The South African health sector and the World Health organization South Africa's health sector and its preparedness for the National Health Insurance (NHI): Challenges and opportunities

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Abstract

The South African health system was and still characterized by social exclusion underpinned by those who can and those who cannot afford. Reflecting on the health sector during the apartheid era, prioritization was to ensure that the minority had access to the best healthcare services available while the majority lingered in poverty unable to access quality basic healthcare services. To gain a deeper understanding of South Africa's health sector, it challenges and the imminent implementation of the NHI, this paper seeks to systematize the existing empirical literature on the South Africa's health sector. By systematically addressing existing empirical research, the paper provides a sound basis for a more evidence-based discussion of this highly debated and politicized issue. The study results highlighted corruption, lack of infrastructure and shortage of well-trained healthcare workers as chronic challenges facing South Africa's healthcare sector. Therefore, the study concludes that although NHI's quest to address injustices of the past and ensuring citizens access healthcare without being subjected to affordability criteria can be characterized as noble, we argue however that, it implementation need to factor in the current challenges in the health sector as without addressing these challenges, the NHI is bound to encounter serious operational issues.

Keywords: Healthcare, Services, NHI, Access, Inequality, System.

Introduction

The South African health system was and is still characterized by social exclusion underpinned by those who can and those who cannot afford. Reflecting on the health sector in an apartheid South Africa, prioritization was to ensure that the minority had

access to the best health care services available while the majority lingered in poverty unable to access basic healthcare services. The current challenges in the health sector can be traced back to the apartheid period (1948–1993) in which the healthcare system was highly fragmented, with discriminatory effect, between four different racial groups (Maphumulo & Bhengu, 2019). Insofar as the right to have access to health care services is a basic human right guaranteed by the Constitution, 26 years into freedom, health care inequality in South Africa is even worse for poor, black South Africans than it was under apartheid (Norris, 2010). While significant efforts have been made to improve the quality of healthcare delivery in South Africa since 1994, there are still considerable challenges that remain. Rampant corruption, brain drain, infrastructure degradation and an increase in those seeking medical services factors compounding the development of the healthcare sector. Notwithstanding these challenges, the South Africa government has advocated for the implementation of the National Health Insurance Scheme which 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. For the government, the inequality in terms of accessing health care is the reason why some South Africans cannot afford the best health care available, hence the government hopes the NHI would rectify this anomaly. However, while this is commendable, there have been questions and doubts with regards to implementing the NHI, especially, relating to its cost. Attard Montalto, believes that NHI would cost SA R165 billion while the initial rollout is expected to cost R33 billion (Hlatshaneni, 2019). The question is where will this money come from? For the government, ensuring that South Africans have access to quality healthcare outweighs the cost involved, besides, the NHI will narrow the gap between the rich and poor in terms of standards of healthcare. While the authors see the nobility in the NHI, we argue that, that South Africa's push to implement the NHI fails to the reflect the economic position of country. Malakoane et al (2020) agree that while welcome, the NHI cannot be implemented at the current state. The authors argue that the South African health care sector is chronically challenged and if these challenges are not addressed, it will be impossible for the NHI to succeed. Additionally, while countries such as Finland, France, Germany, Greece, Iceland and Ireland have universal health care, there is a strong commitment to good governance, accountability and transparency in these countries, not the same can be said for South Africa. It is with the above, therefore, that the study seeks to examine the current state of South Africa's healthcare sector and its preparedness for the rollout and implementation of the NHI. We seek to understand possible opportunities that will be available for the NHI and the challenges that are bound to confront it. This will help examine South Africa's readiness for the NHI implementation.

Methodological issues

This paper employed a qualitative research approach where the review of the literature was undertaken to answer the underlying arguments of the paper. This approach allowed the collection of data from a local, regional and international perspective. This approach was employed to contextualize the understanding of the National Health

Insurance, its possible challenges should South Africa succeed in its implementation and the opportunities it is likely to produce. Therefore, this paper dwelled into the debates, arguments and theoretical literature informing this contemporary issue, especially considering the strides that South Africa has taken in its effort to ensure inclusive healthcare, to ensure healthcare services reaches the most vulnerable and to ensure the access to healthcare should be tied to one's economic standing. Taking into account, colonial and current narratives around the unequal access to healthcare in South Africa, an increasing population and degrading infrastructure, these narratives will therefore become integral in allowing the paper reach a meaningful conclusion hence the reasoning utilization of this methodological approach. Literature which spoke to the key questions of this paper was sourced from research databases such as Sabinet; Ebsco, Emerald Insight Journals; Google Scholar; IBSS; Scopus and Elsevier. Unequal access healthcare in South Africa has historical connotations attached to them; it was therefore important for the paper to examine these historical narratives and debates to understand how they have evolved to inform current debates around the concept of the National Health Insurance. The collected data from these sources was analyzed and interpreted thematically in order to answer the research questions of this paper.

Conceptualizing the Universal Healthcare Coverage

The World Health Organization (WHO) defines universal health coverage as a process of ensuring the people have unhindered access to health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship (Evans et al, 2013). Universal Healthcare as a process whereby all individual and communities receive quality and sufficient health service without suffering financial hardship. For the WHO, access to healthcare should not be viewed within the confines of economic stability (Bloom et al, 2018). Johnson (2020) contended universal health care is a system whereby the governments provides quality health care to all citizens regardless of their ability to pay. The WHO argues that universal healthcare is important in the quest to build inclusive a healthcare system globally. At least half of the world's population still do not have full coverage of essential health services, about 100 million people are still being pushed into extreme poverty (defined as living on 1.90 USD or less a day) because they have to pay for health care and over 930 million people (around 12% of the world's population) spend at least 10% of their household budgets to pay for health care (World Health Organisation, 2017).

Universal healthcare goes back more 3000 years ago in the town of Dier el-Medina in Egypt, workers enjoyed paid time off and home visits from a workplace doctor (Swan, 2019). In Germany in 1883, Chancellor Otto von Bismark attempted to unify German states included the Sickness Insurance Act of 1883, forcing companies to offer insurance to employees through a scheme where both paid into a fund. In 1884, the system has expanded to include accidents, in 1889, it included disability and eventually unemployment insurance in 1927 (Tulchinsky, 2018). Britain in 1911, passed that National Insurance Act. This covered health and unemployment, and

required individuals to pay into a fund alongside contributions from the employer and the state. However, it was not until 1948 that Britons gained universal health coverage, with the establishment of the National Health Service, free at the point of use and financed by the state (Light, 2003). Swan, (2019) reflected that the middle 20th-century, healthcare systems around the world were evolving and human population were growing. In 1945, then US president Harry Truman started a debate over US public healthcare. Subsequently, this led to the creation of two government programmers: Medicare and Medicaid. Medicare, established in 1965, covers the elderly, while Medicaid caters for the unemployed and the poor. However, Swan, (2019) argues the US remains an anomaly among industrialized nations for lacking a universal healthcare system, the United Kingdom, Australia, New Zealand, and Canada, Saudi Arabia, Oman, Cuba, Japan, Sweden and Denmark are some the countries which have implemented universal healthcare systems.

Nonetheless, it becomes important to point out that while there is a need for the easy accessibility of healthcare care, one must note that such systems are free of challenges.

Appraisals and Critiques of the concept of Universal Healthcare

There is no perfect system, whether political or socio-economic. Thus we argue that while the need for universal health care is an important step in the quest to ensure inclusive healthcare, we contend that there are factors that ought to be taken into consideration before such a system is adopted. Johnson (2020) & Gibson (2020) argue that several benefits can be accrued by countries that have such systems in place. Firstly, universal healthcare lowers the overall cost of healthcare and because the government regulates and negotiates prices, this allows for great participation of the population in the healthcare system (Johnson 2020 & Gibson 2020). Secondly, universal healthcare lowers administrative cost because medical professionals deal with a single government agency instead of many. Thirdly, it forces medical practitioners to provide the same quality of service across the board regardless of one's economic standing. Because the government subsidizes healthcare, the same standards of services are offered at a low cost (Johnson 2020 & Gibson 2020). Fourthly, universal healthcare makes it easier for patients to seek treatment and it allows many more families to seek basic treatments such as vaccinations and routine checkups. Finally, Gibson (2020) reflects that the biggest benefit of this type of system is that it could make medical services affordable for more patients. In turn, this means more people seeking out healthcare who might have attempted self-care or no treatment at all.

However, as argued earlier, no system is perfect and thus universal health care systems also face considerable drawbacks challenges. Firstly, Gibson (2020) argues that doctors have less flexibility in rate negotiation. For some practices, this can mean a highly detrimental decrease in profit. Because government agency determines the amount a doctor can charge for services rendered, doctors have little room to maneuverer and this contributes to skills labour migration. Secondly, universal healthcare could in the long run diminish the quality of care people receive. increased demand creates a massive burden as to how to categorize patients in a manner that allows those with the most critical needs to benefit from treatment first (Gibson, 2020).

Additionally, this could exert pressure on medical practices and clinics, and thus meaningless personalized care and an increased chance of a mistake or malpractice. thirdly, people have a less financial incentive to stay healthy: Without a copay, people might overuse emergency rooms and doctors (Johnson, 2020). Fourthly, they are likely to be long wait times for elective procedures: The government focuses on providing basic and emergency health care.

We argue that in South Africa while universal healthcare would be welcomed, considering the growing population and the demand for healthcare. However, implementing such a would require a complete overall of the healthcare sector. From Infrastructure to resource support, to eliminating the threat of brain drain and to reducing corruption are all the factors that need to be addressed before such can be piloted. Furthermore, the demand for healthcare in South Africa outstrips the currently available human resource personnel, thus there is a need to introduce a control mechanism to address this mismatch.

Understanding the National Health Insurance

Understanding the national health insurance requires the indulgent on its models. There are various models used for National Health Insurance purposes. Models are explained below:

Beveridge models (public service)

According to Econex (2011:1-3) This type of model is the simple public service model where healthcare is financed through general taxation and provided 'freely' to the entire population as a public good, just like police services or public roads. The classic example is that of the National Health Service (NHS) in the UK (also where the model derives its name from: William Beveridge initially designed the NHS). In this type of model, healthcare services are fully administered by the state, they control delivery, and the factors of production are largely owned by the state (facilities, human resources, etc.). In some cases, such as the UK, the health system is organised in a highly centralised way, while in Norway and Sweden, for example, the organisation and management is more decentralized.

Chung (2017) laments that the model is also called single-payer National Health Service. The model was first developed by Sir William Beveridge in 1948. It was established in the United Kingdom and spreading throughout many areas of Northern Europe and the worlds. The system is often centralized through the establishment of a national service. Chung (2017) further explains that the government acts as the single-payer, eliminating competition in the market and generally keeping prices low. It funds health care through income taxes allows for health care to be free at the point of service.

Bismarck models (social security based)

Econex (2011) explains that Bismarck models derive its name from the Prussian Chancellor Otto von Bismarck "who invented the welfare state as part of the unification of Germany in the 19th century." Accordingly, Germany is most often

cited as the prime example of such a model. There are a number of different models all forming part of this group, but in its purest form, a Bismarck model is a social insurance model where it is compulsory for all citizens to belong to an insurance fund (also called "sickness funds") which are financed through social contributions or premiums paid by employers and employees. The premiums are usually in the form of payroll deductions and hence costs are still controlled by the government to an extent. The funds are not allowed to make profits and healthcare providers tend to be largely private.
Chung (2017) explains that despite the number of insurers, the government tightly controls prices while insurers do not make a profit. These measures allow for the government to exercise a similar amount of control over prices for health services.

National insurance models
Econex (2011) argue that the NHI system is a form of the Bismarck model and should be seen as a sub-category or variant of that group. Public service (tax-based) models will be contrasted with insurance-based models – the latter group including both Bismarck and NHI models. While both NHI and Bismarck models are insurance-based, the main difference is that NHI models are single payer systems, as opposed to having multiple payers (insurance funds) like the pure Bismarck models. In other words, there is a single, central fund receiving contributions and paying the providers of healthcare services. Payroll contributions are often supplemented by general taxation or other public funds. Providers and facilities tend to be largely private, although mixed systems of public and private providers are not uncommon. Econex (2011) further laments that NHI models are built on insurance principles such as risk pooling and cross-subsidization. It is further characterized by mandatory contributions to a national insurance fund and benefits are also enjoyed by those who do not contribute – in a social health insurance (SHI) model, those who do not contribute do not benefit. NHI-type models also tend to provide universal coverage right from the start, whereas many Bismarck/social insurance models start by providing coverage to only a certain group (usually the formally employed population) before extending insurance to the rest of the population. Taiwan and South Korea are the most well-known examples of countries with NHI systems. One can easily see the similarities between the proposed NHI model in South Africa, and the Taiwanese model.

Out-of-pocket models
Econex (2011) explains that out-of-pocket (OOP) models as a separate category – mainly because it is not truly a structured or planned system. However, since the majority of countries in the world are too poor and the governments too weak to institute a public health system of any kind, and as a result have OOP systems, it is mentioned here as a separate health service model. In OOP models patients pay in cash (or by whatever means they have available such as food products, child care services, etc.) to receive medical care. Often they cannot afford doctors and will see traditional/ village healers which may or may not provide effective remedies. Both public and private providers can provide healthcare services in this type of model.

As in SA, OOP models are often found in conjunction with other models. In systems where there is no universal coverage, the portion of the population that is uncovered or only partially covered has to pay out-of-pocket for medical services.

Universal healthcare in developing countries: progress thus far

Universal healthcare as a process has mostly been studied in the context of developed countries who possess the financial power, human capital and infrastructure to ensure its realisation. However, in the last three decades, population growth has often taken place in poor countries which have exerted pressure on the health systems in the developing world (Chen et al, 2014). The World Bank as of 2015 notes that Argentina, Brazil, Chile, China, Columbia, Costa Rica, Ethiopia, Georgia, Ghana, Guatemala, India, Indonesia, Jamaica, Kenya, Kyrgyz Republic, Mexico, Nigeria, Peru, Philippines, South Africa, Thailand, Tunisia, Turkey and Vietnam were countries rolling out or experimenting with universal health coverage programs designed to expand access to health care and reduce the number of people impoverished by paying for the health care they need (The World Bank Group, 2015). While McKee et al, (2013) argue that over the past 50 years, access to healthcare has become key in contributing towards the development of the nation-state, however, benefits are still denied to many people worldwide. There have been questions as to why so some countries have universal healthcare and others do not and what might be the cause of this. McKee et al, (2013) reveal that there five determinants of universal healthcare namely; left power, economic resources, societal division, existing institutions and windows of opportunity. In developing countries, the situation continues to be quite different than that in developed countries. Firstly, economic models used by developing nations have also relied heavily on extensive foreign investment and integration in global markets, which has constrained their ability to raise taxes and public revenue, a critical precondition for establishing viable universal healthcare (McKee et al, 2013). Secondly, the medical sectors in these countries are characterized by a strong private-sector alliance of insurance companies, medical associations, and pharmaceutical companies that profit from privatized health care finance and delivery. Moreover, in developing countries, progress was more erratic, characterized by debates about the affordability of universal health care and thus such debates have stalled progressive step towards realizing universal healthcare (McKee et al, 2013). In Africa while, UNAIDS (2019) argues that momentum for Universal Health Coverage (UHC) in Africa is building and many African countries have already integrated UHC into their national health strategies, Most of Africa's public health care systems resemble overburdened, under-resourced and sick donkeys. They are often a major epidemic away from collapse. Moreover, financial protection is generally low in Africa, requiring most patients to pay for health services from their household income, so-called out-of-pocket (The World Bank Group, 2015). Thus universal healthcare in Africa would require total reconfiguration of the economic, social structure and the political ideology. In Asia, as the region moves towards universal healthcare, there are considerable challenges that ought to be addressed. Firstly, how to ensure the coverage of the informal sector to ensure universal healthcare is truly universal (Bredenkamp et al, 2015). Secondly, how to integrates universal healthcare amid current challenges in the health sector and finally, how to ensure universal healthcare

is fiscally sustainable and also ensures the quality of services. In Latin America and the Caribbean, countries have made the protection of health is increasingly being recognized as a universal right and gradually de-linked from labour market and thus countries such as Chile, Argentina, Colombia and Cost Rica have been moving towards universal healthcare

The proposed National Health Insurance in South Africa

The quest for government to ensure all South African are afforded their constitutionally legislated right of accessing healthcare services is yet to be realized through the National Health Insurance. The NHI is 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 standing. It seeks to ensure that the use of health services does not result in financial hardship for individuals and their families. The main aim of the NHI is to secure universal coverage for all South Africans, meaning that every South African will have a right to access comprehensive healthcare services free of charge at the point of use at accredited health facilities such as clinics, hospitals and private health practitioners. Healthcare services are to be delivered closer to the people through the NHI.

NHI is being implemented in phases over a 14-year period that started in 2012. It will be established through the creation of a single fund that will buy services on behalf of the entire population. The funding for NHI will be through a combination of various mandatory pre-payment sources, primarily based on general taxes. In December 2015, the White Paper on National Health Insurance was published where the members of the public were to submit their comments by March 2016. The National Health Insurance policy document was subsequently gazetted after it approval by the cabinet in June 2017.

According to the National Health Act (2013) the quest towards Universal Health Coverage (UHC) through implementation of NHI is derived from the following: The Reconstruction and Development Programme (RDP); the Constitutional mandate based on the Section 27 of the Constitution; the 1997 White Paper for the Transformation of the Health System; and Vision 2030 of the National Development Plan Vision 2030 (National Health Act, 2013).

NHI derives its mandate from Section 27 of the Bill of Rights of the Constitution of the Republic of South Africa and is based on the principle of the Constitutional right of citizens to have access to quality healthcare services that are delivered equitably, affordably, efficiently, effectively and appropriately based on social solidarity, progressive universalism, equity and health as a public good and a social investment.

Table 1.1: Timeline of health-financing policy initiatives and proposals since 1994

1994	African National Congress (ANC) National Health Plan recommended that a Commission of Inquiry be appointed to investigate the feasibility of a National Health Insurance (NHI) Fund (17).

1994	National Department of Health's Health Care Finance Committee put forward three possible mandatory insurance options, including NHI (18).
1995	Hospital Strategy Project, initiated by the National Ministry, tasked with setting out a framework or the development and restructuring of the public hospital sector (19).
1995	Committee of Inquiry into a NHI System (20).
1997	National Department of Health releases policy document on Social Health Insurance Scheme for formal sector employees (21).
1997	White Paper on the transformation of the health system in South Africa built upon the ANC's 1994 Health Plan (22).
2002	The Committee of Inquiry into a Comprehensive System of Social Security for South Africa recommends that South Africa move toward a NHI system (23).
2004	Ministerial Task Team on SHI recommended implementation of SHI for the formally employed, since it did not consider NHI feasible in the short term.
2005	Ministerial Task Team commissioned an investigation into low-income medical schemes (24).
2005	Introduction of the Government Employee Medical Scheme (referred to as the government scheme in the article), restricted to public-sector employees.
2007	A policy resolution committed the ANC to introduce NHI (25).
2011 to date	NHI Green Paper released by government detailing a 14-year plan towards NHI (26).

Source**:** Adapted from Govender, et al (2013)

Table 1.1 above shows initiatives and proposals since 1994 of health-financing policies leading to the National Health Insurance Green Paper that was released by government detailing NHI 14-year plan in the year 2011. The government has since the advent of democracy been working together in ensuring that it citizens have access to healthcare services.

South africa the health sectors and its challenges

A major weakness in sub-Saharan African health systems is inadequate human resources. Africa is said to have less than one health worker per 1000 population compared to 10 per 1000 in Europe (Maphumulo & Bhengu, 2019). While efforts have been made to improve the quality of healthcare delivery in South Africa since 1994 elections, but several issues have been raised by the public regarding public institutions.

Infrastructure challenges and increasing population

Infrastructure is crucial for ensuring socio-economic development. Given the importance of the public healthcare sector, the CovId-19 pandemic has laid bare the unequal development in the country's health sector. The pandemic has pressured South Africa to analyze the current state of their healthcare infrastructure and make meaningful investments to improve access to quality health care. In South Africa, the lack of investment healthcare infrastructure and equipment has made it harder for the

country to retain skilled healthcare workers and provide essential medicines (Human Rights Watch, 2020). The lack of consistent planning for healthcare infrastructure and inadequate funds allocation, compounded by economic growth issues have left public the health sector ill-prepared to deal with the novel coronavirus in Africa and other health-related issues. With a growing population, it becomes imperative for South Africa to consolidate its investment in infrastructure development to cater for growing demand. Maphumulo & Bhengu (2019), agreed that public healthcare facilities exhibit numerous shortcomings such as long waiting times, poor-quality healthcare delivery, old and poorly maintained infrastructure, and poor disease control and prevention practices. These facilities had problems such as poor waste management, lack of cleanliness and poor maintenance of grounds and equipment. Therefore, the national health insurance cannot be effectively implemented should the county fail to upgrade or invest in health infrastructure development.

Skills labor migration/brain drain

The public sector is under-resourced and overused, whereas the private sector continues to grow with adequate resources. Additionally, to the challenges facing the South African healthcare is the brain drain of skilled health care workers to more developed countries, due to concerns about the quality of working conditions, pay, and career development created a shortage of health care staff, which profoundly affected the public health sector and in time resulted in several nationwide strikes which were prominent within the hospital sector (Bezuidenhout et al., 2009). In South Africa, an estimated 250,000 skilled health workers left the country between 1989 and 1997 for New Zealand, Canada, Australia, the UK and USA (Padarath et al. 2004), and in 2001, more than 4,000 vacancies for doctors and upwards of 32,000 vacancies for nurses were found (Hall and Erasmus 2003). The decline in quality health care has caused the public to lose trust in the healthcare system in South Africa. We argue that driving the brain drain has been the globalisation of the health sectors coiled with demand for health professionals around the world. We also posit that the poaching of medial personally by rich countries has compounded the development of the health sectors in many poor countries, and South Africa has also not been spared of this rampant poaching. Poor working conditions, salary issues, political uncertainty and underinvestment in the health sector are issues contributing to the brain drain on health professionals from South Africa.

Corruption

The COVID -19 pandemic has laid bare the scourge of corruption in the procurement of personal protective equipment (PPE). The South African government revealed that the health care is the third largest item of government expenditure, it also reflects that the country continues to rank low in global rankings on health care system efficiency owing to, among other things, inefficient resource management, poor institutional accountability, ineffective monitoring and evaluation, and corruption (South African government, 2019). The council for Medical Schemes estimates that the total cost of fraud in the South African private healthcare system amounts to about R22-billion a year (Mafolo, 2020). Corruption in 2018 alone, received 108 reports on corruption in

the healthcare system — including complaints about employment and procurement irregularities, abuse of state resources and abuse of power by officials.

Apartheid legacies

Many of problems in the South African healthcare system can be traced back to the apartheid period (1948–1993) in which the healthcare system was highly fragmented, with discriminatory effect, between four different racial groups (black, mixed-race, Indian and white (Maphumulo & Bhengu, 2019). While South Africa has invested in healthcare development, accessibility and quality, successive governments are still held back by the legacies of apartheid. These range from rural inaccessibility of healthcare, the difference in the quality of healthcare offered, the privatization of healthcare built on the need to exclude and the inability of the government to bright the gap between the unequal nature of healthcare. Today, this is still very much the case in SA, there is still a great divide between the quality of healthcare between rural and urban areas.

Shortages of resources and institutional support

As argued earlier, the geographic spread of health facilities in South Africa continues to be skewed. Shortages of medicines, staff and PPE have all being laid bare by the covid-19 pandemic and this has compounded an already fragile health sector. Arguably, the lack of institutional support has somewhat contributed to this problem. The long waiting times for medical intervention potentially exposed patients to development of complications or even loss of life; public hospitals, in the words of the report, have become a death-trap for the poor'

The National Health Assurance: opportunities, problems and prospects

The roots of a dysfunctional health system and the collision of the epidemics of communicable and non-communicable diseases in South Africa can be found in policies from periods of the country's history, from colonial subjugation, apartheid dispossession, to the post-apartheid period (Coovadia et al., 2009). These were issues which the incoming government had to address to ensure equality and accessibility of healthcare services especially for the previously disadvantaged. The aforementioned discussion dwelled on a plethora of narratives. The first narrative laid bare the problems in the country's health sector. The second narrative examined the need for the National Health Insurance Fund (NHI). However, we argue that despite the negative arguments and debates surrounding the NHI, there are opportunities and prospects for it to succeed provided there are checks and balances within the healthcare system. The South African government for its part has reasoned that healthcare provision and accessibility remains considerably skewered in South Africa, thus the bill is aimed at rectifying this anomaly (Mayosi and Benatar, 2014). Reinforcing the arguments by Mlambo and Adetiba (2019), we posit that South Africa's healthcare system has for decades suffered from underinvestment, brain drain, overcrowding and the degrading infrastructure. The decline of South Africa's healthcare system has been attributed to a plethora of factors. Politicians have attempted to attribute the decline in the public sector to a myriad of ills, none of their making. These include migrants;

insufficient funds; insufficient staff; medical schemes; lawyers suing them for medical negligence; the existence of two tiers and even the middle class (Van den Heever, 2019). The problems in South Africa's healthcare system can be blamed on institutionalized patronage within provincial and national government that has destroyed the capabilities of public health organizations – both national and provincial (Van den Heever, 2019). Subscribing to this view, Maphumulo and Bhengu (2019) mentioned that prolonged waiting time because of shortage of human resources, adverse events, poor hygiene and poor infection control measures, increased litigation because of avoidable errors, shortage of resources in medicine and equipment and poor record-keeping are other issues that ought to be addressed. The COVID-19 pandemic further revealed the segmentation of the health sector in the country. South Africa's health system is deeply segmented. It consists of a well-resourced private sector – mostly funded by expensive medical aid scheme membership – and an overburdened public sector which caters for the majority of poor masses (mostly Africans) (Benatar, 2013). It is estimated that only 10% of Africans belonged to medical aid schemes compared to 73% of whites in 2018. While we support the government's vision of a universal healthcare system, we also caution that without addressing the challenges in the healthcare sector, the implementation of the NHI and its operation may impede the government's ultimate goal.

Coovadia et al, (2009) reflect that perhaps the biggest problem facing South Africa's health sector today has been the legacy of ineffective distribution of staff and poor skills of many health personnel, which has compromised the ability to deliver key programs, notably for HIV, tuberculosis, child health, mental health, and maternal health. This we argue had been coupled with the lack of investments in new health infrastructure and modernization of current processes and methods used to deliver health services. There has also being a reluctance to strengthen the management within the human resource segment. For the author, part of this problem lies mostly with managerial capacity, under apartheid, the system was male and white, and public sector managerial competence was centralized and highly variable (Coovadia et al, 2019). Post-1994, the public health sector had been expanded to reduce white unemployment; a concerted effort was made to include women and black people in senior and top management teams. The changes resulted in a loss of institutional memory and some problems associated with many inexperienced managers placed in positions of seniority (Coovadia et al, 2019). The consequence of this was newly appointed managers were inexperienced and struggled with major challenges associated with health sector transformation and more importantly, how to ensure a more effective and efficient human resource. Today, issues of ill-discipline, moonlighting, absenteeism are widespread and have become the norm. Fourie and Poggenpoel (2017) and Coovadia et al (2019) reflect that there has been insufficient political will and leadership to manage underperformance in the public sector. There also been the notion of retaining incompetent senior staff and leaders. Suspensions take forever to resolve while employees are on full pay and for many years, loyalty—rather than an ability to deliver—has been rewarded in the public sector and there has been no climate of accountability.

Incompetence within the public health sector is so widespread that it is an issue that

has become difficult to deal with. Today, While the challenges in the health sector can be traced back to apartheid, Coovadia et al (2019) contend that it also stems from a disastrous education situation, which has resulted in most individuals emerging from secondary (and often tertiary) education with limited numeracy, literacy, and problem-solving skills. Building on the above insights, Rispel (2018) explained that the health system performs poorly due to a combination of factors including the poor management of public sector hospitals, health professional shortages (particularly in rural areas), low productivity levels among staff, escalating private health care costs and poor quality of care. Access to health care is a particular concern given the centrality of poor access in perpetuating poverty and inequality. Van den Heever (2019), claimed that South Africa's health sector is in need of various reforms, there are considerable inequities in health care between urban and rural areas; between public and private health sectors and between primary health care and hospital care. South Africa has poor health outcomes when compared to other middle-income countries such as Brazil with similar health spending as a percentage of GDP. The country spent over R300 billion on health care (Rispel, 2018). But half is spent in the private sector catering for people who are well off while the remaining 84% of the population, which carries a far greater burden of disease, depends on the under-resourced public sector. Observing these start issues and the need to reform the health sector, the country's proposed national insurance scheme aims to tackle the stark divide in health care between rich and poor (Rispel, 2018).

NHI: opportunities and considerations

Proponents of the NHI have contended that it will unify South Africa's segmented healthcare system, allow for more inclusive accessibility and use and ensure that people are not excluded based on economic status. Moreover, proponents argue that the NHI is needed because as the population increases, there is bound to an increase in the demand for healthcare, and thus people should not be excluded based on affordability. However, despite these underlying reasons, we argue that challenges in the country's health sector need to be addressed to ensure the NHI becomes effective. However, the NHI has not been without criticism and a considerable amount of it has been associated with the cost of setting it up. In Canada, the Canadian Institute for Health Information reported that healthcare spending was $242 billion or 11.5 percent of Canada's gross domestic product (GDP) in 2017 (McQuigge, 2017). In India, when universal health plan was proposed in 2014, it was estimated that it was going to cost an estimated 1.6 trillion rupees ($26 billion) over the next four years and $11.4 billion annually when the entire population was covered (Kalra, 2014). These figures indicate that universal healthcare is very expensive. Apart from being expensive, it requires an integrated health system characterized by the availability of resources and infrastructure. In South Africa, experts have argued that rolling out the NHI will cost the country cost SA R165 billion (Hlatshaneni, 2019). While critics argue that the such a huge amount can be invested to fix the country's health system, Ngcuka (2019) argued that Less than 20 percent of South Africa's population of 58 million can afford private healthcare, while a majority of poor blacks' queue at understaffed state

hospitals short of equipment, hence the NHI will help alleviate this congestion and allow for more seamless access to healthcare in the country. Yates (2019) refutes the allegations that the country cannot afford the NHI, the author maintains that evidence from the globe argues otherwise. For example, South Africa already spends more than 8% of its national income on its health sector, which is very high for its income level. In turkey, a county slightly richer then South Africa, spends 4.3% of its GDP and Thailand (a global universal health coverage leader) spends only 3.7% (Yates, 2019). We argue therefore that South Africa can afford the NHI however, there needs to be adherence to constitutionalism and good governance and the need to eradicate health sector corruption. We posit the infrastructure development, respect for the rule of law, an effective human resource and the emphasis on accountability ought to be consolidated for the NHI to stand a chance of success. Moreover, Yates (2019), contended that the current system is grossly inefficient and inequitable because more than half of these funds are spent through private insurance schemes that cover only 16% of the population — and often don't cover even this population effectively. in a system where resources are channeled through an efficient public financing system, evidence from around the world shows that the health sector would achieve better health outcomes, at a lower cost. Health and income inequalities would fall too. There are opportunities for the NHI to readdress historical injustices with regards to healthcare, however, without or addressing the challenges that exist in the health sector, haphazardly rushing to implement the NHI would have devastating economic effects that would spill over the health sector.

Conclusion and way forward

The concept of universal healthcare is anchored on various models which pre-date democracy in South Africa. South Africa's population is growing; this, in turn, exerts pressure on the health care system, which is already compounded by numerous issues which need to be addressed. The unequal access to health care in South Africa has compounded government efforts to reduce inequality and promote inclusive socio-economic development. Corruption, apartheid legacies, poor accountability and a lack of human resources and poor infrastructure are some of chronic challenge's in South Africa's healthcare sector today. The NHI seeks to address injustices of the past and ensure citizens access healthcare without being subjected to affordability criteria. However, its implementation needs to factor in the challenges in the sector, i,e, without addressing these challenges, the NHI is bound to encounter serious operational issues. Evidence from the global community reveals that while universal health systems are achievable, maintenance costs remains a significant challenge for underdeveloped and developing countries, and with South Africa's sluggish growth, it remains to be seen how the government will source the funds needed for this mammoth project, let alone ensuring its effective operation. Going forward, there is need to address challenges currently facing the health sector, liaise with stakeholders, invest in infrastructure development and human resources to ensure that once implemented, its functioning won't be handicapped by pre-existing issues.

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