EVALUATING THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE THABO MOFUTSANYANA DISTRICT OF THE FREE STATE PROVINCE, SOUTH AFRICA

by

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I declare that the research report titled; **Evaluating the Implementation of the National Health Insurance Scheme in the Thabo Mofutsanyana District of the Free State Province, South Africa** is my work and that each source of information used has been acknowledged using a complete reference. This report has not been submitted before for any other university research project, degree, or examination.

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ABSTRACT

This study evaluated the implementation of the National Health Insurance (NHI) scheme in the Thabo Mofutsanyana District of the Free State Province in South Africa. The NHI is designed to cater to the vulnerable people and disadvantaged in society to enable them to have access to quality health care. The study adopted the qualitative research approach. To collect data, twelve key informants were interviewed and further, six Focus Group discussions were conducted with ten participants per group. The results were analysed through open codes, which were further reduced to axial codes, and finally selective codes which are themes. The themes established in the study were: challenges, impact, support systems, and systems improvement. The study established that there are major medical, information technology support and cleaning staff shortages. These shortages adversely affect the smooth implementation of the NHI scheme. Compounded, they affect the patients waiting time as patients will have to wait for long a long time to get services. This, however, hurts the healthcare delivery system. Lack of proper budgeting was also found to affect the allocation of scarce resources. Due to this, the procurement of medical equipment and medication would be affected and compromise the NHI scheme's efficiency and effectiveness. Institutional support systems such as information technology equipment that could help to access patients' files at the click of a button affect the efficiency of the medical staff. A shortage of data-capturing clerks and pharmacists in clinics adds too much work to the medical staff who are supposed to concentrate treatment of patients. The study recommended the recruitment of medical and support staff to enable the effective implementation of the NHI scheme. It was recommended that medication be supplied to facilitate adequate treatment of patients. Further, financial resources must be availed to facilitate the procurement of medicines, servicing and calibration of medical equipment and maintenance as well as construction of adequate infrastructure to accommodate the patients. There is a need to put in place effective communication structures to enhance good communication between medical staff, patients, and the communities. Staff training and development for example through seminars must be put in place to update staff with the NHI scheme developments. Institutional support systems need to be in place to enable the smooth flow of information within the clinics. Stakeholder engagement is required to ensure that all the stakeholders have a contribution to make towards the NHI scheme.

Key Words: *Data capturing clerks, Health care, Institutional Support Systems, National Health Insurance Scheme*

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CBHI	Community-Based Health Insurance
CHIS	Community Health Insurance Schemes
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
ICF	Informed Consent Form
IFS	Information Systems
NDOH	National Department of Health
NHI	National Health Insurance
NHIS	National Health Insurance Scheme
NSDA	Negotiated Service Delivery Agreement
OOPEs	Out-of-Pocket Expenditures
RUDASA	Rural Doctors Association of Southern Africa
TB	Tuberculosis
TMD	Thabo Mofutsanyana District
UHC	Universal Health Coverage
WHO	World Health Organisation

CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

The South African government has identified health as one of its priorities. This commitment is articulated in the critical legislation- the Constitution of the Republic of South Africa (1996) (section 27 in the Bill of Rights) which reaffirms all citizens' right to (a) health care services, including reproductive health care. Further, Section 27 subsection (3) specifies that no one may be denied emergency medical treatment. To facilitate the actualisation of these Constitutional provisions, the National Health Insurance (NHI) was conceived as a significant vehicle towards attaining universal coverage of access to health. Furthermore, the South African government declared the NHI as a "health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status" (Republic of South Africa, 2015:1). Naidoo (2012) posits that the NHI will herald an era akin to a revolution in health care delivery in South Africa. Against this backdrop, this study evaluates the feasibility of the implementation of the NHI. A case study of the Thabo Mofutsanyana District was used as a case study for this particular research. The rest of chapter one entails a discussion of the contextual setting, problem statement, research questions, research objectives, the sampling procedures, methodology, ethical considerations and the structure of the full dissertation. The below paragraph discusses the research context and background.

1.2 RESEARCH CONTEXT: BACKGROUND

The nexus of this study is the South African national health insurance which has been on the cards for a very long time without any tangible progress. Some countries such as the United Kingdom, Rwanda and Thailand conceived the National Health Insurance idea well after South Africa had debated this framework in the 1940s.

The concept of a tax-funded National Health Service (NHS) in South Africa, was proposed as far back as 1944 by the Gluckman Commission (McIntyre and van den Heever, 2006). The objective was to meet the needs of all South Africans; however, the NHS was never taken forward. The United Kingdom (UK) and Sri Lanka adopted this model in the 1940s and have been reported as successful in these countries. In the 1980s, the NHS debate was resuscitated in South Africa as a response to the government's support for increasing privatisation of healthcare services ((McIntyre and van den Heever, 2006). Over the years there have been calls for the expansion of private sector healthcare with the ultimate goal of reducing government's expenditure on healthcare services. In the 1990s, various stakeholders

considered the NHS proposal mandatory because it is believed to address the problems of the private voluntary insurance (medical aid schemes) environment and address the problems in the public-private mix whilst promoting social solidarity in health care funding (McIntyre and van den Heever, 2006).

The motivation for South Africa to implement the NHI is derived from other countries that have successfully implemented the model. For example, in 1988, the World Health Organisation (WHO) estimated that more than 75% of Brazil's population had health coverage, while in the early 2000s, the United Nations reported that Thailand was on track to meet its millennium development goals (UN, 2005). Closer to home, the Rwandese government reported that its country's life expectancy had improved from 30 to 55 years (UN, 2015). Compared to South Africa which has been paying more than other low-and middle-income countries, some health indicators deteriorated. The mortality rate doubled between 1990 and 2007 (Millennium Development Goals Report, 2013). The successes of Brazil, Thailand and Rwanda act as benchmarks against which South Africa may be measured.

Section 27 of the Constitution of the Republic of South Africa makes it mandatory for every citizen of the country to access and navigate healthcare services without any hindrances or challenges. The 2030 National Development Plan (NDP) (Vision 2030:329) stipulates the need to implement the NHI in phases to reduce the cost of private medical care and to support the public healthcare sector, it is also indicated that the South African's proposal of the New National Health Care Insurance (NHI) system represents a break from the past that saw some members of society being left out in the health system (Vision, 2030). Compared to Brazil's reformed Constitution, which in 1988 declared that health is a human right of every citizen and a duty of the state, this gave birth to the Sistema Único de Saúde (Unified Health System) (WHO, 1988). For example, by the end of 2007, 80% of Brazil's HIV-positive population was eligible for treatment- had access to antiretrovirals compared to South Africa's 505 HIV positive population that has access to treatment.

Statistics South Africa (2019) estimated that 16% of South Africans aged between 15 to 49 years were HIV-positive compared to 0.3% of Brazilians in the same age category were infected. These figures demonstrate the success of the NHI in Brazil which should be a huge motivator for the South African project. There is still the private healthcare sector in Brazil and those people on medical aid schemes get tax rebates but still contribute to the national health system through income tax (United Nations, 2019).

The NHI scheme is designed to fundamentally transform primary healthcare (PHC) in South Africa, which envisages a dispensation wherein private sector healthcare providers and public sector facilities like clinics as independent contracting components to the NHI fund. The NHI system is very important in the pursuance of the goal of achieving a health dispensation wherein there is a realisation of universal health coverage (UHC). Whereas in South Africa, the citizens are guaranteed health as a right by the Constitution, inequalities still persist. The health system in South Africa is highly unequal with fifty per cent of the budget being spent on sixteen per cent of the population that are shielded by private medical insurance schemes. It is approximated that about twenty-eight per cent of the population accesses health care services provided through the PHC the majority of which falls within the bracket of the low-income- those that are not ensured pay for health care services out-of-pocket.

Given the above objectives of the NHI, it is also important to assess how Thailand has become successful with its NHI which was implemented in the 1970s. Thailand's heath reforms were built on a decentralised system, which requires all medical graduates to serve in the public health care sector, thus, adequately staffing healthcare facilities. By the 1990s, all Thai citizens had free access to antenatal care, family planning, immunisation and skilled birth attendance (United Nations, 2014).

The NHI is a response to the notion of universal health coverage (UHC). Every South African should have the right to access comprehensive healthcare services for free at accredited health facilities (clinics, hospitals, and private health practitioners) in the country (Republic of South Africa, 2015). According to Fusheini and Eyles (2016:1), UHC has arisen as a primary goal for health care delivery in the post-2015 development agenda. The NHI would be implemented gradually in three phases over fourteen years to ensure universal access to quality healthcare on a more sustainable and equitable basis than what currently exists for the entire population (Matsoso & Fryatt, 2013). The authors submit that the NHI provides financial protection to the citizenry against health-related expenditures which can be astronomical at the best of times.

Thus, the implementation of NHI since its adoption by the Cabinet in 2011 has become one of the strategic priority areas for the Government of South Africa. The NHI has the potential to guarantee better health outcomes. In addition, the Negotiated Service Delivery Agreement (NSDA) adopted by the government in 2010 was a ground-breaking paradigm shift, promising an outcomes-based approach to service delivery. Of the twelve (12) NSDA outcomes adopted, the health sector is a custodian of outcome two: ***"****A long and healthy life for all South Africans****".*** These outcomes are fundamental in ensuring the transformation of the healthcare system and,

they catalyse the ultimate implementation of the NHI. The NSDA has vital priority areas in the health sector, which comprise the following:

1. Ensuring that the life expectancy of all South Africans increases
2. Decreased maternally and child mortality
3. Combating HIV and AIDS and decreasing the burden of disease from TB
4. Strengthening the health system's effectiveness (Negotiated Service Delivery Agreement (South African Government, 2011).

After reading various government reports, past studies from other countries, there is no clear implementation map or guidelines as to how South Africa will implement the NHI model. In order to examine how the NHI would be implemented the Thabo Mofutsanyana, a district in the Free State province, has been identified as a case study. With the growing financial constraints and operational challenges, there is a need to take off the ground with a pilot project. In addition, the researcher is resident and works in the Free State Province, therefore, undertaking this pilot project would help to assess the feasibility of implementing the NHI at national level.

1.3 PROBLEM STATEMENT

The main problem with the South African health system is that it is inequitable, with the privileged few having disproportionate access to health services. This system is neither rational nor fair. Therefore, NHI is intended to ensure that all citizens will benefit from healthcare financing on an equitable and sustainable basis. The NHI will provide coverage to the whole population and minimise the burden carried by individuals of paying directly out of pocket for healthcare services. The National Development Plan (NDP) states that if we need to fix the health system, we need to deal with the exorbitant cost of private health care and with the problems of the quality of the public health system. The goal of the National Health Insurance (NHI) scheme is to ensure access to quality healthcare services for all South Africans by providing some financial protection for all against any health-related expenditures. Although NHI has been very high on the South African health policy agenda, the transition has been uncertain. It remains contested in some quarters due to the lack of resources to adequately finance free health care (McIntyre and Van den Heever, 2007).

The implementation of the NHI scheme is dependent on a massive reorganization of the healthcare system, which aims to combine the two-tier public and private healthcare systems into one. When the NHI is fully operational, all health revenue will be deposited into a single fund and nationalised to benefit all patients. To achieve this objective, the Department of

Health (DoH) chose clinics and hospitals in eleven districts in all nine Provinces across South Africa for its pilot project of the NHI scheme and began implementation in stages in 2012. Thabo Mofutsanyana district was one of the pilot sites that could provide valuable lessons for full-scale NHI implementation.

The evolving NHI operating principle is to increase access to quality healthcare services for the entire population and provide a financial risk shield against catastrophic health-related expenditures (Green Policy Paper, 2011). Health care that is accessible to the populace can also be provided through a combination of approaches involving known and contracted public and private providers, with a strong focus on health promotion and prevention services at the community and domestic levels.

Challenges in implementation of the NHI, include fixing clinics, replacing those that can no longer be used by the community, working on staffing issues and addressing the attitudes of health workers. The Rural Doctors Association of Southern Africa (RUDASA) and several other organisations identified the main issues as understaffing in rural clinics and hospitals and weak management, poorly constructed structures and delays, which translate into long waiting times, poor quality of care, and avoidable deaths (Bateman, 2012). According to a report by Buthelezi (2019), even though many strategies had been put in place to prepare for the NHI, majority of hospitals and clinics in rural and urban districts were still unprepared for the implementation of this scheme.

The objectives of the pilots include testing the ability of the districts such as Thabo Mofutsanyana to assume greater responsibilities under the NHI, to assess utilisation patterns, and costs and affordability of implementing a PHC service package.

1.4 AIM OF THE STUDY

The aim of this study is to evaluate the feasibility of implementing the National Health Insurance (NHI) with Thabo Mofutsanyana district in the Free State Province as a case study. The findings from the study will be the basis for the recommendations that will be suggested for consideration by policy-makers.

1.5 RESEARCH OBJECTIVES

The objectives of the study were framed as follows:

1. To describe the district's challenges in implementing the NHI project to improve citizens' health.

2. To assess responsiveness in implementing the intervention projects in the Thabo Mofutsanyane district.
3. To assess the institutional support systems that enhance or delimit social and risk protection.
4. To assess the state of readiness to implement the NHI in the Thabo Mofutsanyane district
5. To make recommendations to government about necessary health system reconfiguration to realize improved efficiency of the NHI in the district.

1.6 RESEARCH QUESTION

Does implementing the National Health Insurance (NHI) in the Thabo Mofutsanyana district of the Free State meet national guidelines to provide quality health care to citizens?

1.7 SIGNIFICANCE OF THE STUDY

The study intended to delve into the discourse on the subject matter based on the background on NHI provided above. The study provided a comprehensive understanding of the NHI pilot program in the Thabo Mofutsanyana district regarding tracking and assessing the health scheme. On policy issues, it was hoped that the crucial proposition that local participation in the NHI pilot program cannot be overlooked in developing a robust health system in the districts would be advanced. The study contributes to ongoing discussions on South Africa's NHI scheme by carefully assessing the assumptions against the evidence from the literature. Furthermore, the research uncovers the models, methods, approaches, techniques, and frameworks employed in the piloting program. In this regard, the study's findings were used to inform and advise policymakers on the changing health patterns in the Thabo Mofutsanyana District. This aspect includes studies that add to the existing knowledge of the South African health insurance schemes, focusing on policy reforms. An overview of the theoretical framework that guided this study is presented in the next section.

1.8 THEORETICAL FRAMEWORK

The essence of a health system study is to unravel the challenges and successes of such a system to strengthen the health system by making recommendations that could help upgrade the health services. Other objectives include improving health outcomes and equity, determining how to finance such schemes and the social and financial risks they may pose to citizens, and determining how they can be effectively protected (Rosedale, Smith, and Wood, 2011). To achieve this, the researcher assessed the implementation frameworks and the

policies that add some value to the system, districts, province, and nation at large. Considering the South African NHI is a new health policy that the government and the people have adopted, it is, therefore, useful to apply a health systems theory to unravel the implementation process, which will be ongoing until 2025.

The research adopted the World Health Organisation's (WHO) (2007: 5) six health system building blocks as a theoretical approach. Below are the delineated six-building systems:

i. **Health Service Delivery:** "Good health services deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where they are needed, with minimum waste of resources".
ii. "A well-performing **health workforce** works in responsive, fair, and efficient ways to produce the highest healthcare outcomes possible, given resources available and situational factors." (That is, evenly enough distributed staff; they are competent, responsive, and productive.)
iii. **Health Information:** "A well-functioning health information system ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status".
iv. **Mechanisms of Health Financing:** "A good health financing system raises adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient".
v. **Medicines and Technology:** "A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness, and they are scientifically sound and cost-effective."
vi. **Leadership and Governance:** "Leadership and governance involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability." Further, the Da Vinci TIPS framework will be used to integrate and frame the discussion in this regard

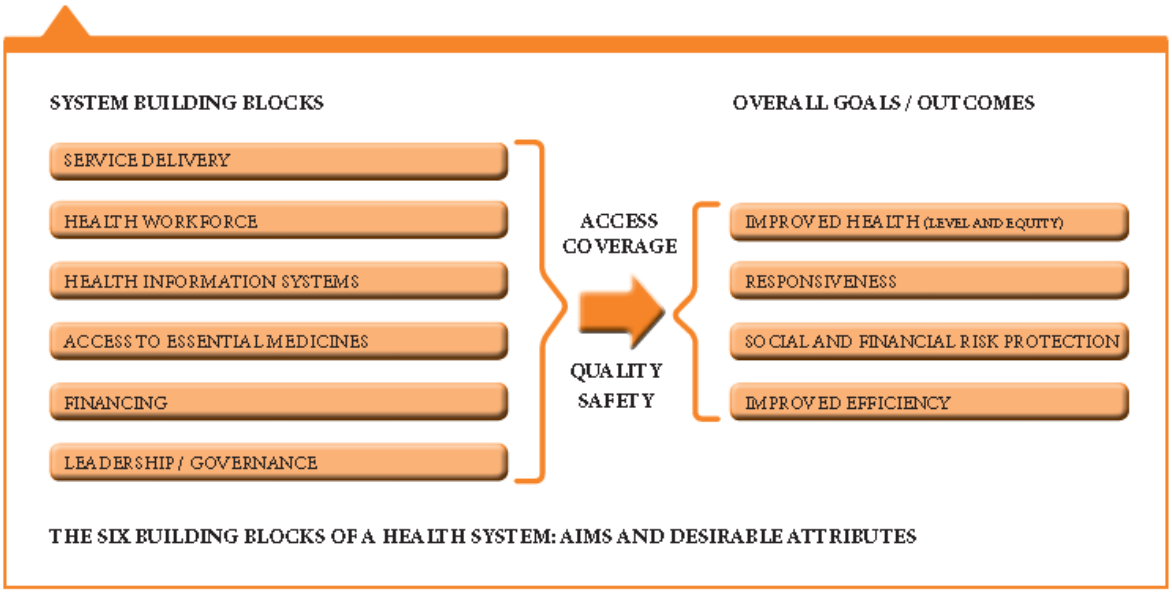

Figure 1:1 WHO Health Systems Framework

Source: WHO (2010)

The underpinning assumptions of the health system approach are to strengthen the systems in general and provide effective, efficient, equitable, and good quality health care while maximising accessibility (finance and proximity) to the entire population. This research to adopt the WHO's six building blocks as outlined in this section as a framework helped the researcher in exploring the prospects, worries, and awareness of the NHI health care system in South Africa by interviewing officials regarding the already implemented pilot of the NHI in the case study area. Notwithstanding the role of the WHO framework in health provision and strengthening health systems, the building blocks are independent. Neither is the role of communities in the process, the underlying social and economic determinates of health, nor the substantial interactions that exist across each component (WHO, 2010:4).

1.9 RESEARCH PHILOSOPHY

There are various scientific research paradigms in social science research, such as ontology, epistemology, axiology, methodology, and methods. Holden and Lynch (2004:3) argue that the methodological approaches are mainly grounded in the philosophical position of the researcher and the intended social phenomenon to be examined (Zukauskas, Veinhardt, and Andriukaitien, 2018). The following is a brief description of the three main philosophical approaches.

1.9.1 The Ontological Assumptions

Before expounding on the type of ontology the study used, it is noteworthy to define what an ontology is. Crotty (2003:10) avers that ontology is "the study of being". This research philosophy is based on questions such as "what kind of world/subject matter we are investigating, the nature of existence, and the structure of its authenticity." Guba and Lincoln (1989:83) corroborate this view by noting that the assumption underlying ontological research philosophy is to pose and respond to questions such as ‘what is there that can be known? ', or ‘what is the nature of reality’?

The researcher has been in the public service for several years and has gained significant policy experience. Moreover, the researcher is an ardent social activist with an incredible drive to make sure that people’s lives are improved. His philosophical outlook is grounded in the indigenous philosophy of Ubuntu, which places people at the centre of development as masters of their destinies. In the context of the definition of Ontology by Crotty (2003), the researcher has taken an ontological stance in this study, because of pursuance to answer the question which seeks to establish the relevance to the NHI system and its authenticity to alleviate the health care burden in the country.

In this era of the fifth industrial revolution, punctuated by a central focus on humanity, the researcher firmly believes that public policy should be framed to bring about real, meaningful, and effective change in people’s lives. NHI is both a catalyst and a means to achieve universal access to health. Access to quality health care is a major social issue in the entire world today. To accentuate this point further, the World Health Organisation (WHO, 1978:5) during the UN International Conference on Primary Health Care of 1978 "reaffirms that health, which is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector".

The study applied an ontological philosophy premised on the social world of experience and meaning. Ahmed (2008:5) describes ontological assumption as the study of being, concerned with the kind of world being investigated. In particular, the researcher used ontological philosophy to make assumptions about the subject under examination. This aspect included investigating the district occupied by human beings with varying perspectives, experiences, thoughts, interpretations, and meanings. This was highlighted through the research methods and techniques of the interpretive design, such as in-depth interviews with officials in the case study district. The study’s methodology focused on interviewing officials to gather their

perspectives on the implementation, the cost of financing, gaps in knowledge, and the government's quest to implement the health care scheme.

1.9.2 The Epistemological Assumptions

Crotty (2003:3) describes epistemology as "a process of understanding and explaining how we know what we know". The assumption underpinning epistemology is based on a "philosophical basis for determining what categories of information are possible to obtain and how that could ensure both adequacy and legitimacy" (Maynard, 1994:10 in Crotty, Ibid., 8). The epistemological assumption supporting this study is constructivism. Crotty (2003:42) defines constructivism as "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices being constructed in and out of the interaction between human beings and their world and developed and transmitted. It assumes that meaning is not discovered but constructed within an essentially social context.

The reason constructivism was adopted as the epistemological stance for this study was because of the researcher's goal of answering the research question: "How do NHI officials assert their expectations, experience, and designation as legitimate officials knowing that the citizenry is those going to benefit from the implementation of the NHI?" The NHI piloting programme in the Thabo Mofutsanyana district was looked into to answer the research question. Moreover, the epistemological position of the study aimed to extract the constructivist meanings conveyed within a social context derived from interviewing health officials from the district. Furthermore, the philosophical approach is also based on the fact that there is no valid interpretation. Hence, the findings of this study will not mean that they are reasonable, but rather that they are interpretations based on the interviews conducted. Similarly, the value of specific theories that "'establish' the relevance of class, gender, race, etc., by theoretical fiat instead of through an attention to the categories that are endogenous to specific, naturally occurring social relationships" (Berard, 2005: 215). Constructivism tends to give rise to practices (Charmaz, 2006:396). In this regard, the critical actors in the pilot implementation are interviewed. These included officials involved in the pilot study at national, provincial, and district levels; community healthcare workers; clinics; community members; and contracted General Practitioners (GPs).

1.9.3 The Axiological Assumptions

Besides the two research paradigms described above, some scholars have argued that social researchers should concern themselves with a third paradigm or factor called axiology. This research paradigm is premised on the "values of being, about what human states are to be

valued simply because of what they are" (Heron & Reason, 1997: 287). The implementation process is based on a participatory paradigm and, as such, tends to respond to axiological questions about human prospects. Heron (1996:11) argues that "processes of social participation in which there is a mutually enabling balance, within and between people, of autonomy, co-operation, and hierarchy. It is viewed as interdependent with the health of the planet's ecosystem." Implementation can thus be perceived as valuable and helpful. Implementation or decision-making based on a participatory approach could be a means to an end, "which enables people to be involved in the making of decisions in every social context, which affect their flourishing in any way" (Heron, 1996:11). The researcher abides by high ethical standards that acknowledge human integrity. As such, it was the researcher's responsibility to ensure all elements that define the trustworthiness of the qualitative research finding report were not doubtful. A trustworthy research report is characterised by credibility, transferability, conformability, and dependability.

1.10 RESEARCH METHODOLOGY

The current study employed a qualitative approach based on constructivist perspectives and used various strategies, including a case study in collecting data (Creswell, 2003).

1.10.1 Population and Sampling Technique

This study adopted a purposive sampling approach to select a sample. A purposive sampling technique was chosen since the method allows for the classification and inclusion of individuals the researcher deems relevant, knowledgeable, or experienced about the phenomenon in question (Creswell and Plano-Clark, 2011). Further, the study adopted purposive sampling because the strategy provides for the researchers' judgment to be relied upon when selecting a population for the study (Saunders, Lewis, and Thornhill, 2012).

The unit of analysis for this study was employees at the Free State Department of Health. These employees oversee the implementation of National Health Insurance in the district. They included twelve health and programme officials—two in each sub-district. The reason for selecting health officials was that the study focused on exploring and describing the challenges in implementing the NHI rather than relying upon statistical data. In this regard, the researcher attempted to discover and understand participants' experiences with the NHI. This way, the sample frame included beneficiaries of the NHI from the Thabo Mofutsanyana District. The researcher could not interview all the beneficiaries due to a lack of time and money. Therefore, a population size of 8–12 participants was selected. Subsequently, the population of the Free State Department of Health is between the ages of 18 and 65 years. Excluding participants

older than 65 is premised on the fact that they’re on a pension and reaching them is challenging. Subsequently, those younger than 18 could not give consent, thus providing the basis for their exclusion.

1.10.2 Data Collection Instruments

According to Bryman (2012), qualitative interviews seek detailed answers and rely more on the participant's point of view. According to Pessoa, Harper, Santos, and Gracino (2019), using qualitative interviews for data collection is beneficial because it allows the interviewer to elicit complex and in-depth information from interviewees. Based on these perspectives, the current study used in-depth, semi-structured interviews to collect data. Furthermore, qualitative case studies allow for various data collection methods (Bhattacherjee, 2012: 40). As a result, the researcher conducted focus groups with NHI beneficiaries.

1.10.2.1 Semi-Structured, In-Depth Interviews

For this study, in-depth interviews were adopted to collect data because answers are unclear and often challenging to manage in unstructured interviews. They only guide conversations or discussions (Gill, Steward, Treasure, and Chadwick, 2008). The researcher adopted face-to-face semi-structured interviews. According to Marvasti (2004), interviewing this way opens a scene in which participants can elaborate on their answers and connect them to other issues that the interviewer might not have been aware of. Boyce and Neale (2006) concur and state that in semi-structured interviews, the interviewer can probe the answers provided by asking "what," "why," and "how." Boyce and Neale (2006) argued that semi-structured interviews produce more detailed data about the individual’s behaviour and thinking, providing the opportunity to unearth emerging issues. However, in the case that conducting face-to-face interviews with the respondents was difficult, the researcher conducted the interviews online (via Microsoft Teams). Merriam and Tisdell (2015) advocate using online discussions as they remove barriers to conducting interviews, especially when the interviewer or interviewee is constrained by location. This is important considering the timing of the study and the need to abide by COVID-19 pandemic regulations on social distancing. Notably, the interview schedule was designed in English and translated into Sesotho, the most spoken language in the Thabo Mofutsanyana District. The researcher can speak and write the two languages, putting him in an excellent position to prompt responses and derive a better understanding of the topic. Each interview will be expected to last 45 minutes.

1.10.2.2 Focus Groups

Focus group discussions are dynamic and were used to capture the various views and opinions of the beneficiaries in the defined area of interest (Onwuegbuzie, Dickinson, Leech, and Zoran, 2009). The focus groups (FGs) were divided into sub-districts to gather perceptions of the challenges that hindered the pilot project implementation.

1.10.2.3 Documents Review

The researcher conducted a document review as part of data collection for the study. Document analysis is an efficient and effective way of gathering data because documents are manageable and practical resources. Ritchie, Lewis, Nicholls, and Ormston, (2013:35) concur that using documents is imperative as it allows the researcher to generate a holistic understanding of the topic by looking at what has already happened. In addition, records are readily available and come in various formats, making them a very accessible and reliable data source. They are also more cost-efficient and time-efficient than other data collection methods. The other reason for adopting this method for data collection is based on the fact that documents are stable, "non-reactive" data sources, meaning that they can be read and reviewed many times and cannot be changed by the researcher's influence or research process (Bowen, 2009). Based on this perspective, the researcher used baseline surveys, reports, white papers, articles, newspapers, magazines, and research papers that have a bearing on the study and will be relied upon to produce a content analysis. The reviews will include monthly and quarterly progress reports of the pilot, government policy prescripts, journal articles, and information on the pilot itself. These documents allowed the researcher to provide recommendations on how the government can reconfigure the health system and improve the efficiency of the NHI in the district.

1.11 DATA ANALYSIS

As mentioned above, the interview questions were designed in English and Sesotho. The data collected from the interviews were analysed using thematic analysis, and specific codes were assigned to information collected from the field. The researcher analysed respondents' responses to interview questions, including familiarising, summarising, paraphrasing, coding, categorising, and triangulating the data obtained (Turner, Cardinal, and Burton, 2017). This aspect included going through the data to identify differences and similarities in data and unforeseen insight (theme coding). After this, the findings were aligned with the study's aim, objectives, and literature (Pope, Ziebland, and Mays, 2000), from which the researcher would make recommendations.

1.12 DELIMITATION AND SCOPE OF THE STUDY

The study was conducted in the Thabo Mofutsanyana District in the Free State province. The district was specifically chosen as the case study. The study was confined to the implementation of the NHI. The study evaluated the challenges faced in implementing the NHI to assess responsiveness in the performance of the intervention projects in the Thabo Mofutsanyane district, to assess the institutional support systems that enhance or delimit the social and risk protection and make recommendations to the government about necessary health system reconfiguration to realise improved efficiency of the NHI in the district. In this study, the researcher collected information from health officials working on implementing the NHI in the district and the target beneficiaries of the NHI. Data were obtained from in-depth semi-structured interviews, focus groups, and document reviews.

1.13 CHAPTER OVERVIEW

This study comprised of six chapters organised as follows:

Chapter 1: Introduction

The first chapter of the current study provides a general background to the study. The chapter contains the problem statement, aim, and objectives of the study, as well as the research question. The chapter also briefly outlines the methodology and the theoretical framework, the significance of the study, delimitation, and the scope of the study. Lastly, the chapter provides an overview of the chapters in the study.

Chapter 2: Literature Review

This chapter presents the literature review. The chapter provide detailed accounts and information on the health finance reforms. Specific attention is on the Social Health Insurance and the NHI. It is important to review literature to obtain facts and information from others and how they arrived at their findings.

Chapter 3: Research Methodology

In chapter three, the research methodology and design are explained. The chapter includes the research philosophy, population and sampling technique, data collection instruments, data analysis, and pilot study. This chapter also provides an overview of the limitations encountered and the ethical considerations held throughout the study.

Chapter 4: Research Findings

In this chapter, the analysis of data that was collected from interviews, focus groups, and document review is presented. The findings from the study are presented, analysed and interpreted in line with the research methodology.

Chapter 5: Discussion of Findings

In this chapter, the findings from the analysis are discussed. It is important to discuss research findings so that readers obtain a better understanding of what is being addressed by the study.

Chapter 6: Conclusion

This chapter provides conclusions to the study. The chapter further offers policy and practice recommendations and advice for future research.

1.14 CONCLUSION

This chapter provides a background on NHI in South Africa. This is followed by a synopsis of the statement of the problem being identified, the study's objectives, and an overview of the research method and design that were used for the study. Other key issues that were discussed in this chapter include the significance of conducting the study, an overview of the theoretical work that guided the dissertation, research philosophy, methodology and how qualitative data were analysed in the study. The last section of the chapter provides a delineation and scope of the study followed by the structure of chapters in the study. The following chapter however, reviews the relevant literature.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter discusses the conceptual framework as well as a detailed review of the literature about the NHI. It is important to review the literature to understand what others have said and established in their findings. That will inform knowledge creation and theory building in the current study. The chapter provides a review of the literature on healthcare financing reforms against which the NHI will be accessed from South Africa's and Africa's context. The NHI model has been successful in other countries such as Rwanda, Brazil and Thailand. Those lessons will be brought to the South African context to establish what could be done to ensure its success is recorded in South Africa.

2.2 THEORETICAL FRAMEWORK

The researcher consulted widely a number of past studies to establish which theoretical frameworks were used that fit the NHS discuss of this study and the WHO Health Systems Framework developed in 2010 was adopted. It is acknowledged that explicating the notion of conceptual and theoretical frameworks in social and management sciences was difficult. This is attributed to the limited understanding and conflation of the two terminologies (Ngulube, Mathipa and Gumbo, 2012). Chigada (2023) states that theoretical frameworks are imperative in research because they help the research to verify what is already known rather than develop new theories. Therefore, the motivation for using a theoretical framework was to address the research question and to situate this study into a specific scholarly discourse. In addition, theory guided the research question of the current study, ultimately leading to data collection, analysis and discussion. Babbie (2012) asserts that theory is the cornerstone for the research because it provides a better understanding of the subject being investigated. For example, the concept of the NHI is not well understood in the South African context especially how it would be implemented and managed, therefore, an appropriate theoretical framework was required to understand this problem in its entirety. The use of a theoretical framework helped to limit the scope of relevant data by focusing on specific issues and viewpoints that were considered in analysing and interpreting research data (Leedy and Ormrod, 2019).

The essence of a health system study is to unravel the challenges and successes of such a system to strengthen the health system by making recommendations that could help upgrade health services. Other objectives include improving outcomes and equity, determining how to finance such schemes and the social and financial risks they may pose to citizens, and determining how they can be effectively protected (Rosedale, Smith, and Wood, 2011). To

achieve this, the researcher accessed the implementation frameworks and the policies that add some value to the system, districts, province, and nation at large. Considering that South Africa's NHI is a new health policy that the government and the people have adopted, it is, therefore, useful to apply a health systems theory to unravel the implementation process, which will be ongoing until 2025.

To this end the research adopted the World Health Organisation's (WHO 20) six health system building blocks. Below are the delineated six-building systems:

i. **Health Service Delivery**—"Good health services deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where they are needed, with minimum waste of resources." The WHO (2010) defines service delivery as the part of the health system where patients receive treatment and supplies they are entitled to. Nolte, Karanikolos and Rechel (2021) state that the definition of service delivery is convoluted however, the authors tend to agree with the WHO (2010) in that service delivery is a broad concept. The illustrations in Figure 2.1 below indicate that health services as one of the core functions of health systems. Murray and Frenk (2000) define health systems as a combination of inputs into a production process leading to the delivery of a series of interventions. The World Health Report 2000 (WHO, 2000) built on the conceptualization of service delivery as proposed by Murray and Frenk (2000), but it did not differentiate the service delivery function beyond personal and non-personal health service delivery.

   Given the above narrative, South Africa has been facing a number of heath delivery service challenges. These include inability to access and navigate specialised treatment such cancer, diabetes etc where specialists are required. People from poor communities cannot access these healthcare services because of inability to afford. Other areas do not have clinics let alone healthcare facilities. Some people travel long distances in search of healthcare services (Sigamoney, 2020). Mayosi (2014) asserts that health and healthcare in South Africa have not improved since the country became a democracy in 1994. Due to the unavailability of healthcare centers, some people die before receiving treatment. This is a huge cause for concern, which has to be addressed in line with the provisions of the Republic's Constitution of 1996 which makes it mandatory that every citizen has a right to healthcare services.

ii. A well-performing **health workforce** works in responsive, fair, and efficient ways to produce the highest healthcare outcomes possible, given resources available and "situational factors." (That is, evenly enough distributed staff; they are competent,

responsive, and productive.). The WHO (2018) states a well-performing health workforce is one that works in responsive ways that are fair and efficient whilst promoting gender equality and women's empowerment to achieve the best outcomes. These individuals utilize available resources and circumstances to achieve the best outcomes. The researcher of this study acknowledges that there has been a huge recruitment drive of healthcare professionals from Africa to work in Europe especially the United Kingdom. There are incentives and relocation allowances that are tied to the recruitment of these healthcare professionals. The drawback is that South Africa and the rest of the countries losing healthcare professionals depleted essential resources. It is costly to retain or train new resources to replace the ones that would have left.

Desirable attributes of a well-performing health workforce include being involved in the design of training and career paths and the development of the human resources policies and human resources management strategies (WHO, 2018). Female workers are legally protected from systemic gender discrimination and violence in education, continuing professional development, and employment systems. South Africa has been reeling from high levels of gender-based violence perpetrated on women and children. The unequal burden carried by women and girls in caring for those infected by HIV/AIDS is challenged and addressed. Health workforce leaders and managers routinely use data to conduct gender analyses to understand the structure, composition and gender dynamics in the workforce.

The employers should develop and enforce zero-tolerance policies, staff education and grievance reporting procedures to eliminate workforce violence and sexual harassment. Affirmative action programmes should be implemented to ensure that a significant percentage or health leadership and management positions are held by women.

iii. **Health Information**—"A well-functioning health information system ensures the production, analysis, dissemination, and use of reliable and timely information on health determinants, health system performance, and health status". Braithwaite et al. (2017) define health information as any personal information about your health or disability. It includes information or opinion about your illness, injury or disability. Some examples of health information include notes of your symptoms or diagnosis. information about a health service you've had or will receive. A health record includes information such as a patient's history, lab results, X-rays, clinical information, demographic information, and notes. Currently, the public healthcare system runs on

limited resources, thus, most of the record keeping and management is still done on a manual basis compared to the well-resourced private healthcare sector. Records are computerized and with the advent of telehealth, doctors in Gauteng Province can access a patient's medical history from another province provided the patient has visited the facilities under the same group of hospitals. For example, a patient from a Mediclinic hospital in Cape Town who visits a Mediclinic hospital in the Free State or the rest of the country does not need to call the Cape Town facility to get their medical report. The consulting doctor can access the record remotely using the Intranet. The records are kept in central database managed by the Mediclinic Group of Hospitals.

iv. **Mechanisms of Health Financing** "A good health financing system raises adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient". In 2005, member states of the WHO committed to attain universal health coverage (UHC) for their citizens. The WHO (2016a) defines the UHC as a process where all people receive health services they need without suffering financial hardships when paying for them. This definition aligns with the South African Constitution section 27(3) which provides that no one may be refused emergency medical treatment. Other subsections of the Constitution make it clear that every child has a right to basic healthcare services and that the environment should not be harmful to health and well-being. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation and palliative care". The WHO member states agreed on the development of their health-financing systems by strengthening the role of prepayment for health care while diminishing direct payments, which were seen as one of the barriers to access to health care (UHC, 2017; UHC, 2015; WHO, 2005). A detailed discussion on the financing of healthcare service will be presented later in this chapter.

v. **Medicines and Technology**: "A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness, scientifically sound and cost-effective." Blandford *et al.* (2019) state that nowadays some healthcare facilities have state of the art technology that allows intravenous medication administration. The practice of using smart infusion devices, where the device is integrated with information systems and drug libraries to set safe limits on medication administration, has been advocated to block critical medication administration errors. However, the importance of staff training and full implementation of smart features are imperative to reduce errors. The

main source of errors is staff overriding smart features. They conclude that smart infusion devices “could prevent medication errors and save lives when properly configured and used”.

vi. **Leadership and Governance** - "Leadership and governance involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability." Further, the Da Vinci TIPS framework will be used to integrate and frame the discussion in this regard. The importance of health management has been long noted and debated in South Africa. Between 2010 and 2014 the Negotiated Service Delivery Agreement identified health management strengthening as a core element of the country’s health system. However, since the establishment of the 2010 health management competency assessment, nothing has been said about the nature of leadership required within the country’s health system. Neither has then been any sustained engagement about how to develop leadership across the system. Gilson and Daire (2011) state that successful implementation of policies to promote equity and inclusion requires a focus on human interactions at the micro level, as well as the development of supportive institutional systems for financing, information and regulation.

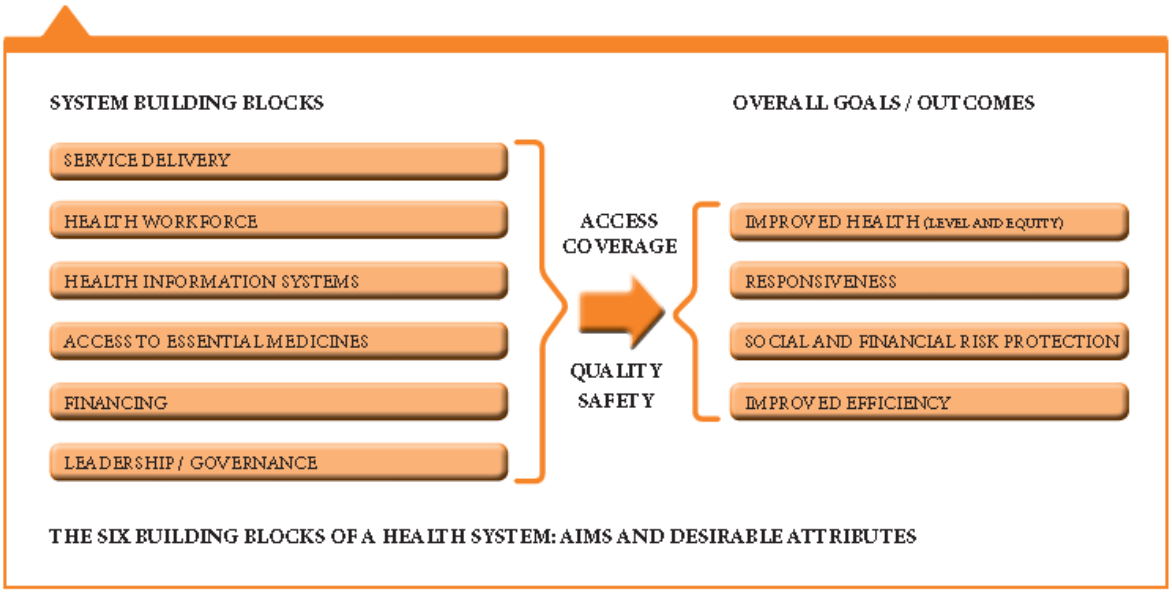

Figure 2.1: WHO Health Systems Framework

Source: WHO (2010).

The underpinning assumptions of the health system approach are to strengthen the systems in general and provide effective, efficient, equitable, and good quality health care while maximising accessibility (finance and proximity) to the entire population. This research adoption of the WHO's six building blocks as outlined in this section as a conceptual framework helped the researcher explore the prospects, worries, and awareness of the NHI healthcare system in South Africa by interviewing officials regarding the already implemented pilot of the NHI in the case study area. Notwithstanding the role of the WHO framework in health provision and strengthening health systems, the building blocks are independent. Neither is the role of communities in the process, the underlying social and economic determinates of health, nor the substantial interactions that exist across each component (WHO, 2010:4).

2.3 SUBFUNCTIONS OF HEALTHCARE FRAMEWORK

The discussion of this framework cannot be done without reference to the WHO framework discussed earlier. Nolte *et al.* (2021) divide service delivery into public health, primary care and specialist care. Public health is concerned with improving health and prolonging life and improving the quality of life among people in a country. The WHO (2020) states that public health is designed to eradicate particular diseases.

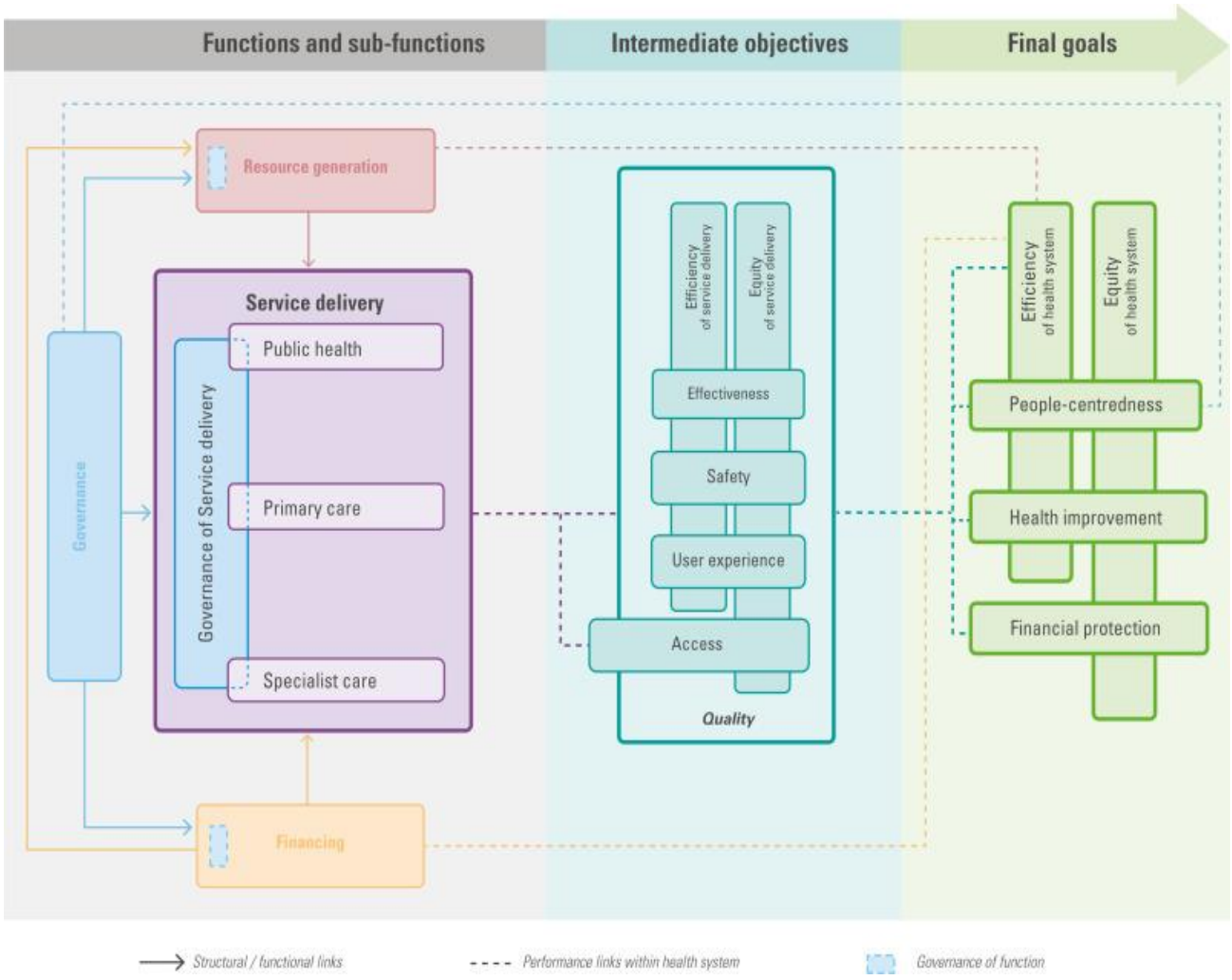

Figure 2.2: Service Delivery sub-functions

Source: Nolte, Karanikolos and Rechel (2021)

The practical application of this overarching understanding has remained complex, and globally there is considerable variation in terms of the essential functions assigned to public health (Martin-Moreno et al., 2016). However, there is greater variation around activities such as disease prevention, healthcare, emergency preparedness, social participation and communication within public health. The aims of defining essential public health functions vary and range from capacity-building exercises to strategies to improve the overall performance of health systems.

There is no agreed definition of primary care, however, the common understanding is that primary care is the first point of contact for unspecified and common health problems. These include healthcare centres, general practitioner practices or clinics as the primary level of care (WHO, 2018). There is a blurred distinction between primary care and specialist care. Many services that fulfil a wider public health function are provided in primary care settings (for

example, vaccination, and family planning), whereas in some countries primary care includes office-based specialists and fulfils a specialist care sub-function Concerning the Thabo Mofutsanyana District, most households access primary healthcare from clinics. However, the challenge is that a few healthcare centres are catering for over eight hundred thousand (800, 000) people. The patient-doctor ratio is not tenable. In addition, the district is classified as a poor rural area, therefore, specialist treatment could be a pipe dream for patients who may need such services. The alternative would be to drive to Bloemfontein which is a distance. This creates a high chance of death because of the distance that is travelled in search of specialist healthcare services.

Concerning Figure 2.2 above, specialist treatment is the third component of healthcare services. This is distinguished into secondary and tertiary care. Secondary care focuses on treatment provided at local hospitals, whereas tertiary care is highly specialised treatment delivered in regional or national hospitals in order to concentrate on expertise. For example, Mediclinic Group of Hospitals has highly sophisticated cancer diagnostic and treatment machines as well as experts (oncologists, gastroenterologists etc). The cost of specialist treatment is very high and beyond the reach of many patients. In a few instances patients on medical aid schemes can access these specialised healthcare services (Sigamoney, 2020).

The researcher of this study acknowledges that the delivery of healthcare services is changing due to technological developments, particularly telehealth and mobile technologies. These technologies make it possible for many service providers to be closer to their patients. In recent years, telehealth technologies allow diagnostic and therapeutic interventions that were only administered in a hospital environment but can be carried out in people's homes or ambulatory settings. In many countries there is also increasing recognition that the rising burden of chronic disease requires a different model of care, away from a dependence on hospital-based episodic delivery, towards one that offers some specialist care in the community. This is seen as a way to increase the accessibility of services, enhance continuity of care and service responsiveness, and, potentially, reduce costs (WHO, 2016a). However, South Africa is still lagging in these developments. The reasons for that slow pace of adaptation are beyond the scope of this study.

The governance of healthcare service delivery is core to each health system function. Governance provides the basis and structure for their function. South Africa has rules, regulations and organisation of health services. For example, the overall regulation and organization of health services is a task of the overall governance function of the system; whereas the purchasing of services and aspects of health service coverage is governed by

the financing function; and the planning and distribution of services is governed by the resource generation function.

2.3.1 Immediate Health System Objectives

Any health systems should have immediate and long-term objectives premised on quality. Frameworks on health systems are premised on seminal work by Donabedian (1998) who states that health services are evaluated on structure, process and outcome. As shown in Figure 2.2 above, the immediate objectives are safety, effectiveness, patient-centredness, timeliness, efficiency and equity.

Effectiveness: Extent to which a service achieves the desired results or outcomes, at the patient, population or organizational level.

Safety: Extent to which health care processes avoid, prevent and ameliorate adverse outcomes or injuries that stem from the processes of health care itself.

User experience: Extent to which the service user perspective and experience of health care is measured and valued as an outcome of service delivery.

Access: Extent to which services are available and accessible in a timely manner that does not undermine financial protection.

Equity: The extent to which the distribution of health care and its benefits among a population is fair; it implies that, in some circumstances, individuals will receive more care than others to reflect differences in their ability to benefit or in their particular needs.

Efficiency: Relationship between a specific product (output) of the health system and the resources (inputs) used to create the product (Palmer & Torgerson, 1999), distinguishing technical and allocative efficiency.

2.3.2 Assessing the Performance of Sub-Functions of Service Delivery

The regional or country-specific contexts determine how sub-functions are organised and financed. Therefore, it varies from one country or region to the other in terms of what constitutes good performance of public health. When one analyses the South African context, one can easily tell if the country's public health system is performing well or below par. Reports from patients, media and workshops paint a different picture altogether. The country's public health care system caters for almost 70% of the population, whilst private health care (medical aid schemes) cater for the remainder (Sigamoney, 2020). It is therefore important for South

African political leaders and policymakers to find ways to assess and improve the performance of the public healthcare system. Available tools use country self-assessments, questionnaires and case studies to evaluate the performance of a given public health function. However, there is no overarching framework for the assessment of public health services that includes real-world indicators (Williams & Nolte, 2018).

The achievement of sustainable development is anchored on primary healthcare services (Global Conference on Primary Health Care, 2018). Globally, it is increasingly becoming important to develop measures that assess the performance of primary health care. For example, initiatives such as the Primary Health Care Performance Initiative (PHCPI), launched in 2015 and the European Commission. The PHCPI focuses on care improvements in low and middle-income countries such as South Africa or the rest of sub-Saharan Africa (European Commission, 2018). The governance, financing and resource generation functions are the key elements for primary healthcare.

Specialist healthcare should also be assessed to ensure that it conforms to acceptable global standards and that patients receive value for money. There are reports in South Africa that one of the top hospital groups has been submitting fraudulent claims to medical aid schemes because patients did not have the mechanisms to check the veracity of claims. Unconfirmed reports state that these nefarious acts were a common practice by many hospitals and other private healthcare providers. Rechel *et al.* (2016) state that tertiary healthcare has been measured more closely in high-income countries and this has been done in the form of performance data of selected hospitals. In the South African context, existing data on quality care has been widely reported within vertical programmes and only focuses on specific areas of a health system. For example, maternal and child health, HIV and TB have been widely reported on for the public's knowledge.

Drawing on the two theoretical frameworks above, the researcher was able to discuss the research problem in its entirety. Some of the viewpoints shared within the context of the frameworks demonstrated that developed countries are using state-of-the-art technologies in medication administration. Some private healthcare facilities in South Africa such as Melomed, Mediclinic and the Panorama Cancer Care in Cape Town are at the forefront of using telehealth technologies. Concerning the use of frameworks, the researcher observed that no universally accepted model fits the needs of every country or region, however, the prerogative rested with the country and region in terms of what worked and did not work for them. The two theoretical frameworks complemented each other in many elements such as the type of healthcare, quality, leadership and governance, and financing, to mention but a few. Thus, the

researcher is convinced that some clarity has been provided in terms of the problem under investigation.

2.4 AN OVERVIEW OF THE NATIONAL HEALTH INSURANCE (NHI)

The National Health Insurance (NHI) is a formal sector socio-social-health programme (Onyedibe, Goyit, Gomam, and Nnadi, 2012). The rising cost of health services and the inability of government health services to cope with increased demands necessitated the establishment of the NHIS (Onyedibe et al., 2012). The NHI was initiated in the 1960s (Alawode and Adewole, 2021:2). Although the NHI received much attention in the early 20th century among the NHIS, the HMOs, and healthcare providers, the model reflects a public-private relationship between relevant stakeholders. As a result, the NHI provides health services with joint responsibility from the public and private sectors (Lopez-Casanovas, Costand Planas, 2003). In this instance, the government and businesses can regulate and facilitate the collection of funds from medical bills. The primary source of revenue for the NHI is the collection of taxes from the public to generate enough income for the public (Mathauer Saksena, and Kutzin, 2019:5). In practice, the health ministry will budget and allocate the collected funds to healthcare providers. After that, the health care suppliers will provide equal access to all people without purchasing power. Mathauer et al. (2019:5) argued that an external pooling and purchasing agency is required to manage and regulate the national fund with a purchaser-power split. In some countries, government oversight would include directly working with the healthcare system, while in others, it involves a combination of private and public delivery methods. Several countries, such as Germany, Japan, the Netherlands, amongst others, have sought to adapt the NHI in government healthcare planning and provision.

2.4.1 The National Health Insurance in Germany

Thomson and Reed, (2011:8) indicate that the SHI (statutory health insurance) covers at least 80% of the German population, while private health insurance covers approximately 10% of the population. Civil servants and the self-employed are the ones mainly using private health insurance. The rest (for example, servicemen and women, law enforcement personnel, and others) are subject to special autocracies. In a medical emergency, illegal immigrants are covered by social welfare. Since 2009, all residents and legal residents have been forced to buy insurance through statutory or private health insurance schemes (Thomson and Reed, 2011).

SHI covers preventative medicine, hospitalisation, physician visits, psychological counselling, dentistry, prescription medicines, medical aids, rehabilitative services, hospice care, and sick leave compensation. SHI's preventive services include routine dental and well-child consultations, essential vaccinations, disease consultations, and cancer screening at an elderly age. All prescription medications, including fully licensed ones, are covered except if expressly exempted by law (as is the case with lifestyle drugs) or after evaluation.

According to the Gemeneisamer Bundessausschus (2019:5), Local and state governments occupy a minimal role in the direct provision of health care. On the other hand, nations already have the majority of university hospitals, and municipalities enjoy a role in public health activities and own roughly half of the hospital wards. A substantial amount of control is assigned to self-governing neoliberal capitalist institutions such as insurance companies and provider associations. The Federal Joint Committee (G-BA), established in 2004, is the most crucial body.

2.4.2 National Health Insurance in Japan

Japan has a national social healthcare system with almost three thousand five hundred (3,500) insurers. Individuals and families (60% of the population) must enrol in the health insurance their employers offer. The remaining 40% (unemployed, self-employed, and retired) are covered by plans managed by their municipality or provincial government. All programs offer a similar set of benefits. However, individuals cannot select their projects. Those who fail to enrol must pay up to two years' worth of insurance premiums when they re-enter the system. Legal residents and long-term tourists must also procure coverage; noncitizens are not covered.

The legislated governmental compensation package includes medical and ambulance care, prescription medicines, and most oral treatments; eyeglasses are not covered. Long-term care has been hidden within its insurance scheme, which is administrated by local authorities. Screening, health education, and counselling are preventive measures for those aged 40 and up. The statutory benefits package also includes mental health care (Thomson and Reed, 2011).

In general, particular treatments are not separated as distinct professions in Japan as in other countries. Instead, specialists are mostly found working in community-based clinics, where they provide a variety of primary care services and are readily available without a referral. Because very few clinics have a formal scheduling system, clients must wait in the waiting room until they can be seen. Outpatient visits are typically brief but familiar in 2009, physician

visits per capita (13.9) were more than twice as frequent as the OECD median (6.2) and three times as frequent as in the United States (3.9). Almost all clinics dispensed medication (which doctors could provide immediately). Clinics are primarily physician-led, with nursing assistants playing a minor role in this process, unlike in the United States. Hospitals also offer outpatient care. On-call physicians typically provide after-hours care. However, there are few emergency departments in Japan.

Nonetheless, the efficiency, equity, and fairness of the healthcare system should be evaluated. Ease of access, quality, and integration are the three determining efficiency factors. Integration indicates that the process works and that the proper healthcare is provided, especially for life-threatening diseases (Fukawa, 2002). In other words, there is a reliable referral program in place. Based on these determinants, it can be concluded that Japan's health care system is accessible. However, its quality remains unknown due to a lack of data and systems methods to mitigate and ensure quality medical health care provision. Additionally, integration is poor since there is no clear and specific referral system (Gunji, 1994).

2.4.3 National Health Insurance in the Netherlands

According to Tapay and Colombo (2004:4) the Netherlands Health Insurance (NHIS) is primarily supported by income-based contributions from members. On the other hand, the formal economy contributes 15% towards SHI, while 15% comes from individuals' salaries. In comparison, individuals and households pay 5% for coverage. An employer may negotiate with an HMO for various additional supplementary benefits and pay the required other contributions. For those working in the informal economy (self-account), they are forced to pay monthly contributions based on their preferred benefits package. Membership fees are waived for the poor, elderly, veterans, and disabled.

2.4.4 National Health Insurance in Brazil

The Sistema Único de Saúde (SUS) is Brazil's national health system that reaches universal health coverage within the country. It is decentralized with administrative responsibilities at all levels of government: federal, state, and municipal. The delivery of care is handled at the state and municipal level. This system was established in 1988 and to date, the WHO (2022) estimates that 80% of the population has access to high quality healthcare services-both t public and private hospitals under agreement. In order to benefit from this system, the insured person must follow a specific care pathway, always visiting a basic SUS unit (posto de saúde or clínica da família) as a first step, which may refer them to another doctor or hospital if necessary.

Many Brazilians choose to obtain complementary solutions to cover for the remaining expenses and any care that is not reimbursed by the SUS. Such solutions include:

- Planos de saúde (health plans), which allow consultation within a local network of affiliated doctors and establishments;
- Cooperativas medicas (health co-ops), which allow members to access all care services provided by a single hospital in exchange for a contribution (or autogestão, when this solution is negotiated by a company for its employees).

A huge observation is that private health care insurance is less developed in Brazil. Residents benefit from the international insurance because it provides extensive coverage and they can be treated at an Institution and by a professional of their choice. This is the opposite of the South African context where the private health insurance through medical aid schemes is well developed, albeit very costly in terms of monthly subscriptions or premiums.

2.4.5 National Health Insurance in Rwanda

Rwanda's CBHI scheme is based on a long history of insurance schemes dating back to the 1960s. Building on experience, the Government of the Republic of Rwanda completed a series of pilot projects in the 1990s to assess financial viability and standardise insurance schemes nationwide. Consequently in 2004 it adopted a national policy to extend schemes to all 30 districts in the country. The official launch of CBHI in 2010 further enhanced delivery of services with an improved implementation structure and stable financial management. Investments in income security, such as the CBHI are essential in building Rwanda's social protection floor to ensure that all in need have access to basic income security, including all permanent and temporary residents and registered migrants (WHO, 2018). The social health protection system in Rwanda consists of Community-based Health Insurance (CBHI) schemes for formal and informal sector members, Rwandaise d'Assurance Maladie (RAMA), Military Medical Insurance (MMI), and private insurance schemes (WHO, 2018).

There is significant effort to develop the Rwandese healthcare system at national and community levels so that most people in the country can access affordable healthcare services. The country is nearing its objective of UHC and contributing to the International Labour Organisation's Social Protection Floors Recommendation, 2012 (202). It is reported that by 2011, 96 percent of the people in Rwanda were covered by the NHI. In line with a well-performing health workforce. The WHO (2016a) reported that the achievement of a high percentage coverage of the NHI is attributable to the linkages between health care centres and hospitals and communities strengthened by a total of 45,000 community health workers.

In addition, many healthcare facilities in Rwanda use technologies for the medication administration, routine surveillance of health events and reach out to people in rural and remote areas.

2.4.6 National Health Insurance in Thailand

Health care system in Thailand is an entrepreneurial health system with public and private providers. Public health facilities were rapidly expanded nationwide since 1961 when Thailand launched the first five-year National Economic and Social Development Plans (1961-1966). Private hospitals also play role in health services. However, they are mostly in Bangkok and urban area. There are also wide spread of private clinics and polyclinics in urban areas, most of them are owned and running out of hour by public physicians. Currently, Public health protection schemes Cover all Thai citizen, 7% of population are covered by public employee benefit schemes, The SSS covers 15% of population, and the rest (76%) are in the UCS. Number of Doctors, dentists, pharmacists, and nurses has tended to gradually increase every year and ratios of health care personnel to population were better. Regarding the education system and qualification for medical care personnel, dentists, pharmacists, nurses, and midwifery must be licensed pursuant to regulations of dental Council, Pharmacist Council, and Nursing council respectively; physicians are required to complete their degrees from medical institutions accredited by Medical Council of Thailand (WHO, 2018).

With reference to the above empirical research from other countries, the researcher can conclude that South Africa still has a lot to do if it has to get closer to what other countries have achieved. For example, the pace at which Rwanda, an African country in the same region as South Africa has achieved a lot of successes in their quest to provide coverage for everyone in the country.

2.5 NATIONAL HEALTH INSURANCE IN AFRICA

The Universal Health Cover was published in Africa in 2016 (Pauw, 2021). Since. various African countries have either started the implementation or have a draft policy, while others are still contemplating the UHC scheme (The World Bank, 2016). Ghana was also the first in Sub-Saharan Africa to propose an NHIS (Alhassan, Nketiah-Amponsah, and Arhinful, 2016). However, in comparison to countries such as France, Thailand, and the United Kingdom (Child and Mashego, 2019), most African countries have been unsuccessful in implementing UHC health systems. The challenges are primarily attributed to demographic disparities and economic, political, and social factors (Crinson, 2009). The World Health Organisation (2016) adds high mortality rates, malnutrition, the prevalence of chronic diseases, and insufficient

resources to the challenges faced in Africa. Using the example of Ghana as a case study, Kusi, Enemark, Hansen, and Asante (2015) reported low and stagnant enrolments in NHI. The authors cited socio-economic status and large household sizes as the reasons for households or individuals not being able to afford insurance (Kusi et al., 2015). The situation described is noticeable in other African countries as well. Thus, as a result, “cash and carry” health financing with out-of-pocket expenditures (OOPEs) of health financing is the only option (Okoroh, Essoun, Seddoh, Harris, Weissman, Dsane-Selby, and Riviello, 2018). However, other countries on the continent used to have Community Health Insurance Schemes (CHIS) or CHIS compounds, which also tend to be high-priced for the poorest groups (Atim, Grey, Apoya, Anie, and Aikins, 2001).

2.5.1 National health insurance in South Africa

The public and private sectors integrate South Africa's health system (Pauw, 2021). However, the country's healthcare system has been chastised for its inequity (Burger and Christian, 2018). This is because most of the population cannot access or afford private health care services, forcing them to rely on under-resourced and overburdened public health services (Krugg and Alacros, 2017; Rispel, Blaauw, Chirwa, and De Wet, 2014). Maseko and Harris (2018:23) recall apartheid-era top-down processes that reinforced racial and spatial disparities in public service access and, more importantly, public health outcomes. In recognition of the situation decoded above, processes towards a "participatory democracy" in South Africa have been marked by policies aimed at reforming health services in the country.

First is the National Policy for Health Act 116 of 1990. According to Van Rensburg (2012), the National Health Act aimed to re-evaluate the national healthcare standards and ensure equal provision of public health insurance. In May 1994, the National Health Policy established the Primary Health Care Facilities (African National Congress, 1994) to enhance health protection for the public. However, the fundamental human right of access to health services is incorporated in the Constitution, acknowledging the progressive realisation of this right given limited resources (Constitution, 1996). However, the democratic government is vulnerable to limited resources to implement the National Health Policy. Hence, the public plan of action has been continuous with amendments and re-establishment of updated public health policies, which includes the establishment of the White Paper for the Transformation of Health Systems (1997) and the National Health Act 61 of 2003 (Hassim, Heywood, and Honermann, 2008). The African National Congress (ANC), through these policies, has made significant progress in moving South Africa forward, most notably by recognising that health care is a human right (Giaimo, 2016). One considerable success has been the development of primary healthcare facilities to increase access to healthcare in rural areas (African National Congress, 2019).

However, Rispel (2016) claims that the government is constrained in operating the PHC facilities. This situation is exacerbated by the overburdened and under-resourced public health sector (McIntyre, Dohert, and Ataguba, 2014).

However, the National Development Plan (NDP) is instructive in its articulation that one of the critical challenges that must be dealt with in South Africa is the unaffordable cost of private health care (National Planning Commission, 2012). Mkhize (2019) contends that there is an increase in unaffordable cases of accessing personal health. This perspective is reinforced by the Department of Health (2017), which provides that the two-tier split between the private and public sectors is highly inequitable, with the private sector giving health services serving 16% of South Africa's population. The poor and those in the informal economy without social protection are however, side lined. Attendant to this is also the quality of public health care if the idea of universal health care (UHC) is realised. To this end, the UHC is being pursued in SA through the government's policy of NHI. Specifically, South Africa's White Paper on National Health Insurance (2017) highlights the need to ensure equity and reduce the divide between rural and urban access to adequate health services. Amando, Christofides, Pieters, and Rusch (2012) claimed that implementing the NHI would improve the population's health. Furthermore, prioritising PHC will improve preventative medicine measures and reduce hospital stays and associated costs (Amado et al., 2012). Notably, there is no single best method for implementing the NHI and ensuring universal health coverage (Yamey and Evans, 2015).

2.6 HEALTHCARE FINANCING REFORMS

Many developing countries are susceptible to a lack of economic growth to finance public health insurance. Therefore, health care reforms are critical social issues to plan for improved provision of equal and quality healthcare (Or, Cases, Lisac, Vrangbaek, Winblad, and Vevan, 2010:271). In developing countries, public money is expected or required to consider and finance health care reform plans. In the late 20th century, developing countries included public health care reforms in the Structural Adjustment Programme to help the governments reduce public spending. As a result, the public sector introduced prepayment and risk-pooling mechanisms (models). These models are established to achieve the objectives of the healthcare system. Healthcare financing is used to raise money for the public health sector (Blas, 2005). The models are, therefore, used to determine "how to assign benefits, how to organise providers, as well as how to outsource and pay for external services," efficiently funding public healthcare (Giedion, Alfonso, and Diaz, 2013:2). Furthermore, healthcare financing reforms are implemented in all countries around the world, including the social health insurance (SHI) model, tax-based insurance model, private health insurance model, NHI

model, and out-of-pocket model (Batalden, 2018; Shimazaki, 2013). However, for this study focus will be on SHI and NHI.

2.6.1 Social Health Insurance Model

Social health insurance (SHI) is a mechanism of health financing that reduces the burden of health services-related costs and shares the risk. It is a system of national social security and health insurance introduced in the eighties (Lawal, 2020). People shared the costs and risks of implementing the SHI to provide the general population with health insurance paid by a third-party through non-risk-related contributions that are kept separate from taxes or other legally mandated payments (Batalden, 2018). SHI is a multiple (dual) financial healthcare model. As a result, spending was reduced; meanwhile, the government improved healthcare status among German citizens (International Labour Organisation (ILO), 2016). The SHI benefited employees working at railways, power plants, and metal works.

SHI's primary welfare goals are to reduce significant out-of-pocket expenses, facilitate universal health coverage, improve healthcare delivery quality, and improve health and wellbeing (ILO 2008; WHO 2010). SHI can improve welfare by improving health status and maintaining non-health consumption goods by smoothing health expenditure over time and preventing a decline in household labour supply (Townsend, 1994). At the very least, insurance must provide excellent care with less financial strain by dividing tasks among all citizens and giving time to help those who become ill cope with daily life.

Social insurance aims to eliminate the regulatory burden of receiving primary healthcare and requires the healthy to help cover the cost of care for the sick; cross-subsidization is crucial (Enthoven 1988). However, when society considers paying for healthcare by giving healthcare coverage to some significant degree at the public's expense, such insurance plans provided through taxation or regulatory requirements are known as social insurance programs (Folland, Goodman, and Stano, 2004; WHO 2010). Inadvertently, SHI contrasts with a tax-based system wherein the Department of Health funds its network of amenities through general taxation that is paid for from a mix of expenditures and income (Wagstaff, 2009). While some operational costs may well be covered by extra-budgetary government revenue, SHI holds a governmental barrier between buyers and social care services, with beneficiaries needing to enrol in the insurance system. The provider’s payment depends on the delivery of healthcare or the admissions of beneficiaries to a particular programme.

For insurance, to fund UHC, the risk pool should have the following common attributes: government-mandated donations to the risk pool; significant numbers of people in the risk

pool, as collections with a small proportion could indeed not spread risk sufficiently but are too weak to accommodate immense health insurance costs; and that there is a substantial percentage of poor people, pooled finances will generally be partially funded from public finances (WHO 2010).

In general, SHI structures are characterised by independent or quasi-independent medical insurance, an overdependence on government budget allocations, and a clear link between these donations and the right to a delineated package of medical benefits (Gottret and Schieber, 2006). SHI enrolment is mandatory for employees and non-employees, and various incentives are available for people of different socio-economic backgrounds.

However, financial implications are just one of a few impediments to health-care access; the intensity of non-price barriers can sometimes be sizable, resulting in an alteration in the basis of health insurance on service utilisation for several demographic groups (Basinga, 2010; Toonen, 2009). Health insurance coverage, for example, may be of little use to families living in rural and remote areas with poor road infrastructure and limited transit options; low education and doubt may amplify such physiological drawbacks over the benefits of conventional medicine (Wagstaff, 2009). Although with health coverage, impediments to healthcare access tend to involve the location of the public hospital; an unawareness, skill sets, and capabilities in having to complete fill out forms and must file claims; a lack of financial resources to pay immediate registration fees; as well as doctors' insensitive behaviours toward an actual and perceived standard of care (Sinha, 2006).

According to Carrin and James (2004:4), over 60 countries have universal healthcare systems, starting with Germany which implemented this is 1883. Twenty-seven countries have implemented universal coverage (Carrin and James, 2004), while in the OECD countries, social health insurance is widespread. Nonetheless, it is used mainly in developing countries, including Latin America (Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, Peru, Uruguay, Republica Bolivariana de Venezuela, and others), and to a slightly lesser degree in Algeria, Kenya, Lebanon, and Tunisia. Many low- and middle-income countries have implemented or are considering instituting SHI systems (Bosnia and Herzegovina, China, Croatia, Estonia, Ghana, Hungary, Indonesia, the Kyrgyz Republic, Macedonia, Moldova, Morocco, Nigeria, the Philippines, Poland, and others).

Very often, policymakers view SHI as an effective way to raise additional health resources and decrease the financing burden of health care coverage (Carrin, 2002). There is also a strong presumption that individuals may be more willing to be taxed (pay payroll taxes) if a specific individual entitlement accompanies the tax (a benefit tax). In some cases, especially in

countries that experienced communist rule, social health Insurance provides an opportunity to reduce the state's role or build democratic and participatory institutions (as in China, Estonia, and Hungary). Finally, countries that used to have National Health Service systems or Beveridgean systems may experiment with social health insurance to improve the efficiency of the health care system by—outsourcing their health insurance coverage (as in Jamaica, Kenya, and Malaysia).

Frequently, policymakers perceive UHC as a beneficial solution to enhance health care services and lessen the burden of medical insurance (Carrin, 2002). Also, there is a widespread assumption that people are more ready and able to be taxed (pay payroll taxes) if an individual privilege is included (a benefit tax). Sometimes social health sometimes occurs, particularly in former communist parts of the world. For instance, in former communist parts of the world, in social health, Insurance presents an opportunity to minimise the government's role or create representative democracy and collaborative institutions. Ultimately, nations that previously had National Health Service or Beveridgean systems could trial social health insurance to help enhance the efficiency of the health care system by outsourcing other nations' health insurance coverage.

2.7 NATIONAL HEALTH INSURANCE CHALLENGES

Research studies as well as anecdotal evidence suggest that there are challenges regarding the NHI plan implementation. These include problems such as an increase in illnesses and a shortage of personnel to drive the project in South African public hospitals. Unfortunately, current indications are that the initiative has serious challenges to overcome such as poor infrastructure, budgetary constraints and lack of interest from other healthcare professionals. Furthermore, corruption issues may also need to be addressed if the NHI is to be implemented successfully. From being denied coverage to facing exorbitant out-of-pocket costs, insured individuals still face significant hurdles to accessing and receiving quality care. These issues highlight the need for comprehensive solutions that prioritize affordability and accessibility.

Access to health care is a basic right as stipulated in Section 27 of the Constitution (RSA, 1996). The majority of the citizens in South Africa do not have access to health care, as they mainly depend upon public hospitals which are not adequately resourced. The South African Human Rights (2017), notes that most of the citizens are unable to afford private health care. The results obtained indicated that 82 out of 100 citizens do not have medical aids; they exclusively depend upon the public health care (South African Human Rights, 2017). The public health system is heavily overloaded, hence the need to decongest the public sector. The major challenges that the public health system faces are shortage of health staff,

overcrowding due to lack of adequate infrastructure, long waiting hours that patients have to endure and lack of medication (South African Human Rights, 2017). These challenges have negatively impacted on the health quality service delivery. The South African government introduced the NHI scheme that is designed to come up with universal health coverage to enable the populace to access quality health care services regardless of the citizens' status and their social status (South Africa Parliament, 2017).

An acute shortage of financial and human resources has affected the implementation of the NHI scheme. There is a need for proper budgeting to enable proper utilisation of the meagre resources that are available. Lack of equipment, medical supplies, infrastructure and shortage of personnel are major challenges that affect the NHI project implementation (Maphumulo & Bhengu, 2019; Malakoane, Heunis, Chikobvu, and Kigozi, 2020). Budgetary limitations restricted the procurement of diagnostic equipment. The Department of Health is the custodian of the financing of hospitals and clinics. It is eventually impossible to procure modern equipment, replenish consumables and work towards the improvement of the health facilities without budgeting for these essential requirements (Manyisa, 2016). Human resource capital training is highly needed for the successful implementation of the NHI scheme. There is a need to align the strategic human resource capital to the NHI implementation programme to enhance the quality of health care service delivery in hospitals and clinics in South Africa (Stewart & Wolvaardt, 2019).

2.7.1 Impact of implementation of NHI scheme

For the NHI scheme to be effective there is a need to evaluate the impact of the scheme. Monitoring and evaluation of the scheme plays a pivotal role towards the addressing of the challenges that might be affecting the project implementation; this has to be done urgently if the project is to be effective. Lack of adequate information as a result of handling various groups taking care of the interventions in the pilot and non-pilot districts as well as lack of baseline measures are deemed to be factors hindering the variations in the establishment of performance indicators (National Department of Health, 2019).

The major impact on the NHI health care project is based upon the following variables which are the patient's dignity, autonomy towards decision making in health-related issues, patients' confidentiality, punctual consideration, sufficient patients health care, effective communication, technological support networks and choice of health care providers (Mirzoev & Kane, 2017).

Hanefeld, Powell-Jackson and Balabanova (2017) is of the opinion that a patient centred system should be endowed with quality throughout the health care range by taking into consideration the social norms, relations, values and societal trust. There is a need to have equity in the health care system, this can be achieved by proper utilization of health care facilities and this is highly critical to ensure that the health care facilities are adequately improved (Malhotra & Do, 2017). It is essential to ensure that the health care system is patient centred.

Although it is difficult to measure the health system impact, it takes strategy modifications and continuous monitoring and evaluation to achieve the anticipated health care outcomes. It is a prerequisite to measure all the health care system aspects and their responsiveness to the system (Health Sector Transformation Ethiopia Plan, 2021). Health care response is affected by a number of factors such as socio-economic factors, environmental factors and community factors. Patients should be satisfied with the health care service provision as well as the perceived quality care that they receive. If patients receive value in the health service delivery system, a positive responsiveness to the health care system is achieved. The expectations of the patients as to how they should be treated and the expediency as to when and how they are treated play a pivotal role towards the responsiveness of the performance of the health delivery system (Asefa, Atnafu, Dellie, Gebremedhin, Aschalew, and Tsehay, 2021).

2.7.2 Institutional Support Systems

Obsolete equipment has made it very difficult for the health care staff to effectively deliver effective health care services. Some equipment requires servicing and calibration. Hence, lack of service renders the equipment to be inefficient and ineffective. The use of current advanced equipment and technologies is required if quality health care service delivery has to be achieved. Poor record keeping challenges as well as monitoring systems can be solved by the availability of technology. Patients waiting time can be reduced due to the availability and use of technology (Netshisaulu, Malelelo-Ndou & Ramathuba, 2019). Integration of patients' health records plays a pivotal role towards the quality of the health service delivery system. There will be no need for patients to open up new files whenever they visit health facilities, if the patients' records are integrated. Complete medical records facilitate proper diagnosis of patients and proper treatments would be done due to the availability of the patients' medical history (Moyimane, Matlala & Kekana, 2017). Globally, health insurance has received much attention. Studies on health insurance mainly focus on financing and its contribution towards universal coverage and promoting quality health service delivery. Germany, Japan, and the Netherlands have adopted national health insurance schemes. Other countries, such as South Africa, are still contemplating the implementation of the NHIS.

2.7.3 NHI Systems Improvement

The improvement of the NHI systems will enable most of the patients who are unable to access private health care to access it, and this would eventually enable patients to make choices on the health care facilities that are available (South African Human Rights, 2017). Establishment of communication channels in wards will go a long way towards the improvement of effective communication between coordinators and medical staff as well as community leaders. Recruitment of pharmacists, increasing doctors and nurses would facility health centres to be effective. This would help to reduce the patients waiting times. Improvements of infrastructure are also critical aspects that need to be improved for the benefit of the privacy and confidentiality of the patients (National Department of Health, 2019).

Maphumulo & Bhengu (2019); Malakoane et al, (2020); Manyisa (2016) are of the view that improvement on the availability of human and capital resources will facilitate the procurement of medical stocks; pay the salaries of medical staff, improve on infrastructure, provide training to the medical staff to keep them abreast with the NHI health care project. It is highly necessary to ensure that proper budgeting is done, since achievement of the project objectives cannot be met without proper budgeting tools and practices.

Health centres need to be equipped with state-of-the-art technologies. Integration and keeping of patients' records requires efficient and effective technology. It makes it easy to keep and retrieve records at the click of a button. Patients waiting time is drastically reduced when records are readily available and easily accessible (Netshisaulu *et al.,* 2019). Complete medical records facilitate proper diagnosis of patients and proper treatments would be done due to the availability of the patients' medical history (Moyimane *et al.,* Matlala, 2017). Alignment of strategies with the strategic human resource capital will help to implement the NHI health care in South Africa (Stewart & Wolvaardt, 2019).

2.8 CONCLUSION

In conclusion, this chapter discussed the role of theoretical frameworks. It was revealed that theoretical frameworks help to situate the study in a specific scholarly discourse and they also help researchers to address the research question and problem under investigation. The WHO Health Systems Framework and the sub-functions frameworks were identified and adopted for this study because they complemented each other. The researcher addressed the research question and problem in-depth. The second part of the chapter focused on an overview of the NHI from a global perspective. Various empirical studies were drawn from other countries across the globe. Of particular interest was the discussion and lessons drawn from Rwanda

whose democracy is still very young but the country's 96 percent of its citizens are covered by the NHI. Challenges and financing models for the NHI were also discussed in this chapter. The next chapter describes the research design and methodology that was adopted for this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides an overview of the research design and methodology that was used in the study. The first section of the chapter provides an overview of the study setting. Which in this case is the Thabo Mofutsanyane District Municipality. This section is followed by a discussion of the philosophical stance that guided this study, then the research design. The other components of the research methodology discussed in this chapter include the target population, sampling strategies and techniques, data collection procedures data analysis, trustworthiness and ethical issues that were considered in this study. It is important to identify a cogent research design and methodology that allows a smooth process of conducting the study. Other researchers may replicate the study in other settings using the adopted research design Levitt (2021) asserts that generalisation and transferability to other settings are common problems in studies using a qualitative approach. However, the applicability of a study in another location rests with the researcher who wants to make the transfer and not with the original researcher.

3.2 STUDY SETTING

Thabo Mofutsanyane District Municipality (DC 19) is one of the NHI Pilot districts, a Category C municipality located in the Eastern Free State province and is bordered by Lesotho, KwaZulu-Natal, and Mpumalanga. These borders make it easy for the citizens from these areas to access health care services in the district. The N3 and N5 National Roads pass through the community, and the famous Golden Gate is found in the area on the slopes of the Drakensberg Mountains. This soft border arrangement negatively impacts the already strained district's budget and other resources. The community comprises six local municipalities: Setsoto, Dihlabeng, Nketoana, Phumelela, Mantsopa, and Maluti, a Phofung which is the most densely populated local area. The municipality is more rural and primarily agricultural; most households are in rural areas. The District has a total population of 714 062, of which 81.9% (584 81) depend on public health services (2015/2016), making health care services less likely to be accessible from the private institutions.

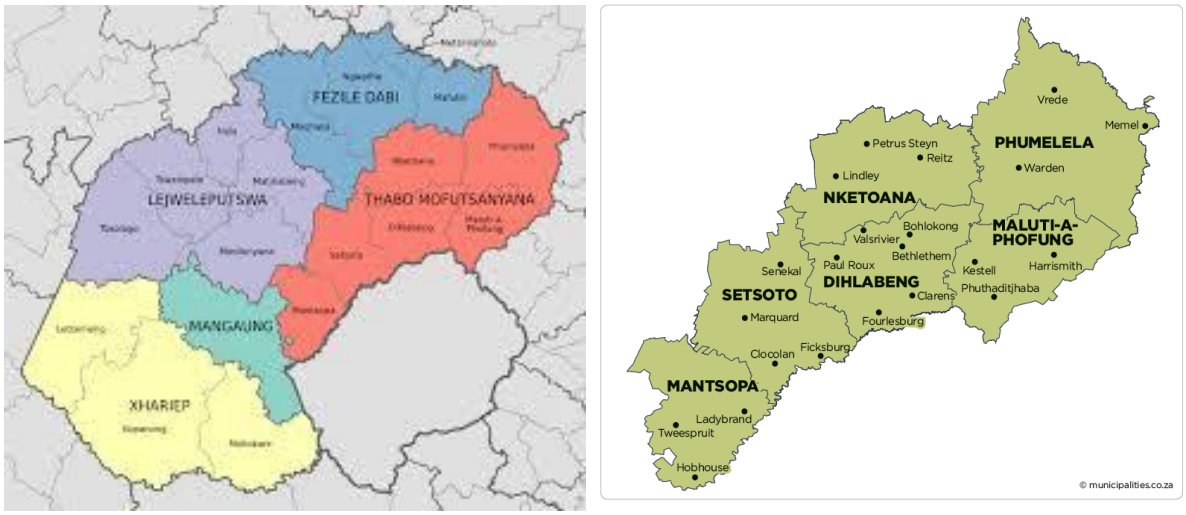

Figure 3.1: Districts in the Free State province and sub-districts in Thabo Mofutsanyane District

3.3 RESEARCH PHILOSOPHY

The term paradigm refers to an approach or belief in understanding problems and the worldview (Ochieng, 2009). The worldview is the thinking that informs the researcher's strategy to answer the research questions and the interpretation of research data (Kivunja and Kuyini, 2017). A paradigm shows an assumption of how a problem should be understood and addressed, it constitutes a way for the researcher to look and understand the world (Rehman and Alharthi, 2016). Hence, paradigms are essential as they influence study phenomenon, methodology, and the interpretation of the results. A paradigm informs the construction of meaning from the collected data based on experiences (Kamal, 2019). It is important to briefly discuss the four key elements of a paradigm and these are:

3.3.1 Ontology

Ontology refers to the assumptions made to believe the reality of something, and the nature of the phenomenon being studied (Rehman and Alharthi, 2016). It is the philosophical study of things that exist and their relations, that examines the researcher's belief system of the nature of social existence (Kamal, 2019). Ontology assists researchers in conceptualising the nature of reality and the belief of what can be known about that reality (Kivunja and Kuyini, 2017). Ontology empowers researchers to examine their belief system and philosophical assumptions about reality and existence (Ciesielska and Jemielniak, 2017).

The philosophical assumptions are important for researchers to make meaning of the data gathered (Rehman and Alharthi, 2016). These assumptions help to align the researchers'

mindset to the research problem, its significance, and the approach so as to contribute to its solution (Matta, 2022). Ontology underscores the foundational concepts such as themes that are analysed to interpret the research data (Erciyes, 2020). The importance of ontology to a paradigm is evident in better understanding the things that comprise the world, as it is known (Khatri, 2020).

3.3.2 Epistemology

According to Chen and Hirschheim (2004), epistemology describes the process to know the truth or reality, what is viewed as knowledge in the world. It focuses on the forms and nature of knowledge, the process to obtain and share it with other people (Chen and Hirschheim, 2004). Kivunja and Kuyini (2017) further assert that epistemology addresses the nature of knowledge, the researcher's ability to obtain an understanding of that knowledge, and to expand the understanding of the research field by contributing to the body of knowledge. When one considers their research epistemology, they should determine if knowledge can be obtained or it has to be personally experienced (De Villiers, 2005).

Furthermore, the relationship between the knower and the nature of knowledge should be determined (Matta, 2022). Also, the relationship between the researcher and what is already known should be identified (Erciyes, 2020). This is crucial as it positions and guides the researcher in the context of the research to explore what is new, considering the known (Kamal, 2019). Epistemology assists researchers to confirm the belief they put in the collected data, and it impacts how researchers discover knowledge in the social context that they will research (Scotland, 2012).

3.3.3 Axiology

De Villiers (2005) defined axiology as the ethical considerations when conducting research. According to Aliyu, Singhry, Adamu and Abubakar (2015), axiology covers the philosophical manner to make the right decisions. It includes the definition and determining what is viewed as right and wrong behaviour during research (Aliyu et al., 2015). Moreover, the value to be attributed to research aspects such as the participants, the data and the audience to which the results of the research will be reported is considered (Rahi, 2017). Axiology simply addresses the nature of ethics and ethical issues, as well as the consideration for human values of all the research participants (Chalmers, Manley and Wasserman, 2009). This consideration includes the values the researcher is guided or lives by while conducting the research, respect of participants' rights, the cultural, and moral issues (Aliyu et al., 2015).

According to Kivunja and Kuyini (2017), the considerations are guided by these ethical conduct elements, teleology, deontology, morality and fairness.

Teleology focuses on morality, and infers that doing what is right is a moral obligation that everyone dealing with humans should pursue (Ronzoni, 2010). Thus, teleology refers to attempts made in research to ensure that the research outcome is meaningful and persuades as many people as possible (Chatzistavrakidis, Erfani, Nilles and Zavala, 2012). Also, the research methods used should make common sense and be pragmatic, and the researcher should consider possible research consequences (Benlahcene, Zainuddin, Syakiran and Ismail, 2018). Teleological ethics prioritises what is perceived as good over right, and actions are evaluated by the goal or consequences that they achieve. Thus, correct actions are the ones that result to good mostly, whereas wrong actions do not contribute to the good (Yönden and Der, 2016).

3.3.4 Methodology

Rehman and Alharthi (2016) defined methodology as the process that advises a researcher on the selection of research methods. This includes participants, data gathering, research instruments, and data analysis. Methodology describes the process and manner in which a research will be conducted, and informs the researcher of the type of required data for a study, and determines data collection techniques that will best fit the study purpose (Krauss, 2005). Rahi (2017) asserts that methodology refers to the methodological question that guides the researchers how to study the world. Generally, the methodology clearly states the process flow of the study in order to acquire knowledge about a research problem (Chen and Hirschheim, 2004). That is, a researcher determines how they will obtain the required data and knowledge, which enables them to answer the research question and, in this manner, contribute to the body of knowledge (Kivunja and Kuyini, 2017). This study adopted a qualitative research methodology. Data were collected from participants' views and experiences. The researcher started with specific observations and then identified patterns and themes in the data collected (Kelly and Cordeiro, 2020). The data collected were made up of texts which were words from the participants, and the text was analysed for common themes in a subjective manner (Clark, Creswell, Green and Shope, 2008).

Many qualitative researchers believe that in order to get in-depth understanding of a phenomenon, it must be viewed it in its context (Conboy, Fitzgerald and Mathiassen, 2012; Posey, Roberts, Lowry and Hightower, 2014). Quantitative research informs the detachment of the researcher from participants, while qualitative research emphasises the importance of the researcher-participant relationship in order to understand the studied phenomenon (Clark

et al., 2008). Coccia (2018) argued that the selected method depends on the research question, what the researcher aims to know, and how the knowledge will be acquired. Furthermore, the research context and study purpose determine the methodological foundations of a study (Collins & Stockton, 2018). Both qualitative and quantitative methods address the research questions through some type of observation, these observations result in the researcher asking why what was observed occurred (Ravitch and Carl, 2015). Similarly, for data interpretation, some form of data analysis tool is used to produce meaning and verification techniques are used for data verification (Coccia, 2018).

The goal of a qualitative investigation was to understand the complex world of human experience and behaviour from the point of view of those involved in the situation of interest (Sutton and Austin, 2015). A qualitative approach allowed the researcher to grasp the point of view of the respondent (Thanh and Thanh, 2015). The ability of qualitative data analysis to generate meaning makes it a unique and powerful epistemological tool for understanding even seemingly ordinary experiences (Krauss, 2005). Hence qualitative approach was suitable and chosen for this research.

3.4 RESEARCH PARADIGM

The common types of research paradigms include positivism, Interpretivism, Advocacy and Pragmatism.

3.4.1 Positivism Paradigm

A positivist defines a worldview to research and is grounded in scientific research methods (Park, Konge & Artino Jr, 2020). The scientific methods include a process of experimentation that is used to explore observations and answer research questions (Paré, 2004). In this paradigm the principle of understanding human behaviour is based on observation, experiment, and reason from experience (Berkovich, 2018). Resultant in extended knowledge and human understanding. Positivism assumes the deductive approach to verify a hypothesis which is often represented mathematically, whereby operational relationships between contributory variables and the results can be obtained (Monethi, 2022).

This positivist paradigm emphasises the significance of big sample sizes instead of small sample sizes, as positivists use scientific methods to obtain knowledge through experiment and observation (Rahi, 2017). Positivism predominates in science, and assumes that science quantitatively measures independent facts about a single apprehensible reality (Aliyu et al., 2015). The positivists believe in empiricism, the idea that observation and measurement are at the core of the scientific endeavour (Krauss, 2005). Thus, the positivist paradigm follows

quantitative research methods to collect, analyse and interpret data, to understand relationships entrenched in the analysed data (Kivunja and Kuyini, 2017).

3.4.2 Advocacy Paradigm

This paradigm emphasises that social science cannot be entirely objective, and the research is based on social justice issues (Mertens, 2010). This paradigm aims to enact change through research, by addressing the economic, social, and political issues (Romm, 2015). These issues result in social struggle, oppression, power structures, and conflict at whatever levels they might occur (Rehman and Alharthi, 2016). The advocacy paradigm is also referred to as the transformative paradigm since it pursues change in politics, in order to confront social oppression and improve social justice (Sławecki, 2018).

The role of research in this paradigm was to promote critical consciousness, address social issues, and shift the power balance so that it could be more justifiably distributed (Kivunja & Kuyini, 2017). The research covered in the advocacy paradigm serves as an act of construction rather than discovery, which leads to liberation, increased social justice, and emancipation (Matta, 2022). Such research is characterised by examining conditions and individuals in a situation, based on social positioning (Rahi, 2017). The advocacy paradigm assumes a transactional epistemology, whereby the researcher interacts with the participants (Aliyu et al., 2015). Its ontology is of historical realism, especially as it relates to oppression (Aliyu et al., 2014). Its methodology is dialogic, and an axiology that respects cultural norms (Kivunja and Kuyini, 2017).

3.4.3 Pragmatic Paradigm

The pragmatic paradigm focuses on what is the appropriate approach for studying the phenomenon at hand, this paradigm promotes the use of mixed methods methodology to understand human behaviour (Maarouf, 2019). This paradigm assumes that relationships in research are best determined by what the researcher deems appropriate to that particular study (Chen and Hirschheim, 2004), and that there is no singular reality but all individuals have their own unique interpretations of reality (Morgan, 2014). A combination of qualitative and quantitative methods is used to conduct research that benefits people (Martina, 2010).

The research located within a pragmatic paradigm is characterised by the use of what works in that specific phenomenon (Rahi, 2017), to enable the researcher to answer the research questions with no concern as to whether the questions are exclusively quantitative or qualitative in nature (Rehman and Alharthi, 2016). This ensures that a worldview that allows

for a research design that is best suited to the study purpose is adopted, and the research methods are chosen based on the purpose of the research (Kivunja and Kuyini, 2017).

Various research modes enable researchers to understand diverse phenomena, the selected research methods are based on what one is trying to do rather than an obligation to a specific paradigm (Maarouf, 2019). Consequently, the selected methods should be aligned with that specific phenomenon under study (Erciyes, 2020), as different phenomena may require the use of different methodologies. Researchers can select appropriate methods for their research by focusing on the phenomenon under study, rather than the methodology (Krauss, 2005).

The positivism, advocacy and pragmatism paradigms were not suitable for this research. Since advocacy asserts that the study ought to be intertwined with both political and social issues (Ochieng, 2009; Rahi, 2017). This translates to research addressing issues of transformation such as inequality, suppression, oppression, alienation, empowerment, and domination (Romm, 2015). Whereas pragmatists assert that knowledge can be acquired using mixed methods (Bettis & Gregson, 2001). Furthermore, pragmatists put less importance on the method, but the focus is on the problem and promotes using all possible approaches to answer the research question (Khaldi, 2017).

3.4.4 Interpretivism Paradigm

The interpretive paradigm researchers believe in the deep understanding of a concept and explore the understanding of the world in which they live (Aliyu et al., 2015). These researchers develop subjective meanings of their experiences or towards certain objects (Heracleous, 2004). Interpretivist researchers discover reality through participants' views, their own backgrounds and experiences (Kivunja & Kuyini, 2017). Interpretivism promotes that knowledge can be obtained by deep interpretation of a subject (Khaldi, 2017). This paradigm provides a framework for researchers to study and understand people's beliefs, values, experiences, and attitudes (Sithole, 2019).

This paradigm's main focus is to understand the subjective world of human experience and interpret the mindset or the meaning made from the context (Guba & Lincoln, 1994). The aim is to understand the subject, their point of view and their interpretation of the world around them (Junjie and Yingxin, 2022). Moreover, the interpretivist paradigm emphasises that reality is socially constructed (Ryan, 2018). Hence, this paradigm is also called constructivism, social constructivism, or qualitative research paradigm.

Interpretivism paradigm assumes a relativist ontology, a subjectivist epistemology, a naturalist methodology, and a balanced axiology (Pervin and Mokhtar, 2022). The relativist ontology

assumes that there are multiple realities, which are intangible mental constructions and are specific in nature. The realities depend on the research participants holding the constructions for their content (Leedy and Ormrod, 2019). Additionally, the realities can be explored and meaning made of them by the researcher and participants (Thorne, 2014).

Given the above narrative, this study adopted an Interpretivist paradigm. The subjectivist epistemology assumes that the researcher and the research subjects are engaged so that the research outcomes are formed and recorded (Putnam and Banghart, 2017). Also, through their own thinking, the researcher was able to make meaning of the data and cognitive processing of data provided by interacting with the participants (Pham, 2018). The researcher gathered data through interviews and reflective sessions to produce construction (Alvermann and Mallozzi, 2010). The constructions can be improved through collaboration between the researcher and participants, and hermeneutical techniques are used to interpret these constructions (Heracleous, 2004). A balanced axiology assumes that the outcome of the research will reflect the values of the researcher, trying to present a balanced report of the findings (Thanh and Thanh, 2015).

The study implemented an epistemological philosophy since the study sought to find answers to the question, "How do NHI officials assert their expectations, experience, and designation as legitimate officials knowing that the citizenry is going to benefit from the implementation of the NHI?" This was done by utilising the NHI piloting program in the Thabo Mofutsanyana district. Moreover, constructivist meanings were conveyed within a social context that allowed the conduct of interviews and the obtaining of rich responses from the officials interviewed.

3.5 RESEARCH DESIGN

Research design can be defined as a process to identify research participants, collection and interpretation of data (Rahi, 2017). This is a whereby the researcher sets up a general plan that entails how to answer the research question (Choy, 2014). The adoption of any research strategy is based on the research objectives and problem statement (Kapur, 2018). Case studies, surveys and experiments are the most used research strategies. The study adopted a case study design to evaluate the challenges faced in implementing the National Health Insurance Scheme in the Thabo Mofutsanyana District.

According to Creswell (1998:61), "a case study is an exploration of a bounded system or a case or multiple case over time through detailed, in-depth data collection methods." Case study research, according to Bhattacherjee (2012), involves a comprehensive analysis of a problem in one or more natural settings (cases) and over a lengthy period of time. Data can

be gathered through interviewing people, direct observations, and reviewing documentation. The advantage of a case study is that it can expose various variety of cultural, political, and social factors related to the phenomenon being studied. Accordingly, when applied appropriately, the case study approach of inquiry can generate reliable accounts and evidence about the study subject, group, or individual (Harrison, Birks, Franklin, and Mills, 2017). Ritchie, et al. (2003:62) add that case studies allow the researcher to understand the interfaces between the participants and different perspectives. A further advantage of case studies is that they use multiple methodologies and sources as long as one can thoroughly investigate a research problem.

However, a case study, like other research designs, has limitations. It may provide little foundation for extrapolating the findings to a larger population; (2) the researcher's overexposure to the case selected may open the door for bias tendencies which may influence their understanding and interpretation of the findings. Furthermore, (3) the design does not allow for the unit of measure of cause-and-effect relationships. Lastly, the case may not reflect or be a character study topic (Sacred Heart University, 2020). Rowley (2002) posited that the historical use of case studies has continuously shown that the design lacks rigour and objectivity, unlike other social research methods. However, despite the critiques, case studies often showcase an understanding that different approaches might miss.

According to Formplus (2020), case studies take time. However, time is a limited resource in research. Another significant disadvantage is that it may be challenging to gain access to certain areas or neighbourhoods during the data collection process, affecting the research's validity (Formplus, 2020). Saunders, Lewis and Thornhill (2019) state that case studies permit exploration and understanding of complex issues. The NHI has been debated over and over again but, there is no one who can confidently explain how the model works and its benefits. Case studies provide a written description of a problem or situation. Yin (2018) asserts that case studies consider strong methods, especially when a holistic and in-depth investigation is required over a short period of time. Researchers can obtain facts as they occur in a natural setting especially when conducting interviews. In this study, the focus was on the NHI, therefore, it became apparent that face-to-face interviews, observations and document reviews were ideal for collecting data.

3.6 RESEARCH APPROACH

The research approach outlines the overall research plan selected by the researcher to answer the research questions (Monethi, 2022). Literature classified research approaches as deductive and inductive (Khan and Ullah, 2010; Casaca and Florentino, 2014). According to

Aliyu *et al*. (2015), deductive research is “a study in which a conceptual and theoretical structure is developed which is then tested by empirical observation, thus particular instances are deducted from general influences.” In a deductive study, empirical observation is used to test a theory, by moving from the general to the specific (Aliyu *et al*., 2015).

The deductive method of inquiry is based on inference by reasoning from general to specific (Coccia, 2018). A deductive study uses a theory to predict and explain observations empirically, and the assumptions are inferred and examined (Choy, 2014). This process tests the theory to validate, refute, or revise the theory (Khan and Ullah, 2010). Choy (2014) stated that the deductive method involves the theory design, defined theory assumptions, and analysis of those assumptions against reality. This is the foundation of the quantitative and positivist research approach (Saunders *et al.,* 2019).

Whereas in inductive research, the theory is “developed from the observation of empirical reality, general inferences are induced from particular instances, which is the reverse of the deductive method since it involves moving from individual observation to statements of general patterns or laws” (Aliyu *et al.,* 2015). Inductive inquiry begins with observing a phenomenon, data is collected to understand why it occurs, trends are examined (Rahi, 2017). Then from the data, a theory is derived to explain the phenomenon (Coccia, 2018). Choy (2014) revealed that the inductive method starts with the observation of specific processes so as to reach wider and more general statements based on the processes. From the research findings, the assumptions are inferred and a theory is created, this is the basis of the qualitative research approach (Aliyu *et al*., 2015).

For this qualitative study, an inductive research approach was used because of the interpretive nature of the study. The researcher depended on participants’ views and lived experiences, thus, allowed the researcher to collect comprehensive details on a specific phenomenon. Thus, it informed the inductive thinking since it moved from specific observations about individual occurrences to broader generalisations and theories (Rahi, 2017). This study was conducted in a natural setting, where the researcher was the data collection instrument (Creswell and Creswell, 2018). An inductive approach allowed the researcher to form an early tentative hypothesis that could be explored, however, as more data were collected, the conclusions evolved continuously. The results of the exploration later led to general conclusions or theories (Coccia, 2018). Ochieng (2009) states that an inductive approach is descriptive and widely used by interpretive researchers.

3.7 POPULATION AND SAMPLING STRATEGY

Population is the total number of people that are possibly the research participants to be understood whereas sampling is the process to choose a subset of the population for research (Guest, Namey & Mitchell, 2013). In this process a sample of units from a data set is selected in order to measure the attitudes, characteristics, and beliefs of the population (Boslaugh, 2007). The population of the study was 831 421 residents of the Thabo Mofutsanyana District. To include this whole population in a qualitative study was not feasible, therefore sampling was adopted to ensure participants were selected based on meeting the inclusion/exclusion criteria. Furthermore, a population includes persons that the researcher intends to study from a larger population. Based on this, the study evaluated the implementation of the NHI scheme in the Thabo Mofutsanyana District. Therefore, this study's population was drawn from the district, and the unit of analysis was health officials employed at the Free State Department of Health. They are responsible for overseeing the implementation of NHI. The population also included beneficiaries of the NHI from the sub-districts of Thabo Mofutsanyana.

A sample is a set of participants selected from the target population for the purpose of the study (Guest et al., 2013). Salkind (2010) defined a sample size as the total number of participants in the study. There are various arguments when it comes to the correct size when deciding on a sample size for qualitative research (Dworkin, 2012; Staller, 2021; Hennink & Kaiser, 2022). However, participants between five and twenty seems to be an acceptable number as a recommended guidance (Dworkin, 2012). Some researchers argue that the primary guiding factor for the sample size should be saturation (Mason, 2010; Salkind, 2010; Guest et al., 2013; Boddy, 2016). Data saturation is reached when there is sufficient data to repeat the research study when the capacity to obtain extra new information has been accomplished (Malterud et al., 2016), and when it is no longer possible for additional coding or repetition in responses starts occurring (Fusch & Ness, 2015).

Probability sampling and non-probability sampling are two commonly used sampling methods (Malterud, Siersma & Guassora, 2016). In probability sampling approach each participant has an equal chance to be selected while in non-probability sampling approach the chance of each participant to be selected is not confirmed (Staller, 2021). This study followed a non-probabilistic, purposive and convenience sampling technique. This approach is purposeful and suitable for a smaller population (Sefotho, 2015). A non-probability sampling technique is often used in exploratory and qualitative research. It is crucial for studying a specific group and probing certain important and attainable phenomenon for comprehensive analysis (Rahi, 2017). In purposive sampling the researcher uses their own judgement to choose participants who are knowledgeable about the phenomenon and satisfy the criteria of being considered to

participate in the study (Boslaugh, 2007). Whereas in convenience sampling the population is close at hand with ease of access for data collection (Sefotho, 2015).

The study adopted a purposive sampling of the National Health Insurance (NHI) officials and target beneficiaries in the TM district. In the words of Robinson (2014), selecting participants using a purposive technique allows the researcher to choose information-rich participants, mainly based on the researcher's defined criterion. In other words, the researcher's ability and judgment will be relied upon to identify and recruit participants who can provide specific and in-depth information (Babbie and Mouton, 2001). Thus, for this study, a purposive sampling technique was chosen since the method allows for the classification and inclusion of individuals the researcher deems relevant and knowledgeable about NHI implementation in the district (Creswell and Plano, 2011). Furthermore, the researcher acknowledged the importance of health officials in ensuring that government is responsive to community needs and services, expressly the Constitutional obligation that: ***"everyone has the right to health care services, including reproductive health care"*** (Constitution, 1996).

As demonstrated in Table 3.1 below, the sample included 12 health officials and programme officials – two in each of the six sub-districts. There will also be six focus group discussions with beneficiaries – one in each of the six sub-districts – with 8-12 participants each.

Table 3.1: Sample size estimation for data collection in the TM district

Sub-district	KIIs with health workers	FGDs with community	
		No of FGDs	**No of participants**
Phumelela	2	1	8-12
Maluti-a-Phofung	2	1	8-12
Nketoana	2	1	8-12
Dihlabeng	2	1	8-12
Setsoto	2	1	8-12
Mantsopa	2	1	8-12
Total	**12**	**6**	**48-60**

3.7.1 Key Informant Interviews

This method was adopted since the research is based on some key districts' health officials or respondents and assesses the critical political, social, and economic factors that have impacted the pilot programmes. The study utilised this method and examined the institutional challenges regarding NHI using the already implemented pilot programme in the Thabo Mofutsanyana District. Considering that the national health officials drove this pilot project, people with expert ideas and information on the research topic were interviewed. These included provincial NHI Projects Managers, the accounting officer for the Free State department of health, the senior manager responsible for District Health Services, District Manager, District Health Management Teams, District Chief Medical Officers, hospital chief executive officers (CEO's) and clinic and hospital governance structures.

3.7.2 Focus Group Discussions

This study paid particular attention to focus group discussion and dynamics to ensure that the various views and opinions in the defined area of interest were considered and fully captured during the data collection phase in this study (Onwuegbuzie, Dickinson, Leech, and Zoran, 2009). The focus groups (FGs) were divided into sub-districts to gather perceptions of the challenges that hindered the pilot project implementation. Because focus group discussions involve human subjects, it is essential to address issues relating to ethical concerns, trustworthiness and how data emanating from the study were analysed.

Participants for FGDs were purposively selected based on their knowledge of health services in the sub-district, experience in using local health services, serving in community structures or as beneficiaries of the national health insurance scheme. Participants in each sub-district represent various groups in the community, such as men, women, old, young, educated, uneducated, employed, unemployed, leaders and ordinary citizens, giving them enough time and opportunity to share. We will select 8 to 12 participants to provide them with enough time and opportunity to share their views and opinions on implementing the national health insurance in the district. Thus, the researcher will use the same category of selecting samples for each sub-district. Below is a tabulation of how the focus groups will be structured.

Table 3.2: Selection criteria of participants in the Thabo Mofutsanyana district

Sub-district	Number of participants per Gender/age group	Employment status	Level of education	Leaders/ordinary citizens
Phumelela	5 males and 5 females (18 to 55 years old)	Employed and unemployed	Educated and uneducated	Leaders and ordinary citizens
Nketoana	5 males and 5 females (18 to 55 years old)	Employed and unemployed	Educated and uneducated	Leaders and ordinary citizens
Maluti a Phofung	5 males and 5 females (18 to 55 years old)	Employed and unemployed	Educated and uneducated	Leaders and ordinary citizens
Dihlabeng	5 males and 5 females (18 to 55 years old)	Employed and unemployed	Educated and uneducated	Leaders and ordinary citizens
Setsoto	5 males and 5 females (18 to 55 years old)	Employed and unemployed	Educated and uneducated	Leaders and ordinary citizens
Mantsopa	5 males and 5 females (18 to 55 years old)	Employed and unemployed	Educated and uneducated	Leaders and ordinary citizens

Selection criteria for participants:

In FGD, homogeneity is key to maximising confidentiality among focus group participants. Thus, the following selection criteria for individual groups, as depicted in Table 3.2 above was followed:

i. Gender: Based on the study objectives, both men and women felt comfortable discussing the topic.
ii. Age: To avoid intimation, young adult participants were included in a group of young adults and the old in their respectful groups.
iii. Power: Power dynamics within the groups were considered to avoid people holding back in their remarks in the group.
iv. Cliques: Participants' selection was not based on relationships but rather on the person's position during the NHI pilot implementation**.**

Criteria for recruiting participants

Focus group participants can be recruited in several ways. The following criteria were followed in recruiting participants:

i. Nomination: The key individuals involved in the district NHI pilot project could nominate people they think could be good participants. Nominees who are familiar with the topic could share their opinions and are willing to volunteer during the hard FGD time.
ii. Random selection: To avoid 'overcrowding' the FGD groups, the researcher randomly draws from the number of desired participants for the discussion.
iii. All members of the same group- where there are already existing groups, the participants from such groups (e.g. Health providers) were invited
iv. Same role/job title based on the study objectives, the pool of participants for the FGD might be defined by position, title, or condition (e.g. community health nurses, pharmacist).

Running an influential focus group is a skill and requires planning. The WHO Patient Safety Programme has produced some training materials to prepare Nominal Group Techniques, which may be helpful in the preparation of focus groups. A nominal group interview is a highly structured technique designed to keep personal interaction between the interviewer and participants at a minimum level during the process of sharing ideas while maximising the individual contribution of each respondent (de Ruyter, 1996).

3.8 DATA COLLECTION

Any data collection method that results in a description of events or non-numerical information is considered qualitative research. According to Sithole (2019), there are several data collection techniques for qualitative research and interpretive approach, but interviews are the predominantly preferred technique. For this study the researcher chose data collection by means of semi-structured individual interviews as a primary source of data collection since it

can stimulate opinions and elaborations from participants (Salkind, 2010). It aims at establishing an insider's viewpoint of their social functions without declaring whatever moral judgements they might make during the data collection phase (Carter and Henderson (2005).

3.8.1 In-Depth, Semi-Structured Interviews

For this study, in-depth interviews were adopted to collect data because answers are unclear and often challenging to manage in unstructured interviews. They only guide conversations or discussions (Gill, Stewart, Treasurer, and Chadwick, 2008). The researcher adopted face-to-face semi-structured interviews. Interviews provide tangible information and permit the researcher to collect in-depth information from several people in different positions and situations (Myers, 2019) and conduct follow-up questions whereby responses are not clear (Boddy, 2016). These types of data collection techniques also enabled the researcher to collect credible information to address the study purpose (Mason, 2010). According to Marvasti (2004), interviewing this way opens a scene in which participants can elaborate on their answers and connect them to other issues that the interviewer might not have been aware of.

Interview questions were developed to answer the main research question and sub-questions. The questions covered the core functions that pertain to the NHI and feasibility of using the framework in South Africa. Prior to the commencement of each interview the researcher gave the background and the study purpose, read participation information and requested the participants to sign a consent form. All participants were asked the questions in the same sequence in order to elicit and correlate data consistently and to avoid bias (Dworkin, 2012). Boyce and Neale (2006) concur and state that in semi-structured interviews, the interviewer can probe the answers provided by asking "what," "why," and "how." Boyce and Neale (2006) argued that semi-structured interviews produce more detailed data about the individual’s behaviour and thinking, providing the opportunity to unearth emerging issues. However, in the case that conducting face-to-face interviews with the respondents was difficult, the researcher conducted the interviews online (via Microsoft Teams). Merriam and Tisdell (2015) advocate using online discussions as they remove barriers to conducting interviews, exceptionally when the interviewer or interviewee is constrained by location. This is important considering the timing of the study and the need to abide by COVID-19 regulations on social distancing. Notably, the interview schedule was designed in English and translated into seSotho, the most spoken language in the Thabo Mofutsanyana District. Each interview will be expected to last 45 minutes.

According to Bryman (2016), interviews are typically audio-recorded and written down as notes in qualitative research. Since the person leading the discussion must focus solely on what is said, it is preferable when they're not occupied or disturbed by writing notes on what has been presented. To collect the required information for the present study, the researcher interviewed critical informants in Thabo Mofutsanyana. Notably, the present study followed McKenna and Main's (2013) criteria for selecting key informants: (1) they must hold a government position in the study area; (2) possess the knowledge as well as timely, accurate information; (3) must be willing to share such knowledge and information, (4) reflect objectivity, and (5) they must communicate well in English.

3.8.2 Focus Group Discussion

The researcher utilised the focus group discussion to obtain information from the participants (NHI beneficiaries or community members) about the program. Van Eeuwijk and Anghern (2017:2) noted that "the focus group discussion is a qualitative research method and data collection technique in which a selected group of people discusses a given topic or issue in-depth, facilitated by a professional, external moderator." During the session, the group being interviewed can probe each other's responses and allow others to modify their responses (Bryman, 2012:501). In addition, during focus group sessions, a wide range of issues relating to the topic or case can be explored. Rabiee (2004:656) believes that focus groups provide "information about a range of ideas and feelings that individuals have about specific issues, as well as illuminating the differences in perspective between groups of individuals." As a result, the researcher ends up with realistic accounts of participants' perspectives because they are forced to think and revisit their views. Specifically, focus group sessions are helpful when evaluating government programs (Heary and Hennessy, 2002:50), including health programmes, to explore the perspectives of patients or beneficiaries on the health care system (Menold and Tausch, 2016).

According to Bryman (2012:501), focus groups consist of more than one interviewee and moderator. FGDs may also represent homogenous groups depending on the study's purpose. However, diversity in the composition may enhance the quality of the discussion. As such, the SDGs conducted in this study consisted of beneficiaries from the sub-district of Thabo Mofutsanyana and employees from the Department of Health. Importantly, findings from the discussions were used in the reporting of the results of the study. Each session had eight to twelve target beneficiaries. Responses from focus groups were tape-recorded and later transcribed. The duration of the focus group discussion was two hours, and refreshments were served at the end.

3.9 DOCUMENT REVIEW

Document or record review is a qualitative method used to collect data after reviewing the existing documents. Document analysis is an efficient and effective way of gathering data because documents are manageable and practical resources. Records are readily available and come in various forms, making them accessible and reliable data sources. Obtaining and analysing documents is more cost-efficient and time-efficient than other data collection methods. Again, documents are stable, "non-reactive" data sources, meaning they can be read and reviewed frequently and cannot be changed by the researcher's influence or research process (Bowen, 2009).

The NHI project is under a specific ministry; as such, a baseline survey, reports, white papers, articles, newspapers, magazines, and research papers that have a bearing on the study will be relied upon to produce a content analysis. The researcher conducted an intensive search and review of documents, including monthly and quarterly progress reports of the pilot, government policy prescripts, journal articles, and information on the pilot itself. Table 3.3 provides detailed accounts of the documents the researcher reviewed with the topic under investigation.

Other important procedures that were followed during the study were to observe the COVID-19 protocols and these include:

i) Educate data collectors and communities about COVID-19

The researcher informed the moderator about the need to protect himself and others participating in the study, particularly against the COVID-19 virus. This included equipping them with the necessary information on COVID-19, how it spreads, how they could catch the virus and infect others, and those symptoms take a while to appear.

ii) Account for personal protective equipment (PPE)

The researcher, moderator, and respondents were provided with masks and hand sanitiser gel when entering the venues.

iii) Interview procedures

The researcher took extra precautions when interviewing people who were elderly and sick (including cough). Other tips to keep in mind: Maintaining distance that was greater than 2 metres; Where necessary, opt-out of interviews with the elderly and coughing and immune-

compromised, rather than strictly using extra caution and use of scripts and role-play practice to help team members graciously opt-out of interviews if they decide to do so.

iv) Planning and executing training and debrief

Since data collection is often accompanied by training and regular debriefs. The project has put in place efforts to make these as safe as possible; these include conducting online training and doing online debriefs.

v) Practice hygienic behaviour

Practice excellent hand hygiene by washing hands with soap and water or using a hand sanitiser. Use hand hygiene at the following points throughout the day: After coughing, sneezing, or blowing your nose, touching your eyes, mouth or nose. After each interview or other social interaction, close physical contact with anyone unwell; after travelling, after exchanging money; after using an ATM; before and after eating and after using the toilet. Hand sanitising guidance includes applying the gel product to the palm of one hand (read the label to learn the correct amount); Rub your hands together; Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds. Other hygienic tips include sneezing and coughing into an elbow; don't spit; try to avoid touching your face and washing and sanitising if you do and cover your mouth/nose with a scarf kerchief or bandana.

vi) Practice social distancing during in-person meetings

Change greeting practices: Data collectors will be reminded to maintain a physical distance of at least two arm-lengths when greeting each other, including hand-over-heart or forearm-to-forearm greetings.

Table 3.3: Summary of data collection methods and data collection tools

Building block	Methodology	Data collection tool
Health Service Delivery	FGDs with community Document review	FGD Guide Document review guide
Health Care Workforce	KIIs with health officials Document review	KII Guide Document review guide
Health Information	KIIs with health officials	KII Guide
Health Financing and its Mechanism	KIIs with health officials Document review (Health Budgets	KII Guide Document review guide
Medicines and Technology	KIIs with health officials	KII Guide
Leadership and Governance	KIIs with health officials FGDs with community	KII Guide FGD Guide
Health Service Delivery	KIIs with health officials FGDs with community	KII Guide FGD Guide

3.10 PILOT STUDY

A pilot study refers to a trial session through which it can be determined whether the methodology, sampling technique, data collection methods and analysis implemented are appropriate for the study (Bryman, 2012). For others, a pilot study denotes a dummy run of the survey (Robson, 20032:385). The aim of conducting a pilot study is to allow the researcher to establish whether the research can be completed and to foresee any problems that might arise so that alternatives and corrections might be made to ensure the feasibility of the study. Based on this perspective, the researcher conducted a pilot study with two respondents who were not part of the main study. The purpose of pilot study is to conduct a mini study that simulates the final research by testing the appropriateness of the questions, facilitating the researcher as a research instrument to gain practice and experience in interviewing skills and

flow of conversation (Majid, Othman, Mohamad, Lim and Yusof, 2017; Malmqvist, Hellberg, Möllås, Rose and Shevlin, 2019). The researcher first drafted the interview questions, structure, content and themes. The questions were submitted to the supervisor in order to review the relevance, wording and language used and also to ensure that there was no violation of ethical issues (Ismail, Kinchin and Edwards, 2018).

For this pilot study, three sample elements were chosen. The members were interviewed and each interview was less than 45 minutes to consider the participants' other commitments (Majid *et al.,* 2017). The sample elements assessed and gave recommendations to ascertain that the questions were objective and probing enough to acquire sufficient data. During this process, the interview schedules were tested. Therefore, it came to the researcher's attention that most of the population in the Thabo Mofutsanyana sub-districts encountered problems understanding English. As a result, the researcher translated questions to Sesotho.

A carefully organised and managed pilot study could potentially increase the research quality because the outcomes can inform subsequent parts of the research process (Malmqvist et al., 2019). Overall, the pilot study was helpful to the researcher to assess practically how the research process is likely to work, and deciding how best to conduct the final research study. As a result, during the pilot study the researcher refined a few interview questions. Also, the pilot study highlighted a practical estimate of how much time, effort and resources will be necessary to conduct the final research.

3.11 DATA ANALYSIS

According to Myers (2019) the analysis of data is a crucial step of the study as it allows the researcher to interpret and convert the data collected to make sense out of the data. The recorded interviews were transcribed, the researcher carefully listened to the participants' responses in order to accurately capture them. In qualitative research, data analysis is a process whereby the researcher systematically explores and organises all the information obtained from, but not limited to, interviews. The information collected is deeded to help the researcher to get a better understanding of a phenomenon. The contents of the transcripts can be analysed using techniques based on the grounded theory method, thematic analysis, qualitative content analysis, or other analysis approaches. However, for this study, a thematic analysis was used because the study hunts for themes and draws conclusions from the data collected. As mentioned, interview questions were designed in English and Sesotho. However, during the focus group discussions, Sesotho was preferred.

There are several methods to performing thematic analysis, including familiarising, summarising, paraphrasing, coding, contextualising, and triangulating data (Turner, Cardinal, and Burton, 2017). At the familiarisation stage, the researcher did an in-depth evaluation and interpretation of the field data while generating a comprehensive and objective synopsis for further analysis. Furthermore, the researcher used to identify the initial codes from the transcripts, which helped to explain the data in nature and context. Subsequent to reviewing the transcribed data, the qualitative data analysis (QDA) method of coding was used to establish what is important to answer the research topic and questions (Ravitch and Carl, 2015). Coding qualitative data is integral to QDA approach, the coding process entails assigning a code to a segment of a material. A code can be described as a label used to name phenomena in a text or an image, a code can be a word or symbol that is applied to characterise a sentence, paragraph, or colour code entire text (Braun & Clarke, 2022). When using coding, the data collected is labelled and organised into certain categories or themes (Myers, 2019).

The regulations were generated by properly scrutinising the field data, unravelling the missing and linking accounts as well as the content of the data to a more significant extent. This was a holistic process or delineation of some critical categories to better encapsulate the meanings and connotations and unpack the field data's subtext. This approach helped bring out the key and specific activities, local perspectives on NHI policy, and the inherent nuances and events in the data. At this point, all issues discussed during focus group sessions were arranged to answer the research study's objectives. The themes were identified using Microsoft Word format, which was used as an input to Atlas.Ti software auto coding function to search for keywords from the final codes on all the documents. The codes were colour coded according to themes. According to Braun and Clarke (2022), thematic analysis helps not only make visible the various elements that need to come together for successful qualitative analysis characterized by integrity, but also to consider how they connect and build on each other (Braun and Clarke, 2006). Thematic analysis provides accessible and systematic procedures for generating codes and themes from qualitative data (Clarke and Braun, 2015) and flexibility in terms of research question, sampling size and constitution, data collection method, and approaches to meaning generation (Braun and Clarke, 2012).

Triangulation means using multiple data sources to strengthen insights and findings from the study. The data sources that were triangulated in this study include primary information that was collected directly through KIIs and FGDs and secondary information collected indirectly through document reviews. Data triangulation has helped this study to develop a

comprehensive understanding of phenomena and to test validity through the convergence of information from the three different sources (Carter, Bryant-Lukosius, et al., 2014).

3.12 ETHICAL CONSIDERATIONS

Monethi (2022) emphasised the application of moral values and adhering to ethical requirements throughout the research project. Adherence is not only crucial to protect the participants; the researcher and the university reputation is also protected. This is done by ensuring participants' privacy, consent of study participation, maintaining anonymity and confidentiality of the participants and the name of the state-owned company used as the research site. The organisation and research participants' privacy were maintained to ensure the research credibility. The collected data for this research was securely stored on an electronic Google Drive and was used only for the purpose of this study. Based on the nature of issues involved, human subjects in any research process, be it through interviews or focus groups, end up being stressed out when there is no demonstrable assurance to participants that they may not be harmed physically, emotionally, or psychologically (Arifin, 2018). The author further argued that applying appropriate ethical principles is essential in qualitative studies to protect human subjects.

Before every interview, the researcher explained the study purpose, the research participation information, and the consent form was signed by all the participants. The consent form covered the recording of the interview, anonymity, privacy, and confidentiality. The participants were informed that their participation in the study is voluntary and have freedom to withdraw from the study at any time. Furthermore, the researcher explained to the participants that their identities and that of the research site will be kept anonymous and confidential as the pseudo names will be used to identify the participants. Personal details of the participants were collected for the sole purpose of scheduling interviews.

In maintaining high ethical standards, the researcher adhered to the following principles:

i. **Honesty and Integrity;** The researcher ensured honesty and integrity. Ethical approval was obtained from the Da Vinci Ethics Committee as a starting point. The approval thereof was shared with the participant ensuring that they gave informed consent to participate in the study.
ii. **Gatekeeper;** Secondly, the study occurred in each geographic area, under the provincial department's authority as a gatekeeper. As such, the researcher obtained approval to access and interview participants from the competent authority.

iii. **Voluntary participation;** The researcher sought voluntary participation and informed consent from all participants. This aspect included providing the participants with detailed information on the nature and purpose of the study. This facilitated an environment wherein permission for participation was given based on a clear understanding of what was asked of participants.

iv. **Informed consent;** It is essential that consenting individuals are competent to do so. The researcher ensured that respondents comprehended the information provided and ultimately had the power of freedom of choice to decide to participate in the study or decline. Lastly, the researcher obtained authentic participants' agreement to participate in the study. Participants consented to participate in the focus group discussion and key informant interviews. Participants gave one copy of the informed consent form, and the focus group facilitator kept a second copy. Participants shared the researcher's permission to use a tape recorder in the FGDs.

3.13 TRUSTWORTHINESS

To validate research conducted within the interpretivist paradigm, Guba and Lincoln (1994) suggested the four criteria of trustworthiness and authenticity, namely, confirmability, transferability, credibility, and dependability.

3.13.1 Credibility

The credibility principle refers to the extent to which data and its analysis are believable, authentic or trustworthy (Alharahsheh & Pius, 2020). Pham (2018) explains that credibility relates to the researcher's ability to determine the alignment between the findings and the reality as constructed by the researcher and the research participants. Dependability refers to the ability to observe the same outcome or finding under similar circumstances (Gichuru, 2017). Guba and Lincoln (1994) argued that since interpretivist research deals with human behaviour within a context, and subject to multiple interpretations of reality, the researcher is unable to replicate the exact same outcomes (Rehman & Alharthi, 2016). However, inferences can be made, even though those inferences are influenced by the researcher's construction of meaning (Kivunja & Kuyini, 2017). The inferences and interpretations are dependable based on the researcher's ability and skills to make sure that the findings were accurately developed from the data gathered and analysed for the research (Pervin & Mokhtar, 2022). In order to ensure the findings were credible, the researcher went back to all participants to verify if their statements were correctly captured. This helped to mitigate reporting misleading information. During the interviews, participants were not allowed to discuss political or any other issues that were alien to the study.

3.13.2 Confirmability

Confirmability refers to the extent to which the research can be confirmed by other researchers (Pervin and Mokhtar, 2022). The prevailing objective of confirmability is to ascertain that the researcher's biases are minimized, and if at all possible eliminated from contaminating the results of the analyzed data (Goldkuhl, 2012). In order to confirm that the findings were based on the data that was collected, the researcher described the research design, its implementation and provided an up-to-date audit trail of note documents and evidence of decisions and choices made during the methodological issues of the study. By carrying out the above processes, the researcher was ring-fencing the correctness of the findings.

3.13.3 Transferability

Transferability refers to the researcher's efforts to ensure that enough contextual research data is provided so that readers of the findings can relate those findings to their own contexts (Guba & Lincoln, 1994). Some researchers argue that by definition, interpretivist research is context-specific with regard to locale and participants (Aliyu *et al.,* 2014; Kapur, 2018). Hence, the generalisability of the findings of research conducted within the interpretivist paradigm is practically impossible (Gichuru, 2017; Kivunja and Kuyini, 2017). Leedy and Ormrod (2019) state that the evidence of outcomes of a study can be applied in another environment involving different participants but under the same conditions. The pilot study was the most appropriate platform to determine if this study could be transferable.

3.13.4 Dependability

In a qualitative study, dependability can be equated to reliability in quantitative research. However, in this study, dependability was evaluated using nonnumeric data (Mabeba, 2018). First, the researcher designed a set of open-ended questions which were used to guide the interview processes. The pilot study was the second step taken to ensure the interview questions were understandable, plausible and that appropriate responses were provided. Feedback from the pilot study participants helped to finetune the final research instrument. The feedback from participants was evident enough that the research instrument could be depended upon and used to gather data in a different environment but still producing the same results.

3.14 CONCLUSION

In conclusion, this chapter presented a detailed overview of this study's research methodology and design. The research adopted an interpretivist philosophical stance that informed all other

processes and procedures for successfully completing the study. Non-probability purposive and convenience sampling techniques were used in the selection of sample elements. Data were collected from twelve participants using semi-structured interviews and focus group discussions. Data were analysed using thematic data analysis approach. Themes were coded and discussed in relation to the research questions. The concept of trustworthiness was discussed under the auspices of credibility, confirmability, dependability and transferability. The researcher discussed the ethical issues that were considered in this study. The next chapter presents, analyses and discusses research findings.

CHAPTER 4: DATA ANALYSIS AND FINDINGS

4.1 INTRODUCTION

Chapter 3 discussed methodology which amongst others included, the study setting, research design, research philosophy, sampling procedure, records review, data analysis, pilot study, limitations of the study and ethical considerations. This chapter discusses results that emanated from data analysis. The characteristics of the participants who offered data for the study as well as the achievement of data saturation which is a critical component that has to be addressed in qualitative data collection are dealt with in this chapter. Data coding processes leading to the identification of themes are presented. The following stage involved focused on the results in relation to the research questions to ensure that the research questions were answered. Further to that, the contributions of the results were discussed as well as presentation of conclusions and summary of the chapter.

4.2 CHARACTERISTICS AND KEY INFORMANTS' IDENTIFICATION

In this section, data were collected from twelve key informants made up of two participants drawn from each of the six districts of the Thabo Mofutsanyane District Municipality. The participants were identified with pseudonyms A to L to ensure that their identities and participation remained anonymous. Table 4.1 below gives the characteristics and identification of the participants.

Table 4.1: Participants Identification

Description	Pseudonym
Sub-District 1	A, B.
Sub-District 2	C, D.
Sub-District 3	E, F.
Sub-District 4	G, H.
Sub-District 5	I, J.
Sub-District 6	K, L.

Source: Produced for the current study

It was critical to focus on the characteristics of the participants since they provided evidence on the suitability and eligibility of the participants to provide answers that addressed the research questions. To ensure that the right participants were identified, particular focus was

directed at involving participants who are directly responsible with the implementation of the NHI pilot project in the Thabo Mofutsanyane District.

4.3 DATA SATURATION

The subjective nature of qualitative data collection and analysis therefore makes data saturation to be a prerequisite (Malterud, Siersma & Guassora, 2016). It is critical to ensure that sufficient data was collected before completing the data collection process (Sarfo, Deborah, Gbordzoe, Afful & Obeng, 2022). Saturation was achieved when there was no new information that was generated from the participant discussions. Saturation was reached at the twelfth participant, as there was no more new different data generated at this stage, the researcher was satisfied to end the data collection process.

4.4 PILOT STUDY RESULTS

A pilot study was conducted with three participants who were not part of the study. The purpose of the pilot study was to provide insights on the accuracy of the research instrument and feasibility of the main actual research. There were no changes on the research instruments as the participants deemed the instrument to be straight to the point, as there were no vague statements. They found the research instrument to be easy to follow and to achieve what it is intended to achieve. The research instrument was therefore adopted with no adjustments as it was deemed to be effective towards answering the research questions at hand. The main concern raised during the pilot study was that the questions were designed in the English language yet the majority of the participants were not conversant with the language. The request was to switch to Sotho language. The researcher acceded to this request.

4.5 DATA CODING PROCESSES

Data coding was an essential component of the study which necessitated the identification of major issues emanating from the data collected. The first stage involved coding of data into open categories. The codes were named based on the ideas that they carried. The words of the participants were incorporated. The inclusion of participants' views was necessary to compare the relationships among the codes during discussion and interpretation of the data.

After the open coding process, the axial coding process was done. Axial coding process entailed the thorough analysis of open codes as well as their characteristics. The axial coding process was based upon the notes derived from the memos, which explained the reason to decide making up of codes in various categories. The axial codes were theorised in

accordance to the purpose of the research. The codes were analysed in view of the research objectives and four major ideas which are the themes. The open, axial and selective codes are reflected on Table 4.2 below:

Table 4.2: Coding and the codes identified in the data

Open Codes	Axial Codes	Selective Codes
Staff shortages, controlled doctors' contracts, old infrastructure, control of medical budgets by provinces and districts, shortages of medical supplies, clinics not big enough, access and quality of treatment, reduction of patients waiting time, up to date filing systems, medical specialists should be based on clinics, stakeholder engagement, supply of medical equipment, standardise health systems.	Financial and material resources, HR skills resources, managerial capacity, distribution of medical facilities, health care professionals, cost and reimbursement of providers	Challenges
Improved access, removed burden from communities, distributing/delivering medication to the aged, free treatment	Standards improvements	Impact
Involvement of programme coordinators, increase on staff across the board, communication systems, information technology systems, communities and leadership support, health professionals support, centralisation of chronic medication, bottom-up approach in terms of budgeting, marketing of the NHI scheme to create awareness. Updating patient of their health conditions.	Staff education and training programmes and seminars as well as patients and communities training.	Institutional support systems
Increased staff, calibrating and purchasing of medical equipment, full time medical staff in clinics, staff training and development, budgeting	Financial and HR resources	Systems improvements

Source: Primary Data

Table 4.2 reflects that there were thirty open codes that were reduced to ten axial codes. The axial codes were further reduced to four selective codes which were the four themes that were used and discussed upon in this study. To obtain the themes, constant comparisons were made from the same codes within the same groups. The themes were challenges, impact, support systems and systems improvement. These themes are discussed below.

Theme 1: Challenges

The first theme that was identified was challenges affecting the NHI implementation in the Thabo Mofutsanyane District. All the participants indicated that they were fully aware of the intended primary objective of the project, which is to ensure that all the people receive equal and better quality of care, and to ensure that no one is deprived quality health care. The participants are fully aware of the challenges that are affecting the NHI implementation programme in the district.

Participant C however, said that:

> "*We are not updated about the particular project."*

The sentiments of participant C are very critical since constant feedback is very important. Stakeholders need to have feedback for them to become effective towards the implementation of the project in the district. Effective communication is highly needed to ensure that the stakeholders have the relevant information that equips them to disseminate the tasks and responsibility for the success of the project.

The participants indicated that various stakeholders such as the National and Provincial health departments, District and Local Clinics, with operational managers as key personnel in the clinics. Health professionals, NGOs and the public are also part of the stakeholders. The project has a variety of stakeholders and this makes the project to be a balanced project.

With regards to challenges faced by the project, various stakeholders have cited financial and material resources, human resources skills, managerial capacity and distribution of medical facilities. In addition, health care professionals and cost and reimbursement of providers were also mentioned.

Participant A indicated that:

> *"There is a high shortage of professional staff such as doctors, pharmacists, nurses, data capturing clerks and cleaning staff in most of the clinics. Doctors rotating in clinics are contracted for few hours by the NHI Department. Further to that there is an acute*

shortage of medical supplies from the medical department and this affects the treatments of patients."

Participant B mentioned that:

"The medical budgets controlled by provinces and districts are the major causes of medical supply disparities. Old infrastructure is also a cause of concern within the clinics. The clinics are not big enough to accommodate patients."

Participants C to L concurred with the views of Participants A and B. the challenges that affect the local districts are basically the same. It however, makes it easy to address these challenges since they are similar in nature.

Participant E indicated that:

"Clinics are not big enough to accommodate patients. This violates the patients' confidentiality. Lack of adequate space hinders the extensions of clinics, hence there is no enough space for the patients."

Participant F noted that:

"Sharing the clinic yard with the local municipality offices is not good enough. The privacy of the patients is infringed. There is however, a need to isolate the local clinic and the local municipality."

Participant G was of the opinion that:

"It is essential to reduce reporting structures. There is a need to standardize the reporting structures across all clinics. Adoption of standardized reporting procedures in all the clinics will help to provide accurate reports in all the clinics."

Theme 2: Impact

The second theme that was identified was the social and economic impact on the NHI implementation in the Thabo Mofutsanyane District. The major issues identified in this theme were improved access, removal of burden from the communities, delivery of medication to the aged by the Community Health Workers, improvements of health delivery services by the clinics and free care and treatments.

Participant C said that:

"There will be improved access to health delivery services to the general populace. The burden will be removed from the communities. Community Workers will distribute medication to the aged people, making it easy for them to access medication easily."

Participant D indicated that:

"Improved health care standards will be maintained. Further to that the burden will be removed from the communities. Community Health Workers will also distribute medication to the aged people. This will encourage the access of health care to the aged people."

Participant F said that:

"The standards in clinics have improved since the Department of Health is putting measures in place to implement the NHI project. Improvement of infrastructure, basic medical equipment is also being supplied to equip the clinics. Treatment and care at all clinics are for free."

Theme 3: Support Systems

The third theme that was identified was institutional support systems that enhanced the implementation of the NHI project at the Thabo Mofutsanyane District. The major issues identified in this theme were improved coordinators involvement in the project, increase staff such as doctors, nurses and data capturing clerks, continuous mentorship and educational workshops, centralisation of chronic medication, improved NGOs participation, lack of centralised information and communication unit, outreach educational programmes failed to reach out to other clinics since staff members did not attend due to staff shortages, lack of health professionals support, communities and leadership and non-existence of the Rural Doctors Association of Southern Africa in the Thabo Mofutsanyane District.

Participant D said that:

"It is essential to improve the involvement of programme coordinators to ensure that the project is well implemented."

Participant E indicated that:

"Staff shortages are hindering the progress of the programme. It is necessary therefore, to increase the doctors, nurses and data capturing clerk to enhance the implementation of the project."

Participant F noted that:

> *"There is a need to have continuous mentorship/educational workshops to ensure that the stakeholders are educated for them to familiarise with the project. Further to that centralisation of chronic medication is critical and has to be done."*

Participant G said that:

> *"Increased participation of NGOs is critical as it facilitates these stakeholders to take part in this important societal project. It is also important to put in place a centralised communication system to enable availability of sound information and effective communication for the project to be successful."*

Participant I said that:

> *"There is a need to initiate the bottom-up approach in the planning and budgeting aspects of the project. The views of the stakeholders in this respect are highly needed. Rural areas need to be empowered the same way urban areas are empowered. It is also critical to bring about the improved referral system in the rural clinics."*

Participant K indicated that:

> *"Unavailability of staff from other clinics due to staff shortages resulted in these staff members' failure to attend. This however, resulted in these staff members inability to get the outreach educational programmes and relevant timeous information. Health professionals support under these circumstances becomes limited."*

Participant L was of the opinion that:

> *"There is a need to have local leadership and community support if the project has to be successful. In addition to that the non-existence of the Rural Doctors Association of Southern Africa in the Thabo Mofutsanyane District makes it difficult for the project to thrive."*

All the twelve participants' general views about institutional support systems that enhanced the implementation of the NHI project were the same. They continuously reiterated the same issues with one voice.

Theme 4: Systems improvement

The fourth theme that was identified was systems improvement and this was paying particular attention to the improvement of the NHI systems at the Thabo Mofutsanyane District. The

major issues identified in this theme were increasing of staff, standardisation of reporting, employment of pharmacists at clinic level, marketing of programme in communities and mobilisation of communities to be health conscious to enable health care participation in the Thabo Mofutsanyane District.

Participant G said that:

> *"It is necessary to increase the existing staff compliment. In addition to that pharmacists need to be employed at local clinic level as well, since the clinics do not have pharmacists in the present set-up. In addition to that there is a need to standardize the reporting system."*

Participant H was of the view that:

> *"The clinic space needed to be increased since there was no adequate clinic space to accommodate all the patients. Further to that, it was of important to ensure that clinics had their own space without sharing space with other institutions."*

Participant I indicated that:

> "The NHI project needs to be vigorously marketed to the communities by radio and social media the same way Covid awareness was marketed to ensure that communities were well concertized."

Participant L purported that:

> *"It is of great importance to mobilise the communities to be health conscious to encourage health care participation."*

All the other participants concurred with the sentiments of Participants G, H, I and L. For the project to be successful, it is imperative to increase the staff compliment, employ pharmacists who are not currently employed in the clinics. It becomes critical to increase the clinic spaces and to finally create community awareness such that the communities are abreast with the project developments.

Focus Group Discussions

In this study section, data was collected from six focus group discussions coded 1 to 6, representing the six Thabo Mofutsanyane local municipal districts. Each focus group discussion had ten participants who were coded 1 to 10. Table 4.2 below gives the characteristics and identification of the focus group discussion participants.

Table 4.3: FGD Identification

Description	Pseudonym
FGD 1	Participants 1-10
FGD 2	Participants 1-10
FDG 3	Participants 1-10
FDG 4	Participants 1-10
FDG 5	Participants 1-10
FGD 6	Participants 1-10

Source: Primary Data

The gender of the focus group discussion participants comprised of five males and five females, five employed and five unemployed participants were also included. Further to that five educated and five uneducated participants were incorporated. Finally, five leaders and five ordinary citizens were incorporated in each FGD. To avoid intimidation, young adult participants were included in a group of young adults and the old in their respective groups. Power dynamics within the groups were considered to avoid people holding back in their remarks in the group. Participants' selection was not based on relationships but rather on the person's position during the NHI pilot implementation**.** People who had a contribution to the study were selected.

FGD 1 Theme 1: Challenges

The main issues that surfaced in this theme were disparities in terms of access and quality of treatment, the need to improve access as well as quality of treatment for all especially for people with low income and without access to medical aids, the need to improve the overall system within the department, standardization of the health system and fostering/strengthening cooperation between the public and private sector.

FGD 1: Participant 1 said that:

> *"Disparities in terms of access and quality of treatment need to be addressed."*

FGD 1: Participant 2 indicated that:

> *"There is a need to improve on the access as well as the quality of treatment for all, especially those with low income and without access to medical aid."*

FGD 1: Participant 4 pointed out that:

"It is a prerequisite to improve the overall system with the Department of Health. The health system needs to be standardized and to foster and strengthen cooperation between the public and private sector."

FGD 1: Participants 3 and 5 to 10 concurred with the views of Participants 1, 2 and 4. All the participants in FDG 2 to 6 were also in agreement with the views and opinions of Participants 1, 2 and 4. They also raised and discussed the same issues discussed in the first FDG. The views of the participants in the key informants' sections were the same as the views of the participants in the FGDs.

FGD 2 Theme 2: Impact

The second theme that was identified in the FDGs was the social and economic impact on the NHI implementation in the Thabo Mofutsanyane Local District. The FGDs in this theme focused on protection of families from financial hardship, equitable distribution of health care among different groupings, affordability- economically to disadvantaged people, reduction or limiting the rising cost of health care services and high standards of health care delivery service.

FDG 2 Participant 3 said that:

"It was highly necessary to ensure that access to the quality of health care is improved."

FGD 4 Participant 4 indicated that:

"Community Health Workers should assess, treat and deliver medication to the elderly people and people with disabilities."

FGD 5 Participant 5 purported that:

"Delivery of medication can also be done to the working class by Health Workers."

FGD 6 Participant 6 said that:

"The idea that treatment at clinics is free makes it easily accessible to the disadvantaged and vulnerable people in the society."

Participants 1, 2, 7, 8, 9 and 10; FGDs 1 and 3 agreed with the perceptions of Participants 3, 4, 5 and 6 in FGDs 2, 3, 4, 5 and 6. The views of the participants in the key informants' sections were the same as the views of the participants in the FGDs.

FGD 3 Theme 3: Support Systems

In the FGDs the theme that was identified was institutional support systems that enhanced the implementation of the NHI project at the Thabo Mofutsanyane District. The major issues identified in this theme were improved coordinators involvement in the project, increase staff such as doctors, nurses and data capturing clerks, medical specialist based fulltime in clinics, reduce waiting periods, improve the filing systems, extend clinics space-this violates patients' privacy, establish mechanism for male patients to access/approach clinics, introduce educational programmes for patients to increase awareness. There is also a need for health professionals to communicate or update patients about their health conditions, nurses to be encouraged to communicate with patients about their health care (at times nurses don't tell patients what is their problem), staff rude to patients, health professionals should respect patients for more often nurses specifically are rude to patients and encourage community involvement in the health care matters.

FDG 1 Participant 1 said that:

> *"Increased staff such as doctors, pharmacists, nurses, data capturing clerks and cleaning staff in some clinics will help to improve on the health care delivery system and enhance the implementation of the project. Medical specialist based fulltime in clinics."*

FGD 2 Participant 2 indicated that:

> *"Encourage community involvement in the health care matters. Male patients should also be encouraged to attend clinics."*

FGD 5 Participant 5 purported that:

> *"Health professionals should respect patients; more often nurses specifically are rude to patients. Health professionals should communicate or update patients about their health condition. It is also essential to reduce patients' waiting time by ensuring that the filing system is well maintained."*

FGD 6 Participant 6 said that:

> *"The idea that treatment at clinics is free makes it easily accessible to the disadvantaged and vulnerable people in the society."*

Participants 3, 4, 7, 8, 9 and 10; FGDs 3 and 4 agreed with the perceptions of Participants 1, 2, 5 and 6 in FGDs 1, 2, 5 and 6. The views of the participants in the key informants' sections agreed with what the FDG participants said.

FGD 1 Theme 4: Support Systems Improvement

In FDG 1 all the participants were of the view that communication needed to be improved to enhance the implementation of the project. Improvement of the healthcare system is needed by supplying up-to-date medical equipment and deployment of medical specialists in rural healthcare facilities. District support through training and procurement need to be enhanced. There is a need to improve on National and Provincial support on NHI implementation. Remote patient care and telehealth need to be introduced. Improvement in technology will assist in the speedy management and treatment of patients. There is ultimately a need to improve on the drug supply chain in the NHI health care system. The results in FDG 2 to 6 are in line with the views of what the FDG 1 participants said.

4.6 THE CONTRIBUTION OF THE RESULTS

The findings obtained from the key informants' data corroborated with the FDGs findings. The results contributed to the academic discourse by reflecting the need to have a properly executed and implemented NHI scheme to ascertain quality health delivery system for the vulnerable. The study showed that there is a plethora of challenges; however, these challenges can be addressed to enhance the implementation of the NHI scheme. The findings also pointed out at the need to have proper functional information technology systems and well-coordinated structures to enable smooth flow of communication among the various stakeholders for the effective implementation of the NHI project.

4.7 CONCLUSION

The chapter discussed the results following the data analysis. Firstly, the chapter addressed the characteristics of participants that provided data and went on to address the attainment of data saturation, which is an essential issue in qualitative data collection. Furthermore, chapter four indicated the results of the pilot study, the process followed in coding data and then the themes obtained from data. The next stage looked at the results against the research questions to make sure results answered the research questions. Further, the contributions of the results were discussed before concluding chapter four with a summary. The following chapter provides a discussion of research findings.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1 INTRODUCTION

Chapter 4 discussed data analysis, which amongst others included, characteristics and key informants' identification, data saturation, pilot study results, and data coding process as a means of providing analysis to this study. This chapter presents the research findings of the analysis from the previous chapter. The discussion of the research findings was based upon the emerging themes. There were four themes that emerged from the key informant interviews which were challenges, impact, support systems and systems improvement. The themes are discussed below:

5.2 CHALLENGES RELATED TO NHI IMPLEMENTATION

The results from the key informants and FGDs on this theme indicated that there are challenges that affect the implementation of the NHI project. This however, has an adverse effect on the health care of the citizens. It is a basic right for everyone to have access to health care as stipulated in Section 27 of the Constitution (RSA, 1996). The majority of the citizens in South Africa do not have access to health care, as they mainly depend upon public hospitals which are not adequately resourced. Most of the citizens are unable to afford private health care in South Africa The South African Human Rights 2017 is in full support of these results. The results obtained indicated that 82 out of 100 citizens do not have medical aids; they exclusively depend upon the public health care (South African Human Rights, 2017). The public health system is heavily overloaded. The major challenges that the public health system faces are shortage of health staff, overcrowding due to lack of adequate infrastructure, long waiting hours that patients have to endure and lack of medication (South African Human Rights, 2017). These challenges have negatively impacted on the health quality service delivery. The South African government introduced the NHI scheme that is designed to come up with universal health coverage to enable the populace to access quality health care services regardless of the citizens' status and their social status (South Africa Parliament, 2017).

The participants cited that there is acute shortage of financial and human resources. Lack of these resources was mainly caused by lack of proper budgeting by the Department of Health. Proper budgeting could have addressed the lack of equipment, medical supplies, infrastructure and shortage of personnel. The NHI project implementation has been stalled by lack of adequate budgeting (Maphumulo and Bhengu, 2019; Malakoane, Heunis, Chikobvu & Kigozi, 2020). Budgetary limitations restricted the procurement of diagnostic equipment. The

Department of Health is the custodian of the financing of hospitals and clinics. It is eventually impossible to procure modern equipment, replenish consumables and work towards the improvement of the health facilities without budgeting for these essential requirements (Manyisa, 2016).

It is essential to have human resource capital training for the success of the NHI implementation. There is a need to align the strategic human resource capital to the NHI implementation programme to enhance the quality of health care service delivery in hospitals and clinics in South Africa (Stewart and Wolvaardt, 2019). Scarcity of skilled personnel is exacerbated by lack of training. In service training and seminars are good to keep the staff abreast with latest technologies and practices. Adequate training enhances the performance of staff.

5.2.1 Impact of the NHI

Evaluation of the impact of the implementation of the health care in the pilot districts regarding the accessing of quality services at the health facilities was not effectively done due to various critical factors. These factors incorporated lack of adequate information as a result of handling various groups taking care of the interventions in the pilot and non-pilot districts. Lack of baseline measures were also a hindering factor as well as the variations in performance indicators. It was difficult to have clear performance measurements indicators over a period of time (National Department of Health, 2019).

The impact of the NHI health care project has been categorised into eight categories which are the patient's dignity, autonomy towards decision making in health-related issues, patients' confidentiality, punctual consideration, sufficient patients health care, effective communication, technological support networks and choice of health care providers (Mirzoev & Kane, 2017). There is much that needs to be done with regards to the impact of the eight categories in the South African NHI health care delivery system. The participants complained on the way they are handled in clinics, this however, undermine the dignity of the patients. The confidentiality of patients is also adversely affected due to inadequate infrastructure. Effective decision making is not done, this result in the prolonging of patients waiting time. Staff shortages also add to long patients waiting times. Sufficient patients' health care is compromised. Patients do not get timely treatments and the service and care they get is not as expected. Communication needs to be highly improved. The clinics staff need to improve on the way they handle patients, further to that there has to be effective communication with the Department of Health as well as clinics staff to ensure that the implementation of the NHI health care programme sails smoothly. There has to be a good rapport existing between the

clinics staff and the patients. Technological support networks will go a long towards the linking of patients' medical records, making it easy to have patients' records intact and easy to access. Finally, it is difficult to have a choice of health care providers, since the public health care system is the only one that is currently available. The NHI health care system will, however, give room for the patients to make their choices regarding the provision of health care services.

A patient-centred system should be endowed with quality throughout the health care range by taking into consideration the social norms, relations, values and societal trust (Hanefeld, Powell-Jackson and Balabanova 2017). There is a need to have equity in the health care system. Equity in the health sector can be achieved by proper utilization of health care facilities and this is highly critical to ensure that the health care system is adequately improved (Malhotra and Do, 2017). It is essential to ensure that the health care system is patient centred. Building up a patient centred system is critical in the NHI health delivery system. The participants' responses have indicated the loopholes that exist in the current service delivery system. Implementation of the NHI health care service delivery system is stalled due to these deficiencies that need to be attended to.

Although it is difficult to measure the health system impact, it takes strategy modifications and continuous monitoring and evaluation to achieve the anticipated health care outcomes. It is a prerequisite to measure all the health care system aspects and their responsiveness to the system (Health Sector Transformation Ethiopia Plan, 2021). Health care response is affected by a number of factors such as the Covid pandemic crisis, socio-economic factors, environmental factors and community factors. If patients are satisfied with the health care service provision as well as the perceived quality care that they receive; it increases their interests in the services. If patients get value in the health service delivery system, a positive responsiveness to the health care system is achieved. The expectations of the patients as to how they should be treated and the expediency as to when and how they are treated play a pivotal role towards the responsiveness of the performance of the health delivery system (Asefa, Atnafu, Dellie, Gebremedhin, Aschalew and Tsehay, 2021).

5.2.2 Support Systems

The major issues identified by the participants on institutional support systems were improved coordinators' involvement in the project, increased staff such as doctors, nurses and data capturing clerks, continuous mentorship and educational workshops, centralization of chronic medication, improved NGOs participation, lack of centralized information and communication unit, outreach educational programmes failed to reach out to other clinics since staff members

did not attend due to staff shortages, lack of health professionals support, communities and leadership and non-existence of the Rural Doctors Association of Southern Africa in the Thabo Mofutsanyane District.

There is a need to upgrade health care equipment. Obsolete equipment has made it very difficult for the health care staff to effectively deliver effective health care services. Patients in most cases receive wrong diagnosis due to obsolete equipment. Some equipment needs to be serviced and calibrated; hence lack of service renders the equipment to be inefficient and ineffective. The use of current advanced equipment and technologies is required if quality health care service delivery has to be achieved. There is a need to equip the health centres with state-of-the-art technologies. These technologies make the job to be easier and efficiently carried out, thereby enabling the health delivery system to flow effectively. Poor record keeping challenges as well as monitoring systems can be solved by the availability of technology. Patients waiting time can be reduced due to the availability and use of technology (Netshisaulu, Malelelo-Ndou and Ramathuba, 2019). Integration of patients' health records plays a pivotal role towards the quality of the health service delivery system. There will be no need for patients to open up new files whenever they visit health facilities, if the patients' records are integrated. Complete medical records facilitate proper diagnosis of patients and proper treatments would be done due to the availability of the patients' medical history (Moyimane, Matlala and Kekana, 2017).

5.2.3 Systems Improvement

The major issues identified in this theme were increasing staff, standardization of reporting, employment of pharmacists at clinic level, marketing of programme in communities and mobilization of communities to be health conscious to enable health care participation in the Thabo Mofutsanyane District. Decongestion of the public sector health system by implementing the NHI project will help to improve the system. Most of the patients who are unable to access private health care will be able to access it, and this would eventually enable patients to make choices on the health care facilities that are available (South African Human Rights, 2017). Establishment of communication channels in wards will go a long way towards the improvement of effective communication between coordinators and medical staff as well as community leaders. Recruitment of pharmacists, increasing doctors and nurses would facility health centres to be effective. This would help to reduce the patients' waiting times. Improvements of infrastructure are also critical aspects that need to be improved for the benefit of the privacy and confidentiality of the patients (National Department of Health, 2019).

It is critical that the financial and human resources shortages be addressed. Improvement on the availability of human and capital resources will facilitate the procurement of medical stocks; pay the salaries of medical staff, improve on infrastructure, provide training to the medical staff to keep them abreast with the NHI health care project. It is highly necessary to ensure that proper budgeting is done, since achievement of the project objectives cannot be met without proper budgeting tools and practices (Maphumulo & Bhengu, 2019; Malakoane *et al,* 2020; Manyisa, 2016). There is a need to equip the health centres with state-of-the-art technologies. Integration and keeping of patients' records requires efficient and effective technology. It makes it easy to keep and retrieve records at the click of a button. Patients waiting time is drastically reduced when records are readily available and easily accessible (Netshisaulu *et al,* 2019). Complete medical records facilitate proper diagnosis of patients and proper treatments would be done due to the availability of the patients' medical history (Moyimane *et al*.; Matlala, 2017). Alignment of strategies with the strategic human resource capital will help to implement the NHI health care in South Africa (Stewart and Wolvaardt, 2019).

5.3 RESEARCH OBJECTIVES

5.3.1 Research Objective 1: To describe the district's challenges in implementing the NHI project to improve citizens' health

In this objective, the challenges that affect the implementation of the NHI project were identified and these were that the majority of the patients were unable to access quality health care due to the overloaded public health system, hence the need for the NHI health programme to carter for all despite of their socio-economic status. The acute shortage of financial and human resources, lack of these resources; these were mainly caused by lack of proper budgeting. In addition to these, lack of equipment, medical supplies, infrastructure and shortage of personnel are other major challenges that affect the effective delivery of quality health care services to the patients in South Africa. The study managed to achieve the research objective by identifying the challenges that affect the health service delivery.

5.3.2 Research objective 2: To assess responsiveness in implementing the intervention projects in the Thabo Mofutsanyane District

The second research objective was: This research objective focused on the impact of the implementation of the NHI intervention projects in the district. Evaluation of the impact of the implementation of the health care in the pilot districts regarding the accessing of quality services was partially done due to lack of adequate information as a result of handling various groups taking care of the interventions in the pilot and non-pilot districts. Lack of baseline

measures was also a hindrance as well as the variations in performance indicators. It was difficult to have clear performance measurements indicators over a period of time. The confidentiality of patients is affected due to inadequate infrastructure, effective decision making is not done and hence patients are not treated in time. Staff shortages contribute much to long patients waiting times. Sufficient patients' health care is compromised. Patients do not get timely treatments and the service and care they get is not satisfactory. Communication channels need to be improved. There has to be adequate stakeholder communication between the medical staff, patients and community leaders for the health care system to be trusted and to be effective. Technological support networks are not in place and this however, makes it difficult to integrate patients' medical records, making it difficult to have patients' records accessible. The research objective has achieved what it is intended to achieve as it has managed to focus on the impact of the NHI health care system and what has to be done for the system to be effective.

5.3.3 Research objective 3: To assess the institutional support systems that enhances or delimit social and risk protection

The third objective was: The major support systems identified in this segment of the study were recruitment of pharmacists at clinic level, improved coordinators involvement in the project, increasing of staff such as doctors, nurses and data capturing clerks, continuous mentorship and educational workshops, centralization of chronic medication, improved NGOs participation, lack of centralized information and communication unit, outreach educational programmes failed to reach out to other clinics since staff members did not attend due to staff shortages, lack of health professionals support, communities and leadership and non-existence of the Rural Doctors Association of Southern Africa in the Thabo Mofutsanyane District. Upgrading of the health care equipment is needed. Obsolete equipment has made it very difficult for the health care staff to effectively deliver effective diagnosis and treatment to patients. There is a need to equip the health centres with state-of-the-art technologies. Poor record keeping challenges as well as monitoring systems can be solved by the availability of technology. Patients waiting time can be reduced due to the availability and use of technology. Although there is much that needs to be done, the research objective has been, however achieved.

5.3.4 Research objective 4: To make recommendations to the government about necessary health system reconfiguration to realise improved efficiency of the NHI in the district

The participants were of the opinion that it was imperative to have the following institutional support systems improvements: increasing of staff, standardization of reporting, employment of pharmacists at clinic level, marketing of programme in communities and mobilization of communities to be health conscious to enable health care participation in the district. Decongestion of the public sector health system by implementing the NHI project will help to improve the system. Patients who are unable to access private health care will be in a position to access it, and this would allow patients to make choices on the available health care facilities. It is critical to establish communication channels in wards as well as in the community to foster good relationships between the medical staff, patients and the community at large. There is a need to address the financial and human resources shortages. Improvement on the availability of human and capital resources will facilitate the procurement of medical stocks; pay the salaries of medical staff, improve on infrastructure, provide training to the medical staff to keep them abreast with the NHI health care project. It is highly necessary to ensure that proper budgeting is done, since achievement of the project objectives cannot be met without proper budgeting tools and practices. There is a need to equip the health centres with state-of-the-art technologies for the integration and safe keeping of patients' records. This objective was achieved.

5.4 CONCLUSION

This chapter discussed the research findings as they were presented in the preceding chapter four. The discussion of the research findings was linked to the established themes that emanated from the key informant interviews and FGDs. The themes that were discussed were challenges, impact, support systems and systems improvement. The next chapter provides the conclusions and recommendations of the study.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

Chapter 5 dealt with discussions and findings. The discussions and findings included the challenge, impact, support systems, systems improvement, and research objectives. This chapter brings the study to conclusion and provides recommendations to address the gaps that emanated on the evaluation of the implementation of the NHI scheme in the Thabo Mofutsanyane District of the Free State Province. The major areas discussed upon included the concise summary of the research process undertaken as well as the study limitations and areas for further study. The purpose of this study was to discover gaps on the implementation of the NHI scheme. To achieve the aim of this study, the researcher conducted a comprehensive literature review pertaining to the implementation of the NHI scheme in South Africa as well as in the Thabo Mofutsanyane District. The phenomenological research approach was adopted to carry out the study; NHI literature that addressed the research objectives was purposefully selected. Key informant questions and FGDs questions were used to collect primary data. The results obtained from key informants were validated with the results obtained from the FDGs. The data obtained was analysed into themes and four themes emerged which were challenges, impact, support systems and systems improvement.

6.2 CONCLUSIONS FROM THE STUDY

Conclusions based upon the research findings are discussed in this section. These discussions are aligned to the four themes that were identified in the study. These four themes are also linked to the research four research objectives.

6.2.1 Conclusions on challenges

This theme was a direct response to the first objective of the study. Given the responses that were shared during the informant interviews and FDGs, it was revealed that people in the Thabo Mofutsanyane District faced accessibility to healthcare centres. In addition, these healthcare centres were under resourced in terms of human, financial and equipment and medication. Shortage of health staff such as doctors, pharmacists and nurses are adversely affecting the implementation of the NHI scheme. Patient-nurse ratio was not fair in that nurses dealt with many patients at any given time, thus, straining their capabilities. Participants indicated that many clinics did not have adequate medical supplies, which affected the treatment schedules. The infrastructure was not conducive for human use and in some instances, clinics did not have the right infrastructure to provide healthcare services.

Participants indicated that many healthcare facilities in the Province were not properly financed, therefore, the implementation of the NHI would not succeed. Procurement of medication and infrastructure construction as well as maintenance needs to be backed by the availability of resources. It was pointed out during the data collection phase that communication was not effective, therefore, posed serious project management challenges. With reference to staff shortage, participants indicated the need for staff training and development. With all the points raised above, this research objective was adequately addressed in line with the aim of the study.

6.2.2 Conclusion on the Impact of the NHI

During data collection and literature review, the researcher established that other countries such as Rwanda, Brazil and Netherlands that have successfully implemented the NHI, have realised positive results. Citizens of these countries can easily access and navigate healthcare service at little or no cost at all. Participants revealed that the impact of the NHI was not known because of a number of factors that include lack of information and lack of baseline measures. However, in line with the dictates of the second objective, the impact of the NHI is not disputable. Patient handling, treatment and access to affordable healthcare services are some of the notable benefits that will accrue from the NHI. Currently there are complaints of poor patients being ill-treated by nurses, their information is not kept private and confidential. With the NHI, there would be proper complaints handling procedures, systems that store patients' information securely and confidentially. Each district would be able to provide instant reports to the National Department of Health of activities they carry out. With reference to the literature review and participants' feedback, the study concludes that the second research objective was adequately addressed.

6.2.3 Conclusions on Support Systems

The third objective of the study revealed that the NHI would improve institutional support systems. Many stakeholders would take a keen interest in the NHI and how it was benefiting society. Given that this pilot study was conducted in one of the Free State Districts, government would be keen to understand how the NHI was successfully implemented, take the lessons and make them national project-based initiatives so that the project could be rolled out to other provinces. Participants indicated that with the implementation of the NHI, healthcare facilities were obliged to upgrade their support systems in line with national and global standards. This also entails disposal of obsolete systems and installation of state-of-the art technologies that enhance the efficiency and effectiveness of the NHI project. The views provided in this section partly address objective number three of the study.

6.2.4 Conclusions on Systems Improvement

As indicated in the preceding section, objective three of the study focused on systems. The researcher concluded that it is a prerequisite to ensure that institutional systems are improved for the effective implementation of the NHI project. Participants and literature review concurred on the understanding that obsolete or legacy systems needed to be disposed of, increasing staff in all departments and ensuring that the NHI was marketed to all communities. In order to facilitate an improvement on the systems, the study concluded that financial and human resources were key to the success of the NHI. With reference to the discussion in the preceding section and what has been shared here, the study concludes that a lot of planning, resources mobilisation and involvement of multiple stakeholders were required if the Thabo Mofutsanyane District were to record a successful NHI pilot project.

6.3 RECOMMENDATIONS

This section is designed to give recommendations based on the findings, conclusions and gaps emanating from the study concerning the implementation of the NHI scheme in the district. The recommendations of the study are discussed below:

6.3.1 Recruitment of more staff

Since access to health care is a fundamental right for everyone, it is a prerequisite to ensure that all the people in the district are afforded the opportunity to have access to health care services. Shortage of health staff such as doctors, pharmacists and nurses are adversely affecting the implementation of the NHI scheme. Doctors do not operate daily due to their contracts. Patients however, need to be treated on a daily basis. These facilities do not have pharmacists to disburse medication. Pharmacists should be a critical staff compliment of the clinics as well, if the health care system has to be effective. Nurses also need to be increased. The workload that these nurses have is too high such that it affects their efficiency as they end up handling a lot of patients at one go. Data capturing clerks are also needed to enable proper capturing of patients' information as well as filing and securing of patients' files. Adequate staff availability as well as good information systems reduces the long waiting hours that patients endured.

6.3.2 Funding of the NHI

Participants and literature pointed out that countries that have successfully implemented the NHI had adequate funding. Different stakeholders contributed towards a noble cause. The challenge that South Africa faces is the lack of communication, unwilling private sector and

lack of information relating to the benefits of the NHI. These factors can hinder stakeholders from making contributions towards the NHI. There is a need to ensure that adequate funding is available to ascertain the supply of medication, infrastructure maintenance and construction. Availability of resources is critical if the NHI project implementation has to succeed. It is necessary to ensure that proper budgeting is done as this helps to avail the much-needed resources as well as proper utilisation of the availed resources. Health facilities need to be improved and this cannot be achieved without having sufficient budgets. Therefore, the study recommends a paradigm shift from government to attract stakeholders from various sectors of the economy, international donors etc to ensure that the NHI is successfully implemented.

6.3.3 Infrastructure Availability

The study revealed that there are insufficient healthcare facilities in the Thabo Mofutsanyana District. Patients walk long distances in search of healthcare services. In addition, the available infrastructure is not fit for human use. Some buildings are dilapidated, whilst others were no longer in use. These challenges created congestion and potential for the spread of communicable diseases. This study recommends that there should be adequate infrastructure to safeguard the confidentiality of patients' information and dignity. Clinics need to have enough space to ensure that all patients can be accommodated and treated as well as maintain their confidentiality. There is a need to ensure that the infrastructure is maintained as some of the facilities end up being dilapidated. Well-maintained infrastructure creates an ambient environment for healthcare services as well as a safe place for patients. Government alone cannot manage these costs; therefore, other players are encouraged to take an active part in the implementation of the NHI through infrastructure development.

6.3.4 Effective Communication

Participants indicated that local communities do not understand what political leaders and healthcare professionals are planning. There is lack of communication or feedback between communities and their leaders. Lack of effective communication has an adverse effect towards the implementation of the NHI scheme. To achieve implementation of the NHI scheme in the district, effective communication needs to be maintained, this should start from the National Health Department as well as the Provincial and District health facilities centres. Staff in clinics should also be given feedback regarding the progress on the implementation of the NHI scheme as they are also custodians of the project at local health clinics level. It is therefore recommended that communication channels be developed and practiced by all the stakeholders. Effective communication necessitates provision of feedback to all the stakeholders such as the National Health Department, staff, community leaders and patients.

This study recommends that a dedicated communications team or department should be established to ensure that proper and timeous communication with communities are achieved. Feedback to communities creates confidence and trust. However, if there is no communication, communities can easily develop mistrust, thereby, sabotaging any projects that might change their lives.

6.3.5 Staff Training and Development

In this highly information intense society, people are exposed to all kinds of information on the Internet. Armed with information, healthcare professionals may come across some training and development programmes offered at other institutions and will thus, decide to leave their current employment. On the other hand, if management does not see the need to upskill their staff, they may think it is a wastage to send their staff for training and development. Staff development is highly needed for the NHI scheme to be effectively implemented. There is a need to ensure that staff receives in service training regarding the implementation of the NHI scheme. Seminars will help the staff to be aware of the developments and requirements of the project. Implementation of the scheme becomes difficult when the implementers at the local clinic level are not fully informed about their roles. This study recommends that staff receives periodic training and development to keep abreast with trends in the medical arena. Skilled employees are able to provide better services, make informed decisions and use technology. The medical field is rapidly changing due to technological advancements such as telehealth, intravenous medication technologies etc. With properly trained staff, the use of medical technologies would ease the burden and lessen errors attributable to human beings.

6.3.6 Impact on NHI Implementation

It is important that the NHI project should have a strong bearing on the welfare of the patients. For the project to have a positive impact it is recommended that structures have to be put in place to facilitate the patient's dignity, autonomous decision making by the health staff to speed up treatment of patients, maintenance of patients' confidentiality, punctual consideration, in dealing with patients' cases and sufficient health care provision at the health facility centres. It is a requirement to ensure that the health system impact is adequately measured. Continuous monitoring and evaluation measures need to be put in place to establish the effectiveness of the health system. Monitoring and evaluation facilitates corrective action to be taken on time before it is too late. Patients need to be satisfied with the health care services that they receive and the service quality. Corrective action has to be seriously looked at if the communities have to trust the health delivery system. The study also recommends that periodic weekly or monthly reports should be generated to provide insights

on the impact or benefits of the NHI. The WHO and sub-functions framework discussed earlier in this study would be useful in measuring the impact of the NHI. There other tools such as surveys, interviews and focus group discussions that can be used to gather data regarding the impact of the NHI.

6.3.7 Technological Support Networks

Participants indicated that in this era of technological advancements, it is important to digitise systems and records for security and easier storage. Brazil, Rwanda, Germany, Netherlands and Thailand have recorded improved access to healthcare services through the aid of technologies. Patients' records are kept in a central repository which is safe and managed by a senior IT person. Technological support networks will go a long way towards the linking of patients' medical records, making it easy to have patients' records intact and easy to access. Treatment of patients becomes effective if there are accurate records in place. State of the art technologies will go a long way towards the improvement of institutional support systems and enhance the implementation of the NHI scheme. The study recommends the adoption of ideal and cost-effective digital technologies that will support the NHI and other information systems. In addition, the systems should be compatible with existing systems or they may be a need to dispose of old/legacy systems. Participants also indicated that the current systems are alienated from patient treatment care. This study recommends a patient-approach where quality, communication and values are entrenched in the healthcare professionals' duties and ethos. It is imperative to develop a patient-centred system that collaborates with the rest of the objectives of the NHI. If on one hand nurses and doctors offer some healthcare services that are alienated from what patients are looking for, therefore, the goals of the NHI will come to nought.

6.3.8 Stakeholder Involvement

Stakeholder involvement is a critical component that is needed to ascertain that the NHI scheme is successful. There is a need to ensure that stakeholder consultation is given a proper platform. It is essential to ensure that stakeholders are incorporated as they add value to the project. Improved coordination makes it possible to engage all the various stakeholders to ensure that the NHI project becomes a success. Projects of this magnitude attract people from various sectors with vested interests. It is important to obtain a register of all stakeholders, their contact details and how they are interested in the NHI project. This approach is very important because the project managers and policy-makers will have an idea of who is involved and interested in what. Appropriate stakeholder communication channels and information will be designed. Involving various stakeholders will be beneficial in the form

of financial support, information and knowledge sharing, and advice. Some stakeholders could be competitors, customers, the community, private and public sector firms etc. Some of them may have varying levels of experiences and knowledge on how to manage projects of this magnitude. This study therefore, recommends the establishment and involvement of stakeholder management relationships.

6.3.9 Maintenance and Purchase of Equipment

It is recommended that equipment has to be regularly maintained to ensure that they remain efficient and effective for the diagnosis of patients' ailment. Accurate results help to give accurate treatments. Purchase of new equipment will also go a long way towards efficient health service delivery. Patients at times receive wrong diagnosis results due obsolete equipment. It was established during data collection where participants indicated that some clinics and hospitals have idle and obsolete equipment in their premises. Upon further enquiries, participants indicated that most of the equipment was neglected, no service and maintenance schedules until the repairs went beyond what was budgeted for. It is important to enhance the longevity of equipment to derive value and service to the patients.

6.3.10 Ensuring there are Shared Values

Healthcare is a specialised service that must be provided irrespective of the person's background. Staff with the right skills and attitude should operate within the auspices of shared values and ethos. Staff should work as a team to ensure patient care and treatment are not compromised. Silo approaches to patient treatment do not yield the desired results. Information and knowledge sharing are common elements that permeate within the healthcare sector. It is imperative for staff to share information about trends, diseases, challenges and other facts that may assist them in dealing with a specific problem should the need arise. The complaints handling, escalation and resolution processes can be good measures of how well firms respond to unusual situations.

6.3.11 Systematising Processes Through Written Procedures

Participants indicated that the NHI is a fairly new project and it is not widely known within the South African context. In order to provide excellent services, staff neds to follow proper procedures and processes, therefore, this study recommends that all processes and procedures be documented for reference purposes. In the event of comebacks or complaints, staff have a reference point which they can consult. It is also a requirement for auditing purposes that such systems must be properly documented. With written procedures, staff

would be able to provide consistent services to each patient each time. Consistency is achieved if staff have strong ideals of what they need to do and how to do it.

6.4 PRACTICAL IMPLICATIONS

This study has a number of practical implications that can be used to ensure that the implementation of the NHI scheme is successful. The practical implications that can be applied are:

1. There is a need to have coordinators who focus on the harmonization of the project at the Head Office level cascading downwards to Provincial, District and clinics levels. A properly coordinated NHI project is likely to succeed. If the organizational vision and mission are clearly spelt out and well-articulated, the NHI scheme is bound to be successful.
2. It is critical to increase staff levels since the current staff is failing to cope with the increasing numbers of patients. Clinics do not have pharmacists, and it is essential to recruit them for the proper distribution of drugs to enhance quality health service delivery.
3. Stakeholder engagement is significant since it facilitates adequate programme support as stakeholders will be very much involved.
4. For an effective NHI scheme, it is recommended that the patients, the community and other stakeholders must be satisfied and have confidence in the health delivery system.
5. Provision of the NHI scheme will go a long way to assist the vulnerable, as well as the general South African populace. The project is meant to provide a reliable and trustworthy health service delivery system to the citizens.

6.5 CONTRIBUTION OF THE STUDY

This study has provided a new body of literature on the implementation of the NHI scheme. Much insight has been given on how the NHI implementation challenges, impact, support systems and systems improvements can be enhanced to ensure that the health care service delivery becomes efficient and effective. It has also indicated how the vulnerable people in society can be able to access health care services through the NHI scheme. Involvement and engagement of the stakeholders has been looked upon and serves as a major contributing factor towards the development of trust and confidence among the stakeholders. Communities and patients need to have confidence in the health delivery system. The study has also advanced knowledge in understanding the importance of a national health insurance to ensure

there is parity when accessing and navigating health care services. Reviewing and contributing to existing literature was the cornerstone of this study, Policy makers and investors will understand the role and importance of the NHI on the South African economy. Notwithstanding that South Africa is a commercial hub for the Southern African Development Community (SADC) region whose majority of citizens come to the Republic for better medical health care services. The study demonstrated that a successfully implemented NHI will alleviate a number of challenges facing patients- traveling long distances for healthcare services only to be turned away because there is no medication or the resident doctor has been called for an emergency.

6.6 THE TIPS FRAMEWORK

There are many factors that influenced this study, chief among which there were no past studies that had examined the challenges of implementing the NHI in South Africa. The researcher of this study was inspired by the Da Vinci Institute Managerial Leadership (TIPS) framework. Having enrolled and studying with a global business school, the researcher was convinced that this research project would expose one to engage with institutions and projects that integrate between government and communities. By conducting this study in the Thabo Mofutsanyana, the researcher gained exposure to the lives of communities but was determined to work cooperatively with communities to understand the importance of the NHI.

This study adopted a case study of one South African district in order to determine the challenges that would arise when implementing the NHI. This approach is in line with the Da Vinci area of business innovation where case studies are brought back into learning, teaching and research. By conducting this study within the Thabo Mofutsanyana, the researcher was actually engaged in a community engagement project. Participants shared their lived experiences. It was revealed that English language was not widely understood nor spoken in the district, let alone the use of technology was alien. These were the major findings that informed and shaped the discussion of results.

The researcher self-funded this research project, however, within the TIPS framework, the Da Vinci Institute garners funding wherever possible. With reference to Return on Investment (ROI) this study conformed to all research requirements. It sought to be relevant to the research site as well as the Free State Province and South Africa. In addition, there will also be huge personal and societal benefit in that the findings will be of great value to the researcher as well the communities. Institutionally, policy makers and investors will understand the importance of the NHI. Given that this project was self-funded, not much money was spent in data collection. However, it is utmost importance to state that large

projects that require huge funding would require proper planning and budgeting in terms of how the finances are used in line with organizational strategic goals.

Stakeholders to this project included the Da Vinci Institute, government, communities, investors and political parties in the Thabo Mofutsanyana District. They have an important assignment to ensure they contribute in various ways to the successful implementation of the NHI. Findings from the study, however, revealed that there were no proper stakeholder relationship plans or registers, therefore, the actual stakeholders and their portfolios/ experiences were not known.

By conducting this study, the researcher acknowledges exposure to information, research skills, learning and knowledge sharing. Participants shared real-life-natural setting experiences which were imperative to understand the subject being investigated. The other ROI for the researcher is that the findings from this study will be shared with management and leadership of the Provincial and National Health departments. The recommendations will be carefully debated and appropriate interventions taken. Given that the NHI has only been given fresh impetus in the few past years, another ROI is that the findings of the research will enhance professionalism and contribute to evidence based decision making with regards to the NHI.

6.7 LIMITATIONS OF THE STUDY

Many studies tend to be exposed to some form of limitations. Limitations are drawbacks that affect the final results and as such, it is the responsibility of the researcher to acknowledge them. Saunders et al (2019) state that it is important to acknowledge limitations so that appropriate action can be taken and that suggestions are provided for future research to mitigate encountering the same conditions. Chigada (2023) states that limitations are used to demonstrate the researcher's critical thought and focus on the research problem. In this study, the researcher encountered both methodological and researcher-related limitations.

The methodological limitations where the sample size of twelve participants was too small for a district with more than eight-hundred thousand (800,000) residents. A large scale would have sufficed for generalisation. The researcher could have used a mixed method research in the study where both qualitative and quantitative data tools and techniques could have been used. In addition, a larger sample size would also have been used. The second methodological limitation was the absence of past studies that had examined the challenges of implementing the NHI in any South African Province. This meant that most of the literature used in this study was taken from outside the Republic. The few recorded works were from

Government Gazettes or reports from the National Department of Health. The third limitation was attributable to the research site. The Thabo Mofutsanyane was the only site chosen for this study. If a comparative case study had been carried the findings from the study would have been different.

The researcher limitations were the ability to identify the right participants with the relevant knowledge and information about the NHI implementation. If past studies had been conducted before, this would have guided the researcher in terms of who would have been the ideal participants for the study. The second limitation was the translation of the interviews from English Language to Southern Sotho and vice versa. This process created opportunities for missing important information. This limitation could have been avoided if the researcher had used one language as specified in international research.

6.8 SUGGESTIONS FOR FUTURE RESEARCH

Research is a continuous process that has to be periodically done. This study supplies insights into areas that can provide further research to improve on the implementation of the NHI scheme in South Africa. The following areas for future research are recommended:

- Since this study adopted the qualitative research method approach, it is recommended that future studies can be done using the quantitative research method.
- A mixed method research approach is also recommended since it combines both the qualitative and quantitative methods. Triangulation of both qualitative and quantitative primary data would help to produce a balanced scientific study with generalisable and credible results as opposed to the use of one research method.
- Another study with an increased population and sample size covering other provinces can also be carried out since it will reflect the position of a larger constituency as compared to a study that covers one province.
- Further studies can be conducted on the impact of the NHI as benchmarked in other successful countries, with a view to tailor-making the research results to improve the South African context.

The role of the private sector can be extensively investigated in funding the National Health Insurance fund as a means to promoting social responsibility. This may include all avenues that may be explored to make sure that the NHI is sustainable and benefiting all members of the society.

6.9 CONCLUSION

The outcomes of the research findings were discussed in this chapter. Further to that the recommendations to deal with the challenges of implementing the NHI scheme in the Thabo Mofutsanyane District were provided in the chapter. The recommendations of the study were in line with the conclusions that were given and were discussed in line with the reviewed literature to address the gaps that were identified in the study. The aim and objectives of the study have been met. Areas for carrying out further studies were suggested and this will help to enrich the knowledge base in the implementation of the NHI scheme in South Africa.

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APPENDICES

APPENDIX 1: Information sheet and Consent Form for In-Depth Interview

This information sheet and informed consent form are for health practitioners working in the health facilities in TMD and who are invited to participate in the KIIs.

This document has two parts: -

- **Information Sheet** (to share information about the research with you)
- **Informed Consent Form** (for signatures if you agree to take part)

PART I: INFORMATION SHEET

Introduction

I am Jabu Mbalula, a Master's student at the Da Vinci Institute in South Africa. We are conducting research on the implementation of the NHI in this district. I will give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the study. Before you choose, you can talk to anyone you feel comfortable with about the research. There may be some words that you do not understand. Please ask me to stop as we go through the information, and I will take the time to explain. If you have questions later, you can ask them about the research assistants or me.

Background and Purpose of the research

The NHI was piloted in this district and ten others a few years ago to test this scheme's implementation for the country. The NHI is now being implemented in the whole country.

Responsible organisations (like WHO) recommend that health care provided to patients in an NHI scheme should be universal, quality care that meets their needs. We are conducting this research to evaluate the implementation of the NHI in TMD and to recommend how this implementation can benefit the people of TMD.

Type of Research Intervention

This research will involve your participation in an in-depth interview that will take about one and a half-hour.

Participant Selection

You are invited to participate in this research because we feel that your experience as a practitioner can contribute much to our understanding and knowledge of local health services.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Your selection will not affect your job or any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier. You have the right to withdraw at any given point.

Procedure

We ask you to help us learn more about your experiences with how health services are given to patients in your community. We are inviting you to take part in this research project. If you accept, you will be asked how the health services are provided, the challenges and opportunities to provide universal health services in the existing healthcare system, and, if possible, at what level of the health system can we integrate services.

You will participate in an interview with me. During the interview, I will sit down with you in a comfortable place in the community. If you do not wish to answer any questions during the interview, you may say so, and I will move on to the next question. No one else but I will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except my supervisor, responsible for monitoring this study, will access the info documented during your interview. The entire interview will be tape-recorded, but no one will be identified by name on the tape. The tape will be kept in a locker /cabinet, which will be locked. The information recorded is confidential, and no one else except me will have access to the tapes. The tapes will be destroyed after 48 months which is the end of this study.

Duration

The interview will take approximately 60-90 minutes.

confidential, and no one else except my supervisor, responsible for monitoring this study, will access the info documented during your interview. The entire interview will be tape-recorded, but no one will be identified by name on the tape. The tape will be kept in a locker /cabinet, which will be locked. The information recorded is confidential, and no one else except me will

have access to the tapes. The tapes will be destroyed after 48 months which is the end of this study.

Duration

The interview will take approximately 60-90 minutes.

Risks

There are no known risks associated with this study. However, you may share personal or confidential information by chance or feel uncomfortable talking about some of the topics; I do not wish this to happen. You do not have to answer any questions or participate in the interview if you feel the question(s) talking about them make you uncomfortable.

Benefits

There will be no direct benefit to you. Still, your participation will likely help us learn more about the health system's challenges in implementing the NHI. Also, your contribution to this study will benefit others in the future by helping to improve the existing health system for tuberculosis and diabetes diseases.

Confidentiality

We will not share information about you outside the research team. The information that we collect from this research project will be kept private. Any information about you will have a number instead of your name. Only the researchers will know your number, and we will lock that information up with a lock and key. It will not be shared with or given to anyone except [my supervisor will have access to the data].

Sharing the Results

Nothing you tell me today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge we get from this research will be shared with you and your community before it is widely available to the public.

Your interview result will be grouped with other individuals on all reports related to this study. If the results of this study are reported in journals or at meetings, your identity will remain secret.

Right to Refuse or Withdraw

You do not have to participate in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations. You may stop participating in the interview whenever you want to without your job being affected. I will allow you at the end of the interview to review your remarks, and you can ask to modify or remove portions of those if you disagree with my notes or if I did not understand you correctly.

Who to Contact

If you have any questions, you can ask me now or later. If you wish to ask questions later, you may contact any of the following:

Jabu Mbalula, phone 082 4613112 or (+40) 735836838 email: mbalulajni@icloud.com

This proposal has been submitted for review and approval by the Research Ethics Committee (REC) of da Vinci Institute, a committee whose task is to ensure that research participants are protected from harm.

APPENDIX 2. PART II: INFORMED CONSENT FORM

I have read the foregoing information. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done: In-depth Interview

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Print Name of Participant_____

Signature of Participant _____

Date _____

Day/month/year

I also consent to having the interview audio recorded.

Signature: _____Date_____

A copy of this ICF has been provided to the participant.

Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____
Day/month/year

APPENDIX 3: KEY INFORMANT INTERVIEW GUIDE

EVALUATING THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME: A CASE OF THABO MOFUTSANYANE DISTRICT OF THE FREE STATE PROVINCE

1. Welcome

Good day, my name is Jabu Mbalula. I am a master's student at Da Vinci Institute conducting research on the implementation of the NHI in TMD.

2. Explanation of the process

Have you participated in a face-to-face interview before? Face-to-face interviews are being used more and more often in conducting research. Information obtained from the interviews will be used only for research purposes and no names of participants will be made known in the report. The interview will be audio-recorded in order to make a transcript for data analysis purposes.

About face-to-face interview*:*

- We learn from your (positive and negative) aspects of the implementation of the NHI.
- Not trying to achieve consensus, we are gathering information.

In this study, we are conducting a face-to-face interview with you. The reason for using this tool is to explore your views, ideas, experiences, and knowledge on the implementation of the NHI in TMD.

1: Discussion on the challenges of the NHI pilot implementation in Thabo Mofutsanyana District, South Africa

Which of these factors the implementation of the NHI encountered;

20 minutes

a) Are you familiar with the NHI pilot project in Thabo Mofutsanyane District?
b) Who was involved in the implementation exercise?
c) What are some of the challenges the district was confronted during the implementation?

- Financial and material resources?
- Human resources skills?

- Managerial capacity?
- Distribution of medical facilities?
- Health care professionals?
- Cost and reimbursement of providers?

2: Discussion of the impact of the NHI project in the Thabo Mofutsanyane district.

Does the NHI have any social and economic impact on the people of Thabo Mofutsanyana district:

a) What are your views on the NHI and family's financial hardship?
b) Do you believe the implementation of the NHI will ensure equitable distribution of health care among different grouping?
c) Will it be affordable- having in mind the economic disadvantage people?
d) Could the NHI reduce or limit the rising cost of health care services?
e) Have the standards of health care delivery service improved?

3: Discussion on the need for institutional support systems that enhanced the implementation of the NHI project

a) What could be the institutional support for the implementation of the NHI in Thabo Mofutsanyana district: What national governments direct/indirect support did the district received during the NHI implementation?
b) Did the district receive any financial or material support from the provincial government indirect/direct funding?
c) Was there any national/provincial education programmes regarding the NHI implementation in this district?
d) Do you have information and communication unit?
e) To what extent are you supported by the experts/health professionals in the district?
f) Any support from the local communities and their leadership?
g) What is the role of those providing primary health care-private/public?
h) Does the Rural Doctors Association of Southern Africa (RDASA) has a role to play?

Discussion on the plausible plans and recommendations to improve the existing NHI systems in Thabo Mofutsanyana district in SA

What are some of the factors that can promote NHI systems in Thabo Mofutsanyane district in SA?

C) Closing remarks – Researcher

END

APPENDIX 4: Information sheet and Consent Form for Focus Group Discussions (FGD)

This information sheet and informed consent form are for patients and the public using the health facilities in TMD, and who we are invited to participate in the FGDs.

This document has two parts: -

- **Information Sheet** (to share information about the research with you)
- **Informed Consent Form** (for signatures if you agree to take part)

PART I: INFORMATION SHEET

Introduction

I am Jabu Mbalula, a Masters student at the Da Vinci Institute in South Africa. We are conducting research on the implementation of the NHI in this district. I am going to give you information and invite you to be part of this research.

There may be some words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or the research assistants.

Background and Purpose of the research

The NHI was piloted in this district and ten others a few years ago with the aim of testing the implementation of this scheme for the whole country. The NHI is now being implemented in the whole country.

Responsible organizations (like WHO) recommend that health care provided to patients in an NHI scheme should be universal, quality care that meets their needs. The reason why we are conducting this research is to evaluate the implementation of the NHI in TMD, and to recommend how this implementation can benefit the people of TMD.

Type of Research Intervention

This research will involve your participation in a focus group discussion that will take about one and a half hours.

Participant Selection

You are being invited to take part in this research because we feel that your experience as a user of health services can contribute much to our understanding and knowledge of local health services.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier. You have the right to withdraw at any given point.

Procedure

We are asking you to help us learn more about your experiences on how health services are given for patients in your community. We are inviting you to take part in this research project. If you accept, you will be asked about how the health services are provided and about the challenges and opportunities to provide universal health services in the existing healthcare system; and if possible at what level of health system can we integrate services.

You will participate in the FGD with me. During the discussion, I will sit down with you in a comfortable place in the community. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question. No one else but I will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except my supervisor, is responsible for monitoring this study, will access to the information documented during your interview. The entire discussion will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept in locker /cabinet which will be locked. The information recorded is confidential, and no one else except me will have access to the tapes. The tapes will be destroyed after 48 months which is the end of this study.

Duration

The discussion will take approximately 60-90 minutes.

Risks

There are no known risks associated with this study. However, you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics; I do not wish for this to happen. You do not have to answer any question or take

part in the discussion if you feel the question(s) are talking about them makes you uncomfortable.

Benefits

There will be no direct benefit to you, but your participation is likely to help us find out more about the challenges of the health system for the implementation of the NHI; and also your contribution in this study will benefit others in the future by helping to improve the existing health system for tuberculosis and diabetes diseases.

Confidentiality

We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone except [my supervisor will have access to the information].

Sharing the Results

Nothing that you tell me today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we get from this research will be shared with you and your community before it is made widely available to the public.

Your interview result will be grouped with other individuals on all reports related to this study. If results of this study are reported in journals or at meetings, your identity will remain secret.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in the interview at any time that you wish without your job being affected. I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

Who to Contact

If you have any questions, you can ask me now or later. If you wish to ask questions later, you may contact any of the following: Jabu Mbalula, phone +27 824613112 or (+40)735836838 /email: mbalulajni@icloud.com

This proposal has been submitted for review and approval by the Research Ethics Committee (REC) of Da Vinci Institute, which is a committee whose task it is to make sure that research participants are protected from harm.

PART II: INFORMED CONSENT FORM

I have read the preceding information. I have had the opportunity to ask questions about it, and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Statement by the researcher/person taking consent

To the best of my ability, I have accurately read out the information sheet to the potential participants and ensured that the participant understood that the following would be done:

Focus Group Discussion.

I confirm that the participant was allowed to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the permission has been given freely and voluntarily.

Signature of Participant _____

Date _____

Day/month/year

I also consent to have the discussion audio recorded.

Signature: _____Date_____

A copy of this ICF has been provided to the participant.

Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____
Day/month/year

APPENDIX 5: FOCUS GROUP DISCUSSION GUIDE

EVALUATING IMPLEMENTATION OF THE SOUTH AFRICAN NATIONAL HEALTH INSURANCE SCHEME: A CASE OF THABO MOFUTSANYANA DISTRICT OF THE FREE STATE PROVINCE

This information sheet and informed consent form are for health practitioners working in the health facilities in TMD and who are invited to participate in the KIIs.

This document has two parts:

- **Information Sheet** (to share information about the research with you)
- **Informed Consent Form** (for signatures if you agree to take part)

PART I: INFORMATION SHEET

Introduction

I am Jabu Mbalula, a Master's student at the Da Vinci Institute in South Africa. We are conducting research on the implementation of the NHI in this district. I will give you information and invite you to be part of this research. You do not have to decide today whether or not you will participate in the study. Before you choose, you can talk to anyone you feel comfortable with about the research.

There may be some words that you do not understand. Please ask me to stop as we go through the information, and I will take the time to explain. If you have questions later, you can ask them about the research assistants or me.

Background and Purpose of the research

The NHI was piloted in this district and ten others a few years ago to test this scheme's implementation for the country. The NHI is now being implemented in the whole country.

Responsible organisations (like WHO) recommend that health care provided to patients in an NHI scheme should be universal, quality care that meets their needs. We are conducting this research to evaluate the implementation of the NHI in TMD and to recommend how this implementation can benefit the people of TMD.

Type of Research Intervention

This research will involve your participation in an in-depth interview that will take about one and a half-hour.

Participant Selection

You are invited to participate in this research because we feel that your experience as a practitioner can contribute much to our understanding and knowledge of local health services.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. Your selection will not affect your job or any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier. You have the right to withdraw at any given point.

Procedure

We ask you to help us learn more about your experiences with how health services are given to patients in your community. We are inviting you to take part in this research project. If you accept, you will be asked how the health services are provided, the challenges and opportunities to provide universal health services in the existing healthcare system, and, if possible, at what level of the health system can we integrate services.

You will participate in an interview with me. During the interview, I will sit down with you in a comfortable place in the community. If you do not wish to answer any questions during the interview, you may say so, and I will move on to the next question. No one else but I will be present unless you would like someone else to be there. The information recorded is I am

Welcome.

Good day; my name is Jabu Mbalula. I am a Masters student at da Vinci Institute researching the implementation of the NHI in TMD.

Explanation of the process

Have you participated in a Focus Group Discussion before? FGDs are being used more and more often in research to obtain information from a group of participants about the implementation or effectiveness of health services and how this affects them. The discussion will be audio-recorded to make a transcript for data analysis purposes.

About the Focus Group Discussion*:*

- We learn from your (positive and negative) aspects of implementing the NHI.
- Not trying to achieve consensus; we are gathering information.

We are conducting an FGD with you and other people in this district in this study. The reason for using this tool is to explore your views, ideas, experiences, and knowledge on implementing the NHI in TMD.

1: Discussion on the challenges of the NHI pilot implementation in Thabo Mofutsanyana District, South Africa

Which factors influenced the implementation of the NHI in the district?

2: Discussion of the implementation of the NHI project in the Thabo Mofutsanyana District.

Does the NHI have any social and economic value on the people of the **Thabo Mofutsanyane district?**

a) Protection of families from financial hardship?
b) Equitable distribution of health care among different groupings?
c) Affordability- economically disadvantaged people?
d) Reduce or limit the rising cost of health care services?
e) High standards of health care delivery service?

3: Discussion on the need for institutional support systems that enhanced the implementation of the NHI project

What could be the institutional support for implementing the NHI in the **Thabo Mofutsanyana district?**

4: Discussion of the plausible plans and recommendations to improve the existing NHI systems in the Thabo Mofutsanyana district in SA

What are some of the factors that can promote NHI systems in the Thabo Mofutsanyana district in SA?

a) Effective communication among public and private practitioners
b) Improve rural healthcare
c) District and community members' support?

d) National and provincial governments' support of the NHI implementation?

e) Remote patient care and telehealth?

f) Precision medication and integrated care for the population?

g) Population health management, lifestyle?

h) Patient empowerment using technology.

i) Improvement in the supply chain (drugs and revenue)

j) Improve premium transitions?

C) Closing remarks –Researcher

APPENDIX 6: RECORDS REVIEW FORM

Criterion	How criterion is addressed or not	Source/Record
Health service delivery – evaluate personal and non-personal health services in TMD.	• Health programmes and clinical services were (priority focus programmes: HIV/AIDS, TB, health education) implemented, • Environmental health	• District programme reports and statistics, 2017-2019 • District environmental policy
Heath care workforce – evaluate whether the health workforce is sufficient, fairly distributed; competent, responsive and productive.	• The District developed a District human resource plan informed by the provincial and national HR plans • Community services programme was also utilised to fairly distribute health professionals to far flung areas in the province • Contracting of GP's • Appointing community health workers	• District human resource plan • Statistics on staff appointments at health services, 2017-2019 • Reports on contracting of GPs and Signed appointment contracts for GP's Report on appointment of CHWs
Health information - evaluate whether there is a well-functioning health information system that ensures the production, analysis, dissemination and	• District Health Information systems	• Monthly reports, quarterly reviews and annual reports

use of reliable and timely information on health determinants, health system performance and health status.		
Health financing and its mechanism - evaluate whether there are adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.	• Budget reprioritisation • Monitoring and evaluation of financial performance • Auditing of financial statements	• Quarterly reviews • Annual reports, 2017-19 • And audited financial statements, 2017-19
Medicines and technology - evaluate whether there is equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use."	• Essential Drug List (EDL) reviewed on annual basis • Protocols and guidelines • Medicines and consumables availability reports	• Records of EDL reviews • Medicines and consumables availability reports
Leadership and Governance - evaluate whether a strategic policy framework exist and whether there is effective oversight, coalition-building, regulation, attention to system-design and accountability.	• Development of District health plan	• District health plan

APPENDIX 7: LETTER REQUESTING PERMISSION TO CONDUCT A STUDY IN THABO MOFUTSANYANA DISTRICT

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2nd Floor

District 1, Bucharest

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Head of the department

P.O Box 227

Corner Harvey Road and Charlotte Maxeke Streets

Bophelo House

Bloemfontein

9301

Dear Dr Motau

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am currently a Masters student through a distance mode of delivery at Da Vinci Institute of Technology Management and Innovation, presently engaging in a research study entitled *"Evaluating the implementation of the National Health Insurance Scheme in the Thabo Mofutsanyana District in the Free State Province",* under the supervision of Professor Geoffrey Setswe.

The objectives of the study are: 1) to examine the challenges facing the district in the implementation of NHI pilot project, 2) to assess the impact of the intervention projects in Thabo Mofutsanyana district, 3) to evaluate the institutional support systems that has enhanced or delimit the implementation of the NHI pilot project and 4) to make recommendations to government about necessary health system reconfiguration in order to realise a working efficient NHI for the district.

To achieve these objectives, the researcher needs to conduct a field interviews in all the sub-districts in Thabo Mofutsanyana municipal district. This will include identified district health

officials of the Free State department of health that were involved in the implementation of the NHI pilot. This research study is strictly for academic purpose and all the information gathered from the field study, discussions with district or provincial health officials and other documentary evidence will be kept for analysis and verification of the findings by the researcher.

The direct benefit to the Free State department of health and Thabo Mofutsanyana district is that the summary of the research findings will be made available to the department. In the long term the benefits are that the research findings will be used to inform planning in the department. Moreover, it is the intention of this research project to provide relevant policy recommendations that will be channelled through appropriate district and provincial departments to ensure their full implementation.

I trust that this request will receive your utmost favourable consideration

Thanking you in advance

Yours sincerely

Mr. Jabu Mbalula

APPENDIX 8: GATKEEPER PERMISSION LETTER

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

08-Feb-2023

Dear Mr Jabu Ntsokolo Ishmael Mbalula

Ethics Number: UFS-HSD2021/0322-0002

Ethics Clearance: **EVALUATING THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE THABO MOFUTSANYANA DISTRICT OF THE FREE STATE**

Principal Investigator: **Mr Jabu Ntsokolo Ishmael Mbalula**

Department: **External Affiliation**

Submission Page

SUBSEQUENT SUBMISSION APPROVED

With reference to your recent submission for ethical clearance from the Health Sciences Research Ethics Committee. I am pleased to inform you on behalf of the HSREC that you have been granted ethical clearance for your request as stipulated below:

Continuation report: This project's ethics clearance is extended until 07 February 2024.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2020); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

The Principal Investigator (PI) bears final responsibility for the RIMS application. In the event of any misconduct or improper activities perpetuated by a third party, the PI will be held vicariously liable. The HSREC will bear no responsibility or liability for any actions of a PI and/or third party or breach of confidentiality caused by the PI and/or third party.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this request for ethical clearance and we wish you continued success with your research.

Yours Sincerely

Prof. A. Sherriff
Chairperson : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee
Office of the Dean: Health Sciences
T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za
IRB 00011992, REC 230408-011; IORG 0010096; FWA 00027947
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APPENDIX 9: ETHICS CLEARANCE LETTER

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE WES-VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

23-Jan-2024

Dear **Mr Jabu Ntsokolo Ishmael Mbalula**

Ethics Number: **UFS-HSD2021/0322-0003**

Ethics Clearance: **EVALUATING THE IMPLEMENTATION OF THE NATIONAL HEALTH INSURANCE SCHEME IN THE THABO MOFUTSANYANA DISTRICT OF THE FREE STATE**

Principal Investigator: **Mr Jabu Ntsokolo Ishmael Mbalula**

Department: **External Affiliation**

Submission Page

SUBSEQUENT SUBMISSION NOTED

With reference to your recent submission for notification of the Health Sciences Research Ethics Committee. The HSREC took note of the following:

Final Report.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2020); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this matter for the attention of the HSREC.

Yours Sincerely

Dr. C. Armour (Barrett)
Chairperson : Health Sciences Research Ethics Committee

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