The Views of Public Service Managers on the Implementation of National Health Insurance in Primary Care

Shane Darren Murphy (murphy.shanedarren@gmail.com)
University of the Witwatersrand

Shabir Ahmed Moosa
University of the Witwatersrand

Research Article

Keywords: Universal Health Coverage, National Health Insurance, Managerial Capacity, Qualitative research, Decentralised governance, Primary care

Posted Date: June 15th, 2021

DOI: https://doi.org/10.21203/rs.3.rs-515206/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License

Version of Record: A version of this preprint was published at BMC Health Services Research on September 15th, 2021. See the published version at https://doi.org/10.1186/s12913-021-06990-4.
The Views of Public Service Managers on the Implementation of National Health Insurance in Primary Care

Authors:
Shane D. Murphy\textsuperscript{1} MBChB, MPH, Dip PEC, Dip HIV Man
Shabir A. Moosa\textsuperscript{2} MBChB, MBA, PhD
\textsuperscript{1}Department of Family Medicine, School of Clinical Medicine, University of the Witwatersrand, Johannesburg, South Africa. Email: murphy.shanedarren@gmail.com
\textsuperscript{2}Department of Family Medicine, School of Clinical Medicine, University of the Witwatersrand, Johannesburg, South Africa. Email: shabir@profmoosa.com

Corresponding Author:
Shane Murphy
murphy.shanedarren@gmail.com
Abstract

Background
The South African government is implementing National Health Insurance as a monopsony health care financing mechanism to drive the country towards Universal Health Coverage. Strategic purchasing, with separation of funder, purchaser and provider, underpins this initiative. The NHI plans contracting units for primary healthcare services to function as independent sub-district purchasers and District Health Management Offices to support and monitor these contracting units. This decentralised governance model to the operational unit of primary healthcare, the heartbeat of any universal healthcare system, is critical to programme success. The views of district-level managers, who are at the centre of the planned phased rollout will shed light on current policy implementation.

Objectives
This is a qualitative study to explore district and sub-district managerial views on National Health Insurance and its implementation.

Methods
Purposive sampling was used to identify key respondents from a major urban district in Gauteng, South Africa, for participation in exploratory in-depth interviews. This study employed framework analysis within MaxQDA software for robust thematic analysis.

Results
Managers viewed National Health Insurance as a social and moral imperative but lacked clarity and insight into the National Health Insurance Bill and relevant implementation strategies. The majority of respondents had not received any engagement or had the opportunity to engage in policy formulation. District managers highlighted several pitfalls in current organisational operations. National and provincial government continue to function in a detached and rigid top-down hierarchy. The voices of coalface managers and workers, who live the reality of South African healthcare service provision, go unheard and unengaged. The findings of this study dishearteningly echo lessons already learned around established pillars of universal healthcare implementation such as human resources, multi-lateral stakeholder engagement and collaboration, devolution of governance with empowerment and capacitation of district managers. These findings imply that the South African Government has failed to anticipate and address these challenges and raises questions around reflective and experiential practices of the South African government.

Conclusion
It appears that strategic purchasing is not being operationalised in PHC. NHI policy implementation appears trapped in a rigid top-down hierarchy. District managers need to be engaged and capacitated to operationalise the planned decentralised purchasing-provision function of NHI.

Keywords:
Universal Health Coverage, National Health Insurance, Managerial Capacity, Qualitative research, Decentralised governance, Primary care.
Background

South Africa’s current health system is overwhelmed by a quadruple burden of disease, aggravated by the bi-partite structure of public and private health care services that started in the late apartheid era, with the private sector growing strongly in the post-apartheid era to preserve privilege. National government has moved towards implementing National Health Insurance (NHI) as a mechanism to fulfil the plans of the National Development Programme (NDP 2030) to attain Universal Health Care (UHC) as mandated by the South African Constitution. UHC is a critical component of Target 3 of the Sustainable Development Goals (SDG’s) that pursues financial risk-protection and accessible, equitable and quality healthcare services.

The current legislative framework for healthcare delivery, as set forth in the National Health Act (NHA of 2003), creates a three-tiered, top-down structure. The national health council is primarily responsible for policy formulation and national priority setting, while provincial government is legislated (intergovernmental fiscal relation system) to receive the bulk of financing and is responsible for healthcare service delivery through the district health system. The Public Finances Management Act of 1999 sought to decentralize governance to the provincial level as part of the reconstruction and development programme to reform the inequitable health system. Coupled with this law, other legislation (NHA, Local Government Municipal Systems Act of 2000) provided little means for decentralised governance at the district level.

The NHI Bill repeals these laws and plans to vest operational control of a district on district and sub-district managers with contracting units for primary healthcare services (CUPS). CUPS are intended to function either as purchasers funded by the NHI fund or as independent public-service providers contracted with NHI to provide personal services. Current district managers are to assume the role of District Health Management Offices (DHMOs) to support and monitor CUPS and provide non-personal health services. The decentralized governance of CUPS to the district health system is regarded by the Joint Learning Network and other international bodies as fundamental to implementing strategic purchasing through CUPS. District level managerial capacitation facilitates targeted decision-making and increases accountability.

NHI is currently in its second phase of implementation (of three) that seeks to build on achievements from phase 1, expand multi-sectoral collaboration, continue infrastructural development and finalize NHI bill and related implementation regulations. The first phase (2012-2017) piloted several health services strengthening initiatives targeted at PHC – the “heartbeat of NHI.” A total of 10 interventions were implemented throughout 10 pilot sites across the country. A recent collaborative evaluation report of phase 1 was released in 2019. While this report showed mixed success across the 10 pilot-sites, the authors highlighted shortfalls in critical governance components. These findings were similar to those from shared learning from several countries implementing UHC that underscored the role of district and sub-district-level managerial awareness, engagement and alignment with the principles as well as the processes of NHI implementation. The authors proceeded to provide strategic recommendations for phase 2 that parallel those of the updated National Strategic Plan: collective participation with a focus on consensus orientation, transparency, accountability, responsiveness and efficiency within governing structures made possible through prioritization of district health system managerial capacitation.
The qualitative component of the evaluative report explored managerial views of the NHI phase 1 interventions. However, this evaluation sought fixed outcomes, through structured interviews, that focused on the success of interventions, rather than district health systems and district level managerial views themselves. A thorough literature review yielded no studies targeting district and sub-district managerial views on NHI or their engagement with NHI policy development and implementation. Further, no evidence could be found that explored the readiness of district managers in coping with phase two.

We aimed to explore the views of district and sub-district level managers of NHI, as well as their experienced engagement in policy development and implementation.

Methods

This was an exploratory qualitative study with an overt policy orientation. Our study was conducted within Johannesburg Health District, one of Gauteng province’s health districts, between 2020 and 2021. This district was selected as it is a major district with geopolitical proximity to provincial and national governance structures. Delays and non-response in obtaining district ethics approval hindered a planned evaluation of other Gauteng districts.

Purposive sampling was used to identify data rich participants. Further, purposive sampling was done through a framework of stratified random sampling so that a balanced mix of DMs and sub-DMs of all backgrounds would be sampled. Ethics approval of the research protocol was obtained from the University of Witwatersrand’s Human Research Ethics Committee M191046 as well as the Research Committee of the Johannesburg Health District GP_202006_048. All methods were carried out in accordance with the guidelines and regulations set forth by the above-mentioned ethics committees. A participant information sheet that had been approved by both ethics committees was provided to each respondent. The interviewer went through the interview with each participant to clarify any uncertainties and address any questions. Written informed consent was taken separately for participation in the interview as well as the audio-recording of the interview.

In-depth interviews were used to attain study objectives. The four main questions are described in table 1. Interviews were recorded via a dictaphone and transcribed verbatim into Microsoft Word. Pragmatic sampling saturation was reached following seven interviews although a total of ten interviews were conducted. Transcripts were sent back to participants for member-checking. Transcripts were then imported into computer-assisted qualitative data analysis software (MaxQDA) to facilitate robust and explicit data analysis. Data analysis followed the five-step approach of Framework Analysis: familiarization, data mining, coding, and indexing, charting, and mapping, and interpretation. Peer-checking of the thematic analysis, as well as the greater framework analysis, was performed by the second researcher.

Table 1: Overarching questions in the interview schedule

|   | Question                                                                 |
|---|--------------------------------------------------------------------------|
| 1 | What are your views on National Health Insurance?                        |
| 2 | Can you tell me about your engagement in NHI policy development?         |
| 3 | What is your perception about the implementation of NHI?                 |
| 4 | Is there any other view or thought you would like to express?            |
Results:

Ten district managers were interviewed for the study. Table 2 provides a summary of the respondent profiles while Table 3 provides a summary of key findings. Participant ages and work experience ranged between 35-65 years and 6-42 years respectively. However, the duration of their current position as a district or sub-district level manager ranged from one month to six years. Six participants were female and four were male. Seven participants were district-level managers, and three participants were subdistrict-level managers. All the research participants were employed within the Johannesburg Metropolitan district health care system in Gauteng.

Table 2: Respondent Profiles

| Identifier | Ethnicity | Gender | Managerial Level | Time in Current Position |
|------------|-----------|--------|------------------|--------------------------|
| Respondent 1 (R1) | African | Male | District | 1 month |
| Respondent 2 (R2) | African | Male | District | 3 months |
| Respondent 3 (R3) | Coloured | Female | District | 6 months |
| Respondent 4 (R4) | White | Female | District | >1 year |
| Respondent 5 (R5) | African | Female | Sub-District | >1 year |
| Respondent 6 (R6) | Indian | Male | District | >1 year |
| Respondent 7 (R7) | African | Male | Sub-District | >1 year |
| Respondent 8 (R8) | African | Female | District | 4 Months |
| Respondent 9 (R9) | African | Female | Sub-District | >1 year |
| Respondent 10 (R10) | Coloured | Female | District | 3 months |

Table 3: Summary of key findings

| Views on NHI |
|--------------|
| **Favourable Views** |
| - Redistribute resources |
| - Benefit the poorest members of society and marginalized groups the most |
| - Drive social equity |
| - Reduce healthcare costs; utilizes scales of economy |
| - Improve buying-power |
| **Doubtful/Concerned Views** |
| - Lack of familiarity with content of policies and constructs of NHI |
| - Distrust towards governing structures: potential for mismanagement and corruption |

| Experiences on Engagement in NHI Policy Development |
|---------------------------------------------------|
| - Near-absent information and awareness in certain sectors |
| - Sense of disempowerment |
| - Uncertainty around role |
| - Unable to vocalise opinions; experienced as a one-sided narrative |
| - When high levels of engagement were present, they were driven by personal interest and self-learning or involvement with NGO’s |
| - Prevailing desire for regular and clear communications around NHI with entrenched feedback mechanisms |

| Perceptions of public sector readiness to implement NHI |
|-------------------------------------------------------|
| - Myriad concerns around inadequate quantity and quantity of infrastructure |
| - Maldistribution of resources |
- Grossly inadequate surveillance systems and epidemiological data to guide healthcare services
- Overworked and de-motivated staff
- Lack of leadership
- Poor organizational culture
- Recent freezes of much-needed posts and incremental salary increases

**Perceptions of Challenges and Solutions**

**Challenges:**
- Lack of leadership
- Fiscal recession and inadequate resources
- Poor governance
- Corruption
- Unchecked and escalating public concerns around NHI intentions and strategies

**Solutions:**
- Capacity-building
- Employment of staff dedicated to implementing NHI
- Introduction and widespread uptake of Health Information Systems
- Greater stakeholder engagement
- Ensure continuity, accountability, transparency and consensus orientation
- Stepwise implementation with critical reflexivity and shared learning experiences from local and international partnerships

Results are presented as themes that emerged during framework analysis.

**Managerial Engagement in Policy Development**

The respondents’ described ambiguous experiences with regards to engagement in policy development. Respondents cited uncertainties around rollout plans as well as their own managerial responsibilities that attributed to a near absence of communication on NHI. Several respondents were aware of policy implementations such as PHC re-engineering and Ideal Clinics, as part of the greater NHI communication and implementation but struggled to see the bigger picture, often leaving them with more questions than answers:

"You don’t get the total information, you get an introduction of what you might do for their target." - R3

"(We are) at the coalface of service delivery… to engage and to request for our inputs. I think it was not done properly" – R7

"Basically, we hear NHI from the media; we haven’t really had people come in and talk to the people" – R5

Some respondents depicted their absence of engagement and the one-sided narrative around NHI as a recurrent organisational practice, to the detriment of policy development. Other respondents felt disillusioned by the lack of senior managerial engagement and commitment to NHI:

"But what can I say, because the government has decided they will implement what they have decided to do." – R7

"But really, I would not know why the department is not giving it the attention that it needs” – R10

**Managerial Views of NHI**
A prevailing theme across all the interviews was that respondents were not familiar with NHI documents, policy, and law. This finding reflects the overarching theme of poor managerial engagement described above.

"on that… what was the meaning of that?" – R2
"I don’t know, I really don’t have an idea..." – R4

The interviewer frequently needed to describe the content and concepts contained within the NHI policy document to the managers. Consequently, interviewees often lacked insight and capacity to provide meaningful commentary.

"Maybe, I’m not so sure… So I don’t know, I don’t want to comment on something that I’m not so sure of… how is it going to work, or what." – R5
"I’m not sure by facility, or … by municipality, or the service provider… then to, I suppose…So I’m not too sure, I haven’t looked at the detail.” – R6

Despite a lack of familiarity with NHI policies, most interviewees viewed NHI as a mandatory social intervention to redress social inequities and unequal access to quality healthcare. This was coupled with the impression that NHI would redistribute resources from the private to serve as a panacea to current public sector challenges:

"The issue of overcrowding on public institutions, I think it will also reduce that… which will actually reduce on the number of litigation” – R1
"So that they are equally empowered to render services, or better services to our citizens.” – R1
"I think NHI aims to ensure that the issue of social solidarity between the healthy and the sick, those who have and those who have not” – R4

There was a singular deviant case that saw the NHI as a scheme that was not applicable to the South African setting. The participant regarded the current private health system as adequately suited to the South African context and felt that more meaningful interventions could be made towards improving existing public health services.

Perceptions of NHI implementation

Infrastructure:
All participants regarded the current public healthcare system as not ready to implement NHI. Respondents expressed concerns around infrastructure, human resources, administration, health information systems and organizational culture:

"You cannot be sitting with a hospital that is built fifty years back…but 90% of them are very old, so they are not ready. " – R1
"but we know that those things are made worse by, actually, the feeling of being overwhelmed by health workers… If you go in the place, it’s full, it’s dark, in terms of work environment” – R8
"The second thing is, remember, our health information system, our epidemiological data, is limited; how do they begin to develop appropriate plans” – R6

Further, respondents emphasized that system readiness was not standardized and varied across the country:

“What about the areas where people still need to travel about a hundred kilometres to access a clinic?” - R5

Health Systems
Respondents expressed several concerns around current performance and quality appraisal mechanisms. They saw current indicators as invalid and unreliable - often mis-represented to appease executives:

"There will be no questions to say, how did you reach this target, how did you do whatever. As long as you are presenting, to say, I’m at 55%, when the target was 50%." – R2

Most respondents felt disempowered and lacked clarity on their role in the NHI. They expressed concerns around poor quality and one-way communication, as well as not knowing what the requirements or procedures would be.

Respondents described doubt around readiness to implement the NHI policies due to experiences with several long-standing policies and laws that had not yet been effected:

"We are still far, because even the tools for the hospitals… it’s still on the trial, on the draft." – R5

**Corruption**

A major theme that emerged was that of corruption throughout all tiers of governmental structures. Distrust towards government seemed to be magnified when managers discussed the proposed increased fiscal expenditure on health:

"Well, I definitely don’t think that the current structure should govern it." – R3

"When you look what is really happening in terms of government, there are so many corruptions, so many things, every day… when you listen to the news, it’s all about corruption, people who are enriching themselves" – R5

To the contrary, one respondent held that corruption would be avoided if the private sector was not allowed to administer the NHI fund due to their ‘for-profit’ orientation (R4).

Respondents suggested a reform of managerial structures that fostered good governance, transparency and accountability:

"but if ever you don’t have a consequence management approach, and accountability, things can just fall through, without anybody really paying attention or taking responsibility." – R9

Challenges around good governance were exacerbated by marked deficits in human resource management at national and provincial levels. Respondents expressed concerns around staff retention and ineffective devolution of management. Further, respondents described an absence of consensus orientation or succession planning towards NHI implementation:

"What we’re supposed to be doing now, is to do succession planning and align it to National Health Insurance." – R1

**Human resources**

Several respondents highlighted challenges around understaffing within the district, resulting in over-worked and demotivated employees:

"…and she said to me, it’s because of workload; I’m frustrated before nine o’clock, because I have to stand and attend to more than fifty people… then I ask in private, in private I’ll be allocated only five…” – R1
Respondents held that national government needed to expand multilateral collaborative efforts alongside in-house managerial capacitation to nurture comprehensive NHI implementation strategies:

"…trained, specifically on National Health Insurance; and not from one discipline, it must be a multi-tasked or disciplinary team" – R1

"So I think it’s to listen to the community, hear what all the stakeholders have to say…to what could be better solutions." – R4

**Fragmentation**

Several respondents expressed that healthcare service delivery systems functioned in a siloed fashion. This is to say that managers had to divert energy and resources to ancillary supportive services to compensate for defective national and provincial departmental counterparts:

“So we do have the generators now, but we do have lots of unforeseen problems, to ensure that there’s still uninterrupted electrical supply at the clinics.” – R4

"But apart from making sure that the service standards are complied to…we need to make sure that other systems are in place…adequate for the work we have to do for that particular community." – R6

**Digital Health**

Participants emphasized the need for national-level government to facilitate the digitalisation of healthcare to map community profiles which would allow for tailored health service planning. This would simultaneously address deficient communication to all stakeholders - another major theme. Respondents also spoke to the development of a booking system to optimize flows of patient care throughout clinics and improve user experience:

"If we had to look at a first step, I would say, going electronic is very much needed…especially that we can start keeping track of our patients" – R3

"But if proper SMSs or appointments were sent…reduced waiting time will definitely improve services" – R8

Respondents felt that national government should iteratively appraise NHI strategies through shared international learning and reflection to guide efficient local NHI implementation:

"I think we’re very fortunate in the sense that we can learn from lessons learnt in other countries." – R6

**Discussion:**

Public sector managers in this study view the NHI as the necessary mechanics to fulfil the fundamental moral obligation set forth by the Constitution to progressively achieve UHC for all South African citizens. However, the ideology of UHC apparent in several government policies fails to realise at the operational unit of PHC – the DHS. A major theme was that of an unawareness of current policy as well as the near absent engagement of district managers. This is strikingly discordant with the NHI Bill implementation strategy, as well as lessons learnt from international works and implementation imperatives posited by organisational bodies such as the Joint Learning Network. The stark deficits in managerial awareness coupled with their exclusion from engagement of policy formulation and rollout is contradictory to the revisions of the NHI Bill that serve to empower district health systems to assume responsibility for the needs of predefined municipal areas with dynamic approaches to healthcare provision across municipals that vary significantly (eg. urban, rural, wealthy, under-resourced). Further, DHS comprise local stakeholders who are intimately involved and
aware of contextual struggles as well as local individual and organisational collaborative partners.

The NHI bill has stated that the DHS is responsible to form and collaborate with implementation structures such as DHMOs and CUPs. Capacitated DHMOs and CUPs are the bedrock of strategic purchasing that aims to address health system fragmentation, improve healthcare infrastructure, as well as accountability and transparency of financial management. This mismatch creates a watershed area where the concerns around wanton corruption described in this work, as well as preceding studies, could materialise.

Lastly, the lack of strategic visioneering, consensus orientation and succession planning desynchronises NHI implementation interventions to the detriment of allocative, technical and productive efficiencies – pillars of health system governance. If the current lack of coordinated efforts remains unchecked, the NHI could further propagate the catastrophic and wasteful expenditure that it was designed to address.

Limitations

Only one district in Gauteng was sampled for this study - a large urban district that is well-capacitated and in close contact with national and provincial governing bodies. The findings of this study do not accurately reflect all districts of South Africa, especially rural areas.

Recommendations

This study could be repeated across the spectrum of rural and urban districts to corroborate findings and expand on contextual nuances for community-specific health system planning. It is recommended that plans for NHI include specific engagement and capacitation of the managers of the 52 districts within South Africa to prepare for district level contracting. Recent studies have illustrated the efficacy of brief training interventions.

Declarations

Ethics approval and consent to participate

All methods were carried out in accordance with the guidelines and regulations as set forth by the University of Witwatersrand’s Human Research Ethics Committee (reference: M191046) as well as the Research Committee of the Johannesburg Health District (reference: GP_202006_048). An approved Participant Information Sheet was provided to each respondent that clearly detailed the nature of the research. Written informed consent was taken separately from each participant (one form for consent to partake in the interview and another for the audio-recording of the interview). All interviews, as well as their recordings have been anonymized and are stored securely on a password-locked computer and will be stored for at least five years as required by the ethics committees mentioned above. The dataset is available at https://doi.org/10.5281/zenodo.4765125.

Consent for publication

Not applicable.
Data availability

The dataset of this work is available in the Zenodo repository, https://doi.org/10.5281/zenodo.4765125.

Competing interests

None to declare.

Funding

None.

Author Contributions

This work was completed as part of the fulfilment of requirements for a Master of Medicine by SDM, supervised by SAM. Protocol development, ethics applications, interviews and data analysis were performed by SDM. SAM was responsible for peer review and supervision of the project.

Acknowledgements

The corresponding author would like to thank all of the district managers who willingly agreed to participate in this study.
References:

1. Bradshaw D, Nannan NN, Wyk VP, Laubscher R, Groenewald P, Dorrington RE. Burden of disease in South Africa: Protracted transitions driven by social pathologies. S Afr Med J. 2019 Dec 5;109(11b):69–76.

2. Constitution of the Republic of South Africa, 1996 | South African Government [Internet]. [cited 2021 Mar 25]. Available from: https://www.gov.za/documents/constitution-republic-south-africa-1996

3. Dodd R, Palagyi A, Jan S, Abdel-All M, Nambar D, Madhira P, et al. Organisation of primary health care systems in low- and middle-income countries: review of evidence on what works and why in the Asia-Pacific region. BMJ Glob Health. 2019 Aug 1;4(Suppl 8):e001487.

4. National Health Act 61 of 2003 | South African Government [Internet]. [cited 2020 Feb 20]. Available from: https://www.gov.za/documents/national-health-act

5. Public Finance Management Act 1 of 1999 | South African Government [Internet]. [cited 2021 May 11]. Available from: https://www.gov.za/documents/public-finance-management-act

6. Local Government: Municipal Systems Act 32 of 2000 | South African Government [Internet]. [cited 2021 May 11]. Available from: https://www.gov.za/documents/local-government-municipal-systems-act

7. National Health Insurance Bill B11-2019 | South African Government [Internet]. [cited 2019 Aug 25]. Available from: https://www.gov.za/documents/national-health-insurance-bill-b-11-2019-6-aug-2019-0000

8. Von Pressentin KB, Mash RJ, Baldwin-Ragaven L, Botha RPG, Govender I, Steinberg WJ. The bird’s-eye perspective: how do district health managers experience the impact of family physicians within the South African district health system? A qualitative study. South Afr Fam Pract. 2018;60(1).

9. On Prioritizing Health: A Background Analysis | Joint Learning Network [Internet]. [cited 2021 May 11]. Available from: https://www.jointlearningnetwork.org/resources/on-prioritizing-health-a-background-analysis/

10. Fusheini A, Eyles J. Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision. BMC Health Serv Res. 2016 Oct 7;16(1):558.

11. Day C, Zondi T. Measuring National Health Insurance: towards Universal Health Coverage in South Africa. South Afr Health Rev. 2019;2019(1):55–68.

12. Yeoh E-K, Johnston C, Chau PYK, Kiang N, Tin P, Tang J. Governance Functions to Accelerate Progress toward Universal Health Coverage (UHC) in the Asia-Pacific Region. Health Syst Reform. 2019 Jan;5(1):48–58.
13. Atun R, de Andrade LOM, Almeida G, Cotlear D, Dmytraczenko T, Frenz P, et al. Health-system reform and universal health coverage in Latin America. The Lancet. 2015 Mar;385(9974):1230–47.

14. Ramesh M, Wu X, Howlett M. Second Best Governance? Governments and Governance in the Imperfect World of Health Care Delivery in China, India and Thailand in Comparative Perspective. J Comp Policy Anal Res Pract. 2015 Aug 8;17(4):342–58.

15. Fryatt R, Bennett S, Soucat A. Health sector governance: should we be investing more? BMJ Glob Health. 2017 Jul 1;2(2):e000343.

16. Greer SL, Méndez CA. Universal Health Coverage: A Political Struggle and Governance Challenge. Am J Public Health. 2015 Jul 16;105(S5):S637–9.

17. Amado LA, Christofides N, Pieters R, Rusch J. National health insurance: A lofty ideal in need of cautious, planned implementation. South Afr J Bioeth Law. 2012 Jun 14;5(1):4-10–10.

18. Hort K, Jayasuriya R, Dayal P. The link between UHC reforms and health system governance: lessons from Asia. J Health Organ Manag. 2017 May 15;31(3):270–85.

19. Brinkerhoff DW, Bossert TJ. Health governance: principal–agent linkages and health system strengthening. Health Policy Plan. 2014 Sep 1;29(6):685–93.

20. MAXQDA: Qualitative Data Analysis Software | Windows & Mac [Internet]. MAXQDA - The Art of Data Analysis. [cited 2019 Aug 25]. Available from: https://www.maxqda.com/

21. Exploring corruption in the South African health sector | Health Policy and Planning | Oxford Academic [Internet]. [cited 2019 May 21]. Available from: https://academic.oup.com/heapol/article/31/2/239/2355603

22. Esau N, English R, Shung-King M. An assessment of a ‘training-of-trainers programme for clinic committees’ in a South African district: a qualitative exploratory study. BMC Health Serv Res. 2020;20(1):1–16.