of the following four criteria should be sufficient to validate the new theory's explanatory power (Ngwenyama & Nielsen, 2013).

1. Does the case study consider predictions through which the theory could be falsified?
2. Are all of the predictions consistent with each other?
3. Does the case study confirm the theory through empirical evidence?
4. Does the case study rule out rival theories?

According to the researcher, this case study research satisfies the criteria based on points 1, 3 and 4 above, and these are explained in the context of the study as follows:

1. The researcher postulates a set of propositions grounded on empirical observations, and in accordance with the literature on leadership and governance theories, quality in health service delivery model and stakeholder theory, and these may be falsified in future testing.

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2. Empirical evidence from this case study indicates that, in order to successfully reform the health system, leadership and governance, service delivery, and stakeholder dimensions at the macro, meso and micro levels of the health system should be considered.

3. There is a need to determine how health system reform may be implemented, informed by the analysed multi-dimensionality of the phenomenon.

The case study strategy enabled the researcher to explore and describe the complexities within the health system by analysing, multi-dimensionally, the role of leadership and governance in health system reform; how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities; and the role of stakeholders and their influence on this health reform process.

A case study was, therefore, used to generate an in-depth, multi-faceted understanding of a complex phenomenon in its real-life context (Crowe, Cresswell, Robertson, Huby, Avery & Sheikh, 2011; Starman, 2013) with a focus on the dimensions of *leadership and governance*, *stakeholders,* and *service delivery*.

4.2 Research Design

A research design is a plan according to which research must be carried out and specifies the observations to be made (which variables to focus on), how to make them (which measurement procedures to adopt), and when to make them (Burns & Grove, 2005; Stommel & Wills, 2004). The research design outlines the general approach involved in planning and executing a research project (Kent, 2007).

In the study, the health system is argued to be a complex, multi-dimensional phenomenon. Therefore, to profoundly understand the phenomenon, there was a need to explore and describe each dimension in the context in which it happened. An explorative and descriptive research design (Wegner, 2000) was considered suitable for this study.

Exploratory research design

> This research design method generally uses a qualitative approach to collect and analyse data; and mainly involves non-numeric concept-testing, where little is known about the problem (Wegner, 2000). This approach assisted the researcher to solicit the participants' views about the health system reform based on the reviewed literature concepts of leadership and governance, stakeholders, and service delivery.

Descriptive research design

> Descriptive design is important and appropriate for research questions that are focused on discovering the 'who', 'what', and 'where' of events or experiences, and to gain understanding from participants about a poorly understood phenomenon (Kim, Sefcik & Bradway, 2017). This helped the researcher to describe the views of participants about the health system reform based on their understanding of the phenomena.

A qualitative exploratory descriptive research design was, therefore, suitable for the study to help in determining how a developing country such as South Africa may implement health system reform. The research design guided the researcher to plan and implement the study in a manner that enabled the achievement of the objectives.

4.2.1 Unit of analysis, context, population and sampling

Unit of analysis

> The unit of analysis describes the level at which the study is conducted, and the objects being studied (Lewis-Beck, Bryman & Liao, 2004). The unit of analysis for this study was South Africa (health system) as a developing country.

Research setting

> Refers to the selection of a location where specific events are expected to occur, and information is expected to be gathered (Van Dyk, 2016). As the study was multi-level, it was conducted at macro, meso and micro levels of the health system.

Population

Refers to the group the researcher wanted to gather information from and make conclusions about (Polit & Beck, 2004). A population is comprised of an entire set of individuals having some form of common characteristics (Ibid., 2004). As the study was multi-dimensional and multi-level, the participants were comprised of stakeholders such as Department of Health, regulators, medical schemes, medical scheme administrator, healthcare facilities, funder association, and trade unions.

Sampling

Refers to the selection of a group of people or elements for inclusion in the study (Burns & Grove, 2005). Sampling is a subset of the population that is selected to participate in a study (Polit & Beck, 2004). The sampling was within the health system stakeholders. The non-probability (non-random) sampling method (Wegner, 2000) was used in this study.

Non-probability sampling (non-random) is also known as the purposive sampling method (Chisnall, 2005). Purposive sampling refers to selective sampling, where the researcher intentionally chooses the participants to include in the study (Burns & Grove 2011). The inclusion or selection of the sample is dependent on the judgment of the researcher (Chisnall, 2005). This is usually associated with an element of bias, as the representativeness of the sample cannot be validated statistically (Wegner, 2000).

Participant selection should have a clear motivation and fulfil a specific purpose related to the research question, which is why qualitative methods are generally described as 'purposive' (Cleary, Horsfall & Hayter, 2014).

Purposive sampling was used to identify participants from each stakeholder within the health system. Subsequently, the actual study participants were purposively selected based on their positions and roles:

- Each position had a role that was defined, in terms of knowledge, skills, competencies and experience, with respect to the health system.

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Sample (participants)

The participants were stratified per level of analysis as follows:

- Macro level – NDoH, regulators, funder association, and trade unions
- Meso level – medical schemes, and an administrator
- Micro level – public and private healthcare facilities, and an independent medical practitioner.

The sample for collecting data on the *leadership and governance* dimension at macro, meso and micro levels, in the context of NHI, included the following participants:

Table 4.1: Sample for collecting data on leadership and governance

STAKEHOLDERS	PARTICIPANTS	SUBTOTAL
National Department of Health	Deputy Director General	1
Academic/tertiary hospital	Medical Superintendent	1
District hospital	Chief Executive Officer	1
Private hospital	General Manager	1
Medical schemes	Principal Officers	2
Medical scheme administrator	Chief Executive Officer	1
TOTAL		**7**

The sample in Table 4.1 allowed the researcher to gather data on the role of leadership and governance in health system reform. The leadership dimension was looked at, considering the *organisational structures, processes,* and *organisational performance* concepts. In terms of governance, concepts relevant to this study are the *inputs* (participation, consensus orientation, strategies and policies); *processes* (accountability, transparency, and control of corruption); and *outcomes* (responsiveness, equitable access, and efficiency), in the context of health system reform.

The sample for collecting data on the *service delivery* dimension at the micro level, in the context of NHI, included the following participants:

Table 4.2: Sample for service delivery elements

STAKEHOLDERS	PARTICIPANTS	SUBTOTAL
Public healthcare facilities	Head of Finance	1
	Head of Supply Chain	1
	Head of Pharmacy	1
	Head of Diagnostics and Radiology Services	1
	Head of Nursing Services	1
	Head of Human Resources	1
	Head of Quality Assurance	1
	Professional and Administrative Staff	6
TOTAL		**13**

The sample in Table 4.2 enabled the researcher to analyse how leadership might influence service delivery and determine the service delivery challenges in South African healthcare facilities. Service delivery which reflects the health system outputs was looked at, considering the *structure* (resources and administration); *processes* (culture and professional co-operation); and *outcomes* (satisfaction with services, that is, affordable, accessible and acceptable to the population).

The sample for collecting data for the dimension of *stakeholders* at macro, meso and micro levels in the context of NHI, was comprised of the following participants:

Table 4.3: Sample for the stakeholder dimension

STAKEHOLDERS	PARTICIPANTS	SUBTOTAL
National Department of Health	Deputy Director General	1
Academic/tertiary hospital	Medical Superintendent	1
District hospital	Chief Executive Officer	1
Private hospital	General Manager	1
Medical schemes	Principal Officers	2
Medical scheme administrator	Chief Executive Officer	1
Independent medical practitioner	Public Health Medicine Specialist	1
Regulators	Council for Medical Schemes (CMS)	1
	South African Health Professions Council (HPCSA)	1
Funder Association	Board of Health Care Funders (BHF)	1
Trade Unions	Health and Other Personnel Trade Union of South Africa (HOSPERSA)	1
	Solidarity Union	1
TOTAL		**13**

The sample in Table 4.3 enabled the researcher to analyse, and describe the role and influence of stakeholders in implementing health system reform. This was done with a focus on stakeholder *identification* and *roles*; *stakeholder attributes* (legitimacy, power and urgency); *engagement*; and *management*, taking into consideration the stakeholder gaps identified, namely *types and roles*; *interests and powers*; *needs and viewpoints.*

4.2.2 Data collection methods and procedures

Data collection refers to the collection of all the information that is relevant to the research questions (Stommel & Wills 2004). In qualitative research, data collection is performed in a natural setting sensitive to participants; and data analysis is both inductive and deductive, and establishes patterns or themes (Creswell & Poth, 2018). The methods and procedures of data collection used in this study are explained next.

4.2.2.1 Data collection methods

> The approaches or methods that may be used in collecting qualitative data include observation methods and interviews (face-to-face and focus group discussions) (Busetto, Wick & Gumbinger, 2020; Wegner, 2000). In this study, focus group and individual interviews were conducted, and observations made.

- **Sample size**

The sample of the study was comprised of 26 participants. The *sample size* was stratified based on the dimensions of the study as follows:

> ⬩ **Leadership and governance dimension**
>
> Individual interviews were conducted, comprised of seven participants who were leaders in their organisations. Each participant's position had a role that was defined, in terms of knowledge, skills, competencies and experience, with respect to the health system. The leaders were Deputy Director General of the NDoH; Medical Superintendent of an academic hospital; Chief Executive Officer of a district hospital; General Manager of a private hospital; Principal Officers of two medical schemes; and Chief Executive Officer of a medical scheme administrator.

Service delivery dimension

o *Individual interviews:*

Individual interviews were conducted and were comprised of seven participants, namely the Director of Finance; Deputy Director Supply Chain; Nursing Services Manager; Pharmacy Manager; Chief Radiographer; Quality Assurance Manager; and Human Resources Manager.

o *Focus group interview:*

A total of six participants were included in the focus group interview. The participants were from the nursing services; finance; supply chain; food services; an anti-retroviral clinic; and customer services.

Stakeholder dimension

Six participants were included in the study to collect data for the stakeholder dimension. The participants were comprised of leaders from the Council for Medical Schemes (CMS); Health Professions Council of South Africa (HPCSA); Board of Healthcare Funders (BHF); Solidarity Union; Health and Other Personnel Trade Union of South Africa (HOSPERSA); and an independent medical practitioner.

The participants also included seven stakeholders for the leadership and governance dimension, which were the Deputy Director General of the NDoH; Medical Superintendent of an academic hospital; Chief Executive Officer of a district hospital; General Manager of a private hospital; Principal Officers of two medical schemes; and Chief Executive Officer of a medical scheme administrator.

- **The environment**

The success of interviews relies on the creation of a non-threatening environment. An accessible and safe environment was sought based on the guidance of the participants. The venue and seating arrangements were organised to allow participants to be heard, seen and recognised during the discussions. The researcher utilised an interview guide to collect data, facilitate discussions, summarise main points, seek clarity and take field notes.

- **Conducting the interview**

  Qualitative interviewing helps the researcher to structure conversations to gather insights from participants and probe their understanding about the phenomenon under investigation (Ennis & Chen, 2012). This approach assists with gaining a deeper understanding of the participants' perspectives about the topic (Ibid., 2012).

  The researcher introduced herself to the participants and allowed them to introduce themselves to gain rapport. The researcher explained the purpose of the study and the duration of the interviews, and requested permission to record the interviews. Open-ended, in-depth interviews were conducted to gather information to gain a holistic understanding of the participants' point of view.

  Aspects relating to the type of interviews conducted; observations made and reviewed documents; and how data was recorded are discussed next.

Individual interviews

Individual interviews involve talking to one person at a time, giving the participant personalised attention, and providing more time to discuss a topic in detail (Ennis & Chen, 2012). The focus is to understand the interview subject from the participant's perspective and there are no group dynamics (Busetto *et al*., 2020; Ennis & Chen, 2012; Wegner, 2000).

Individual interviews were conducted to collect data from the stakeholders, namely NDoH, regulators, healthcare facilities, medical schemes, medical scheme administrator, independent medical practitioner, funder association, and labour unions. This allowed the researcher to gather data from the identified leaders on the role of *leadership and governance* in health system reform; investigate how leadership may influence service delivery, and determine the *service delivery* challenges in South African healthcare facilities; and analyse and describe the role and influence of *stakeholders* in implementing health system reform.

The researcher heard the participants' voices and expectations in detail, understood their perceptions and obtained their in-depth personal views. Some of the participants' views were also relevant to the study dimensions, which were not their primary focus. The interviews were conducted to allow the participants the opportunity to communicate their experiences, thoughts and views. The interviews were conducted until saturation was reached.

Focus group interviews

Focus groups are designed to obtain participants' views from a group of individuals on a specific topic in a supportive and non-threatening environment (Burns & Grove, 2005; Ennis & Chen, 2012). Burns and Grove (2011) explained that the focus of qualitative research is on the quality of information, rather than the size of the sample.

A focus group interview which included six participants from a district hospital was conducted to explore and describe the *service delivery* dimension. This allowed the researcher to gather data on the status quo, issues and challenges, and how the reform would affect future work performance.

Observations and documents

Participant observation was done to enable the researcher to develop mutual trust with the participants, take notes and discover context-specific information.

Acts, Bills, White Papers, annual reports, policy and other relevant documents were reviewed to better understand the macro environment, strategies, missions, objectives, resources, financial and operational performance, and market footprint of the identified stakeholders in the health system.

Recording the interviews

The interviews were audio-recorded to allow the researcher to retrieve the collected data for analysis and reporting purposes.

- **Interview guide**

A semi-structured interview guide was used in this study. The semi-structured interview guide allows the researcher to ask open-ended questions based on a topic in which the areas of interest, sometimes including sub-questions, are defined (Busetto *et al*., 2020). This approach assists with ensuring that the same general areas of information are collected from each interviewee, thereby providing more focused interviewing, while still allowing a degree of freedom and flexibility in obtaining information from the participants (Ennis & Chen, 2012; Turner, 2010).

A semi-structured interview approach, therefore, allowed for more focused interviewing, while still allowing the freedom and adaptability to obtain additional information. The interview guide assisted with ensuring that the information on generally similar concepts was collected from the participants.

An interview guide was developed based on the theoretical frameworks and concepts of the literature review, focusing on the *leadership and governance dimension*; *service delivery dimension*; and *stakeholder dimension.* In terms of the leadership dimension, environmental factors were not included because these factors were explained in detail in the literature review. However, *organisational structures, processes* and *organisational performance* are components of the internal organisational environment.

Pre-testing of the interview guide was performed on four individuals who were not included in the study, but had similar characteristics to the participants, in terms of their roles, skills, competencies and experience in the health system. This was done to determine whether the questions were clear, identify problems with the questions, and reach a more accurate determination of the possible duration of interviews.

4.2.2.2 Data analysis

Qualitative data analysis is a process to review, synthesise and interpret data to describe and explain the phenomena being studied (Fossey, Harvey, McDermott & Davidson, 2002). Data analysis is conducted to condense, organise and give meaning to data (Polit & Beck, 2004). Empirical analysis involves a multi-stage process in which content analysis, coding and interpretive processes are required (Ngwenyama & Nielsen, 2013).

This study was inductive in nature and, therefore, content analysis and thematic analysis were the data analysis methods employed.

Content analysis

This involves the examination of data, printed images, sounds and texts, in order to understand the information conveyed and their meaning (Krippendorff, 2018). Content analysis is an empirically grounded method, and an exploratory process that is predictive or inferential in intent (Ibid., 2018). All the collected data was examined throughout the analysis process to understand the information conveyed by the participants and the meaning thereof.

Thematic analysis

This is the process of identifying patterns or themes within qualitative data which are important or interesting, and using these themes to address the research, or state something about an issue (Maguire & Delahunt, 2017). Thematic analysis focuses on developing categories which are derived inductively from the data to make sense of the data (Fossey *et al*., 2002; Maguire & Delahunt, 2017).

There is a top-down or theoretical thematic analysis, driven by the specific research questions and the researcher's focus (Braun & Clarke, 2006). There is also a bottom-up or inductive thematic analysis that is more driven by the data (Ibid., 2006).

In this study, thematic analysis comprising both the top-down (driven by the specific research questions and the researcher's focus) and bottom-up approaches (driven by data), was applied. The analysis of data was also performed in a stepwise manner to understand leadership, governance, service delivery, and stakeholder aspects necessary for health system reform. In cases where participants expressed views that also applied to the other study dimensions, the views were included in the relevant dimensions.

Step 1 – data collected through interviews was transcribed from an audio-recorder into an MS Word document. The interviews were transcribed verbatim without annotations for behaviour (Busetto *et al*., 2020) because data collection sought to establish the participants' views on specific topics relating to theoretical concepts of the study. The data collection process did not seek to determine individual behaviour or actions in a certain context.

Step 2 – the interview scripts were imported from the MS Word document into the qualitative data analysis package (Atlas.ti).

Step 3 – paragraphs from transcripts were coded or marked with descriptors to link the raw data with theoretical concepts of the study (Busetto *et al*., 2020). This made it possible to examine the transcribed data in relation to the relevant study concepts. The following concepts from the theoretical frameworks were used to link and code the collected data:

- o *Organisational structures, processes* and *organisational performance* in the leadership dimension. These concepts relate to the internal organisational environment.
- o Governance *inputs* (participation, consensus orientation, strategies and policies*); processes* (accountability, transparency, and control of corruption); and *outcomes* (responsiveness, equitable access, and efficiency), in the context of health system reform.

- Structure (resources and administration); *processes* (culture and professional co-operation); and *outcomes* (satisfaction with services, that is, affordable, accessible and acceptable to the population) in the service delivery dimension.
- Stakeholder *identification* and *roles*; *attributes* (legitimacy, power and urgency); *engagement* and *management*.

Stage 4 – to synthesise data collected, the codes were grouped, summarised, and categorised to generate themes (Busetto *et al*., 2020; Fossey *et al*., 2002) and sub-themes based on the topic under investigation. A theoretical explanation of the empirical observations was provided based on the literature reviewed (Ngwenyama & Nielsen, 2013).

Thematic analysis was performed considering the study objectives and the proposed conceptual framework. The following themes formed the basis of the analysis:

- Theme 1: The Role of Leadership in Health System Reform
- Theme 2: The Role of Governance in Health System Reform
- Theme 3: How Leadership May Influence Service Delivery
- Theme 4: The Service Delivery Challenges in South African Healthcare Facilities
- Theme 5: The Role of Stakeholders in Implementing Health System Reform
- Theme 6: The Influence of Stakeholders in Implementing Health System Reform

The data analysis process enabled the researcher to explore and describe, by analysing multi-dimensionally, the role of leadership and governance in health system reform; how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities; and the role of stakeholders and their influence in this health reform process. A multi-dimensional framework for implementing health system reform was conceptualised as a research contribution.

4.2.3 Measures to ensure trustworthiness

Trustworthiness ensures that qualitative research is credible and defensible (Van Dyk, 2016). According to Guba and Lincoln (1994), trustworthiness is determined by four indicators, namely credibility, transferability, dependability and confirmability (Kumar, 2011). Criteria for data quality in this study are explained based on the principles of credibility, transferability, dependability, confirmability and authenticity.

Credibility

Credibility refers to "the confidence that can be placed in the truth of the research findings" (Korstjens & Moser, 2018:121). Credibility involves establishing that the research results are believable from the participant's point of view (Kumar, 2011).

To achieve credibility in a case study, Starman (2013) recommends the following strategies:

- Procedures for data collection should be explained.
- Data collected should be presented and be ready for re-analysis.
- Negative occurrences should be reported.
- Bias should be acknowledged.
- Fieldwork analyses need to be documented.
- The relationship between assertion and evidence should be clarified.
- Primary evidence should be distinguished from secondary evidence; the description and interpretation should also be distinguished.
- Diaries or logs should be used to track what was done during different stages of the study.
- A means should be developed to check the quality of data.

In-depth interviews were conducted and audio-recorded, and observations done. Diaries were kept, in order to track the events, including audit trails to ensure credibility of the findings.

Transferability

This is the extent to which the findings may be generalised to other situations, target populations or contexts (Stommel & Wills, 2004; Kumar, 2011).

Transferability was attained through conducting interviews until saturation was reached. The experiences of participants, and the context were described to make the interpretation meaningful.

Confirmability

Confirmability refers to the degree to which the results could be confirmed by others (Kumar, 2011). Confirmability assessment is used to determine whether two or more researchers can agree on the process, steps and decisions about the type of data to collect, and how to interpret the data (Stommel & Wills, 2004). This includes the inferences or significance of the study findings for practice field (Ibid., 2004). Confirmability can be ensured, if both researchers follow similar research for the results to be compared (Kumar, 2011).

Confirmability was achieved through describing the research steps taken, and providing the interpretations and conclusions from the interviews that were conducted.

Authenticity

Authenticity refers to the extent to which the researcher shows a range of realities faithfully and fairly (Elo, Kääriäinen, Kanste, Pölkki, Utriainen & Kyngäs, 2014).

Authenticity requires the researcher to ensure that both the conduct and evaluation of research are genuine, and credible, not only in terms of participants' lived experiences, but also in relation to the wider political and social implications of research (Given, 2008).

Authenticity necessitates that the researcher be concerned that the study is worthwhile, and think about the impact of the research on members of the culture or community being researched (Given, 2008). Authenticity is seen as an important component of establishing trustworthiness in qualitative research, so that the study may be beneficial to society (Ibid., 2008).

There are five key criteria to strengthen claims for authenticity (Given, 2008).

- *Fairness*: qualitative researchers need to ensure that participants have equal access to the research enquiry to avoid bias, such as developing research relationships that go beyond conventional roles of question asking and question answering from the outset of the research. Implementing this approach enables the participants to become responsible for the cultural reproduction of the research enquiry and helps with reaching authentic outcomes.

- *Ontological authenticity*: research should help the participants to develop a better understanding of the social context being studied.

- *Educative authenticity*: research should show that individuals appreciate the viewpoints of people other than themselves through cultural, social and organisational engagement.

- *Catalytic authenticity:* refers to the extent to which the research stimulates some form of action on the part of the research participants.

- *Tactical authenticity:* refers to the degree to which participants (and stakeholders) are empowered to act – to engage in action not only as individuals, but also as members of their community – with a view to positively changing their circumstances.

The researcher analysed statements provided by the participants, and left audit trails that documented the participants' consciousness and understanding of the world. Data was interpreted critically to reflect the participants' views and emotions as they were expressed.

4.3 Ethical Considerations

Burns and Grove (2005) indicate that ethical rigour requires the researcher to acknowledge and discuss the ethical implications related to the conduct of a study.

Right to privacy (autonomy, confidentiality)

Confidentiality is "the management of private data in research, so that participants' identities are not linked with their responses" (Burns & Grove, 2005:731).

The researcher ensured confidentiality by not revealing the participants' identities when reporting the research findings. Personal identifiers were removed from research-related information; data was encrypted; and pseudonyms were used. Focus group participants were advised that confidentiality could not be assured.

Informed consent

Informed consent describes the nature of the research project and the nature of one's participation in the research (Leedy & Ormrod, 2005). The researcher obtained ethical clearance from the Ethics Committee of the University of South Africa Graduate School of Business Leadership.

Approval to conduct the study was sought from Department of Health, regulators, health facilities, medical schemes, a medical scheme administrator, funder association, and labour unions. Permission to conduct the study was also sought from the selected participants in the specified organisations.

The purpose of the research was explained verbally and in writing by the researcher. This allowed the researcher to obtain informed consent from the participants. The participants were made aware that participation was voluntary and that they had the right to withdraw from the study at any time.

Protection from harm (emotional and physical)

In research, the researcher's main responsibility is to protect the participants (van der Wal, 2006). If there is conflict of interest, the participants must be prioritised and protected (Ibid., 2006).

The researcher must totally protect the participants' physical, social and psychological welfare, and honour their dignity and privacy (van der Wal, 2006).

The researcher ensured that the participants' rights and dignity were respected at all times. As most interviews were conducted in the settings where the participants worked, the participants provided venues that were safe and well ventilated, with proper lighting.

4.4 Chapter Summary

This chapter discussed the research methodology. The research philosophy, research approach and research strategy were explained first. Secondly, an overview of the research design, including the context, population and sampling; data collection methods and procedures; tool construction; data analysis; and measures to ensure trustworthiness, was given. Ethical considerations were discussed last. The next chapter discusses findings of the study on the leadership dimension.

CHAPTER 5: RESEARCH FINDINGS ON LEADERSHIP DIMENSION

5.1 Introduction

In the preceding chapter, Chapter 4, the research methodology was discussed. The goal of the study was to conceptualise a multi-dimensional framework for implementing health system reform in South Africa. This chapter focuses on the findings of the study and relevant literature, with regard to the study objective on the *leadership* dimension. The findings are reported, indicating the perspectives of the public and private sector participants, respectively. The aim was to establish the areas of similarities and differences in participants' views.

5.2 Leadership dimension

The objective for this dimension was:

- To analyse the role of leadership in health system reform

Based on this objective, the interviews were conducted to gather data on the role of *leadership* in health system reform. Questions were posed to address the identified knowledge gaps, namely:

- *Management – processes and procedures:* There was a lack of clarity on how the management processes and procedures would affect health system reform. The study intended to bridge the identified gap by unravelling the processes and procedures necessary for health system reform in a developing country.

5.3 Background of the participants

A total of seven individual, face-to-face interviews were conducted with stakeholders, namely the NDoH; two public healthcare facilities; one private healthcare facility; two medical schemes; and a medical scheme administrator. From these stakeholders, organisational leaders were purposefully selected for inclusion in the study. Each participant's position had a role that was defined, in terms of knowledge, skills, competencies and experience, with respect to the health system.

The leaders that were selected from the stakeholders to participate in the study were the Deputy Director General of the NDoH; Medical Superintendent of an academic hospital; Chief Executive Officer of a district hospital; General Manager of a private hospital; Principal Officers of two medical schemes; and Chief Executive Officer of a medical scheme administrator.

The interviews were audio-recorded with the permission of participants. The leaders were allocated identifying codes such as leader 1, leader 2, leader 3, leader 4, leader 5, leader 6 and leader 7. This was to maintain confidentiality and anonymity of the participants.

5.4 Theme 1: The Role of Leadership in Health System Reform

Contingency theory of leadership was used as a theoretical framework for the leadership dimension. Contingency infers that the structures and practices of an organisational system depend on the environment or situation relevant to the system (Longenecker & Pringle, 1978). Leadership dimension was looked at considering the *organisational structures, processes,* and *organisational performance* concepts in the context of health system reform.

Although environmental factors influence organisational performance, the analysis focuses on *organisational structures, processes* and *organisational*, and these relate to the internal organisational environment. Macro-environmental factors are not the focus of the analysis because they were extensively covered in the literature review. Aspects under this theme are discussed under categories listed in the next table.

Table 5.1: The role of leadership in health system reform

Categories	Subcategories
1. Organisational structures	
2. Organisational processes	
3. Organisational performance	Missions, technology, and communication

5.4.1 Organisational structures

The researcher's aim was to solicit the participants' views on whether their organisational structures and the structure of the Department of Health were aligned to health system reform. The analysis of empirical data regarding organisational structures within the health system is discussed under the private and public sectors, and the Department of Health.

Private sector

Well, I think even before you get to looking at our structure and our scale, I think you need to ask the question, does the NHI allow us to exist? Because it's only if it allows us to exist that we become relevant in structure and size, etc. So yes, we are large, and very proud to be. And obviously, that comes with a lot of skills as well and resources, and capability. I will work on the assumption that we continue to exist within the NHI environment, in a parallel environment. (Leader 1)

We don't really know exactly what the NHI means. I think it's hard to predict exactly how it turns out and could well be in the end that they decide they'll do some stuff themselves. But they're better off outsourcing quite a lot to different administrators, even schemes. And if that starts to be a consideration, I would say we're very well prepared for that too. (Leader 2)

It is a challenge for the structure to be geared to the unknown. There is a lot of uncertainty about the role of private sector in the NHI. The private sector might be allowed to tender for work with the State. It's not clear if the private sector will be allowed to do work for the State. It's not clear. We've strategically ... has positioned itself. I think we are geared, or try to gear ourselves to the best of our knowledge, given what we read between the lines. (Leader 3)

Given the above assertions, it is evident that the participants were not sure of their role in the envisaged NHI. The main reason cited was that the NHI policy documents did not provide clear guidance on the exact roles of private hospitals and medical schemes in the future NHI environment. In addition, the NHI Bill still had to undergo varihapter 4

Cous legislative processes before being enacted. Due to the uncertainty, it was difficult to predict how things might turn out and, therefore, challenging to align the organisational structures with the envisaged NHI. However, the sizes of their organisations and their strategic positioning make them adaptable, depending on how things develop.

The participants believe that they have the capacity, resources, skills and competencies for the NHI implementation, and they are willing to work with government. There is also a view that schemes should be allowed to continue to function in parallel to the NHI, to allow healthcare access to the population that can afford private healthcare. Three scenarios were proposed in which medical schemes and administrators might play a role in the NHI environment. The scenarios are: 1) medical schemes should continue functioning in a more or less similar manner; 2) supplementary benefits and non-medical scheme insurance products should be provided; 3) the administration capability for the NHI should be outsourced.

Ginter *et al.* (2013) posit that organisational structures vary, depending on the firm's vision, mission, purpose and strategy, and the structures are expected to facilitate overall strategy implementation. Once the directional, market entry, competitive and service delivery strategies have been developed, management must determine the structure suitable for the organisation. Republic of South Africa (2019) mentions that, once the NHI has been fully implemented, medical schemes may only offer complementary cover for services not funded by the Fund.

The NHI will ensure that all South Africans have access to comprehensive quality healthcare services closest to where they live and at the appropriate level of care, delivered through certified and accredited public, and private providers using the NHI Card (Department of Health South Africa, 2015).

Public sector

In the analysis of the structure of public hospitals, the participants had different views about their organisations being geared towards NHI implementation**.**

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...Hospital is partially ready and there are some few things that need to be ironed out. But it's more of administrative issues which can be easily done. I think the way it is now, it is functionally, ready. (Leader 6)

I think the organisational structure needs some minor changes. The alignment is not hundred percent. I think maybe what we need is to capacitate the office of the hospital information. As a district hospital, we are not offering the full-service package. We need to make sure that critical services are be provided. The staffing alignment at the lower level, whether it's nurses, doctors, the porter, the cleaner, we need that. (Leader 7)

In relation to State facilities, the organisational structure of the academic hospital was, to some extent, geared for the implementation of the NHI. Changes were anticipated in the administrative and financial arrangements. The district hospitals raised several concerns regarding their organisational structure and capacity, which might hamper the implementation of health system reform at that level. There is a need to improve the ICT system, the package of services offered and human resources capacity for effective service delivery.

Attaining UHC goals does not only depend on the collection of revenue, but also on how other functions such as risk pooling, purchasing of goods and services, and service delivery are performed (Giedion, Alfonso & Díaz, 2013). Efficiency is vital in the allocation of healthcare resources and provision of healthcare services to optimise utilisation, and maximise results (Sambo & Kirigia, 2014). The World Health Organization (2008) mentions that countries must promote intersectoral collaboration and public-private partnership, including civil society and communities, with a view to improving the use of health services.

Leadership and governance challenges continue to prevail at various levels of the public sector, despite the government's efforts to inculcate a culture of good leadership and governance (Department of Health South Africa, 2017). The private sector also has weak systems of leadership and governance, rendering it poorly regulated and less accountable, in terms of quality and costs (Ibid., 2017).

Gilson and Daire (2011) postulate that leadership reforms are needed to transform health systems, in order to deal with a variety of existing health challenges, but there has been limited discussions on the nature of leadership required across the health system.

Department of Health

All the participants agreed that the structures of the Department of Health are not aligned with the envisaged health system reform.

> *The current organisational structures are far from the alignment as they can be right now. The system is more aligned to different kind of model like the British NHS. It followed money flowing from National Treasury, to the Provincial Treasury, from there through Persal to Payroll. And that is the opposite of a procurement-driven kind of insurance, where you have a purchaser, which is the NHI, and a provider, which is the delivery.* (Leader 2)

> *Post-1994, one of the biggest responsibilities was to change from where we had multiple departments of health to come up with a new structure. The current healthcare structure, its effectiveness, it's not. Not everybody would admit that it's been effective because of National only doing policy, Province supposed to implement. It was well intended, but it doesn't seem to have worked.* (Leader 4)

> *The reason that we are introducing the NHI is by implication that the current structure is not appropriate. It's not just the current structure of the National Department, the current structure of the health system, in general. Each of the Provincial Departments have their own powers and difficulties between National and Provincial Departments. The provinces have their own structural problems.* (Leader 5)

There was a general consensus among participants that the current organisational structures of the Department of Health in South Africa are not effective and are misaligned with the envisaged health system reform of UHC through the NHI. The existing structure is based on the health reforms after the democratic dispensation, in 1994, which resulted in the country having nine provincial departments of health. The NDoH is responsible for policy design, while the provincial departments implement the policy directives. The intentions of the current structures might have been good, but they have not worked.

According to Lunenburg (2012), earlier organisational structures were often based either on product or function. Later approaches then examined the relationship between organisational strategy and structure.

5.4.2 Organisational processes

The participants' views regarding the organisational processes used were solicited to determine how these affect the achievement of organisational and strategic objectives. The processes by which work is organised within their organisations were explained by participants.

Private sector

Transparency, accountability and understanding one's risk appetite improves collaboration. We have an administrator that we have outsourced our various functions to and for us, that outsourcing model is critical. That outsourcing model is completely integrated completely. The fact that we have that kind of arrangement means we are much more efficient in getting information quickly, which is critical in being agile and adjusting quickly to our needs. (Leader 1)

At the most basic level, it's about hiring, the best people. You can find people who are hardworking, honest, and have the best interests of the customer and the company, or the organisation at heart. Because, if you've got people like that, you can do anything. The next most important thing is, it needs to start with the basic, you know, mission, or philosophy of the organisation. Policies will never be implemented properly of without hiring good people. I think maybe the third, I would say it's linked to the best people is kind of strong leadership. (Leader 2)

I've seen in the hospitals that I've managed, when you apply discipline into the workplace, that's where you get the successes. That's when you start seeing quality improve in all aspects. Basic management principles are required, that is plan, organise, control and lead. People fail to control. Because the principle is when you control, you measure. (Leader 3)

The participants are of the view that policy implementation requires the hiring of the best people for the job, and finding the people who are hard-working and honest, who have the interests of the customer and the organisation at heart. Strong leadership and understanding the mission of the organisation are also important for achieving the desired goals. The participants' main emphasis was to appoint competent people to achieve organisational goals and policy implementation. The organisation's strategy, governance structures, benchmarking, decentralisation and quality assurance mechanisms are crucial to improving organisational processes.

Basic management principles, which include planning, organising, controlling and leading, are required to ensure organisational success. On the other hand, the key to success is to focus on the needs of the clients, accountability and consequence management. The participants also mentioned that outsourcing provides a good opportunity to improve business processes and achieve operational efficiencies. Proximity to the outsourced company, a trust relationship and addressing soft issues enhance effective communication and improved efficiencies in the delivery of care.

Irrespective of the manager's title, level, designated role and type of organisation, management is comprised of four functions, namely planning, organising, controlling and leading (Brevis & Vrba, 2018; Lombardi & Schermerhorn, 2007). Management is the process of getting things done with and through people to achieve organisational objectives (Brevis & Vrba, 2018; Olden, 2015). Six components of management are managing as a process; working with people and through others; achieving organisational goals and objectives; balancing effectiveness and efficiency; making the most of limited and scarce resources; and coping with change (Brevis & Vrba, 2018).

Public sector

The system can tell you this patient consulted on this day oncology and then also went to ophthalmology. After ophthalmology, the patient went to pharmacy, got the medication. It means the file is in pharmacy. So, it basically can trace with the number. What happens in those units is not captured but is in the file. (Leader 6)

So, for us it's everything manual. You see if you go and interview maybe quality assurance and a person who deals with the waiting times, you will see how laborious that task is because there is a sheet that we put in everybody's file and then somebody must tick. (Leader 7)

The participants mentioned that there were hindrances in the public sector, due to lack of information systems to support work processes. In an academic hospital, there is an electronic system that is used to track patient movement from one service area to another. The system is, however, limited in functionality. The system cannot be used to record patient information on file. Patient data is captured manually in files, without converting the manual information to electronic health records.

In the district hospitals, there is a lack of information systems to support work processes. This affects how information is stored and retrieved. Most of the information is still being stored manually in paper format. These challenges pose risks to these organisations, as there is no system to backup records; data sources for decision-making may be unreliable; there is possible loss of medical records; and a high risk of fire hazard exists.

General provisions applicable to operation of the Fund mention that the Fund must contribute to the development and maintenance of the national health information system; and establish an information platform to enable the Fund to make informed decisions on population health needs assessment, financing, purchasing, patient registration, service provider contracting and reimbursement, utilisation patterns, performance management, and setting the parameters for the procurement of health goods (Republic of South Africa, 2019).

5.4.3 Organisational performance

In this subsection, aspects that influence organisational performance are analysed and discussed, in relation to health system reform of UHC.

5.4.3.1 Organisational missions

Private sector

We've always had a very clear view of what our mission is: to put the customer first. So, every decision we ever make, in terms of services, or technology or product is, how will this serve the customer? We've, always been aligned to that very big objective, at a macro level of saying, good quality healthcare for all citizens, dealing with inequality. (Leader 2)

We're living our mission and are in line because Universal Health Care is about access to health in an equitable manner, in an affordable manner, but most importantly, protecting families against bankruptcy in the event of catastrophic health emergencies. (Leader 4)

The participants indicated that their organisational missions were in line with the principles of UHC. They believe in collaborative work with relevant stakeholders, and advocate for greater effectiveness in the healthcare system and regulatory reform, including contributing towards health policy and legislation amendments. They are customer-centric, which guides their approach to the services or products being offered, and to designing the technological tools to meet customer needs. The aim is to be aligned at a macro level with the principles of UHC to offer good-quality healthcare for all citizens, while addressing issues of inequality.

The participants generally believe that their organisational missions are aligned with UHC principles, which are aimed at promoting equitable access to healthcare, while offering financial protection to families.

Broadly defined, UHC, means all people receiving quality and effective healthcare services according to need, while ensuring that the use of services does not expose individuals to financial hardship (Fusheini & Eyles, 2016). The Ministry of Health is embarking on massive reform, covering health systems, personnel and financing, among others. Health stakeholders are also called on to collaborate with each other and with government, to be open to new ways of doing things, and to put patients first (Department of Health South Africa, 2015).

Public sector

> *I guess, you know, when you talk to health systems, people will tell you, no health system reaches its end. I suppose the key question is, are we moving closer to the goal, or are we moving in the opposite direction, away from the goal? I think it would be fair to say that we are moving towards the goal. I think if you were talking about pace, it can certainly be argued that we could move much faster and we could be more efficient with the resources we have. I think that's the key issue that we in the NHI are trying to fix.* (Leader 5)

> *I think we are living up to that mission of improving the health status through prevention, promotion. I think, the resources are not enough.* (Leader 7)

According to the participants, the missions of their organisations are aligned with the principles of UHC to improve the population health status through prevention of disease and health promotion. However, there are challenges of access to healthcare, for various reasons. Progressive realisation of access to quality healthcare is key to improving the health status of the population, and the country is moving towards that goal.

Countries are supposed to promote equitable access to healthcare while protecting individuals from financial hardships that can result from catastrophic healthcare expenses. However, as a country, there is a need to use the resources efficiently and accelerate efforts to move closer to UHC. Implementing NHI is viewed as a means to reform the health system to achieve UHC. NHI implementation is consistent with the constitutional commitment for the State to take reasonable legislative and other measures within its available resources, to achieve the progressive realisation of the right to have access to healthcare services, including reproductive healthcare (Department of Health South Africa, 2015).

5.4.3.2 Technology

The participants' views were sought to determine how technology is used in their organisations to enable NHI implementation. Variations were reported, in terms of the availability and usage of ICT systems between the private and the public sectors.

Private sector

We have advanced data collection systems, in terms of business intelligence, which help to measure all the business activities. We use data quite a lot to inform these things and to guide processes. All of that is being used to inform decision-makers. (Leader 3)

There is no way you can handle the scale of claims and membership, and dealing with entitlements, rules for payment, without being technologically savvy. We should be able to be a successful and technologically able company, with the most relevant and latest technology, being cognisant of the need for up-scalability and interconnectivity or integration. Another important thing is to be able to work in a secure environment considering issues of cyber threats. (Leader 4)

The participants mentioned that their organisations use advanced data collection systems to input and measure all the business activities, and deal with deviations to improve processes and outcomes. Information for decision-making is collated into the database, benchmarks are set and outcomes measured.

In terms of the use of technology to enable NHI implementation, the participants stated that innovation was needed to improve health system performance and service delivery. The NHI will require systems that are able to handle big data, cope with the changing technological trends and increasing demands, and support business processes while ensuring sustainability. Systems should be enhanced to detect and identify activities of fraud, waste and abuse. Technology that is used must have features of interconnectivity and integration.

The developments in information technology have fundamentally changed the way business is conducted, allowing for less expensive communication, easier sharing of information, and greater efficiencies in production, and management of goods and services (Brevis & Vrba, 2018; Hallinger & Snidvongs, 2008; Thompson *et al.*, 2012). Technological astuteness offers great opportunities for the healthcare industry to address the most pressing global challenges of making healthcare more accessible, faster and better (PricewaterhouseCoopers, 2014). Effective management of innovation and technology can be a great source of competitive advantage (Brevis & Vrba, 2018).

Public sector

> *I think the challenge about it is twofold. One is about, obviously the innovation to achieve it. And then the second is health professionals buying into it because many health professionals see technology as a threat, if they feel it is replacing them. There is huge benefit from it. I don't think the various places in the health system appreciate it. I don't think that they want to embrace it because some feel threatened by it.* (Leader 5)

We were one of the pilot hospitals for going paperless in future. That's why they decided to start scanning the files, so that the patient notes can be accessible electronically. The reason to stop the scanning is beyond the hospital because these people were brought here to help with the scanning. So, that was the part of the first project to go fully electronic. (Leader 6)

I can't even say, they are outdated; they are not there. It's manual and if we go back to the ICT information, we include records management under ICT, and we don't have a proper records management system. And then we don't have a proper patient registration system. (Leader 7)

Irrespective of the importance of having technologically savvy systems that provide a competitive edge for organisations, public hospitals are still lagging behind, in terms of ICT systems, to support their business processes, decision-making and data security. There was also a challenge in an academic hospital of sustaining projects that were aimed at improving systems to generate, store and disseminate information.

In the district hospital, the systems were considered to be non-existent, manual and very labour-intensive. The challenges in the public sector regarding ICT infrastructure and support may hamper the achievement of strategic and organisational objectives. Although technology can be used very effectively to improve access to healthcare, enhance efficiency within the system and reduce costs, it is not appreciated because it is seen as a threat. Healthcare workers have a challenge to adopt certain forms of technology because of fear of being replaced by it.

Complete health system reform will mean that there is a greater use of ICT, and systematic use of data at all levels; and the infrastructure backlog is cleared (National Planning Commission, 2011). Acquisition of health technology should take into consideration the available related infrastructure components (Sambo & Kirigia, 2014). Each country should have a national health technology policy as an integral part of the overall national health policy legislation (Ibid., 2014). Technological changes may involve replacing people with robots, changing equipment, or introducing new systems or processes of production (Smit *et al.*, 2018).

5.4.3.3 Communication

The objective is to seek the views of participants on how they communicate within their organisations and to establish whether communication exists within these organisations regarding the NHI.

Private sector

We design for it, we don't leave it to chance, where today one wakes up and thinks that maybe I need to ask this question. We have a board, I account to the board, the board has its own subcommittees. That's why I'm saying, it must be designed into the process and to a level of granularity that says we need to see this piece, we need to see the auditor report, it must cover x y and z, has a delegation of authority. (Leader 1)

I don't think there's any formula for how you communicate. What matters is the most senior leadership. Do they understand that communication to all levels of people in the organisation is fundamental to success? Mission and vision and a clear strategy in the heads of the most senior leaders is worth nothing, unless you can cascade that all the way down. Each layer of leadership must feel part of its strong responsibility is to clearly communicate to the level below. (Leader 2)

I think we all have an understanding of the company's goals, the visions and it's starting a process of cascading it down. So, in terms of communication, it starts from the top to make sure that you bring everybody on par. You need to get your messages through and find different ways to communicate and get messages to everyone. (Leader 3)

Everybody has to contribute to the strategy. We always try to demonstrate to the organisation how it cascades, then anybody is made aware that, that thing of saying we want to, we are aligning ourselves with NHI. We communicate that at every opportunity, in quarterly meetings where the whole entire organisation meets. (Leader 4)

According to the participants, communication must be planned at strategic level, explaining the roles, expectations and responsibilities of different role-players. Nothing must be left to chance. Managers need to know the strategy and vision, the external environment and what they need to know. Managers at various organisational levels must communicate the vision, the mission, the strategy, the tactics, the objectives and the results to their subordinates.

Organisations must have a culture and leadership that drive communication, and take advantage of modern technology to communicate. Opportunities should be created and various platforms used to allow for communication. System design considering outcomes is critical, and exception processes must also be considered. These tactics will assist in ensuring that every employee contribute to organisational strategy. The participants indicated that they were using various opportunities and means to communicate about the NHI.

Leadership process involves developing a vision for the organisation and aligning people with that vision through communication (Lunenburg, 2011). This includes establishing clear channels of communication, and the arrangement, and coordination of activities for individuals and groups to implement plans (Brevis &Vrba, 2018; Lombardi & Schermerhorn, 2007).

Public sector

> *Government communicates through documents and so, the White Paper is the key document that outlines the process. The difficulty is that many people don't read the White Paper. In general, when people say to us that we have not engaged the comments and then you dig a bit deeper to understand how would they know whether we engaged or not? So, if they don't see their text written there, they believe they're not consulted. But I own, the public can say they don't know about NHI and whether they made an effort to understand it in detail, is up to them. What we can do is talk about it and link it to where you will get the material to read it right. You'd have to go read it yourself.* (Leader 5)

We have a communication office. We have an internal and external communication strategy. With management, I have already informed them and if they want to say something, there are written submissions, and there's going to be public hearings. I am not mandated to teach the NHI. It is only now that the Department is appointing a team to work on the NHI. But look at where we are now, we are starting public hearings. But I don't think all is lost. (Leader 7)

Government indicated that it generally communicates through documents. In terms of communication about the NHI, the White Paper is the key document that outlines the process. However, gaps in communication have been noticed and articulated by various stakeholders regarding how government has communicated on the NHI. One of the reasons is that some people have not read the White Paper. In certain instances, when inputs regarding the NHI are sought from individuals or their constituencies, if they do not see their text incorporated in the documents, they tend to believe that they have not been consulted or engaged.

According to the participants, communication regarding the NHI was generally provided. Various platforms were used to convey government's intentions to implement health system reform of UHC through NHI. A communication strategy is required to guide organisations on how to communicate. One of the participants expressed the view that they were not mandated to teach about the NHI, and that government would be starting with public hearings to provide people with information on the NHI and seek citizens' views on the NHI.

In terms of leading change, a range of communication techniques are needed, such as clearly communicating to the organisation the risks of clinging to the status quo; and the potential rewards of embracing a completely different future (Gilley *et al.*, 2008). South African Lancet National Commission (2019) explains that NDoH should design campaigns with inputs, including partnerships with the GCIS, the Presidency, South African Human Rights Commission, OHSC and civil society organisations.

5.5 Chapter Summary

The participants indicated that, irrespective of the size of the organisation, the organisational structure is crucial to implementing mission, strategy and organisational goals. Generally, the organisational missions of the stakeholders are aligned with the principles of UHC. There are hindrances in the public sector processes and systems, due to lack of ICT systems to support work processes. Key to having good processes and systems within organisations is the appointment of competent people to drive the achievement of organisational goals, and the implementation of policy. In terms of communication within organisations, there was an indication that a communication strategy is required and that communication must be planned at strategic level. Leaders need to promote an organisational culture that drives communication. Innovation and the use of various forms of technological platforms are needed to effect health system reform. Mission, technology as an enabler of performance, and communication should be aligned to enhance organisational performance. In the next chapter, research findings on the governance dimension are discussed.

CHAPTER 6: RESEARCH FINDINGS ON GOVERNANCE DIMENSION

6.1 Introduction

In the preceding chapter, Chapter 5, research findings on leadership dimension were discussed. This chapter focuses on the findings of the study and relevant literature, with regard to the study objective on the *governance* dimension. The findings are reported, indicating the perspectives of the public and private sector participants, where possible. The aim was to establish the areas of similarities and differences in participants' views.

6.2 Governance dimension

The objective for this dimension was:

- To analyse the role of governance in health system reform.

Based on this objective, the interviews were conducted to gather data on the role of *governance* in health system reform. Questions were posed to address the identified knowledge gaps, namely:

- *Governance (ministerial, provincial and district levels) – strategy and policies:* There was a lack of available information on governance measures required for health system reform. Strategy and policies would be articulated in the study.

6.3 Background of the participants

- A total of seven individual, face-to-face interviews were conducted with stakeholders, namely the NDoH; three healthcare facilities; two medical schemes; and a medical scheme administrator. From these stakeholders, organisational leaders were purposefully selected for inclusion in the study. Each participant's position had a role that was defined, in terms of knowledge, skills, competencies and experience, with respect to the health system.

The leaders that were selected from the stakeholders to participate in the study were the Deputy Director General of the NDoH; Medical Superintendent of an academic hospital; Chief Executive Officer of a district hospital; General Manager of a private hospital; Chief Executive Officer of a medical scheme; and Principal Officers of two medical schemes.

The interviews were audio-recorded with the permission of participants. The leaders were allocated identifying codes such as Leader 1, Leader 2, Leader 3, Leader 4, Leader 5, Leader 6 and Leader 7. This was to maintain confidentiality and anonymity of the participants.

- The views of some of the participants from the stakeholder dimension, solicited through individual face-to-face interviews, were also included in this dimension. The participants were comprised of stakeholders, such as the Board of Healthcare Funders (BHF); Council for Medical Schemes (CMS); Solidarity Union; Health & Other Services Personnel Trade Union of South Africa (HOSPERSA); and an independent medical practitioner. The participants were identified as Stakeholder 1, Stakeholder 2, Stakeholder 3, Stakeholder 4, Stakeholder 5 and Stakeholder 6.

6.4 Theme 2: The Role of Governance in Health System Reform

A framework to assess governance of health systems in low-income countries (Baez-Camargo & Jacobs, 2011) was considered suitable for this study. Based on the adopted framework, the focus in health systems should not only be on formal governance, but also on the informal institutions and stakeholder networks which affect public governance processes.

A theme relating to governance is discussed, with a focus on the concepts relevant to the study, namely *inputs* (participation, consensus orientation, strategies and policies); *processes* (accountability, transparency, and control of corruption); and *outcomes* (responsiveness, equitable access, and efficiency), in the context of health system reform. Categories relating to governance that are discussed under this theme are listed in Table 6.1.

Table 6.1: The role of governance in health system reform

Categories	Subcategories
1. Inputs	Strategies and policies; participation; and consensus orientation
2. Processes	Accountability; transparency; and control of corruption
3. Outcomes	Responsiveness; equitable access; and efficiency

6.4.1 Governance inputs

The participants' views in relation to participation, consensus orientation, strategies, and policies, are explained next.

6.4.1.1 Strategies and policies

The participants' views were solicited to determine how the health system institutions should be set up to achieve health policy goals.

Private sector

The government should set out the entire policy framework, you know, very clearly, and it should set up very effective regulatory institutions. But it should then leave as much as possible of the delivery, you know, to autonomous entities, which could be private, say administrators like us, or, you know, autonomous districts that are formally or part of the public service. (Leader 2)

Government must take leadership and then provide an oversight role to ensure that the ideal, which is an ideal of UHC, is achieved. I mean, that's the responsibility of government to ensure that everything we do results in better outcomes. (Leader 4)

What I'm very scared of is a huge bureaucracy of public sector employees. Poorly led and managed, not incentivised to look after the interests of customers and then what will we have? We'll have what you've got today with the ... where you can't get a claim paid up, or the ... where you can't, or the workman's compensation, where you can't get money out, even if you deserve the money, and you've been injured on duty. For me, the best role, and I don't think this is realistic, it just my dream is the government plays the stewardship role. So, here's the rules and regulations. (Leader 2)

So, it would have been much better if the NHI goes under the under private's control, with oversight from government as the policeman. (Leader 3)

The participants mentioned that government has the responsibility to create an environment where delivery is offered by autonomous entities such as medical scheme administrators or districts that are part of the public service. In that environment, government should play a stewardship role and provide rules, and regulations while promoting fair competition. Government will be judged by its ability to deliver on its promises. The most important measure of governance is the impact on the population. There is also a need to minimise bureaucracy within the system, and to lead and manage employees in the public sector efficiently to enhance service delivery. Mechanisms should be put in place to incentivise and reward performance excellence. Government, therefore, has to provide leadership, regulations and oversight to ensure the realisation of UHC.

Population health must be explicitly recognised as a key governance role of national government, and intersectoral collaboration should be supported at national, regional and local level to promote concerted action on wider determinants of health (World Health Organization, 2011). Legal provisions in that regard should be amended to ensure that regulations are based on the current national and global experience (Ibid., 2011).

On the other hand, health workers that are competent, motivated, empowered, equitably distributed, accessible and adequately supported by the health system are able to deliver quality healthcare that is appropriate, and acceptable for the sociocultural expectations of the population (World Health Organization, 2016).

Public sector

I think the way the structure is, it is set nicely. I understand it's studied; it's tested, tried and tested. I strongly feel that we should not ignore the benefits we have from this structure that is existing. Central hospitals are national assets basically, they cross-border, they are across the provincial lines. Like now we see Mpumalanga, we see Limpopo, we see some part of North West, so basically, it is really not provincial. It's more national. It makes sense for central hospitals to report directly to the National Department of Health. (Leader 6)

The nice thing with the coming NHI is that with District Health Management offices, there will be subcomponents of National Office. (Leader 7)

The participants are of the view that the benefits of the current structures should not be ignored. A move to have academic hospitals reporting to the national department is supported, as these entities are national assets. There is a relief at district level that there will be a subcomponent of the national office at District Health Management offices for better support of healthcare delivery.

According to the World Health Organization (2008), countries must focus on local health system development to improve access, equity and quality of health services, in order to meet the health populations' needs better.

The District Health Councils, which are the key service delivery structures, are very dysfunctional on the Hospital Boards, Clinic Committees etc. are not operating well. The governance structures are not there, the leadership is missing, as a result of that. So, at all levels, there are problems, in terms of the structure of the organisation and its current functioning. In addition to that, in the private sector, there are other structural problems, clearly. There are organisation issues about how patients access care, how the governance happens, etc., which we also tried to solve, but I would say this is the, the key structural problem. (Leader 5)

According to the participant, there are also leadership and governance weaknesses at all levels of the health system that need to be reviewed. There is an indication that there is a need to strengthen leadership and governance systems, in both the public and private sectors. Hospital boards and relevant committees must be established in the public sector to ensure accountability, oversight, operational efficiencies and the realisation of health system reform of the NHI.

Strengthening the health system with a focus on performance drivers is vital and can be accomplished by more inclusive changes in policies and regulations, organisational structures, and relationships across the health system building blocks to enable the effective use of resources, in order to improve healthcare services (Chee *et al*., 2013).

6.4.1.2 Participation

The participants provided views on how stakeholders that are involved in defining and designing health policy are identified.

I think, to be honest, in terms of the process, from Green Paper, White Paper, all of those, I think there is a structure that is there, until when it ends, and people also have an opportunity to talk. I'm sure if you were to challenge government and say that you guys are not communicating this, they will say, we've put it there, we advertised in this, but which is the minimum that is required of them, they will have met the minimum. So, it's a challenge. (Leader 4)

Sometimes, when you talk about the NHI, you need to try and put some framework, because some people will tell you that historically, we've had these discussions as a country. You know, around 1944, when the NHS was established in the United Kingdom, there were discussions at parliamentary level, in terms of whether we should adopt a system like that. And obviously, that never materialised. And then you've had subsequent commissions. We've had the Taylor commission, you've had the Shisana-Broomberg commission, and you have the Ministerial Task Teams, you have had the Green Paper, you had the White Paper, you've had the policy. Now all of those elements, in my view, have provided for public engagement. (Stakeholder 1)

According to the participants, the legislative process followed by government is considered fair. In addition, the government has met its minimum requirement by communicating through NHI documents that were published. The process of NHI started around 1944. Various discussions were put before Parliament in the past, but they never materialised. Subsequently, the Taylor Commission, Shisana-Broomberg Commission and other committees were established to determine the path towards UHC. In addition, the Green Paper, White Paper and the NHI Bill were published, and these policy documents provided for public engagements. The parliamentary processes have been followed so far.

The World Health Organization (2014) explains that public participation is the practice of involving members of the public in the agenda-setting, decision-making and policy-forming activities of the institutions responsible for policy development. The concept involves interaction and dialogue and, therefore, goes beyond situations where institutions simply provide information to the public, or simply obtain information from the public.

I would have thought by now that most of this has been public. When it's published, it means anybody can have access to it and most of the times there's also a request for comments. So, if you're a serious organisation, you will then comment and once there's a comment, and your comment makes valuable points, then the policymakers will come to you, will engage you because they can see there is a good input. (Stakeholder 3)

The participant indicated that, since the NHI Bill has been published, stakeholders still have the opportunity to be involved until the NHI is enacted. Public hearings have been planned to give citizens the opportunity to contribute towards the process. Regulations still have to be published beyond proclamation of the NHI Act to provide a detailed implementation plan.

In terms of the principle of public participation, active enhancement of leadership capacity of community members, leaders and groups within the community should be enhanced (South Africa, 2019).

6.4.1.3 Consensus orientation

I think that, when they raise concerns, people, or maybe decision-making bodies, think that we are negative towards Universal Health. We are not negative towards Universal Health. We want universal and quality health for everybody, and we also agree that there's lots of problems with medical aid. Overcharging, it's too expensive, all those things we know. But we are concerned about the way that it's going to be implemented. (Stakeholder 2)

The participant believes that when concerns are raised, the stakeholders are perceived as being negative towards the NHI. The stakeholders understand that private healthcare is expensive and overcharged. They also want UHC to work for the provision of quality healthcare. There are concerns, therefore, that the private sector might also experience challenges of overcrowding and efficiencies in the future.

Protectionism – that is a huge one. If, for example, as a scheme, we feel, maybe not even as a scheme, as Board of Trustees of a scheme, we say, if we go into this thing, or if we merge, I'm going to lose my job. I'll do everything I can to mess it up. So, protectionism, I think for me is a huge thing. So, not having the end goal in mind, or not sharing a common vision. (Stakeholder 5)

Protectionism is a huge challenge because stakeholders may engage in putting their interests first, while overlooking the intended goal of health system reform. There are numerous barriers to effective community participation, which, in turn, influence accountability (South African Lancet National Commission, 2019). In the case of a heterogeneous and multi-cultural society, the challenge might be how to derive strength in diversity (Sindane, 2011).

Stakeholders, I'm talking about the GPs that are on the ground, the specialists that are out there, the nurses and allieds that are out there. They don't feel that they're a major part of this. They feel like this NHI is taken up by big business. (Leader 6)

The practitioners that are generally rendering patient care are so involved with their patients that they do not pay attention to political processes. General practitioners, specialists, nurses and allied healthcare practitioners believe that they were excluded from the process, and that the process has been influenced by the business sector.

According to McIntyre *et al*. (2009), there has been limited stakeholder engagement regarding the NHI implementation in the country.

We have been part of the process from the beginning, when the Minister, before the Green Paper, when it was still his idea, he mentioned it on various platforms. Part of our job as a union was to listen to him. (Stakeholder 6).

The participant stated that the Minister of Health communicated on the NHI in various platforms. The communication started when NHI was still an idea. Various NHI policy documents were subsequently drafted and published. Merryl (1994) posits that healthcare reforms require that the process through which major policy decisions are made should be participatory, involving all the stakeholders in the deliberations.

The other thing is the uninformed. If we do not have a consumer that knows and I'm sure you've heard it, a lot of people don't even know what we are talking about when you talk NHI. So, we need to empower them, not just the consumer, but also the practitioners. (Stakeholder 5)

According to participants, apathy, and inadequate and inefficient communication have influenced the process. The leadership process involves developing a vision for the organisation; aligning people with that vision through communication; and motivating people to action through empowerment and fulfilment of their basic needs (Lunenburg, 2011).

6.4.2 Governance processes

The views of participants were explored to determine how they perceived governance in the current healthcare environment in South Africa. The majority of participants expressed dissatisfaction with the existing governance processes. The responses are provided based on accountability, transparency, and control of corruption.

6.4.2.1 Accountability

Private sector

The last 10 to 12 years have been characterised by leaders who sucked the lifeblood out of SOEs. They put weak people around them to allow them to do what they wanted to do. If I start with the private sector, there are many private organisations that are very well governed and I include the pharmaceutical companies. I think the hospital groups are well governed. I think that many medical schemes and many administrators are well governed, but not all. I think, in short, not enough. (Leader 2)

I think in the State environment, the problem is that power, I think it seems to be centralised somewhere. I believe, and I don't know if that's true, that at hospital level, if bread is needed, you need to get approval from the regional, from the provincial office in the Department of Health. I don't know, that's the stories I've heard. (Leader 3)

Well, I think it's a mix. We've got challenges in our healthcare system. We all know that procurement has been a big problem; budget has been a big problem. I think there are still pockets of good governance. It's often not spoken about. So, good governance is there, but there are lots of challenges that we need to address. Our academic institutions are still holding up, albeit with some challenges at the different levels. (Leader 4)

The participants view power in the public sector as very centralised, which results in a great deal of red tape and inefficiencies. There are budgetary constraints and challenges of procurement, but academic institutions are still doing well. In both the public and the private sectors, there are entities that are well governed and some that are not. In the last decade, leaders of State-owned entities (SOEs), in particular, have virtually destroyed these organisations. This creates mistrust towards State-run organisations.

Accountability is one of the important requirements for preventing abuse of power and misuse of public resources, as well as ensuring responsiveness, efficiency, effectiveness, and transparency in public service (Nyawo, 2017). Governments are urged to share the relevant information widely and strategically to promote public participation, and accountability (Nyawo, 2017; Owe Chi & Namara, 2012).

Public sector

"If the purchaser is not obvious, then there is a problem with governance because in the public system, the provider doesn't know what the purchaser has paid. The provider does not see an obligation to basically be transparent, accountable, to be effective, etc. The health service in the public system is perceived as a gift. The people that are sitting there are trapped, or they perceive themselves as trapped. So, you can't demand a certain service. (Leader 5)

There are just so many things that as government, our processes and policies, they must be fool proof. For now, they've got too many gaps. If they don't have gaps, people who are implementing them are not committed and why would you employ people that are not committed? I don't know because somewhere, it means when we were vetting staff, it means we did not do a proper job of vetting. You will never go anywhere where you find that they are talking about ethics. It's not talked about. It's not promoted. (Leader 7)

According to the participants, governance in the public sector is not how it is supposed to be. Policies and processes are considered to have many loopholes. Employing people that are not fit for purpose is a challenge because the incumbents fail to implement what they are tasked to do. Ethics is not emphasised. On the other hand, healthcare providers do not see the need to be accountable and transparent because public health services are perceived to be free.

In addition, the people utilising the public sector do not know that they pay for the services, and they see healthcare as a gift, and they are, therefore, willing to tolerate the poor service offered to them. The future challenge is the State's ability to deliver on UHC.

Governance denotes an arrangement of different, but interconnected elements which include organisational, financial, and programmatic structures; guidelines and institutional rules; resources; priorities; service production and service delivery processes (Siswana, 2007). Governance processes are crucial to the quality of the health outcomes produced (Baez-Camargo & Jacobs, 2011). Notwithstanding the enabling Constitution, strong health legislation and numerous health policies that express government's commitment to a high-quality health system, gaps in ethical leadership, management and governance contribute to the poor quality of care (African Lancet National Commission, 2019).

You have people who, some don't see properly, and you appoint them, they are clerks. They can't even read a document. There are some things that we really need to tie. They come here and say, I have got this condition, I can't work in this particular area and you have just appointed the person. There are too many gaps. You can dismiss somebody based on incapacity, but the process is long, and it's not supported. I don't know how many people are on this long-term sick leave in government. Why are we unable to manage such things? (Leader 7)

When you go to supply chain, somebody wants to remain in supply chain doing the buying all the time, but when you look at PFMA, somewhere you need to be rotating. You can't be doing the same thing because it promotes corruption. People refuse and then it's the unions, and somewhere the case drags and then it suddenly dies. (Leader 7)

There are gaps pertaining to employment contracts, pre-employment screening and termination of employment. There are instances when people are appointed, but are not fit for purpose and this does not add value to organisations. In certain cases, employees deliberately breach their employment contracts or policies because they know that there is poor consequence management. Unions are seen to be acting against employer interests. This makes it difficult for employers to take disciplinary action, or terminate employment, where necessary.

Notwithstanding the enabling Constitution, strong health legislation and numerous health policies that express government's commitment to a high-quality health system, gaps in ethical leadership, management and governance, contribute to the poor quality of care (African Lancet National Commission, 2019). These gaps are exacerbated by evidence of mismanagement, inefficiencies and incompetence at various levels of the health system (Ibid., 2019).

6.4.2.2 Transparency

Private sector

We're reactive in that people don't know before we want to do something, what we're going to do, and I see that as a failure of governance. If you have your governance structures right, that kind of flow of information into the system and out into the whole population needs to flow swiftly in a controlled way. Being reactive is a challenge and it creates uncertainty in planning. (Leader 1)

Public sector

Having gone through the medical aid and I realised that people are going to copy what is existing, meaning what medical aid is using as a funding model, and bring it into NHI and say, this is what we do, we control this, we don't pay this one. That's going to be a bit of a challenge. And that's where now you selectively choose to pay service provider x, more than service provider y. (Leader 6)

With governance, you need to have clear systems and processes that inform how we do things. There must be good governance systems. It must be there, and it must be supported at all levels. And the people who are implementing the system must not look at the SOPs and the procedures only. It must also look at the people who are implementing it. Are the people capacitated to deal with those issues? (Leader 7)

The governance structures are not streamlined to produce documents and information in a coordinated manner. The governance policies are perceived as not being readily available to the public. There are regulatory gaps which are created by reactive policies. This creates a lot of uncertainty and makes planning difficult, especially in the private sector. There is also a concern that medical schemes' funding model may be introduced into the NHI environment, which might create problems of restricting access to certain services, and different payment of providers. There is a need to have clear systems and processes that inform how things are done.

The systems and processes must be supported at all levels. There is also a need to have competent people to implement governance policies, systems and processes.

Transparency requires that political information be properly communicated to citizens through various media platforms to enable the people to participate in public policymaking and supervise the process of public administration in an effective manner (Keping, 2018).

Transparency and openness in government procurement, subsidies, interventions and fiscal policies provide the public with information which may lead to successful political and economic reforms (North, Acemoglu, Fukuyama & Rodrik, 2008). Increased transparency improves the level of good governance (Keping, 2018). According to South African Government (2019), the policies and processes should be revised to ensure that competent and skilled incumbents are recruited in the health system.

6.4.2.3 Control of corruption
The participants shared extensively about fraud and corruption and perceive South Africa as fraudulent and corrupt.

Private sector

I think fraud, waste and abuse happen everywhere. I think the fact that you haven't picked it up, doesn't mean it's not there. Let's take RWOPS, doctor can practice both in the public and private sector. Specialist doctor arrives in the morning into a public hospital, hangs his jacket on his chair in his office. Everyone has seen him in the morning, takes his bag and goes and works in the private healthcare system all day. What happens at the end of the month? (Leader 1)

I think fraud and corruption seems to be in the DNA of South Africa. (Leader 3)

So, in the NHI environment, wherever there's money, there's potential for fraud, waste and abuse, that's just the reality. (Leader 4)

The participants are of the view that activities of fraud and corruption are common in South Africa, and these were prominent during the previous government administration. The lack of structural arrangements, especially in the public sector, to identify, and deal with fraud and corruption does not mean these issues do not exist. There are doctors employed by government who work more in the private sector than in the public sector. However, these providers still get remunerated by the State on a monthly basis. This is a known phenomenon, but it has not been addressed. There has been poor consequence, which creates a lot of mistrust and lack of confidence in the State to administer the NHI Fund.

Corruption and fraud are major threats to equitable access to quality healthcare (South African Lancet National Commission, 2019). Gaps in ethical leadership, management and governance are exacerbated by evidence of mismanagement, inefficiencies and incompetence at various levels of the health system (Ibid., 2019).

Public sector

I don't think the current government policies go far enough. When people talk about corruption, there is somebody that is offering funds and there's somebody that's receiving. The public servant is receiving, but there's never a discussion about the person that's offering. (Leader 5)

People look only at us and say, yeah, CEO and their people, they are corrupt. Supply chain is corrupt, conflict of interest, all these things, but you'll find that it's even more than the CEO. It's politicians who are entrusted with these. There's the MEC and the Minister, beyond them, where do you raise your concerns, in terms of governance? (Leader 7)

I can divide it into fraud in the NHI funding part. That I see too many role-players. That is going to make difficult for fraud to be detected. The bigger side of fraud is in terms of the middle person being given R28 million, R200 million, R2 billion to capture an area like Tshwane, a particular section where they will try and break that money into funny things, and very little will be left for service delivery. A lot of fraud will happen in administration, on the service delivery part that you pay a doctor that didn't come to work. (Leader 6)

According to the participants, there is a view that fraud will happen on the administration side of the NHI Fund, if third party organisations are outsourced for service delivery. There is a concern that the public perceives leaders of organisations and supply chain departments as corrupt. However, the politicians, at times, have unduly influenced certain processes at facilities. There must also be a focus on business because public servants do not corrupt themselves. The public servant might have been weak, but there is someone who encouraged the civil servant to engage in corrupt behaviour.

In terms of governance of entities, public administration must be governed by democratic values and principles, which indicates that a high standard of professional ethics must be promoted and maintained; efficient, economic and effective use of resources must be promoted; public administration must be development-oriented; public administration must be accountable; and transparency must be fostered by providing the public with timely, accessible and accurate information (South Africa, 2003).

The participants were asked to propose solutions, in terms of dealing with fraud and corruption in the country.

Private sector

The experience that has been gathered in the current health environment or the medical schemes must never be ignored. So, there may well be areas where there is need for improvement. And I think with the initiative of the Regulators, you know, that summit, all of these initiatives must be carried forward into that environment. There will be a benefit to the NHI environment. (Leader 4)

There must be a structure to deal with fraud and corruption. (Leader 1)

You have to put systems in place. Whether it's SOPs, we have the procedures. (Leader 4).

The participants are of the view that a formal structure is needed to deal with fraud and corruption in the South African health sector. Structures that have been established, which are experienced in dealing with fraud and corruption in the medical scheme environment, should be carried into the NHI setting to deal with the challenges within the health sector.

The South African Lancet National Commission (2019) recommends that both public and private health authorities communicate a message of no tolerance to fraud and corruption in the healthcare sector; and that the NDoH draw on the expertise of the National Prosecuting Authority, the Public Service Commission and civil society organisations to combat corruption through prevention, detection, disciplinary action and possible prosecution.

Public sector

I think fraud and corruption must be more public and transparent. So, when there are incidences of it, those need to be made public. Secondly, the action that is taken against the culprits must be known, to discourage other parties from committing similar offences. Where you have legislative process, there is a hotline that the police or whoever would have, somebody reported it there, but nothing happened, then the civil society organisations need to take it up as well. (Leader 5)

You need to put systems in place, basically to pay the providers equally. (Leader 6)

I think we must have systems that prevent these fraudulent activities. We must be fool proof because now, I think we're very open to those fraudulent activities and the stealing. We need to be vetted and the system must allow for that. If a person refuses vetting, it is breach of contract. In terms of the qualifications also, it's very important that they do those checks. The processes must be very clear to support us when we deal with those cases to make sure that people are given proper delegations, accountabilities. (Leader 7)

The participants indicated that there must be fool proof systems to prevent, detect and deal with fraudulent activities. Proper systems must be in place for screening of employees, validation of qualifications and verification of other pertinent issues material to appointments. Clear processes, procedures and systems must be in place to effect the NHI implementation. In addition, systems must be in place to ensure fair and equal remuneration of service providers.

There is also a view that incidents of fraud, and how they are dealt with, need to be made public to discourage others from engaging in these irregular activities. Where legislative processes have failed in dealing with fraud and corruption, civil society organisations have a role to play to ensure that fraud and corruption are dealt with in a decisive manner. The people who deal with cases of fraud and corruption must be empowered to responsibly carry out their tasks without fear, favour or prejudice.

There is a need to deal with fraud and corruption; and improve governance within institutions (South African Government, 2019). The NHI Fund must establish an information platform to make informed decisions on service provider contracting and reimbursement, and fraud and risk management (Republic of South Africa, 2019).

We need people who are committed and decisive, very firm and decisive. We need those people. Firm and decisive, and properly trained people. Labour Relations is one area that needs to be capacitated. Fraud, corruption, without government being firm, governance structures, without leadership and leaders who are committed to improving everything, we are not going to get it. (Leader 7)

The other level is the Public Service Commission and then you've got, these days they say even the Public Protector where we can take anything that deals with the public, fraud and other things besides the SAPS and other entities. We just need to strengthen the system, but some of the stakeholders like the unions do not act in the interest of the employer. I have two cases where I don't know what to do because I just feel these people must be medically boarded. (Leader 7)

According to the participant, improved governance requires people who are committed, firm and decisive. Proper governance structures and committed leadership are needed to effect health system reform. There is a need to enforce compliance with policies and regulations across all levels of the health system. Collaboration and strengthening of relationships between employers and the labour unions are necessary for the benefit of both parties.

The ability of a health system to achieve optimal health outcomes is determined by the legislative framework, which is based on structures that give effect to the legal provisions (South African Lancet National Commission, 2019). Although governance arrangements for public health differ between countries, broad governance principles, such as accountability and transparency remain constant (World Health Organization, 2011). Consistency in strategy and direction across different levels of organisation should be secured, using systems for monitoring performance and ensuring accountability (Ibid., 2011).

6.5 Outcomes

The views of the participants addressed issues which relate to responsiveness, equitable access, and efficiency.

6.5.1 Responsiveness
Private sector

I think, if you've got great people with clear vision and strong leadership, you can sort out virtually any problem and deliver and so, build a great National Health Insurance that delivers good quality healthcare. (Leader 2)

The key for success is to appoint competent people. There must be specific goals, specific timelines linked to specific goals, and it must be measurable, and it must be reported in public forums. And there must be consequences, if people don't comply. There must be accountability at the end of the day. If there's no accountability, then obviously, you will do whatever you want. (Leader 3)

Clear vision, great leadership and good people will drive NHI policy implementation and the delivery of quality healthcare. According to South African Government (2019), policies and processes should be revised to ensure that competent, and skilled incumbents are recruited in the health system.

6.5.2 Efficiency
Private sector

There is a need for clear description of tasks and responsibilities, timelines and how they will be achieved. Clarity is needed for everyone to know what is happening. NHI talks about the contracting unit. What gets written into those contracts, is critical because those are the contracts that are going to govern the relationship between the public and the private sector. (Leader 1)

You have to build the trust. You have to build the trust. And that's hard to do. That's hard to do. There has to be leadership and there has to be accountability. That specialist who is doing it, has to be accountable to somebody. There has to be accountability. There has to be consequence management, something has to happen to that practitioner. If it means going as far as the HPCSA getting involved and the HPCSA taking that case seriously, and understanding its impacts, and having a sanction that is that meets the matter at hand. Then that's what needs to happen. We've got to root it out. Otherwise, it just perpetuates. (Leader 1)

The participant stated that when policies are designed, there should be a clear description of tasks and responsibilities, timelines and how they will be achieved. In the NHI environment, there will be contracting units that will contract service providers for healthcare delivery. It is, therefore, vital to develop clear contracts that govern the parties in the public and private sectors, and clearly address how deviations will be dealt with. In addition, an environment of openness and trust is needed to encourage unhindered, and fair collaboration between the public and the private sectors. Leaders are role models and should remain accountable. Therefore, consequence management is required to deal with unethical conduct or practices among leadership.

Governance guarantees the combating of corruption; promotes participation of different stakeholders; ensures that decisions and processes are open, and understandable for improved decision-making and enhanced implementation of those decisions; improves the legitimacy of institutions; strengthens democracy; and leads to effective public administration (Toksöz, 2008).

Public sector

I think that the key requirements are the ones that we spoke about, transparency, accountability, consequence management, effectiveness, efficiency. (Leader 5)

The basic principles of governance are consistency, responsibility/responsiveness, accountability, equity, transparency, participation, effectiveness, and adherence to law (Keping, 2018; Toksöz, 2008).

6.5.3 Equitable access
Private sector

We're living our mission and are in line because Universal Health Care is about access to health in an equitable manner. (Leader 4)

I think we are going to have to relook our governance arrangements. When you read the NHI Bill, you know, it kind of feels like everything is going to be controlled at National. And I wonder how efficient that's going to be; I would think a much more decentralised model would work better. I think what also needs to be bedded down, obviously, is the standardisation to ensure that quality of care is delivered in an equitable manner. (Leader 1)

The concern expressed is related to governance and that at the executive level or Ministry level. There seems to be too much power vested there to elect all the NHI structures. There must be separation of powers, meaning that the bodies that are going to be responsible for NHI oversight must be independent of the Executive. (Leader 4)

Decentralisation, especially at district level, is important in the NHI environment. Avoid too much central authority. If there are no good people, leadership, NHI will not work. (Leader 2)

There is a consensus that governance arrangements require change. Decentralisation, especially at district level, is needed to make services available, closer to the people. Services must be standardised to ensure equity. NHI oversight must be separated from the Executive Authority, which is the Department of Health. Organisational missions must be aligned with UHC principles, which are aimed at promoting equitable access to healthcare, while offering financial protection to families.

Decentralisation holds a strong political element, as it deals with the balance of power between the centre and the periphery to provide more effective, efficient, equitable and responsive government (Van Rensburg, 2004). Some theorists suggest that public power, responsibility, and accountability should be delegated to the lowest level (Hsiao, 2003). However, there is a concern that local governments often lack enough capacity and human resources to manage the public healthcare services (Ibid., 2003).

> *So, if it was me, I would put systems to manage community health workers. Make sure that the community health workers do fit into what happens in the primary healthcare clinics. The referral system is the main thing that will make us succeed. or not succeed because if suddenly 54 million people have access to this national health, we have to control how people access it, and that's the main system control that must put in place, then everything can fall into place.* (Leader 4)

There is a need to have systems to manage community health workers, as they are part of the human resources for health. A clear referral system is required to control healthcare access, from primary healthcare to the tertiary level of care facilities. There is also a need for the public and the private sector to co-operate, and share knowledge and capabilities. Successful governance requires the appointment of skilled and competent people in positions, and accountability among players.

The World Health Organization (2011) states that health policy priorities, and strategies should be revised based on the assessment of current health needs and inequalities in health, and equitable access to preventive services should be enhanced. Consistency in strategy and direction across different levels of organisation should be secured using systems for monitoring performance, and ensuring accountability. Governments should ensure that resources are targeted at delivering essential public health operations, services and activities.

If we say that NHI means one healthcare system, it means we need to strengthen Primary Health Care because the load is coming from the Primary Health Care. If we don't fix the Primary Health Care system, we're still going to overload the hospitals. That is my greatest fear. (Stakeholder 3)

The participant mentioned that for UHC to work, resources at Primary Health Care must be strengthened to alleviate the load at higher levels of care or hospitals. One of the key interventions identified as crucial to the health reform process is the provision of a comprehensive package of care underpinned by re-engineered Primary Health Care (Jobson, 2015).

6.6 Chapter Summary

The participants indicated that the current structures of the Department of Health have not worked and there is a need for decentralisation, especially at district level, to improve access and equity in healthcare. There are several governance challenges in both the public and private sectors, and there is a lack of functional boards at various levels of the public health sector. Fraud and corruption are perceived to be in South Africa's DNA and have been prominent in the last decade. The NHI contracting unit, and contracting arrangements are seen as vulnerable to fraud and corruption. The NHI unit must, therefore, be well equipped and the contracts tightened to close gaps. NHI oversight must be separated from the Executive Authority, which is the Department of Health. The existing policy gaps, such as the RWOPS, need to be reviewed, as they have failed to protect the public sector from abuse.

Structures that have been established in the medical scheme environment, and the entities of government to deal with fraud and corruption must not be ignored. Fairness, transparency, accountability, consequence management, effectiveness and efficiency are key to improving governance at all levels. Clear vision, great leadership and good people will drive NHI policy implementation and the delivery of quality healthcare. Public and private sector collaboration is required to ensure that the resources from both sectors are utilised to ensure sustainability of the health system.

According to the participants, the NHI legislative process followed by government is fair. In addition, the government has met its minimum requirement by communicating through NHI documents that were published. Findings on the service delivery dimension are discussed in the next chapter.

CHAPTER 7: RESEARCH FINDINGS ON SERVICE DELIVERY DIMENSION

7.1 Introduction

In this chapter, the findings on how leadership may influence service delivery are discussed first. This is followed by the views of the participants on the service delivery challenges in South African healthcare facilities.

7.2 Service delivery dimension

The objectives for this dimension were:

- To analyse how leadership may influence service delivery
- To determine the service delivery challenges in South African healthcare facilities

Firstly, service delivery reflects on the immediate outputs of the health system, namely the availability and distribution of care (World Health Organization, 2010). Secondly, one of the key interventions for NHI implementation is the complete transformation of how the healthcare services will be provided and delivered (Jobson, 2015).

According to Meyer and Bonineli (2004), organisations that went from good to great achieved success because of leadership and not due to systems, strategies or structures alone. Leaders must predict forces that will cause change, identify opportunities that will require change, react to unforeseen events that make change urgent and work with others to overcome resistance (Alkahtani *et al*., 2011).

7.3 Background of the participants

The interviews were conducted in an academic hospital and a district hospital in the Gauteng province of South Africa because the State provides healthcare to 84% of the country's population. In addition, Gauteng is the most populous province in the country. The researcher intended to conduct individual, face-to-face and focus group interviews in these facilities. The interviews were conducted as follows:

- Academic hospital

Two individual, face-to-face interviews were conducted with the Director, Supply Chain Department; and the Deputy Director, Finance Department. Focus group interviews could not be conducted at this facility, due to logistical challenges that were experienced by the researcher.

- District hospital
- Five individual interviews were conducted with managers of the facility. Participants included the Nursing Services Manager; Pharmacy Manager; Chief Radiographer; Quality Assurance Manager; and Human Resources Manager.

    One focus group interview was conducted. The focus group was comprised of seven participants that were selected by their managers to participate in the study. The participants were from nursing services; finance; supply chain; food services; the anti-retroviral clinic; and customer services. The participants for individual interviews from both the academic and district hospitals were allocated identifying codes, with the abbreviation SD for Service Delivery, namely SD1, SD2, SD3, SD4, SD5, SD6, and SD8. The focus group was identified as SD7. This was to maintain confidentiality and anonymity of the participants. Each participant's position had a role that was defined, in terms of knowledge, skills, competencies and experience, with respect to the health system. The participants gave permission for the interviews to be audio-recorded.

- The views of the participants from the leadership dimension solicited through individual face-to-face interviews were also included in this dimension. The leaders were the Deputy Director General of the NDoH; Medical Superintendent of an academic hospital; Chief Executive Officer of a district hospital; General Manager of a private hospital; Chief Executive Officer of a medical scheme; and Principal Officers of two medical schemes. The interviews were audio-recorded with the permission of participants. The leaders were allocated identifying codes such as Leader 1, Leader 2, Leader 3, Leader 4, Leader 5, Leader 6 and Leader 7. This was to maintain the confidentiality and anonymity of the participants.

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7.4 Theme 3: How Leadership May Influence Service Delivery

The researcher's aim was to determine what the participants considered effective leadership to influence service delivery, which will, in turn, affect the health system reform process. In addition, the role of the private sector in health system reform was explored. The participants also proposed mechanisms to redesign the health system. Categories relating to this theme are shown in Table 7.1.

Table 7.1: The influence of leadership on service delivery

Categories
1. Leadership effectiveness
2. Private sector role in the NHI
3. Mechanisms to redesign the health system

7.4.1 Leadership effectiveness

The views of the participants were sought regarding how a leader should influence the organisation to achieve organisational and strategic objectives in the current setting, and in the envisaged health system reform environment. These are explained next.

Private sector

Value-based leadership. I think it's so deficient right now and that's what I think the country needs. They need to know what the values of our government is. What are the values of our government? Government must express their value system. An effective leader is the one that is able to withstand the 360 degree assessment. (Leader 1)

I think the leaders of the NHI are going to have to tick quite a few boxes. I think they're gonna have to be very smart. People who are reading, travelling, understanding what's being done, best and worst everywhere. Strong people leaders because it's all about the people. Open-minded, and not come at this job with a very particular ideology. (Leader 2)

An effective leader must be able to give good direction, have an inspiring vision for the organisation that will energise the staff to do what they need to do, but all these may be challenging in big institutions. (Leader 3)

It is leadership that knows the healthcare system. So, by that I mean, you cannot have, and I mean the former Minister used to say you cannot have a person who is not a teacher by profession, being the principal of the school. I mean, even with clinical people who are supposed to lead and become managers or executives, they must naturally also learn the other side. (Leader 4)

The participants are of the view that an effective leader for health system reform must have knowledge of the health system. It is necessary for the leader to have the business acumen to be able to lead effectively. Effective leaders are value-based, and those values are demonstrable and known; they are able to give good direction; and have an inspiring vision that will energise and motivate staff to achieve organisational objectives. The leader should also have strong people skills, and be smart, knowledgeable, resilient and open-minded. The leader must be conversant with global and macro-environmental factors, and be able to withstand appraisal and feedback from all stakeholders.

Health system researchers acknowledge that for countries to have well-performing health systems, leaders need to set appropriate goals and strategies; enhance commitment and compliance with organisational objectives, and productivity; promote a culture of teamwork and dynamicity in organisations; and create commitment across the health sector to address identified priorities for improved healthcare delivery (Figueroa *et al*., 2019; Ghiasipour *et al*., 2017; Saroja & Reddy, 2018).

Public sector

You need leaders who have the vision and who are able to take people along from the current to the new, accepting that people all can't see what you can see, but, in general, a person who comes out with a registered management training would have a more balanced look at things and not come with their own bias. (Leader 5)

With NHI, you need a leader who is a trendsetter, who takes the lead in that, who is very open to explore because it's bound to go out of control. NHI needs an innovative leader. Once again, NHI needs a leader that is going to take decisions, not being afraid. (Leader 6)

You have the vision yourself about where we are going, in terms of the NHI or health. So, if you don't have that vision of where we want to go as South Africa, in terms of healthcare, it's going to be very difficult. Besides all the documents, all the policies and all the tools that are there, something in you must be able to make you inspire people to work. They must believe in you. If you are not believable, people cannot listen to you. I don't think you lead anywhere. (Leader 7)

You need to move from different types of personalities based on the situation and quickly. You must be able to be led. Understand yourself. You can't know everything, but you don't always want to follow. You need to be able to assume whatever role is required at that moment, as it is required. So, it's much more than what you can go and train for. You must understand the politics of South Africa, global trends in IT, even religious sometimes, everything. You must be balanced in everything. (Leader 7)

The participants generally agreed that a leader should be a visionary and be able to take people along from the current to the future. The participants stated that a leader should be innovative and not afraid to take risks. The leader needs to listen and acknowledge the views of others to get their buy-in. The leader must be teachable, resilient, open-minded, innovative, inspirational, influential, believable, adaptable, teachable, business-minded and systems-focused. The leader must be conversant with global matters and macro-environmental factors, and have the capability and skills to lead people, and be led. A leader with a business qualification generally has a balanced approach in leading organisations.

The best way to design, manage and lead the organisation depends on the characteristics of the environment (Grant, 2013). A leader should be able to identify the leadership style most suitable for the situation and then implement that leadership style (Arfeen *et al.*, 2015). Skills

related to the advancement and effectiveness of leaders are technical skills; conceptual skills; interpersonal skills; emotional intelligence; social intelligence; systems thinking; and ability to learn (Yukl, 2013; Olden 2015; Schermerhon *et al.*, 2008).

In terms of *leading change*, the participants from public sector facilities indicated the following:

Principle number one is communication. Effective communication makes things to work better, even the person at lower level may have better idea than you and he can advise, and the leader might put that into action. People must see you as someone's who is also approachable. You need to make sure that people do not undermine you. You need to firm and approachable. (SD2)

I think the one who comes up with ideas and sells them to you and asks for inputs, and discusses and then you come to the party. The person who engages and interacts. I think it's within a person to know yourself, how you can deal with specific people, but you mustn't have favouritism. You treat them the same, but understand they are not the same. (SD4)

I think the leader should not never contradict themselves. What I'm trying to say is that whatever the policies you implement, or the objectives you put out there, you must leave them yourself. When you are a leader, the people you work with, you must achieve with them. (SD5)

The participants are of the view that an influential leader is the one who communicates effectively; is approachable, but firm; interacts with staff; consults and considers the views of personnel and other leaders; understands and acknowledges individual differences; is able to come up with ideas and sell them; is consistent, impartial and walks the talk; believes in teamwork and collective success; and knows the leadership style to adopt, depending on the situation.

Leadership style depends on factors such as the people, the task, the situation, the organisation and the environment (Bolden *et al.*, 2003). Factors that positively influence the change process are driven by fostering agreement, active involvement, commitment and congruence of support at all levels of leadership (Aarons *et al.*, 2014).

Both the perceptions and attitudes of employees are very important in any organisational change (Alkahtani *et al.*, 2011). For leaders to bring about change, they should be involved in their employees' activities and should not be aloof (Ibid., 2011).

Before implementing the NHI, the participants mentioned that the leaders need to consider a pragmatic approach to understand the challenges that are being experienced at grassroots level, in order to find concrete solutions.

> *You need to be practical and involved in whatever that is happening in your directorate. Get reports and you need to visit them to hear what are the challenges. You will expect results, but nothing will come through, if you are not addressing those challenges.* (SD2)

> *Whoever is the leader, the overseer, must just go back and check, and tick. Not just sit there and tick, and tick. Go out there, like coming here, asking the people. The people that are going to implement that, are they ready. Not looking for a report because a report can be very misleading.* (SD5)

Leading change is a significant part of the policy process (Alkahtani *et al.*, 2011). It is not enough to identify policy issues, develop potential solutions, and allocate the necessary resources. In order to implement policy in organisations, the community and society as a whole, leaders must learn how to initiate and plan for change, how to communicate the need for change, how to make a change appealing to gain support from others, and to consolidate the results, so that the changes endure and have the intended impact (Ibid., 2011).

7.4.2 Private sector role in the NHI

The researcher's aim was to explore the views of private sector stakeholders regarding the role they can play in the NHI environment. This was done because some of the stakeholders were not sure of their role in the envisaged reform.

I will work on the assumption that we continue to exist within the NHI environment, in a parallel environment. I'm taking it as an 'as is' approach. I think we have incredible resources. I think government has recognised that, explicitly stated that. I think what they also need to explicitly accept is that we are willing to partner with government, that we agree with them that there is inequality and we need to address that, and that we want to work with them to address those deficiencies, and we just need to be given an opportunity. (Leader 1)

I hope there's much more consultation, and what role could we play is sharing good ideas. What we have done is built up expertise and knowledge, which we'd be very happy to share and we've actually built up assets. Electronic health records, claims systems, fraud, and forensic management systems, you know, billing systems. We've repeatedly said we will give them to the government for no money. We would love you to use them if it helps you. We can contribute skills and assets. And then, as I said, there is a model of the NHI, where we could do some of the delivery of procurement and, you know, administration. But you know, that depends on the ultimate model that they want to come up with. (Leader 2)

The end point of our current strategy is very clear. We are saying, we want to be the blueprint of the NHI. So, by that, what we simply mean is whatever is needed to ensure that NHI is implemented through us Universal Health Care, we always gearing ourselves to ensure that we participate meaningfully in that. So, we model our benefit design in a manner that's anticipating what may be needed in an NHI environment. (Leader 4)

The participants are of the view that they have the resources, skills and capabilities to share with government, to support the NHI implementation. They have built assets over time such as electronic health records, claims systems, fraud and forensic management systems, and billing systems. They are willing to partner and participate meaningfully with government to effect NHI implementation.

The participants mentioned that government acknowledged the extent of resources that are available in the private sector, and they need to be afforded the opportunity to exist in parallel with the State in addressing the deficiencies in the health system to improve access to quality and affordable healthcare.

Department of Health South Africa (2015) states that the NHI will ensure that the State optimally utilises the available resources to benefit the country's population. Financing and delivery of healthcare services in the private sector will be expected to be aligned with the principles of access, affordability, effectiveness, efficiency, equity, health as a public good, and social solidarity.

According to the Department of Public Service and Administration (1997), national and provincial departments are required to identify, among others, the potential partnerships with the private sector, non-governmental organisations (NGOs) and community-based organisations, which will provide more effective forms of service delivery.

7.4.3 Mechanisms to redesign the health system

The participants mentioned proposed measures to be considered in the health reform process.

We do need to look at our current delivery mechanism. We hope that the models that have worked somewhere should work. (Leader 4)

The approach the government has taken is at a broad level, is to introduce a purchaser-provider split which largely influences the public health system. There will have to be a radical change in the way the organisation is structured when the NHI Fund comes in because the Fund is a purchaser and there is a provider which is a public health system and private health system. (Leader 5)

So, you have to take this public sector and break it into two pieces. You have to, you know, keep the hospitals and clinics as service delivery. But you have to create procurement capability. The vision that's set out in the NHI Bill is a very complex one of district purchasing agents, Primary Care purchasing entities and then a central NHI office. So, is that doable? Yes, it's doable. It's going to be very hard work. I think, if you've got great people with clear vision and strong leadership, you can sort out virtually any problem. (Leader 2)

Participants are of the view that the structures in the health system need to be aligned with the vision of the NHI as explained in the NHI Bill. The approach that government took to align the structure with the envisaged health system reform at a broad level was in order to introduce a purchaser-provider split, which largely influences the public health system. Radical changes are necessary to clearly delineate the purchaser functions, which will be effected by the NHI Fund from the provider, namely the public and private healthcare systems.

However, there might be a need to look at models that worked in other countries. The structure, if supported by great people, clear vision and strong leadership, will build a great NHI. The implementation might not be easy. The governance and the system as a whole will need to be changed.

7.5 Theme 4: The Service Delivery Challenges in South African Healthcare Facilities

In a health system, provision of quality healthcare service delivery is crucial. The Donabedian model recognises the existence of three essential factors in assessing quality of healthcare (Voyce *et al.*, 2015), namely: the *structure* (resources and administration); *processes* (culture and professional co-operation); and *outcomes* (satisfaction with services, that is, affordable, accessible and acceptable to the population) (Kunkel *et al.*, 2007).

The Donabedian model was adopted to address the identified *service delivery knowledge gaps*, namely:

- *Structure measures:* There was no clear guideline on the context-specific inputs required for the planned health system reform.
- *Process measures:* It was not clearly articulated how the process would be measured.
- *Outcomes measures:* There was no specific tool to determine how service delivery would be measured, in relation to health system reform.

The model was adopted to unravel the structure, process, and outcomes measures necessary for delivery of quality healthcare in the health system reform. Face-to-face, individual and focus group interviews were conducted with a focus on the *structure, process* and *outcome measures* within a health system to determine the service delivery challenges in South African healthcare facilities.

7.5.1 Subthemes on service delivery challenges
Three subthemes are discussed, namely

- Subtheme 1: Structure measures (resources and administration)
- Subtheme 2: Organisational processes (culture and professional co-operation)
- Subtheme 3: Outcomes measures (satisfaction with services, that is, affordable, accessible and acceptable to the population).

7.5.2 Subtheme 1: Structure measures (resources and administration)
Structural capacity is based on elements such as fiscal resources, human resources, information and physical resources (Handler *et al.*, 2001). The views of participants were sought regarding the administration and resources provided to run their facilities. These are discussed under four categories listed in the next table.

Table 7.2: Structure measures

Categories	Subcategories
1. Sources of funding	• Allocation of budget to run facilities • Impact of budget allocation on healthcare delivery
2. Revenue generation	
3. Human resources to deliver healthcare	• Availability of personnel to meet operational requirements • Staff composition • Employee support by the employer • Impact of financing on human resources • The regulators' role in maintaining practice standards
4. Strengthening resources for UHC	• Healthcare financing • Human resources • Infrastructure

7.5.2.1 Sources of funding

'Sources of funding' refers to the mechanisms used to finance the public healthcare facilities to enable them to achieve their operational and strategic objectives. There are two subthemes that emerged under sources of funding, which are discussed next.

➕ *Allocation of budget to run facilities*

Each and every year after the first quarter, we need to start preparing our request for next year, after we have analysed whether our budget will meet our needs. Actually, we inform the budget speech, in terms of our request, and then from there, they allocate funds to different departments. That's the only source of funding, so we don't have any partnerships. (SD2)

We get our money from the province. The money is divided into several grants. So, the first grant, which is Equitable Share, is the money directly received from the Province. The second chunk is the National Tertiary Services Grant, which is allocated via the National Department via the Head Office to us. And the third part is the Health Professionals Training Grant, but it's a very limited budget. And then we get a little bit of money for what we call, I must find the correct words, but they call it HIV Grant. (SD1)

The National Tertiary Services Grant is for specialists. We get this fund because running this hospital is higher than money allocated for smaller hospitals. We also get the Health Professionals Training Grant for training institutions and the HIV grant, which is very low; it is not even 2% or 3% of the budget because it is treated at primary level. (SD2)

The participants mentioned that their facilities are mainly funded by government. The State allocates various grants, depending on the level (primary, district or tertiary) of the hospital and the services offered in a particular facility. Major sources of funding for academic hospitals, also known as tertiary hospitals, include the National Tertiary Services Grant, which is allocated by the NDoH; an Equitable Share Fund, which is provided by the provincial government; and the Health Professionals Training Grant, provided for training institutions. The annual allocation of funds is influenced by the needs of facilities and hospitals are expected to report monthly on their spending. Funding for healthcare services is solely provided by government.

History, political ideology and the economic status of a country determine the funding mechanisms, types and characteristics of health systems (Green 1999; Roemer 1993). Public financing may be sourced through earmarked revenues such as payroll taxes, general revenues, or donor-supported incomes (Sachs, 2012).

◈ *Impact of budget allocation on healthcare delivery*

Despite the influence of facilities in the budgetary process by government healthcare facilities, the participants indicated that the resources allocated are not enough to meet the needs of hospitals.

The budget allocation is not sufficient. We never stop rendering services, but in the last couple of years, everything that's not paid in this financial year stands over to the next financial year. It's becoming a vicious cycle now because the previous financial year expenditure is tapping into the allocation or the current, and it's getting bigger and bigger. (SD1)

Overall, as an institution, the PFMA states we can overspend up to 2%; anything above that, you need to have valid reasons because, unfortunately, it is not allowed. However, as a health institution, it is very difficult to run an institution within the allocated budget, but we always try. I mean, to keep our services within. So, we monitor it and prioritise the services, and defer what can be deferred to the next financial year because not everything can be done in one year. (SD2)

"I think as South Africa, our resources are far, far less to reach our targets. We are barely reaching the targets that are set." (SD3)

The participants mentioned that the needs of the facilities exceed the available financial resources that are allocated to them. It is, therefore, challenging for hospitals to deliver services with the set budget. The facilities have to prioritise some services and delay others to the next financial year. It is, therefore, crucial to constantly monitor the budget to meet the immediate needs of facilities. However, hospitals always have budget overruns that do not exceed the allocated budget by up to a 2% margin based on the Public Finance Management Act (PFMA). There was an increase in the annual budget overruns, which limits the State's ability to sustain its financial resources.

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According to Department of Health South Africa (2017), almost 50% of the total health expenditure is spent on the 16% of the population covered by medical schemes. The other 50% is spent on the 84% of the people utilising the public sector. Financial resource allocation and healthcare expenditure do not match the needs of the population, with the distribution being higher towards the private sector.

Countries are required to increase domestic resources through improved efficiencies in tax revenue collection and prioritisation of government budgets to meet the 15% requirement defined by the Abuja commitment (Sambo & Kirigia, 2014). Once government has raised sufficient revenue and decided on how to risk pool, resources should be used in these pools to finance services of high quality that are effective and accessible (Lagomarsino *et al.*, 2012).

7.5.2.2 Revenue generation

State hospitals are expected to generate revenue for the services rendered. The patient's ability to pay needs, firstly, to be classified through a means test and, thereafter, the patient makes payments, in relation to the Uniform Patient Fee Schedule (UPFS), which is a billing mechanism used in the public sector. The participants indicated that there are challenges experienced in obtaining payments from patients.

Tertiary hospitals are considered to be national assets, if I can put it that way. They are open for the population of South Africa, but they are also open to the population of Africa. Even legal or illegal immigrants. We don't turn them away either. The embassies no longer really support their citizens who arrive in this country. So, they don't honour those agreements that we had in the past, and you can see that our request or demand of services is actually growing and growing and growing. (SD1)

We don't demand money from people who are unable to pay. So, we classify according to UPFS. So, if you are going to be paying, how much are you earning, so that we can classify you accordingly. If you are private, foreigner, medical aid, South African Police Service, Correctional Services, Road Accident Fund, all those. You can't refuse, but we do follow up. (SD2)

There will be this perception from the patient. Isn't that when our principals go out to canvas for votes, they will say, free healthcare. And when the patient comes to the hospital, you say for this consultation, let's say it's R40 because it's what we charge for the lowest-income earners, maybe they don't have money to pay, but at the end, you still need to follow up on that debt by means of calling the patient to say, remember, you still owe the hospital. Sometimes, some of the answers that we get are not nice because they will say, go to …, he will pay for me. It's where get the challenge when we do the follow-ups on the outstanding debts, we are being told not nice words. (SD7)

The public sector is expected to provide healthcare services to all the citizens of the country, regardless of the person's ability to pay. The public sector also caters for the healthcare needs of other African country citizens, irrespective of their legitimacy to be in the country. In addition, other State entities such as Correctional Services and the Road Accident Fund utilise public sector hospitals. However, over the years, government facilities have been experiencing a decline in funding for healthcare services from other African countries because foreign countries do not honour their agreements with South Africa anymore.

In addition, other entities that utilise the public sector facilities do not always pay for the services timeously. Therefore, they need to be followed up until their debt is settled. The other challenge is an expectation that emanates from politicians' communication during the election period that healthcare is free. This misunderstanding makes it difficult for certain people to pay for services because of the belief that healthcare is free.

Compulsory prepayment into a fund for health services before a need arises is recommended as a way of removing financial risks and barriers to accessing healthcare services (Sambo & Kirigia, 2014). Prepayments may be organised through general taxes or compulsory contributions for health insurance or both (Ibid., 2014).

7.5.2.3 Human resources to deliver healthcare

The views regarding the availability of human resources to deliver healthcare could only be sought from the participants employed at a district hospital.

+ *Availability of personnel to meet operational requirements*

The participants had mixed views on whether the available resources to provide healthcare services were sufficient or not.

We don't have enough personnel to handle everything. There's a lot of logistics that we deal with, as well. We have to order our own stock; we have to label our own stock and give it to the patient. So there's a lot of systems that are affected by human resources in pharmacy. (SD3)

All managers in radiography say, I've got shortage of staff, but when I go there, there is nothing, there's no standard. There hasn't been any tool that was created for us radiographers to say, I've got shortage of staff, especially district. It's not even only us radiographers; all allied workers don't have a standard. Department has not set up a standard. There is no standard in Gauteng to say, district hospital because they are operating 24-hour service, they need so many radiographers. So, we differ. (SD5)

The capacity we do have. We just need more skilled and experienced nurses. (SD6)

The Pharmacy Department indicated that there is a shortage of personnel in their unit. The Radiology Department is also short-staffed, but has a challenge to justify the need for more staff because there is no benchmark for staffing. The Nursing Department, however, stated that they are well staffed, but there is a need for more experienced and skilled nurses. Therefore, staff shortage varies across departments.

In terms of availability of human resources, the issue is not only to have a sufficient number of human resources (O'Connell & Sharkey, 2013). It is also important to have personnel that are trained to provide quality and effective interventions or services (Ibid., 2013).

Staff composition

According to the participants, there is an imbalance of the skills and expertise required to enable the personnel to do what is expected of them.

I've got four pharmacists and four assistants and, on a monthly basis, they handle five and a half thousand patients. Not all four of them are dispensing. Someone needs to order stock, someone needs to handle inpatients. We are relying on community service, which we are only approved for two. Even the interns that come, or the pharmacist assistants that are training with us, we say please help us here and there, and then we try to push the queue. When one personnel is not at work, you feel it, you feel it so much, because it's not nearly enough. (SD3)

In nursing, there is nothing more important than experience. Recently, we got a vast number of newly qualified nurses in this institution, especially professionals. That actually affects service delivery. Remember with the community service nurses, we used to absorb them, hence now, as we're sitting here, there's more younger nurses and less mentorship because there is nobody to mentor sometimes. We do have operational managers, but they are not always there. You need somebody that will take you by the hand when you are newly qualified. That is what we miss. (SD6)

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According to the participants, the number of personnel in the Pharmacy Department does not correspond with the number of patients that are seen on a monthly basis and the tasks that need to be carried out. The skills and expertise are also not sufficient to meet the needs of the facility. The pharmacy also still needs to provide support to interns and pharmacy assistants who work under supervision of the pharmacists. The pharmacy staff are, therefore, not coping with the existing workload. On the other hand, the nurse-to-patient ratio at the facility is perceived to be sufficient. The challenge with the existing staff composition is that most professional nurses have recently qualified and lack clinical experience. There is minimal mentorship that is provided to the newly qualified nurses, which poses a challenge, in terms of delivering quality and safe patient care.

There is increasing evidence that directly links increased availability of skilled health workers with improved health outcomes (O'Connell & Sharkey, 2013). Supervisory and incentive systems are needed to motivate and enforce compliance with global and national norms, and standards (Ibid., 2013).

Employee support by the employer

One of the participants expressed serious discontent with the lack of support from the employer, regarding the challenges faced within the facility. There is a perception that employees are not appreciated, irrespective of the workload facing them.

> *Our people are not machines, they've got emotions and they are passionate about their work that they cannot carry out successfully because the system is holding them back, and you do that on a daily basis. It's not just about knocking off late and being tired, but also your emotions. Our people are tired. We are all suffering from long queues.* (SD3)

You're also down because of the complaints that you have to deal with on a daily basis. We are not receiving those thank yous anymore. People are not satisfied and people don't see the hard work that you are putting in. And when your patients are taking out frustrations on you on a daily basis, when do we get time to debrief? When does someone come and say it's going to be okay? Is it really going to be okay? Are we gonna ever be able to satisfy our patients? (SD3)

It's really sad that we cannot provide some things as simple as a microwave or a fridge for someone who comes to work, to be comfortable and be able to do their work. (SD3)

The participant has a strong view that the employer, which is government, does not provide an environment that promotes the mental and physical wellbeing of staff. Employees have to deal with increased patient load relative to available staff. Staff have to manage long queues of patients waiting for their medicines to be dispensed and still respond to complaints relating to poor service. The participant added that the dedication and hard work of staff under these difficult circumstances go unnoticed.

According to the World Health Organization (2008), countries must implement strategies to address the human-resources-for-health needs by improved planning, strengthening of the capacity of health training institutions, management, motivation and retention to enhance the coverage and quality of healthcare.

Impact of financing on human resources

Based on the participants, the human resources deficiencies are related to insufficient financial resources from government to fully support the operational activities of the hospital.

Posts are not opening up in our system. Posts are there, but they're not funded. (SD3)

Remember with the new dawn of democracy, most of the nurses left South Africa. They went overseas, they went somewhere. (SD6)

The nurses come and go because they go to the private sector. They feel private sector pays more. The environment is better for them because in government hospitals, it happens that they sometimes do not have all the necessary equipment and things that they need to work with, due to budget constraints. Things are there for them to do the work. So that's a big problem. (SD8)

According to the participants, the public sector is not able to care well for its employees. Irrespective of staff shortages in certain areas, vacant posts are not filled because of lack of funding. Nurses, in particular, work in the private sector to augment their income. These health professionals prefer working in the private sector because the working conditions are better, as there are resources available to them to perform their duties. Some nurses left the country after the dawn of democracy and others work outside the public sector, which has created a skills gap.

There is a trend of under-investment in education and training of health workers in certain countries. There is also a misalignment between health systems' education strategies and population needs. The mismatch results in continuous shortages of health workers (World Health Organization, 2016).

♣ *The regulators' role in maintaining practice standards*

One of the participants highlighted that there are regulatory gaps in the nursing profession which affect the training and quality of nurses being produced in the country.

Training of nurses as a whole at the moment is a challenge. Even the number of trained nurses has reduced. So, there is a gap in nursing. There is a gap. The sad part is that they are approving every corner schools. I don't know what curriculum are they using. You find the sister doesn't know how to put up a drip. Remember, nursing is not supposed to be a business. It's supposed to be a training college. If you have to repeat a module or repeat a year of study, it's a business loss for them. There's no profit. Hence, people are going to pass. You never find them failing. (SD6)

The participant expressed concern about the role of the regulator of the nursing profession in South Africa. There is a concern that few nurses are being produced and the demand generally exceeds the supply. On the other hand, there are several private nursing institutions that were accredited to train nurses to augment the number of nurses produced in the country. However, the quality of nurses produced by these private institutions has been questionable, as some of the nurses lack certain minimum competencies. There is a view that, because these are profit-making entities, the private institutions would rather advance a student, even if the requirements to pass were not met, which poses a risk to population health and safety.

There are governance weaknesses in the South African Nursing Council, which is one of the regulators of health professionals in South Africa (South African Lancet National Commission, 2019).

7.5.2.4 Strengthening of resources for UHC

In terms of strengthening resources, the participants mentioned that three areas require attention, namely healthcare financing; human resources; and infrastructure.

Healthcare financing

The government funds the public sector facilities through various grant allocations. There is a perception that the resources are generally deficient and may negatively affect the country's ability to implement the NHI. The participants indicated that the budget needs to be increased to address the country's healthcare demands.

When you go to Treasury, they will always say they don't have money. The issue of budget, if it can be looked at, it will solve most of our problems. The thing is that we need to get more money from Treasury. They must grant us more money. (SD7)

If you look at private institutions, where will the money come from to upgrade these government hospitals because there are already budget constraints. So, how will they upgrade these government hospitals to get to half level of the private sector? So, it means to me that private sector services will go down because all have to be on the same level. (SD7)

The challenges in this hospital is the budget part because, from time to time, also in government departments, they had to put a moratorium on filling of posts, due to budget that there's not enough money to fill the vacant posts. And most of the hospitals also have some posts that have been vacant for some time that could never be filled because of the situation. (SD 8)

There is a strong view from the participants that the existing financial resources are not sufficient to meet the needs of the population served. In addition, the government does not have the financial means to achieve what is planned. Lack of sufficient funding from government also impacts negatively on the filling of vacant posts. On the other hand, there are no established standards on how the public sector will match the quality of service that is being offered in the private sector. The view is that the public sector has been failing to offer quality service and this may make it difficult to match the private sector standard. If the private sector is expected to provide the same service as the public sector, the private sector will have to downgrade to be at the public sector level.

Attaining UHC goals depends not only on the collection of revenue, but also on how other functions such as risk pooling, purchasing of goods and services, and service delivery are performed (Giedion *et al.*, 2013). Public financing may be sourced through earmarked revenues such as payroll taxes, general revenues, or donor-supported incomes (Sachs, 2012). Once government has raised sufficient revenues and decided on how to risk pool, resources should be used in these pools to finance services of high quality that are effective and accessible (Lagomarsino *et al.*, 2012).

🞣 *Human resources*

According to the participants, several interventions are needed to address human resources challenges in the country.

1. *Education and training*

The participants stated that the education and training must be context-specific and relevant to deal with existing challenges.

I think they need to look into the curriculum. I am worried about the curriculum. It's too old for this generation. I trained years back. I cannot have the same book as the people that are training now. Conditions have changed, demographics have changed. So many things have changed. When we were training, there was no Quality Office. There was no Complaints Office. There are human rights issues, Public Service Commission, Public Protector, Human Rights Commission. These people are not just nursing the patient holistically. They are also nursing the environment and political issues. They must be very cautious. So, we must go with technology. You cannot teach them outdated things. (SD6)

District hospital is not a good platform for newly qualifieds. It destroys their career path. Remember, we are dealing with smaller cases. They don't progress because of being in a small hospital. So, as a person, you don't have much exposure. Except when you are a student, but when you are a student, you are learning. Even if there are posts in bigger hospitals, they are very much unlikely to get the posts because they don't have experience. So, they become stagnant. According to me, a cluster approach would assist. We are within seven kilometres of each other. We can rotate the nurses for experience purposes (SD6)

Participant mentioned that there was a need to review the curriculum for healthcare workers to make it relevant to address population healthcare needs. There is also a necessity to incorporate the political, economic, social, and legal factors affecting health and healthcare provision in the education system. The use of technological systems should be promoted for effective and efficient delivery of healthcare services. The participants cautioned that the facility where a healthcare professional works after the completion of their studies may hamper the advancement of their career. If a staff member is newly qualified and works in a small hospital, experience acquired from working in a small hospital may be limited and a barrier to career progression. Therefore, a cluster approach was recommended, where staff members are permitted to work at different facilities on a rotational basis for professional growth.

There is a trend of underinvestment in education and training of health workers in certain countries (World Organization, 2016). There is also a misalignment between health systems' education strategies and population needs. The mismatch results in continuous shortages of health workers (Ibid., 2016). To improve health system capacity, the educational system must be able to prepare the next generation of healthcare providers and leaders, and the nation should develop a stable, competent workforce committed to providing patient-centred, high-quality care (Papanicolas & Smith, 2013).

2. Increase human resource capacity

I think the first step on the NHI is to capacitate every unit. So that we will be able to see to it that we have other resources for us to work. We need resources, we need human sources and the ones that are available need to be taken care of. They need to be debriefed as well, so that they can carry out their work successfully. (SD3)

We need to have capacity-building for our leaders in health. We need to have that, including doctors. (SD6)

According to the participants, there is a need to increase human resource capacity to meet the country's healthcare demands. To promote employee productivity, the employer should provide an environment that protects employees and promotes their wellbeing. In addition, the employer needs to ensure that employees are empowered, and build leadership capacity in the health sector.

The foundation to having a strong and effective health workforce is the ability to respond to 21st century priorities (World Health Organization, 2016). This requires countries to match the supply, and skills of health workers to the population's current and future needs. Health workers that are competent, motivated, empowered, equitably distributed, accessible and adequately supported by the health system are able to deliver quality healthcare that is appropriate and acceptable to the sociocultural expectations of the population (Ibid., 2016).

3. Standardise the allocation of human resources

The participants also stated that there is a need to set standards for resource requirements.

Other district hospitals near us, they've got logistic officers, they've got clerks, others don't have. The ratio of pharmacies to patients? What is it? When are we standardising that ... a day ... a pharmacist should see how many patients? Not just patients, but as well as doctors. If a doctor see 10, then the pharmacist must see 20. Why is it that we have to see more patient that the doctors have to see? (SD3)

If we can have a standard to say how many radiographers should work in a district hospital. (SD5)

It's not about shortage. It's how you use the resources. I'm still saying we don't have shortage of nurses. There is a general shortage of nurses, but how you utilise these resources is an issue. Look at what caused the shortage. Absenteeism, presenteeism. How many nurses are in the institution today? It's how we are doing things that make us think that there is shortage. They don't even work systematically. It's how we're doing things that make us to think that there is shortage. (SD6)

The participants proposed the need to standardise the allocation of resource requirements across various professions, taking into consideration the facility needs. Managers should also have skills to utilise the existing resources efficiently and effectively.

According to the Department of Public Service and Administration (1997), national and provincial departments are required to identify *service standards, defined outputs and targets, and performance indicators*, benchmarked against comparable international standards; monitoring and evaluation mechanisms; and structures, designed to measure progress and introduce corrective action, where required.

4. Review the policy on Remunerative Work outside Public Service (RWOPS)

In addition, the participants indicated that work done by healthcare professionals in the private sector for the purpose of earning additional income must be revisited because it negatively affects employee performance in the public sector.

> *Moonlighting should also be looked into. It's a hazard. It affects public hospitals because people go for quick money. They come to government hospitals very tired because they have been smiling in private because there they make money. They are so tired. They can't smile in our institutions because here, they don't make money. This moonlighting for doctors and nurses is a problem. They must find a way of controlling it.* (SD6)

Critical interventions related to human resources for health are needed, with a focus on human resources policy; governance, leadership and management; education, training, and development; and working with partners to ensure health workforce wellbeing and advocacy (South African Government, 2019).

The plan proposes intervention through the design of a human resource development and management roadmap that includes forecasting, production, posting, retention, and continuous training and management improvement (South African Government, 2019).

- *Infrastructure*

The participants stated:

We are not renovating our facilities, not just pharmacies, but the hospital facilities. When the health standard compliance came, did their assessments and they were saying a whole number of facilities are not up to standard, the Department of Health was surprised, but really, when are we going to renovate our facilities to a standard that is satisfactory to the standard that provides good health for our personnel as well? (SD3)

Coming to our hospital, I think our hospital is more than 40 years old. I think the infrastructure. Those are the things. I think if they can look at them, our service delivery will be up there, and more personnel and also the issue of our ICT system is very bad. Our system that we use to register patients, you know every week, there will be a crash somewhere. We will be three to four hours without a system.(SD7)

According to the participants, the hospitals are not being renovated. The infrastructure needs to be refurbished to the standards that are satisfactory for delivery of healthcare services. ICT systems need to be improved to ensure seamless processing of information for healthcare delivery.

South African Government (2019) posits that the current infrastructure construction has either failed to meet the standards, or even cost far more than it should have. Maintenance of existing infrastructure and new capital are not prioritised. The 10-year Health Infrastructure Plan was developed, but never adopted by the National Health Council, nor shared with the private sector. Therefore, execution of the infrastructure plan is needed to ensure that the health facilities are appropriately distributed and well maintained.

7.5.3 Subtheme 2: Organisational processes (culture and professional co-operation)

Processes refer to a set of activities that take place between professionals, and between professionals and patients, including technical and interpersonal aspects (Voyce *et al.*, 2015). Processes help with identifying, prioritising and addressing health problems, resources and outputs (Handler *et al.*, 2001). Process measures are discussed under the categories listed in Table 7.3 below.

Table 7.3: Process measures

Categories	Subcategories
1. Setting standards for performance	
2. Measuring of organisational performance	
3. Internal and external communication	• Awareness of the NHI • Communication between managers and staff • The role of employees in organisational communication
4. Purchasing of goods and services	
5. Operational challenges	• Ailing infrastructure • Administrative bottlenecks • Increased demands on human resources • Shortage of medicines and consumables • Poor accountability of service providers • Limited resources to meet patients' needs • Challenges with outsourcing • Staff attitude • Influence of patients' behaviour on healthcare delivery

Table 7.3: Process measures (continued)

Categories	Subcategories
6. Complaints resolution	
7. Readiness of facilities to implement health system reform of the NHI	
8. Process measures for health system reform	• Strengthen revenue generation mechanisms • Improve supply chain processes • Enhance pharmaceutical services • Redefine organisational culture

7.5.3.1 Setting standards for performance

The participants were requested to mention the ways in which their organisation set standards for performance.

There is a set of performance indicators being developed, either by National or Provincial Health, which we report on a monthly basis. However, indicators don't really touch the supply chain management. The focus is on average length of stay, number of caesarean, number of babies being born, stillbirths. So it's very medical related. Those indicators they also very, very old and have not been adapted. (SD1)

In terms of targets in finance, performance indicators, from our stats are the main, main items that also influence our budget. Let's say you want to treat a patient, how much can it cost for each patient to be treated, Patient Day Equivalent, they just open that system and check what the indicators are. There are also targets relating to the revenue collection. Every year, we receive targets that we are supposed to reach. It's not easy, but we do try and reach whatever targets that we have set for ourselves. (SD2)

According to the participants, performance indicators are developed by national or provincial departments of health. The indicators include caesarean section rates, and pregnancy outcomes such as the number of live births and stillbirths. These indicators are monitored and reported by facilities. There is a concern that the indicators used are very old and have not been modified. On the other hand, there are financial performance indicators that influence the annual budget allocation to facilities for healthcare delivery. The financial performance indicators also help with determining the average patient cost. There are also targets set for revenue collection, which have to be met.

Organisational performance is regarded as a set of financial and non-financial indicators which offer information on the degree of achievement of objectives and results, using the available resources in a structured manner (Hodge & William, 2004; Ricardo & Wade, 2001; Short *et al*., 2007). If both operational and financial performance are used to measure organisational performance, the aspects that need to be measured should be clearly defined (Gentry & Shen, 2010).

The dimensions of health system performance include *population health, health service outcomes*, *patient experience or responsiveness*, *financial protection*, *equity and productivity* (Papanicolas & Cylus, 2015).

7.5.3.2 Measuring of organisational performance

In relation to measuring performance against the performance standards, the participants mentioned several ways in which their performance is monitored and evaluated.

> *We are also audited or visited by the Office of a National Core Standards, where they have a set of parameters which you need to comply, which to me seems very administrative. It doesn't really measure outcomes according to me, but it's a lot of work.* (SD1)

We also have what we call non-negotiable items in a hospital. So, let's say, for example, I am a patient, I come here. I start from cleanliness. I start from whatever, attitude that we were talking about, availability of medicine, safety of patients, and then now, as a patient when I leave, I try to check all those points and find that out of 10. I can rate 10 out of 10. I think even ourselves that's how now we measure ourselves to say, they are those six key Ministry priorities. Even our national core standards, they require those. Those are the things we can't run a hospital without. So, if we scored 90 on those, it means we are doing well. (SD2)

Fortunately, we've got an electronic system that controls our stock. So, on every Thursday, we send that dashboard report to National. And then I know there is SVS, it's that one for the cell phone where at the clinic level where they don't have computers, they can capture data into an app and send it to National. So, we do communicate our challenges. (SD3).

The participants stated that the facilities are audited against the National Core Standards for Health Establishments in South Africa. The facilities also have to measure their performance against the six key Ministerial Priority areas, which include cleanliness; safety and security; patient waiting times; staff attitudes; infection control; and medicine stocks. The evaluation against the six areas is based on feedback received from patients and the reviews done by the facilities. Based on the assessment scores, the facility is able to determine if performance is satisfactory, or if there is need for improvement. To curb medicine shortages at facilities, an electronic system is used to control stock levels. Weekly, the system sends information to the NDoH on available medicines and challenges experienced. The information helps with generating valuable information for decision-making.

Countries recognise that without measuring health system performance, it would be difficult to identify good and bad service delivery practice, or good and bad practitioners (Papanicolas & Smith, 2013). If both operational and financial performance are used to measure organisational performance, the aspects that need to be measured should be clearly defined (Gentry & Shen, 2010).

7.5.3.3 Internal and external communication

The views of the participants were sought to determine how information is shared across the organisation and to establish whether employees are aware of the NHI.

🔲 *Awareness of the NHI*

Regarding awareness about NHI implementation, there were mixed views from participants about what the NHI was intended to achieve. The participants stated:

It's not well published, but maybe it's too early. I don't know. I mean, I don't understand fully. (SD1)

We appreciate NHI and we understand what it wants to do. For me, I find it more effective when you have someone from outside to come in, give them that thorough understanding to say this is NHI, the reason behind it is 1-2-3, and we want you to move 3-4-5. (SD3)

I think with NHI, there is a lot of misconception. People think that it is still far. (SD6)

Although the NHI Bill was published, the participants mentioned that the intentions of the NHI were not clear. There is a need for someone who understands the NHI to explain how the NHI will be implemented, and the role that facilities and individuals ought to play for its successful implementation. This may help with closing the existing knowledge gaps and promoting individual buy-in at facility level.

McIntyre *et al.* (2009) explains that there is inadequate public engagement and awareness about the NHI. On the contrary, the public is the beneficiary and the contributor that will directly be affected by the NHI, and will also affect its implementation. According to the World Health Organization (2014), governments and other relevant institutions may be held accountable for ensuring that proper participatory processes are in place.

🔸 *Communication between managers and staff*

In organisations, communication takes place at various levels and for several reasons to provide an understanding among employees of what is expected of them. The participants' views were as follows:

> *I like this approach that our CEO is currently doing so much. We always have this sort of imbizos with directorates to hear what are their challenges, what is working, and what you think is not working and what could be maybe, in your view, solution to that, and then we also explain to them what we expect.* (SD2)

The participant indicated that the Chief Executive Officer (CEO), at times, arranges face-to-face engagement with the whole organisation through mass gatherings, called *imbizos*. This allows the CEO the opportunity to provide staff with pertinent information. This process also allows staff to engage with the CEO on issues affecting them. Staff are also empowered to come up with solutions to the challenges faced. On the other hand, staff are provided with information on how their proposals might be realised and what the organisation aims to achieve.

Leading includes establishing clear channels of communication; and the arrangement and coordination of activities for individuals and groups to implement plans (Brevis &Vrba, 2018; Lombardi & Schermerhorn, 2007). Leaders should be able to guide, influence and motivate subordinates to contribute willingly toward the effective and successful achievement of organisational goals (Murry, 2010). The ability to connect with employees and offer a high level of support has been positively related to innovation and creativity (Gilley *et al.*, 2008).

As a manager, you are invited to different forums. So, after those meetings and projects that we understand, we would go back and have, we normally have monthly meetings and others I wouldn't want to put them in a meeting. The challenge I think is to translate it in the manner that they will understand, as well as to win their belief and their understanding. (SD3)

The participant mentioned that when managers attend meetings that do not involve their subordinates, they have an obligation to ensure that feedback is provided to staff. It is important to provide feedback at a level which employees can understand because, if staff do not understand what is being communicated, miscommunication may hamper their understanding of what is expected of them and may also negatively affect the implementation of operational objectives.

Management entails implementing the vision and direction provided by leaders, and coordinating and managing the day-to-day activities (Lunenburg, 2011). Motivating others requires skilled managers to organise and foster a motivating environment, communicate effectively, address employees' questions, generate creative ideas, prioritise ideas, direct personnel practices, commit employees to action, and provide follow-up to overcome motivational problems (Gilley *et al.*, 2008).

The managers highlighted several challenges that are being experienced, if communication is poor between departments, or is unclear to staff.

We operate in silos. So, finance wouldn't really speak to supply chain management and supply chain management wouldn't really speak to HR. Now something happens in finance and the communication doesn't flow through to supply chain management. (SD1)

I think sometimes lack of reading or lack of knowledge, I don't know exactly. Sometimes, it's just the lack of information from just calling somebody and saying, there is this issue. I think that I have seen here and there, not always, but sometimes. People sometimes work in silos and that creates a lot of problems because patients will be frustrated. Mostly, it's not even amongst managers, I think it's more amongst the employees. (SD5)

I realise when people don't understand, they would be resistant and then they don't say out their resistance. You will see with their actions or their performance declining. As some of them, even if you go one-on-one to interview them, you realise that they don't open up and you don't get to understand. (SD3)

According to the participants, communication has an impact on the understanding of the employees to do what is expected of them. Managers are urged to create an environment that promotes open channels of communication with staff. This will allow employees to seek clarity in cases of uncertainty. In addition, information that is conveyed to staff must be clear to enable them to make informed decisions on matters that affect their work.

Uncertainty may result in a lack of buy-in from staff, poor staff morale and difficulty in achieving organisational objectives. Managers should perform an analysis of the reasons for poor performance, as these may be related to lack of employee understanding of what is expected of them. In addition, managers should find ways to improve on their engagements with staff to empower them. Managers should also encourage coordinated engagements with other units to minimise silo functioning.

Leaders should have the ability to guide, influence, and motivate subordinates to contribute willingly toward the effective and successful achievement of organisational goals (Murry, 2010). This requires establishing clear channels of communication, and the arrangement and coordination of activities for individuals and groups to implement plans (Brevis &Vrba, 2018; Lombardi & Schermerhorn, 2007).

- *The role of employees in organisational communication*

Regarding the employees, irrespective of their role within the organisation, they are expected to communicate clearly and show empathy to patients.

> *If you know as a clerk, this how you address patients. As a nurse, this is how you address patients. It will go, because most of the issues emanate from communication.* (SD6)

There is a need to develop, through training, a customer care culture and approaches to service delivery that are sensitive to issues such as disability, gender and race (Department of Public Service and Administration, 1997). Organisations are required to design their processes to be 'customer-centric' to be able to respond to changing customer needs (PricewaterhouseCoopers, 2007).

7.5.3.4 Purchasing of goods and services

In establishing the process followed in public hospitals to buy goods and services, the participants mentioned that there are steps that need be followed. The purchasing process is initiated at facilities, but hospitals do not pay for the goods and services directly. Head Office has the responsibility to pay for the requests.

> *Gauteng is unique. In the hospital, we can't even create the order or do a payment. It is all centralised in our Head Office. So, we've captured it on a system called… So, every item that is on contract, the order is created automatically. When it's on quotations, there is another little process. However, the gist of it, we've got the CEO who signs a document to say she's happy that you can order this item, but you're still dependent on a clerk in Head Office who must push a final button. And if he's not satisfied, it doesn't work either. He's got more power than the CEO to say, no, I'm not going to order that item for you.* (SD1)

The function of paying itself is not within the hospital. It's also done by Head Office. None of the institutions have that function. However, processes are started here, but the paying part, that part is still something that doesn't exist. We authorise them to say from our institution, we are happy. Goods have been received, services have been rendered; you can go ahead and pay. (SD2)

We are dealing with budget, and health does not have enough budget and there are so many demands. Every time, people need new things forgetting that we don't just buy. We have to follow the procedure of budget and there is a demand plan. It has to be on demand plan. Sometimes they feel like we are failing them if we don't buy for the patient; it affects the nurses, the patient and everyone around the hospital. (SD7)

According to the participants, a centralised purchasing system is used to buy goods and services in the public sector. The process to request for the purchasing of goods and services starts at facilities. There are procedures that need to be followed, which include specifying the request and providing supporting documents for that request. The identified goods and services that need to be purchased must be specified on the demand plan for a given period. Once the internal processes have been completed, Head Office of the Department of Health will fund the goods and services that are needed. Facilities do not have control over the payment process.

On the other hand, if an item is not included in the demand plan, it will not be prioritised and, therefore, not purchased. The process being followed of buying only the items listed in the demand plan is not flexible because it does not cater for emerging needs. The individuals making urgent requests get frustrated, and may perceive government as being unable to meet their needs and those of patients, thereby hampering service delivery.

According to South African Government (2019), to improve access to essential medicines, vaccines and medical products, three interventions relating to better management of supply chain equipment and machinery were proposed, namely: 1) establishing a centralised procurement system with a decentralised ordering and purchasing system; 2) developing a

national policy on capital equipment purchasing; 3) and ensuring that skilled persons are involved in the development of specifications for tenders.

7.5.3.5 Operational challenges
The participants indicated that there are several challenges that hamper the delivery of quality healthcare, which are discussed next.

Ailing infrastructure
The participants highlighted concerns about the poor maintenance of existing infrastructure in healthcare facilities.

We are in the situation that all the equipment is coming to the end of life, but all at once, not like all the places where they had the chance to do it over a period. We receive like R100 and something million for equipment, but to equip the hospital in 2006 was already a 500 million investment. That has a negative impact on our service delivery because the medical equipment is starting to fail, but you don't get the money to replace. (SD1)

Our systems are really collapsing. When we've got crisis, I take everyone from the pharmacy, I say let's go and shorten the queue. We've got only two windows. Files are piling up. We're supposed to give patients, but we don't have space to give patients. So we still have infrastructural issues. We've got patient files, we've got patient waiting. Everything is ready, but you cannot issue to patients because your infrastructure is holding you back because you've got only two windows and we are dispensing on those two windows. (SD3)

With us in the food service, we've got challenges with equipment, servicing, and maintain of the equipment. (SD7)

According to the participants, medical equipment is starting to fail and there are no funds to replace the needed equipment. There is generally poor maintenance and servicing of equipment. On the other hand, there is no building of new infrastructure to improve service delivery. One of the reasons for long queues in pharmacies is the lack of sufficient windows to dispense medicines. The lag in maintenance and the building of new infrastructure hampers efficient service delivery.

The current infrastructure construction has failed to meet standards, and costs far more than it should (South African Government, 2019). Maintenance of existing infrastructure, as well as new capital (whether upgrades or new sites), is not prioritised (Ibid., 2019).

✚ *Administrative bottlenecks*

The participants are not happy with the status quo, which is perceived to be full of red tape and inefficiencies.

Let me talk in terms of money. Currently, we are sometimes frustrated by our systems and these reporting structures. In other provinces, things are much quicker, but here, processes are a bit long when you want things to be done. The suppliers, this fourth industrial revolution, they are now submitted through a system that will go straight to Head Office. If it comes straight to me, of course, I will act immediately. So those are the kind of frustration, but, unfortunately, supplier will call me to say now I have not been paid and I have rendered the service. (SD2)

If you take a commodity like asset management, which is also very important. We don't have an electronic scanning system at the moment; it collapsed. We are waiting on Head Office, once again, to roll out a new electronic. We can't count assets in the hospital by hand, we've got over 60 000 assets in the hospital. Yet, the expectation is there that we should do, but it doesn't. We've got no emergency delegations. So we had a case where there was a big water leak, which needs attention today. We couldn't fix it. We needed head office approval. (SD1)

You cannot buy linen while it's not on demand plan. We are practicing now that whatever we purchase needs to be on the demand plan. (SD7)

According to the participants, the goods and services need to be on the demand plan before they can be prioritised and purchased. Items that are not included in the demand plan will not be prioritised and, therefore, not purchased. On the other hand, the systems and reporting structures are a source of delay in how requests are processed and paid. When the suppliers have rendered services to the facilities, the providers send invoices directly to Head Office for processing and payment. However, before Head Office pays the suppliers, the facilities are required to validate the claims.

The participants posited that, if the invoices were sent to the facilities first, the hospitals would be able to act immediately and ensure that the necessary payments are made by Head Office. The process is frustrating because the facilities still have to deal with enquiries from the providers, if they have not been paid by Head Office. The current administrative processes and systems need to be improved to remove bottlenecks that cause unnecessary delays in health service delivery.

Reform of the public health system should focus on improved management, especially at institutional level; more and better trained health professionals; greater discretion over clinical and administrative matters at facility level, combined with effective accountability; and better patient information systems (National Planning Commission, 2011).

Increased demands on human resources

The participants are of the view that the demand on human personnel does not match the available resources.

There are more projects and more systems that the government has put, the Department of Health to try and improve pharmaceutical services, but, unfortunately they don't come with personnel, those projects. It's not like each project every time it's launched, you are given one pharmacist to deal with it, unfortunately not. The same people that are dealing with the long queues and everything they need to look into saying how are the scripts, how many people are we going to refer and all those things. (SD3)

Although the Department of Health is trying to improve pharmaceutical services through the use of ICT systems to enhance healthcare access, those systems require human intervention. In the light of existing human resource challenges, the extra projects are seen to be adding more work to the already stretched workforce. Therefore, a project plan is needed to align the roll-out of government's ICT infrastructure projects with existing capacity to improve access to healthcare and to curb long queues in facilities.

There is currently a clear acknowledgement that weak health systems hinder the delivery of health services, and waste valuable economic and human resources, and that addressing the health system's inadequacies could be beneficial to the country (Samuels *et al.*, 2014).

✚ *Shortage of medicines and consumables*

The participants indicated that there is a general shortage of medicines and consumables that directly affect patient care. The deficiencies are attributed to the unreliable supply of these items by the providers.

Other challenge is that with the depot items, we've got contracts. Unfortunately, most companies do not bid for certain items. And then you have service challenges where you're expected to receive stock on a certain time. There are delays, or they send you part deliveries with stock that will sustain you for only two weeks and you will wait for another delivery. It's serious challenges that we're having with companies, but they would give us the reasons that they don't have maybe the active ingredient. So, medicine availability, it's a serious challenge right now. (SD3)

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The other thing could be the frustration of not having particular resources to attend to a patient like maybe dressings. And you say, let me compromise and use this one. And then the next thing you know, everybody is learned these days with Google and will say, but my father or my mother was supposed to be dressed with GORE-TEX and why are using ordinary gauze. As a nurse, you are challenged by such things. (SD7)

You do an operation and the patient needs a colostomy bag. You refer him back to his hometown in Pietersburg. He arrives back at the hospital with a plastic bag around his wound because in that whole chain, he couldn't find a colostomy bag again. So, I'm buying products for what clinics and district hospitals should be able to supply their patients locally. Now you can't turn away a patient in front of you with a plastic bag around his wound, but that is applicable to too many things. (SD1)

According to the participants, the unreliable supply of medicines and consumables is frustrating and impacts negatively on the quality of care rendered. There are also patients that need to be referred from tertiary or academic hospitals to primary healthcare centres or district hospitals for lower level of care. However, the facilities where patients are referred to do not always have the resources to meet patient needs for continuation of care.

Although there is a vertical integration of primary, secondary and tertiary levels of care services in the country, the lack of resources at lower levels creates a gap in healthcare service delivery in those areas and compels individuals to seek care at the higher levels of care facilities. This results in unnecessary overcrowding in tertiary institutions and long waiting times, and makes planning and funding for tertiary services difficult.

Among the main motivations for UHC are the improvement of population health and the promotion of a fair distribution of health in society (World Health Organization, 2014). Improving access to medicines and medical products requires the establishment of a centralised procurement system with a decentralised ordering and purchasing system; the development of a national policy on capital equipment purchasing; and assurances that skilled persons are involved in the development of specifications for tenders (South African Government, 2019).

- *Poor accountability of service providers*

The participants highlighted gaps in the supply chain processes and lack of accountability from the providers.

> *You get a company that is awarded a contract to deliver bread to the hospital, but doesn't deliver bread, he just switches off his phone. You can't get hold of that company, until he delivers again.* (SD1)

> *We've got a split tender, for instance, the tender that is released, it's a 60% company A, 40% Company B. When you send the order, it gets split into 60% and 40%. When we receive stock, you only receive 40% and then you make another order and your only 40% is coming from one company. So, you ask the other company what is the challenge and they don't have stock. Then it becomes your 60%, its lies as a back order, what they're supposed to still supply to us. There's no way in the legislation where it says I must cancel all the 60% that the other company is supposed to deliver because they become back orders, and I'm forced to keep on ordering and ordering so that I rely on this little 40% that I keep on receiving.* (SD3)

The participants mentioned that there are companies that have been allocated contracts to render services to the healthcare facilities. However, there is lack of accountability by service providers to deliver on their contractual obligations. There is also poor consequence management, in relation to dealing with poor performance from the service providers concerned. There are legislative deficiencies that make it difficult to apply corrective or punitive measures relating to provider non-compliance.

The public officials are responsible for the resources, the budgeting, and the reporting of those resources and their expenditures (Toksöz, 2008). It is, therefore, necessary to look at several levels and sectors of the health system to determine the nature, and extent of the inefficiencies (Cylus *et al.*, 2016). Tackling inefficiencies has an important accountability value, which is to reassure payers that their money is being spent wisely, and for the patients, caregivers and the

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general population to know that their claims on the health system are being treated fairly and consistently (Ibid., 2016).

    🞕 *Limited resources to meet patients' needs*

The participants mentioned that the high number of patients, in relation to the limited resources available, makes planning for healthcare delivery difficult.

Currently, our pharmacy is seeing more than 1 000 patients a day. And many of us just say, but we can't get this medicine at our clinics. So, when there is a failure there, they just move here. And obviously now, instead of spending all our money on pure tertiary services, we cater for a lot of level 1 and 2 services. (SD1)

Once stock starts running out, there are certain places where it hits them first. You quantify 10 000, but you take half of the patients from somewhere else to come and use the 10 000 that we have. We have a lot of influx of patients from other provinces or other facilities. It becomes a challenge to quantify. There are so many unforeseen emergencies. So now we're being very reactive. You don't even follow your demand plan. (SD3)

The participants indicated that the hospitals in Gauteng province experience a high demand for services from other provinces. The increased demand also comes from some of the facilities within the province that do not have medicines and consumables needed by patients. Therefore, demands on the hospitals in Gauteng province make it difficult for the facilities to properly plan for services and adhere to their demand plans.

According to the Department of Public Service and Administration (1997), government institutions must be reoriented to optimise citizens' access to the needed services within the context of fiscal constraints and the fulfilment of competing needs, considering that the objectives of service delivery include welfare, equity and efficiency.

↓ *Challenges with outsourcing*

The participants indicated that shortages in linen at their hospital are due to the centralised system that is being used to wash linen. In the past, hospitals could wash their own linen, and had better control over the use and supply of linen.

In the past, each and every hospital was washing their own linen, but now it has changed. The washing of the hospital linen has been centralised. There is an area called ... All the hospitals must take their linen there. And if we buy new linen here, and then we take it to... when they deliver, they might not deliver our linen. They will give it to another hospital because with them, they will tell you that they are also prioritising. They are looking at big hospitals like George Mukhari and Steve Biko, and we come last. They will say, but you don't have big demand like they are having. (SD7)

In this area, time and again, the machine are not working. And now they don't have linen. We send them dirty linen. They cannot return it because the machines are broken. And that's the answer that hospital will get, we cannot deliver, our machines are broken. So, we have to use linen sparingly. (SD7)

According to the participants, in the past, the facilities washed their own linen. Currently, soiled linen is taken to a centralised area for washing, but the designated area is failing to meet the demands of hospitals. There are inefficiencies related to the machines that are not functional from time to time. Even if a hospital acquires new linen and sends it for washing, there is no guarantee that that particular linen will be returned to the original facility. Priority is given to bigger hospitals, while smaller hospitals are being under serviced. The outsourcing process hampers the continuous supply of clean linen to the facilities which are supposed to maintain cleanliness to promote a safe and therapeutic environment. There is a need to review this system to meet the needs of facilities.

- *Staff attitude*

In relation to staff attitude, the participants stated that nurses are the culprits because they are the majority and are always at the forefront of healthcare delivery.

You know, always they're talking about nurses, nurses, nurses. I think it's because we are always in the front. When they say hospital or clinic, it's a nurse. Even if the porter did something wrong, it will be a nurse. Even if, like our casualty, a patient is waiting for the doctor for a long time, it will be a nurse. (SD4)

I think the issue of attitude is a challenge. It's not only nurses that are having that negative attitude, but it's everybody. And, unfortunately, because the nurses are in the majority in the healthcare facility, they are being blamed for the rudeness of everybody. Although some of them really are rude. (SD7)

Sometimes there are nurses that work according to their scope of practice and that do respect the patients, but you do get lots of them that are rude, but I believe also in private sector you will also pick it up sometimes. But maybe more in government hospitals because of shortage of staff. People maybe are overworked and stressed out, and burnt out because of all the extra shifts and stuff that they have to do. You know and the way management is, and how they roll out downwards, how they treat people and the training also of the people. It's very important. (SD8)

The participants stated that there is a general negative attitude of staff towards patients in government facilities. There are nurses who respect patients, but there are also nurses that are very rude. The reasons cited for the rudeness of nurses are shortage of staff; being overworked; stress and burnout. Issues such as training on customer service, and how managers deal with staff attitude also have an impact on how employees engage with patients and the community.

Public services in a civilised and democratic society are a legitimate expectation and not a privilege (Department of Public Service and Administration, 1997). The South African Constitution, through the Bill of Rights, gives citizens certain rights to act against the State, if they believe their constitutional rights have been infringed (Ibid., 1997).

➕ *Influence of patients' behaviour on healthcare delivery*

According to the participants, some of the patients are a source of conflict in healthcare facilities.

> *Environment as well that we are working in is not conducive, in terms of our community. We are nursing a different community. It emanates from the fact that they don't respect us. So, when they come to hospitals, they are worse. Attitude attracts another attitude.* (SD6)

> *But at the same time in nursing, we are addressing the nurses' attitudes every day, but we are also meeting a very difficult public. The public is very demanding, but as nurses we are trying.* (SD7)

The participants are of the view that the community around them is difficult and makes the working environment hostile. The public do not respect nurses, and come to the hospital with preconceived ideas about hospital personnel. The way patients sometimes interact with personnel is perceived to be a trigger for negative staff attitude.

Organisations are faced with external and internal sources of pressure which necessitate change (Rizescu & Tileaga, 2016). Change involves the continuous adjustment of organisations in the operating environment to external conditions (Ibid., 2016). Organisations need to anticipate and adjust to demographic changes, global politics, competition, social trends, outsourcing and a multi-cultural environment, in order to survive (Brevis & Vrba, 2018; Robbins & Judge, 2013). However, there must be provision of appropriate regulations, coalition-building, effective oversight and accountability (World Health Organization, 2007).

Isn't that we encourage them to bring back their expired medication, so that the disposal can be safe. We will dispose them safely for them, but when you analyse, it's a bag full of insulin. And you look at this insulin and you say, but I don't issue this insulin as ... and when you read the labels, this person has taken the same insulin from me, on the same month they've taken it from Tshwane. On the same month, they've taken it from another facility. And now I mean, one person taking three months' medication which was supposed to be taken in three months, but wants to take it in one month, it's a challenge. And they expire. We need to go into our patients and really study their concept on medication. So we, it's not just internal issues, but also our patients. (SD3)

The participant mentioned that there is the challenge of patients hopping from one facility to another to collect their chronic medication. This hopping is not related to the unavailability of stock in facilities. Patients were found to be in possession of three months' supply of stock for a condition they were being treated for. This trend was observed when patients were requested to return expired medication for safe disposal after it had expired. The hopping and keeping of excessive stock by patients worsens a situation where there is a chronic shortage of medicines in facilities.

Global trends such as rising customer expectations, budgetary constraints, global competition for investment, reform programmes and changing demographics have transformed the environment in which the public sector operates (PricewaterhouseCoopers, 2007). These changing expectations of customers require the public sector to redefine its role, strengthen customer focus and build integrated service delivery models (Ibid., 2007).

7.5.3.6 Complaints resolution

Based on the operational challenges experienced within facilities, the participants' views were solicited to determine the nature of complaints reported and to establish the mechanisms used to deal with complaints.

The patients cannot understand the root of not having stock. So it's a serious challenge. Yes, you deal with the patient, we make them try to understand and all that. We get complaints and sometimes it's how to tell the story of our frustrations to patients. It's not an easy one. Patients cannot bear our bad news every day; at some point they need to complain. (SD3)

In the past, we had so many complaints about staff attitude. You know, a patient will come here complaining about staff attitude. So, you know, sometimes if you don't make them to see, to say, you know, the patient can't come here and just complain for nothing to say, you know, staff give me attitude. (SD4)

I can say that we're doing well because I haven't had any complaints from patients. I think this year I haven't received a complaint to say this patient was in X-ray, received this bad treatment and all that. So, that's sort of my monitoring tool. If quality assurance can call me and say, you know, this form from patient says this, this and this and I will know that something is not right, then I have to go back to my staff and say, what are we actually doing wrong? Can we improve on this, but I haven't received any patient complaint. (SD5)

The complaints that facilities deal with mainly involve staff attitudes and the shortage of medicines. According to the participants, patients complain because of dissatisfaction with the level of service that is provided at healthcare facilities. The patients' unhappiness is a reflection of the facilities' inability to meet their healthcare needs.

Increased patient loads and utilisation in the public sector have compromised the quality of healthcare provided in this setting (Department of Health South Africa, 2017). The unhappiness of the public regarding the quality of services in the public sector has led to increased medico-legal claims, which put enormous strain on the fiscus and the healthcare professionals (Ibid., 2017).

The participants stated that a Quality Assurance Office was established to handle complaints. Internal processes are followed to deal with complaints and these were found to be successful in reducing complaints in facilities.

We've got a form for complaints, compliments or suggestions. So, usually they give them to the patients. We encourage them to give them to the patients on a daily basis for the patients to say something. We are having ones in English, Afrikaans, Zulu and Tswana. There are four languages. (SD4)

The complaints are acknowledged and investigated. You make use of that complaint for the other personnel to learn from that one. It is about improvement. Compliments will be a motivation to the staff. The same with suggestions. We will take the suggestions, but some minor issues like TV we cannot give. The important thing is about patient care and improving their health status. So, the TV, we will explain the issue of the budget. We don't have enough budget. (SD7)

Usually this committee, the chairperson is the Clinical Manager. All the managers of the hospital are there because incident can happen anywhere. So, all of them take decisions. So, you know, this ethics in service training was done. You will be disciplined and also be sent for training and Batho-Pele Principles. I think we are really trying, the staff is really trying hard. We try to satisfy our patients; I even encourage staff. (SD4)

According to the participants, the patients that are hospitalised are provided with complaint forms to lodge complaints, if they need to. The complaint forms are made available to patients on a daily basis. In areas where patients are not hospitalised, posters are available to explain the process that patients should follow to lodge a complaint. Because of the diversity of the South African population, complaint forms are available in four main languages spoken in the area. When complaints have been lodged, they are acknowledged and investigated.

There is a committee that is dedicated to handling complaints received. This committee is represented by all the managers within the facility to enable them to obtain first-hand information about issues affecting their areas. If there is misconduct, employees are disciplined and are also sent for targeted training to prevent a recurrence of the problem. These interventions are done to improve staff-patient interaction, and to enhance patient experience. Compliments are also welcome because staff is able to see areas that patients are happy about. There are also suggestions provided by patients, which are prioritised based on budget availability and the need to improve health.

PricewaterhouseCoopers (2007) posits that improvements in customer experience and outcomes should focus on the *speed* to deliver the service correctly the first time, and *responsiveness* to the customer needs.

7.5.3.7 Readiness of facilities to implement health system reform of the NHI

The participants mentioned that lack of resources, facility-related complaints and low staff morale negatively affect service delivery, and may hinder the successful implementation of the NHI.

Unfortunately, the stock outs lead to these bad news, lead to the frustration of the patients. It leads to longer queues because you have to send the patient back to the doctor, they have to be switched from one item to another, they have to come back; you have to look for that. By the time you get there, at the end of the day, you only have this little much stock, you still don't certify the patient. (SD3)

Already now, there is staff attitude because of shortage of staff. Now we are putting NHI on top of all those problems. What's gonna happen? Are we not creating an explosive bomb? Is the structure ready? If the foundation is not ready and you are forcing to build, by the time you put a roof, what's gonna happen? Especially staff shortage, attitude, equipment, resources. Are we ready? (SD5)

We know the six key priorities, you know, cleanliness, patient safety, security, attitude of staff, availability of medicine. Do we have that in place to say NHI is ready? If you are leader, the top leader, when they look at what they have drafted, how far are they? Realistically so, how far are they? My question is are we ready, or pushing? For me, most hospitals, including our hospital, the infrastructure has not changed at all, but we are saying in 2026, we're implementing the NHI. (SD5)

The challenges identified were linked to the existing inefficiencies within the health system. The participants had a strong view that the country is not ready to implement the NHI and were, therefore, sceptical of the government's ability to implement reform through the NHI. The participants indicated that certain key priority areas were identified by the Minister of Health during the NHI pilot process as being crucial in addressing service delivery challenges. The areas included cleanliness, patient safety, security, attitude of staff, and availability of medication. There is a view that achieving the set objectives is not realistic. Therefore, expecting additional changes, after failing to achieve the initial milestones, is unreasonable.

Attaining UHC goals depends not only on the collection of revenue, but also on how other functions such as risk pooling, purchasing of goods and services, and service delivery are performed (Giedion *et al*., 2013). During the NHI pilot process, six ministerial or priority quality areas were identified which had to receive urgent attention (Harvard Medical School, 2015; Madisha, 2015). The areas were cleanliness; safety and security; patient waiting times; staff attitudes; infection control; and medicine stocks (Ibid., 2015; Ibid., 2015). The progress in the pilot districts was slow and dissimilar, and districts were struggling to improve quality of healthcare and build capacity (Harvard Medical School, 2015).

7.5.3.8 Process measures for health system reform
The participants mentioned that the processes to implement the NHI at facility level were not articulated.

Currently we are not yet clear on what could be the processes after this whole implementation. (SD2).

Public accountability and participation are also related to, and partly overlap with several other important aspects such as transparency, voice, inclusion, empowerment and responsiveness (World Health Organization, 2014).

I've been to conferences where we were discussing to say, where are we as pharmacy, in terms of NHI? What is expected of us? Unfortunately, you, you've got the Bill and the Bill does not give you structures, or does not give you processes. Us as managers, we need to develop those processes and say how do we reach this goal. (SD3).

According to the participants, although the processes of the NHI implementation have not been communicated, managers may be expected to develop these processes within their facilities to operationalise the NHI implementation.

Management is the process of getting things done with, and through people to achieve organisational objectives (Brevis & Vrba, 2018; Olden, 2015). Management requires implementing the vision and direction provided by leaders; coordinating and staffing the organisation; and managing the day-to-day problems (Ibid., 2011).

The participants' views regarding how the processes may be improved were solicited. The participants made various recommendations on how processes may be improved to strengthen the health system and improve delivery of healthcare.

 Strengthen revenue-generation mechanisms

There is a view that government needs to find ways to strengthen revenue-generation mechanisms by healthcare facilities.

Up until such time that we have proper controls, like policies or something that is documented some way, to say yes, we are not refusing patient services. However, if … has treated this patient here, we know we are definitely guaranteed that we will get our money back. It's guaranteed that after you rendered service to Mpumalanga or wherever, you will just send the bills, but what guarantee do we have, nothing. Not allowing things to go beyond like three or four years. Because now, it becomes very difficult to collect after so many years of having the debt. So far, we rely on only ourselves making follow-up with them up until it's done. (SD2)

The participant is of the view that there must be policies in place to determine how services offered to other provinces; government entities such as the Road Accident Fund, Correctional Services and the South African Police Service; and African countries are funded. The policies must clearly articulate how funds should be recovered to settle debts. This will serve as a form of guarantee for payment of services and will improve debt recovery measures.

There is a need to address capacity constraints and revenue-generation mechanisms that exist in the public sector; and improve governance within institutions (South African Government, 2019).

🞤 *Improve supply chain processes*

In terms of supply chain processes, there is a need for the current processes to be improved to enhance operational efficiencies and quality healthcare delivery.

Actually, as many as possible items should be awarded on a contract basis. So, we run the tenders for those, and it gets awarded. Then you deal with the same company all the time and you can start to build relationships. However, now today, we buy needles from ABC; tomorrow from BCD. You never get a chance to build a relationship with a company to discuss product for what it is. We need a massive change management still to run those systems in the hospital and it is getting a bit frustrating. (SD1)

In the current environment, there are instances where facilities are required to rotate suppliers to purchase certain goods and services. However, this system poses a challenge to facilities because they cannot establish a trusting relationship with the suppliers and find ways to deal with challenges that affect both parties. There is a need to rather use a tender process, which allows for many items to be put on tender. This will allow for a wider pool of suppliers to service the facilities. When contracts are awarded for items on tender, the contracts should be awarded for a period that guarantees the procurement of quality goods and services, and ensures continuity, and an enhanced working relationship between suppliers and facilities.

On the other hand, the Radiology Department mentioned that they do not experience challenges with their suppliers because most of the consumables the facilities use are on contract, which helps to obtain efficient service from the service providers.

According to South African Government (2019), three interventions were proposed to improve the management of supply chain equipment and machinery, and these include establishing a centralised procurement system with a decentralised ordering and purchasing system; developing a national policy on capital equipment purchasing; and ensuring that skilled persons are involved in the development of specifications for tenders.

We follow the supply chain process. As I said, I already know how long it takes, if I order now. So, I just monitor my consumables, I order in time. Even if there is delay, two weeks or whatever, I still have things. Unless, if there is something because our consumables are under contracts and there are different contracts, companies that are contracted by Gauteng Department of Health. We don't use three quotations. There is a contract for five years for our consumables. (SD5)

General provisions applicable to the operation of the Fund state that the Fund must be an active and strategic purchaser of healthcare services on behalf of users, according to need; establish an information platform to enable the Fund to make informed decisions on population health needs assessment, financing, purchasing, patient registration, service provider contracting and reimbursement, utilisation patterns, performance management, setting the parameters for the

procurement of health goods, and fraud and risk management; and determine the nature of provider payment mechanisms and adopt additional mechanisms (Republic of South Africa, 2019).

> ➕ *Enhance pharmaceutical services*

The participant made several proposals on how various issues in the pharmaceutical value chain may be improved.

> 1. *Improving human resource capacity*
>
> *I would like to see us having clerks, trained personnel and for us to open more windows. I would like to see us having supply chain because when we look at the amount of items that we order, maybe 25% of them are almost the same as supply chain, and I think it warrants that someone who is qualified in supply chain can come and work fulltime in pharmacy to assist us to have this 100% availability. And we are honestly not trained in logistics and supply chain, and you find that I have to take a pharmacist who's doing stock control to do those things.* (SD3)

The participant indicated that there is a need to have the skills to match the needs of the Pharmacy Department. As 25% of pharmaceutical work involves supply chain processes, there is a need to have an employee in the unit with supply chain skills. There is also a need to have a clerk to deal with administrative duties of the unit. These resources are needed to allow pharmacists to focus on their key deliverables. There is also a need to have more dispensing outlets to allow for maximum utilisation of resources for reducing patient waiting times.

The basis for a strong and effective health workforce is the ability to respond to 21st century priorities (World Health Organization, 2016). This requires countries to match the supply and skills of health workers to the population's current and future needs (Ibid., 2016).

2. Review of legislation to improve access to medicines

The participants mentioned that there are instances when certain drugs are not available in the public sector, but those medicines are available in the private sector. Legislation on procuring pharmaceutical products should be amended to allow facilities to source medicines directly from the private sector and make direct payments for those transactions.

We are in a very, very tight position and our red tapes are mostly legislation to say, I cannot take hundred thousand and go and buy Oxazepam from a nearby pharmacy, even if they had stock. I need that money to be released first. By the time the money gets released, that recommendation to treatment alternatives will be on my table. It won't be ethical for me to take the money now and go and buy. (SD3)

Our PFMA does not exclude medicinal products or pharmaceuticals to be specialised items. I think legislation needs to assist us in that sense to see if I don't do three quotations then I'm bypassing the process. (SD3)

There is also a request for policy review to allow for the ordering of items without following the supply chain processes (of supplying three quotations) in instances where there is a known shortage or limited availability of certain drugs.

There are inadequacies in the pharmaceutical supply chain and the annual inventory procurement costs (Department of Health South Africa, 2017). Meaningful public-private partnerships are needed, in the context of the NHI (National Planning Commission, 2011). Best practice purchasing, provisioning and procurement, as well as sound financial management are important in these partnerships to improve access, equity, quality and innovation for efficient service (Ibid., 2011).

3. Integrate systems across the pharmaceutical value chain

The participants mentioned that there is a need for an integrated ICT system to generate and track orders between facilities, and suppliers in the country, and to be able to generate data for decision-making at various levels of the organisation.

We've got an electronic system. We are encouraged to do everything both electronically and manually. We want the … system to be centralised at the hospitals as well, so that you put all your data and then, after a certain period, maybe after 12 months, you calculate to say how much did I use in the previous year. So, the system will help us generate a report that considers everything in one. We need a system where we can be alerted when we are about to run out of stock, not that when we are already out of stock; we need a proactive system. Government wants to introduce a centralised database patient information. That will really, really help us because we've got patient hopping; they hop from one facility to another. Their medication even get expired. (SD3)

An integrated system is needed across the pharmaceutical value chain to help with the real-time monitoring of stock levels to minimise medicine shortages, and improve communication between suppliers and facilities. There is also a need to have a national, integrated system to enable facilities to track patient movement between facilities, so that they can curb patient hopping from one facility to another for the same treatment.

There have been media reports of medicine shortages in health facilities (Barron & Padarath, 2017). The reasons cited were varied, and ranged from shortage of personnel to lack of communication between suppliers, depots and health facilities (Ibid., 2017). Complete health system reform will mean that there is a greater use of ICT and systematic use of data at all levels (National Planning Commission, 2011). The development and implementation of an integrated health information system is needed to focus on the management of the system, the efficiency and efficacy gains, and the quality of the health system (South African Government, 2019).

4. Promote public-private partnership

According to the participant, there is a necessity to collaborate with the private sector when dealing with challenges experienced regarding the availability and distribution of pharmaceutical products.

We need to develop that relationship between the State and private because currently, it will be illegal for me to go and borrow Oxazepam from the private sector; I need to buy it. And how many patients do I have that are on Oxazepam, and private wants their money now. The only money I can use now is petty cash, I don't know. (SD3)

We need to develop a good relationship with the private sectors, especially with the manufacturing companies. They need to be made aware that it's human right to receive medication. And we need to strengthen legislation as well. They need to be accountable for not providing medication. We need to start being very strict. If the active ingredient is stuck on a ship in the ocean, the ship has been stuck for four days, there has been a delay ... I understand that we have challenges, but we need to find a way to make them accountable. (SD3)

There is a need for government facilities and the private sector to work together for the common good of the country's healthcare needs. Patients have a right to receive medication. If there is a shortage of medicines in the public sector, there must be a system that allows patients to obtain medicines from the private sector, without them incurring additional costs for that treatment. In addition, legislation needs to be strengthened to address issues of non-compliance, where there is a failure by suppliers to deliver on their contractual obligations, to ensure the continuous supply of stock to facilities.

Meaningful public-private partnerships are needed in the context of the NHI (National Planning Commission, 2011). Best practice purchasing, provisioning and procurement, as well as sound financial management are important in these partnerships to improve access, equity, quality and innovation for efficient service (Ibid., 2011).

+ *Redefine organisational culture*

There is participant who is of the opinion that public sector facilities do not have a culture that differentiates them from other organisations.

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So, we need a culture, that's where we need to say, this is government hospital. From the security when you enter, ma'am, do you know where you are going? Government hospitals don't have a culture. We need to have a culture. Let's start with a culture. We need to look at the face of the organisation. If our government, if our department needs to change, they should change the culture. That's all I can say because each and every department or every organisation, they have a culture. There is a reason they call it organisational culture. We need to have a culture. If it means we should form a certain group of people, we pilot it, let's start here, I'm ready to do it. (SD6)

According to the participant, one of the causes of poor customer service in the public sector is the lack of organisational culture. To improve service delivery in organisations, change in organisational culture should be prioritised. There is a need to design policies that clearly articulate organisational culture to address issues of branding, communication, consistency and organisational reputation.

Leaders create organisational structure, shape organisational culture, and set standards to guide organisational culture and the results to be achieved (Franco & Almeida, 2011; Shriberg *et al.*, 1997). Leadership is needed to transform the existing organisational structures and culture of the public health system, in particular, and translate new policies into routine ways of doing business within the system (Gilson & Daire, 2011).

7.5.4 Subtheme 3: Outcome measures (satisfaction with services, that is, affordable, accessible and acceptable to the population)

The Donabedian model indicates that the *outcomes* are the consequences for the health and wellbeing of individuals and society, and include clinical outcomes, quality of life and satisfaction with the healthcare provided (Voyce *et al.*, 2015). The views of the participants under this subtheme are explained based on Table 7.4.

Table 7.4: Outcome measures

Category
Impact on the quality of healthcare

7.5.4.1 Impact on the quality of healthcare

The participants are of the view that the challenges experienced at facilities directly impact on their ability to meet the needs of patients.

Remember the estimates that we normally send is according to what we use. So, now when item B is not in, we're going to item C and we exhaust our estimates on it because it was not intended for half of the patients on item B. We move patients from one product and then, once the product is back, we try to move the patient back. Where is the quality of our services in that case? In a government sector, you cannot say to the patient go and buy. Unfortunately, you are in a tight corner and do not know what to say to a patient. You try to explain to them, but patients are patients. What they are expecting is their tablets, not an explanation why they cannot get their tablets. (SD3)

Unfortunately, the stock-outs lead to these bad news, lead to the frustration of the patients. It leads to longer queues because you have to send the patient back to the doctor, they have to be switched from one item to another, they have to come back, you have to look for that. By the time you get there, at the end of the day, you only have this little much stock, you still don't certify the patient. (SD3)

I think the waiting time is definitely a problem. They say they wait long. You know what, everywhere you go in government, there is a queue. You have to wait. We help people with disabilities, they come first and casualty comes first. In the end, if all the cashiers are there, it goes fast. If they are not there, then it is a problem. Sometimes, when the system is down, that also makes it difficult for them to register patients fast. They have to work manually and you can't get files of people without card numbers; that is why we always urge people to bring their cards. (SD7)

Doctors are worse than nurses because they leave the patients to go and work in their private surgeries. Nurses don't. It's either you are here, or not. With us, it's more of absenteeism or presenteeism because somebody will come and just loiter around, and that makes others very unhappy. (SD6)

The participants indicated that doctors leave patients to go and work in the private sector. On the other hand, nurses that also work in the private sector do not rest and they are not productive when they are at work in the public sector. The other issue that affects service delivery is the waiting times in government departments. The situation is made worse when the systems that are used to capture health information to produce patient records are off. The manual generation of medical records is time-consuming and causes unnecessary delays.

The disruption in the supply of medicines makes it difficult to continuously provide patients with the drugs prescribed for them. If a prescribed medication is not available, patients have to be switched to other drugs, which may not necessarily be as beneficial as the initial treatment prescribed. Patients have to deal with adjusting to new side-effects and, sometimes, ineffective regimens. However, when the patients' original treatment become available, they are switched back to their first treatment, which affects the quality of care provided to patients. All the issues mentioned negatively affect the access and quality of the healthcare provided.

Increased patient loads and utilisation in the public sector compromise the quality of healthcare provided in this setting (Department of Health South Africa, 2017). Improving service delivery is an important goal of the public service transformation programme and calls for a shift away from inward-looking, bureaucratic systems, processes and attitudes, supporting a search for new ways of working which prioritise public needs, is better, faster and more responsive to the citizens' needs (Department of Public Service and Administration, 1997). It also means a complete change in the way that services are delivered (Ibid., 1997).

7.6 Chapter Summary

The views of the participants indicated that delivery of healthcare services is complex, and influenced by factors that are internal and external to organisations where healthcare delivery takes place. In terms of the structure measures, government funding, revenue generation, and human resources play a crucial role in enabling organisations to achieve their operational and strategic objectives. The participants' views demonstrated that funding from the State is limited and, therefore, affects the ability of facilities to fulfil their mandate of providing quality healthcare to the country's citizens.

Various service delivery challenges exist, relating to the ailing infrastructure; administrative bottlenecks; increased demands on human resources; shortage of medicines and consumables; poor accountability of service providers; limited resources to meet patients' needs; challenges with outsourcing; bad staff attitude; and the negative influence of patients' behaviour. Most complaints reported relate to bad staff attitude and medicine shortages.

There is a general view from the participants that the facilities are not ready to implement health system reform because they failed to achieve on the initial minimum standards that were set. During the NHI pilot process, there were six ministerial or priority quality areas that had to be attended to urgently, namely cleanliness; safety and security; patient waiting times; staff attitudes; infection control; and medicine stocks (Harvard Medical School, 2015; Madisha, 2015). The progress in the pilot districts was slow and dissimilar; districts were struggling to improve quality of healthcare and build capacity (Harvard Medical School, 2015).

According to participants, several flaws, in relation to the existing systems and processes, need to be reviewed. Processes regarding the implementation of health system reform have not yet been articulated. Nevertheless, managers will be expected to outline processes to operationalise the implementation of health system reform. Several proposals were made regarding the processes that need improvement, including refining the supply chain processes; improving revenue-generation mechanisms; reviewing the pharmaceutical value chain; and redefining organisational culture.

Regarding outcome measures, *firstly*, the issue that negatively impacts on the quality of care is the long waiting times in government departments, which is sometimes attributed to the systems being down and medicine being out of stock. *Secondly*, the disruption in the supply of medicines is a challenge, as this makes it difficult to continuously provide patients with their needed treatment. Patients have to deal with adjusting to new side-effects and sometimes ineffective regimens. *Thirdly*, doctors and nurses who are employed in the public sector and work additional hours in the private sector are compromised because they focus more on the private sector, which negatively impacts the quality of care provided in public healthcare facilities.

The participants indicated that an influential leader is required to enable the achievement of organisational and strategic objectives, and effect health system reform. An influential leader is one who communicates effectively; is approachable, but firm; interacts with staff; consults and considers the views of personnel and other leaders; understands and acknowledges individual differences; is able to come up with ideas and sell them; is consistent, impartial and walks the talk; believes in teamwork and collective success; and knows the leadership style to adopt, depending on the situation. Health system strengthening is needed, with a focus on human resources; infrastructure; and healthcare financing. An effective leader is required to drive the implementation of health system reform and organisational transformation. The leader should be value-based, innovative, teachable, resilient, open-minded, inspirational, influential, believable, adaptable and systems-focused. The next chapter discusses findings on the stakeholder dimension.

CHAPTER 8: RESEARCH FINDINGS ON THE STAKEHOLDER DIMENSION

8.1 Introduction

In this chapter, the findings of the stakeholder dimension are discussed. The objectives for this dimension were:

- To analyse the role of stakeholders in implementing health system reform
- To analyse the influence of stakeholders in implementing health system reform.

Stakeholder theory was used as a theoretical framework for this dimension. Stakeholder theory is about creating value and managing a business effectively, and is concerned with the relationship between the organisations and their stakeholders (Freeman *et al.*, 2010; Fernando & Lawrence, 2014).

In this study, it is argued that there is a need to identify, manage and engage various stakeholders. *Stakeholder knowledge gaps were:*

- *Types and roles:* The types of stakeholders and their roles in implementing health system reform were limited in the literature, especially in the context of a developing country.
- *Interests and powers:* In practice and in theory, the interests and powers of stakeholders in the context of a developing country were inadequate.
- *Needs and viewpoints:* The literature and practice did not provide clarity on the needs and viewpoints of the stakeholders that are necessary for the reform.

Stakeholder concepts were, therefore, analysed and described, focusing on stakeholder *identification* and *roles*; *attributes* (legitimacy, power and urgency); *engagement* and *management*. This was done, taking into consideration the stakeholder knowledge gaps that were identified, namely the *types and roles*; *interests and powers*; and *needs and viewpoints.*

8.2 Background of the participants

A total of six individual, face-to-face interviews were conducted with stakeholders, namely the Board of Healthcare Funders (BHF); Council for Medical Schemes (CMS); Solidarity Union; Health & Other Services Personnel Trade Union of South Africa (HOSPERSA); and an independent medical practitioner. The participants were identified as Stakeholder 1, Stakeholder 2, Stakeholder 3, Stakeholder 4, Stakeholder 5 and Stakeholder 6.

The participants also included seven stakeholders for the leadership and governance dimension, namely the Deputy Director General of the NDoH; Medical Superintendent of an academic hospital; Chief Executive Officer of a district hospital; General Manager of a private hospital; Chief Executive Officer of a medical scheme; and Principal Officers of two medical schemes. The leaders were allocated identifying codes, namely Leader 1, Leader 2, Leader 3, Leader 4, Leader 5, Leader 6 and Leader 7.

The participants were purposefully selected for inclusion in the study. Each participant's position had a role that was defined, in terms of knowledge, skills, competencies and experience, with respect to the health system. The participants gave permission for the interviews to be audio-recorded.

8.3: Theme 5: The Role of Stakeholders in Implementing Health System Reform

The researcher sought to identify the types of stakeholders needed for health reform, in order to be able to describe their roles. These are discussed based on categories listed in Table 8.1 below.

Table 8.1: Stakeholder roles in implementing health system reform

Categories
1. Stakeholder identification
2. Stakeholder types
3. Stakeholder roles

8.3.1 Stakeholder identification

The views were sought regarding how stakeholders for implementing health system reform should be identified.

> *You see to me, I would not like the government to submit criteria. Because I think that they will be subjective in their view of which criteria you should be. I think that if the stakeholders feel that they want to be involved, they should be allowed to be involved. I don't think that they should prescribe. I think we would prefer representation.* (Stakeholder 2)

> *I think people will need to apply their minds to who the key stakeholders are. I know already, there are certain stakeholders that have been identified, like civil society, the public health entities, the regulatory councils, and all of those, but when you get into civil society, who is the stakeholder there? Because that's a diverse, and often, you know, complex groups that you have there. So, the careful choice there is going to be important, but the important thing is that it needs to be all inclusive because if we have people that are left outside, they will then use that, you know, as a platform to criticise, and, you know, saying negative things about the NHI.* (Stakeholder 1)

The participants indicated that stakeholders such as civil society, public health entities and regulators were identified for the NHI implementation. The challenge arises when stakeholders have to be identified from civil society because the communities have diverse and complex groups of individuals. People should, therefore, apply their minds to identifying key stakeholders, and the process must be inclusive. Government alone should not prescribe the criteria for stakeholder identification, but should rather allow those that would like to participate in the process, to do so through their various constituencies.

Society is composed of numerous, diverse autonomous and semi-autonomous groups that might cause one to question whether people can realistically speak of a society in a definitive sense of having any generally agreed-upon meaning (Buchholtz & Carroll, 2012). If the total number of relationships are an indicator of complexity, the argument may be easily made that

the firm's current relationships with different segments of society constitute a truly complex social environment (Ibid., 2012).

> *I think you can't start without having a clear policy because the policy then outlines what the needs are, the requirements and how to approach it. And in the policy, you can even then do stakeholder identification and the implementation path. Everybody else will follow, but then it must be translated into a governed policy.* (Stakeholder 3)

> *The stakeholder matrix for policy reform is defined in policy textbooks. You need to go back and say, have you consulted all the groups of people, all the provinces, all the people who can hear, all the people who can't hear. You know the demographics of your country.* (Stakeholder 4)

> *The custodian of any legislative process will always be the State or government. However, from an advisory point of view, we believe that there should be wide net of participation. I think that is a process that must be well thought out. The easiest thing would simply be based on interest and anybody who will be impacted by the reform would definitely be considered. Other people would be more representative. So, we could actually have a few criteria and so that we have a fully representative body to make sure that you cover everything or at least most of the elements.* (Stakeholder 5)

The participants indicated that the legislative process is driven by government and the process of identifying stakeholders should be well thought out. A clear policy is needed for stakeholder identification and implementation of the process. In addition, stakeholder identification will necessitate policymakers to consider stakeholder interests and the impact of policy on stakeholders. Criteria are required for inclusivity, while ensuring that a manageable size of stakeholders is represented. Stakeholder matrix in health policy reform provides guidance on the stakeholders that should be consulted.

The government is important, as the State represents the public (Buchholtz & Carroll, 2012). It is crucial to understand the role and workings of government to best appreciate the business's relationships with other groups (Ibid., 2012). Organisations need to consider stakeholders in their *strategies*; make decisions that protect and benefit all stakeholders as part of *corporate governance*; and understand 'who and what really counts', using qualitative criteria of power, legitimacy and urgency in their *corporate social responsibilities* (Freeman, 2004).

8.3.2 Stakeholder types

The participants generally agreed that the citizens of the country in totality are the stakeholders that will be affected by health system reform.

> *You've got, in any policy review, two big types of stakeholders. Stakeholder with vested interest. These ones already have a voice. They are either proponents or opponents. And a stakeholder who actually have no knowledge. These ones are very, very important because we call them the voiceless because they are the uneducated masses. Both the stakeholders are important.* (Stakeholder 4)

According to the participant, stakeholders may be classified into two broad categories, namely those with vested interest, which may be opponents or proponents of health system reform; and those who have no knowledge, and are considered the uneducated and voiceless stakeholders, which are the majority of the population. Generally, there are two broad groups of stakeholders, namely internal and external (Buchholtz & Carroll, 2012). Employees and business owners are considered internal stakeholders. External stakeholders include the government, consumers, the natural environment and community members (Ibid., 2012).

> *I think the entire population of the current key stakeholders in various groupings. It could be unions, it could be a community based organisation, your faith based organisation, or it could be groups that have been organised around specific social issues. Whether it's people like pressure groups that are fighting for prevention of gender violence, and all of that. Or your HIV, or TB groups.* (Stakeholder 1)

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I think that you should start from the bottom. You should actually start with every person in the community that will be a patient sometime in their life. (Stakeholder 2)

I think every member of society, because NHI, health affects everybody. The Bill has been published and for everybody to embrace it now that the NHI is becoming a reality, it is a reality because the President is leading from the front and he's the one who has embraced it and then the country has to follow. (Stakeholder 3)

According to the participants, health affects everyone, and the entire population will be affected by the NHI in several ways. A bottom-up approach was recommended in this regard. Every sector of the country should be involved in the discussions concerning the NHI. The stakeholders to be included are community-based organisations; faith-based organisations; and activists around social issues such as gender-based violence, HIV and TB. The president of the country should lead from the front and drive the process to enable the country's population to embrace change.

Considering the policy actors in health system reform of UHC, it is necessary to identify and prioritise stakeholders (Gilson *et al*., 2012). The approach that may be considered is to initially identify influential stakeholders, considering their in-depth knowledge in a particular context, including interactions with some policy actors (Gilson *et al*., 2012).

I think the professional bodies and the different professional sectors should be involved. I also think that experts in terms of administration, in terms of financial management, in terms of data management, ethics, all of those stakeholders up to the point of the level of government. And also of course, like they did with the elders, people from different countries with more experience in NHI, bringing NHI to work, they should also be consulted. (Stakeholder 2)

The professional bodies and the various councils, obviously, because they regulate either practitioners or schemes etc. Then you also have other sectors that participate, for example, your NGOs, your donors and there is a political element, you've got political parties, you've got labour unions, for example. Then you've got associations and lobby groups. (Stakeholder 5)

I would therefore like the unions become a very good stakeholder, but also the NEDLAC process is also quite important, because there, I mean, you know, you'll have your government, business and labour discussing the issue. And I think also various other organisations that they haven't necessarily brought in, so your, the NGO space for example. (Stakeholder 6)

The participants mentioned that other stakeholders that need to be included in the process are the different professional and funder associations; regulators; trade unions; National Economic Development and Labour Council (NEDLAC); NGOs; and experts in administration, financial management, data management and ethics.

According to Republic of South Africa (2019), the Minister must, after consultation with the board, establish the Benefits Advisory Committee and Health Care Benefits Pricing Committee; and appoint a Stakeholder Advisory Committee comprised of representatives from the statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers, as well as patient advocacy groups, in such a manner as may be prescribed.

Members of current schemes need to understand what's going to happen to the schemes, what's going to happen to their benefits, what's going to happen to their reserves, what's going to happen to all their assets that sit with schemes. They also need to understand what benefits will not be covered by NHI, and covered by schemes as part of complementary cover. (Stakeholder 1)

In the same way that schemes, and administrators also need to understand how this implementation process is going to unfold. When NHI is fully implemented, they need to make those adjustments to their business models, so that they're able to adapt to the new role that they will be playing. The same thing applies to brokers, managed care organisations, in the landscape. (Stakeholder 1)

So, when we looked at the stakeholders, there is a wide variety. Whether you're talking about it from the supply side, and the supply side, you are talking about the practitioners and the facilities for example. (Stakeholder 5)

So, the 16% of us that have medical aid are still being exploited. So, you can't now bring in NHI without consulting these, let's call them the exploiters because basically they are profiting from sick people. The ones that are trading on the JSC ... all of those, the pharmaceutical companies as well. They are also a big stakeholder. (Stakeholder 6)

According to the participants, members of medical schemes, the medical schemes, administrators and brokers are stakeholders in the health system reform process. In the NHI environment, medical schemes will be expected to offer only complementary services. NHI will, therefore, have an impact on products and services that can be offered by medical schemes. The private healthcare providers, which include the practitioners, hospitals and pharmaceutical organisations, are also stakeholders in the NHI implementation process.

Once the NHI has been fully implemented, medical schemes may only offer complementary cover for services not funded by the Fund (Republic of South Africa, 2019). Department of Health South Africa (2015) mentions that the NHI will ensure that the State optimally utilises the available resources to benefit the country's population. Financing and delivery of healthcare services in the private sector will be expected to be aligned with the principles of access, affordability, effectiveness, efficiency, equity, health as a public good, and social solidarity.

The National Ministries will have to undergo changes to accommodate NHI unit, because it's going to be embedded there, grow and then be hived off as a section 3A. Provinces are going to be affected, because some of the powers are going to be taken to National, some will be delegated back to the provinces. But, really, the establishment of the District Health Management authorities as purchasing agents of the NHI also means there are going to be fundamental changes in the way the health system is organised, at provincial, and district level. (Stakeholder 1)

The National Ministry of Health is expected to undergo structural changes to effect the NHI implementation. The changes will affect processes within provinces and districts, in terms of procurement of goods and services, and service delivery. These Departments of Health (national, provincial and district) are stakeholders in the NHI implementation to enable health system reform. One of the key interventions proposed for South Africa's health system reform is radical changes in administration and management (Jobson, 2015).

So, the short answer is the entire population, even the immigrants will be affected. Because if you are not registered, you will not be part of the NHI. If you don't qualify to be a member, you will only be given access to emergency services, etc. So, it goes even beyond the 58 million population. (Stakeholder 1)

Social Development is a key partner. The issues of the homeless, abandoned children, orphans or those that we do not know where they come from, we end up keeping them for long in the hospitals because we do not know where to refer them and they do occupy beds. There must be some things that are done with Home Affairs. We just have a lot of patients who don't have documents. So how do you bill a patient who does not have documents? Who does not have an address? The Department is losing money. We can't collect proper revenue and revenue is one of the indicators of efficiency. (Leader 7)

The participants indicated that even immigrants will be affected by the NHI because non-registered individuals will not benefit from the NHI. The Department of Social Development and the Department of Home Affairs are also stakeholders in the process, and will deal with social issues (homelessness, abandoned children and orphans) and undocumented migrants. The Ministry of Health is embarking on massive reform, covering health systems, personnel and financing, among others (Department of Health South Africa, 2015). Health stakeholders are requested to collaborate with each other and with government, to be open to new ways of doing things, and to put patients first (Ibid., 2015).

8.3.3 Stakeholder roles

The participants' views were sought to determine their perceived role in the NHI environment and to establish how that will be achieved.

So, if there's going to be a shift towards full implementation of the NHI where schemes will only be providing complementary cover, it also means that… mandate will need to be adjusted accordingly. Our mandate is very clear. We don't have an option, but to support that as an organisation, and find ways of making sure that that policy position translates into a strategy and a plan that makes those changes possible in society. (Stakeholder 1)

According to the participant, the role of the organisation is to support the implementation of the NHI. The entity will, therefore, be required to make the necessary strategic amendments to effect the NHI implementation. "Leadership is needed to transform the existing organisational structures and culture of the public health system, in particular, and translate new policies into routine ways of doing business within the system." (Gilson & Daire, 2011).

The guidance is contained in the Bill, to a large extent, because it starts to define what services are covered. It also talks about under what circumstances the new entity would fund healthcare services. People with refugee status, for example are not contained in the definition, would still have to find funding elsewhere. The second area that would still be important to non-state funders is where benefits are either not affordable or catered for by the State. The last part is that where a beneficiary elects to source healthcare services outside of normal referral pathways or protocols. So, for anybody in one of those three circumstances have to find funding somewhere. (Stakeholder 5)

The role of non-State sector funding is based on the NHI Bill, which provides guidance on the services that will be covered under the NHI and those that will be excluded. There are three situations where individuals are excluded from benefiting from the NHI, namely: 1) refugees; 2) where benefits are either not affordable, or not catered for by the State; 3) where a beneficiary chooses to obtain healthcare services outside the stipulated referral pathways or protocols. Republic of South Africa (2019), states that, once the NHI has been fully implemented, medical schemes may only offer complementary cover for services not funded by the Fund.

As a regulator, our primary role is to protect the public. So, in our role, we have to look at both the public and the professions. Our role is to ensure that when we implement NHI, we have sufficient numbers of registered practitioners who can provide support to NHI and we need to refocus the training of practitioners. We need to play an advocacy role for improving the facilities infrastructure. The second part, which we have not yet done is to accredit the private institutions for training. Meaning that you've expanded training platform in the public sector. So, then you can attract the practitioners who are in the private sector. (Stakeholder 3)

The participant mentioned that the healthcare regulator has to ensure that there is a sufficient throughput of personnel to meet the country's healthcare demands. Private institutions should be accredited to augment the existing training platforms for healthcare professionals. The training of practitioners should promote quality healthcare and patient safety. There is also a need to advocate for improved infrastructure which is conducive to teaching and learning, and safe for work. The foundation of having a strong and effective health workforce is the ability to respond to the 21st century priorities (World Health Organization, 2016). This requires countries to match the supply and skills of health workers to the population's current and future needs (Ibid., 2016).

I think as a medical profession we are central to the debate of the NHI. Without the medical professionals, there is no health system, there is no national health system. And when you think of health professionals, you're talking about the providers and the planners of the health system. So, I think we play a very critical role in terms of defining the benefits and the healthcare that needs to be provided, and actually being the hands-on front soldiers that need to provide the service. (Stakeholder 4)

According to the participant, the medical professionals play a critical role in the health system because they are the planners and providers of healthcare. The healthcare providers should drive health policy, define benefits and determine the healthcare that needs to be provided.

Now our role with this is to grapple with the issues that we think would affect our members and try and find a way of making sure that nobody strikes, that nobody is against it, but also that, obviously that the workers' rights are also protected. You don't want NHI to work, but again at the expense of workers. So, we are pushing for, as much as the reform must happen, we are also pushing then on our side for human resources, and how that is going to work. How are they going to fill the posts, how is training going to work, all of those kinds of things. (Stakeholder 6)

The participant stated that the focus of the trade union is to ensure that health system reform does not negatively affect employees. Workers' rights have to be protected, and solutions need be sought for filling the vacant posts. Guidance is required regarding the training needs of employees to deal with change. Therefore, finding ways to avoid industrial action is necessary.

According to the World Health Organization (2008), countries must implement strategies to address the human-resources-for-health needs by improved planning, strengthening of the capacity of health-training institutions, management, motivation, and retention to enhance the coverage and quality of healthcare.

8.4 Theme 6: The Influence of Stakeholders in Implementing Health System Reform

This theme is discussed under categories shown in Table 8.2 below.

Table 8.2: Influence of stakeholders in implementing health system reform

Categories	Subcategories
1. Stakeholder interests	
2. Stakeholder powers	
3. Stakeholder needs and viewpoints	- Stakeholder challenges and issues - Stakeholder needs - Stakeholder engagement - Barriers to stakeholder participation - Stakeholder management - Fair stakeholder treatment

8.4.1 Stakeholder interests

The participants' views on health system reform matters that affect them were sought and are discussed next.

I think my first interest would be that there would be a responsible, and very careful implementation of the whole system. We are not against National Health, or you know, Universal Health Coverage. We support, quality health for all, but we do not trust the government at this stage. So, at this stage there's a mistrust in terms of the management. (Stakeholder 2)

The governance structure that we have for Schedule 3A companies is not working. So, if they want to make it a Schedule 3A, they need to improve the governance structure for Schedule 3As. (Stakeholder 4)

The other thing we know is the corruption. I mean, if you are not going to curb people from stealing, where's all the money that was stolen. I mean, big amounts of money in provinces that were just stolen. Money that could have bought ambulances. If we, root out the corruption, employ the right people and all of us move forward. It definitely can work. There's money for this. (Stakeholder 6)

According to the participants, there is mistrust regarding the financial management and administration of government entities. Corruption is embedded in the country and is hampering service delivery. There is support for UHC to provide quality healthcare for all citizens. However, the implementation must be carefully and responsibly done. The governance structures for State-owned entities should be improved to achieve the desired objectives.

Corruption and fraud are major threats to equitable access to quality healthcare (South African Lancet National Commission, 2019). There are several failures of governance in the private health sector, including a lack of transparency and lack of accountability to members of the public that belong to medical schemes (Ibid., 2019).

The interest must be for the community we serve. It should be, we are there to provide guidance for the practitioners and as I said, for the public good. If we don't train competent practitioners, it will serve no purpose that we increase access, but we don't improve the health of the population. So there must be good health outcomes, especially when you've got competent practitioners. I think that's what you want to do, that we have good health outcomes and productivity of the country is paramount. (Stakeholder 3)

According to the participant, NHI implementation should improve population health, which will, in turn, affect productivity. It is, therefore, important to have competent healthcare practitioners to enable the achievement of good health outcomes. The foundation to having a strong and effective health workforce is the ability to respond to 21st century priorities (World Health Organization, 2016). This requires countries to match the supply and skills of health workers to the population's current and future needs (Ibid., 2016).

Wherever we've looked, there isn't a single country where you have total abolition of the private sector, even when you've got a fully functioning Universal Healthcare model. So, we need to make sure whatever size the private sector would remain, even under Universal Healthcare Coverage, whatever the percentage remains is still fully functional, it's sustainable and it's aligned with the principles of Universal Healthcare Coverage. (Stakeholder 5)

According to the participant, achieving UHC requires collaboration between the public and private sectors. There is no country that has demolished the private sector to achieve UHC. Irrespective of the size of the private sector in the NHI environment, the remaining percentage should be fully functional, sustainable and aligned with UHC principles.

Meaningful public-private partnerships are needed in the context of the NHI (National Planning Commission, 2011). Best practice purchasing, provisioning and procurement, as well as sound financial management, are important in these partnerships to improve access, equity, quality and innovation for efficient service (Ibid., 2011).

There isn't a system that is fully comprehensive. You can have essential coverage, but the so-called comprehensive, it is difficult to measure comprehensiveness. If you were to ask people what it means if you've got comprehensive cover, does it pay for any healthcare service, or only those that are medically necessary, or only those that are evidence-based? You can still throw a lot of money, but if you have an inefficient system, it'll actually be a waste. So, the sustainability that I'm talking about needs to make sure that whatever is available within the Fund is adequate and even the private entities that participate in the healthcare system are able to provide that, and any other top up that is required. (Stakeholder 5)

The participant is of the view that, although countries are aiming for UHC, these countries are able to provide essential services. If the system provides comprehensive health coverage, it will be necessary to determine what constitutes a comprehensive package and establish a measure thereof. On the other hand, financing healthcare in an inefficient system is not useful. Achieving UHC requires efficient utilisation of resources that exist within the health system to ensure sustainability.

Essential health services are services that all countries are expected to provide, irrespective of their demographic, epidemiological or economic profile (World Health Organization, 2017). Informing healthcare decisions requires a consideration of costs and benefits (Drummond, 2015). The use of a comprehensive set of indicators is needed to enable the public to hold decision-makers accountable for taking the right steps towards UHC (World Health Organization, 2014).

I think there are several issues. In an ideal world, you will have an NHI that is well run, that is servicing people optimally and access is enhanced. Access in terms of speed, in terms of range of services, etc. I don't think we are at a stage where we can be confident to say, State will have adequate capacity to provide the services. The second capacity is in terms of running the Fund and the State may require assistance. There are actually implementers in what they call these contracting units and that's where there might be a problem with capacity. An ideal NHI would then be able to utilise existing services that are deployed in the private sector. (Stakeholder 5)

If we say NHI is going to be the single payer, where will it get the capacity to do that? So, what may well happen is, the NHI may actually absorb this capacity, from the multiple corners that it's sitting and bring it into the central point. In other words, instead of outsourcing it, they may use it as a service, and get the skilled people, get the systems that are out there to efficiently run this thing. But I understand their position and I think government does too. Because it's natural for people to protect their vested interests. (Stakeholder 1)

There are many areas of collaboration in terms of exchange of expertise, network management, administration, managed care, quality assurance, audit and things like that, that the private sector has invested a lot of money in over time. In my opinion, it will not be efficient for the State to try and set them up. (Stakeholder 5)

The participants indicated that the State does not have the capacity and facilities to provide services to all the citizens in the country. Lack of capacity will have a bearing on the ability to offer a variety of services and the time it takes to deliver those services. Government will also require additional capacity for the NHI contracting units. The private sector has built capacity, resources and skills over time. The private sector resources that can be shared with the public sector include network management, administration, managed healthcare, quality assurance and auditing. Government can acquire more beds at private facilities to augment their bed capacity. There is, therefore, a strong need for public-private partnership.

Meaningful public-private partnerships are needed in the context of the NHI (National Planning Commission, 2011). Best practice purchasing, provisioning and procurement, as well as sound financial management, are important in these partnerships to improve access, equity, quality and innovation for efficient service (Ibid., 2011).

> *We also need to say there is a role for funders and then the rider on that is that, currently the Medical Schemes Act makes a provision for healthcare funders to provide services in terms of the definition of the business of a medical aid. So, a medical aid can morph itself to an HMO type of service. The HMI now has recommended that there be consideration of even regional schemes. So, it actually makes it possible for a scheme that is regional. For example … largely in Gauteng could become an HMO, put up facilities and then that sort of scheme could then contract with the NHI.* (Stakeholder 5)

The participant proposed that the Medical Schemes Act should make provision for medical schemes to offer the services of a Health Maintenance Organisation (HMO). The Health Market Inquiry (HMI) has recommended that regional schemes be considered to improve access to healthcare. A medical scheme in a certain area can, therefore, operate as an HMO, develop infrastructure and contract with NHI for service delivery.

Best practice purchasing, provisioning and procurement, as well as sound financial management, are important in private-public partnerships to improve access, equity, quality and innovation for efficient service (National Planning Commission, 2011).

> *We are also workers, we're asking the Health Department to prioritise workers' health and wellbeing. We have huge challenges with occupational diseases and injuries that are just plaguing our hospitals and clinics, and workers often have to use their own medical aids to get the healthcare that they need. So, that will be our interests that NHI relieves the pressure on workers and households to provide healthcare for the family, where it should be, it should be provided, if we work together.* (Stakeholder 6)

There is a human resource plan that is a draft form still, Human Resource 2020. So it's for next year. So, we are saying that it should be implemented. (Stakeholder 6)

The participant mentioned that the role of the trade union is to ensure that workers' rights are protected. There is currently a huge challenge of occupational diseases and injuries, and workers have to use their medical schemes to fund these claims. When NHI is implemented, employees will be relieved from spending their salaries on healthcare expenses. Human-resources-for-health strategy must also be implemented.

Countries need to implement strategies to address the human-resources-for-health needs by improved planning, strengthening of the capacity of health-training institutions, management, motivation, and retention to enhance the coverage and quality of healthcare (World Health Organization, 2008). The human-resources for health plan proposes intervention through the design of a human resource development and management road map, which includes forecasting, production, posting, retention, and continuous training and management improvement (South African Government, 2019).

8.4.2 Stakeholder powers

According to Schmeer (1999), stakeholder power refers to the stakeholder's ability to effect the implementation of the health reform policy. The participants' views are explained next.

Everybody has got the power to influence the process moving forward. Remember, currently, we're just dealing with the legislative process of getting the Bill to go through, you know, the parliamentary processes. Usually, the way the Bill is put together is that it talks to the high-level ideas and concepts, and never really includes the nuts and bolts. So obviously, I've already said we'll need to engage nationally. (Stakeholder 1)

The current Minister indicated that time for talking is over, it is now the time to implement. I think I agree with him. So now that people know that it is time to implement, I think there'll be more inputs to try to shape the future direction of the Bill. I think there will be what we call push backs, from other quarters to say that their voices were not listened to. The Minister is pushing ahead which is good because once you make a decision, as a leader, you need to forge ahead with it, but still listen to the voices of dissent because the voice of dissent help to sharpen the argument. (Stakeholder 3)

According to the participants, the country is currently dealing with the NHI legislative processes that will finally lead to the NHI Act. The policy documents, such as the Bill, make reference to high-level ideas and concepts. There is still a need for further engagements with stakeholders beyond the publication of the NHI Bill. The current Minister of Health has indicated that it is time for NHI implementation. In this instance, implementation is necessary. More people may see the need to give input, in order to shape the future of the NHI. The voices of dissent still need be accommodated because they help to sharpen the debates. However, there might be resistance from stakeholders who believe that their views were not acknowledged.

A clear, crosscutting, government-wide guiding policy should exist on stakeholder engagements because including key stakeholders in the development of policy and strategy allows a comprehensive range of factors that promote good-quality health services to be addressed (Organisation for Economic Co-operation and Development, 2018; World Health Organization, 2018).

We have power to form pressure groups. We also have the power to litigate and to put forward commentary, and documents and everything. We will do everything we can to try to make sure that there is responsible, effective management, leadership, implementation, management of finances, whatever, as far as we can, with our means. But I think there's been a decision and they're going to push through. (Stakeholder 2)

At some point the acknowledgement that ...got from the steering committees that are looking at NHI seemed encouraging. Like they've taken all our comments, they've reflected on them. If I had to say why we are in a unique position is because we haven't just made comments without looking at real solutions as well. (Stakeholder 6)

According to the participants, the trade unions influenced the process differently. One of the participants indicated that their entity has the power to provide written submissions, form pressure groups and litigate. They will continue to emphasise the need for effective management and leadership, the management of finances and responsible NHI implementation. Another participant, however, mentioned that they provided substantive inputs towards the documents which were acknowledged.

One of the principles of public involvement requires the utilisation of diverse stakeholder views to deepen the shared understanding, and produce sustainable outcomes for society (South Africa, 2019).

I think the shape of the NHI has been changing because of the inputs from the stakeholders. Because when you listen to other players, they will tell you how things were in the Green Paper and how things are changing. The only reason I can postulate is that the crafters of the Bill, they listened and took into consideration the comments that were made. But I don't think the substance of the NHI will change because I think the policymakers know exactly where we need to be going. (Stakeholder 3)

So, in terms of the impact, there have been specific inputs that have been considered and then included in a final report or even a draft Bill, but, obviously, because the policymakers have to look at various angles and manage various stakeholders. It would be foolhardy of us to think that whatever we put in hundred percent of it will be regarded. So, there are some pieces of policy direction that we've put as suggestions and some of those have been considered. (Stakeholder 5)

The regulators and funder association are of the view that, as stakeholders, they influenced the contents of the NHI policy documents, and changes were noted in the successive documents. Considering the amendments that were made, one can postulate that crafters of the Bill considered the input and solutions that were put forward. The substance of the NHI will, however, not change because policymakers are decisive about the direction the country is taking. The stakeholders believe that they have the power to influence the NHI process.

Stakeholder engagement is expected to provide stakeholders with mechanisms that impact outcomes, rather than simply making normative appeals for managers to protect their interests (Dawkins, 2014).

> *Well, the question is, how much power do you hold in this political environment? It's all about relative power. I thought the medical professionals have power, but looking at the extent to which our inputs were taken, I'm starting to realise, ah, ah, this is political power dynamics. So, of the submission that at least we made, only a few were taken. You can see it's a political game. The people who have political power in this game are trade unions, but they do not have capital. They don't have knowledge of the subject to influence. It's all about elective power.* (Stakeholder 4)

> *I think that there's been, to a certain extent, ideological, political force to establish it and I think all the stakeholders' concerns, and all their comments are forced into that viewpoint. If it's negative, or if it's not fitting, or they don't acknowledge the critique or whatever, it won't be taken into account in the process. There's no real respect for different viewpoints, or for critique.* (Stakeholder 2)

> *The long and short of answer of why that is happening is because of, you know national healthcare has become political. What makes us different from the United States of America? Well Obamacare has faced the same problems and that's a reality. So, the reality is yes, those exclusions are because the healthcare delivery is politically driven.* (Leader 4)

According to the participants, national healthcare is politically driven. The relative political power of stakeholders determines their impact on health system reforms. In the context of South Africa, the medical professionals thought they have power, but their capability has not been sufficient to influence the NHI policy direction. Trade unions are perceived to have political power, but not the insight into the subject to have an influence. Political power dynamics have, therefore, influenced the process.

Effective regulatory structures require partnerships between the State and other stakeholders, and that the formulation of evidence-based national health policy necessitates the wide participation of stakeholders, which provides long-term strategic vision (Sidiqqi *et al*., 2008).

At some point, you could see that the Department of Health was trying to appease the medical schemes by publishing those tenders. It's all an appeasing thing. And now, they are appeasing the medical profession with the GP contracting, but it's not coming out. You know what? I think that, I don't know, because I think maybe if you speak to medical schemes, they might think medical associations have the power. But then if you speak to medical associations, they might think medical schemes have the power. I don't know. Really, this is I didn't know. (Stakeholder 4)

Stakeholders, I'm talking about the GPs that are on the ground, the Specialists that are out there, the Nurses and Allieds that are out there. Medical schemes use these bodies as gatekeepers, but NHI does not. For me the agenda is bigger than what we see. There's a bigger agenda that is not said that will unfold as time goes by. (Leader 6)

I actually don't know. I don't have enough knowledge to know which stakeholders really has the power to influence. Maybe also the other unions like …, or the nurses' union, or, I don't know if the professional bodies like the HPCSA. I don't know what, how deep their influence would be. I don't have the knowledge. (Stakeholder 2)

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At this point, stakeholders have different views about who might be more powerful than the other in influencing the NHI process. According to the participants, medical schemes might believe that medical associations have the power and vice versa. HPCSA and the nurses' union are also perceived to be having the power to influence the process. Healthcare providers, namely the specialists, nurses and allied healthcare practitioners are of the view that they were excluded from the process, and that the process has been taken over by the private sector.

Responses of stakeholders to policy proposals are varied and complex because different dimensions of the same policy may have a contrary impact on stakeholders (Gilson *et al.*, 2012). There has been a low commitment to national contracts among these practitioners (Hongoro *et al.*, 2015). This is attributed to the lack of effective communication and consultation from national government, thereby creating mistrust and uneasiness among local private doctors (Ibid., 2015).

8.4.3 Stakeholder needs and viewpoints

The focus was to explore the stakeholder needs and perspectives regarding the health system reform process.

8.4.3.1 Stakeholder challenges and issues

During the interviews, participants expressed their challenges regarding the planned NHI, and the processes followed so far. These relate to their perceptions and experiences of the NHI process.

> *So, critics obviously will not participate and I suppose the challenge that we have is to say to the critics, you know, come and tell us how you could do this alternatively. But they have a fundamental difference and so that's why they won't participate. It's not about the system at a micro level, it's one issue at a macro level. So, anything that doesn't talk to the two tier system is a problem.* (Leader 5)

If I was a medical scheme administrator, then I'm a profit making entity and my job is to administer claims and do other functions on behalf of schemes. If I hear that the new dispensation is talking about a single payer or administrator, and we say schemes maybe smaller in size, because they are providing a complementary coverage, I would feel that my business would be threatened moving forward. So, I would not support the single payer. I would say government, look at us, see how you can bring us into the party. (Stakeholder 1)

According to the participants, the fundamental difference regarding health system reform is at macro level. Certain individuals support the two-tier system, and see the proposed single-payer NHI system as posing a challenge to the livelihood and sustainability of medical schemes. In the NHI environment, medical schemes will fund services that are not in the NHI package. Some stakeholders decided not to participate in the NHI process because they still see the need for a two-tier health system in the country.

South Africa's health system is two-tiered, comprised of the public and private sectors (Deloitte, 2015). Competition for privately funded healthcare resources is perceived to have a negative effect on the quality of care in the public healthcare sector (Ramjee & Vieyra, 2014; Rowe and Moodley, 2015).

The single payer has got this advantage that you will get scale of economies and that will reduce the cost of administration by up to between seven and 10%. People are currently saying our administration costs are between 10 and 50%. But in countries where there's self-administration of the NHI, the costs are running at the level of 3%. So, there has been consideration there. (Stakeholder 1)

The participant highlighted that the single-payer system has the advantage of economies scale, which will reduce administration costs by up to 10%. The administration costs in the country range between 10 and 50%. Countries that self-administer their NHI have administration costs of 3%.

NHI implementation will be effected through the creation of a single fund that is publicly administered and financed (Department of Health South Africa, 2017). The Department of Health South Africa (2015) mentions that the NHI will ensure that the State optimally utilises the available resources to benefit the country's population.

Our concerns and if they listen, one of the doctors said that he's very concerned because he sees panic, in terms of the doctors and his colleagues. People are immigrating, they don't know if they must leave. They don't know what their future will hold and the other …, I forgot her name. She's an Advisor, she said that immigration is not a problem because it's a global thing. So that's not a really comforting. The words are kind of cheap. There's no really doing something about it. (Stakeholder 2)

There is concern that the State has already made a decision about the path to follow and will force the government's political ideology on everyone. Consultations with stakeholders should accommodate views of dissent, address the concerns raised and not deal superficially with issues.

One of the principles of public involvement requires the consideration of diverse stakeholder views to deepen shared understanding, and produce sustainable outcomes for society (South Africa, 2019).

We are worried the doctors will be controlled, in terms of the protocols that they are prescribed because you're in this huge bureaucratic system now, and you can't just do you can't just ask for a scan. You have to follow the protocol. And will there be long queues? Will there be long waiting times? Will people have to lie on the floor because there's no beds, etc., etc. Will there be enough medication? Did they order the right medication at the right time? You know. (Stakeholder 2)

Sometimes, some of us are supporting the NHI for political expedience and the question that is not clear in my mind is the reality of overcrowding. The fear that we may kill what is working. What seems to be efficient now in no time will be inefficient because of the numbers, and I think that's what makes the public hospitals inefficient. It is because of the numbers, they are overloaded. Much as I also support the NHI, but I am not sure whether it will ultimately destroy what is good. I think that's what most of the people are saying even some of the colleagues, family. (Stakeholder 3)

According to the participants, there is concern that in the huge bureaucratic system, doctors may not have the autonomy to decide on interventions because protocols will be prescribed. There is also a concern about possible long queues and long waiting times in private hospitals, as is the case with public hospitals. The other worry is whether there will be sufficient beds and medication, at the right time, when people seek care. However, when these concerns are raised, the stakeholders are perceived as being negative towards the NHI. The stakeholders understand that private healthcare is expensive and overcharged. They also want UHC to work for the provision of quality healthcare. There are concerns, therefore, that the private sector might also experience challenges of overcrowding and efficiencies in the future.

Section 27 (2010) states that many South Africans view the private sector as providing high-quality healthcare, personal attention to patients and 'state-of-the-art' facilities. In contrast, the public sector is perceived as overcrowded and offering substandard healthcare. Although this picture is understandable, the perception is not totally correct. Private healthcare is expensive and is not always of high quality. Although the public sector is underfunded, public health policies are more rational and the employees more community focused.

There's a debate around the bias towards the poor to the exclusion of entitlements of the haves. So, in as much as social solidarity says, the haves subsidise the poor, but there must be acknowledgement of everybody. So, in terms of the Bill of Rights, there must be universality. So, just because it protects the poor, it does not mean it should infringe on my rights. (Stakeholder 5)

The participant is of the view that the implementation of UHC through NHI should not primarily focus on the poor while excluding those that are more privileged. Inasmuch as the NHI is based on the principles of social solidarity, societal issues must be addressed with consideration of the rights of all citizens.

Countries are urged to design their healthcare packages according to country-specific needs (Gedion *et al.*, 2013). Healthcare benefits must be explicitly defined, while ensuring that services are targeted at poor and vulnerable groups, but not overlooking those that are not poor. When countries embark on changing their healthcare benefits, the impact of costs to the providers and financiers should be assessed. (Ibid., 2013).

So even within ourselves, we have to start having the difficult conversations to say that for everyone to have a share, someone is going to have to lose something. So, whether as a worker you lose a subsidy. So, it's that social justice, like all of us must, you know. People must have equal access to healthcare and I think one of the things that was started and needs emphasis is the People's Health Movement. It's very community focus based. In that system, you also then have a responsibility. So, all of those types of movements should happen. (Stakeholder 6)

NHI is seen as a way to improve access to care by individuals, especially in previously disadvantaged communities. People need to engage about the need to share the resources within the country. Citizens should take responsibility for their own health and actively participate in matters that affect their health, including policymaking processes.

Merryl (1994) proposes that, in healthcare reforms, the process through which major policy decisions are made should be participatory, involving all stakeholders in the deliberations. A nation must clearly define their needed healthcare benefits and determine how to fund those needs. Empowered members of society are knowledgeable and committed, and engage in constructive participation in the affairs of the public or an institution (Sindane, 2011).

8.4.3.2 Stakeholder needs

The aim was to solicit the views of the participants regarding their needs in health system reform.

> *There needs to be more collaboration with all the stakeholders. So, you know, medical schemes, and their administrators should be collaborating more.* (Leader 2)

> *There must be competition. Competition will make sure that you are kept on your toes. If you pride yourself in what you do in your day to day work, and you want to be better, you will render a better service.* (Leader 3)

> *We should collaborate to ensure that we achieve the that ideal of Universal Healthcare because it doesn't help that all of us that find some when some are pulling in one direction and others are pulling in the other direction so that is, have one goal, which is the improvement of the healthcare process.* (Leader 4)

> *Universal healthcare for everybody. Good quality, less corruption, availability of resources when you need them, equitable access to everybody, improved governance, making this a Schedule 3A company leaves a lot to be desired.* (Stakeholder 4)

The participants indicated that there is a need for collaboration as stakeholders; a competitive environment; and good governance that will promote the efficient use of resources, and ensure access to quality and equitable healthcare, and a sustainable health system.

There are several engagement mechanisms between the public and private sectors, but there are no formalised and legitimate structures between the two sectors (South African Government, 2019). To address the public sector crisis, a credible engagement structure will be established between these sectors to provide a platform for raising concerns, contribution and collaboration (Ibid., 2019). Avoiding market failures requires the maintenance of effective competition (Hsiao, 2003).

From the department, they haven't said that 1, 2, 3 is going to happen. They haven't said you're going to be paying 2% tax, you will be losing a subsidy, but we have no idea financially what it's going to look like for workers. The other thing that we've asked was about the package of service. We would like much more clarity on what exactly the package of service is covered by NHI. So that also if workers now know. So those are the two important things that as a worker, you need to know. (Stakeholder 6)

The participant indicated that the Department of Health has not yet communicated how much citizens will be contributing towards the NHI, in the form of taxes, and what would constitute the package of services. The two issues are important for workers to understand the impact of tax deductions from their net income. Employees also need to know whether there will be gains from the NHI package, in relation to their contribution towards the NHI.

Leading change is a significant part of the policy process (Alkahtani *et al.*, 2011). It is not enough to identify policy issues, develop potential solutions, and allocate the necessary resources. In order to implement policy in organisations, the community and society as a whole, leaders must learn how to initiate and plan for change, how to communicate the need for change, how to make a change appealing to gain support from others, and how to consolidate the results, so that the changes endure and have the intended impact (Ibid., 2011).

We would want to assist in that, we free practitioners from the fear of being sued or charged or brought to book before the…for practicing unethically or missing the diagnosis. If there are proper peer review mechanisms, each practitioner having a coach or something of that nature. (Stakeholder 3)

The participant indicated that there is a need to better support healthcare providers to enable the provision of quality healthcare and reduce litigation. Peer review mechanisms are needed, where a practitioner is allocated a coach and the means to support the process. Critical interventions related to human-resources-for-health are needed, with a focus on human resources policy; governance, leadership and management; education, training, and

development; and working with partners to ensure health workforce wellbeing and advocacy (South African Government, 2019).

So, the regulating of pricing, that is not a, you don't then need…group to be a stakeholder, you need… to accept that you're not going to overcharge us any longer because, you know. The regulations will now state you can't make a 200% profit on you know, a certain needle, that costs 12 rand and you selling it for 300 rand, that kind of thing. (Stakeholder 6)

If we have one single tariff, so that no one should be guessing as to how much should I charge for this particular ailment or not. But if that is clarified and it is contained in the NHI Bill, it becomes clear and the basic service package. And then the other issue that we spoke about is group practices, you know, the ethical rules that have been criticised that our own ethical rules don't allow for group practices and so we are busy amending those rules. (Stakeholder 3)

The participants raised concerns about tariff structures and solo practices in the private sector environment. There is a need for regulations on tariffs to be funded in the NHI environment. In addition, ethical rules for healthcare practitioners should be amended to make room for multidisciplinary practices to promote care coordination.

According to the Competition Commission South Africa (2018), another characteristic of the country's healthcare market is the preservation of solo practices in the private sector, with minimal, or a lack of integrated healthcare. In most cases, there is a failure to explore the multidisciplinary models of healthcare. The absence of appropriate market transparency in the private sector may harm competition and distort outcomes of healthcare markets.

8.4.3.3 Stakeholder engagement

The views were solicited to establish whether the stakeholders were engaged in the NHI process. The participants stated the following:

In terms of the legislative framework, we know that the Green Paper evolved into a White Paper and a White Paper was put before parliament in the form of a Bill. Then people are given a chance to participate by giving their inputs, then there's even public debates when it goes to Parliament and NCOP. (Leader 4)

The participant indicated that the NHI process had followed normal parliamentary procedures up to that point. The policy documents produced are in the public domain, but do not provide a detailed implementation plan. The Green Paper was published, followed by the White Paper, which was put before Parliament as the NHI Bill. Stakeholders still have the opportunity to engage with the process until the NHI is enacted and implemented.

In strengthening the health sector, national health systems stewards need to ensure alignment, and coherence of policies and priorities among different stakeholders; and manage and coordinate partnerships, and expectations (Senkubuge *et al*., 2014).

The organisation has been included as a key stakeholder because, you recall, even when the previous Minister, Honourable Dr Motsoaledi released the NHI Bill for the first time for public comment, he did that together with the Medical Schemes Amendment Bill. We made comments on both Bills and then those were sent through to the National Ministry. Since the new Minister took over, we have had several engagements with him on the NHI Bill. But we've also been invited when he has presented this Bill, as part of his budget speech. (Stakeholder 1)

Before the Minister went to Parliament, to Cabinet, to place the NHI Bill before parliament. We met all of us as the Regulators. Yes. We call ourselves the Statutory Health Regulators. So, that includes HPCSA, Pharmacy Council, Nursing Council, Allied Disciplines and Traditional Healers, though they have not been properly regulated, but they are part of the health system. The Minister took us through the process, just to share the blueprint and the implementation. So, we have a full picture of what is going to happen with the implementation of NHI, how the various bodies will be structured, the districts, even the project management officer. (Stakeholder 3)

The participants indicated that their organisations were involved in the NHI process as key stakeholders. The previous Minister of Health consulted with the Regulator of Medical Schemes on the health reforms. Meaningful contributions were made towards the NHI policy documents. In the current dispensation, the Minister of Health also engaged with the Regulator of Medical Schemes on the NHI and invited the entity to Parliament when the NHI Bill was presented.

The Statutory Health Regulators, which include the Health Professions Council of South Africa (HPCSA), South African Pharmacy Council (SAPC), South African Nursing Council (SANC), and Allied Disciplines and Traditional Healers, have also been engaged on the NHI by the Minister of Health. The Minister shared the NHI blueprint with these bodies, and how the NHI would be implemented. The information provided by the Minister enabled the entities to have an understanding of the envisaged structure and the implementation process.

Dawkins (2014) states that substantive stakeholder engagement is needed, and the process requires an inclusive and participative forum of interaction; reduced power asymmetries; and the ability to impact distributive outcomes.

> *If you speak to the doctors, you will get two views depending on where you are sitting.*
> *Those who have vested interest are not in the hospitals. They are sitting there on the*
> *table with policymakers. These ones are already involved. The majority of doctors tend*
> *to be naive to political debates because they are so engrossed with the sadness of their*
> *patients. Others will say that if government wanted to include us, they would have gone*
> *out and did the road shows. The government, in fairness does not have the capacity to*
> *do road shows for everybody. So, one needs to be intentional in going to where they*
> *are and reaching them.* (Stakeholder 4)

> *Stakeholders, I'm talking about the GPs that are on the ground, the specialists that are*
> *out there, the nurses and allieds that are out there. They don't feel that they're a major*
> *part of this. They feel like this NHI is taken up by big business.* (Leader 6)

According to the participants, the involvement of doctors in the process depends on their vested interest in political debates. Those that are involved in the health system reform process are not providing patient care. The practitioners that are generally rendering patient care are so involved with their patients that they do not pay attention to political processes. General practitioners, specialists, nurses and allied healthcare practitioners believe that they were excluded from the process, and that the process was influenced by the business sector.

During the NHI pilot process, the challenge of recruiting and retaining GPs in private practice to increase patient access to PHC was identified (Harvard Medical School, 2015). There was a low uptake of national contracts among these practitioners (Hongoro *et al.*, 2015). This may be attributed to the lack of effective communication and consultation from national government, thereby creating mistrust and uneasiness among local private doctors (Ibid., 2015).

In terms of participation of trade unions in the process, the participants provided different views on the process.

> *Where we begin is to do research on various issues as well as in depth analysis of what we see is different in the legislation, in the Bills. We also do research with our members. To be part of the process the whole time, we kind of have to force ourselves into the process as well because somewhere along the process, we realised that our views are not really recognised. We try to address the concerns, but then as we are a Union, we can form a pressure group. We can go into a process of litigation, hand in documents, hand in commentary on the whole process from our place as a Union.* (Stakeholder 2)

The participant mentioned that the role of their organisation is to do an in-depth analysis of various issues affecting the entity as a trade union. Members of the trade union are afforded opportunities to provide their views on the NHI and give guidance on how the organisation should be involved in the process. The trade union also has an obligation to keep their members informed and address their concerns. The organisation provided written input on the NHI. Nevertheless, they are of the view that their input was not acknowledged. The participant

indicated that the entity has an option to form pressure groups and follow a process of litigation, where necessary.

Effective regulatory structures require partnerships between the State and other stakeholders, and that the formulation of evidence-based national health policy necessitates the wide participation of stakeholders, which provides long-term strategic vision (Sidiqqi *et al*., 2008).

> *We have been part of the process from the beginning when the Minister, before the Green Paper, when it was still his idea, he mentioned it on various platforms. Part of our job as a Union was to listen to him. So, from then already, we were in full support of the NHI. So, our role then first was to communicate the plans that the Minister has to our members, which would be the nurses, doctors, allied health workers. We are quite unique because we have both private and public members as well. Most of our members are saying, yes, it has to happen, but there are some concerns that workers do have and how that is going to work. How are they going to fill the posts? How is training going to work? All of those kinds of things.* (Stakeholder 6)

The participant stated that the Minister of Health communicated on the NHI on various platforms. The communication started when NHI was still an idea. Various NHI policy documents were subsequently drafted and published. The responsibility of the trade union requires them to engage with their constituencies and obtain guidance on how to support the NHI process. The trade union members include nurses, doctors, and allied health workers from both the private and public sectors. Throughout the process, the trade union was in support of the NHI. However, the members have concerns relating to the implementation of NHI and the filling of vacant posts to meet the demands for healthcare delivery.

According to Merryl (1994), healthcare reforms require that the process through which major policy decisions are made be participatory, involving all the stakeholders in the deliberations.

Since the various iterations of the policy documents, through the Green Paper, the White Paper and the first draft Bill ... has submitted its inputs and the usual process is, when the Bills are put out for comment, we subject them to a technical review and then there is a formal consultation process with the membership. There are other informal engagements that are usually sought with the policymakers. (Stakeholder 5)

The participant indicated that the organisation representing healthcare funders had been actively involved in providing substantive input to the various NHI policy documents since the process began. Before the input is submitted, the policy documents are technically reviewed. There is also a formal consultation process with members through various forums. The organisation also takes part in informal engagements with the policymakers, where necessary.

Stakeholder engagement is expected to provide stakeholders with mechanisms that impact outcomes, rather than the stakeholders simply making normative appeals for managers to protect their interests (Dawkins, 2014). Empowered members of society are knowledgeable, committed and engaged in constructive participation in the affairs of the public or an institution (Sindane, 2011).

McIntyre *et al.* (2009) provides a contrary view that there is inadequate public engagement and awareness regarding the NHI. The fact is that the public is the beneficiary and the contributor that will directly be affected by the NHI, and will also affect its implementation.

For me, one of the sad things of the last 10 years, you know, has been that the guys writing all this policy have really hardly consulted at all with the private sector. It's really, they say there's been a lot of consultation, but it's not true. (Leader 2)

According to the participant, although there is a notion that the stakeholders were engaged, the private sector was not engaged in the process.

People participate in this for different interests. I mean, it's something that is observable that not everybody has been taken along. It is also unavoidable possibly unfortunate that big policy shifts like the implementation of universal healthcare naturally become political and as a result of that, that is where you start finding that some people are included some people excluded. So, policymaking is a structured process. However, it depends on how much of an activist people are. It cannot be that everybody, 54 million, 57 million of us will be, you know, contribute. There will always be those that are at the forefront. (Leader 4)

The participant stated that policymaking is a structured process. People participate in the health policy reform process for various reasons. The process is politically driven and it is, therefore, unavoidable to have certain individuals or stakeholders excluded from the process. There are, however, stakeholders that are actively involved and some engage through their constituencies, as it is not possible to have the entire population of the country actively participating in the process.

Empowered members of society are knowledgeable, committed and engage in constructive participation in the affairs of the public or an institution (Sindane, 2011).

8.4.3.4 Barriers to stakeholder participation

Based on the challenges expressed by the participants, in terms of the NHI process, their views were sought to determine what they perceived as hindrances to stakeholder participation.

You know, the tendency in life here is that when you want to implement a project, you tend to select people that, you know, have got an alignment with your own thinking around how the project needs to be executed, and the outcomes. (Stakeholder 1)

You are biased. There is professional bias. That's one of the things that you don't broaden your stakeholders because you're looking at one sector, you know. (Stakeholder 3)

According to the participants, there is a tendency to include stakeholders whose thinking is aligned with the project that needs to be executed, and the intended outcomes. Professional bias is, therefore, a barrier to stakeholder participation. Factors that positively influence the change process are driven by fostering agreement, active involvement, commitment and congruence of support at all levels of leadership (Aarons *et al.*, 2014).

If you open the floodgates and get everybody. Firstly, you tend to have larger groups than you can manage. People will also want to make sure that their voices are heard, and they are there in the final outcome documents. You will also provide a platform for people that are natural enemies, to come into that engagement, you know, to fight for certain positions. The others, I talked about inequities, are also the racial differences, cultural differences, you know, different backgrounds, class differences. (Stakeholder 1)

I think it's a huge and very difficult, it's a complex system. It's a huge change. I think the administration, the management, the legislation, there's so much that's involved in this whole process. I think that's one of the barriers and it's been around for years in discussion, and there wasn't a lot of, what do you call it, progress. So, I think it's just a huge process. (Stakeholder 2)

Having large groups of stakeholders is a barrier to stakeholder engagement. Large groups are difficult to manage. This may also serve as a platform for rivals to fight for position. The environment may also create a gap where there are differences in background, race, culture and class. The majority of stakeholders may want their voices to be heard and their input reflected in the final documents. In addition, the system that requires change is huge and complex, and is, therefore, difficult to administer and manage. Therefore, the complexity of health system reform, and the size and diversity of stakeholders are barriers to stakeholder engagement.

There are numerous barriers to effective community participation, which, in turn, influence accountability (South African Lancet National Commission, 2019). In the case of a heterogeneous and multicultural society, the challenge might be how to derive strength in diversity (Sindane, 2011).

There's a lot of stress in our country and people are concerned about lots of things. I think the NHI and land grabs, and things like that, it's just an extra stress. I think people are to a certain extent apathetic. People are tired of economic hardship and maybe corruption and mismanagement, and ineffective enterprises. So, I think NHI is just another thing that they don't want to struggle with, they don't want to be stressed about it. (Stakeholder 2)

Communication. How do you communicate to all the stakeholders? So, I think we need to utilise all platforms correctly so that you communicate adequately. So, if you link it with something that they will gain from, it will attract them, but if it has nothing for them, they don't come. Those are the challenges that we've identified. (Stakeholder 3)

The other thing is the uninformed. If we do not have a consumer that knows and I'm sure you've heard it, a lot of people don't even know what we are talking about when you talk NHI. So, communication, let me say inadequate communication. If we were to run a referendum on NHI, there will be a lot of people who will either say yes or no, not understanding what it means. So, we need to empower them, not just the consumer, but also the practitioners. (Stakeholder 5)

According to participants, apathy, and inadequate and inefficient communication are barriers to stakeholder participation. The leadership process involves developing a vision for the organisation; aligning people with that vision through communication; and motivating people to action through empowerment and the fulfilment of their basic needs (Lunenburg, 2011).

"Reaching the stakeholders in remote areas is tough. That's why people don't want to do it and nobody from Department of Health wants to go there. I mean, it's not logistically feasible. Other areas there is no airport. You have to drive. It is difficult to get to these rural areas. You need to be intentional. Access is a big barrier." (Stakeholder 4)

I think one of the biggest barriers is that we do not acknowledge that our people, or our citizens, have got their own agency and accountability for their own health. The shift has not happened. For as much as we are saying we are bringing NHI, even saying the words, when we say we are bringing NHI to you. It's, you are giving me something, it shouldn't be like that. (Stakeholder 6)

Barriers to stakeholder participation include the inability to access people in remote and rural areas, especially those with poor road infrastructure. In addition, not acknowledging citizens' accountability for their own health, and the lack of citizens' accountability towards matters affecting their health are barriers to stakeholder participation.

Community participation is encouraged in health policy design, and incorporates listening and communicating openly with stakeholders about their concerns, and contributions, and adopting processes and behaviours that are sensitive to the concerns of stakeholders (Clarkson, 1999).

Protectionism – that is a huge one. If, for example, as a scheme, we feel maybe not even as a scheme as Board of Trustees of a scheme, we say, if we go into this thing or if we merge, I'm going to lose my job. I'll do everything I can to mess it up. So, protectionism, I think, for me, is a huge thing. So, not having the end goal in mind or not sharing a common vision. (Stakeholder 5)

Protectionism is a huge challenge because stakeholders may focus on putting their interests first, while overlooking the intended goal of health system reform. There are numerous barriers to effective community participation, which, in turn, influence accountability (South African Lancet National Commission, 2019). In the case of a heterogeneous and multicultural society, the challenge might be how to derive strength in diversity (Sindane, 2011).

8.4.3.5 Stakeholder management

After soliciting the views of participants on their challenges, needs and viewpoints, and hindrances to stakeholder participation, the researcher asked their views on how stakeholders should be managed. The following was highlighted:

You need to understand your stakeholders and what are the barriers and then, and then be intentional about minimising those barriers in your policy. You do not think stakeholder engagement will be a passive process. You can't rely on your stakeholders. That's why we want government to provide their perspective first. They need to initiate these town hall meetings. You need to provide some little incentive to call the masses like they will do with the elections. If you are a government and you are going to have policy, you need a budget for policy engagement. (Stakeholder 4)

Stakeholder engagement requires planning and resources strategy. Stakeholder engagement is viewed as an active process that must be driven by government. There must be a government strategy and resource allocation for policy engagement. The policymakers must understand the stakeholders and the barriers to stakeholder participation. This will assist with intentional planning of the interventions and minimising the barriers to stakeholder participation. Policy consultation should be driven as an election manifesto.

Once the organisation has established the threats and opportunities, the responsibilities for managing stakeholders must be identified (Buchholtz & Carroll, 2012). Careful and thorough strategic thinking regarding communication, degree of collaboration, development of policies and programmes, and resource allocation are important (Buchholtz & Carroll, 2012).

Whilst it's simple to get everybody under one roof and try and discuss these, if you don't understand the individual nuances in positions of the different stakeholders, you may find it difficult to navigate through those difficult discussions. But I think if you look at stakeholder associations and bring them and they bring a principled organisational view, then you can have a much more nuanced and rigorous engagement. (Stakeholder 1)

But obviously, you cannot have 50 people advising. So, we think that you could have representation of some sort from these various groups, for example, the councils will have one or two people; professionals, police, one or two people; NGOs. And then what we think is critical is that these people that participate as an advisory panel must do so under mandate from their constituencies. So, this makes sure that there's accountability and there is actually feedback. (Stakeholder 5)

You may identify stakeholders, but you can't always predict what their position will be on various issues. A framework actually gives you a sense on how to engage with the different stakeholders. So, the selection of the stakeholders is key, (Stakeholder 1)

The participants mentioned that there should be representation of various stakeholder groups and the representatives must participate under the mandate of their constituencies. This is to ensure accountability and feedback. The selection of stakeholders to take part in this process is very important, and should allow homogenous groups to be engaged at a given time; and prevent antagonistic interaction that may arise from stakeholders who are natural enemies.

Strategy development should be based on the classification of stakeholders' potential for co-operation and threat. (Buchholtz & Carroll, 2012). Successful steps in stakeholder management include making the stakeholders part of the guiding philosophy, creating value statements, and developing measurement systems to monitor results (Ibid., 2012).

Number one, everybody has to abide by the law. Number two, if we take the private sector, even if they have a profit motive it must be within the ambits of the laws of the country. That is the most important in relation to the stakeholders. And that's accountability. (Leader 4)

Those terms of reference are very important in terms of how do you actually get issues resolved when you've got a group of people that may have diametrically opposed views, you know, decisions. Is it by consensus? Do you get some kind of a voting system? You need to be clear in terms of the status of those decisions in the first place. What's allowed and what's not allowed? You may even want to put in a code of conduct in terms of those discussions, so that people address one another in a civil way. (Stakeholder 1)

It must be formalised through MOUs or terms of references because once you agree on the rules of engagement, who engages, in what manner, then you only have to manage compliance to that document. And also, the value that the stakeholders are bringing in. If there are transgressions in terms of the agreement, there must be consequences. (Stakeholder 5)

According to the participants, stakeholders have various interests and needs. However, irrespective of these interests and needs, they need to abide by the laws of the country and be accountable. The participants mentioned that a framework is needed to guide the stakeholder management process. Terms of reference are essential for resolving issues. A code of conduct may be needed to guide the rules of engagement, so that stakeholders engage with one another in a civil manner. The rules of engagement may be formalised through a memorandum of understanding (MOU) or agreement. This approach will assist in managing stakeholder compliance, co-operation and transgressions. There should also be consequence management, in cases of contravention.

The rule of law is intended to regulate citizens' behaviour and maintain order in society (Keping, 2018). The goal is to protect human rights, particularly of the minority, including freedom and equality (Ibid., 2018). In keeping with the pluralist perspective, the parties involved should preferably engage directly and represent their interests within a framework of rules that restrict opportunism; and the processes of stakeholder engagement should be put in place to reduce the impact of power asymmetries (Dawkins, 2014).

I think the stakeholders are independent of us and it would be difficult to make them account to us. But I think they account to society in general. And over time, their views or actions, you know, are in the court of public opinion, make the final judgment about what is right or wrong. (Leader 5)

According to the participant, the stakeholders that are engaged, act independently from government. Despite the independence of stakeholders, they are still accountable to society. Over time, society will judge stakeholders and determine whether their views or actions were appropriate or inappropriate.

All the stakeholders that influence the health system and the pursuit of UHC are expected to be accountable to the public in a meaningful way, especially for national and local government, and service providers (World Health Organization, 2014).

I think, if also, you use the stakeholder engagement as an engagement and not a decision-making process. You know, then you're likely to succeed. And what I mean by that is, if there's a majority view after a rigorous discussion of a position, and you have those that are dissenting in that they disagree, despite all the rigorous discussions, then you need to move forwards with the majority view, whilst you have noted the inputs of those that have a dissenting view. (Stakeholder 1)

I think there should be kind of a disciplined and a structured way to begin with, in terms of filtering different sectors inputs up, so that it can actually reach the decision-making bodies. And that's actually all that I can say in terms of management. But it's a huge process. I don't know, how they will structure and get involvement. So that's difficult. (Stakeholder 2)

Stakeholder engagement should be viewed as a process to engage stakeholders, rather than a decision-making process. The input of the stakeholders should be considered in a fair and transparent manner. The views of the majority need to be considered while noting dissenting opinions. There is a need to have a disciplined and structured way of filtering the input from different sectors, before decisions are made by the relevant bodies.

According to Buchholtz and Carroll (2012), one of the principles of stakeholder management includes acknowledging and actively monitoring the concerns of all the legitimate stakeholders, and taking their interests into consideration when making decisions.

Some stakeholders would have critical role in certain aspects. So, when we develop the benefits package which will be the guidelines, we would clearly have to make sure that we have the appropriate health professional groups. You can't write a clinical guideline without nurses, you can't write it, if you're doing a surgical guideline, you will need surgeons etc. (Leader 5)

The participant indicated that clinical guidelines require input from professionals involved in healthcare provision. Stakeholders that play a crucial role in the provision of healthcare will be included in the process of developing the NHI benefits package.

Buchholtz and Carroll (2012) state that stakeholder management requires listening and open communication with stakeholders about their concerns, and contributions, and adopting processes and behaviours that are sensitive to the concerns of stakeholders.

So, it's important for over and above all the other structures that government has to have this what we call a brains trust, to actually be able to give feedback to the State. It's like a trust fund of brains, brains trust. (Stakeholder 5)

Stakeholders are very important. The NHI Bill incorporates a specific role for stakeholders. Stakeholder Advisory Committee in Law, made up of all of the sectors from the providers, to the patients, to labour, civil society, etc. and the intention is that these people provide feedback about the way that systems operate through their structures, because many countries health systems benefited from that feedback engagement. (Leader 5)

The participants indicated that there is a need to have structures that give feedback to government. The NHI Bill incorporates a specific role for stakeholders from various sectors of society such as healthcare providers, labour and civil society. This is to facilitate stakeholder engagement, and gives the opportunity for government to be provided with feedback from various constituencies.

The Minister must, after consultation with the board, establish the Benefits Advisory Committee and Health Care Benefits Pricing Committee; and appoint a Stakeholder Advisory Committee comprised of representatives from the statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers, as well as patient advocacy groups, in such a manner as may be prescribed (Republic of South Africa, 2019).

We need to get everyone around the table to see NHI in the same way. To see NHI as something that is needed to bring, not just healthcare, but social justice for people so that everyone in our society is not burdened with healthcare. Where our country comes from, structurally, we are not the same. (Stakeholder 6)

There should be a drive to raise awareness among stakeholders that NHI is not only about healthcare, but also about social justice. The NDoH should lead national campaigns to increase public awareness regarding quality-of-care issues (South African Lancet National Commission, 2019). The campaigns must focus on health rights within the context of the Bill of Rights, the responsibility of individuals for their health, and the rights and responsibilities of health workers (Ibid., 2019).

I think we need to educate the media because we don't have what we call an educating media in our country, the media tends to take the opponent and the proponent view. We don't have the factual media in the country that says ok, this is health financing in South Africa. You find that the uneducated and voiceless, sometimes they just get stuck between the proponent and the opponent. They get confused and then block it out. I think we need proper information strategy. And for me, we need to educate our media impartially. (Stakeholder 4)

The media is seen to be playing a part in communicating about the NHI. Yet, the media may not be clear and factual in their communication. This may confuse citizens and create uncertainty. Media should be involved and play a role in an impartial manner to educate citizens about the NHI. A proper information strategy is required to educate the media to provide a balanced view on health system reform.

Transparency requires that political information be properly communicated to citizens through various media platforms to enable the people to participate in public policymaking and supervise the process of public administration in an effective manner (Keping, 2018).

8.4.3.6 Fair stakeholder treatment

The aim was to determine what the participants consider fair treatment of stakeholders.

I think there's only one way you can do it. That is the people must vote. (Leader 3)

A more guaranteed way of saying everybody has been consulted is a referendum. With a referendum, you know that people, but it is tricky because you don't know the outcome. But I think it's critical, especially with South Africa being such a very divided society on this issue of NHI because it is a very touchy subject and it can be divisive. If you do a referendum, then at least you've got a choice. (Stakeholder 3)

The participants stated that the nature of democracy requires the acknowledgement of different stakeholder views before reaching a consensus. Engaging stakeholders constitutes a key factor to avoiding policy capture during the policymaking process (Organisation for Economic Co-operation and Development, 2018).

So, some people may feel, oh, you know, we should have had more say in this. But the nature of democracy is that whilst you listen to all the multiple voices, we still need to forge out a logical, you know, consensus approach to a policy making process. So not all your views will make it to the final document. And I think that's right. (Stakeholder 1)

Inputs have been given. That's what the fair process would have been. Consider the inputs of the stakeholders. Involve stakeholders that are playing a major role in healthcare. (Leader 5)

The policy documents will not include all the input provided. A fair process would entail the consideration of stakeholder input and the involvement of stakeholders that play a major role in healthcare.

In strengthening the health sector, national health systems stewards need to ensure alignment, and coherence of policies and priorities among different stakeholders; and manage and coordinate partnerships, and expectations (Senkubuge *et al.*, 2014).

They don't really listen to the concerns, and why we are maybe negative, they just say it's a good process, you should be involved in it. I think that the government and various committees should try more to put information, clear information out there to everybody in the country and communicate very effectively, answer concerns and questions so that people are more informed. (Stakeholder 2)

We must communicate better. We must explain what the NHI is and how it's going to affect everybody. At the moment, I don't think we've communicated adequately as to how it's going to work out. There have been attempts, but I think it should be clear, in no uncertain terms, to say that's what's going to happen. In that way, it will be clarified in the minds of people. (Stakeholder 3)

So, from the time that the idea or the concept comes, so the Minister had a concept of putting South Africa in line with Universal Health Coverage, we're going to call it National Health Insurance. So, from then as a stakeholder we should have been, it should have been communicated somehow. (Stakeholder 6)

The participants stated that government needs to communicate clearly and effectively to the citizens of the country about the NHI and the intentions behind it. Government should have started communicating to stakeholders about the concept of NHI when the process started. The Department of Health should also advise the stakeholders on the process to be followed to become involved. Clear communication is required to encourage inclusive participation, as this approach is necessary for health system reform. The focus should not only be on those who support the government's position, but also on acknowledging diverse views.

The values and principles of public participation involve providing stakeholders with the information they need to enable them to participate meaningfully in the process (South Africa, 2019).

If you can't touch everybody, you need to have a representative sample from the population. Will your sampling include white people in the country, the black people, the disabled, the young people, the elderly, the rural population? Did you go to all the doctors that are looking after the patients? It must be representative sample is here. If you're a government and you want to reach your doctors and your patients, you go where they are. Simple as that. You have to be intentional. (Stakeholder 4)

Government must be intentional in its stakeholder engagements. Planning and resources should be allocated to stakeholder engagements. The stakeholders to be included should be representative of the country's population. In the organisation of health services, communities and populations are usually not consulted concerning their needs, and expectations from the health systems (South African Government, 2019). A patient charter and feedback system exist, but is not working optimally (Ibid., 2019).

I think when there's adequate consultation, or at least opportunity to consult. The public hearings, give everybody the opportunity to participate. So, nobody can claim that they have been excluded. They may not have been included that at the beginning of the more technical level of the policy. But now that it is there and there is a lot of talk, and I'm sure most people belong to one or two of the political parties. If you don't participate, the political party may represent you. (Stakeholder 3)

So, giving you enough time to sit with the idea, to look at it critically, to ask the questions, to get the feedback, and throughout the process to have the platform of the engagement. But also, it took a lot from us as a stakeholder to get involved. So, no one is going to send you invites or send your emails. It's up to you, you know, to engage government and say, we are this and this, how do we get involved? (Stakeholder 6)

The participants mentioned that the planned public hearings will give people the opportunity to express their views about the process. Stakeholders should be consulted and given reasonable time to engage with the issues, and provide feedback after consulting relevant constituencies. According to Dawkins (2014), substantive stakeholder engagement is needed, and the process includes an inclusive and participative forum of interaction; reduced power asymmetries such that either side can prevail in a dispute; and having the capacity to impact distributive outcomes.

Did you see how the Health Market Inquiry was transparent? You know what? All the submissions were on the website, they acknowledged everything in the report. They even tell you on this issue, SAMA said 123 and Discovery 123. Medscheme said 123, after considering their submissions, we still posited 123. It's transparent. They still said, we heard what you said. We thank HMI for that. We didn't know because when you don't know, when you live in a corrupt country, you don't know what transparency is. (Stakeholder 4)

So, in a similar way that you put together the Health Market Inquiry, the technical committee would look at it and say in terms of constitutionality, in terms of trends observed elsewhere, in terms of the principles of UHC, does this fit? So that the process is as apolitical as possible, but still subscribes to the social compact of healthcare. I think for me that might be the missing. Healthcare is a technical area. It needs people who understand healthcare. (Stakeholder 5)

The other issue would be in terms of feedback. I think the amount of the volume of work that will be submitted will be a lot. But if there could be an attempt to give feedback on the substantive inputs, because there are some people who are collecting signatures as a petition, either for or against it. That is not substantive because there'll be organisations that say, I've got a million signatures for the NHI. It's not input, it's just support. (Stakeholder 5)

Based on the participants, the input from stakeholders must be acknowledged in a transparent manner, as this approach will help with addressing issues of mistrust, and people feeling excluded from the process. Lessons may be learned from how the HMI dealt with stakeholder input in a transparent and apolitical manner. Technical experts should be included in the whole process because NHI is about healthcare. It is not only a political process. Giving feedback to stakeholders on substantive input is also necessary. According to the values and principles of public participation, participants must be provided with feedback on how their input shaped the decision (South Africa, 2019).

8.5 Chapter Summary

The participants indicated that the process of identifying stakeholders may be complex, as the stakeholders are many and varied. Every citizen in the country, including immigrants, will be affected by health system reform. Policymakers need to consider stakeholder interests and the impact of policy on stakeholders. The State has the responsibility to drive the NHI policy reform process.

Stakeholders have been classified into two broad categories, namely those with vested interest and those who have no knowledge. The stakeholders gave their views about their participation in the NHI process. There was a strong view that the private sector was not involved in the engagements about the NHI. The healthcare providers were also excluded from the processes. However, the regulators and trade unions were actively involved in the NHI processes. On the other hand, there were no attempts by the State to communicate with the workers and ordinary citizens about the NHI. This creates uncertainty and confusion.

The participants indicated that their current and future roles are influenced by the regulatory frameworks of the country. The stakeholders believe that they have a role to play in the future environment. Public-private partnerships are needed to sustain the health system. Identifying barriers to stakeholder participation is necessary for managing stakeholders effectively. Stakeholder management should be done within the framework of engagements, MOUs, terms of reference and codes of conduct.

A strategy for stakeholder engagement is needed and must be budgeted for. Fairness in treating stakeholders is necessary to ensure accountability and trust. The government must also make efforts to acknowledge the voices of dissent. Transparency when dealing with stakeholders and their input is essential.

The stakeholders mentioned that, for an effective and sustainable health system, there is a need for proper regulation of the NHI Fund; collaboration with other stakeholders; and competition. There are other areas, such as tariff setting and multidisciplinary practices, which need to be better regulated to improve access to quality and affordable healthcare. Innovative regulation is needed to strengthen human resources capacity for a better quality of healthcare.

Change management processes should not be overlooked to effect the implementation of the NHI by government and various stakeholders. The next chapter focuses on how health system reform may be implemented, and informed by the analysed multi-dimensionality of the phenomenon.

CHAPTER 9: A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM – RESEARCH CONTRIBUTION

9.1 Introduction

As a research contribution, this chapter conceptualises how health system reform may be implemented in South Africa. The conceptualisation is informed by the literature reviewed, the theories underpinning the study and an interpretation of findings.

9.2 Framework for Implementing Health System Reform in South Africa

This section discusses the framework as a tool for implementing health system reform. The elements of theories (leadership and governance; service delivery; and stakeholders) and the study findings, informed by the analysed multi-dimensionality of the phenomenon, were integrated to conceptualise a framework on *how health system reform may be implemented*. Figure 9.1 depicts the conceptual framework.
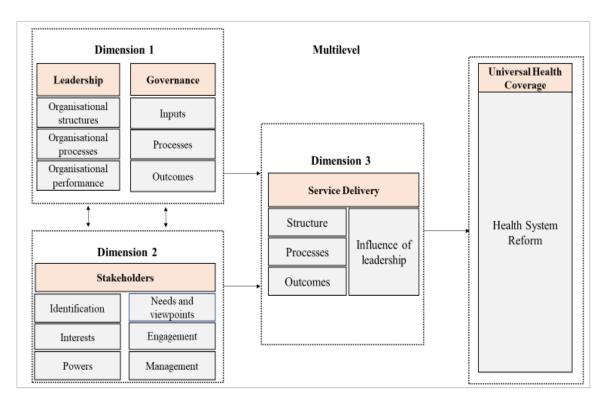

Figure 9.1: Framework for implementing health system reform

This framework (Figure 9.1) represents three levels of the health system, namely the macro, meso and micro levels. There are three dimensions, namely *leadership and governance*; *stakeholders* (those affected by health system reform); and *service delivery*. The dimensions of the framework affect and effect health system reform in the following ways:

9.2.1 Dimension 1: Leadership and governance

This dimension focuses on leadership and governance in health system reform.

9.2.1.1 Leadership

The elements critical to the leadership dimension are depicted in the below diagram.

Contingencies

Organisational structures

Organisational processes

Organisational performance

- Missions
- Technology
- Communication

Figure 9.2: Leadership elements

  o **Organisational structures**

Organisational structures are crucial to implementing the mission, strategy and organisational goals. Organisational structures in both the private and public sectors should be aligned with the vision of UHC. The private sector has the capacity, resources, skills and competencies for NHI implementation, and they are willing to work with government in realising the envisioned health system reform. There is a role that the private sector (healthcare providers, funders and administrators) can play to promote access to quality healthcare, in line with the country's policies.

o **Organisational processes**

An organisation's strategy, governance structures, and benchmarking, decentralisation and quality assurance mechanisms are crucial to improving organisational processes. The key to success is to focus on the needs of the clients, and accountability and consequence management. Outsourcing may be considered to improve business processes and achieve operational efficiencies. Proximity to the outsourced company, a trust relationship, and addressing soft issues enhance effective communication and improved efficiencies in the delivery of care. Strong leadership and understanding the mission of the organisation are also important for achieving the desired goals. Appointing competent people is critical to achieving organisational goals and policy implementation. Policy implementation requires the hiring of the best people for the job, and finding the people who are hardworking and honest, who have the interests of the customer and the organisation at heart.

o **Organisational performance**
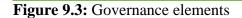
Organisations need to have missions which are in line with UHC principles to promote equitable access to healthcare, while ensuring financial protection of the population and sustainability of the system. There is a need to use resources efficiently and accelerate efforts to move closer to UHC. Organisations must have the culture and leadership to drive communication, and take advantage of modern technology to communicate. Various communication tools, and platforms may be used to communicate across organisations to achieve organisational and strategic objectives. There is a need to have advanced data collection systems to input and measure all the business activities, and deal with deviations, in order to improve business processes and outcomes. Technology with features of interconnectivity and data security may be used effectively to improve access to healthcare, enhance efficiency within the system and reduce costs.

9.2.1.2 Governance

The governance elements are shown next.

Governance context

Inputs

- Strategies and policies
- Stakeholder participation
- Consensus orientation

Processes

- Accountability

- Transparency

- Control of corruption

Outcomes

- Responsiveness

- Efficiency in the use of resources

- Equitable access

Figure 9.3: Governance elements

The governance elements are explained as follows:

- **Inputs**
  - **Strategies and policies**

Government has to provide the leadership, regulations and oversight to ensure the realisation of UHC. The State should play a stewardship role, and provide rules and regulations while promoting fair competition. There is a need to strengthen governance systems in both the public and private sectors. Hospital boards and relevant committees must be established in the public sector to ensure accountability, oversight, operational efficiencies and the realisation of health system reform of the NHI. Mechanisms should be put in place to incentivise and reward performance excellence. The benefits of the current structures should not be ignored, and there is a need to minimise bureaucracy within the system.

- o **Participation**

Health system reform is a legislative process which requires the State to engage with all sectors of society. Various policy documents were published to inform the public about the envisaged health system reform through the Green Paper, White Paper and the NHI Bill. These policy documents provided for public engagements. Public participation also took place to allow ordinary citizens to share their views about the planned reform. Nevertheless, when a policy process begins, there is also a need to engage ordinary citizens through their various representative structures or constituencies. In addition, information should be provided on how they need to participate in the process.

- o **Consensus orientation**

Clear and targeted communication is required to encourage inclusive participation, as this approach is necessary for health system reform. Engagements must also aim to accommodate dissenting views.

- **Processes**
  - o **Accountability**

Consequence management is required to deal with unethical conduct or practices. The success of governance requires accountability among players and the appointment of skilled, competent people. Preventing and reporting the abuse of power, and misuse of public resources is crucial to ensuring accountability. Accountability, transparency and control of corruption are key to addressing governance issues.

- o **Transparency**

Clear processes, procedures and systems are essential to effecting the NHI implementation. Systems and processes must be supported at all levels of the health system. Clear contracts that govern parties in the public and private sectors must be developed, and these must clearly address how deviations will be dealt with. There must be specific goals, specific timelines linked to these specified goals, and they must be measurable. The government must be proactive in generating and disseminating

information in a coordinated manner to reach the targeted audience timeously. The governance policies should be readily available to the public. This will minimise information gaps and uncertainty in planning for healthcare delivery. There is also a need to have competent people to implement governance policies, systems and processes.

   o **Control of corruption**

Existing structures that are experienced in dealing with fraud and corruption should be strengthened to proactively deal with challenges within the health sector. Consequence management must be enhanced to improve trust and confidence in the State to administer the NHI Fund. A high standard of professional ethics must be promoted and maintained. There should also be a focus on external parties who unduly influence employees to commit fraud and corruption. Both the corruptor and the person being corrupted must be dealt with. Clear processes, procedures and systems must be in place to effect the NHI implementation. Systems must also be in place to ensure fair and equal remuneration of service providers to ensure consistency, and fairness. Compliance with policies and regulations must be enforced across all levels of the health system. Proper governance structures, and committed and decisive leadership are needed to effect health system reform.

- **Outcomes**
   o **Responsiveness**

If clear vision, great leadership and good people drive NHI policy implementation, health system will be responsive to the needs of the population. Government will be judged by its ability to deliver on its promises.

   o **Efficiency in the use of resources**

Resources which offer the best value for money must be prioritised. In developing policies, a clear description should be given of tasks and responsibilities, timelines and how they will be accomplished. It is also vital to develop clear contracts that govern the parties in the public and private sectors, and clearly address how deviations will be dealt with. An environment of openness and trust is needed to encourage unhindered, fair

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collaboration between the public and the private sectors. Leaders are role models and should remain accountable. Consequence management is required to deal with unethical conduct or practices in leadership.

- o **Equitable access**

Transparency, accountability, effectiveness and efficiency play a role in ensuring equitable access to healthcare. Decentralisation, especially at district level, is needed to make services available and closer to the people. Services must be standardised to ensure equity. Primary healthcare needs to be strengthened to alleviate the load at higher levels of care or hospitals. A clear gate-keeping system is required to control access to healthcare at various levels of the health system. There is a need to have systems to manage community health workers, as they are part of the human resources for health. The public and the private sector should co-operate, and share knowledge and capabilities to strengthen the health system. Organisational missions must be aligned with UHC principles, which are aimed at promoting equitable access to healthcare, while offering financial protection to families. The success of governance requires the appointment of skilled, competent people, and accountability among players. The most important measure of governance is the impact on the population.

9.2.2 Dimension 2: Stakeholders

It is argued that, in health system reform, it is vital to identify stakeholders, in order to determine their roles; understand their interests, needs, and powers; engage and manage them to establish their influence in the health system reform. The stakeholder elements are shown next.

| **Stakeholder context** |
| Stakeholder identification |
| Stakeholder interests |
| Stakeholder powers |
| Stakeholder needs and viewpoints |
| Stakeholder engagement |
| Stakeholder management |

Figure 9.4: Stakeholder elements

9.2.2.1 Stakeholder identification

The legislative process is driven by government and the process of identifying stakeholders should be well considered. A clear policy is required for stakeholder identification and implementation of the engagement process. Stakeholder identification requires policymakers to consider stakeholder interests and the impact of policy on stakeholders. Criteria are required for inclusivity, while ensuring that a manageable number of stakeholders are represented. Stakeholder matrix in health policy reform provides guidance on the stakeholders that should be consulted.

9.2.2.2 Stakeholder interests

Government alone does not have the capacity and facilities to provide services to all the citizens in the country. Achieving UHC requires efficient utilisation of resources that exist within the health system to ensure sustainability. Public-private partnerships are needed, so that the resources in the health system are shared to improve population health, which will, in turn, positively affect productivity. The resources that may be shared with the public sector include ICT infrastructure, healthcare service delivery platforms and healthcare administration. It is also important to have competent healthcare practitioners to enable the achievement of good health outcomes.

9.2.2.3 Stakeholder powers

Stakeholders have powers based on their mandates to provide oral or written submissions, form pressure groups and litigate. This is to ensure effective management and leadership, and responsible NHI implementation. As national healthcare is politically driven, the relative political power of stakeholders determines their impact on health system reforms. Inclusiveness and collaboration of the affected stakeholders are necessary to ensure fairness, and transparency.

9.2.2.4 Stakeholder needs and viewpoints

Implementation of UHC through the NHI should not primarily focus on the poor, while excluding those that are more privileged. It is essential to strengthen resources at primary healthcare to alleviate the burden at higher levels of care or hospitals. There is a need for stakeholder collaboration; a competitive environment; and good governance that will promote efficient use of resources, and ensure access to quality and equitable healthcare, and a sustainable health system. Healthcare providers must be supported to enable the provision of quality healthcare and reduction of malpractice lawsuits. Citizens should also take responsibility for their own health and actively participate in policymaking processes.

9.2.2.5 Stakeholder engagement

Stakeholder engagement requires strategy and resources. The engagement must be actively driven by government. Policymakers must understand the stakeholders and the barriers to stakeholder participation, as this will assist in minimising the barriers to stakeholder participation. Stakeholder engagement should be viewed as a process to engage stakeholders in a fair and transparent manner.

Government needs to communicate clearly and effectively to the citizens of the country about the NHI, and advise stakeholders on the process they need to follow to be involved. Clear communication is required to encourage inclusive participation, as this approach is necessary for health system reform. Stakeholders to be included should be representative of the country's population. The focus should not only be on those who

support the government's position, but also on acknowledging diverse views. Input from stakeholders must be acknowledged in a transparent manner, as this approach will help with addressing issues of mistrust and people feeling excluded from the process. Giving feedback to stakeholders on substantive input is also necessary.

9.2.2.6 Stakeholder management

Stakeholders have various interests and needs. It is advisable for stakeholder groups to participate under the mandate of their constituencies to ensure accountability and feedback. Homogenous groups need to be engaged at a given time to prevent antagonistic interaction that may arise from stakeholders who are natural enemies. There is a need to have a framework to guide the stakeholder management process. Terms of reference are essential to resolving issues. A code of conduct may be required to guide the rules of engagement. The rules of engagement may be formalised through an MOU or agreement. There should also be consequence management, in cases of contravention. Irrespective of the differences, stakeholders need to abide by the laws of the country and be accountable. Structures are required that give feedback to government to ensure a continuous flow of information between government and stakeholders. A proper information strategy is necessary to educate the media on providing a balanced view on health system reform.

9.2.3 Dimension 3: Service delivery

Once the NHI policy is implemented and service delivery effected, the result will be health system reform, and the process is iterative. This is envisaged for the varied levels of the health system. Improving the quality of healthcare delivery is one of the goals of UHC. This dimension was, therefore, looked at with a focus on aspects that impact on the quality of healthcare. In addition, leadership influence is central to the delivery of quality healthcare and health system reform.

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Service delivery context

Structure measures

- Resources
- Administration

Process measures
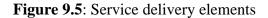
- Identifying, prioritising and addressing health problems, resources and outputs

Outcome measures

- Acceptable and accessible service

The influence of leadership

- Ethical, situational and visionary leadership

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Figure 9.5: Service delivery elements

9.2.3.1 Structure measures

The main source of funding for public sector facilities is government. Despite the influence of facilities on the budgetary process, the resources allocated by government are not enough to meet the needs of their institutions. There is a need to strengthen resources for improved service delivery. Four areas require attention, namely *healthcare financing; human resources; infrastructure;* and *information technology.* To generate revenue, there must be policies in place to determine how services offered to other provinces, government entities and African countries are funded. The policies must clearly articulate how funds should be recovered to settle debts. The human-resource-for-health strategy of the country needs to be implemented to deal with human resources challenges in the country. Investment in infrastructure and information technology are needed to enhance the delivery of quality healthcare.

9.2.3.2 Process measures

Supply chain processes should be improved to enhance operational efficiencies and quality healthcare delivery. This should be done to guarantee the procurement of quality goods and services, and ensure continuity, and an enhanced working relationship between suppliers and healthcare facilities. There is a necessity to work with the private sector in dealing with challenges experienced regarding the availability and distribution of pharmaceutical products. There is also a need to have a national integrated system to enable facilities to track patient movement between facilities. Change in organisational culture should be prioritised. Policies should be designed to clearly articulate organisational culture and address issues of branding, communication, consistency and organisational reputation.

9.2.3.3 Outcome measures

Addressing hindrances that result in long waiting times, which are sometimes attributed to systems being down and medicine being out of stock, should be prioritised. Policies that promote the unequal distribution of resources between the private and public sectors need to be reviewed to ensure equity in healthcare access.

9.2.3.4 The influence of leadership

An effective leader is required to drive the implementation of health system reform and organisational transformation. An effective leader is an individual who has strong people skills, and is a risk-taker and smart. The leader should be a visionary, value-based, innovative, teachable, resilient, open-minded, inspirational, influential, believable, adaptable and systems-focused. The leader must be conversant with the health system, and global and macro-environmental issues, be able to withstand appraisal and feedback from stakeholders, and have the capability and skills to lead people. A leader should be able to identify the leadership style most suitable for the situation and then implement that leadership style. A combination of ethical, situational and visionary leadership is needed to effect organisation change, and health system reform.

9.2.4 A tool for implementing health system reform

The conceptual framework is a tool for bridging the identified gaps in literature, and guiding policymakers in implementing health system reform.

Bridging knowledge gaps

> This study intended to bridge knowledge gaps with a multi-dimensional framework that would address the *leadership and governance*; *service delivery*; and *stakeholder aspects* necessary for health system reform. The contribution is in providing the theory on the 'how' to implement health system reform in a developing country such as South Africa.

Policy implementation

> The researcher envisages that the framework will be a useful tool for guiding policymakers in effectively implementing health system reform. The framework provides practitioners with the 'know-how' on the implementation of health system reform in a developing country such as South Africa. Health system reform is seen as the realisation of UHC through NHI coverage and access to all. When the policy of the NHI is implemented and service delivery effected, the result will be health system reform, and the process is iterative. This is envisaged to happen at the varied health system levels as well.

9.3 Chapter Summary

This chapter discussed the framework as a tool for implementing health system reform. The elements of theories (leadership and governance; service delivery; and stakeholders) and the study findings, informed by the analysed multi-dimensionality of the phenomenon, were integrated to develop a conceptual framework on *how health system reform may be implemented*. Health system reform is seen as the realisation of UHC through NHI coverage and access to all. Once the NHI policy is implemented and service delivery effected, the result will be health system reform, and the process is iterative. This is envisaged for the various health system levels as well. The framework will provide practitioners with the 'know-how'

on the implementation of health system reform in a developing country, addressing the dimensions of leadership and governance, stakeholders, and service delivery.

CHAPTER 10: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

10.1 Introduction

This chapter concludes the study, discusses the limitations and makes recommendations based on the objectives of the study. The goal of the study was to conceptualise a multi-dimensional framework for implementing health system reform in South Africa. The objectives of the study were:

- To analyse the role of leadership and governance in health system reform
- To analyse how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities
- To analyse the role and influence of stakeholders in implementing health system reform
- To determine how health system reform may be implemented, informed by the analysed multi-dimensionality of the phenomenon.

10.2 Conclusions on the Findings, in Relation to Study Objectives

South Africa aims to implement the health system of UHC through the NHI. In this study, it is argued that health system reform requires a focus on leadership and governance; service delivery; and stakeholders at all health system levels. The literature reviewed provides insights into conceptual foundations of the study (health systems, health system reforms and UHC; leadership and governance; service delivery; and stakeholders). The conclusions in this chapter were drawn in terms of the objectives of the study and research findings.

10.2.1 Conclusions on the role of leadership in health system reform

The first objective was, 'To analyse the role of leadership in health system reform', and the contingency theory of leadership was adopted to address this objective. Contingencies, which are the *organisational structure*, *organisational strategy* and *organisational environment*, influence *organisational performance* (Blanton *et al*., 1992).

Consensus was reached that policy implementation requires effective leadership that will drive the country's vision of achieving UHC, starting at organisational level. It is evident that there is a need to align organisational strategies with organisational structures for improved organisational performance. In addition, the internal and external environments should not be overlooked, as they influence organisational performance. Successful strategy requires alignment between the organisation's external environment (threats and opportunities) and internal environment (mission, goals, values, structure, systems, resources and capabilities), with the firm's strengths and weaknesses (Venter, 2018).

Hindrances in the public sector processes and systems are caused by a lack of ICT systems to support work processes. Due to the scale of the envisaged health system reform through the NHI, there is awareness among leaders regarding the importance of having advanced and reliable ICT systems with a clear communication strategy for improved health system performance. The leaders in organisations indicated the need to maximise the use of technology for improved performance and competitive advantage. Developments in information technology have fundamentally changed the way business is conducted, allowing for less expensive communication, easier sharing of information, and greater efficiencies in production, and management of goods and services (Hallinger & Snidvongs, 2008; Thompson *et al.*, 2012; Brevis & Vrba, 2018). Technology and innovation are crucial to enabling NHI implementation, and improving health system performance and service delivery.

The leaders agree that public and private sector collaboration is necessary to maximise the utilisation of resources available in both sectors, and to ensure sustainability of the health system. Outsourcing the NHI administration may be considered, using the existing medical scheme administrators in the private sector, as the industry has the resources and capacity to administer the envisaged NHI. According to the Department of Public Service and Administration (1997), it is necessary that national and provincial departments identify, among others, potential partnerships with the private sector, NGOs and community-based organisations to provide more effective forms of service delivery. The findings also show that accountability and consequence management are key to organisational success and health system performance.

10.2.2 Conclusions on the role of governance in health system reform

The second objective was, 'To analyse the role of governance in health system reform', and a framework to assess governance of health systems in low income countries was used to address this objective. The framework explains that *governance inputs*, *processes* and *outcomes* are interlinked against the World Health Organization's building blocks of the health system (human resources, medicines and technology, financing, information and delivery of health services) (Baez-Camargo & Jacobs, 2011).

In line with this theory, the findings indicate that there is a need to strengthen governance inputs, that is, the *strategies* and *policies* in both the public and private sectors, to improve health system performance. Policymakers need to provide oversight and clear regulations for NHI implementation while promoting fair competition in the health system. There is a dire need to have functional boards at various levels of the public sector. Effective governance is crucial to ensure accountability and sustainability of the health system.

In terms of governance processes, the findings show that *accountability* and *transparency* are key to promoting stakeholder trust and co-operation. A need also exists to enforce compliance with policies and regulations across all levels of the health system. Governance needs to be strengthened to *control corruption*. This concurs with Chee *et al*. (2013), who mentioned that strengthening the health system with a focus on performance drivers is vital, and may be accomplished by more inclusive changes in policies and regulations, organisational structures, and relationships across the health system building blocks to enable the effective use of resources, in order to improve healthcare services.

The findings also show that health outcomes are influenced by the government's *responsiveness* to the needs of the population, *efficient* use of resources, including clear gatekeeping, and *equitable access* to healthcare services.

10.2.3 Conclusions on the influence of leadership on service delivery

The third objective was, 'To analyse how leadership may influence service delivery', and the contingency theory was also applied to address this objective. The contingency theory showed that the contingency elements, which are *organisational structure, organisational strategy* and

organisational environment, influence organisational performance and service delivery. The leaders stated that the current organisational structures and strategies need to be aligned with the country's vision of UHC at a macro-level. Enablers of service delivery, namely financing, health information systems, health workforce, medical products, vaccines and technologies, should not be ignored.

The findings indicate that effective leaders should drive organisational performance and implementation of health system reform. These are individuals who are value-based, innovative, teachable, resilient, open-minded, inspirational, influential, believable, adaptable, systems-focused, risk-takers, smart, open to criticism, conversant with the health system, and global and macro-environmental issues, and have strong people skills. Pardey (2007) mentions that purposeful change is driven by vision, goals and a clear sense of direction.

10.2.4 Conclusions on the service delivery challenges in South African healthcare facilities

The fourth objective was, 'To determine the service delivery challenges in South African healthcare facilities', and the Donabedian model was adopted to unravel the *structure*, *process* and *outcomes measures* necessary for delivery of quality healthcare in health system reform. The findings show that the structural capacity of the State hampers organisations' ability to achieve operational and strategic objectives. Structural capacity depends on elements such as fiscal resources, human resources, and information (Handler *et al.*, 2001).

The findings indicate that there are service delivery challenges, due to ailing infrastructure; administrative bottlenecks; increased demands on human resources; a shortage of medicines and consumables; poor accountability of service providers; the influence of patients' behaviour; staff attitude; and challenges with outsourcing. Funding is deficient and there are gaps in revenue collection from the public, State entities, and foreign countries that utilise State sector resources.

The structural deficiencies negatively affect organisational processes of prioritising and addressing health problems, resulting in poor service delivery. Strengthening structural capacity will facilitate the provision of timely, customer-centric, efficient and equitable

healthcare. PricewaterhouseCoopers (2007) posits that improvements in customer experience and outcomes should focus on the *speed* of delivering the service correctly the first time, and *responsiveness* to customer needs.

The findings show that provision of quality healthcare is a complex phenomenon. Strengthening structural capacity and organisational processes is key to improved service delivery and enabling the realisation of UHC. The health system needs to be strengthened, with a focus on human resources; infrastructure; healthcare financing; and information systems.

10.2.5 Conclusions on the role and influence of stakeholders in implementing health system reform

The fifth objective was, 'To analyse the role and influence of stakeholders in implementing health system reform', and an integrative stakeholder theory was applied to attain this objective. This theory postulates that organisations are comprised of various stakeholder groups with different interests; appropriate management of stakeholder interests is important to contribute positively to organisational objectives; and organisations need to be ethical and objective when dealing with stakeholder interests (Donaldson & Preston, 1995; Hörisch, *et al*., 2014).

The findings highlight that the stakeholder identification process is important for determining stakeholder roles; understanding their interests, needs and powers; and engaging and managing them, so that their influence may be established in health system reform. Despite government's efforts to engage stakeholders through the legislative process, stakeholders are of the view that the engagements were politically driven, thereby excluding other key stakeholders such as ordinary citizens and the private sector. Therefore, identifying barriers to stakeholder participation is necessary to engage and manage stakeholders effectively in a fair, consistent and transparent manner.

Government must be intentional in its stakeholder engagement, and plan and allocate resources to engage stakeholders. The State is responsible for driving the NHI policy reform process. According to Merryl (1994), healthcare reforms require that the process through which major policy decisions are made be participatory, involving all the stakeholders in deliberations. The

stakeholders highlighted that stakeholder management is important and should be implemented within the framework of engagements.

Despite different views regarding stakeholder engagement, various stakeholders mentioned that they have a role to play in the NHI environment based on the mandates of their organisations and directives of NHI policy. Public-private partnerships are needed to sustain the health system. Best practice purchasing, provisioning, procurement and sound financial management are important in public-private partnerships to improve access, equity, quality and innovation for efficient service (National Planning Commission, 2011). Media should also be empowered to communicate impartially. Therefore, the role of the affected stakeholders needs to be acknowledged in policy decision-making to improve health system performance.

The findings indicate that healthcare providers require support at all levels of the health system to facilitate the provision of quality healthcare. Innovative regulation is needed to strengthen human resources capacity, care coordination and improved quality of healthcare. There is also a need for price regulation in the NHI environment to curb over-servicing and control healthcare costs. Careful and thorough strategic thinking in communication, the degree of collaboration, the development of policies and programmes, and resource allocation is important (Buchholtz & Carroll, 2012).

Corruption has been highlighted as a stumbling block to an efficient health system and financing healthcare in an inefficient system will not be beneficial. This position corroborates the view of South African Lancet National Commission (2019) that corruption and fraud are major threats to equitable access to quality healthcare. Stakeholders mentioned that they are keen to collaborate for improved governance that will promote the efficient use of resources, and ensure access to quality and equitable healthcare, accountability, and a sustainable health system. Although the NHI is based on the principles of social solidarity, the rights of all citizens must be respected, including the rights of foreign nationals.

10.2.6 Conclusions on how health system reform may be implemented, informed by the analysed multi-dimensionality of the phenomenon

In addressing the last objective, the empirical study provided substantial data to support the development of a conceptual framework. It was proposed that the conceptual research

framework was in line with the research arguments and served as a lens for the study in the following ways:

- This research framework depicted in Figure 9.1 shows how dimensions of leadership and governance, and the stakeholder dimension influence and effect service delivery as the other dimension.

- In this study, leadership is looked at, considering the *organisational structures, processes,* and *organisational performance* concepts.

- In terms of governance, concepts relevant to this study are the *inputs* (participation, consensus orientation, strategies and policies*); processes* (accountability, transparency and control of corruption); and *outcomes* (responsiveness, equitable access and efficiency), in the context of health system reform.

- Service delivery, which reflects the health system outputs, is looked at, considering the *structure* (resources and administration); *processes* (culture and professional co-operation); and *outcomes* (satisfaction with services, that is, affordable, accessible and acceptable to the population).

- *Identification* of stakeholders; *stakeholder interests* and *power*; *engagement* and *management* are important in the context of this study.

- In this study, health system reform is seen as the realisation of UHC through NHI coverage and access to all. When the policy of the NHI is implemented and service delivery has been effected, the result will be health system reform of UHC, which is characterised by *improved health, responsiveness* and *financial protection*. This is envisaged to happen at the varied levels of the health system.

- The goal of the study was to conceptualise a multi-dimensional framework that will provide the 'know-how' to implement health system reform in a developing country, such as South Africa, cognisant of the preceding dimensions. That is, the framework will provide practitioners with the 'how' for implementing health system reform in a developing country, addressing the dimensions of leadership and governance, stakeholders, and health system indicators.

It is, therefore, concluded that there is an alignment between the conceptual framework to implement health system reform and the empirical data considering the dimensions of the study (leadership and governance; service delivery; and stakeholders). In health system reform, it is vital to identify stakeholders; understand the interests, needs and powers of stakeholders; and manage stakeholders. Service delivery is influenced by structure, process and outcome measures. Governance strategies and policies should be reviewed, in line with the planned reform. An effective leader is required to effect the transition.

10.3 Thesis Contributions

The literature reviewed and the empirical research findings contributed to the body of knowledge in the field of business leadership, and the context of health system reform, in relation to the dimensions of the study, which are leadership and governance; service delivery; and stakeholders. This also helped in conceptualising a multi-dimensional framework on how a health system may be implemented. A discussion of the contributions follows.

10.3.1 Theoretical contribution

The contingency theory of leadership, health system governance framework, Donabedian model of quality, and stakeholder theory were used to discuss the paradigm perspective of this study. Triangulation of the four theories was necessary, considering the complexity of the health system. These theories were adopted to explore and describe the complexities within the health system by doing a multi-dimensional analysis of the role of leadership and governance in health system reform; how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities; the role of stakeholders and their influence in the health reform process; and how to conceptualise a multi-dimensional framework for implementing health system reform in South Africa. The theoretical contribution is in providing the theory of 'how to' implement health system reform in a developing country such as South Africa. The theory and 'how to' are in the form of a multi-dimensional framework. This contributes to the literature, as well as future research on the dimensions of the study.

10.3.2 Methodological contribution

An exploratory and descriptive qualitative study was conducted to provide the 'know-how' and 'how' to implement health system reform in a developing country. A case study strategy was used to explore and describe the complexities within the health system by doing a multi-dimensional analysis of the role of leadership and governance in health system reform; how leadership may influence service delivery and determine the service delivery challenges in South African healthcare facilities; and the role of stakeholders and their influence on this health reform process.

A case study permits 'thick descriptions' of the phenomena under study, and explores a real-life, contemporary bounded system (a case), or multiple bounded systems (cases over time), through in-depth and detailed data collection which involves multiple information sources such as interviews, observations, documents and reports (Creswell & Poth, 2018; Yin, 2014). The case study enabled a detailed collection of data through interviews with the health system stakeholders, who provided rich descriptive data on health system reform considering the dimensions of the study. The study, therefore, contributes to the body of knowledge by using a case study strategy to determine how health system reform may be implemented, informed by the analysed multi-dimensionality of the phenomenon.

10.3.3 Contextual contribution

The South African health system has unique challenges that require a multifaceted approach to effectively implement the planned reform. There are weaknesses in leadership and governance at various levels of the health system, and these negatively affect service delivery. Based on the literature reviewed, most leadership studies were conducted in developed countries and in areas outside healthcare, and only very few in the healthcare domain and developing countries (Figueroa *et al*., 2019; Ghiasipour *et al*., 2017; Saroja & Reddy, 2018). The literature on governance of the health system is also not sufficient (Barbazza & Tello, 2014; Kaufmann & Kraay, 2007; Siddiqi *et al*., 2008). Despite the importance of engaging stakeholders regarding policy reform, there was also inadequate stakeholder engagement and awareness of the NHI (McIntyre *et al*., 2009).

The study provides more insights into the existing health system challenges. The views of stakeholders at various levels of the health system in South Africa provide a profound understanding of the elements necessary for the health system reform. This study bridges the knowledge gaps with a multi-dimensional framework that will address the *leadership and governance*; *service delivery*; and *stakeholder aspects* necessary for health system reform.

10.3.4 Practical contribution

The practical contribution of this study is a multi-dimensional framework for implementing health system reform in South Africa. The framework will be a useful tool for guiding policymakers in effectively implementing health system reform. The framework provides practitioners with the 'know-how' on the implementation of health system reform in a developing country such as South Africa. Health system reform is seen as the realisation of UHC through NHI coverage and access to all. When the policy of the NHI is implemented and service delivery effected, the result will be health system reform, and the process is iterative. This is envisaged for the varied health system levels as well.

10.4 Limitations of the Study

The sample in this study comprised of 26 participants. As the study was multilevel and multi-dimensional, sampling was performed among the health system stakeholders, which included the NDoH; an academic/tertiary hospital; a district hospital; a private hospital; two medical schemes; a medical scheme administrator; regulators; funder association; labour unions; and an independent medical practitioner. The actual study participants included leaders who were purposively selected from these health system stakeholders based on their positions and roles, which were defined, in terms of knowledge, skills, competencies and experience, with respect to the health system.

The researcher wanted to conduct interviews for the leadership and governance dimension with three major private hospital groups as stakeholders in the health system, but only one of the private hospital groups agreed to the request. The researcher also sought to gather data in two provinces for the service delivery dimension, in order to compare the responses from the different provinces. However, only the Gauteng Provincial Department of Health responded

positively to the request for interviews and granted the researcher permission to conduct the study at its facilities.

Depth of information provided by the participants might have varied, depending on their knowledge, and understanding of the UHC and the NHI, their perceived expectations, and their understanding of leadership and governance; service delivery; the role of stakeholders; and how the health system functions. The study results might also have been influenced by the diverse organisational and governance structures, policies, processes and systems. The external environment might also have had a bearing on the performance of organisations.

10.5 Recommendations

The research provides useful insights into the role of leadership and governance in health system reform; the influence of leadership on service delivery and service delivery challenges in South African healthcare facilities; the role and influence of stakeholders in implementing health system reform; and how health system reform may be implemented and informed by the analysed multi-dimensionality of the phenomenon. Based on these insights, recommendations are proposed, in relation to the dimensions of the study.

10.5.1 Recommendations on improved leadership in health system reform

1. Effective leaders are required to drive organisational strategy and organisational performance. Organisations can apply the research findings in empowering their managers to enhance their leadership style.
2. Leaders in both the private and public sectors should ensure that their organisational structures and strategies are aligned with the vision of UHC.
3. Leaders should find ways to promote public-private partnerships to promote access to quality healthcare, in line with the country's policies. Public-private partnerships are necessary to maximise the utilisation of resources and achievement of optimal outcomes.
4. Outsourcing where there are clear service-level agreements may be considered for improving business processes and achieving operational efficiencies.

5. A review of recruitment policies is needed to ensure that personnel that are fit for purpose are appointed at all levels.

6. There is a need to design policies that clearly articulate organisational culture and address issues of branding, communication, consistency and organisational reputation. This will help with minimising complaints related to staff attitude.

7. Leaders should drive a culture of effective communication at all levels of the organisation and take advantage of modern technological tools to communicate. Communication provides clarity about the roles, expectations and responsibilities of different role-players, and improves trust and co-operation.

8. The organisation's systems, resources and capabilities should be enhanced to achieve operational efficiencies and sustained competitive advantage.

10.5.2 Recommendations on improved governance in health system reform

Proper governance structures, and committed and decisive leadership are needed to effect health system reform.

1. The State should play a stewardship role, and provide rules and regulations, while promoting fair competition. Health policies and other informative documents should be made readily available to the public to minimise information gaps.

2. There is a need to strengthen governance systems in both the public and private sectors. Where boards are non-existent, these must be established to ensure accountability, oversight, operational efficiency and the realisation of health system reform of the NHI.

3. Regulation of prices for healthcare provision is needed to create clarity on the cost of healthcare services. Relevant stakeholders need to be considered to determine fair remuneration in both the public and private sectors.

4. Policies should be revised to close regulatory gaps in institutions that are responsible for education and training of healthcare workers, healthcare delivery and funding.

5. Compliance with policies and regulations must be enforced across all levels of the health system. This includes the appointment of competent people to implement governance policies, systems and processes, and the establishment of proper control systems.

6. Primary healthcare needs to be strengthened to alleviate the load at higher levels of care or hospitals, and a clear referral system is required to control access to healthcare at various levels of the health system.

7. Community health workers should be integrated into the health system, as they are part of the human resources for health.

8. Public and private sector collaboration is crucial and should be promoted to strengthen the health system. Such collaboration should be fair and transparent.

10.5.3 Recommendations on capacitation for enhanced service delivery

Considering the findings of this study, the following recommendations are provided for improved service delivery:

1. Investment in infrastructure and information technology is needed to enhance the delivery of quality healthcare. Reliable ICT systems with features of interoperability should be provided across regions and provinces. This would avoid duplication of services when accessing patients' health information for the provision of healthcare across regions and provinces.

2. Implement the human-resources-for-health strategy that is in line with the changing needs of the country, and international best practice.

3. Employer support and fair remuneration of healthcare workers to enable them to focus on providing the necessary services.

4. Care coordination models with clear gate-keeping pathways are necessary to ensure that patients are managed at correct levels of care for improved efficiencies.

5. The basket of healthcare services provided within the NHI environment should be specified and easily accessible to the population. Packages of services must be defined and standardised to ensure equity. Criteria for exclusions must also be specified and made publicly available.

6. Alternate ways of providing healthcare services in patients' homes, or closer to where they live, at mobile clinics, must be established to reduce waiting times in healthcare facilities.

7. Collection or delivery of chronic medicines should be done at locations closer to where patients leave, to minimise the number of patients that go to facilities to collect their medicines.

8. Alternate reimbursement models such as Capitation Fees or Diagnosis-Related Groups (DRGs) should be considered for cost-effective billing, and risk-sharing between the provider and payer.

9. There is a need to strengthen clinical governance committees for the provision of quality and safe clinical practice, and determining standards for measuring quality in healthcare, and incentivising providers based on good health outcomes.

10. Strengthen public-private partnerships to maximally utilise the resources available in both sectors. The partnerships will require effective regulation to ensure accountability, define and standardise the packages of services offered, set tariffs charged for healthcare services, determine clear gate-keeping pathways, and guarantee the equal distribution of resources between the public and private sectors to achieve equity in healthcare access.

10.5.4 Recommendations for inclusive stakeholder engagement

Government has a role to provide policy directives and guide policy implementation. Health system reform will affect all the country's citizens, and government should consider an inclusive and transparent approach to ensure that all affected stakeholders are informed, and contribute meaningfully to the process.

1. A clear policy is required for stakeholder identification and implementing the engagement process. Stakeholder identification necessitates that policymaker consider stakeholder interests and the impact of policy on stakeholders.
2. Policymakers need to make resources available for stakeholder engagement. It is necessary to consider the use of various technological platforms to reach a wider population. A better approach to stakeholder engagement will foster good working relationships among affected stakeholders.

3. As stakeholders have various interests and needs, a framework is necessary to guide the stakeholder management process. Important principles of strategy include proper stakeholder management to minimise obstacles which may adversely affect the implementation process.

10.6 Future Areas of Research

Further research should be conducted in the following areas:

- The experience of patients from interactions with healthcare personnel and how that affects their perceptions of healthcare personnel
- The influence of patient behaviour on staff attitude and how that manifest in healthcare facilities
- Determining a causal relationship between organisational culture and service delivery
- Determining the factors that influence the interrupted supply of pharmaceutical products in healthcare facilities.

10.7 Chapter Summary

The research provided useful insights into the role of leadership and governance in health system reform; the influence of leadership on service delivery and the service delivery challenges in South African healthcare facilities; the role and influence of stakeholders in implementing health system reform; and how health system reform may be implemented and informed by the analysed multi-dimensionality of the phenomenon. The participants who were stakeholders within the health system had extensive knowledge, skills and experience in leadership and governance, health systems, policy reforms and implementation within the health system. The respondents were, therefore, able to provide reliable information on the UHC and NHI, as well as making recommendations on effecting reform. The chapter covered conclusions, limitations and recommendations based on the empirical literature reviewed, and the data analysed. Recommendations were made on how the research findings may be utilised to strengthen the health system and effect NHI implementation. Areas of future research were also proposed.

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Annexure A

Ethical Clearance Certificate: UNISA School of Business Leadership

SCHOOL OF BUSINESS LEADERSHIP
RESEARCH ETHICS REVIEW COMMITTEE (GSBL CRERC)

16 August 2019

Ref #: 2019_SBL_DBL_014_FA
Name of applicant: Mrs MM Kgasi
Student #: 32459165

Dear Mrs Kgasi

Decision: Ethics Approval

Student: Mrs MM kgasi, kate.kgasi@gmail.com, 082 442 2730

Supervisor: Prof R Kekwalestwe, raykekwaletswe@gmail.com, 082 685 2903

Project Title: A multidimensional framework for implementing a health system reform in a developing country

Qualification: Doctorate in Business Leadership (DBL)

Expiry Date: July 2023

Thank you for applying for research ethics clearance, SBL Research Ethics Review Committee reviewed your application in compliance with the Unisa Policy on Research Ethics.

Outcome of the SBL Research Committee:
Approval is granted for the duration of the Project

The application was reviewed in compliance with the Unisa Policy on Research Ethics by the SBL Research Ethics Review Committee on the 13/08/2019.

The proposed research may now commence with the proviso that:
1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2) Any adverse circumstance arising in the undertaking of the research project that is

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> relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the SBL Research Ethics Review Committee.
>
> 3) An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.
> 4) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

Kind regards,

Prof R Ramphal

Chairperson: SBL Research Ethics Committee

011 – 652 0363 or ramphrr@unisa.ac.za

Prof RT Mpofu

Executive Dean (Acting): Graduate School of Business Leadership

011- 652 0256/mpofurt@unisa.ac.za

Annexure B

Permission Letter: National Department of Health

2030
NDP

Private Bag X828, PRETORIA, 0001, Civitas Building, 242 Struben Street, Pretoria
Tel (012) 395 8170/1, Email: Anban.Pillay@health.gov.za

RE: GRANTING OF PERMISSION TO UTILISE NATIONAL DEPARTMENT OF HEALTH DATA FOR RESEARCH.

Dear Kate Mamokgati Kgasi

I, Dr Anban Pillay, the Deputy Director General – National Department of Health grant permission to be interviewd for your research project titled "A multi-dimensional framework for implementing health system reform in South Africa

I grant this permission as the authorized person to do so in this company and am aware of the following,

1. The study is conducted as a UNISA researcher and remains the property of UNISA
2. You can use the name of the company in your research project
3. All data and information collected will be solely in the procession of the researcher
4. I will require feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor

I wish you the best and success in this research.

Dr Anban Pillay
Deputy Director General
National Health Insurance
National Department of Health

Annexure C

Permission Letter:
Academic Hospital

STEVE BIKO ACADEMIC HOSPITAL

Enquiries: Dr JS Mangwane
Tel No: +2712 345 2018
Fax No: +2712 354 2151
e-mail: joseph.mangwane@gauteng.gov.za

For attention: ___ Mrs Kate Kgasi

NHRD Ref Number: GP_201906_002

SBAH Ref Number: _____ SBAH_ 201906_04

Re: REQUEST FOR PERMISION TO CONDUCT RESEARCH AT STEVE BIKO ACADEMIC HOSPITAL

TITLE:

You will find a list of all comments made on the selected research application. The list below displays comments visible to both the Applicant and Research Committee.

Permission is hereby granted for the above-mentioned research to be conducted at Steve Biko Academic Hospital.

This is done in in accordance to the "Promotion of access to information act No 2 of 2000".

Please note that in addition to receiving approval from Hospital Research Committee, the researcher is expected to seek permission from all relevant department.

Furthermore, collection of data and consent for participation remain the responsibility of the researcher.

The hospital will not incur extra cost as a result of the research being conducted within the hospital.

You are also required to submit your final report or summary of your findings and recommendations to the office of the CEO.

Approved

Comment:

Date: 2019/07/01

Dr. JS Mangwane
Manager: Medical Service

2019 -07- 0 1

405

Annexure D

Permission Letter: District Hospital

Enquiries: Dr. Mpho Moshime-Shabagu
Tel: +27 12 451 9036
E-mail: Mpho.Moshime@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 27/08/2020
PROJECT NUMBER: 33/2020
NHRD REFERENCE NUMBER: GP_201906_002

TOPIC: A Multi-Dimensional Framework for Implementing Health System Reform in South Africa

Name of the Researcher: Mrs Kate Kgasi

Name of the Supervisor: Professor Ray Kekwaletswe

Facilities: Pretoria West Hospital

Name of the Department: UNISA

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

....
Dr. Mpho Moshime-Shabangu   Date..27/08/2020
Deputy Chairperson: Tshwane Research Committee

....
Mr. Mothomone Pitsi   Date: 2020.08.28
Chief Director: Tshwane District Health

Annexure E

Permission Letter:
Healthcare Regulator

553 Vermeulen Street
Arcadia, Pretoria

PO Box 205
0001 PRETORIA

Tel: +27 (12) 338 9476
Email: SadickaB@hpcsa.co.za
Website: www.hpcsa.co.za

Ms Kate Kgasi

Department:	**OFFICE OF THE REGISTRAR**
Designation:	Registrar/CEO
Reference:	**Research Request 2019**
Date:	29 July 2019

Email: kate.kgasi@gmail.com

Dear sir/madam

TEMPLATE GRANTING OF INSTITUTIONAL PERMISSION FOR RESEARCH

I, Dr M R Billa the Registrar/CEO of the Health Professions Council of South Africa grant permission to collect data at this site for your research project titled **A Multi-Dimensional Framework for Implementing Health System Reform in South Africa.**

I grant this permission as the authorized person to do so in this company and am aware of the following,

1. The study is conducted as a UNISA researcher and remains the property of UNISA
2. You can use the name of the company in your research project
3. All data and information collected will be solely in the procession of the researcher
4. I will require feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor

I wish the best and success in this research

Yours faithfully,

DR M R BILLA
REGISTRAR/CEO

Annexure F

Permission Letter: Medical Scheme Regulator

Date: 3 July 2019

Dear Kate Kgasi.

I, Dr Sipho Kabane, the CE & Registrar of Council for Medical Schemes grant permission to collect data at this site for your research project titled "Multi-Dimensional Framework for Implementing Health System Reform in South Africa".

I grant this permission as the authorized person to do so in this company and am aware of the following,

1. The study is conducted as a UNISA researcher and remains the property of UNISA
2. You {can use}, {not use} the name of the company in your research project
3. All data and information collected will be solely in the procession of the researcher
4. I will {require}, {not require} feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor *with our consent.*

I wish the best and success in this research

Yours faithfully,

DR SIPHO KABANE
CHIEF EXECUTIVE AND REGISTRAR
COUNCIL FOR MEDICAL SCHEMES

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Annexure G

Permission Letter:

Funder Association

GRANTING OF INSTITUTIONAL PERMISSION FOR RESEARCH

Dear Kate Kgasi

I, Charlton Murove, the Head of Research of this company grant permission to collect data at this site for your research project titled A Multi-Dimensional Framework for Implementing Health System Reform in South Africa.

I grant this permission as the authorized person to do so in this company and am aware of the following,

1. The study is conducted as a UNISA researcher and remains the property of UNISA
2. You can use, the name of the company in your research project
3. All data and information collected will be solely in the procession of the researcher
4. I will require feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor

I wish the best and success in this research

Charlton Murove

Head of Research

Board of Healthcare Funders

Annexure H

Permission Letter:
Medical Scheme

Enquiries: Motumi Mokoena
Tel   : (012) 366 4500
Cell   : (072) 657 0450
Email   : motumi@gems.gov.za

Kate Mamokgati Kgasi
Graduate School of Business Leadership
University of South Africa
PO Box 392
Pretoria
0003
Email: kate.kgasi@gmail.com / k.kgasi@medicalschemes.com

Dear Kate Mamokgasi Kgasi

RE: Authorisation to use data and Information from the Government Employees Medical Scheme (GEMS)

This letter authorises the use of GEMS data and information for the research study:

A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

I, Dr Stan Moloabi, the Principal Officer of Government Medical Scheme Employees (GEMS) grant permission to collect data at this site for your research project titled above. I grant this permission as the authorized person to do so in this company and am aware of the following,

1. The study is conducted as a UNISA researcher and remains the property of UNISA.
2. You can use, the name of the company in your research project.
3. All anonymised data and information collected will be solely in the procession of the researcher
4. I will require feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor.

The authorisation restricts the use of the data and information only towards her research study on the above mentioned topic.

Kindly contact Motumi Mokoena, GEMS Data Analyst: Manager for any queries regarding this letter.

Yours sincerely,

Dr. B.O.S Moloabi
30/10/2020

GEMS Vutomi House, 124 Mercy Avenue, Menlyn Maine Precinct, Waterkloof Glen Ext 2, Pretoria.
GEMS Private Bag X1, Hatfield 0028 ● **Phone:** 086 111 4367 ● **Fax:** +27 (12) 362 6413 ● **Website:** www.gems.gov.za

Working towards a healthier you

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Annexure I

Permission Letter: Medical Scheme Administrator

10 June 2019

Ms Katie Kgasi
Council for Medical Schemes
By email: kate.kgasi@gmail.com, k.Kgasi@medicalschemes.com

Dear Ms Kgasi,

Research project - A multi-dimensional framework for implementing health system reform in South Africa

I, Dr Jonathan Broomberg, the Chief Executive Officer of this company, grant permission to collect data at this site for your research project titled "A multi-dimensional framework for implementing health system reform in South Africa".

I grant this permission as the authorised person to do so in this company and am aware of the following:

1. The study is conducted as a UNISA researcher and remains the property of UNISA
2. You can use the name of the company in your research project
3. All data and information collected will be solely in the procession of the researcher
4. I will require feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor

With best wishes for your success in this research.

Regards

Dr Jonathan Broomberg
Chief Executive Officer
Discovery Health (Pty) Ltd

Annexure J

Permission Letter: Trade Union 1

HEALTH AND OTHER SERVICE PERSONNEL
TRADE UNION OF SOUTH AFRICA

11 June 2019

Attention: Kate Mamokgati Kgasi

Dear Kate

GRANTING OF INSTITUTIONAL PERMISSION FOR RESEARCH

I, Noel Desfontaines, the General Secretary of this company grant permission for you to collect data at this site for your research project titled "How to implement a health system reform in a developing country such as South Africa".

I grant this permission as the authorized person to do so in this company and am aware of the following:

1. The study is conducted as a UNISA researcher and remains the property of UNISA;
2. You can use the name of the company in your research project;
3. All data and information collected will be solely in the procession of the researcher;
4. I will require feedback of the research;
5. The research may be published in the public domain under the supervision of the supervisor

I wish the best and success in this research

Your faithfully

Mr N Desfontaines
The General Secretary

Annexure K

Permission Letter: Trade Union 2

GRANTING OF INSTITUTIONAL PERMISSION FOR RESEARCH

Dear Kate Kgasi

I, Nicolien Welthagen, the manager of the Solidarity Research Institute grant permission to collect data at this site for your research project titled **A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA**.

I grant this permission as the authorized person to do so in this company and am aware of the following,

1. The study is conducted as a UNISA researcher and remains the property of UNISA
2. You can use the name of the company in your research project
3. All data and information collected will be solely in the procession of the researcher
4. I will require feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor

I wish the best and success in this research

Signature

Name: Nicolien Welthagen

Organisational Title: Manager Solidarity Research Institute

Full contact details: 0825775177 / 012 666 4400

www.solidariteit.co.za

T: 012 644 4300 | C: 0861 25 24 23 | P: Posbus 11760, Centurion, 0046
H.v D.F Malan- en Eendrachtstraat, Kloofsig, Centurion

Deel van die Solidariteit Beweging

Annexure L

Permission Request Letter to Selected Organisations

Graduate School of Business Leadership, University of South Africa PO Box 392 Unisa 0003 South Africa
Cnr Smuts and First Avenue Midrand 1685 Tel: +27 11 652 0000 Fax: +27 11 652 0299
Email: sbl@unisa.ac.za Website: www.sblunisa.ac.za

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

TOPIC: A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

CONTACT PERSON:

BUILDING NO. OR ROOM NO:

DEPARTMENT:

TELEPHONE NUMBER AND EMAIL ADDRESS:

Dear [INSERT TITLE AND NAME OF COMPANY REPRESENTATIVE]

Your permission is herewith requested to allow KATE MAMOKGATI KGASI, a Doctor of Business Leadership student at the UNISA Graduate School of Business Leadership (SBL), to conduct academic research in your organisation.

I am currently engaging in a research project with the following specific details;
The purpose of the study is to analyse, describe and determine how a developing country such as South Africa may implement a health system reform.

The study will entail conducting interviews to gather data on the role of leadership and governance in the health system reform; analyse how leadership may influence service delivery; and analyse and describe the role and influence of stakeholders in implementing the health system reform.

The research findings will help in providing a profound analysis and understanding of how a health system reform may manifest and be implemented in South Africa. The findings will also provide the "know how" and "how" to implement a health system reform in a developing country such as South Africa through a multi-dimensional framework.

Recommendations about the "how" to implement a health system reform in a developing country such as South Africa will be provided.

There are no foreseeable risks of harm or side-effects to the potential participants. Participants will not be coerced into taking part in the study.

Feedback procedure will entail a summary of the research report and a copy of journal article to the organisation.

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Graduate School of Business Leadership, University of South Africa PO Box 392 Unisa 0003 South Africa
Cnr Smuts and First Avenue Midrand 1685 Tel: +27 11 652 0000 Fax: +27 11 652 0299
Email: sbl@unisa.ac.za Website: www.sblunisa.ac.za

According to the UNISA Research Ethics Policy the following should be noted;

All participation will be on a voluntary basis, with the participant's prior consent and right to exit the process at any time without any recourse,

All information gathered will remain as the property of the researcher and UNISA and will only be used for this research project,

The data will be securely maintained by myself for a period of 5 years after which it will be destroyed,

The researcher will ensure confidentiality and anonymity of the respondents and your organisation

There will be no payment, gifts, rewards or any other incentives to the participants

Please note that the study has <u>not</u> been approved by the SBL Research Ethics Committee and you can report to the Chair (ramphrr@unisa.ac.za) should you want to raise any concerns on the process and conducting of the research. The Ethics certificate is <u>not yet</u> attached.

You are also free to engage with me or my supervisor, Professor Ray Kekwalestwe on e-mail raykekwaletswe@gmail.com.

Please use "**TEMPLATE GRANTING OF INSTITUTIONAL PERMISSION FOR RESEARCH**" which is provided with this request for the granting of the requested permission. This template must be placed onto your company letterhead.

With appreciation
Yours sincerely

Kate Mamokgati Kgasi
Researcher

Company letter head

TEMPLATE GRANTING OF INSTITUTIONAL PERMISSION FOR RESEARCH

Dear ….. {Name of Researcher}

I, {full name}, the {management title} of this company grant permission to collect data at this site for your research project titled {title of research project as in the request}.

I grant this permission as the authorized person to do so in this company and am aware of the following,

1. The study is conducted as a UNISA researcher and remains the property of UNISA
2. You {can use}, {not use} the name of the company in your research project
3. All data and information collected will be solely in the procession of the researcher
4. I will {require}, {not require} feedback of the research.
5. The research may be published in the public domain under the supervision of the supervisor

I wish the best and success in this research

Signature …..

Name

Organisational Title

Full contact details;

Annexure M

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

TITLE: A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

Dear Prospective Participant

Student research project

My name is Kate Mamokgati Kgasi and I am doing research with Professor Ray Kekwaletswe, a Thesis Supervisor at the Graduate School of Business Leadership (SBL) towards Doctor of Business Leadership degree at the University of South Africa. We are inviting you to participate in a study entitled "a multi-dimensional framework for implementing health system reform in South Africa".

WHAT IS THE AIM/PURPOSE OF THE STUDY?

The purpose of this study is to analyse, describe and determine how a developing country such as South Africa may implement a health system reform.

WHY AM I BEING INVITED TO PARTICIPATE?

In this study, the research participants consist of individuals in key decision-making positions of the various organisations within the health system, and employees of some of the public healthcare facilities.

Regarding participants in key decision-making positions, individual interviews will be conducted to gather data on the role of leadership and governance in the health system reform; analyse how leadership may influence service delivery; and analyse and describe the role and influence of stakeholders in implementing the health system reform.

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Concerning the employees in public sector facilities, focus group interviews will be conducted to gather data on the status quo, issues and challenges, and how the reform will affect future work performance.

Your contact details were obtained from your employer after permission was sought to conduct the study at your organisation.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY /WHAT DOES THE RESEARCH INVOLVE?

Your organisation's participation in this study is very important to us. An interview will be conducted to allow the participant the opportunity to communicate the experiences, thoughts and views regarding the topic. The interview will take 30 to 60 minutes.

Any questions regarding the study should be directed to Kate Kgasi at 082 4422 730,
or kate.kgasi@gmail.com.

CAN I WITHDRAW FROM THIS STUDY?

Being in this study is voluntary and you are under no obligation to consent to participation. There is no penalty or loss of benefit for non-participation.

If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

The research findings will help in providing a profound analysis and understanding of how a health system reform may manifest and be implemented in South Africa. The findings will also provide the "know how" and "how" to implement a health system reform in a developing country such as South Africa through a multi-dimensional framework.

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Graduate School of Business Leadership, University of South Africa PO Box 392 Unisa 0003 South Africa
Cnr Janadel & Alexandra Avenue Midrand 1685 Tel: +27 11 652 0000 Fax: +27 11 652 0299
Email: sbl@unisa.ac.za Website: www.sblunisa.ac.za

Recommendations about the "how" to implement a health system reform in a developing country such as South Africa will be provided.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

There are no foreseeable risks of harm or side-effects to the potential participants. Participants will not be coerced into taking part in the study.

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

To ensure anonymity and confidentiality, the researcher will not reveal the participants' identities when reporting the research findings.

The researcher and the statistician will have access to the data. Once the data is analysed, the records will be kept by the researcher in a safe environment.

Anonymous data may be used for other purposes such as journal articles and conference presentation. *A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.*

HOW WILL INFORMATION BE STORED AND ULTIMATELY DESTROYED?

Hard copies of your answers will be stored by the researcher for a period of 5 years in a locked cupboard / filing cabinet for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard copies will later be destroyed through paper shredding. Electronic copies will be deleted from the computer.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There is no payment or reward offered for taking part in the study.

First in Leadership Education in Africa

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study will receive written approval from the SBL Research Ethics Review Committee. A copy of the approval letter will be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS?

Feedback procedure will entail a summary of the research report and a copy of journal article to the organisation.

Should you have concerns about the way in which the research has been conducted, you may contact Professor Ray Kekwaletswe – raykekwaletswe@gmail.com.

Thank you for taking time to read this information sheet and for participating in this study.

Kate Mamokgati Kgasi

Annexure N

Informed Consent for Participation

**Informed consent for participation in an
academic research project**

A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

Dear Participant

You are herewith invited to participate in an academic research study conducted by Kate Mamokgati Kgasi, student in the Doctor of Business Leadership at UNISA's Graduate School of Business Leadership (SBL).

The purpose of this study is to analyse, describe and determine how a developing country such as South Africa may implement a health system reform.

All your answers will be treated as confidential, and you will not be identified in any of the reports emanating from this research.

Your participation in this study is very important to us. You may however choose not to participate, and you may also withdraw from the study at any time without any negative consequences

Please note that completion of this form is voluntary and that all information is confidential. You are free to withdraw from the research at any time without penalty.

It will take a maximum of an hour to conduct the interview for the researcher to gather data on the experiences, thoughts and views regarding the topic.

The results of the study will be used for academic purposes only and may be published in an academic journal. A summary of the research findings and a copy of journal article will be provided to your organisation.

Please contact my supervisor, Professor Ray Kekwaletswe – raykekwaletswe@gmail.com if you have any questions or comments regarding the study. Please sign below to indicate your willingness to participate in the study.

Yours sincerely

Kate Mamokgati Kgasi

I, _____, herewith give my consent to participate in the study. I have read the letter and understand my rights with regard to participating in the research.

_____   _____
Respondent's signature   **Date**

Annexure O

Interview Guide: Leadership and Governance Dimension

INTERVIEW GUIDE:

A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

1. LEADERSHIP AND GOVERNANCE DIMENSION

Individual interviews will be conducted for 30 to 60 minutes to allow the participants the opportunity to communicate their experiences, thoughts and views.

1.1 Questions on the leadership dimension

1.1.1 Questions on organisational structure

- Is the size of your organisation geared for the implementation of health system reform (HSR) of the NHI in SA?
- Is the structure of your organisation aligned with the envisaged NHI implementation?
- Do you think organisational structures in the current healthcare sector promote effective implementation of NHI in SA?
- What can be done to the current organisational structures in SA to ensure effective implementation of the NHI?

1.1.2 Questions on organisational processes and practices

- Is your organisation's mission statement in line with the implementation of the NHI?
- How is work organised across business units or departments in your organisation for implementation of the NHI?
- How is information communicated within your organisation regarding NHI implementation?
- How is information communicated across organisations in the healthcare sector regarding NHI implementation?

Kate Mamokgati Kgasi 32459165

- How is technology in your organisation used to enable successful NHI implementation?
- Are your organisational processes and practices in alignment with the NHI implementation?
- What are the processes and procedures required to implement the NHI successfully in SA?

1.1.3 Questions on leading
- Is leadership important in the success of the healthcare sector in SA?
- What type of leadership is effective for the current healthcare sector in SA?
- What type of leadership is needed for effective implementation of the NHI in SA?
- How should leadership serve as a driver for NHI implementation in SA?

1.2 Questions on governance dimension
- Do you think that there is good governance in the current healthcare environment in SA?
  - Basic principles of good governance are *consistency, responsibility/responsiveness, accountability, equity, transparency, participation, effectiveness*, and *adherence to law*.
- What is the role of government in implementation of health system reform (HSR) in SA?
- What is the role of stakeholders in the implementation of HSR?
- Do you think that stakeholders are actively involved in implementation of HSR?
- Should accountability be fostered amongst all stakeholders in implementation of HSR? How?
- Should the public participate in policymaking to ensure successful implementation of HSR? How?
- Is fraud and corruption a problem in the current healthcare sector?
- Do you think that fraud and corruption will be a problem in the implementation of HSR?
- What do you think should be done to minimise or stop fraud and corruption during implementation of HSR?
- Are governance policies with regards to NHI implementation clear and accessible to stakeholders?

- What are the governance measures required for the HSR in SA?

The end

Annexure P

Interview Guide: Service Delivery Dimension

INTERVIEW GUIDE:

A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

RESEARCH QUESTIONS ON SERVICE DELIVERY DIMENTION

Individual interviews will be conducted for 30 to 60 minutes with the Heads of Facility Units to allow the participants the opportunity to communicate their experiences, thoughts and views.

1.1   Questions for Heads of Facility Departments (individual interviews)

1.1.1   Questions on structure measures

- Please share with me your organisation's reporting structure?
- Where do you get the funds or money to run the facility (budget allocation)?
- How do you plan for healthcare delivery?
- Are there any partnerships in place with other organisations to enhance service delivery?
- How do you appoint service providers?
- In your view, what type of leadership is effective for service delivery?
- What type of structure will be effective for healthcare delivery in your facility?

1.1.2   Questions on process measures

- Is there a mission statement on service delivery? If so, what does it seek to achieve?
- What are the service delivery challenges you are experiencing?
- Are there performance indicators (targets) for service delivery? Are you able to meet those targets?
- How is benchmarking of service standards done?
- How is monitoring and evaluation done for the standards in place?
- What are the corrective actions for non-compliance?
- How do you inculcate a culture that promotes service delivery that is sensitive to people's needs?

- What can be done to improve service delivery for health system reform?

1.1.3 Questions on outcome measures
- Are you able to achieve the targets you set for the hospital?
- What can be done to improve the way in which outcomes or results are achieved?
- What can be done to measure service delivery?

The end

INTERVIEW GUIDE:

A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

RESEARCH QUESTIONS ON SERVICE DELIVERY DIMENTION

Focus group interviews will be conducted for 15 to 60 minutes to allow the participants the opportunity to communicate their experiences, thoughts and views.

1. **Questions for professional staff and administrative personnel (focus group interviews)**
   - Please share your experience of service delivery in this facility.
   - What were the motivating experiences?
   - What were the demotivating experiences?
   - Are the people satisfied with the service they receive?
   - What do you do to provide service that meet the needs of people?
   - Do you have suggestions on how things should be done?
   - How can service delivery be improved for health system reform?
   - How should service delivery be measured in relation to health system reform?

The end

Kate Mamokgati Kgasi 32459165

Annexure Q

Interview Guide: Stakeholder Dimension

A MULTI-DIMENSIONAL FRAMEWORK FOR IMPLEMENTING HEALTH SYSTEM REFORM IN SOUTH AFRICA

RESEARCH QUESTIONS ON THE STAKEHOLDER DIMENSION

Individual interviews will be conducted for 30 to 60 minutes to allow the participants the opportunity to communicate their experiences, thoughts and views.

i. **Questions on stakeholder types and roles**
- As a stakeholder, what role do you think your organisation can play in the implementation of health system reform (HSR) of the National Health Insurance (NHI)?
- Has your organisation been included in the HSR process? If not, what do you think could be the reason for non-inclusion?
- Who do you think are the stakeholders that need to be involved in the HSR of the NHI?
- In your opinion, what should be the criteria to select (identify) stakeholders for NHI implementation?

ii. **Questions on stakeholder interests and powers**
- What are your interests as a stakeholder in the HSR?
- Do you think your organisation has the power to influence the NHI implementation?
- In your view, do you think other stakeholders have the power to influence the HSR process?
- What would you consider as fair treatment of the stakeholders?

iii. **Questions on stakeholder needs and viewpoints**
- Do you think that your needs and viewpoints as a stakeholder are acknowledged?
- What are the barriers to involve stakeholders in agenda-setting, decision-making and policy-forming activities?
- How can the society be involved in the process of defining healthcare benefits they need?
- How can stakeholders influence the implementation of the health system reform?

Kate Mamokgati Kgasi 32459165

- How can the stakeholders be managed for the successful implementation of HSR?

The end

Kate Mamokgati Kgasi 32459165

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Annexure R

Editing Certificate: Professional Editor

EDITING CERTIFICATE

I, HADASSAH DANNHAUSER, hereby declare that I edited the final changes effected to the following dissertation, according to the supervisor's guidance, submitted to the University of South Africa, in fulfilment of the requirements for the degree of Doctor of Business Leadership:

A Multidimensional Framework for

Implementing Health System Reform

In South Africa

by Kate Mamokgati Kgasi

Student Number: 3245-916-5

I declare that my amendments related only to grammatical and other linguistic aspects, in order to improve the clarity and readability of the presentation. I made no comments or amendments relating to the actual content of the thesis.

Date: 13 July 2022

Signed: