The perceptions of private health insurance administrator senior managers about the National Health Insurance (NHI) in South Africa

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DECLARATION

MPH (Health Systems) Mini-Dissertation

I, ***Nonkqubela Mxoli***, Student No. **MXLNON001** hereby declare that the work on which this dissertation/thesis is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

Signed: NMxoli (signed electronically)

Date: 10 September 2023

DEDICATION

This mini dissertation is dedicated to my late mother, Nomfusi Mxoli; she has been my pillar of strength and encouragement from the day I was born until her last days. You have died for me to gain an angel to watch over me. May the Lord almighty be with your spirit and always stay in the light. I love you and appreciate the unconditional love you gave me while you were alive. Thank you for choosing me as your daughter.

I always remember you and the time we spent together by playing one of your memorable songs by Uncle Sam, "*When I See You Smile."*

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I want to express my gratitude to the Lord Almighty. Your everlasting love and mercy have been upon me, and may you continue to guide me through this life journey.

To my Supervisor, Associate Professor Maylene Shung King, thank you for your patience, time, support, and guidance during this research project. It was tough, but you have never given up on it. I am profoundly grateful for that.

Thank you to all the research participants for their time and valuable contributions toward the fulfilment of this research.

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Acronyms

AIDS	Acquired immunodeficiency syndrome
BHF	Board of Healthcare Funders
DCSTs	District-based Clinical Specialist Teams
DHS	District Health System
DOH	Department of Health
DTC	Davis Tax Committee
FWA	Fraud, Waste and Abuse
GDP	Gross Domestic Product
HIV	Human immunodeficiency virus
HPSR	Health Policy and Systems Research
LMIC	Low-and-middle-income countries
MDG	Millennium Developmental Goals
MIC	Middle-income-countries
MSA	Medical Scheme Administrator
NDOH	National Department of Health
NHI	National Health Insurance
NHIS	National Health Insurance Scheme
NHS	National Health Service
OOP	Out-of-pocket
OOPP	Out-of-pocket payments
PHC	Primary Health Care
PHI	Private Health Insurance

PHIA	Private Health Insurance Administrator
PMTCT	Prevention of mother-to-child transmission
PPE	Personal Protective Equipment
SA	South Africa
SAMA	South African Medical Association
SDG	Sustainable Development Goals
SHI	Social Health Insurance
SIU	Special Investigating Unit
SA	South Africa
SOE	State Owned Entity
UC	Universal Coverage
UMIC	Upper-middle-income countries
UHC	Universal Health Coverage
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organisation

PART A: RESEARCH PROTOCOL AND LITERATURE REVIEW

The perceptions of private health insurance administrator senior managers about the National Health Insurance (NHI) in South Africa

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1. Introduction

Health equity, a significant societal and health system goal, is potentially realisable but remains a global challenge. Ghiasvand et al. (2021) identified crucial inequities in various aspects of health, such as health outcomes, health services utilisation, and health financing, particularly in low, middle- and high-income countries (LMICs). Jensen, Kelly, and Avendano (2022) argue that a well-known inadequacy is the challenge of deciding when differences in health are redundant and preventable. This requires context-specific judgment, sometimes easily translated back to a broader set of standardised obligations and moral standards regarding which health differences are considered unjust and why. Moreover, Jensen et al. (2022) state that the lack of conceptual clarity is a critical barrier that impedes the operationalisation of equity in health policy and practice - thus, attempts to clarify and standardise equity parameters are essential.

The World Health Organization (WHO) affirms that access to equitable quality healthcare standards for the public, regardless of race, religion, political idea, financial or social condition, is a fundamental human right (Williams and Jackson 2005 cited by Liburd et al., 2020). A concurring definition posits that health equity is the achievement of health for all people at the highest level by valuing everyone equally through directed and continuous societal efforts that are set to discourse inequities and past and modern injustices while eliminating health and healthcare disparities (Liburd et al., 2020). Dover and Belon (2019) concur that equity in health and the social determinants of health (SDOH) are at the front line of modern public health.

Given the complexities in attaining health equity, in 2005, the World Health Assembly (WHA) of the WHO inspired countries' representatives to strive towards the realisation of universal health coverage (UHC) (Awoonor-Williams et al., 2016). According to Verrecchia, Thompson, and Yates (2018), UHC is recognised as the key driver of the global health agenda to achieve the “health for all” Sustainable Development Goals (SDGs) by the year 2030 and has a designated United Nations (UN) UHC Day, on the 12th of December annually. Universal Health Coverage is constructed based on human rights and

equity, with health services designed according to people's needs and funded according to their ability to pay (Verrecchia, Thompson, and Yates 2019). Moreover, UHC is envisioned to expand access to health services and quality healthcare and lessen the financial risk to patients by reducing or eliminating unaffordable out-of-pocket payments (OOPP) (Obermann et al., 2018; Obare et al., 2014; Kutzin, 2013).

The literature review for this study will be covered under sections 2 to 4. For the literature search, the researcher used keywords such as "*Universal Health Coverage; National Health Insurance AND Healthcare Financing; Private Health Insurance AND Medical Schemes OR Medical Aid; Medical Schemes Administrators AND Private Health Insurance Administrators"* and accessed PubMed, PubMed Central, Google Scholar, African Journals (Sabinet), and Policy documents (Sabinet). Search limitations such as 2012 -2023 and peer-reviewed journals were applied to ensure the researcher picked the relevant source.

2. Healthcare financing role in achieving UHC

In working towards attaining UHC, it is well-recognised that a financing model must be in place. Therefore, many countries have thus adopted health financing mechanisms tailor-made for their context (Govender et al., 2013; Alhassan, Nketiah-Amponsah and Arhinful, 2016). The financial funding models adopted range from a National Health Service (NHS) to National Health Insurance (NHI), Social Health Insurance (SHI), and others (Alhassan et al. 2016). Derkyi-Kwarteng et al. (2021) argue that the UHC funding provisions in most countries include some form of instalment from general taxes, insurance premiums or a mix.

High-income countries like South Korea and Canada were among the countries that moved towards UHC-focused healthcare reforms. In South Korea, an NHI was implemented as early as 1963 (Choi et al., 2015), and in 1977, an SHI was also introduced in the country for industrial workers (Kwon, 2009; Choi et al., 2015). Canada introduced its NHI programme, financed by the general taxes through the single-payer system, in 1971 (Ridic, Gleason, and Ridic, 2012). The Australian healthcare financing model is regionally administered as a joint venture between national and state public hospital funding, known as the Universal Public Medical Insurance Program or Medicare (Mossialos et al., 2016). Similarly, in Canada, Medicare funding is generated from general tax revenue and the earmarked income tax of citizens (Mossialos et al., 2016).

In their study, Kasilo et al. (2019) mentioned that African countries have embraced the SDGs, particularly SDG3, aimed at achieving good health and well-being, which has "to achieve universal health coverage" as one of the 13 targets. However, the delicate health infrastructure in many African countries has raised some uncertainties about whether this continent can attain equitable access to

healthcare for its population (Jaca et al., 2021). African countries require significant efforts to build and refine their health systems. Special attention to how these health systems are structured, including the reduction of out-of-pocket payments and the increase in population health service coverage, is paramount (Jaca et al., 2021). Many African countries, including SA, have embarked on various kinds of healthcare reform, including revised health financing models to achieve UHC (Fusheni 2016).

3. South Africa and UHC

The South African health system is regarded as a dual system, comprising of a public sector, which services about 84% of the population, primarily those without medical insurance, and the private healthcare sector serving the insured and those able to pay out of pocket (van Den Heever, 2012; Department of Health, 2017; Department of Health, 2015). There are also non-governmental organisations (NGOs) and non-for-profit organisations (NPOs) that assist in providing healthcare services in the country (Jobson, 2015).

In 2019, South Africa, as a middle-income country, had a per capita Gross Domestic Product (GDP) of US$ 13,080 (Jabartch, 2023), which showed an increase of US$5,468 from the previously reported GDP of US$7,612 in 2010 (van Den Heever, 2012). South Africa has a GDP health expenditure of 8,4% (Department of Health, 2017), a fair health expenditure compared to other countries, with an allocation of 8-10% (OECD, 2021; Chopra et al., 2009).

The 8.4% GDP expenditure is then split between the private and public health sectors, with the private sector being allocated 4.1% and the public sector being allocated 4.2% (Department of Health, 2017). The remaining 4.2% is assigned to the public sector, which serves 84% of the population (approximately 42 million individuals) without insurance coverage (National Department of Health Republic of SA, 2017; Surender et al*.,* 2015; Sithole, 2015). The public sector healthcare system faces numerous challenges, including staff shortages, poor administration, poor infrastructure, and inequities in funding (Sithole 2015). It partly explains the discrepancy between GDP health allocation and health outcomes.

South Africa's maternal mortality remains high despite efforts made towards reduction. In 2016, the maternal mortality rate was reported to be at 135, a decline compared to 189 deaths per 1100,000 lives reported in 2009 (Bomela 2020). However, the country still has a long way to go to reach the sustainable developmental goal (SDG) 3.1, the global target of 70 deaths per 100,000 births 2in 030 (Bomela 2020). Between 2006 and 20111, the country's under-five death rate was reduced by 40% because of the effective scale-up of the prevention of mother-to-child transmission (PMTCT) (Maredza et al., 2016). However, the country is still behind in achieving health outcomes compared to countries with similar income statuses like China. For instance, China reduced the under-5 mortality rates by 78% between

1990 and 2013 and achieved the Millennium Developmental Goal (MDG) 4n years before the year 2008, a targeted date (Wang et al., 2016).

The high unemployment rate in the country also impacts health outcome discrepancies, as realised with the life expectancy of the richest in the country surpassing that of the poorest by a minimum of 10 to 15 years, depending on whether countries have adopted such (Council for Medical Schemes, 2017). South Africa has an estimated 60 million people, with a roughly equal distribution of females (51.1%) to males (Stats SA, 2022). Notably, the 2022 mid-year estimate reported a high structural unemployment rate of about 34.5. Consequently, many households within the country live below the poverty line, which emphasises the need for access to affordable health care (Stats SA, 2022). Pratap et al. (2021) point out that although unemployment is often viewed as an economic problem, it is a complex and multifaceted public health issue that interacts with numerous social determinants of health and plays a crucial role in perpetuating health inequities.

On a positive note, the Health Systems Trust (2017), in their annual South African Health Review (SAHR), stated that globally, life expectancy at birth saw an increase of more than 10 years between 1980 and 2015, from 61.7 years to 71.8 years (Day and Gray, 2014). A similar rise was noted in sub-Saharan African countries in 2005 and 2015, probably due to improved access to antiretroviral therapy (ART), as is also the case in SA (Health Systems Trust, 2017). Despite improving life expectancy in SA, Omotoso and Koch (2018) identified that socioeconomic health disparities remain among the significant challenges to public health in SA.

The country's healthcare system still falls far short of providing equitable healthcare access due to substantial hindrances to accessing healthcare services (Marten et al., 2014). Additionally, the country's healthcare system is fragmented, with diverse financing systems and a range of healthcare providers who are paid from diverse pools of finances (McIntyre et al., 2008). This fragmentation refers to individuals or households from diverse socio-economic groups being covered by various funding pools, such as the various medical aid schemes and government funding and being served by different providers from the private and public sectors. The fragmentation of the South African health system reduces the potential for income and risk cross-subsidisation and adversely restricts the prospect of universal coverage (UC) (Department of Health, 2015). This is the central aim of the NHI, which seeks to achieve equitable access to health care through pooling risk and gaining efficiency of health care funding (McIntyre et al., 2008).

The administrative shift of the country from the apartheid system to full democracy in 1994 has led to significant transformations in broader society, including the country's healthcare system (Van Rensburg, 2014). The public healthcare system pre-1994 was constructed to maintain racial segregation and propagate racial laws during the apartheid era (Sithole, 2015). To redress historical imbalances, the

current government recognised the need to transform the public health system (Sithole, 2015). Johnston and Spurrett (2011) argued that the country's public healthcare system is as big, complicated, and divided as the private health sector. Therefore, transforming the country's healthcare system requires the public and private health sectors to change. Some believe that public-private partnerships (PPPs), where the private sector players such as GPs and hospital groups have an opportunity to contract with government entities to share resources, invest in infrastructure or provide services to assist with the attainment of UHC (Prof. Johnston and Spurrett, 2011) and ensure that the risk and resources are shared amongst the two healthcare sectors.

The South African move towards implementing the NHI to ensure UHC is a result of various policy documents, such as the Reconstruction and Development Programme (RDP), the Section 27 Constitutional mandate, the White Paper (1997), and the National Development Plan (NDP) Vision 2030 (Department of Health, 2015; Moosa et al., 2016). SA is keeping with the modern international method, as the WHA and the United Nations (UN) General Assembly agreed to a resolution to implement UHC in 2012 (McIntyre et al., 2013).

The introduction of the NHI as a healthcare funding is intended to help realise the predominant restructuring goal of guaranteeing Universal UHC to the country's citizens. A specific target for government expenditure on GDP-related health care will likely be a compelling means for holding governments accountable for moving towards UHC (McIntyre, Meheus, and Røttingen, 2017). Therefore, the key objective of the NHI is to guard citizens from economic adversities suffered due to healthcare requirements by ensuring prepaid healthcare system funds, barriers to redistribution, and reducing disintegration and pooling of funds (Department of Health Republic, 2011).

4. Towards an NHI in South Africa

In 2007, during the 52nd National Conference of the African National Congress (ANC), the leading political party in the country, the elected leadership made commitments to establish an NHI system to achieve UHC (Ataguba and Akazili 2010; Whyle and Olivier 2023). According to the National Department of Health Republic of SA (2015), the NHI in SA is characterised by various features such as:

- **being progressive** – "to *enable the State to progressively realise the right to access health and ensure the progressive realisation of universal health coverage;"*
- **with mandatory pre-payment** – "*there will be mobilisation of additional revenue for the NHI through the introduction of mandatory prepayment from those who are eligible*;"

- **offering comprehensive services** – "*will cover a comprehensive set of health services that will provide a continuum of care from community outreach, health promotion and prevention to other levels of care;"*
- **ensuring financial risk protection** – "*will ensure that citizens do not suffer financial hardship and are not deterred from accessing and utilising needed health services;"*
- **single fund** – "*integrated sources of funding into a unified health financing pool that caters for the needs of the population;* "
- **strategic purchaser** – "*where there is an entity that actively utilises its power as a single purchaser to proactively identify population health needs and determine the most appropriate, efficient, and effective mechanisms for drawing on existing health service providers;"*
- **single-payer** – "*where an entity that pays for all health care costs on behalf of the population; and being publicly administered."*

The above NHI features are distinctly different from the current health system in South Africa, as it is described as a pluralistic system that consists of private and public health care, with inequitable access to healthcare services, and with those who can afford to have to pay OOP to cover services not covered or partly covered by their medical schemes (Delobelle 2013).

The NHI is planned over three phases as proposed in the National Developmental Plan (NDP) 2030 (National Developmental Plan 2011) and was initially envisaged to take at least 14 years to implement (Mayosi 2012; Naidoo 2012). The first phase started in 2012/2013 to 2016/2017, the second phase was planned to commence in 2017/2018 to 2019/2021, and the third from 2021/2022 to 2024/2025 (NPC 2011). The first phase involved re-engineering the Primary Health Care (PHC) system in ten pilot districts of the country, alongside investment infrastructures that included the construction of a new medical school in one of the most disadvantaged provinces of the country (Naidoo 2012). The first phase was intended to bolster the ailing PHC infrastructure as the first step towards building the public health sector infrastructure. This effort had mixed results, and interventions such as district-based specialist teams (DCSTs), getting general practitioner doctors into primary-level clinics, and ward-based outreach teams and school health services faced many implementation challenges (Nelson and Madiba, 2020; Oboirien et al., 2018; NDOH10/2017-2018; Blecher et al., 2017).

In the private sector, the planned yet unannounced amendments to the Medical Schemes Act were deemed crucial for phase two of the NHI implementation. These amendments will be centred around the notion that the medical schemes will not be allowed to offer services already included in the NHI benefit package. Some progress has been made in issuing final regulations that demarcate the boundaries between the business of a medical scheme and that of insurance companies (Gray and Vawda, 2016). Currently, the country is in the second phase of the NHI implementation, but with slow progress. Phase three of the implementation was planned for between 2021 and 2025 (Hongoro, 2014).

However, this has not yet started due to challenges and delays in implementation (Mukwena and Manyisa, 2022). Phase three is meant to introduce the obligatory NHI prepayment, contracting for authorised private hospitals and specialised services, and finalising and implementing the Medical Schemes Act and the NHI Act (Department of Health, 2018).

1.1. The private sector's role in the South African healthcare system

The 4.1% of the 8.4% GDP expenditure as a fraction allocated to the private sector ensures coverage to only 16.2% of the population, making up 8.2 million individuals on medical aid (National Health Insurance Policy 2017; Surender et al., 2015). The private health sector is financed via structured voluntary Private Health Insurance (PHI) plans, often called medical schemes (Ataguba and Goudge, 2012). This is further confirmed by The Davis Tax Committee Report (2017), with the health spending portion of approximately 52% from the PHI (The Davis Tax Committee Report, 2017). Ramjee and Vieyra (2014) and McIntyre (2010) argue that medical schemes are viewed as not-for-profit organisations that are primarily owned by members who joined and are ed by boards of trustees (BOT).

McIntyre and Thiede (2007) state that the expenditure in the private sector has continued at rates far exceeding the inflation rate since the 1980s due to the concomitant increase in contribution rates or payments charged by medical schemes. In the late 1980s and early 1990s, the rates for contribution were snowballing between 25% and 30% per year in real terms (McIntyre and Thiede, 2007).

The population served by the private health sector also include those having to pay out-of-pocket (OOP) for healthcare services (Ataguba and Goudge, 2012), such as primary health care (PHC) serviced by private healthcare providers like GPs and those who purchase voluntary PHI (Ataguba and Akazili, 2010; Ataguba and Goudge, 2012; National Planning Commission, 2011). The risk rating is utilised to register individuals in a medical scheme and has the likelihood to exclude some people from accessing health services (National Planning Commission, 2011). The private sector is, therefore, designed for persons who are healthier and who can afford to pay the ongoing medical scheme monthly premiums (Sarwal and Kumar, 2021) rather than those with poor health and with unstable or no source of income (CMS, 2019a; National Planning Commission, 2011).

The South African Health Research (SAHR) (2013/2014) identified the private health sector stakeholders according to their functions as follows: income collection (individuals, employers, brokers, and taxpayers); Pooling (medical schemes and medical scheme members); Purchasing (medical schemes, medical scheme administrators, managed care organisations); and Delivery (hospitals, pharmaceutical industry, medical practitioners, nurses, pharmacists, pharmacy owners, and others).

1.1.1. Private Healthcare Insurance

Paccagnella et al. (2013) argue that voluntary PHI, as opposed to mandatory NHI, plays an integral part in the healthcare system, such as providing coverage for services not included in the public health insurance system. This is remarkably so in European countries where voluntary private health care insurance that exists alongside the national health system assists individuals in avoiding having to pay out-of-pocket payments (OOPP) (Paccagnella et al., 2013; Canterero-Prieto et al., 2017; Ataguba and Goudge, 2012). For example, in Spain, the private health sector provides voluntary health insurance schemes to individuals (Bernard-Delgado et al., 2018). The voluntary private health insurance schemes constitute the alternative network for 80% of the civil servants that are insured within the Mutualism for Civil Servants (MF), and it provides services such as dental care and optical care that are not covered by the national health system (Bernard-Delgado et al., 2018).

Over time, the PHI industry has faced challenges; as McIntyre (2008) points out, the medical schemes have revealed slight growth in intensifying their insurance coverage in the country, with a decay in benefit packages and providing cover to either in-hospital care or chronic ailments as specified in the Prescribed Minimum Benefits (PMB) regulation (CMS, 2019a). This may be due to the unrestrained increase in medical scheme expenditure and the decline in contributions made (McIntyre, 2010). The medical scheme's future role in the NHI environment is, therefore, one that is still uncertain (Gray and Vawda, 2016). It is not clear whether the medical schemes will be permitted to offer just a complementary cover, which is a top-up for services that are not covered by the NHI benefits package, or if the schemes will be allowed to offer a comprehensive cover for individuals in addition to their mandatory payment contributions to the NHI fund (The Davis Tax Committee Report, 2017). However, they are anticipated to operate in the NHI environment with a requirement to shift their approach (Engelbrecht and Crisp, 2010).

1.1.2. Private Health Insurance Administrators

Private Health Insurance Administrators (PHIA) are contracted third-party administrators with medical schemes to perform functions such as member registration, claims processing, and management (van Den Heever, 2012). The PHIAs and managed care business organisations often operate by launching new medical schemes or taking over the administrative function of existing medical schemes (Erasmus et al., 2016). Examples of active PHIAs or managed care organisations in the country consist of corporations like Fedsure, Norwich Life, Old Mutual, Sanlam, Southern Life, Liberty, Momentum, Metropolitan, and Discovery (Erasmus et al., 2016).

The PHIAs will become important stakeholders in the implementation of NHI in South Africa. Their existing function is one of negotiating tariffs with service providers on behalf of the medical schemes (CMS, 2019b). The service providers involved are often the hospital facility groups and General

Practitioner (GP) facility groups amongst others (CMS, 2019b; Competition Commission South Africa, 2018). The General Practitioner facility groups in this context are referred to as those facilities where a group of GPs comes together to establish facility groups, and all GPs will be operating under the group practice number while retaining their practice number as regulated by BHF. In the NHI environment, the PHIAs can potentially play a role in providing these services as they have years of experience and expertise in the field. However, the recently released NHI Bill (2019) and the NHI White Paper (2017) were silent about the PHIA role, except for mentioning the medical scheme's role, and the private service providers being the contracted strategic purchasers (Ramjee and McLeod, 2010).

5. Study Rationale

Currently, in SA, the medical scheme's role, and health insurance administrators in the NHI implementation are still uncertain. While the views of multiple stakeholder groups have been sought or strongly expressed in debates and forums in recent years, the voices of health insurance administrators, despite the potential role they could play in an NHI, have been relatively silent.

This study explored insights into senior PHIA managers' perspectives about the NHI and adds an essential voice to current debates. It further provides some ideas on the potential role of this stakeholder group in the implementation of the NHI. Refer to **Appendix I** to see where the PHIAs are located within the private health sector.

The NHI is on the policy agenda, and a Bill has been passed and published in 2019. As with any health system like the health systems building block (WHO 2009), as illustrated in *Figure 1* below, people are at the centre of any policy initiative and its implementation, so understanding what people think and feel is essential, as this will ultimately influence their willingness to participate, and their commitment to implementation. The senior managers in the PHIA industry are the key role players in decision-making and informing policy changes for the companies they work for, ensuring the private healthcare services quality and the performance and efficiency of PHIA's performance.

Figure 1: The dynamic architecture and interconnectedness of the health system building blocks

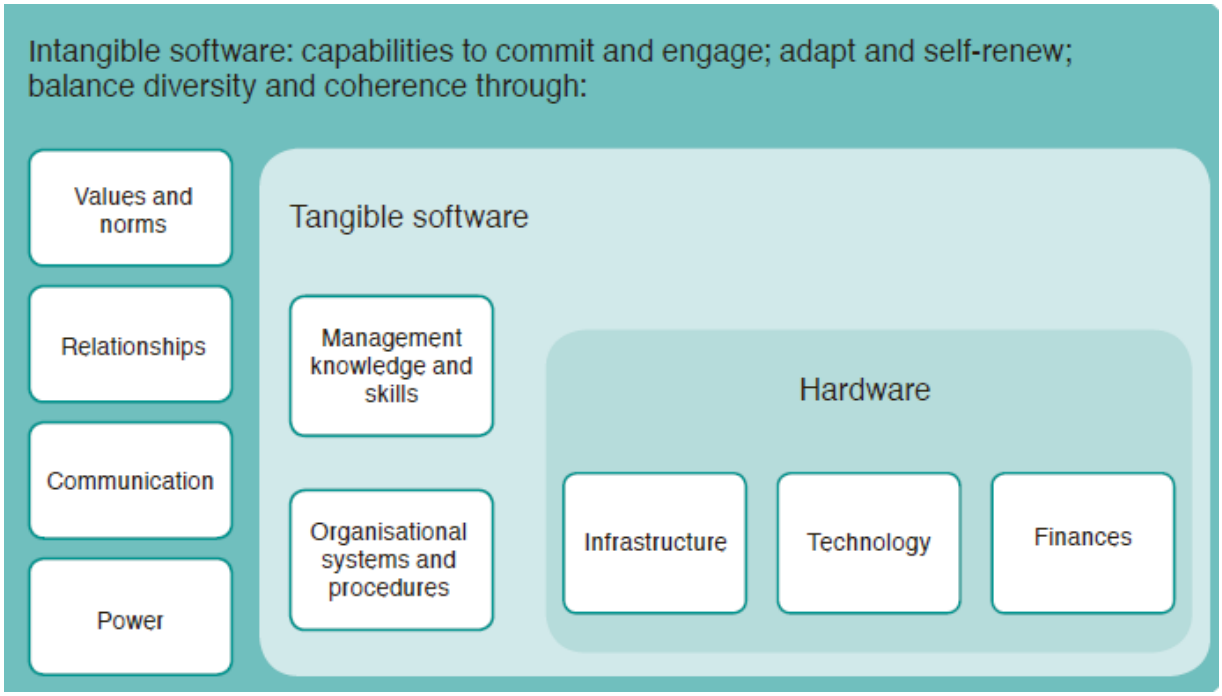
Source: De Savigny and Taghreed (2009)

Several studies have been done to elicit the perspectives of various role-players about the NHI reforms in South Africa. However, this revolved around health professionals and health professional bodies in the private healthcare sector. Given the significant space that the private sector occupies in the SA health care system and given the importance of medical schemes in the funding and administration of private health care, a better understanding of their perspectives seems essential.

Given the researcher's position as an employee in the private health insurance environment, she is unaware of any previous attempts at eliciting the perspectives of the administrators. This study is deemed the first in the country to determine the perceptions and attitudes of senior managers in the PHIA industry. Therefore, it is vital to gather how they reckon the NHI implementation will impact their corporations and what their positionality about the NHI implementation is. Their views will assist the policymakers and government in establishing a stage and approaches to engaging with the PHIAs.

Figure 2: Organisational capacity

6. Conceptual framework



Source: Ortiz Aragon, 2010 cited by Elloker et al. (2011)

Based on the purpose of this study, the researcher decided to draw on the Aragon framework cited `by Nyikuri et al. (2015) and Elloker et al. (2011). Permission to use the diagram was obtained from the authors. Elloker et al. (2011) argue that the capacity of an organisation depends on three interacting dimensions: "the hardware of infrastructure, technology, and funding levels; the tangible software of knowledge, skills, and processes of decision making; and the intangible software of relationships, communication practices, values, and norms". Therefore, it was important to use this framework as the topic guide was constructed from software issues such as communication and engagement. The Aragon framework will ensure that the researcher engages with both hardware and software aspects in developing the topic guide for the interviews and makes sense of the data afterwards, as the default tendency when exploring something such as an NHI is to focus only on hardware aspects such as money and human resources.

7. Research Question

What are the senior manager's perceptions of the private health insurance administrator (PHIA) industry on the NHI in SA, and how do they see their contribution towards this policy initiative?

8. Aim

Analyse the PHIA industry senior manager's perspectives on the NHI implementation of an NHI in SA.

1.2.Objectives

1. Describe the governance and management structures, and roles of senior managers in the private health insurance administrator or medical schemes administrator companies in SA.
    a. Ascertain potential implications for the role of senior administrators in the development and delivery of the NHI.
2. Describe current proposals on the role of medical insurance schemes in recent government policy proposals for the NHI.
3. Explore the perspectives of senior managers in the private health insurance administration industry about the implementation of NHI in South Africa.
4. Identify policy-relevant recommendations for how to draw on the experiences of this group of health system actors.

1.3.Research Methodology

This section focuses on the research methods that will be used for this study.

1.4.Study Setting

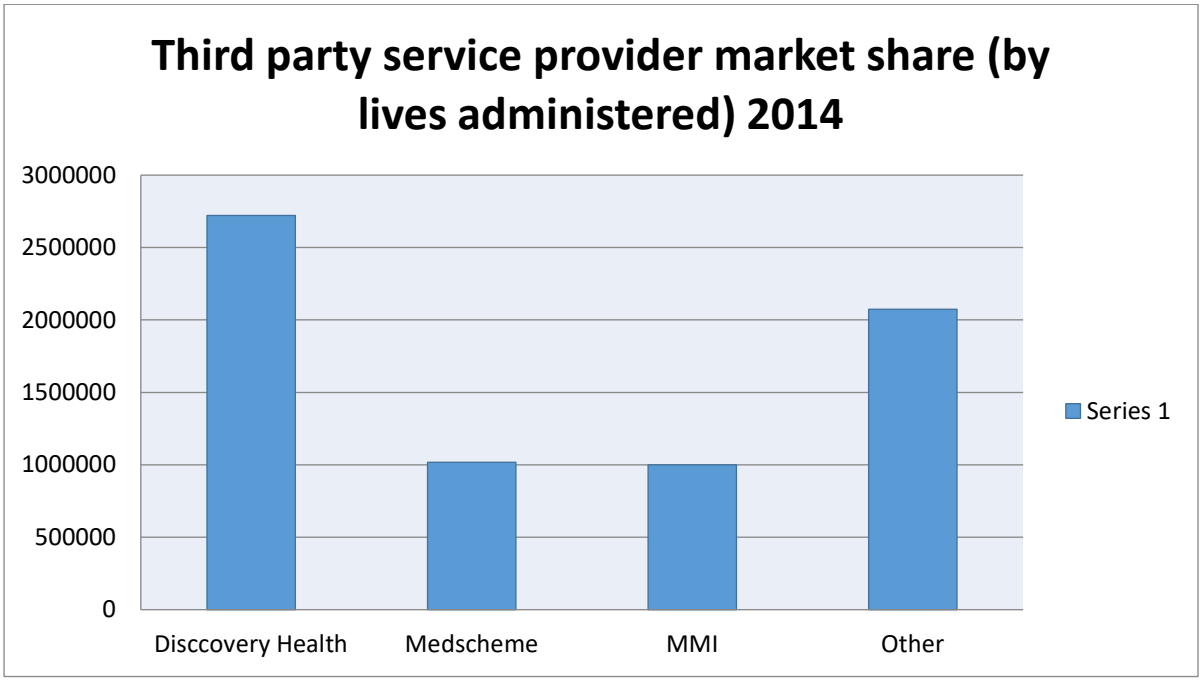
The proposed study will include senior managers employed by Discovery, Medscheme, and Metropolitan Momentum Holdings (MMI) located in Cape Town, which are the largest PHIAs in the country, with several branches countrywide. However, their head offices are in Cape Town.

They have a market share of 40% of the medical scheme market and manage at least 18 closed schemes for corporate clients. Their focus is on 'improving the value of healthcare by focusing on providing efficient and quality services to the members to warrant better health outcomes.' They also offer services such as long-term and short-term insurance, rewards programmes, savings, and investments.

Medscheme is by far the second largest PHIA in the country and only offers healthcare administration services and health risk management for several medical schemes such as Polmed, GEMS, Samwumed, and South African Broadcasting Corporation (SABC). MMHI was formed in 2010 from a merger of Metropolitan Holdings and Momentum Group and became the third-largest life insurer in the country. Same as Discovery, MMI Holdings provides both long-term and short-term insurance, services on asset management, savings and investment, healthcare administration, health risk management, benefits for employees, and a rewards programme.

This distribution validates what has been noted by McIntyre (2010) and Erasmus et al. (2016), that Discovery, MMI Holdings, and Medscheme are the top three largest PHIAs in South Africa.

Figure 3: Third-party service provider market share by lives administered



Source: Council for Medical Scheme (2014)

1.5.Study Design

This study will employ a qualitative method, using semi-structured key informant interviews, to elicit the perspectives of senior administrators in the Medical Scheme industry. This is the most appropriate method for this purpose. A qualitative study process is regarded as useful in pursuing to investigate the 'micro and macro' levels of a certain occurrence (Warren and Karner, 2015). Similarly, Wellman et al. (2005) argue that the qualitative method consists of investigative techniques that pursue to explain, interpret, and come to terms with the meaning of a plausible occurrence in the social world. Qualitative research is characterised by being inductive and becomes the best choice for this study, as opposed to the quantitative method, which is deductive (Warren and Karner, 2015).

The researcher will utilise an inductive approach to code and make sense of the interview data. Unlike the deductive approach which is used to test theory or hypothesis in quantitative research, the inductive approach is used primarily in qualitative research methods. It means that new theory will be generated out of the data collected from the participants (Hesse-Biber and Leavy, 2011). The inductive approach often starts with the observations, followed by theories proposed towards the end of the research process as a result of observations. However, there are limitations in the sense that the validity of the research is debatable, and findings cannot be generalised as opposed to the deductive approach (Park, Bahrudin and Han, 2020).

In this study, the researcher will only come up with generalised statements from a specific set of ideas, not from a broader population that represents the senior managers working in the PHIA industry. The researcher will have a topic guide for the interviews containing pre-determined semi-organised questions to guide the interviewer, which will allow participants to raise their ideas that were not included by the researcher but are appropriate to the study.

1.6. Study Population and Sampling

The sampling technique that will be used for this study is the purposive one, together with snowballing recruitment, with the target to cover at least between 15 and 20 participants. The inclusion criteria for the study entail senior managers who are employed at MSAs companies (Discovery, Medscheme, and MMI Holdings). The senior managers will be included in the study according to their willingness to participate. They will be selected according to the seniority of their position within the company, as a member of the executive team, and at the level of decision-making and policy change influence in those companies.

Moreover, the senior managers to be included are those who have worked for the organisation for at least two years or more, as they are viewed to be able to provide more insight into the study. This will be done after reviewing the three company's organisational structure documents available in the public domain which will give more insight into who are these senior managers and the type of work they do for the company.

The age difference and gender do not play a role in determining the participants for this study. The operational managers, business unit managers, and team leaders will be excluded from the study as they only implement what has been decided by the executive team of the organisations and will add no value in determining the perceptions around the implementation of NHI in the country. The researcher will first ascertain the number of senior managers employed in these three companies through the organisational structure document reviews.

The researcher will then identify those in the health business sector of these companies and responsible for influencing policy change and implementation. Therefore, the key informants, the individuals who hold the organisational design (OD) manager portfolio at the health segment of the three companies will be identified. These individuals are viewed to know more about the organisational structure of their company and know the functions of various portfolios in their organisations.

1.7.Data Collection

The data collection will be through a desk-based and primary data collection co. Information will be collected from relevant policy documents and key informant interviews of senior managers from the private medical insurance industry. The relevant policy documents for this study will be the NHI policy

documents produced In the past eight years, including the NHI Green Paper, the two NHI White Paper drafts, and the NHI Bill.

The focus of the review will be on the policy statements about the private health care insurance companies and their role and position towards the NHI implementation, and other relevant policy statements made by the representatives and umbrella bodies linked to the private insurance scheme such as the South African Medical Association (SAMA). These documents will be reviewed to ascertain how policy statements have changed over time.

The first step of the primary data collection phase of the proposed research is to review the organisational governance and management structure documents for the three PHIAs targeted for the study to fulfil objective 1 of the study. The documents will be accessed by asking for permission from each company's key stakeholders. The only documents to be reviewed are those with information about the company's organisational structure and the role of the senior managers in the organisation.

The review of the organisational governance and management structure of each company will assist in identifying the similarities and differences that may be there in these companies. The review will also assist in answering objectives 1 and 2 of the study which is about identifying the roles and designation of the senior managers in the three selected PHIAs.

Objective 3 of the study will be best achieved through conducting in-depth semi-structured interviews with the senior managers in the three identified PHIAs to gather information about their understanding and perceptions of the NHI in SA and the impact of the NHI in their organisations and on themselves individually.

The key informant's interviews will be in a face-to-face format. According to Pietkiewicz et al. (2014), semi-structured interviews in qualitative research are beneficial as they help both the researcher and the interviewee to engage in a conversation in real-time. Moreover, they provide space and flexibility for the expected and unexpected matters that may arise (Pietkiewicz et al., 2014).

The qualitative data collection instrument will be a semi-structured interview topic guide. The topic guide will include a set of questions that will assist the researcher in encouraging the participants to speak about the issue at hand. Warren and Karner (2015) argue that interviews in qualitative research are viewed as a special kind of conversation whereby the researcher as the interviewer questions the participant on a topic of interest to the interviewer but also relevant to the participant.

The interviews will be conducted in the English language after the appropriate training of the researcher in conducting interviews.

Furthermore, the researcher has also made provision for those who would like to participate, but do not have time to sit for interviews. In these cases, the set of qualitative questions with instructions on how to complete the guide will be sent to the participants to complete at their most convenient time and return to the researcher.

The topic guide questions are listed in **Appendix B**. Questions such as "What do you mean by…?" will be used to probe for further information from the respondents. The demographic-related information such as age, gender, and occupation will be completed by the participants on the face-to-face sheet whilst the interviewer is busy preparing the audiotape before the interview takes place.

1.8. Data Management Plan

A password-protected cellular smartphone will be used to record the interviews with the participants' permission. The interview audio will be transferred to a password-protected research folder stored in the computer and the USB stick immediately after the completion of each interview. The audio will be cleared from the smartphone immediately after the data has been transferred to both the research file on the computer and the USB stick to avoid formation leakage to people outside of the study. The computer will be secured with a password that is only known by the researcher, and the research file on both the computer and the USB stick will be encrypted with the password known by the researcher as well to avoid other people outside of the study accessing the data stored on those platforms.

The research data will only be kept for five years after the study, and the participants' real names will be coded to protect their identity. The data will be kept safe in a University of Cape Town repository to ensure access to other researchers in the institution, with permission obtained from the Principal Investigator. The audiotaping, transcribing, and typing of the interviews conducted will be done by the researcher with assistance from the professional transcriber, to ensure proper data analysis and management.

After transcription, the data will be reviewed by both the researcher and the transcriber to ensure data accuracy. After that, the data collected will be grouped according to conceptual similarities. This will be done by developing labels immediately after the first review of the data transcripts and grouping all the data that belong to the same code under the respective label.

Data analysis will be done immediately after data has been transcribed and coded, according to Braun and Clarke's six steps of thematic analysis, which are explained by Hangulu & Akintola (2017). Hangulu & Akintola (2017) state that the first step of Braun and Clarke's thematic analysis is for the researcher to read all transcribed scripts to become familiar with the data collected. Then, the next step is to identify and generate themes from the data.

In the third stage, the researcher must re-read all the transcripts identified and generate the codes. Then, in the fourth step, the researcher will create themes from the codes. In the fifth step, the researcher will read and group all the identified themes and identify their sub-themes. Lastly, the researcher will discuss each theme and sub-themes with a second researcher (in the instance of this study, the supervisor).

1.9. Rigour

To ensure the quality and rigour of the study, the questions for the in-depth interviews will be pre-tested by the researcher before the initiation of the study. This will be done through a mock interview with the participant with similar characteristics to the target group. The interviews will be used together with documentary reviews to illustrate and give the local context to the perceptions of the senior managers in the health insurance administrative industry. Additionally, data triangulation will be ensured to enhance truth and validity by comparing the data collected from the interviews with the data collected from the self-administered questionnaires.

Moreover, member checking with the study participants will be held after each interview to detect any data errors or omissions. The member-checking method will ensure that the findings produced by the study are valid (Anderson, 2010), to also ensure the credibility of the research and eliminate bias, particularly during the data analysis and interpreting stage (Anney, 2014).

During the report writing stage of the research, the researcher will present the findings to the other peers in the field to obtain their perceptions in developing the study conclusion. The MSA companies became appropriate for this kind of research as the researcher is currently employed in a similar setting. This is envisaged to lead to easy access to research participants as the researcher shares some similar values and beliefs with the members of the organisation.

9. Ethics

The approval to conduct the study will be obtained from the University of Cape Town's (UCT) Research Ethics Committee. The researcher will also send a letter to the targeted companies for approval to conduct the interviews. The letter to the targeted companies is attached to **Appendix C** of the document. The permission to publish the study will be obtained from the UCT Research Ethics Committee and the study participants.

1.10. Informed Consent Process

The information leaflet regarding the research will be issued to the senior managers a few days before the study, and any concerns that arise from it to be addressed to ensure that the participants are aware of the purpose of the study, risks, and benefits involved in this study. Then, the purpose of the study will be explained again to participants before the commencement of the interviews. Participants will

sign the informed consent before the commencement of the interviews. The interviewer, as the researcher will keep on checking with the participants if it is still comfortable to continue with the interview. The informed consent and the information leaflet about the study are found in **Appendix A** of the document.

The information leaflet and the informed consent will be written in English, in a manner that will be easily understood by the participants. Then, the senior managers as participants will return the signed informed consent just before the commencement of the interviews. Before and during the interviews participants will be made aware that participation in the study is voluntary and that they have a choice to opt-out from the study at any stage, without any harm or penalties when they do so. A tape recorder will be used in each in-depth interview conducted with the informed consent obtained from the participants before the initiation of the interviews.

1.11. Privacy and Confidentiality

The interviews will be conducted after working hours or at a time convenient to the participants in closed rooms at the company premises to ensure privacy and confidentiality. Confidentiality will be maintained by coding the data according to alphabets starting with 'A' instead of using the participant's real names. The face-to-face sheet will be used for the demographic data, and the notes taken during the interview process will have the same code as the one used on the audiotapes to allow for accurate data analysis. Furthermore, as mentioned in the data safety and management field, the data will be kept secured in a research folder stored in both the computer and the USB with a password will be used to encrypt both folders to ensure the privacy and confidentiality of participants.

1.12. Protection from Harm

The researcher will make sure, as far as possible, and practical, that the participants are protected from any emotional and social difficulties by excluding all questions that may lead to such discomfort and maintaining confidentiality and anonymity throughout the process. This will be done following the 1966 Public Health Service policies that were set to protect humans as research participants (Warren and Karner 2015).

1.13. Risks and Benefits

There are no physical or emotional risks involved with this study as there will be no intervention or personal information involved. The results of this research study may directly or indirectly benefit the participants in a sense that it will give some insight into the senior manager's positionality and perceptions of NHI in SA and offer the policymakers and government officials some idea on how to engage with senior managers in the PHIA industry to make the NHI implementation work successfully for both the private sector and the public sector.

1.14. Reimbursement for study participants

There will be no reimbursement offered to participants as the interviews will be conducted in the participant's working environment and at a time convenient to them. There will be no travelling involved.

10. Knowledge Translation

The results of the study will be disseminated in a thesis format and to the research participants in the form of a workshop presentation in the workplace. The presentations will involve visual aids such as PowerPoint. A research article will be published in the Global Health Action journal. Global Health Action is a journal publication site that accepts and reviews articles that are original, short communications, and of current debate. It also allows for student manuscript publication with the specification of 6000 words for PhD studies. However, this study is for the Masters level and allows for more than 6000 words (refer to **Appendix H** for the journal guideline). The results will also be made accessible to interested parties such as policymakers, academics, private health sector officials, and government officials through conferences and workshops. However, before the publication, the results will be verified with the participants, and publication permission is to be obtained.

11. Timeline

The proposed study will commence soon after the study has been approved by both the Department of Public Health and Family Medicine Ethics Committee and the University of Cape Town Ethics Committee. Therefore, the collection of data is estimated to commence in February 2019 and to be finished in April 2019. The data analysis will start a month later soon after data collection has started, and to be finished in May 2019. The manuscript, editing, and final submission are projected to be done in June 2019. The whole project is envisaged to take fifteen months as indicated in *table 1* below.

Table 1: Study Time Frame Estimation

Activities	Jan 2018	Feb 2018	Mar 2018	Apr 2019	May 2019	Jun 2021	Jun 2021	Oct 2021	Mar 2022	July 2022	Nov 2022	Sept 2023
Concept Note												
Literature Review												
Proposal submission and approval												
Data Collection												
Data Analysis and transcribing												

Manuscript and editing												
First draft thesis submission												
Second draft thesis submission												
Final thesis submission												

12.

13. Budget

The proposed research project is self-funded with an estimated total cost of about R17,075.00 (see *Table 2* below). The transcribing of the data collected is the one item that will cost the researcher the most, as a professional transcriber must be hired for the job. The researcher will be the one to finance the research project as part of fulfilling the master's in public health studies.

Table 2: Estimated Budget

Item	**Cost**	**Comment**
Writing pad	R 50. 00	To take notes during interviews
Pens	R 25. 00	To take notes during interviews
Recorder	R 0. 00	An existing smartphone recorder will be used
Printing	R 500. 00	To be outsourced
Transcribing	R 15 000. 00	A professional transcriber will be used
Editing	R 500. 00	A professional academic editor will be used
Total cost	**R17 075. 00**	

14.Conclusion

Part A of this document is a separate section from Part B and should be read as a background to how Part B was constructed. Part A serves as the research protocol that guided the study and provides a background to the study, literature review of the UHC financing models in various countries and the intended NHI fund in a South African context, and the methods for the study. Part A was also submitted and approved by the UCT's Human Research Ethics Committee to obtain ethics clearance for the study.

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PART B: MANUSCRIPT

The perceptions of private health insurance administrator senior managers about the National Health Insurance (NHI) in South Africa

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16. Abstract

This paper explores the perspectives of senior managers in the private health insurance administrator (PHIA) industry about the implementation of National Health Insurance (NHI) in South Africa and their perceived role in it. Results were derived from 13 in-depth interviews with senior managers employed by the three largest PHIAs in South Africa, as well as a review of NHI policy documents. Private health insurance administrators play a significant role in managing the proportion of health care funds for various medical schemes in the health care system. The results presented a gap in current policy about the future role of the PHIA/MSA industry in an NHI system, and value of exploring otherwise unheard voices within the context of the NHI implementation in South Africa. Moreover, senior managers in the PHIA industry are willing to contribute their experience and expertise to overall Universal Health Coverage (UHC) efforts.

Keywords: *Universal Health Coverage, National Health Insurance, Private Health Insurance, Private Health Insurance Administrators, Medical Schemes, Medical Aid, Medical Schemes Administrators, Healthcare Financing*

17. Introduction

Health equity is an important societal goal but remains a challenge to achieve globally. Ghiasvand et al. (2021) identified persistent inequities in various aspects of health such as health outcomes, health services utilisation, and health financing across most countries. Jensen et al. (2022) argue that a well-recognised inadequacy is the difficulty in determining when differences in healthcare are avoidable. Moreover, Jensen et al. (2022) state that the lack of conceptual clarity is a key obstacle to the operationalisation of equity in health policy and practice and requires efforts to clarify and harmonise existing equity. The World Health Organization (WHO) affirms that access to equitable quality healthcare for all people, without distinction by race, religion, political belief, economic or social condition, is a fundamental human right (Williams and Jackson 2005 cited by Liburd et al., 2020). It requires directed and continuous societal efforts to address the past and current inequalities and thus eliminate health- and healthcare differences (Liburd et al., 2020). Dover and Belon (2019) further argue

that health equity and the social determinants of health (SDOH) are at the forefront of contemporary public health concerns.

Given the complexities in attaining health equity, in the year 2005, the World Health Assembly (WHA) of the WHO inspired all country representatives to pursue the move towards universal health coverage (UHC) and guarantee access to defined 'promotive, preventative, curative, rehabilitative, and palliative' health care for people (Awoonor-Williams et al., 2016). The importance of UHC is recognised as a motivation for financial protection, especially of the key drivers poor and indigent, from catastrophic consequences due to achieving the global out-of-pocket payment (OOPP) for health agenda of "care (Verrecchia, Thompson, and Yates 2019). health for all" by the year 2030, as expressed in the Sustainable Development Goal (SDGs) 3.8, which encourage member states to achieve UHC and financial protection for all (Obermann et al., 2018; Obare et al., 2014; Kutzin 2013).

In working towards UHC, several countries have implemented health funding mechanisms that are ideal for their background (Govender et al., 2013; Alhassan, Nketiah-Amponsah and Arhinful, 2016). These health financing mechanisms vary depending on whether countries have adopted the NHI, National Health System (NHS), or a community-based Health Insurance System (CBHIS) such as the Ugandan Community Health Insurance (Alhassan et al., 2016).

In response to the global call for UHC, South Africa (SA), deemed a highly inequitable country, started with the process of establishing an NHI; whilst simultaneously aiming to strengthen the public sector system and primary health care (Fusheni and Eyles 2016). South Africa has an estimated population of 60 million people (Stats SA, 2022). Despite the country's upper-middle-income economic status, the most recent structural unemployment rate is estimated at 34.5% (Stats SA, 2022). While unemployment is often viewed as an economic problem, as raised by Pratap et al. (2021), it is a *complex* and *multifaceted* public health issue that interacts with numerous other social determinants of health and plays a key role in perpetuating health inequities.

To achieve UHC, countries must ensure that they improve the amount of gross domestic product (GDP) health expenditure, as the extent of financial resources is a crucial factor in determining whether health outcomes can be achieved. South Africa has a GDP health expenditure of approximately 8.4%, which is a fair distribution compared to other countries which varies between 8-10% (OECD, 2021). South Africa certainly fares well compared to other African countries, where for example, in 2019, Botswana reportedly allocated 6% for health expenditure (OECD, 2021).

However, the allocation itself is not a guarantee for good health outcomes, as the distribution of health expenditure in South Africa is highly inequitable. The South African health outcomes are less favourable compared to other countries with a comparable or often lesser income status. Countries such as China and Brazil, with smaller GDP allocations to health, with a health expenditure share of 5.1%

and 3.6% of GDP, fare infinitely better and have achieved their MDGs well ahead of South Africa (Sahoo, Rout, & Jakovljevic, 2023; OECD, 2021; Chopra et al., 2009).

Beyond the inequitable expenditure, the public health system further faces many resource challenges such as staff shortages, poor administration, and poor infrastructure (Sithole 2015). McIntyre, Meheus, and Rottingen (2017) in their paper on assessing the level of domestic government health expenditure for universal health coverage argue that a specific target for government expenditure on healthcare, related to gross GDP, promises to be an important mechanism for holding governments to account in moving towards UHC. In the quest to correct the inequities and the ailing public sector system, and to reduce the impact of financial stress related to health service access. In response, the present government has decided to introduce the NHI as a healthcare funding mechanism, with the hope of achieving the UHC.

18. The South African healthcare system

The South African health system is regarded as a two-tier system, consisting of a public sector which services about 84% of the population, those without medical insurance, and the private healthcare sector serving the insured and those able to pay out of pocket (van Den Heever, 2012; Department of Health 2017; National Department of Health, 2015). There are also non-governmental organisations (NGOs) and non-for-profit organisations (NPOs) that assist in providing healthcare services in the country (Jobson, 2015). There are about 4200 public healthcare facilities, and the healthcare budget is proportionally allocated to the nine provincial departments of health to service these healthcare facilities (Jobson, 2015).

18.1. The private sector's role in the South African healthcare system

The private health sector is financed through controlled voluntary private health insurance (PHI) arrangements, known as medical schemes. In 2010, the private health sector expenditure was reported to be at 3.4% of GDP (van Den Heever, 2012), making the expenditure in the private sector that only serves about 16% of the country’s population, equal to that of the public sector that serves the other 84%. McIntyre (2010) argues that even though PHI covers only 16.2 % of the population through medical schemes, 44% of total healthcare expenditure is attributable to these schemes. However, the population served by the private health sector still pays substantial OOPs for healthcare services (Ataguba and Akazili, 2010). Medical scheme members also make substantial OOP co-payments for services not covered by schemes or once the annual benefits have been exhausted (McIntyre, 2010). Medical schemes are, therefore, not providing adequate financial protection for their members. There are around 200 private hospitals throughout the country and can only be accessed with private insurance or self-pay.

According to the National Planning Commission (2011), a body that is appointed by the South African President to advise on issues that impact long-term development (National Development Plan 2030), the PHI system in SA is viewed as not being operative in delivering universal healthcare funding for those who are insured due to its voluntary nature. This voluntary nature of registering in a private medical scheme makes use of a risk rating that has the likelihood to eliminate some people from accessing health services (National Planning Commission, 2011). The private sector is, therefore, tailored for individuals who are healthier and who can afford to pay the medical scheme premiums monthly, rather than those with poor health and unstable or no source of income builds a compelling case for reforming the PHI, alongside the establishment of an NHI as intended by government.

18.2. Private Healthcare Insurance

Paccagnella et al. (2013) argue that voluntary private healthcare insurance (PHI), as opposed to mandatory NHI, plays a key role within the healthcare system, such as covering services not rendered through the public health insurance system. This is particularly so in European countries where voluntary private health care insurance that exists alongside the national health system assists individuals in avoiding having to pay out-of-pocket payments (OOPP) (Paccagnella et al., 2013; Canterero-Prieto et al., 2017). For example, in Spain, the private health sector provides voluntary health insurance schemes to individuals (Bernard-Delgado et al., 2018).

The voluntary medical schemes constitute the alternative network for 80% of the civil servants that are insured within the Mutualism for Civil Servants (MF), and it provides services such as dental care and optical care that are not covered by the national health system (Bernard-Delgado et al. 2018). In SA, the PHI vehicle is in the form of medical schemes, and regulated health insurance providers (van Den Heever, 2012). Ramjee & Vieyra (2014) and McIntyre (2010) argue that the medical schemes in the country are based on not-for-profit organisations that are owned by their registered members and managed by boards of trustees (BOTs).

Over time, the PHI industry has faced challenges, as McIntyre (2008) points out the medical schemes have revealed slight growth in intensifying their insurance coverage in the country, with a decay in benefit packages and providing cover to either in-hospital care or chronic ailments as specified in the Prescribed Minimum Benefits (PMB) regulation (CMS, 2019a). This may be due to the unrestrained increase in medical scheme expenditure and the decline in contributions made (McIntyre, 2010). The medical scheme's future role in the NHI environment is, therefore, one that is still uncertain (Gray and Vawda, 2016). It is not clear whether the medical schemes will be permitted to offer just a complementary cover, which is a top-up for services that are not covered by the NHI benefits package, or if the schemes will be allowed to offer a comprehensive cover for individuals in addition to their mandatory payment contributions to the NHI fund (The Davis Tax Committee Report, 2017). However,

they are anticipated to operate in the NHI environment with a requirement to shift their approach (Engelbrecht and Crisp, 2010).

18.3. Private Health Insurance Administrators (PHIAs)

Private Health Insurance Administrators (PHIAs) or Medical Schemes Administrators (MSAs), an important group of actors in the private health insurance environment, will become important stakeholders in the implementation of an NHI in SA (van Den Heever, 2012). Their current role is negotiating prices or tariffs on behalf of the medical schemes with service providers such as hospital facility groups and General Practitioner (GP) facility groups, amongst others (CMS, 2019b; Competition Commission South Africa, 2018).). The General Practitioner (GP) facility groups in this context are referred to as those facilities where a group of GPs comes together to establish facility groups, and all GPs will be operating under the group practice number while retaining their practice number as regulated by BHF.

In the NHI environment, the PHIAs can potentially play a role in providing administrative services for services rendered by the GP and hospital facility groups as they have years of experience and expertise in the field. However, both the recently released NHI Bill (2019) and the NHI White Paper document of 2017 do not mention any role that will be played by the administrators, except for the private service providers as purchasers (Ramjee and McLeod, 2010). Currently, the role of PHIAs is one of performing the administrative services on behalf of the medical schemes they are contracted with. The administrative services include membership management, claims management, tariffs and billing management, underwriting, and price negotiations with suppliers and providers.

19.Towards an NHI in South Africa

In the quest to correct the inequities and strengthen the ailing public sector system, the current government has decided to introduce an NHI as a mechanism of healthcare financing, with the hope of achieving the overarching reform goal of the UHC. At the 52nd National Conference of the African National Congress (ANC) that was held in 2017, the leading political party in the country, the ANC leadership committed to the establishment of an NHI (Whyle and Olivier 2023). The planned NHI is aimed at protecting people from economic adversities triggered by health-related problems by guaranteeing prepaid healthcare system funds and pooling funds across the public and private sectors. It aims to reduce fragmentation in the system and reduce barriers to the redistribution of available healthcare funding (Department of Health, 2015; Ataguba and Akazili, 2010).

The South African move towards UHC is guided by various international frameworks such as the Sustainable Developmental Goals (SDG) 2030 targets, particularly SDG 3 *"Good Health and Well-being''*. This further aligns with the WHO frameworks for moving towards UHC, and the associated

goal of ensuring access to essential quality health services, financial risk protection, and responsiveness is achieved.

According to the National Department of Health (2015), the intended NHI is characterised by various features such as being financially progressive, with mandatory pre-payment, offering comprehensive services, ensuring financial risk protection, having a single fund, and being publicly administered. Meanwhile, there is not yet a defined package of care, it is envisaged that citizens will gain access to a range of promotive, preventive, curative, rehabilitative, and palliative healthcare services, which will be of decent quality and affordable.

The NHI in SA was envisaged to be implemented in three phases over 14 years (Mayosi 2012; Naidoo 2012; NPC 2011), with the first phase having started in 2012/2013 to 2016/2017, the second phase from 2017/2018 to 2019/2021, and the third from 2021/2022 to 2024/2025 respectively (NPC 2011). The first phase included the piloting of various interventions in ten districts of the country. These interventions were aimed at re-engineering the PHC system and institutional development, such as the construction of a new medical school in one of the provinces (Naidoo 2012). This included initiatives such as district-based clinical specialist teams (DCSTs), ward-based outreach teams and strengthened school health services and placing general practitioners in clinics to support an otherwise nurse-driven service at the primary level (Oboirien et al*.,* 2018); Gaede, 2020, Nelson and Madiba, 2020). However, these initiatives had variable success, and the pilot sites were similar.

The second phase (2022 to 2026), involving the continuation of health system strengthening initiatives, the mobilisation of additional resources, and the selective private provider's health care services contracting is currently underway but progressing slower than expected (NHI Bill 2019). Phase 3 implementation has not yet started (Mukwena and Manyisa, 2022). Phase three is meant to introduce the obligatory NHI prepayment, authorised private hospitals and specialised services contracting, and the finalisation, and implementation of the Medical Schemes Act and the NHI Act (Mukwena and Manyisa, 2022).

Amidst the attempted implementation of the distinct phases, much contestation occurred, with stakeholder constituencies offering sharp criticism or outright rejection of the NHI. How the NHI as a new phenomenon will operate seems to be unclear to most people. Sekhejane (2013) argue that the public is still unsure of how it will contribute to the implementation of the NHI, and Passchier (2017) said that the government's lack of clarity on the practical steps required in each implementation phase of the NHI, coupled with inadequate communication, has contributed to confusion and negative public perceptions.

In particular, the role and place of the private health sector and the various entities that constitute private health care in South Africa is a hotly contested area. Resultantly, the perspectives of many diverse groups had been solicited, at times through empirical research and other public forums, town hall

meetings and opinion pieces in several publications. For example, Yeates and Surrender (2021), in their comprehensive documentary review, found a strong orientation towards partnership with the private sector in all the nine African regional economic communities they studied and that vigorous participation of countries with private-sector stakeholders is actively encouraged. Similarly, Mureithi et al. (2018) argue that provincial leaders also saw this as an extension of their existing engagement with private sector providers, as the contracting-in and out concept of the NHI provides options for engaging private practitioners to work in PHC settings to provide services based on need.

20.Study Rationale

Currently, in SA, the role of the medical schemes and PHIAs within the NHI environment is still uncertain. While the views of multiple stakeholder groups have been sought or strongly expressed in debates and forums in recent years, the voices of health insurance administrators, despite the potential role they could play in an NHI, have been relatively silent.

This study explored insights into senior PHIA managers' perspectives about the NHI and adds an important voice to current debates. It further provides some ideas on the potential role of this stakeholder group in the implementation of the NHI. Refer to **Appendix I** to see where the PHIAs are located within the private health sector.

The NHI is on the policy agenda, and a Bill was passed and published in 2019 and later updated in 2023. As with any health system like the health systems building block (WHO 2009) as illustrated in *Figure 4* below, people are at the centre of any policy initiative and its implementation, so understanding what people think and feel is important, as this will ultimately influence their willingness to participate, and their commitment to implementation. The senior managers in the PHIA industry are the key role players in decision-making and informing policy changes for the companies they work for, ensuring the private healthcare services quality and the performance and efficiency of PHIA's performance.

Figure 4: The dynamic architecture and interconnectedness of the health system building blocks

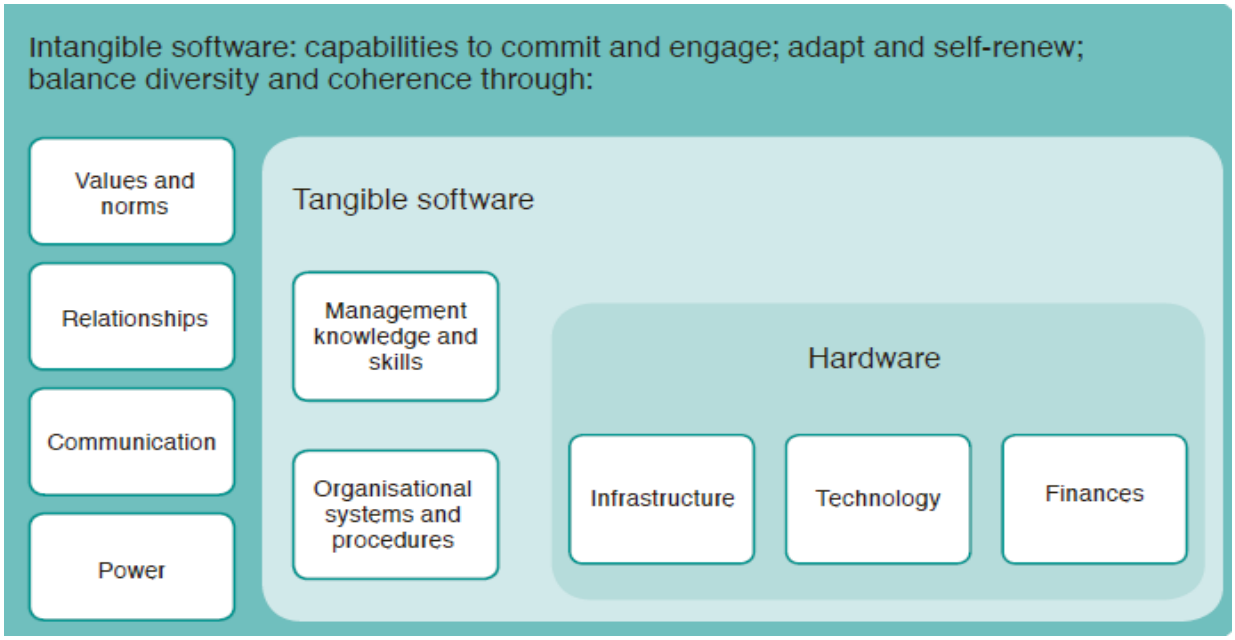
Source: De Savigny and Taghreed (2009)

Several studies have been done to elicit the perspectives of various role-players. However, in the private healthcare sector, this revolved around health professionals and health professional bodies. Given the significant space that the private sector occupies in the South African health care system and the importance of medical schemes in the funding and administration of private health care, a better understanding of their perspectives seems important.

Given the researcher's position as an employee in the private health insurance environment, she is unaware of any previous attempts at eliciting the perspectives of the administrators. This study is deemed the first in the country to determine the perceptions and attitudes of senior managers in the PHIA industry. Therefore, it is vital to gather how they reckon the NHI implementation will impact their corporations and what their positionality about the NHI implementation is. Their views will assist the policymakers and government in establishing a stage and approaches to engaging with the PHIAs.

Figure 5: Organisational Capacity

21.Conceptual Framework



Source: Ortiz Aragon, 2010 cited by Elloker et al. (2011)

Based on the purpose of this study, the researcher decided to draw on the Aragon framework cited `by Nyikuri et al. (2015) and Elloker et al. (2011). Permission to use the diagram was obtained from the authors. Elloker et al. (2011) argue that the capacity of an organisation depends on three interacting dimensions: the hardware of infrastructure, technology, and funding levels; the tangible software of knowledge, skills, and processes of decision-making; and the intangible software of relationships, communication practices, values, and norms. Therefore, it was important to use this framework as the topic guide was constructed from software issues such as communication and engagement. The Aragon framework will ensure that the researcher engages with both hardware and software aspects in developing the topic guide for the interviews, and makes sense of the data afterwards, as the default tendency when exploring something such as an NHI is to focus only on hardware aspects such as money and human resources.

22.Research Question

What are the senior manager's perceptions of the private health insurance administrator (PHIA) industry on the NHI in SA, and how do they see their contribution towards this policy initiative?

23.Aim

Analyse the PHIA industry senior manager’s perspectives on the NHI implementation of an NHI in SA.

23.1. Objectives

1. Describe the governance and management structures, and roles of senior managers in the private health insurance administrator or medical schemes administrator companies in SA.
    a. Ascertain potential implications for the role of senior administrators in the development and delivery of the NHI.
2. Describe current proposals on the role of medical insurance schemes in recent government policy proposals for the NHI.
3. Explore the perspectives of senior managers in the private health insurance administration industry about the implementation of NHI in South Africa
4. Identify policy-relevant recommendations for how to draw on the experiences of this group of health system actors.

24. Research methodology

24.1. Study Setting

This study took place within the private health insurance environment, which in South Africa is large and complex. There are approximately 72 registered medical schemes, which are either open or restricted. About 17 schemes are regarded as open medical schemes, meaning that they register members who can afford to be on a medical aid scheme from a diverse population. The remaining 56 are restricted and enrol members from specific employer groups in the country, for example, GEMS, which is designed for government employees only. The 72 registered medical aid schemes in the country cater for about 8.95 million beneficiaries registered (Council for Medical Schemes Report, 2022), which translates to 16% of the country's population. The selected PHIA/MAS for this study are part of the 27 accredited PHIA/MSAs registered by CMS.

This study focused on the largest three health insurance administrator groups located in Cape Town, where the head offices of three companies are based, Cape Town is the capital city of the Western Cape Province, one of nine provinces in South Africa. The three MAS are Discovery Health, Medscheme, and Metropolitan Momentum Holdings (MMI), profiled in *Table 3* below.

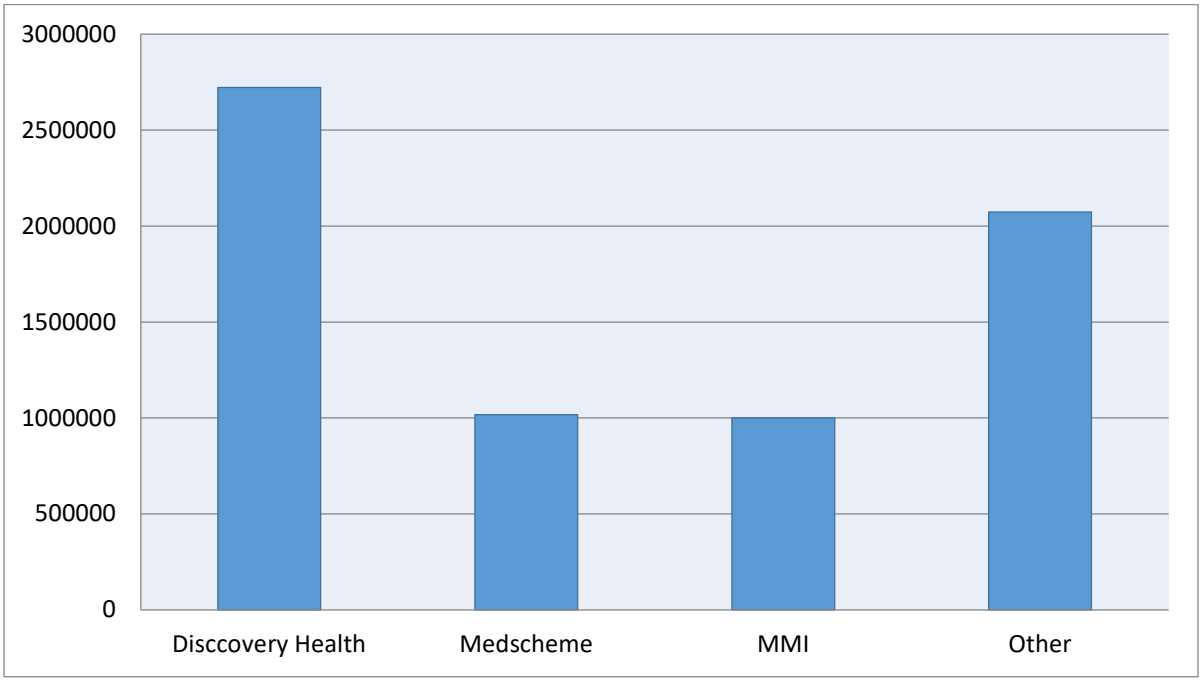
Table 3: Study Setting Profile

Discovery Health	**Medscheme**	**MMI**
Discovery Health is part of Discovery Limited which was established in 1992.	Medscheme is part of the Afrocentric Group, which focuses on health administration, health risk	Metropolitan is part of the Momentum Metropolitan Holdings Limited (Momentum Metropolitan) which is the

	management, pharmaceuticals, wellness, and disease management as well as health-centric information and communications technology-based solutions. Medscheme is proud of itself for delivering sustainable healthcare through comprehensive solutions that offer health risk management services.	merger between the two companies (Metropolitan and Momentum). MMI is a South African-based financial services group.
Discovery owns over 40% of the medical scheme market share in South Africa and with 16.5% market share for health administration services, where they service about 18 restricted medical schemes.	The Afrocentric Group has more than 3.8 million lives under management (39% market share) serviced in the region. Medscheme provides administration and managed care services to the 13 Medical Schemes, including one that is based outside of South Africa.	Metropolitan Health only provides administrative services to GEMS as their client

Figure 6 below depicts the distribution of members administered by various health insurance administrators, showing that Discovery is the leading role player in the medical scheme administrator industry, followed by Medscheme and MMI Holdings, respectively. (Council for Medical Schemes, 2014). The three companies provide healthcare services such as administration, risk management, and rewards programme, for various medical schemes in the country, as well as offering services such as long-term and short-term insurance, rewards programmes, savings, and investment.

Figure 6: Third-party service provider market share by lives administered



Source: Council for Medical Schemes (2014

Whilst not included in the chart, the Government Employee Medical Scheme (GEMS) is one of the country's biggest medical schemes and is administered by both Medscheme and MMI Holdings (Council for Medical Schemes, 2015; Competition Commission South Africa, 2018). These MSAs and others not included in this study are responsible for managing the administrative processes of 72 registered medical schemes. The three MSAs included in this study manage 33 out of 72 registered medical schemes as described in *Table 3*.

24.2. Study Design

This study employed a qualitative study design to elicit the perspectives of senior administrators in the PHIA industry. A qualitative study method is viewed as one that is informative in terms of seeking to explore both the micro and macro levels of a particular phenomenon (Warren and Karner 2015). A phenomenon in this instance refers to the perceptions of senior managers in the PHIA environment about NHI implementation in South Africa. Similarly, Wellman et al (2005) argue that a qualitative approach is an umbrella term that covers a range of exploratory methods that seek to describe, translate, and come to terms with the meaning of sensible observed phenomena in the social world. Unlike quantitative research, which is deductive, qualitative research is characterised as both deductive and inductive.

Objectives 1,2, 4, and 5 of the study were best achieved through conducting in-depth semi-structured interviews with senior managers in the three identified PHIAs, to elicit their understanding and perceptions of the NHI in SA. Warren and Karner (2015) argue that interviews in qualitative research

are viewed as a special kind of conversation, whereby the researcher as the interviewer questions the participant on a topic that is of interest to the interviewer, but also relevant to the participant. Interviews in this study helped to explore the perceptions of senior managers in PHIA companies about the impact of the NHI on their organisations and themselves individually. These interviews were intended to be conducted face-to-face with the key informants.

Following the interviews, these were then transcribed and coded. The researcher utilised an inductive approach to code and make sense of the interview data and the policy documents data. Unlike the deductive approach, which is mainly used to test theory or hypothesis in quantitative research, the inductive approach is mainly used in qualitative research methods and allows for new theories to be generated out of the data collected from the participants (Hesse-Biber and Leavy, 2011). The policy documents were reviewed to look for any information that speaks to the role of PHIAs in the NHI environment to assist with guiding the study questions and topic guide for interviews.

The inductive approach often starts with the observations, followed by theories that are proposed towards the end of the research process as a result of observations, however, there are limitations in the sense that the validity of the research is debatable, and findings cannot be generalised as opposed to the deductive approach (Park, Bahrudin and Han, 2020). The researcher had a topic guide for the interviews; containing a set of pre-determined semi-structured questions to guide the interviewer. The semi-structured nature of the topic guide allowed the possibility of having participants raise innovative ideas that were not prepared by the researcher, but relevant to the study.

24.3. Study Population and Sampling

The researcher included only the senior managers employed at the top three health insurance administrators located in Cape Town. The researcher then went on to ascertain the number of senior managers employed in these three companies through the analysis of documents outlining organisational structures. From the documents, those who are in the health business sector of these companies and responsible for influencing policy change and implementation were identified. Those holding specifically, the following positions were identified as potential key informants:

- Organisational Design were who (OD) Manager,
- Head of Information Technology,
- Executive Hospital Risk Management and Epidemiologist
- Managing Executive: Clinical and Risk Advisory
- Fund Manager

- Advanced Specialist Medical Advisor
- Chief Executive Officer (CEO)

All the portfolios above are in the health segment space of the three companies. These individuals are expected to know more about the organisational structure and key functions in their organisations. One of the fundamental roles of these senior managers is to assist with drafting and influencing the strategic focus of the organisation, hence their identification as the most suitable key informants for this study.

The senior managers were selected according to their position within the company and included based on their willingness to participate. Seniority in this instance meant that they had to be members of the executive team and involved in decision-making and policy influence. The senior managers also had to have worked for the organisation for at least two years, as this would have allowed them time to gain insight into the medical scheme environment and its place and role in the healthcare system. A researcher purposively identified and selected the initial participants and through using a snowballing technique, these participants then referred or guided the researcher to other individuals who were then assessed against the inclusion criteria for the study.

The operational managers, business unit managers, and team leaders were excluded as they only implemented what had been decided by the executive team of the organisations and were not likely to add value to the study objectives.

The study recommenced in 2021, but the original fieldwork plan was interrupted by the COVID-19 pandemic. South Africa had strict lockdown measures and face-to-face interactions were not permitted. Organisations and individuals directed their focus to COVID-19-related matters, and individuals and their families, including the researcher, were profoundly affected. The researcher initially planned to recruit between 15 and 20 participants, however, only 13 interviews were eventually conducted.

24.4. Data Collection

In addition to the primary interviews with the senior managers, the researcher also engaged in a document analysis.

Policy document analysis

Bowen (2009) defines document analysis as a systematic process applied to review or evaluate document material. Policy document analysis is a recognised qualitative research method, particularly for postgraduate students engaged in educational leadership and policy studies as they offer background insights into understanding educational or policy problems in both research and practice (Cardno 2018). From a health policy research perspective, Dalglish et al (2020) found document analysis to be one of the most frequently used and influential approaches to define the content or classify the approaches to

explicit health problems in existing policies. For this study, policy document analysis was conducted to fulfil objective 2 to understand the role of medical insurance schemes in recent government policy proposals for the NHI.

The policy document analysis process reviewed publicly available NHI policy documents to gain an understanding of what the policy positions were on the future role of medical schemes in a South African NHI environmental context.

The READ approach was used to analyse documents systematically. The READ approach consists of four steps, starting from reading the materials, data extraction, data analysis and distil findings (Dalglish et al, 2020). The document analysis results provided more insight for the researcher to engage more meaningfully with interviewees regarding current NHI policy positions as they pertained to the medical scheme industry. **Appendix J** contains the list of policy documents that were reviewed to understand the NHI proposal policy stance about the role of medical insurance schemes.

Key informant interviews

Due to COVID-19 restrictions interviews had to be conducted virtually instead of the originally planned face-to-face modality. The virtual interviews were conducted via Microsoft Teams platforms with a camera on as consented by the participants. This did not pose any threat in terms of the integrity of the data collected and participants were comfortable with the platform, as they used it frequently for their work meetings. Participants consented to the interviews, the online mode of interviewing, as well as the recording of the interviews.

A semi-structured interview topic guide as in **Appendix B** was used to facilitate the discussion. All the interviews were conducted in English as all participants were familiar and fluent with the language. This assisted with promoting the rapport and the conversational nature of the interviews.

Interview topics centred broadly on the perceptions of senior managers in the health insurance administrator industry about NHI in SA; their role in the NHI environment in SA; and their views on the strategies and policy developments that will help to ensure the successful implementation of the NHI in SA.

The researcher also made provision for those who agreed to participate but did not have time to sit for interviews. In these cases, the set of qualitative questions with instructions on how to complete the questionnaire was sent to the participants to complete at their most convenient time and return to the researcher. Only one participant utilised this option due to the tight work schedule experienced during the time of the study. In this instance the demographic data sheet was sent via email, together with consent forms, to be filled in and returned before the interview took place.

The semi-structured interviews allowed for flexibility in the interview structure and space for innovative ideas to be brought. It also allowed for questions to be adapted or adjusted to the participant's level of knowledge around the implementation of NHI in SA and the role of the PHIAs or MSA companies.

24.5. Data Management Plan

A password-protected cellular smartphone was used to record the interviews with the permission of the participants. Interview audios were transferred to a password-protected research folder stored in the computer and a USB stick immediately after the completion of each interview. The audio was cleared from the smartphone immediately after the data had been transferred to both the research file on the computer and the USB stick to avoid the leakage of information to people outside of the study. The computer was secured with a password that is only known by the researcher, and the research file on both the computer and the USB stick was encrypted with the password known by the researcher as well to avoid other people outside of the study accessing the data stored on those platforms.

The research data will only be kept for five years after the study has been completed and the participants' real names are coded to protect their identity. The audiotaping, transcribing, and typing of the interviews conducted were done by the researcher, with the assistance of a professional transcriber, who signed a confidential agreement in **Appendix G** not to disclose any of the information transcribed, to ensure proper data analysis and management. After transcription, the data was reviewed by both the researcher and the transcriber to ensure data accuracy. Furthermore, the data collected were grouped according to conceptual similarities. This was done by developing labels immediately after the review of the data collected and listing together all the data that belong to the same code under the respective label.

Data analysis was done immediately after data was transcribed according to Braun and Clarke's six steps of thematic analysis as explained by Hangulu & Akintola (2017). Hangulu & Akintola (2017) states that the first step of Braun and Clarke's thematic analysis is for the researcher to read all transcribed scripts to become familiar with the data collected. After reading the transcribed data, the researcher recalled all the transcripts identified and generated codes which led to the development of the codebook according to the generated themes.

Data cleaning of each transcript was done, by filling in gaps in the transcribed data from the recordings and correcting misspelt and duplicated words. After reading the transcribed data, the researcher generated inductive themes, which led to the development of the codebook according to the generated themes.

The codebook generated in a Word document was systematically applied to all interviews. The responses were coded according to words and phrases. Following the coding of the data, the researcher

commenced with the analysis within each theme and across themes and identified the key findings that emerged from the data.

24.6. Rigour

To ensure the quality and rigour of the study, the questions for the in-depth interviews were pre-tested by the researcher before the initiation of the study. This was done through a mock interview with a participant who held similar characteristics as the target group. The actual interviews were used together with documentary reviews to illustrate and give local context to the perceptions of the senior managers in the health insurance administrative industry. Additionally, data triangulation to enhance truth, validity and avoiding bias was ensured by comparing the data collected from the interviews with data collected from the self-administered questionnaire. The data from the interview and questionnaires was later compared to the data collected from the document reviews.

Moreover, member checking with the study participants was done after each interview to detect any data errors or omissions thereof. Member checking was done by summarising the key findings of the study with the participants and they responded by indicating their comfort with the findings. The member-checking method ensured that the findings produced by the study were valid (Anderson, 2010). This process also ensures the credibility of the study and eliminates bias, particularly during the data analysis and interpretation stage (Anney, 2014). There were no innovative ideas or findings emerged during the member-checking stage.

24.7. Ethics

The approval to conduct the study was obtained from the University of Cape Town's (UCT) Research Ethics Committee with a renewal applied since the study was not completed in one year as attached in **Appendix D and E** of the document (HREC Reference number 156/2019). The researcher also sent a letter to the targeted companies for approval to conduct the interviews. The approvals received from the two companies are attached in **Appendix F** of the document.

For one company, the researcher struggled to get approval as the study participant referred to as the gatekeeper to access participants clearly stated that there was no other person to do the interviews with besides themself and the interview continued to take place with the participant with the hope that maybe after the interview the stance will change but the status quo remained. The permission to publish the study will be obtained from the UCT Research Ethics Committee and the study participants.

24.7.1. Informed Consent Process

The information leaflet regarding the research was issued to the senior managers a few days before the study and there were no concerns raised from it. The participants were made aware of the purpose of

the study, risks, and benefits involved in this study and were comfortable with the information received. Then the purpose of the study was explained again to the participants before the commencement of the interviews whether face-to-face or on a Microsoft Teams virtual platform. Participants signed the informed consent before the interviews took place. The researcher kept on checking with the participants if it was still fine to continue with the interview.

The information leaflet and informed consent were written in English and in a simple manner that was easily understood by the participants. Then the senior managers as participants returned the signed informed consent just before the commencement of the interviews. Before and during the interviews, participants were made aware that participation in the study is voluntary that they have a choice to opt-out of the study at any stage of the research, and that there will be no harm or penalties involved when they do so. A tape recorder was used in each in-depth interview conducted with the informed consent obtained from the participants before the initiation of the interviews.

24.7.2. Privacy and Confidentiality

The face-to-face interviews were conducted after working hours or at a time convenient to the participants in closed rooms at the company premises to ensure privacy and confidentiality. The virtual interviews were conducted also at a time convenient for participants which were either early morning before work or after working hours. During the stage where the virtual interviews were an option, most participants were working from home, and it was important to ensure that there was no disturbance by other members of the family from both sides. Also, it was important to ensure that connectivity was not going to be a challenge during the interview. The connectivity issues were likely to be caused by the poor electricity supply during the times of load-shedding. Therefore, on the day of the interview, it was important to check the load-shedding schedules for both parties and continue with the interview when it was safe to do so.

Confidentiality was maintained by coding the data according to alphabets starting with A instead of using the participants' real names. The face-to-face sheet that was used for the demographic data and the notes taken during the interview process had the same code as the one used on the audiotapes for each participant which ensured accurate data analysis. Furthermore, as mentioned in the data safety and management field, the data was kept secured in a research folder stored in both the computer and the USB with the password used to encrypt both folders to ensure the privacy and confidentiality of participants.

24.7.3. Protection from Harm

The researcher ensured that the participants were protected from any emotional and social difficulties by excluding all questions that may lead to such discomfort and maintaining confidentiality and

anonymity throughout the process. This was done following the 1966 Public Health Service policies that were set to protect humans as research participants (Warren and Karner 2015).

24.7.4. Risks and Benefits

There were no physical or emotional risks involved with this study as there were no interventions or personal information involved. The results of this research study may directly or indirectly benefit the participants in a sense that it will give some insight into the senior manager's positionality and perceptions of NHI in SA and offer the policymakers and government officials some idea on how to engage with senior managers in the PHIA industry to make the NHI implementation work successfully for both the private sector and the public sector.

24.7.5. Reimbursement for Study Participants

There was no reimbursement offered to participants as the interviews will be conducted in the participant's working environment and at a time convenient to them. There was no travelling involved either.

24.8. Knowledge Translation

The results of the study are disseminated in a thesis format and are to be communicated to the research participants in the form of a workshop presentation in their workplace. The presentations will involve visual aids such as PowerPoint. A research article will also be submitted for publication in the Global Health Action journal. Global Health Action is a journal publication site that accepts original research articles, review articles, short communications, and current debate articles. It also allows for student manuscripts publication with the specification of 6000 words for PhD studies, which will also apply to this study (refer to **Appendix H** for the journal guideline).

25. Results

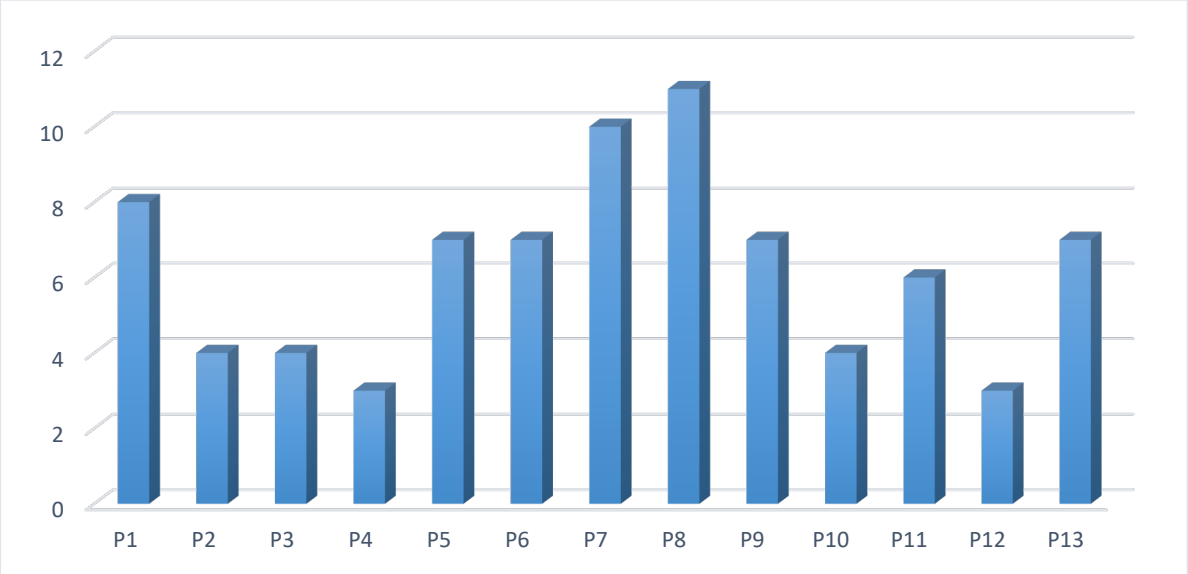
The findings presented in this section describe the perceptions and suggestions of senior managers employed by the three largest PHIAs/MSAs in the Cape Town region about the implementation of NHI in SA as derived from key informant interviews held with the senior managers between 2019 and 2021. In addition, specific policy positions from NHI-related policy documents are included.

Of the original 20 senior managers approached to participate in the interviews, an eventual 13 participated in the interviews. The remaining seven declined for reasons of time pressure and work-related challenges brought about by the COVID-19 pandemic, as they had to attend to the management of the pandemic in their companies instead. Of the 13 participants, one worked in Company A, six in Company B, and five in Company C. The uneven distribution across companies is due to the availability

and willingness of the managers to participate in the study, and not due to any company-specific aspects. Moreover, the lack of Company A participants did not have any discernible bearings or influence in the final findings of the study as there were common themes across participants from different organisations.

Despite the smaller number of interviews, the researcher felt that saturation was reached across the 13 interviews and that additional participants would not necessarily have added more detail to the findings. The insights gained from the interviews conducted with these senior managers add to our knowledge base of what stakeholders from different environments feel about the NHI policy proposals in South Africa and this instance may help inform the role and place of health insurance administrator companies and their personnel in the intended NHI system in South Africa.

Figure 7: Senior Manager's work experience in years



Source: Compiled by the researcher (20th of June 2021)

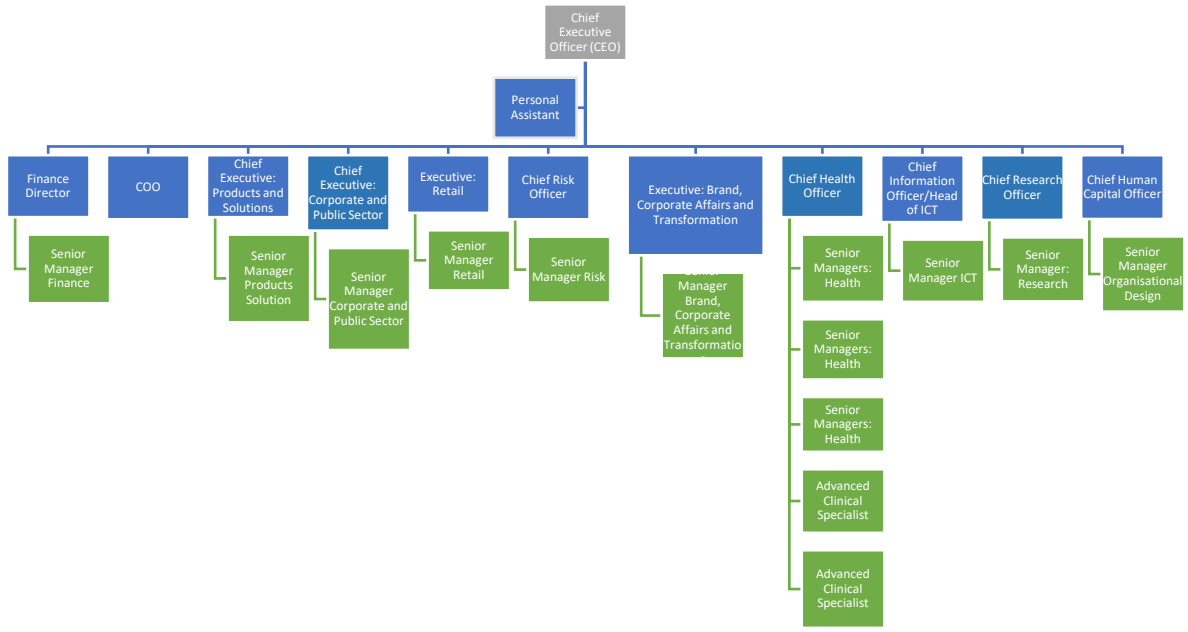
Figure 7 above confirms the seniority of the participants in their organisations. The average number of years of senior management experience in the interview cohort was seven years, with a range of three to 11 years. This duration of service in a senior management capacity would have allowed them to sufficiently know the health administration environment to respond to the interview questions. Those with long-term experience also had more relevant qualifications and were more likely to have had direct engagements with the government, and more opportunities to contribute to policy formulation. Senior managers with longer experience spoke more confidently about their experience in contributing to public health policy and their knowledge and insights into the NHI proposals. For example, Participant 8 reported having achieved several qualifications in the public health care field and mentioned that *"I*

have certain skills and experience, and I am very happy to use that to contribute to a sustainable solution to our country. That is what I am trying to do currently as well."

26.1. Senior Manager's Roles

Senior managers hold various roles in their organisations depending on their speciality and expertise. In all three organisations, the senior managers report directly to the members of the executive, such as the Chief Health Officer (CHO). Figure 8 below, is an illustration of where exactly the senior managers fit organisationally. The highlighted roles with the green colour are those of the participating senior managers, who in turn report to the Chief Executive members (blue blocks). The main function of these senior managers is to provide support to the Chief Executive members in designing the strategy for their respective roles and ensure that the strategy is cascaded to the operational divisional units and measured against annual targets.

Figure 8: Blended Organogram for the three participating organisations- to depict where the senior managers fit in within their organisations



Source: Compiled by the researcher (21st of September 2022)

26.2. Key Findings

The findings of this study are presented according to the key themes that emerged from the inductive coding, with examples of responses in each theme outlined in *Table 4* below. Reflecting on the themes as outlined, these were a combination of hardware elements, but unsurprisingly mostly the software elements as outlined in the Ortiz Aragon Health Systems Framework: values such as accountability and

corruption featured strongly and spoke to the intangible software aspects, while aspects around data availability and information systems speaks to tangible software elements.

Table 4: Themes showing the perceptions of PHIA senior manager's perceptions about NHI implementation in SA

No.	Themes	Ortiz Aragon health system elements	Quotes
1	NHI Funding	Finances	*"…you see, for the implementation, they are still looking at the areas where they can get the funding for the NHI."* **[Participant 6]** *"…So, my understanding is that one common thing is funding which will be channeled to NHI fund and that there would be a common risk pooling. Although there is recognition by all parties that the disease burden of the poorer quintile is different from the burden of the wealthier quintile…"* **[Participant 4]** *"…the whole debate on where the money will come from…"* **[Participant 11]**
2	NHI as a basic human right	Values and norms	"*… one would think it is a travesty, … it is a basic human right, and if NHI works. I would do everything in my power to try and help to enable it…"* **[Participant 1]** "*… is that we must respect human rights and the right of a member of this country to belong and participate in NHI or not must be respected… You cannot stop insurance solutions…. We fought for those rights and those rights are enshrined in our Constitution..."* **[Participant 3]**
3	Private sector involvement in the NHI implementation	Management, knowledge, and skills	*"The private healthcare sector will play a complementary role or the part beyond the PHC package. But that PHC package has not been clarified. The private health sector has a lot of knowledge and skills in formulating policies for primary healthcare packages. We have lots of Schemes that have low contribution options that force medical schemes to look at a package that covers the most basic healthcare services."* **[Participant 7]** *"I see the current healthcare administration will be playing a major role in the administration of the primary healthcare package."* **[Participant 12]**
4	Accountability	Management, knowledge, and skills	*"… thinking accountability for even 300 billion rands must come with extremely strict sound governance because there is no more room for failure. The risk is too big, it can cripple us as a country, and it can cripple our health system… The problem is how we can gain significant confidence in terms of the how…"* **[Participant 3]** *"… So now the main concern is with the mismanagement of funds and the corruption. So now we want to understand how the government will manage the NHI funds and ensure accountability*" **[Participant 13]**
5	Healthcare resource shortage	Management, knowledge, and skills	*"It depends on what the government wants to sell, but when it comes to analytics, in any healthcare system you have always got scarce resources, so you do not have enough resources, so you must prioritise where you allocate care."* **[Participant 11]** *"We have the human resource strategy that has expired…We do not know what the plan is to dramatically increase human resources for health, whether to increase or change the skills for primary health care into a multi-disciplinary approach"* ***[Participant 5]***

6	Reduced quality healthcare	Management, knowledge, and skills	"*In terms of facilities, I mean the whole notion of the quality of care provided to everybody…there's currently huge disparities and differences in terms of quality of care delivered in the existing facilities."* **[Participant 5]** *"So, I think the overarching concern is that NHI will not improve healthcare for the masses other than it will reduce the quality of healthcare for everyone."* **[Participant 12]**
7	Senior Manager's potential role in the NHI environment	Management, knowledge, and skills	*"…because there will be an opportunity for those who are involved with the technical…"* **[Participant 5]** *"My role would have been 10 times busier with the NHI. There will be huge demand in terms of energy, technical work, and research."* **[Participant 12]**
8	Corruption	Power	*"My perception of the NHI is that it's the right thing to do but if we don't get a proper way to do it, in terms of how then it's creating more risk than solving a problem and I think we have to recognise that in the context of what we are seeing with State Capture and corruption and SOEs (State-owned enterprises), the way that has landed and I think we would be short-sighted if we do not signal that as a concern…"***[Participant 3]**
9	Private Health Insurance Administrator (PHIA) foreseeable changes during NHI implementation	Technology	*"The technology, the innovation, the thought leadership, the key assets… and so there are opportunities for both the supply side and there is an administrative side. So, I am very excited about those opportunities."* **[Participant 3]** *"…R250 billion in claims amongst three of the large administrators. So just imagine that the scale of the full population to build a system to pay providers vector amounts of money is going to be a problem. And so, there are opportunities for both the supply side and there are opportunities and their administration side. So, I am very excited about those opportunities."* **[Participant 7]**
10	PHIA's potential contributions to the NHI environment	Technology	*"The technology, the innovation, the thought leadership, the key assets… and so there are opportunities for both the supply side and there is an administrative side. So, I am overly excited about those opportunities."* **[Participant 3]** *"…to connect the community healthcare worker to specialists or whether it be the nurse because we have scarce resources in the country, we need to apply the right technology at the right time."* **[Participant 9]**
11	Data sharing and integration	Technology	*"…it is going to be easy to have one platform or one health information system where data can be shared across."* **[Participant 3]** "*We have launched a project internally called the health information exchange, which is in conjunction with Administrator A and big industry players…to ensure that all the hospital groups see how we effectively share data across… I think there was a seed for NHI…"* **[Participant 10]**

All participants understood the concept of the NHI and were able to explain it about UHC attainment. Participants had different perspectives though of the value of an NHI, of which some are next outlined.

> *"That funding will be channelled to NHI fund and that there would be a common risk pooling. The understanding about the implementation of strategic purchasing, with one centralised risk pool creating a single public purchase, was raised." (Participant 4)*

> *"…there is a similarity with the NHS in that the NHS is largely tax-funded, however, the difference between South Africa and all the other countries is that the choice to belong to the NHI is not there. There is a mandatory obligation to belong but there is no restriction on what else you choose…" (Participant 13)*

Even though the senior managers demonstrated their understanding of the proposed funding mechanism for the NHI, some still were not clear about where the pooling of funds would come from. For example, Participant 6 raised that the government is still looking at the areas where they can get the funding for the NHI, while Participant 11 stated that the whole debate on where the money will come from brings uncertainties as to whether there are enough funds available for the implementation of the NHI.

Participants did not only view the NHI in terms of a funding mechanism but also regarded it as a basic human right and a fundamental tool to achieve UHC (Participants 1, 2, 3 and 5). These participants believed that quality healthcare and access to basic healthcare services are fundamental human rights, and the implementation of the NHI will contribute towards that basic human right. The participants also raised the importance of social values that should be considered in access to health care.

Of interest is that these participants defaulted to the overarching intention of UHC, as opposed to the somewhat narrower concept of an NHI.

While most of the participants agreed that the NHI is a fundamental human right for the population, concerns were raised about the NHI implementation as a potential infringement on the rights of individuals if belonging to the NHI Scheme becomes mandatory rather than voluntary. The option of belonging to a different scheme other than the NHI, especially if the NHI package of care may not cover an individual's specific health needs, seems to be a contested notion for participants. Participant 3 alluded that it may not be affordable for some individuals and households to belong to both the NHI and then must purchase additional cover for other conditions. One of the participants believed that the NHI product will be a comprehensive cover and that the need for further insurance cover for services outside of NHI will be dependent on individuals' needs and affordability (Participant 5). In contrast, participants believed that the NHI Scheme will be more affordable, as it seeks to eradicate the out-of-pocket payments due to benefit shortfalls within the current medical scheme's benefit structure.

Most participants raised uncertainties as to how the private health sector will be involved in the implementation of the NHI, particularly the medical schemes and PHIA industry. The main concern

was around what they call a lack of private-sector engagement by the government. Some participants raised some form of uneasiness about the role of the private sector during the NHI implementation, even though the 2019 draft Bill indicates that medical schemes will continue to exist. The majority feeling was that quite a few changes will be required by medical schemes, but that the current policy does not provide clarity as to what those changes would or should be.

Unsurprisingly participants indicated that medical schemes and administrators are keen to know what role they will be playing during the NHI implementation. This was coupled with the fact that they felt that there had been some expression of willingness from the government to collaborate with the private healthcare sector, as compared to a previously closed door.

According to the senior managers interviewed, the PHIAs view the proposed NHI as an opportunity to expand their services and to change the landscape of their capabilities rather than seeing it as a threat to their business. Participants 11, 4 and 5, also alluded to the mutual benefit between the public and private sector, where the public sector could benefit from the expertise and experience of private providers. The opportunities identified are those of the supply side (where the private practitioners can be contracted to provide health care services to public sector patients) and their administration side for managing the NHI benefit package and claims process, as the PHIAs can leverage their claims processing systems and experience that that is already functioning well in the private healthcare sector space (Participant 11).

The participants stated that they can be beneficial within the NHI system as the fund will be larger than what already exists in the private health sector space and will require more personnel to manage it. They further elaborated that they could assist in onboarding and training the inexperienced staff at various divisions, such as, but not limited to membership; administration and transaction services; fraud, waste, and abuse (FWA). However, there is nothing specified in the NHI policy documents on the role that the senior managers in the MAS industry could play, which was of concern to them.

Even though most participants have raised uncertainties in terms of exactly how the NHI is going to be implemented and funded, and what the role of the PHIAs will be in the future, there has been a notable agreement that the PHIAs are gearing themselves up for the NHI implementation. Participant 5 argued that there are preparations in place, ranging from improving their existing technologies to structuring the medical schemes' benefit packages and improving the quality of services such as managed care protocols and claims processing that are done by the MASs. This improvement of existing technologies in structuring the medical scheme packages will be beneficial for the NHI benefit package structuring.

Participant 9 suggested that in keeping with the NHI's goal of bringing primary healthcare services to all, the right technology "can be in the form of a mobile application where the community healthcare workers can connect with the doctor to get assistance on how they can provide the appropriate care at the right time". Another crucial point raised by participants around technology is one of maximising

existing technology, such as medical imaging equipment used by the private health sector. They felt that the NHI system, instead of buying new such technologies for public health facilities, could rent the technologies that already exist in the private sector, akin to making public-private partnership arrangements.

For themselves, the senior managers believed that they had a significant role to play in the NHI environment. Participant 9 raised that she/he believes that her/his current role will be more relevant in the NHI environment as there will be an opportunity to market and sensitise private sector stakeholders on what they can provide for state patients through provider contracting. Participant 12 believed that there would be a huge need for technical work and research, for which. Similarly, Participant 5 identified those who are involved with the technical and administrative areas can easily use those skills to provide services such as user and service provider management; healthcare benefits and provider payment design; health product procurement; health systems digital information; and fraud management within the NHI environment.

During the interviews with the senior managers, a few dominant concerns on the ability to implement an NHI were raised as next outlined.

Concerns around corruption, capacity and accountability were uppermost for participants. Although the senior managers believed that having the NHI in the country was the right thing to do, corruption came up as a major concern in all the interviews that were conducted. Questions were raised about the government's mismanagement of funds in recent reports around State Capture, which may thwart the intention of expanding health coverage and access to the entire healthcare system.

Accountability was an uppermost concern, especially when it came to managing a big fund like the NHI. Participants felt that the government cannot be trusted with the responsibility to manage the NHI funds due to ongoing reports about the mismanagement of the State-Owned Entity (SOE) funds and other funds overseen by the government. One participant made an example about the Eskom situation (Eskom is SA's national electricity utility that is meant to supply stable electricity in an efficient manner (Eskom Integrated Report, 2021), which has been going on for years now, resulting in the country experiencing load-shedding due to insufficient power supply.

In addition to the issue of accountability, the senior managers also raised issues around fraud, waste, and abuse (FWA), where they reflected on the case related to Section 59 of the Medical Schemes Act No.131 of 1998. The inquiry was about the allegations of unfair racial discrimination and procedural unfairness by medical schemes, whereby the healthcare providers of largely an African race, submitted a complaint to the CMS that the large medical schemes such as Discovery, GEMS, and Medscheme are racially profiling them and not paying their claims for services provided to their members citing Fraud, Waste and Abuse (FWA) (Adv Ngcukaitobi, Adv Hassim, and Adv Williams, 2021). The unfair racial allegations emanated from the claim from the providers that the alleged Medical Aid Schemes were

treating them differently as opposed to the non-Black providers. The investigation revealed over the period between 2016 and 2019 Black practitioners or providers were 1.4 times more likely to be classified as having committed FWA than those identified as non-Black (Adv Ngcukaitobi, Adv Hassim, and Adv Williams, 2021).

While participants understood the proposed funding mechanism, they also expressed concern about the sustainability of the funding base if done through a relatively small percentage of the population. Over and above the general concerns about human resource constraints, participants were also concerned about the potential poor administration of this new system.

The quality of healthcare provided in the country remains a contentious issue, and most of the senior managers interviewed were not confident enough that the NHI model delivered through a struggling public healthcare system will offer citizens quality healthcare. Participant 4, saw an opportunity for the government to improve the quality of healthcare services in a public sector space and suggested that: "*… NHI forces attention on how we create quality healthcare and starting to measure and monitor…"* (Participant 4). In contrast, other participants viewed the NHI implementation as an opportunity to improve the quality of healthcare in the public healthcare sector space and to make private healthcare insurance affordable. The quality of healthcare provided to citizens should not be the responsibility of the private sector alone (Participant 3).

Furthermore, the private health sector should not be forced to provide services that they are not fully reimbursed for therefore damaging the quality of private healthcare provided in the private health sector, while also noting the waste in the private sector in terms of over-servicing that exists (Participant 3). Meaning that there should be measures in place to measure the utilisation of services and healthcare outcomes thereof. The other belief is that there is plenty of excellence from both the private and public health sectors, which can be capitalised on to improve the quality of healthcare provided in both sectors (Participant 7). The challenge to provide quality health care to all via the provider contracting model proposed while there are huge disparities and differences in terms of quality of care delivered in the existing facilities was raised (Participant 5).

A common concern across all participants was the challenges faced in the South African healthcare system that may make the implementation of an NHI difficult and unfeasible. One of the key concerns raised was the availability of human resources, particularly doctors and nurses, coupled with the ability to deliver quality health care in the face of shortages. Participants alluded to the fact that the shortage of healthcare professionals contributes to the inferior quality of healthcare provided to the population and this will continue to plague the implementation of healthcare should an NHI come about. They questioned how private healthcare providers would be persuaded to get on board with the NHI. This concern was fuelled by the current shortage of general practitioner providers and the possibility that

some of the providers might leave the country, as they might be assigned to catchment areas which they will not be happy about when the NHI gets implemented (Participant 2).

It was interesting to note that most participants referred to the data sharing across organisations and health sectors; and the integration of information communication technology (ICT) systems that speak to one another as a critical point that would enable the successful implementation of the NHI. They reflected on the importance of data sharing amongst health information systems (HIS) to allow for continuity of care to be offered. Participant 10 reflected on a data-sharing project that his/her organisation partnering with administrator A has embarked on, where data is shared across the different HIS platforms and healthcare providers. He/she deemed that using existing platforms such as the business intelligence systems to extract data for reporting could be beneficial for the NHI, instead of reinventing the wheel and developing systems from scratch. It was also highlighted that an exciting possibility about NHI is that it will allow for all the healthcare data to be stored and accessible for both the private and public sectors.

Such data sharing and integrating health information systems were deemed to be able to promote continuity of care and improve healthcare outcomes. Current systems work independently. The public health sector is currently busy with the rollout of a single HIS for public health facilities across the country. The private sector has multiple systems that do not allow for data sharing across different service providers and medical schemes. However, an important question was raised, as to whether a single platform would be ideal for a country with approximately 60 million people, or whether two HIS (one each for the public and private health sector) can co-exist and promote data sharing across these two systems seamlessly. This option will require data standardisation where there is a specified set of data that can be captured to ensure data quality and accuracy across systems.

27. Discussion

The study's purpose was to explore the perceptions of senior managers working in the PHIA/MSA industry about the NHI implementation in SA. Senior PHIA/MSA managers have indicated their support for the NHI implementation and expressed their interest in being part of the implementation process. However, the raised concerns straddle both the hardware of a health system, such as human resources, and several software issues such as trust, accountability, and corruption amongst others (Elloker et al., 2011; Nyikuri et al., 2015). They raised several concerns around data sharing and integration capabilities, human and other healthcare resource shortages, corruption and accountability issues, and funding for an NHI. However, coupled with the concerns, they highlighted opportunities for the private sector to make valuable contributions. They highlighted aspects such as the NHI and public health sector benefiting from the existing private sector's existing information systems, expertise, resources, and experiences.

These perspectives of the senior managers working in the PHIA/MSA organisations are in line with those expressed by other stakeholder groups in studies conducted by, amongst others, Passchier (2017), who explored people's perspectives (people being referred to people on the ground level, the users of the healthcare system and the workers) and Molokomme and Goon (2018) who assessed the perceptions of Professional Nurses working in Private Sector in Gauteng, to name the few. Also, Surender et al. (2015) conducted a study, where similar perspectives as those of senior managers in PHIA/MSA, such as corruption and poor governance were raised. These studies confirmed that the practical concerns around the NHI are widespread and not new. However, this is the first exploration of the views of senior managers in the context of the PHIA/MSA organisations and adds to the understanding of this previously unheard stakeholder group. Expressed by other stakeholder groups as researched by Passchier (2017), Molokomme and Goon (2018), and Surender et al. (2015), demonstrating that some of the practical concerns around the NHI are widespread in the context of the PHIA organisation, better understanding concerning this stakeholder group's views were not previously highlighted.

Furthermore, many stakeholder groups have expressed several reservations about the NHI and its implementation, including the public which is still unsure of how it will impact them (Sekhejane, 2013). The government's lack of clarity on the practical steps required in each implementation phase of the NHI, coupled with inadequate communication has contributed to confusion and negative public perceptions (Passchier, 2017). The ongoing negative comments made by the private sector about the NHI implementation in the country are somewhat misleading, as one would easily assume that all private sector stakeholders are against the implementation of the NHI and feel threatened that their businesses would be affected when the NHI is implemented (Mathew and Mash, 2019). This study revealed the opposite, as all thirteen senior managers indicated support for the implementation of the NHI despite some concerns and issues that they still feel uncomfortable and unclear about.

In terms of senior managers identifying their role within the NHI environment, there has been a positive response from the participants as they expressed how they envisage their role. However, there has not been any research or evidence that provides clarity on what role the senior managers would play in the South African NHI environment, except for studies that looked at the role of the medical schemes. Engelbrecht and Crisp (2010) support the argument that the private sector plays a pivotal role in providing health care and medical scheme administration in the country. However, in the current NHI policy proposals reviewed, the role of the medical schemes requires re-examination as it is envisaged that the medical schemes will have to provide only the top-up for what the NHI cannot provide (Engelbrecht and Crisp 2010).

The so-called 'open schemes' will nonetheless be required to restructure their packages for those members who choose to remain with the schemes (Engelbrecht and Crisp 2010). This is similar to

Canada's NHI system, where citizens have private insurance as supplementary coverage for uncovered services like prescription drugs and dental services (Ridic, Gleason, and Ridic, 2012). When the role of the medical schemes undergoes re-examination of the NHI environment, the PHIAs should be included in the discussions.

Concerning the quality of healthcare provision, the senior managers' concern was within the public and private healthcare sectors. For instance, the Health Market Inquiry (HMI) report alluded to the finding that private healthcare facilities operate without any scrutiny about the quality and clinical outcomes of the services they render (Competition Commission South Africa, 2019). This is due to the lack of measures of quality and healthcare outcomes that are standardised and available in the public domain (Competition Commission South Africa, 2019). Furthermore, it was found that public healthcare facilities are not able to compete with private healthcare facilities for clients due to the quality of public healthcare not being on par with private healthcare facilities in the country (Competition Commission South Africa, 2019).

There appears to be the assumption by administrators that all private health care necessarily means quality health care, while it is widely known that there is cost inefficiency, over-servicing, and lack of quality control in the private sector, as much as in the public sector. For example, Solanki et al. (2019), in their cross-sectional analytic study found that there are no tangible reasons why the caesarian section rates are higher in a private health setting than public. The recommendation was, therefore, as the NHI will rely on a mix of public and private providers, that the high caesarean section rates in the private sector are not transferred to the public sector but transfer the skills and knowledge of the private sector to assist the public sector where there is currently a lack of capacity (Solanki et al., 2019).

An interesting prospect raised by senior managers was streamlining the Health Information System (HIS) both within each sector and between the public and private sectors. A health information system is a challenge that the country is experiencing as there is no single platform where healthcare entities, whether private or public can share data efficiently and effectively. The private health sector on its own has different HISs that they operate with, however, with time, they have found a solution where their different HISs can communicate with each other in the form of data sharing, which is mostly happening amongst the pathology laboratories and the managed care organisations or healthcare administrators when sharing the results.

The HIS barriers include a lack of secondary infrastructure, user training and commitment, political will or strategy, regulations, and the lack of implementation and management outline of the electronic health records (EHRs) system (Katurura et al., 2018). To resolve the challenges faced by the HIS, it is recommended for the NDoH to enable and organise the formation, application, and upkeep of the HIS by both public and private health sectors to generate an all-inclusive national HIS (English et al., 2011).

Also, the HIS in the MSA space is used to improve member or patient coordination of care, where members are encouraged to consult with one GP and utilise a nominated or allocated pharmacy to get their prescribed medication. Schultz and McDonald (2014) identified that care coordination is essential for various stakeholders at different levels within healthcare systems, such as funders (Medical Schemes) and policymakers who strive to provide care efficiently to populations of patients, including clinicians, patients, and families as it assists with improving quality of care offered and reducing the out-of-pocket payment. Laal (2012), in a study about the benefits of the HIS, found that the utilisation of information technology in healthcare, whether in a clinical environment or administrative sector assists with improving patient safety, enhancing the patient's treatment, and decreasing medical errors.

A key concern of participants was the human resource shortages, particularly in the public healthcare space that may compromise the NHI implementation. One of the participants highlighted that DOH has a human resource strategy that has expired, and there is uncertainty of the future would be to dramatically increase human resources for health, and to increase or change the skills for primary health care into a multi-disciplinary approach. This is also echoed by Maphumulo and Bhengu (2019) that the sub-Saharan African health system has a major weakness in human resources. In SA, this issue is exacerbated by the health professional distribution that is unequal between the public and the private health sector.

Importantly, the identified corruption in the healthcare system poses a risk to the sustainability of the NHI fund and may lead to limited healthcare services and poor-quality healthcare service rendered which is the opposite of what the NHI is trying to build to ensure universal health coverage. Moreover, the concerns raised by the senior managers about the issues of corruption and FWA are not unique to this study, nor the South African context. A study evaluating the performance of Nigeria’s health insurance found that administrative efficiencies that affected the scheme, such as the delayed reimbursements to service providers, have the potential to lead to poor quality services offered by these service providers (Mohammed et al., 2014). Fusheini et al (2016) also reported that Ghana's NHIS suffered many setbacks during the initial stages of its implementation, such as the service providers claiming for services that they did not offer or offer services but claimed for something else.

However, as time progressed, during the 2010 clinical audit, it was envisaged that with the procurement and utilisation of the advanced data management system to run the scheme, it would be easy to identify fraud within the system and achieve value for money in the purchasing and supplying of services (Fusheini et al., 2016). These are some of the issues that SA needs to avoid in ensuring the success of the NHI implementation. Participants referred to recent corruption scandals to emphasise their concern and felt this was corroborated in a commission of inquiry into State Capture, where questions were raised as to how the NHI fund will be managed with the level of corruption that is so high in the country.

Importantly, good governance is required, with a strategy to eradicate corruption, and that idea must be pursued by stakeholders throughout society Passchier (2017).

The senior managers understood the proposed funding mechanism for the NHI but expressed concern about the sustainability of the funding base if done through general taxes, as there is a small percentage of the population that contributes towards general taxes in the country. According to the participants, looking at other forms of generating funding is a way of ensuring the sustainability of the NHI fund. Similarly, to the concerns raised by the senior managers around NHI funding, Christmals and Aidam (2020) stated that various stakeholders in SA are seeking clarification on the source of funding modes of facility reimbursement and the ability of the system to resist corruption. This is the concern that the South African government and those responsible for NHI policy formulation must address and clarify to ensure a smooth progression to NHI implementation. McIntyre et al. (2009)), in their study assessing the prerequisites for NHI implementation, concluded that public engagement around what an NHI involves and the rationale for fund pooling is required.

The other concerns raised by the senior managers were the uncertainties about the role of medical aid schemes in the NHI environment, which they believe has not been clearly articulated in any of the Bills. They believed that the affordability of those medical aid schemes would become a problem, where there would be an anticipated consolidation in the number of medical schemes that exist. However, with all these anticipated changes in the medical aid scheme's role and existence, the senior managers strongly believe that the role of the PHIAs/MSAs will be more vital as they are the ones leading the role of administration function for various medical aid schemes, ensuring that befits and funds are allocated correctly for members.

The overarching concerns raised were around the issues of trust, accountability, transparency, and social values. Participants wondered how the government would succeed in convincing people that public money would be spent in the right way, due to the amount of corruption and mismanagement of the public funds that the country has been exposed to. Gaining public trust and getting the right government structures in place is what most participants believed should be of priority, followed by the human rights aspect of healthcare, ensuring that citizens do enjoy the right to access quality healthcare services irrespective of their socio-economic status.

Of interest is that Participant 4 defaulted to the overarching intention of UHC, as opposed to the somewhat narrower concept of an NHI. The participant also raised the importance of social values that should be considered in access to health care. Emphasising this, Whyle and Olivier (2016), in their study found that systems-thinking can offer an "explanatory theory" for the social value in health systems and use those systems to build resilient, cohesive, and just societies. Moreover, Whyle and Olivier (2016) strongly believe that incorporating social values into policy decisions requires policymakers to act as interpreters of social values, as social values change over time, which helps with

understanding the policy changes or system reforms are feasible in that context, and to formulate a resonant rationale for the proposed initiative. In line with what Participants 1 and 4 believe in, as probably to health and human rights, London et al. (2015) argue that the rights-based approach to health that incorporates human rights norms in health policies and programmes is fundamental to achieving universal healthcare. This approach is required to include individual and collective action (London et al., 2015).

The strength of this study lies in its inclusion of the three leading PHIA companies in the country. The threats to validity include a purposive selection of senior managers in their interest and availability to participate in the study. In a broader health system consideration, this study highlighted the importance of private-public partnerships and working together for the greater good when seeking to strengthen the country's health system. The issues of trust and poor governance processes can be addressed through stakeholder engagement and transparency. The findings of this study contribute to the few studies available about the private health sector's perceptions of the implementation of NHI in South Africa, particularly, the PHIA industry. This study's strength relied on reviewing the existing NHI policy documents and the in-depth individual interviews to gain more context about the senior manager's perceptions.

28. Study Limitations

The study is based on an explorative research design on the perceptions of senior managers employed at the three largest PHIAs/MSAs about the NHI implementation in the country, and the participants are only limited to the head offices and views of participants located elsewhere might have been different, although not likely as none of the responses indicated a particular geographic bias. Furthermore, there were constraints and limitations, and the researcher did not get a 100% response rate from the senior managers who were initially targeted to participate, which may have introduced limited generalisability. This was due to COVID-19 pandemic interruptions in accessing the targeted participants and other issues around the unavailability of some of the individuals who were targeted.

The decision to conduct virtual interviews due to the COVID-19 pandemic might have influenced the depth of data collected compared to face-to-face interactions and may have introduced limitations in terms of building rapport with the participants and missing non-verbal cues during the interview. The researcher tried to mitigate the non-verbal and rapport limitations by asking the participants to allow for video recording. The process of data triangulation applied by the researcher during the data analysis stage assisted with eliminating any potential bias that could have been introduced by different methods of conducting the interviews and the research questionnaire data. Despite these limitations, the study does offer insights into the views of senior managers working in PHIA/MSA companies in the country.

29. Researcher Reflexivity

The NHI implementation talks and debates sparked the researcher's interest in this study since there seemed to be a lack of information about how the PHIA industry perceives this initiative. The researcher was aware of her experiences and beliefs and remained objective throughout the data interpretation and analysis stage. Before starting this research project, the researcher thought that the private sector was against the NHI implementation. These assumptions were based on what is reported via media platforms and what other private healthcare role players would assert during interviews and industry talks. However, the results revealed otherwise. The researcher was surprised to hear almost all the participants were for the NHI implementation.

30. Conclusion

In conclusion, the study revealed that not enough attention was paid to identifying the context-specific gaps in ensuring universal coverage, particularly from the perspective of PHIAs/MSAs in South Africa. Also showed a gap in knowledge related to the role of the PHIA/MSA industry in the environment of national health financing schemes, particularly in the South African context.

Additionally, both the reviewed literature and contributions made by the senior managers, strongly suggest that there should be a collaborative effort between the private sector and the public sector to ensure a successful implementation of the NHI in South Africa. The willingness of this group of stakeholders may help facilitate such collaboration, and current resources and processes available in the private health sector can further help to strengthen aspects of the proposed policy reform. Given the conceptual and implementation concerns raised in this study, it points to the need for further robust debate that includes all healthcare stakeholders to explore solutions towards UHC attainment for South Africa.

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PART C: APPENDICES

The perceptions of private health insurance administrator senior managers about the National Health Insurance (NHI) in South Africa

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32. Appendix A - Informed consent and the information leaflet

Title: Exploring the perspectives of private health insurance administrator senior managers about the National Health Insurance (NHI) in South Africa.

I. Who is conducting the study?

Nonkqubela Mxoli

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Background:

The purpose of this research is to learn and understand the perceptions of the senior managers in the private health insurance administration or medical scheme administrator industry about the implementation of the NHI in South Africa. This is a qualitative form of research and will be conducted through one-hour in-depth interviews, where you will be asked a series of questions relating to your

experience within the PHIA/MSA industry and your understanding of the NHI in the country. The interviews will be tape-recorded to ensure that the researcher gathers accurate data for transcribing and analysis.

II. What is the purpose of this research?

III. What would I have to do?

IV. What will happen with the study results?

V. What are the benefits of participating in this study?

We do not anticipate any form of direct benefit to the participants, and there is no payment involved in participating in this study.

VI. Are there any risks involved with this study?

In this research, we do not foresee any form of risk associated.

VII. How will your identity be protected, and your privacy maintained?

If you agree to participate in this study, we will ensure that your information is kept confidential. We will not associate your name with any of the information provided for this research. Instead, we will use numbers to code your real identity in each of the resources that will be used during the research.

VIII. Who can you contact in case you have questions related to the study?

IX. Who to contact in a case where you have complaints or concerns about the study?

Informed Consent

Dear Participant,

Thank you for taking the time to consider participating in this research. This research is supported by the University of Cape Town (UCT), School of Public Health and Family Medicine as part of the master's in public health degree fulfilment for the candidate. The information below is provided to enable you to make an informed decision regarding participation in this research. Participation in the study is voluntary, and you may refuse to participate by not signing the form provided. Refusal to

participate will not lead to any punishment or discrimination. Also remember that once you agree to participate, you are still at liberty to withdraw from the study at any stage, and this will not affect your relationship with the research or UCT.

Additionally, you have the right to cancel your permission to use and disclose the information provided by you in writing at any time. This can be done by sending the written request to Prof Maylene Shung King at the School of Public Health and Family Medicine Department, UCT. For any questions related to this research, please contact the Principal Investigator (Prof Maylene Shung King) on 0712003607.

Participant certification:

I have read this consent form and understood the information provided.

I, therefore, agree to participate in this study as I believe it will contribute to the body of knowledge about the NHI in South Africa and the private health insurance administrator industry. Furthermore, I understand and agree that the information provided by me will be used but without disclosing my identity. By my signature, I confirm that I have received the copy of the consent document, read, and understood the content in it, and agree to participate.

…… ……

Type/Print Participant's Name Date

……..

Participant's Signature

33. Appendix B - Topic guide

Medical Scheme Administrator	Code
Participant	Code

Section 1: Biographic data

Age:	
Gender:	
Years of experience:	
Service years with the company:	
Years of service as the senior manager:	

Section 2

This section contains semi-structured questions about the perceptions of senior managers located in a private health insurance administrator industry about NHI in South Africa. The questions will be looking at ascertaining on the senior managers think the proposed medical scheme role will impact their business as administrators of medical schemes.

For instance, The NHI White Paper 2017 document suggests that "with the implementation of the NHI, the role of medical schemes in the health system will change and once NHI is fully implemented medical schemes will offer complementary cover to fill gaps in the service coverage offered by the NHI. The State will identify all the funding for medical scheme contribution subsidies and tax credits paid to various state employee medical schemes and consolidate these into the NHI funding arrangement. In the initial stages, all benefit options in the various schemes will be consolidated from the current 323 benefit options in 83 schemes to one option per scheme. Schemes covering state employees will be consolidated into one scheme, the Government Employee Medical Scheme (GEMS). The other activities to be undertaken will involve the creation of a uniform information system and standardisation of healthcare services across the medical schemes to be aligned to comprehensive healthcare services for NHI."

Part C: Appendices

The interview questions will focus on the perceptions and attitudes of senior managers in the private health insurance administrator industry on how they think they will be affected by the proposed medical scheme changes during the implementation of the NHI.

Please give a detailed answer to the questions below. In cases where the question requires a yes or a no answer, please make a strikethrough the appropriate option, e.g. Yes or No

Research questions

1. Have you heard about the NHI? (Yes or No)

2. What is your understanding of the NHI?

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3. How do you think the NHI will be implemented in South Africa (SA)?

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4. How do you think the private sector will be involved in the implementation of NHI in the country?

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5. What do you think is the position of your company about the implementation of NHI in SA?

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6. Do you foresee any changes in terms of the private health insurance administrator (PHIA) industry role during the implementation of the NHI in the country? (Yes or No)

If yes

- What changes do you foresee?

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- How will these changes affect the business of the company?

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- What are your concerns or doubts about the NHI implementation in the country?

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7. What are the company's preparations in terms of involving itself in the implementation of the NHI?

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Section 3

1. What are your industry concerns about the NHI implementation in the country?

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2. How do you think your position or current job will be affected by the NHI implementation in the country?

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3. If you could send a message to the current Minister of Health (Dr. Zweli Mkhize) what would that message be about the NHI?

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4. Is there anything else you would like to add related to the NHI?

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Thank you for giving me your time and insights.

34. Appendix C - Letter for approval to conduct a study in an organisation

95 Matt Road
Pretorius Park
Pretoria East
29 October 2019

To whom it may concern

Medscheme
37 Conrad Street
Florida North
Roodepoort
1709

Re: Permission to Conduct Research Study

I am writing this letter to request permission to conduct a research study at your organisation. I am currently enrolled in the Master's Public Health programme at the University of Cape Town (UCT), and I am in the process of authoring my Mini-Thesis to complete the programme. The research study is entitled "The perceptions of private health insurance administrator senior managers about the National Health Insurance implementation (NHI) in South Africa."

I hope that the company will allow me to recruit senior managers in the health sector segment who have been with the company for at least two years and above for individual semi-structured interviews. Additionally, to get more information about the structure of the organisation, it is also required to go through the organisation's structural guidelines as well. The interested candidates to participate in the study will be given an information leaflet that explains the nature of the study to them to make informed consent to participate. Participation in the study will be voluntary and the informed consent will be explained carefully to participants before the study. The completed consent forms will be returned to the researcher a few days before the commencement of interviews.

If approval is granted for the study, the interviews with participants will be conducted in a quiet setting that the participant feels comfortable with –preferably the workplace environment and at a time that is convenient for the participant. The interviews will take approximately one hour to finish and will be conducted in English. Privacy, anonymity, and confidentiality will be always maintained during the

study as the participant's real details will be coded by alphabet. For any publication purposes, the research will maintain anonymity and confidentiality in terms of the participant's details and company the company they work for. There will be no costs involved by either the company or the individuals towards the study.

Your approval to conduct this study will be greatly appreciated. For any questions or concerns relating to this study, please contact the study Principal Investigator – Associate Professor- Maylene Shung King at 0214066580 or 0712003607, email Maylene.shungking@uct.ac.za.

If you agree to the study to be conducted, please kindly sign below and return the signed copy via email or enclosed envelope. Alternatively, you may submit a signed letter of permission with the organization's letterhead to acknowledge your consent and permission for me to conduct the study in your organisation.

Sincerely,

Nonkqubela Mxoli – UCT MPH Student

cc: Professor Maylene Shung King, UCT, Department of Family Medicine and Public Health

Approved by:

…….. …… ……

Print your name and title here Signature Date

35. Appendix D - UCT Human Research Ethical Approval

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6626
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

10 April 2019

HREC REF: 156/2019

A/Prof M Shung King
Health Policy and Systems Division
Public Health & Family Medicine
Falmouth Building

Dear A/Prof Shung King

PROJECT TITLE: THE PERCEPTIONS OF HEALTH INSURANCE ADMINISTRATOR SENIOR MANAGERS ABOUT THE NATIONAL HEALTH INSURANCE (NHI) IN SOUTH AFRICA (Masters' Candidate - Ms N Nxoli)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until 30 April 2020.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

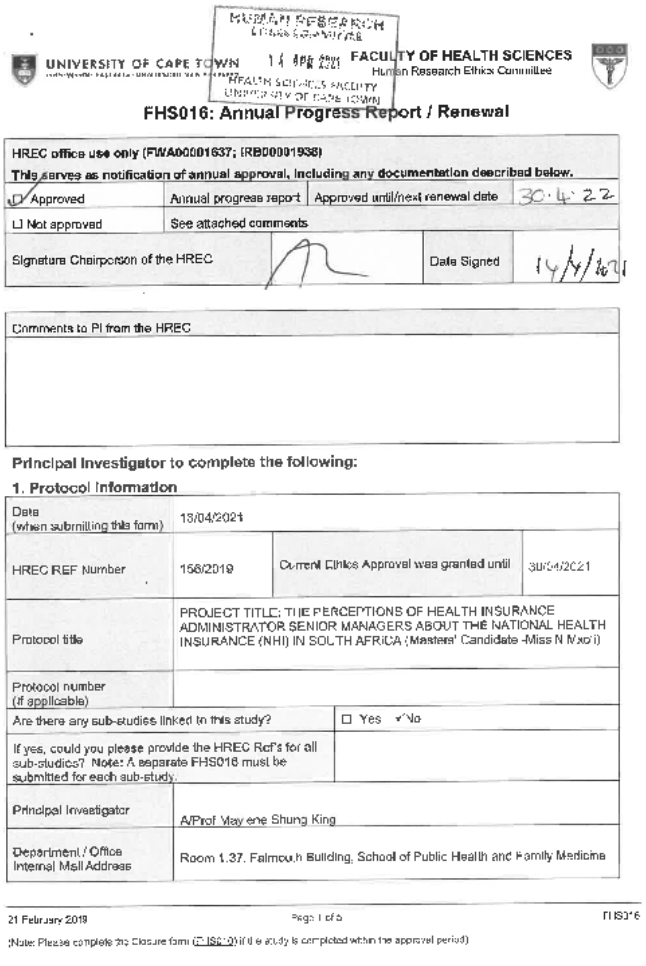
The HREC acknowledge that the student, Nonkqubela Nxoli will also be involved in this study.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.

HREC 156/2019

36. Appendix E - UCT Human Research Ethics Renewal 2021



UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938)			
This serves as notification of annual approval, including any documentation described below.			
☑ Approved	Annual progress report	Approved until/next renewal date	30.4.22
☐ Not approved	See attached comments		
Signature Chairperson of the HREC		Date Signed	14/4/21

Comments to PI from the HREC

Principal Investigator to complete the following:

1. Protocol Information

Date (when submitting this form)	13/04/2021		
HREC REF Number	156/2019	Current Ethics Approval was granted until	30/04/2021
Protocol title	PROJECT TITLE: THE PERCEPTIONS OF HEALTH INSURANCE ADMINISTRATOR SENIOR MANAGERS ABOUT THE NATIONAL HEALTH INSURANCE (NHI) IN SOUTH AFRICA (Masters' Candidate -Miss N Nxoti)		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?	☐ Yes ☑ No		
If yes, could you please provide the HREC Ref's for all sub-studies? Note: A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	A/Prof Wayene Shung King		
Department / Office Internal Mail Address	Room 1.37, Falmouth Building, School of Public Health and Family Medicine		

21 February 2019 Page 1 of 5 FHS016

(Note: Please complete the Closure form (FHS020) if the study is completed within the approval period)

37. Appendix F - Study Approval: Administrator A

Rodney Gounden <rodneyg@medscheme.co.za>
To:Nonkqubela Mxoli
Cc:nmxoli@yahoo.com
Mon, Dec 9, 2019 at 1:43 PM

Hi Nonku

Your study has been approved by our Group CEO.

I will introduce you to Elizabeth today and she can assist you with a list of employees to contact.

You can use this email when you approach the Senior Managers as proof that your study has been approved.

All the best with your research

Kind Regards

Creating a world of sustainable healthcare

Rodney Gounden CA(SA), CIA, CCSA

Executive Manager: GEMS Managed Healthcare

Tel +27 11 758 8306 | Cell +27 83 558 6969 | RodneyG@medscheme.co.za

PO Box 1101, Florida Glen, 1708 | 37 Conrad Road, Florida North, Roodepoort, 1709
www.medscheme.co.za

38. Appendix G – Transcriber confidentiality agreement

Title: The perspectives of private health insurance administrator senior managers about the National Health Insurance (NHI) in South Africa.

Dear Transcriber,

Thank you for taking the time to assist with the data transcription for this research. This research is supported by the University of Cape Town (UCT), School of Public Health and Family Medicine as part of the Masters in Public Health degree fulfilment. The information contained on the next page is provided to enable you to understand the context and background of this research. As already explained during our face-to-face discussion, that the data for this research is to be kept private and confidential. The sharing of this information by yourself to any stakeholders or individuals either than the researcher or the Principal Investigator of this study is prohibited and failure to adhere to theagreement may lead to a breach of the non-disclosure agreement and require furthersteps. If there is anyclarification needed, please do not hesitate to contact me via email at nmxoli@yahoo.com or call 0828375844 for any urgent clarifications or requirements.

Participant certification:

I have read this consent form and understood the information provided. I, therefore, agree to assist with the transcription of this research data in a form of recorded interviews. Furthermore, I understand and agree that the information entrusted with me will be treated with privacy and confidentiality at all times. By my signature, I confirm that I have received the copy of the consent document read and understood the content in it, and agree to adhere to the rules.

22 February 2022

Type/Print Transcriber's Name — Date

Transcriber's Signature

39. Appendix H – Journal Guidelines

Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals

Updated May 2023

I. About the Recommendations

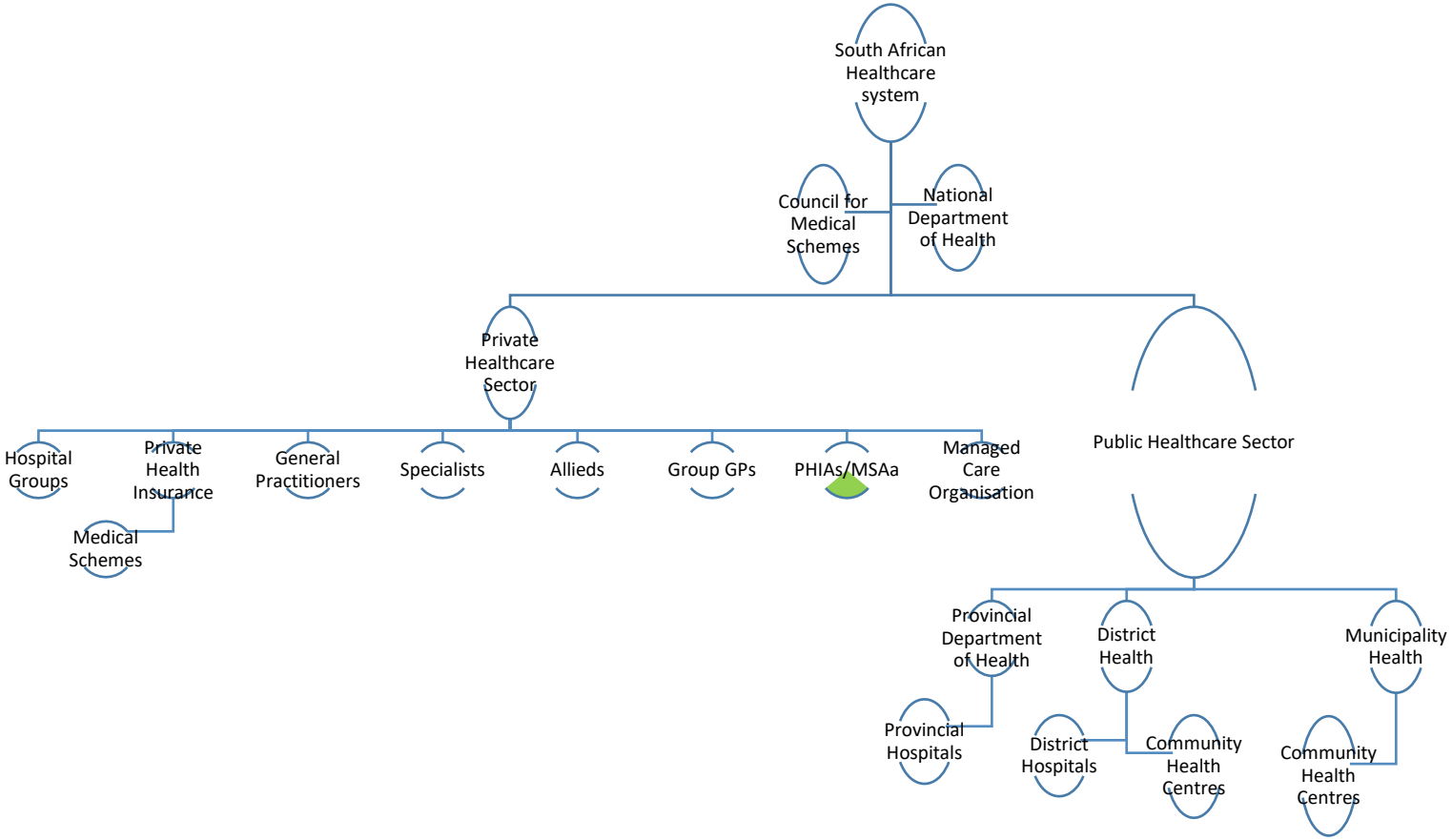
A. Purpose of the Recommendations

ICMJE developed these recommendations to review best practice and ethical standards in the conduct and reporting of research and other material published in medical journals, and to help authors, editors, and others involved in peer review and biomedical publishing create and distribute accurate, clear, reproducible, unbiased medical journal articles. The recommendations may also provide useful insights into the medical editing and publishing process for the media, patients and their families, and general readers.

B. Who Should Use the Recommendations?

These recommendations are intended primarily for use by authors who might submit their work for publication to ICMJE member journals. Many non-ICMJE journals voluntarily use these recommendations (see www.icmje.org/journals-following-the-icmje-recommendations/). The ICMJE

40. Appendix I - PHIAs location within the private health sector.



41. Appendix J - List of policy documents reviewed to understand the NHI proposal policy stance about the role of medical insurance schemes

Year	Title	Role of Medical Scheme
2011	Green Paper	"Presently the most reliable source of healthcare financing for individuals is in the form of medical schemes and various hospital cash plans. However, over the years many of them have experienced problems of sustainability. A few medical schemes have collapsed, been placed under curatorship, or merged. They have dropped from over 180 in the year 2001 to about 102 in 2009. This was due to the overpricing of health care." "In a bid to sustain their financial viability, many schemes resorted to increasing premiums, in many cases at rates higher than CPIXT. When this was not successful, the schemes resorted to decreasing members' benefits. This has led to an increasing number of members exhausting their benefits midyear or towards the end of the year. This has been worsened by non-health-related exorbitant administrator's fees, oversupply of brokers, disproportionate to the membership, and managed care costs. As a result, increased deductions of medical scheme contributions from member's salaries have resulted in wage inflation." "However, it is evident that the above measures did not improve or have worsened the cost-escalation because at the centre of this problem is the uncontrolled commercialism of healthcare as described by the World Health Organisation. The intervention by the Competition Commission was also clearly based on the understanding that the scenario is as mapped above. Something completely different is needed in the South African health sector."
2015	White Paper	"The role that medical schemes will play within NHI must be considered within the current context of the existing two-tiered health system. The establishment of NHI will ensure that the State optimally utilises available resources to benefit the national population including post-retirement entitlements. This requires that the government intervenes strategically and decisively to eliminate fragmentation in funding pools which has been shown to adversely impact the performance of the current health system. This fragmentation and resulting inequities in access to and use of health services provide the basis upon which NHI is necessary to ensure the progressive realisation of universal health coverage." "NHI funding will be mobilised through mandatory prepayment. Individuals will not be allowed to opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise the benefits covered by the NHI Fund." "One of the core objectives of NHI is to optimise the utilisation of available resources, including financial and human resources, and to ensure that people do not insure against the same health care costs twice. To this effect, mechanisms must be put into place so that medical schemes work in tandem with the NHI Fund in streamlining covered healthcare entitlements to

		ensure value for money and to eliminate duplicative cover and double dipping. This requires an alignment of the health benefits offered by the medical schemes industry and those covered by the NHI Fund." "Medical schemes currently operate as voluntary prepayment health financing intermediaries, offering private medical insurance cover to those that can afford and are employed. Medical schemes are funded from the contributions of employees and employers in various permutations. The State makes contributions to medical schemes on behalf of its employees, mainly in the form of subsidy contributions and tax credits administered via the tax system. In many instances, medical scheme cover for many individuals and households ends with the termination of a person's employment, for example, upon retirement or retrenchment which means that such individuals and households will then fall back onto the State for the health care they need." "In line with international experience, individuals and households can purchase voluntary private medical scheme memberships to complement this universal entitlement if they choose to. Private health insurance coverage, such as that offered by medical schemes can play various roles within South Africa's universal coverage health system. As part of the transition process medical schemes will play a supplementary role. Once NHI is fully implemented medical schemes will offer complementary cover to fill gaps in the universal entitlements offered by the State." "With the implementation of NHI, the role of medical schemes in the health system must change. A key step in leading to this change is that the State will have to identify all the funding for medical scheme contribution subsidies and tax credits paid to various This gazette is also available free online at www.gpwonline.co.za Staatskoerant, 11 December 2015 No. 39506 93 82 medical schemes (such as the Government Employees Medical Scheme, the Police Medical Scheme, Parliamentary Medical Scheme, Municipal Workers Union Medical Scheme, State entity medical schemes e.g. Transmed as well as various private medical schemes to which State employees belong) and reallocate these fund towards the funding required for NHI. However, it is necessary to consider the reality that irrespective of how comprehensive the NHI entitlements will be, some personal healthcare services will not be covered. This may result from these health services not fitting into the mainstream of medically necessary and efficacy-proven interventions approved for NHI." "In future, all medical schemes will only offer complementary cover for services that are not included in the health service benefits and medicines approved by the NHI Benefits Advisory Committee. The cover provided by medical schemes must only complement (and not duplicate) the NHI service benefits. Part of this work will require a complete overhaul of the existing Prescribed Minimum Benefits regime, considering the burden of disease and changing population demographics. This will ensure that the population is granted the greatest possible access to health care services by everyone within their available resources."

		"When NHI is fully implemented, it is anticipated that the number of medical schemes will reduce from the current 83 to a much smaller number." "The transition from the current role to a future evolved role of medical schemes will require changes to the Medical Schemes Act. The amendments will be initiated in the second phase of implementation as part of the broader phased implementation approach." "The government recognises that there is existing expertise residing in the medical schemes industry regarding various areas of the NHI. Where necessary and relevant, this expertise may be drawn upon to support the implementation activities for the establishment of a single-payer, publicly administered NHI Fund over the 14-year phased implementation period. The expertise will be drawn upon where necessary to build in-house capacity within the publicly administered Fund, rather than to outsource any component to a private entity."
2017	White Paper	"Once NHI is fully implemented, medical schemes will transform to providing complimentary cover." "A major characteristic of the South African health system is the fragmentation of funding pools within and between the public and private sectors. In the private sector, 83 medical schemes are funding the health needs of only 16.2% (8.8 million lives) of the population. Spending through medical schemes in South Africa is the highest in the world and is six times higher than in any OECD country and represents more than six times the 2013 OECD average of 6.3%." "Medical schemes are fragmented along the lines of occupational categorisation as well as the ability of individuals to afford the medical scheme contributions associated with a specific benefit option. The overall consequence of this fragmentation is that there is limited cross-subsidisation within the private medical scheme's environment." "As the NHI evolves, the tax treatment of medical expenses and medical scheme contributions will be reviewed. It is also expected that there will be a reduction in the need for medical scheme contributions and/or the level of coverage required. The resulting savings in tax expenditure could help to reduce the proposed tax increases. With the implementation of NHI, the role of medical schemes in the health system must change. A key step in leading to this change is that the State will have to identify all the funding for medical scheme contribution subsidies and tax credits paid to various medical schemes (such as the Government Employees Medical Scheme, the Police Medical Scheme, Parliamentary Medical Scheme, Municipal Workers Union Medical Scheme, State entity medical schemes e.g. Transmed as well as various private medical schemes to which State employees belong) and reallocate these funds towards the funding required for NHI." "Making progress towards universal health coverage requires transformation and reconfiguration of institutions for pooling of funds and purchasing of services to achieve income and risk cross-subsidisation whilst improving the efficiency in purchasing

		of personal health services. NHI funding will be mobilised through mandatory prepayment. Individuals will not be allowed opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise NHI healthcare services." "One of the core objectives of NHI is to optimise the utilisation of available resources, including financial and human resources. To this effect, mechanisms must be put into place to streamline healthcare services to ensure value for money and to eliminate duplicative cover and double dipping." "Medical schemes currently operate as voluntary prepayment health financing intermediaries, offering private medical insurance cover to those that can afford it and are employed. Medical schemes are funded from the contributions of employees and employers in various permutations. The State makes contributions to medical schemes on behalf of its employees, mainly in the form of subsidy contributions and tax credits administered via the tax system. In many instances, medical scheme benefits for many individuals and households end with the termination of a person's employment, such as upon retirement or retrenchment, which means that such individuals and households will then fall back onto the State for the healthcare they need." "With the implementation of NHI, the role of medical schemes in the health system will change and once NHI is fully implemented medical schemes will offer complementary cover to fill gaps in the service coverage offered by the NHI. A key step in leading to this change is the consolidation of Government funding of medical schemes. The State will identify all the funding for medical scheme contribution subsidies and tax credits paid to various medical schemes (such as the Government Employees' Medical Scheme, the Police Medical Scheme, Parliamentary Medical Scheme, Municipal Workers Union Medical Scheme, State-owned entity medical schemes e.g., Transmed as well as various private medical schemes to which State employees belong) and consolidate these into the NHI funding arrangement." "The government recognises that there is existing expertise residing in the medical schemes industry. Where necessary and relevant, this expertise may be drawn upon to support the implementation activities for the establishment of a single-payer, publicly administered NHI Fund to build in-house capacity."
2019	NHI Bill	"Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund."