An evaluation of the feasibility of the national health insurance system in South Africa

PD Molebatsi
23907312

Mini-dissertation submitted in partial fulfilment of the requirements for the degree Master in Business Administration at the Potchefstroom Campus of the North-West University

Supervisor: Dr W Coetzer

November 2014
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December 2014
ACKNOWLEDGEMENTS

I would like to express my gratitude and appreciation to the following people who all played a great role in the completion of my study:

- The Lord Almighty for all the strength and believe he imparted in me although sometimes not all went as planned during my journey in completing this study.
- Dr Wilma Coetzer for her advice, patience, expertise and guidance as supervisor.
- My wife Mmabatho Herriet Molebatsi for the love and encouragement she has shown me. You are truly a pillar of strength.
- My boy, Paballo, and the new member of the family my daughter Poloko. The two of you brought the best out of me.
- For the general practitioner who gave time from their busy schedules to be interviewed for the purpose of this study.
- My parents Mr Pitso Paulus Molebatsi and Mrs Nomvula Veronica Molebatsi. You, have always been my role models, much love.
- My siblings, Masabata and Makana. Thanks for always believing in your big brother, you helped me achieve greatness.
- My mother-in-law, Ms Mapila Jane Mogotsi, your daughter is the best thing that has ever happened in my life, much appreciation.
ABSTRACT

According to the World Health Organisation (WHO) the goal of universal health coverage is to ensure that all people obtain the necessary health services without being financial limped because of the payable fees. This requires:

- A strong, efficient, well-run health system;
- A system for financing health services;
- Access to essential medicines and technologies; and
- A sufficient capacity of well-trained, motivated health workers.

In an effort to compliment the abovementioned, the South African government proposed the National Health Insurance System (NHIS) to address the health inequality and to improve access to quality healthcare for its citizens. The National Department of Health (NDOH) has already consulted with several stakeholders since the launch of the NHI Green Paper in August 2011. Already 11 National Health Insurance (NHI) pilot sites have been established in the nine South African provinces to assess the feasibility, acceptability, effectiveness and affordability to engage the private healthcare sector.

This study aimed to evaluate the feasibility of the NHI in South Africa as well as the way in which it could be implemented to be more acceptable to all stakeholders involved. A qualitative research approach was followed due to the nature of the study. Furthermore, an exploratory methodology was applied in order to generate hypotheses. The research design for this study included a literature review, participatory data collection, semi-structured interviews and data analysis. The study found that there is a need for NHI in South Africa. However, medical practitioners (also referred to as general practitioners or GPs further in the study) feel uncertain about the implementation progress which is unclear to them. Also evident is the, fear for loss of income should the NHI be implemented and thus the remuneration package remained a main concern for all.

Keywords: Healthcare system, National Health Insurance (NHI), public healthcare sector, private healthcare sector, financing
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LIST OF ABBREVIATIONS

AMA: American Medical Association
ANC: African National Congress
BMJ: British Medical Journal
CME: Continuing Medical Education
DOH: Department of Health
EHR: Electronic Health Record
GPs: General Practitioners
IPA: Independent Practitioner Association
KOSH: Klerksdorp Orkney Stilfontein Hartbeesfontein
KOSHMED: Klerksdorp Orkney Stilfontein Hartbeesfontein Medicals
MBA: Masters in Business Administration
NDOH: National Department of Health
NHI: National Health Insurance
NHIS: National Health Insurance System
NHS: National Health Service
NWU: North West University
PHC: Primary Health Care
RHAs: Rural Health Authorities
SA: South Africa
SAMA: South African Medical Association
SAMJ: South African Medical Journal
SARRAH: Strengthening South Africa’s Response to HIV and Health
SSNIT: Social Security National Insurance Trust

USA: United State of America

WHO: World Health Organisation

W-M-D: Wegner-Murray-Dingell bill
CHAPTER 1: INTRODUCTION AND PROBLEM STATEMENT

1.1 INTRODUCTION

This study focuses on the challenges that the South African health sector faces as a result of the proposed National Health Insurance (NHI) and the perception of medical practitioners within the private sector regarding the feasibility and consequences of NHI. The study specifically focuses on the views of medical practitioners within the Dr. Kenneth Kaunda District Municipality, as it is one of the pilot sites for NHI.

Chapter 1 contains the problem statement, research objectives and research methodology that were employed. The chapter opens with the problem statement, followed by an overview of related research specifically regarding National Health Insurance Systems and Health in general. Previous research that is available is then linked with the current study and its objectives. The methodology that was applied is discussed with details regarding the empirical study, the research design, the demographics of the participants and the data analysis. The chapter concludes with an outline of the chapters to follow.

1.2 PROBLEM STATEMENT

From ancient Egypt, Greek through to ancient Roman, medicine has evolved resulting in a drastic increase in demand for medicine (History of medicine, 2014). Historically derived from plants, animals and natural resource minerals, medicine was used to treat diseases of both natural and supernatural means (Van der Grabben, 2011). Consequently, the increased need for medicine surged for a higher want of improved healthcare. Revolutionary, healthcare has grown tremendously, from the first known surgery being performed in Egypt, the first known medical school in Greek, the Romans’ invention of surgical instruments to the modern day healthcare (Lazzeri et al, 2012:163).

Due to the improved recognition of healthcare in the public domain, the practice of medicine grew to be quite expensive. Kuan and Chen (2013:921) note that high medical expenses have become a major risk that challenges the livelihood of households and have resulted in people being obliged to save more and consume less. Unprivileged households (with insufficient financial income) have to either tolerate the medical condition without any treatment or find
alternative ways to gain the necessary funds to be treated properly (Van Hartesveldt, 2010:30). In 1945 the National Health Services was established in Britain (Rivette, 2014). The National Health Services provided a system through which medicine and medical treatment could be offered to all households regardless of their wealth. This caused a major turn in the healthcare industry.

In 1948, the Labour Government of Atlee followed this movement with its introduction of a National Health System for free healthcare to all people. This was the result of the then Minister of Health, Mr. Aneurin Bevan's observation that although medical care was provided to 21 million people in 1911 by the National Health Insurance system, the majority of people were still not being treated for medical conditions as it was too expensive (History of medicine, 2014).

It became evident that the initial financial projections of free healthcare for all undermined the actual costs. As a result the system, as was initially perceived, could not be sustained without suppressing the demand surge (Gorsky, 2008:443). Although the National Health System in Britain contributed to the improvement in healthcare facilities, some aspects defied the principles of free healthcare to all people. These include the quality of care and medical science, the efficiency in health delivery and the escalated costs of healthcare as a result of the then Labour Party that introduced a fee for prescriptions (Marsland, 2005:60).

From 1942 to 1944, the National Health Commission in South Africa was tasked to establish ground rules for a National Health Insurance System in line with the National Health Services of Britain (Harrison, 1993:679). They also had to launch progressive features such as instituting 400 healthcare centres and had to focus on preventive medication (Freud, 2012:170). The implementation of such a system was however cancelled due to factors such as poverty, lack of education, poor housing and sanitation as well as the poor overall nutritional status of the population.

This ultimately resulted in the South African private health sector growing substantially over years. In the early 1990s, the continuous growth of the private health sector resulted in approximately 60% of the South African healthcare expenditure being funded by private sources (McIntyre, Dohetery, & Gilson, 2003:47).

However, in 2007 at the Polokwane conference, the African National Congress (ANC) as the South African government, gain proposed a National Health Insurance System (NHIS). The
aim of the NHIS is to improve access to quality healthcare services for the entire population as well as to provide financial risk protection against health-related catastrophic expenditures (Matsoso & Fryatt, 2013:156). Almost all advanced economies have already established universal health insurance coverage to provide equal access to healthcare and to improve the health of their populations (Chen, et al., 2006; Mulupi, Kiringa, & Chuma, 2013). Thus, the proposed new health system is perceived to align South Africa with other advanced economies' tendency towards healthcare provision. Yet, the success of such a system depends on a proper feasibility study to determine the complete focus and dealing of a National Health Insurance System and secondly on assessing the viability, long term sustainability and benefits of such a system.

Swensen, et al. (2010:2) specifies the value of healthcare as a function of its design (the right treatment for the right patient at the right time), its execution (reliably doing it right thing every time to achieve the best outcomes) and its cost over time (. Furthermore, a fundamental premise of predictive health is to be cheaper and more efficient and to have a greater return on investment for keeping people healthy opposed to awaiting disease intervention (Brigham, 2010:298). The primary responsibility of healthcare is the continuous prevention of diseases (Terris, 1976:1155). In line with this, the objectives of the NHIS are (Matsoso & Fryatt, 2013:156):

a. To improve access to quality health service for all South Africans, irrespective of whether they are employed or not;
b. To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund;
c. To procure services on behalf of the entire population and efficiently mobilise and control key financial resources; and
d. To strengthen the under-resources and strained public sector so as to improve health systems performance.

NHI (sometimes called statutory health insurance) refers to the health insurance that covers a national population for the costs of healthcare and is usually instituted as a programme of healthcare reform (Wikipedia). Several low- and middle-income countries have already introduced some form of extension of state-sponsored insurance programmes to people in the information sector. These insurance programmes aim to enhance access to healthcare and provide financial protection from the burden of illness (Acharya, et al., 2012:7).
In Ghana, healthcare financing began with a tax funded system that provides free public healthcare services to all (Blanchet, Fink, & Osei-Akoto, 2012:76). However, the economic stagnation in the 1970s prevented the system from being financially sustainable. During this period low user fees for hospital services were introduced and the unnecessary use of hospital services were discouraged to recover some costs and to generate provider performance incentives. In 2003, the NHIS was established in Ghana (Blanchet, et al., 2012:76) with the aim to provide a broad range of healthcare services to citizens through mutual and private health insurance schemes of the district. The NHIS in Ghana is financed from four main sources, namely a value-added tax on goods and services, an earmarked portion of social security taxes from formal sector workers, individual premiums and other miscellaneous funds from investment returns and from Parliament or donors (Blanchet, et al., 2012:77). It was proposed that in South Africa the NHIS be funded through taxation and a social security contribution in addition to medical aid contributions (Ramjee & McLeod, 2010:182).

Strong evidence was found that a national health insurance system with comprehensive coverage is an effective way to reduce access disparities (Chen, et al., 2006). Blanchet, et al, (2012:81-82) found in their study among Ghana women enrolled in the NHIS, that they were 40% more likely to have visited a clinic over the past year and they have received about 57% more prescriptions than women not enrolled in the NHIS. Also, the NHIS-enrolled women almost stayed two times more overnight at a hospital than non-enrolled women. These findings together with the NHI objective to ensure improved access to quality healthcare services to all South Africans (Matsoso & Fryatt, 2013:156), confirm that the South African Government will have to overcome some challenges.

The proposed NHIS seems to pose quite a challenge to both the public and private sector (Gantsho, 2012:13). The envisaged merging of these two sectors, which currently function in silos, along with the dynamics of ensuring an effective administration system may hinder the successful implementation of the NHI. The government will also need to invest more in training to ensure that healthcare staff complies with the necessary qualifications in order deal with the demands of the newly proposed health system (Sekhejane, 2013:3).

The private sector, on the other hand, appears to be reluctant to cooperate in the proposed healthcare system due to the current state of public health facilities (Good, 2013). These facilities are perceived to be in poor condition compared to the private sector facilities which are perceived to be at a first world level (Good, 2013). Therefore, Government faces a great
challenge to achieve the level of infrastructure that is needed for the implementation of the proposed NHIS. Furthermore, the various stakeholders doubt the survival and sustainability of such a health system in South Africa. In this regard, stakeholders pointed to the delay in contracting private doctors and signing service delivery agreements with the private sector. In addition, providing Electronic Health Records (EHR) (Vegter, 2009) is expensive and complex, specifically regarding the skills needed to run the technology (Weeks, 2013:146).

Still, despite the indicated concerns, the South African Government decided to pilot the proposed NHI across the nine provinces at 10 district hospitals. The aim of the NHIS pilots was to determine which innovations are needed for the successful implementation of such a system (Mataboge, 2012). The pilot phase has run now for two years and is envisaged to be rolled out over a 14 year period. Nursing staff has been trained on the reengineering of health services and have already started with house visits. The reengineered teams have also completed the necessary referrals to clinics and hospitals (Pillay, 2012:2).

In May 2011, the Minister of Health Dr Aaron Motswaledi, mentioned in his budget speech that there is an obvious negativity among parts of the nation regarding the NHI system reasoning that it will be unsustainable, destructive, extremely expensive and hospital-centric or curative in nature (Motswaledi, 2011). According to Blaauw (2012) the Government gives NHI top priority and see it as the magic bullet to solve all health problems whilst other policies seem to be ignored. Despite the noted concerns, the main challenge will be to ensure that the NHI meets the criteria of a high value care system.

Thus, the main aim for this study is to evaluate the challenges that the South African healthcare sector faces in determining the feasibility of the newly proposed NHIS. The research focuses on the Dr. Kenneth Kaunda District Municipality (Dr KKDM) as it is one of the NHI pilot sites.

From the above problem statement, the following research questions emerged:

- How is the National Health Insurance System (NHIS) and its components being conceptualised according to available literature?
- What is the understanding and conceptualisation of the NHIS and its components as perceived by random selected sample of medical practitioners in the private sector?
- How will the NHIS be financed?
• What is the perception of medical practitioners regarding the technical feasibility of the NHIS?
• What is the level of involvement of relevant stakeholders in planning for the NHI?
• How prepared is South Africa for the NHI?

1.3 RESEARCH OBJECTIVES

The research objectives for this study are divided into general and specific objectives and set out below.

1.3.1 General Objectives
The general objective of this research is to determine the feasibility and perceived problems of the proposed NHIS in South Africa from the perspective of medical practitioners within the private sector.

1.3.2 Specific Objectives
The specific objectives of this research are:

• To conceptualise the National Health Insurance System (NHIS) and its components according to the available literature.
• To determine the understanding and conceptualisation of the NHIS and its components as perceived by a random selected sample of medical practitioners in the private sector.
• To determine how the proposed NHI will be financed.
• To determine medical practitioners’ perception regarding the technical feasibility of the NHI.
• To determine the level of involvement of relevant stakeholders in planning for the NHI.
• To analyse the perceptions regarding the preparedness of South Africa for the NHI.
• To make recommendations for future research.

1.4 RESEARCH METHOD

For the literature review, academic articles were investigated and derived from Ebscohost, Google Scholar, NWU Institutional Repository as well as medical journals such as the British
Medical Journal (BMJ), South African Medical Journal (SAMJ) and Continuing Medical Education (CME). Internet sources from different sites were also browsed for more comprehensive information gathering.

The topics that were addressed include:

- The definition of national health insurance and the way in which it could be funded. The aim is to compare South Africa with other developing and African countries that have already applied the NHIS.

1.4.1 Empirical study
Exploration of perceptions expounds from a qualitative research design that is explorative-descriptive (Burns & Grove, 2009:359), contextual and phenomenological (Cresswell, 2007:57) in nature. A qualitative research, (Cresswell, 2007:536-37) is appropriate as the researcher wants to comprehend healthcare workers’ perception in their own words, as well as unique meanings that the healthcare workers attach to this concept.

As indicated in the background, there is ambivalence in literature regarding the meaning of accountability. Accountability within the South African public health sector has not being extensively explored. Therefore, the best point of departure of a relatively unknown phenomenon is to explore and describe the phenomenon in-depth and record all the findings. This research is also phenomenological (Cresswell, 2007:57) as the researcher wants to explore and describe healthcare workers’ perception of accountability from their real life and lived experience and meanings attached to these experiences.

Finally, this research will be contextual in nature as the researcher will only focus on healthcare workers employed as the primary healthcare providers, either in public or private healthcare sector in the North West province.

1.4.1.1 Research design
The purpose of the research design is to ensure that all criteria of a scientific study are met.

A qualitative approach was followed for this research design as it best serves the objectives of the study. Welman, Kruger and Mitchell (2005:188) explain qualitative research as a descriptive form and ideal to describe groups, communities and organisations. In this study, the qualitative approach is appropriate as insight into medical practitioners' perceptions on the feasibility of the proposed NHIS is sought. Therefore, the study requires that medical
practitioners' views and experiences are described for which the qualitative approach is best suited.

Furthermore, qualitative research presents the researcher the opportunity to truly understand the in-depth feelings and motivations of participants (McDaniel & Gates, 2005:109; Nuttall, Shankar, Beverland & Hooper, 2011:153). Thus, this approach enabled the researcher to deeper explore each participant's point of view as a semi-structured interview was applied to gather information. The semi-structured interview method presents participants with open ended questions to give the researcher scope for explorative questions. Qualitative research further allows for theoretical insights to be tested and expose theoretical constraints (Bansal & Corley, 2012:513).

1.4.1.2 Demographics of participants
A purposive sample of general practitioners (GPs) within the Dr. Kenneth Kaunda District Municipality was used for this study. Due to the general practitioner’s movement and responsibilities, their long working hours and little time to spare for interviews, the researcher envisaged to continue interviews with GPs until a saturation point was reached. A total number of thirteen interviews were conducted.

The study population consisted of black doctors (77, 00%) and white doctors (23, 00%), males (84, 60%) and females (15, 40%). The age range of the participants was between 31 and 60 years.

1.4.1.3 Ethics
Consent from respondents to participate and use the information they provide is a very important prerequisite for research. For this study, only participants that gave consent and were available, working in KOSH area were interviewed. The gathered information was treated anonymously and confidentially. The participants also had the opportunity to withdraw from the interview at any stage. Also, data originally collected from the research was not altered.

To further comply with the ethical prerequisites for research, an unbiased sample was applied, specifically regarding the respondents' age, occupation, race, gender and educational level. The questionnaire was also structured according to the focus of the study, namely to
establish the views of general practitioners in the private sector regarding the feasibility of the proposed NHIS in South Africa.

1.4.2 Data Gathering

1.4.2.1 Interviews

Interviews allow the researcher the opportunity to gain knowledge from participants (Doody & Noonan, 2013:31). Semi-structured interviews targeted at general practitioners are conducted. Welman et al. (2005:166) indicated that semi-structured interviews are between the two extremities of unstructured and structured interviews. The interviews are, with permission of the respondents, recorded on tape. The responses of the interviewees determined the flow and direction of the interviews.

The ten questions from the World Health Organisation (2001) report is used as a guide and modified to a questionnaire that fit the South African setting. However, the interview was not fixed to these questions as the interviewees are also probed to elaborate on their answers and comments. Thus, probing is used to gather more information and clarity on the participant's point of view. This resulted in questions varying from one interview to another. As the semi-structured interview allows the researcher and participants more flexibility to explain complex or personal topics, participants are allowed to explain open ended and close ended questions through answering additional questions like: “Could you kindly share your opinion on...” and “Why do you think...” (De Vos, Strydom, Fouche & Delport, 2005:296; Doody & Noonan, 2013:30; McDaniel & Gates, 2005:133).

1.4.2.2 Research procedures

All general practitioners were contacted telephonically to schedule interviews at their respective consulting rooms. This was the best arrangement as it suited the medical practitioners best and also limited any possible interruptions. Additionally, practitioners with membership to the Independent Practitioner Association (IPA), KOSHMED, were interviewed during one of the KOSHMED meetings. The purpose of the study was explained to the medical practitioners during the initial telephone conversation. During this conversation, the practitioner’s willingness to participate in the study was determined. The researcher conducted the interviews himself.
The time for completion of each interview ranged from 10 to 30 minutes. Most interviews were recorded on tape and for some notes were taken. After the interviews were conducted, the recordings were transcribed. These transcripts were then interpreted by way of thorough content analyses.

1.4.2.3 Data analysis

Data that is relevant and accurate forms the basis of quality research (Watkins, 2006:108).

The recordings of interviews were transcribed and the field notes processed, which allowed for the analysis of raw data. As the identification of themes is one of the most crucial tasks in content analysis, themes were identified and extracted prior to, during and after the interviews (Welman et al., 2005:211).

Subsequently, a report on the identified themes is written.

1.5 LIMITATIONS/ANTICIPATED PROBLEMS

Time constraints are the biggest problem for scheduling interviews with the general practitioners. The general practitioners preferred to be interviewed at their consulting rooms and in most cases their diaries were already fully booked. Another limitation was to gain consent to be interviewed. Most initial requests to participate in the survey were declined because of the time constraints and unwillingness to provide information to be used in research. The recording of interviews also caused respondents to be reluctant to participate and some refused to be audio taped.

1.6 CHAPTER DIVISION

The chapters' layouts are as follows:

- Chapter 1: Introduction and problem statement.
- Chapter 2: Literature Review.
- Chapter 3: Empirical study.
- Chapter 4: Conclusions and Recommendations
CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In the previous chapter matters around National Health Insurance Systems (NHIS) in general were discussed as well as the envisaged implementation of such a system for the South African context. Chapter 1 has also set out the problem statement the research questions and objectives of the study. The purpose of the study was also broadly discussed. To reiterate, the study aims to evaluate the feasibility of the NHIS in South Africa, focusing on the Dr Kenneth Kaunda District Municipality as it is one of the pilot sites to test the application of NHIS in the South African context.

The study contextualises the NHIS through a discussion of its origin and the reasons for its evolvement. Specific attention is given to the advantages and disadvantages of a NHIS with the aim to investigate the proposed NHIS for South Africa.

In the investigation to the reasons for the introduction of national health systems, it is evident that such system was regarded necessary as key in providing sustainable economic development, global security, effective governance and human rights promotion (Thompson, 2014). Secondly, it developed due to the growth in the perceived importance of health and unprecedented influx of funds (although still insufficient)—into the healthcare sector. A third reason for the introduction of national health insurance systems was the burst of new initiatives to such systems as the core of the global health system and a fundamental strategy to achieve health-related Millennium Development Goals (Frenk, 2010).

According to Ocampo (2007:22) access to healthcare services makes an indispensable contribution to the effort to reduce poverty, promote full and productive employment and foster social integration. It also implies that a healthy nation is portrayed by a healthy lifestyle of its population as well as economic growth.

2.2 A BRIEF HISTORY OF HEALTH

According to the World Health Organisation's (WHO) definition of health, it is ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or
infirmity’ (World Health Organisation, 1948). This definition has not been amended since 1948. From the definition it is evident that the focus on health is multifaceted and not just referring to physical and mental health but also includes the social wellbeing of individuals inclusive of aspects such as employment, housing, educational level, and poverty.

During the 19th century, medical care was provided privately or voluntarily and patients had to pay for everything that was needed in their treatment (Smart & Humphries, 2008). The overall perception was that healthcare was only for the civilised society due to its cost implication. This resulted in exclusion of the majority of the population as many people were poor (Smart & Humphries, 2008). The extreme increase in infectious diseases as a result of people living in poorly built, rack rented and poor ventilated buildings public health initiatives were taken to address the housing challenges of the 19th century (Howden-Chapman, 2004:162). During this period, multiple reports followed, as did legislation which required that buildings have windows that opened to outside air as opposed to air shafts. Also, separate “water closets” for each apartment, functional fire escapes, adequate lighting in hallways, proper sewage connections and regular waste removal were prerequisites for the establishing of buildings (Krieger & Higgins, 2002:761). These reforms succeeded in controlling the epidemics of infectious diseases at international context.

The first and second world wars again worsen health conditions as many people were killed immediately. Not only did the wars caused destruction to properties, disrupting economic activity and diverting resources from healthcare but it lead to huge refugee flows resulting in crowded conditions without access to clean water and food (Ghobarah, Huth, & Russett, 2004:1). All these factors contributed to an overall poor health state and an immediate need for better healthcare for populations worldwide.

2.3 THE NATIONAL HEALTH SYSTEM

The National Health System (NHS) was established and implemented on 5 July 1948 in the United Kingdom after a century’s discussion on providing healthcare services to meet the long recognised need of access to such services for all people irrespective of their wealth (Rivett, 2014). The main aim of the NHS was to provide free medical care to everyone, with Mr. Aneurin Bevan, the then Minister of Health, as the main driving force behind the initiative (Butt, 2014). The NHS was seen as a breakthrough in healthcare provision with the
inclusion of a huge part of the population that was previously left out because of affordability. 

Hayes (2012:625) indicates that the establishment of the NHS was the most popular post-war achievement of the Labour government. It was regarded as the Labour Government's most original and audacious intervention regarded almost as a religion to the British and a national treasure on a pedestal because of popular fears of half-imagined alternatives.

However, the majority of medical practitioners opposed the implementation of the NHS due to a fear of financial loss as well as jeopardising their professional freedom (Light, 2003:26). Rivett (2014) indicates that there was the perception that the NHS would inhibit citizens to choose their own health provider. However, the perception was but was proved to be unfounded.

The successful implementation of the NHS in 1948 depended on everyone, including medical practitioners, involved and committed to the system. Thus the then Minister of Health, Mr Bevan, pulled the medical practitioner towards cooperation through a lucrative agreement that guaranteed the practitioners' autonomy (Light, 2003:26). This resulted in up to 95% medical practitioners joining the NHS.

Even though the NHS was a noble concept, it was challenged with the ever increasing costs in healthcare because of the advances in medical knowledge, medicines and technology on the one side and the unavoidable financial restrictions of a centrally funded service amid changing management dogmas and political beliefs on the other hand (Rivett, 2014). This influenced the sustainability of the system negatively and compromised its future due to a lack of sufficient funding. Unfortunately, the NHS’s popularity since its introduction resulted in quick depletion of its resources although it was anticipated to be sufficient. The NHS soon surpassed the estimated cost that the government budgeted for the system (History of medicine, 2014). The NHS is still applied in Britain today, however, due to problems such as long waiting lists for procedures or admissions the private health sector has not been abolished. Consequently, those who can afford private healthcare rather access the private sector for quicker and well-resourced treatment (Doyle, 2000).

As early as the late 1800's, the United State of America also considered universal coverage of health (Palmer, 1999), but all attempts to implement such a system failed each time. During
the early 1900's, President Theodore Roosevelt, also supported a nationalised health insurance and believed that a country's health is dependent on its population being healthy. His idea to implement such a system was however postponed by his successors for about another 20 years (Palmer, 1999).

During President Franklin Roosevelt’s period in office (1933-1945) which portrayed World War II, the Great Depression and the New Deal (inclusive of the Social Security Bill), the inclusion of the National Health Insurance was opposed and feared even though the conditions favoured its inclusion at the time (Baum & Kernell, 2001). This was as a consequence of many physicians at the time objecting the concept. President Franklin Roosevelt then approved a staff plan to set up a Medical Advisory Committee composed of leading physicians, with hope that this move would not only quiet the public attacks by the physicians, but that the Medical Advisory Committee could also become the vehicle through which negotiations would continue between administration and the medical profession.

After the death of President Roosevelt, President Truman took over the presidency representing the time of the Cold War and Communism. He fully supported the National Health Insurance despite the strong opposition of the American Medical Association, American Hospital Association, American Bar Association and most of the national press (Palmer, 1999). President Truman proposed the Social Security Expansion Bill, known as Wagner-Murray-Dingell (W-M-D) bill, which led to the American Medical Association (AMA) launching spirited attacks against the bill, capitalising on fears of Communism in the public mind (Poen, 1989). The bill could not be employed due to the factors mentioned which did not favour its implementation.

In 1965, the Medicare System (a National Social Insurance Programme administered by the United State Federal Government) was established in the United State of America (USA) under President Lyndon Baines Johnson. Also, amendments to the social security programme followed soon (Anon., 2012). The government envisaged to incorporate health economics, health insurance and healthcare for all individuals aged 65 years and above. The lack of adequate protection for the elderly against the cost of healthcare contributed to the establishment of health insurance for senior citizens. Data showed that the cost of healthcare increase greatly in old age whilst at the same time, senior citizens experience a significant decline in their income (King, 2013).
Prior to the establishment of Medicare, Federal-State Programmes of medical assistance to the elderly were also implemented (Dowdal, 1997). However, these programmes failed to meet the need for medical care of the elderly. This was due to the fact that the programmes were restrictive both in terms of people being eligible for help as well as scope of the covered care that. Consequently, only a few people were allowed in the programme and thus the right to health. Another problem was that the medical needs and associated costs of the elderly escalated with age, resulting in unaffordable medical care for most people.

The Medicare System comprised of two related health insurance plans for persons aged 65 and above (Dowdal, 1997):

- A hospital insurance plan providing protection against the costs of hospital and related care, and
- A supplementary medical insurance plan covering payments for physicians' services and other medical and health services to cover certain areas not covered by the hospital insurance plan.

Although the Medicare System is still used in the USA, President George W. Bush approved the Medicare Prescription Drugs, Improvement and Modernisation Act in 2003. This Act authorised changes to the programme (Olivier, Lee, & Lipton, 2004:283). The Act also addresses the gap in coverage under Medicare where certain drugs, for example the outpatient drugs, were not covered. In 2010, President Barack Obama approved the Patient Protection and Affordable Care Act, also known as Obamacare. This Act's is to provide more Americans access to quality health insurance by expanding the affordability, quality and availability of private and public health insurance through consumer protections, regulations, subsidies, taxes, insurance exchanges and other reforms (Anon, 2014).

Important to note is that the Obamacare is not to replace the private insurance, Medicare or Medical Aid. It will neither regulate healthcare (Obamacare facts, 2014). However, the Obamacare will regulate the health insurance and some of the flawed practices of the for-profit healthcare industry (Supreme Court, 2011). In contrast to the Obamacare, the NHIS proposed for South Africa is aimed to replace the existing system of private healthcare versus the public healthcare sector with a new healthcare system in the long run.
The move to Obamacare has caused confusion among Americans with the opposing Republicans wanting to repeal the Act when taking over during the next elections (Popik, 2014). The main criticism of Obamacare is that it has too many mandates and too many regulations which escalate premiums.

Examining health insurance systems in other countries, Canada and Australia also practice NHS, but together with the private healthcare sector. Canada has a predominantly publicly financed health system with approximately 70% of health expenditures financed through the general tax revenues of the government (Marchildon, 2013:19). According to Marchildon (2013:19) the health services governance, organisation and delivery are highly decentralised for at least three reasons:

- Provincial (and territorial) responsibility for the funding and delivery of most health care services;
- The status of physicians as independent contractors; and
- The existence of multiple organisations, from Regional Health Authorities (RHAs) to privately governed hospitals that operate at arm’s length from provincial governments.

Similar to other countries using the National Health System with the primary objective of delivering health equity, the Australian Medicare has also been grounded on providing access to health on the basis of need rather than on affordability (Johar, Jones, Keane, Savage, & Stavrunova, 2012:2). The Australian health system still provides a mixture of both private and government institutions, which may be somewhat contradicting the latter. According to Cheng, Joyce and Scott (2013:43), the combination of public and private medical practice is widespread in many health systems. This leads to governments managing the public sector in the decision making on the degree of regulation and/or incentives to medical practitioners to influence their choice whether and how often they will work in each sector.

The Australian universal health insurance system, Medicare, provides free or subsidised treatment by doctors and free public hospital treatment (Cheng, et al., 2013:44). Medical practitioners in private practice and private hospitals have the liberty to charge patients what the market will bear, with a fixed subsidy from Medicare resulting in various patient co-
payments. Private hospital expenses are mostly paid for through private health insurance, which is held by roughly half of the Australian population (Cheng et al, 2013:44).

In the African context, countries like Ghana, Nigeria and Uganda also use the National Health System. In 2003, the Ghanaian government adopted the NHIS (National Health Insurance System), and by 2005 it was fully operational (Blanchet, et al., 2012:76). This system had many people enrolled by 2009. The NHIS in Ghana is financed through a National Health Insurance levy of 2,5% on certain goods and services, 2,5% monthly payroll deduction which forms part of the contribution to the Social Security and National Insurance Trust (SSNIT) for formal sector workers, government budgetary allocation and donor funding (Adinkrah, 2014).

Health services in Uganda are delivered within the framework of decentralisation in which the local governments are empowered to appoint and deploy public servants, including health workers, within the districts through the District Service Committees (Work, 2012:9). There are relevant health policies and regulations in place, many developed through a participatory multi-stakeholder process.

The Nigerian government launched the National Health Insurance System (Dutta & Hongoro, 2013), which is unfortunately currently in a poor state due to a lack of medical practitioners in the country. It is estimated that the current Nigerian doctor-patient ratio is 39:100 000 (Obom-Egbulem, 2010). This is mainly because highly-trained experts often leave the country in order to pursue their profession in countries with better infrastructure and/or higher wages.

From 1942 to 1944, the National Health Commission, also known as the Gluckman Commission, was tasked with the establishment of ground rules for a National Health Insurance in South Africa (Naidoo, 2011:678). Although aimed on progressive features such as health centres and preventative medicine, the proposed National Health Insurance ultimately proved to be unsuccessful.

This system was perceived to be funded by a common health tax and administered by committees with considerable public representation (Freud: 2012:171). However, the South African Government rejected the concept as the envisaged National Health Service required
drastic reforms and a higher tax burden on the dominant White population, both of which exceeded the public temperament and political will of the times (Kautzky & Tollman, 2008:19). Consequently, no health tax was authorised and no nationalisation of the provincial health system to focus on major hospitals took place.

2.4 THE SOUTH AFRICAN HEALTH SYSTEM

The current South African healthcare systems consists of both the public and private health systems and are very similar to the types found in similar middle income countries as well as other developed markets (Willie, 2014). The private sector caters for middle to high class populations, mainly medical aid members and those in a financially sound position to be able to pay cash. Most of the poor and people with low socio-economic status use the public health sector (Harris, et al., 2011:102).

This shows a huge discrepancy as the private sector serves around nine million people in South Africa whilst the public sector serves over 40 million South Africans (Willie:2014). Similarly, a large part of the funding goes to the private sector, which is small but fast growing. At the same time the public sector, although serving the majority of the population, remains relatively under-resourced (Department of Health, 2011).

The South African health system has been affected by racial and gender discrimination, the migrant labour system, the destruction of family life, vast income inequalities and extreme violence (Coovadia, Jewkes, Baron, Sanders, & McIntyre, 2009:817). The health system in South Africa went through various changes over the past centuries (Coovadia, et al., 2009:820).

Next a timeline of important events in the healthcare industry of South Africa are presented, (Coovadia, et al., 2009:820-824).


Key health challenges

- 17th century: diseases of poverty, epidemics of smallpox and measles, poisons; malaria, famines, schistosomiasis and trypanosomiasis.
• 19th century: epidemics of syphilis, tuberculosis, bubonic plague, yellow fever, typhus, cholera, soil parasites and malnutrition.

Healthcare resources
• Traditional healers, European-trained doctors, missionaries and other health providers offered a mix of services.
• Early 19th century: domination by medically trained doctors; indigenous and traditional healers were marginalised.
• Late 19th century: orthodox medicine became a professional practice with trained nurses and doctors.

Health system
• 17th and 18th centuries: hospital care provided by Dutch East India Company, colonial governments and Christian missions.
• 1807: first health legislation; establishment of Supreme Medical Committee to oversee all health matters.
• 1830: Ordinance 82 allowed for regulation of all health practices in Cape Colony; other three colonies followed the Cape’s lead.
• 1883: Public Health Act in response to the smallpox epidemic made notification and inoculation of smallpox compulsory.
• Mid-1800s: hospitals in most major centres.
• 1897: Public Health Amendment Act separated curative and preventive care.
• Missionaries provided orthodox medical healthcare for black Africans.

1910–1948: Period of segregation

Key health challenges
• Poor urban working and living conditions with diseases caused by overcrowding, poor sanitation and diets, stress, and social disintegration.
• Syphilis, tuberculosis, malaria, venereal diseases continue to spread.
• Maternal mortality high.
• Malnutrition increased.
• Lung disorders and mesothelioma among mineworkers.
Healthcare resources

- 1940: overall ratio of one doctor per 3600 population, but the mineworkers noted that there was one doctor for every 308 white people in Cape Town compared with one doctor for 22 000 to 30 000 people from other nationalities.

Health system

- 1910: establishment of the Union of South Africa; health services were fragmented among the four provinces.
- 1919 Health Act established the first Union wide Public Health department.
- 1942–1944: Gluckman Commission advocated for a unitary national health service.
- 1945: Polela Experiment; Gluckman became Minister of Health in 1945 and at the same time several community health centres were established. These centres were the forerunners of community-based primary healthcare, with the health of the population the prime concern.

1948–1994: The apartheid years

Key health challenges

- Non-communicable diseases rise in white people and poverty-related diseases persist in black people.
- Maternal, infant, and child mortality high.
- Apartheid-related mental disorders common in black and coloured people.
- Tuberculosis rates and deaths much higher in black and coloured populations than in white populations.
- In urban areas, teenage pregnancy rises and unsafe abortion and infanticide escalate.

Healthcare resources

- Doctor to patient ratios in the provinces increased from 1:2427 in 1946 to 1:1721 in 1976.
- Early 1970s: in the Bantustans, the doctor to population ratio was estimated at 1:15 000 compared with 1:1700 for the rest of the country.
- Health services in Bantustans were systematically underfunded.
- 1980, 40% of doctors worked in the private sector, increasing to over 60% by 1990.
Health system

- 1952: segregated medical school established for black students in Durban.
- State takeover of missionary hospitals, which formed the backbone of the Bantustan health services.
- 1977 Health Act perpetuated the fragmentation with curative services being a provincial responsibility and prevention a local government responsibility.
- 1978: Alma-Ata Declaration failed to have an effect on an increasingly isolated South Africa.
- 1983: Tricameral Parliament further fragmented health services with white, coloured and Indian “own affairs” departments.

1994–2008: Post-apartheid democracy

Key health challenges

- Quadruple burden of disease recognised: diseases of poverty (perinatal and maternal diseases), non-communicable diseases, HIV/AIDS (communicable diseases), violence and injury cause mortality and loss of healthy years of life.

Healthcare resources

- Stagnation in government funding of healthcare.
- Expenditure per head on medical schemes was three times greater than was public expenditure in 1996; this difference had increased to almost six times more by 2006.
- By the end of the 1990s, almost three-quarters of general practitioners practiced in the private sector.
- Redistribution of government funding between geographic areas.

Health system

- 1996: free care for children younger than six years and pregnant women, and free primary health care for all.
- 1996: the Choice on Termination of Pregnancy Act legalised abortion, increased access to abortion; marginal declines in septic abortions and stabilisation in maternal mortality from septic abortions.
• A rights-based approach to youth sexuality: promotion of information and youth-friendly sexual health services, banning the exclusion of pregnant pupils from schools; teenage pregnancy declined by 56% from 124 births per 1000 women aged 15–19 years in 1987–1989 to 54% per 1000 in 2003.

• 2002: Mental Health Care Act legislates against discrimination against mental healthcare users.

• 2004: National Health Act legislates for a national health system incorporating public and private sectors and the provision of equitable healthcare services; provides for fulfilling the rights of children with regards to nutrition and basic services and entrenches the rights of pregnant women and children to free care throughout the public sector if not members of a medical scheme; legislates for the establishment of the district health system to implement primary healthcare throughout South Africa.

In 2014, the National Health Act was legislated to provide a National Health System which incorporates the public and private health sectors in terms of the provision of equitable healthcare services (Coovadia et al, 2009). This led to the ruling party’s decision to resolve the adoption of the National Health Insurance during the Polokwane conference in 2007. The then Minister of Health, Dr. Aaron Motswaledi, believed that the proposed NHI will reshape the primary health system and place the general practitioner, who currently works independently in the private sector, in the heart of primary health care (Bateman, 2012).

The proposed NHI is expected to strengthen the South African health system based on a re-engineered primary health care approach. It is proposed that the system is focused on outreach services. It emphasises prevention of ill health and disease whilst promoting good health and wellbeing (Naidoo, 2011). If achieved and implemented properly, the NHI should address the issue of health inequality that South Africa is currently facing.

However, since the introduction of the NHI by-law in 2009, questions arose regarding the way the system will be funded, the right to healthcare, access, fairness, efficiency, costs and the quality of healthcare (Ncayiyana, 2009). This has led to uncertainty regarding a feasible funding model for NHI considering the current tax pool and high level of unemployment in the country against the learning curves of other countries.
The South African health system has shown a lot of commonalities with the American Health System, where both countries spend a huge amount of money on health. Yet, the countries lag behind in such measures as infant mortality, maternal mortality and life expectancy compared to nations of equivalent wealth and development (OECD Health Statistics, 2014). Both countries have a costly private health insurance sector with premium rates rising unsustainably amidst steadily diminishing client benefits.

The USA medical debt is considered one of the principal causes of personal bankruptcy (Mangan, 2013). In South Africa the public service was a safety net and last resort for people running out of benefits from their medical scheme and/or people discarded by the private health care system (Ncayiyana: 2009).

With the challenges faced by both the public and private health sectors in South Africa in terms of social justice, efficiency and sustainability, the proposed NHI system will establish a single-payer system of healthcare financing (Ncayiyana, 2009). This way of financing is acknowledged to be more cost-effective than a multiplicity of funders as in the present system of numerous and mutually competing medical aids (Light, 2003; Ncayiyana, 2009).

The private sector, as indicated, is only available to a small portion of the population at a very high cost but with infrastructure equal to first world countries. The successful implementation of the proposed NHI will therefore require the public sector to be upgraded which is currently characterised by poor infrastructure, corruption and incompetency (Harris et al.: 2011).

In an attempt to merge the two sectors, the South African government has constantly engaged with the private healthcare funders in the hope to urge and enable faster progress towards a more equitable healthcare system (Bateman: 2014). This has pave way to accommodate and include the private healthcare sector to obtain consensus into the Committee for the Essential Drug List (Department of Health; 2012). This is a movement to assist in the effort to establish the same treatment of disease protocol in both the private and public health sector.

These kinds of endeavours are much needed in order to have a nationalised protocol on patient care. It will also assist in combining both systems without much friction between the two sectors. When taking cognisance of the principles of NHI including the right to health, free at-point-of-use and a choice of care provider, social solidarity and universal coverage
(Van Niekerk, 2010), there will be an even greater need to have both the public and private sector working together.

The Government proposed to fund this model by establishing a NHI fund with an independent board (Van Niekerk, 2010). Sources of revenue was suggested to include general tax increase in the public health budget as well as the roll-out of the South African Revenue Services (SARS) to collect progressive payroll contributions from employers, employees and the self-employed taxpayers. There will also be tax subsidies to those who contribute towards a private health insurance.

These tax subsidies will be directed towards the NHI fund and the contribution from out-of-pocket payment from the uninsured like tourists (Department of Health, 2011). Citizens with current medical aid cover will irrespectively fall under the NHI, as provision will still be made for anyone to voluntarily contribute to a medical aid whilst contributing to the funding of the NHI (Van Niekerk, 2010).

Van Niekerk (2010) indicates that highly qualified and trained personnel are core areas for the successful implementation and sustainability of the NHI. The financial viability and sustainability of the NHI also needs to be addressed through cost containment and economies of scale (Van Niekerk, 2010). It is however evident that the burden of disease has been imparted, yet the implementation will be slow and could take years.

2.5 PROGRESS REGARDING THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SYSTEM IN SOUTH AFRICA

On 12 August 2011, the South African government through the National Department of Health published a green paper on the National Health Insurance (NHI) (Thulare, 2013:4). The implementation of the NHI forms part of the Department of Health’s ten point plan. The intention with the NHI is to bring about reform that will improve service provision in the health sector. According to the Department of Health’s (DOH) policy paper (2011:4), the NHI will promote equity and efficiency to ensure that all South Africans have access to affordable, quality healthcare services regardless of their socio-economic status.
In addressing its objective to provide access to quality healthcare for all its citizens, the South African government introduced the National Health Insurance via the phase-in approach (Pilot Project) to be rolled out over a 14 year period.

In April 2012 the first phase of 10 NHI pilot districts was announced (SARRAH report, 2013:9). These districts are situated in every province and specifically in areas with high levels of underserved communities. In the North West province, the Dr Kenneth Kaunda District Municipality was chosen as the pilot site for NHI. These pilot sites will focus on key elements such as district health services, service delivery, strengthening of health systems and health financing (Khumalo, 2012: Online).

According to the SARRAH report (2013:9), the NHI pilot districts were established to assess: the ability of districts to assume greater responsibility for purchasing health care services; the feasibility, acceptability and affordability of engaging the private sector; and the costs of introducing a fully developed district health authority and implications for scaling up. This then mean that the pilot districts will have to work very hard in order to uplift the implementation of the NHI as the assessment report will play a vital role in determining the way forward for the NHI project.

However, the SARRAH report found that the 11 pilot districts were able to provide the majority of the data requested prior to the SARRAH team visits. The SARRAH team was thus able to obtain additional information during their visits. Due to the limited timeframe, it was not possible to verify all the data, particularly: hospital status; human resources; and facility equipment and infrastructure (NHI report, 2013).

### 2.6 CONCLUSION

This chapter provided an overview of the concept of National Health System and the reasons for establishing this type of health systems worldwide. The purpose was to inform on the importance of the concept of this study. The chapter highlighted the application of national health systems and/or health insurance in different countries from various continents in order to demonstrate the future of healthcare in the world.
The chapter also explained the NHI which the South African government proposed. The relevancy of this type of health system in dealing with health inequality was also emphasised. The next chapter will deal with the empirical research which was done through semi-structured interviews to evaluate the feasibility of the NHIS in South Africa.
CHAPTER 3: EMPIRICAL STUDY

In this chapter the results of the empirical research is reported and discussed in terms of the results obtained through the qualitative approach. The results are presented based on the proposed research questions as indicated in Chapter 1.

3.1 RESEARCH DESIGN

For the purpose of the objectives of this study, a qualitative approach, in the form of semi-structured interviews was used. Welman, et al. (2005:188) describes qualitative research as a descriptive form and notes that qualitative research is ideal in the description of groups, communities and organisations. Qualitative research affords the researcher the opportunity to truly understand the in-depth feelings and motivations of participants (McDaniel & Gates, 2005:109; Nuttall, et al., 2011:153). It also allows for theoretical insights to be tested and expose theoretical constraints (Bansal & Corley, 2012:513).

3.2 PARTICIPANTS

The initial goal was to interview doctors from both sectors, public versus private health sector, including other allied health service providers such as dieticians and pharmacists in order to determine their understanding of the NHIS, how they perceived it to be financed and whether they believe the country is ready for the application of such health system. The interviews with public sector members failed due to the gateman issue while allied healths from private sector were not keen to take part in the study. Therefore, the study continued with the private general practitioners as indicated below (Table 3.1).

A purposeful sample of general practitioners operating from the Klerksdorp Orkney Stilfontein and Hartbeesfontein (KOSH) area was applied. The management of the Anncron clinic in Klerksdorp provided a list of general practitioners practicing in KOSH for the sample purposes. The list contained information such as practice’s addresses and telephone numbers. An attempt was made to contact all doctors on the list (n=55). In addition, a meeting that was scheduled for the KOSHMED IPA (Independent Practitioner Association)
was attended as most doctors from the list are members of the the association. During the meeting the purpose of the current research were explained and copy of the consent form and interview questions were made available.

Initially the study intended to focus on the perception of public versus private health sector, to include all under this two sectors dealing with primary healthcare. The reason for choosing private health sector doctors only was the lack in permission from public health authorities to include the public health sector doctors in this study. Time constraints to complete the study also played a role in the public sector not participating in the study. Descriptive information of the sample is given in Table 3.1 below.

<table>
<thead>
<tr>
<th>Description</th>
<th>Range</th>
<th>Sample (N=13)</th>
<th>Frequency (Percentage)</th>
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<tbody>
<tr>
<td><strong>Age</strong></td>
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<td>Age 20 – 30</td>
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</tr>
<tr>
<td>Age 31 – 40</td>
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<tr>
<td>Age 41 – 50</td>
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<td>30.77%</td>
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</tr>
<tr>
<td>Age 51 – 60</td>
<td>4</td>
<td>30.77%</td>
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<tr>
<td>Age 61 +</td>
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<td>0.00%</td>
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<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Gender Male</td>
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<tr>
<td>Gender Female</td>
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<tr>
<td>environment 21 – 30</td>
<td>3</td>
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<td>environment 31 – 40</td>
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<tr>
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<tr>
<td>Qualification(s) 1</td>
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<tr>
<td>Qualification(s) 2 - 5</td>
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<tr>
<td>Qualification(s) 6-10</td>
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<tr>
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<td></td>
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</tr>
<tr>
<td>Race Blacks</td>
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<td>76.92%</td>
<td></td>
</tr>
<tr>
<td>Race Whites</td>
<td>3</td>
<td>23.08%</td>
<td></td>
</tr>
</tbody>
</table>

The participants consisted mainly of black (77,00%), male (84,60%) general practitioners with two to 25 years experience in the private health sector.
3.3 RESEARCH METHOD

The qualitative study by means of semi-structured interviews was conducted at the practices of the general practitioners in the Dr Kenneth Kaunda District. A total of 13 general practitioners were interviewed, with four of those requesting not to be audio-taped during the interviews.

3.3.1 Interview procedure

Semi-structured interviews were conducted with the general practitioners ranging between 10 and 30 minutes. All interviews were done at the respective practitioners consulting rooms. The consent form was made available to practitioners, which explained the purpose of the study in full detail. It also gave the practitioners the authority to choose to take part in the study or not. Interviews were relatively brief to minimise inconvenience, and confidentiality was assured. Interviews with the general practitioners included questions that were aligned with the 10 questions from the WHO to countries intending to adopt social health insurance (Doetinchem et al., 2010).

Semi-structured interviews were conducted with 13 general practitioners within the private health sector of which four did not give their consent to be audio-taped. Open-ended questions were asked and as the interviews progressed it was needed to add and omit a few questions based on the answers received. Interview saturation has been reached with the number of 13 interviews as no new themes emerged and further interviewing was not necessary as confirmed by the grounded theory approach, (Glaser & Strauss, 1967).

3.3.2 Analysis

All the audio-taped interviews were transcribed. After transcription, the interviews were read at least twice and emerging themes were identified. All identified themes were then categorised according to the major themes of the questionnaire. The themes were therefore grouped into four categories, namely:

- The understanding of National Health Insurance system;
• The financing of the system;
• The involvement of relevant stakeholders, and
• The readiness of the country to have a National Health Insurance System.

3.4 RESULTS

All the general practitioners from the provided list were contacted to be interviewed. One doctor was reported to have demised, one doctor has graduated as a specialist physician, three doctors reported to have closed their private practices (two of those went back to the public sector and one is a businessman), fifteen of the practitioners could not be reached as either the number were incorrect or the call was never answered. Of the remaining 35 general practitioners, 11 were too busy or declined without giving a reason leaving 24 practitioners willing to participate in the research.

There were however five more general practitioners who were contacted but were not on the list, probably because they were relatively new in the private sector. From the practitioners who confirmed to take part, only 13 interviews were successfully completed whereof four interviewees refused to be audio-taped.

Since the goal of the study was to enhance understanding and generate hypothesis rather than achieving significance in a statistical sense, (Glaser & Strauss, 1967), the findings will not be presented in a quantitative, numerical way. However, general indication is given regarding the number of participants that expressed each theme.

3.4.1 Understanding and Conceptualisation of National Health Insurance system (NHIS)

The NHIS is understood to be a health system that the South African government intends to implement with the aim of improving access to quality healthcare services for the whole population as well as the provision of financial risk protection against health-related catastrophic expenditures (Matsoso & Fryatt, 2013:156). It is intended to provide comprehensive quality healthcare that is accessible to all citizens in South Africa.

All the practitioners confirm to have heard of the proposed NHIS in South Africa. Mutual understanding exists that the NHIS is a way of providing universal access for all people to
healthcare by means of socialising the health system or creating a medical aid that would cater for everyone. The use of the words private health sector versus public health sector were commonly used by 61.54% of general practitioners and the understanding was that Government wants to address the discrepancy between the two sectors.

92.31% of general practitioner believe NHI will have a positive contribution towards South Africa’s health system, but only if it is implemented properly. Even though 23.08% of practitioner indicated to have been negative about the NHI, 69.23% of them believe there is a need for this type of health system in the country. One participant indicated, “you see on paper is quite a good approach, but then I think that practically speaking we are still far from implementing the NHI with desirable benefits”.

Another participant showed positivity and expressed, “Yes, I think is going to benefit a lot because people who do not have access to private health will now have that access. We all know that private healthcare or private institutions are quite advance compared to public institution, so everybody will be free to access care from private or public institutions”.

30.77% of general practitioners felt that the NHI will improve the problems that of the current health system face. One participant indicated “it will improve those indexes like your infant mortality, the maternal mortality and all those things. It will be very good for the country actually if it is done properly”. However 46.15% believe that a lot of work is still needed to improve the current health system before even considering a NHI. In this regard, one participant noted, “and the fact that our healthcare system (public) is looking the way as it is at the moment in time, it needs to be picked up quite a ways before we could do the national health at all”.

3.4.2 Financing of the National Health Insurance system

According to Van Niekerk (2010), the NHI is envisaged to be funded by establishing a NHI fund which would be financed from general tax increase in the public health budget and the South African Revenue Services collecting progressive payroll contributions from employers, employees and self-employed taxpayers. The Department of Health (2011) has also indicated tax subsidies from those who will be contributing towards the private health insurance and
from those uninsured who pays out-of-pocket like tourists. These deductions will be directed towards the NHI fund.

Participants noted that they were not actually sure how the NHI will be financed. There was an indication that they believe it will be funded through taxation, “I am not sure but I think it is going to be from the taxpayer, because that is the only revenue for the Government”. 53.85% of general practitioners believe that the Government will have to do more in terms of revenue collection as they believe tax alone as a way of funding the NHI might not sufficient for the sustainability of the fund.

The perceptions exist that more is needed to be done than funding alone in order to sustain the NHI. The following were noted, “Funds alone cannot sustain the NHI but administrative issue and changing peoples’ attitudes”. 38.46% of general practitioners believe that considering the distribution of doctors, the Government should also consider infrastructure improvements in terms of schools and an overall better environment for the whole family as was noted by one participant, “those are the ripple effect of how this thing become ultimately sustainable, because it is not just about bringing Neurosurgery to a town like this, it is about how the Neurosurgeon’s family adapt to this kind of environment in terms of all of those things. This is the kind of sustainability I see forth if you think out of the box about this”.

3.4.3 Involvement of relevant stakeholders to support NHI

According to Matsoso & Fryatt (2013:156), the National Department of Health (NDOH) has consulted with several stakeholders such as medical scheme administrators, labour, pharmaceutical industry, professional associations for various occupations, statutory bodies, Government departments, academia, civil society and Parliament since the launch of the NHI Green Paper in August 2011.

The Health Minister has also lashed on private general practitioners saying that they are too greedy for NHI and that they only think of money, (Khan, 2014). This was after the Government has failed to secure the service of private general practitioners to contract to NHI and serve at their respective local clinics. The reality was that the Government failed to understand the financial needs of the general practitioners according to Angelique Coetzee, who is the General Manager of South African Medical Association (SAMA Marmol Stoltz
who heads the SAMA committee on doctors in private practice said, “there hasn’t been proper consultation with doctors”, (Khan 2014).

All doctors believe even though there was an effort from the Government to discuss the NHI project with them, it was not sufficient as Government has already decided on the process prior to these discussions. 76.92% of participants believe that these sessions were more like a session to inform than a session to consult. Comments include, “my understanding from where I am currently residing, we just heard that NHI is coming, this is how it is going to work and basically that is that. There were not like really serious input from healthcare practitioners, for me it felt like something that has already been decided and we were just told that this is what is going to happen, it is something that was decided long time ago”.

From the responses, it appears that Government did not do enough to get the support of all stakeholders with regards to NHI. One participant indicated, “that is why perhaps the uptake of this is not so good as one would have loved in certain areas because of people’s questions, and some were not thoroughly answered. People still have some dissatisfaction with certain areas, especially when it comes to remuneration and things like those, they were already decided, that is why I call it an after consultation”.

Participants were of the opinion that although the Minister of Health discussed the NHI, much more were expected from local authorities to further run with the project and engage all stakeholders within a specific region. A comment in this regard was “we would have expected the local healthcare management in our district to be running now with the project but it is rather silent. They are hardly there. You don’t hear about them. We tried very hard, our organisation KOSHMED has tried very hard to invite them to come and talk to us but it is difficult”.

3.4.4 South Africa’s readiness for NHI?

The infrastructure as mentioned in the ministerial 10-point plan need to be revitalised, more so when focusing on the public sector infrastructure. The majority of the practitioners were in agreement that the state of the public health facilities is poor. A comment in this regard was “so as far as infrastructure is concerned we still have a long way to go, our hospitals are dilapidated, human resource as well, we don’t have appropriate people to run our hospitals”.
Participants indicated that the administration component is the main concern that Government needs to address in synchronising the public and private health sector. Participants noted that it is imperative to have the relevant people executing specific job. One participant indicated, “The main problem would be money and administration, get good administration people, people like you that did your MBA, myself I did MBA in healthcare as well, ask us and we will be able to help and be able to look at this things. But they don’t look at that. They put people in place who does not have any qualifications at all”.

23.08% of participants believe that there might be a shortage in terms of skills and human resources to run the project. One participant even referred to the issue of certificate of need which the Government revoked in July 2014 “the certificate of need about July of this year was called off because it didn’t make sense that things they said they would do would happen. Because they don’t have capacity to send their inspectors to say that you are complying with the law, they don’t have that kind of will with the law to deal with those kind of problems. So they called it off on the basis that they don’t have the requisites, manpower and skills to deal with those things with regard to the certificate”.

The general perception of the participants is that at present the country may not be ready for the NHI. Comments included “no, definitely not at this point in time, it is too soon to try and implement it”. Another participant commented as follows “No, not yet, we are very far from ready for NHI, for us to be ready we need to improve the way the clinics functions, we need to involved clinics in a lot more areas, we need to develop a proper referral system, we need have management working in all these”.

3.5 CHAPTER SUMMARY

National health insurance (sometimes called statutory health insurance) refers ti health insurance that covers a national population for the costs of healthcare and is usually instituted as a programme of healthcare reform (Wikipedia). The current Government has proposed the implementation of NHI with the objectives to (Matsoso & Fryatt, 2013:156):

- Improve access to quality health service for all South Africans, irrespective of whether they are employed or not;
- Pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund;
- Procure services on behalf of the entire population and efficiently mobilise and control key financial resources; and
- Strengthen the under-resourced and strained public sector so as to improve health systems performance.

The general perception of participants is that South Africa is in need of a system such as the NHI in order to improve health in general. Also, such a system should reduce health inequalities by providing people the opportunity to have access to decent health services. However, concerns exist regarding the way Government attempts to implement such as system. There is concern with regards to the limited room for proper engagement with the relevant stakeholders to firstly ensure support and secondly to have a mutual understanding of the NHI, its purpose and execution.

The legalities in terms of the governance, the amount of independence to manage its resources and the determination of remuneration packages of accredited providers, seem to be vague. Along with this, participants noted a concern regarding how the NHI will be administered and the suitability of public infrastructure (which are currently perceived as poor).

Furthermore, there seems to be much confusion with regards to the sustainability of the funding for NHI. Van Niekerk (2010) indicates that it has been suggested that sources of funding for NHI will include general tax increases in the public health budget. The South African Revenue Services will also collect progressive payroll contributions from employers, employees and the self-employed taxpayers. There will also be tax subsidies to those who contribute towards a private health insurance. These tax subsidies will be directed towards the NHI fund and the contribution from out-of-pocket payment from the uninsured like tourists (Department of Health, 2011). Participants noted that funding of the NHI will, according to their knowledge, occur through national tax but they express doubt whether this type of funding will be sustainable.
Participants displayed a general belief that the implementation of NHI in South Africa should be cautious and slow. It became evident that although participants agree that a much needed improvement in the health sector (public and private) is required, that the country is not ready for the NHI unless the level and infrastructure of the public health sector are improved to the extent that it meets the standards of the current private sector.

Chapter 4 set out the conclusions, recommendations and limitations of the study.
CHAPTER 4: CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

The purpose of this chapter is to provide conclusions regarding the results obtained in the literature review and empirical study of this research. Conclusions were made with regards to the research objectives. Furthermore, limitations that have been identified throughout the course of the study are discussed. Finally, recommendations relevant to the proposed NHI are made and future research opportunities that emanate from this research are presented.

Furthermore, the relevance of the study in terms of reaching its set objectives was assessed and forms the basis for the recommendations. Each specific research objective was analysed to indicate whether the objectives of the study were achieved are also set out in this chapter.

4.1 CONCLUSIONS

In chapter 1, the study introduced the National Health Insurance System (NHIS) as the South Africa government has proposed it as a future health system for our country. This was proposed as a solution to the problems of health inequality that is currently experienced within the public and private health sectors as well as the concurrent imbalances between the two systems. The problem statement outlined the health issues in general and provided an overview of the NHI and its objectives as a South African concept.

Furthermore, research objectives and methodology (literature review and empirical study) and the significance of the study were thoroughly explained.

Chapter 2 provided the theoretical perspective on health and universal health insurance systems, explaining the need for such a system in countries. The chapter provided thorough details regarding the National Health System (NHS), from its inception to it operation today. Further focus was allocated to the success and adaptations needed for the implementation of a NHS in other countries. Finally, focus was given to the South African health systems from the early years to the currently proposed National Health Insurance (NHI) system. In addition, an overview was given of the current status of the NHI since the rollout of phase one in 2011.
Chapter 3 provided the analyses of the collected data through interviews that were conducted with general practitioners from the private sector in the Dr Kenneth Kaunda District Municipality. These interviews focused to obtain the general practitioners' views on the NHI in South Africa. The chapter explained qualitative research as an approach as well as the method of semi-structured interviews which was applied for this study. The data gathered through the interviews were presented and the findings interpreted based on the information in the previous chapters.

The primary objective of this research was to determine the feasibility and perceived problem of the proposed NHIS in South Africa from the perspective of general practitioners within the private health sector in the Dr Kenneth Kaunda District.

The first objective was to conceptualise National Health Insurance System (NHIS) and its components according to available literature. National health insurance (sometimes called statutory health insurance) is health insurance that insures a national population for the costs of healthcare and is usually instituted as a programme of healthcare reform (Wikipedia). In South Africa, the proposed NHIS is aimed at improving access to quality healthcare services for the whole population along with the provision of financial risk protection against health-related catastrophic expenditures (Matsoso & Fryatt, 2013:156).

The second objective was to determine the understanding and conceptualisation of the NHI and its components as perceived by a random selected sample of general practitioners in the private sector. Participants indicated that the NHI is a way of providing universal access for all to healthcare by means of socialising the health system or creating a medical aid that would cater for everyone. The general perception displayed was that the NHI might be good for the country provided it is introduced in a proper manner. The NHI is perceived as a positive contribution towards dealing with health inequalities and improving the health status in general.

The third objective was to determine the perspectives of the participants on how the proposed NHI will be financed. Van Niekerk (2010) indicates that the government has proposed to create a NHI fund with sources of revenue to include a general tax increase in the public
health budget, contribution from employers, employees and self-employed taxpayers, redirected money from existing medical aid schemes and out of pocket payments from the uninsured like the tourist. Participants indicated that the funding of the NHI will most probably be from national tax. Some participants indicated a perception that there would be a special taxation from the working class known as health tax and that it is possible that this tax will fall under the current contributions that are collected from all people in the working class.

The fourth objective of the study was to determine the perception of the participants regarding the technical feasibility of the NHI. Participants displayed a concern that, when considering the funding model, that the NHI will not be feasible. Some felt that the pool of taxpayers in South Africa is too small to sustain the NHI fund. A further threat to the sustainability of the NHI was said to be the possibility of corruption, as is eminent in various government departments.

Van Niekerk (2010) indicates that one of the core areas of the successful implementation and sustainability of the NHI is highly qualified and trained personnel. Harris et al. (2011) further indicated that the successful implementation of the proposed NHI will require upgrading the public sector that is currently characterised by poor infrastructure, corruption and incompetency. Participants agree that government still need to do much to improve the standard of the public health sector including upgrading of infrastructure, the nationalising of protocols and the training of health professionals. Participants displayed a concern that the country faces a huge shortage of health professionals and skilled people who could run the project successfully.

The proposed NHI in South Africa is to replace the existing system of private versus public health sector with a proposed new health system in the long run. In the countries explored within this study, it is evident that together with a National Health Insurance, provision has also been made for private healthcare services (Cheng, et al., 2013:43; Doyle, 2000; Marchildon, 2013:19; Obamacare facts, 2014). It is the perception of participants that Government wish to address the discrepancy between the private and public health sectors through the application of the NHI. Gantsho (2012:13) notes that the proposed NHIS seems to be posing quite a challenge to both the public and private sector. Participants confirmed to be confused on how the NHI will incorporate the two sectors.
The fifth objective was to determine the level of involvement of relevant stakeholders in planning for the NHI. Bateman (2014) indicates that in an attempt to merge the two sectors, the South African government has been in constant engagement with the private healthcare funders with the hope to urge and enable faster progress towards a more equitable healthcare system (Bateman: 2014). This has resulted in the private healthcare sector being included in the Committee for the Essential Drug List (EDL) expecting to urge and enable faster progress towards a more equitable healthcare system. The National Department of Health (NDOH) has also consulted with medical scheme administrators, labour, the pharmaceutical industry, professional associations for various occupations, statutory bodies, government departments, academia, civil society and Parliament on the plan to implement the NHI in the country (Matsoso & Fryatt, 2013:156).

However, participants however indicated that this engagement was introduced too late to permit all stakeholders the opportunity to fully grasp the concept of NHI and its intended purpose for the South African context. This little time also limited stakeholders to carefully consider if the NHI will be a threat to practitioners' independence. Participants noted that they are still uncertain on the remuneration structure for general practitioners practicing within the NHI. The perception was further that the engagement with the various stakeholders reflected as being an information session, presenting to practitioners a decision that was already made prior to these sessions. It was noted that these engagement efforts were more of an after consultation than securing the buy-in of and gaining input from the stakeholders.

The last objective of the study was to analyse the preparedness of South Africa for the implementation of the NHI. From the research it is evident that although the country needs to address health inequalities as well as the need for a system such as the NHI, there are still too many challenges that the South African government needs to address in order to upgrade and prepare the public healthcare sector. Aspects that need attention include the current insufficient infrastructure, the work attitude of most employees in the public healthcare sector, the training of healthcare professionals e.g. re-engineering primary healthcare trained nurses and medical doctors as well as the nationalisation of protocols. The Government also need to improve public healthcare in general including its administration to ensure the effective and efficient functioning of the public health sector.
Participants further indicated that although Government attempts to deal with the challenges to prepare the public sector for the implementation of NHI, a further effort is needed in this regard. Participants indicated that if the NHI implementation is rushed into action, it may result in a disaster for the country as it might fail totally. Overall there was agreement that the country may not be ready to implement the NHI in the current timeframe set by Government if challenges and concerns are not addressed proficiently.

4.2 LIMITATIONS

The researcher encountered problems in setting up appointments for interviews due to the busy schedules of the general practitioners. Appointments would have been made for a certain time only to find that the practice is too busy at the specified time and appointments had to be either rescheduled or cancelled all together. To address this problem, the researcher attempted to pay a normal consultation fee but none of the general practitioners agreed to such an arrangement. Availability of participants was perceived as the major limitation within this research.

There was a fear of victimisation among some of the practitioners, more so for those that have being contracted with the NHI by the Government. Some even requested no to be audiotaped despite being assured of the anonymous and confidential treatment of information. Also those general practitioners involved in the public sector, tend to withhold information and only posed their true feelings once the interview was concluded and the audiotape switched off. This poses a challenge to the reliability of their responses regarding the study.

Since NHI is only in its initiation phase in South Africa, little research exists on the topic in the South African context. Thus, a further challenge was in terms of the availability of relevant literature. In many instances the researcher had to utilise information that was not published in a scientific peer reviewed academic journal.

Another limitation was that the research only included general practitioners in the private sector working in a specific district. The sample size of the study population was also small due to the lack of willingness under general practitioners to participate in the study.
4.3 RECOMMENDATIONS

4.3.1 Recommendations pertaining to the National Health Insurance

The recommendations presented below rely on the empirical findings and literature review of this study. In terms of objectives one and two the following recommendations are made:

- Local district management should have regular meetings with all stakeholders to explain the process of NHI and to keep everyone up to date of the progress made in its implementation.
- Government should communicate directly on a regular basis with the general practitioners from both healthcare sectors via emails or post to inform on the progress of NHI.
- General practitioners should be advised to sign up for medical journals like the South African Medical Journal because most information on the development and progress of NHI is published in these journals.

In terms of financing the NHIS, the following are recommended:

- The Government should adopt the Ghanaian health financing system which was reoriented towards attaining social health protection for the disadvantaged by introducing participation of community and Non-Governmental Organisations (NGOs) to use the health insurance scheme. The advantage of this scheme is that it is a prepaid and risk pooled health financing mechanism. It is also linked with the country's poverty reduction strategy, which will also benefit South Africans.
- The Government could also introduce co-payment to promote individual responsibility as is the case in Singapore. However it should also limits the co-payment to be manageable.

In determining the feasibility and the engagement of stakeholders (objectives four and five) as well as analysing the preparedness for the NHI, the following can be recommended:
Local district managers should schedule quarterly meetings with all the relevant stakeholders in their respective districts to discuss ways forward and provide quarterly reports on the NHI progress.

The Government should be open to opinions and allow for constructive criticism in order to ascertain that there is mutual understanding in the successful implementation of NHI. It should avoid enforcing its own plans and believes on everyone without understanding the general opinion of all stakeholders involved in the successful implementation of the health system which aims to benefit all its citizens.

The government should introduce more projects together with the private healthcare sector like nationalising the protocols, should include the managers from the private sector into their local district management teams to encourage assistance and cooperation with one another on the issues and challenges facing NHI.

The Minister of Health, as already embarked on, should consider campaigning to everyone that is in the private healthcare sector. It was in this instance noted that when the Minister of Health was in the Dr Kenneth Kaunda District Municipality, only doctors from KOSHMED were invited but the other group not belonging to this association did not receive any invitation. Therefore, there should be people tasked to invite all practitioners in the private sector to such meetings as well as quarterly meetings with the local district managers as it forms the basis for relaying important messages.

There should be a clear mandate on how NHI is going to operate and all accredited service providers should understand the remuneration packages for NHI. Stakeholders should also be allowed to engage in negotiations for remuneration.

The abovementioned recommendations will afford the government to assess the feasibility to engage in the NHI and realise the best ways for its implementation. NHI is needed in South Africa, however it should be properly planned and introduced to ensure its success avoid failure as has occurred in several other countries.
4.3.2 Recommendations for future research

This study focused on the National Health Insurance and the understanding of it by the private healthcare sector's general practitioners. However, for future research it is recommended that the views of doctors from the public healthcare sector in the primary health care setting be obtained. The public versus private approach could have provided more insight on the existing understanding of NHI in the South African context. Future research may also include how these two sectors can be merged to benefit both worlds. Also, research could focus to determine how to address concerns such as poor infrastructure and the lack of qualified health professions.

Future research should also focus on a more comprehensive sample to include the whole country and not be restricted to one district.

A greater focus on the financing of this system would be to the advantage of the body of knowledge as funding appears to play a vital role on the success or failure of such a health system. Various funding models should be investigated to determine the best suited model for both the country and its citizens. Further research is also needed on the remuneration model of accredited service providers under NHI.

Finally the National Health Commission should be explored as it seems to be mandatory in attaining the sustainability of the NHI through exploring preventive healthcare for the South African population.

4.5 FINAL CONCLUSION

Many countries worldwide are moving towards the implementation of a National Health System and South Africa should follow the trend. A healthy nation contributes to the country’s economic growth. Therefore NHI should focus on preventive healthcare. Engaging all the citizens and orienting them to take responsibility for their health will ensure a general improvement in negative habits that causes health problems for the nation.

The study provided the reader with knowledge and understanding on the proposed National Health Insurance and its feasibility in South Africa. Concerns were noted with regards to the
funding of the system, the remuneration of the health providers and the merging of the public and private health sectors. From the research it was clear that the perception is that the country may not as yet be ready for the full implementation of the NHI, without addressing the identified challenges.
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