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The NHI as an alternative to developing South Africa's healthcare system: A retrospective policy analysis

By

Thobani Mthokozisi Mthetwa

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Supervisor: Mr. Anthony Bizos

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DECLARATION OF ORIGINALITY

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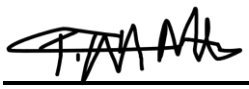
FACULTY OF HUMANITIES

I, **Thobani Mthokozisi Mthetwa** with student number **16321732** certify that this dissertation is hereby presented for the degree of Master of Social Science in Development Studies at the University of Pretoria. The research project titled: The NHI as an alternative to developing South Africa's healthcare system: A retrospective policy analysis has been researched and written by myself, is my work and has not been submitted for any other degree or professional qualification at any other institution. Where secondary material is used, this has been carefully acknowledged and referenced under university requirements. I understand what plagiarism is and am aware of university policy and implications in this regard.



Student: Mr. Thobani Mthokozisi Mthetwa

Thursday, 14 July 2022

DATE

ABSTRACT

The purpose of this study is to retrospectively analyse the formulation phase of the National Health Insurance (NHI) policy in South Africa. This policy was formulated in 2007 by the ANC-led government to bridge the gap between the private and public healthcare sectors so as to create a unified healthcare system. This study contends that the NHI policy faces implementation challenges today because the policy formulation stage reflected an exclusionary criterion when selecting stakeholders during the policy formulation stage. This study argues that policy formulation in South Africa is elite-driven and characterised by the bureaucracy adopting a top-down policy formulation approach. Furthermore, South Africa's healthcare policies are incrementally path dependent. This suggests that new policies are only slightly different from older policies. This illuminates the reality that despite having laws and policies in place, South Africa still faces poor implementation of these policies. This is due to public policies remaining stuck on a specific historical path coupled with institutional rigidity.

The study employs a retrospective policy analysis based on a document review of both primary and secondary data sources. The primary sources include the ANC's 2007 Polokwane Conference resolutions document. This document outlines resolutions 53, 54, 55, and 67 which speak specifically to the NHI. This study also reviews the Green Paper (2011) and the White Paper (2017) of the South African National Department of Health. The secondary sources include the works of policy scholars to generate a deeper understanding of policy formulation, incrementalism, path dependency, bureaucratisation, and elitism in policymaking whilst expanding on the challenges that the NHI policy faces in its implementation.

DEDICATION

This dissertation is dedicated to all my late family members; my Grandfather Mabonakala Jan Shabalala, Uncle Vusimuzi, Delamaswazi, and, Joseph. To my late aunt's Ivy, Florence, and my late sister Zinhle Tshabalala as well as my brother Malusi Thabani Mthetwa: All the memories we made are forever in my heart and I will hold on to the love and not the loss. More importantly, my late grandmother Zandile Thelma Tshabalala (1943-01-01: 2020-07-21). You did not only raise and nurture me but also dedicated yourself dearly over the years of pain and illness for my development and success. I was finalising my research proposal, on the day you left us, but as each day passes, I feel your love, compassion, and protection. I know you are watching over and advocating for me. Thank you for always being wonderful to me since childhood. Through all of you, I have gained the greatest ancestors. I will always work hard to make sure to make you the proudest.

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I am thankful to God and my ancestors, who throughout my life have kept me in the midnight hour, for his never-ending love and grace that offered me the strength to undertake this exigent academic journey. I, therefore, bow with humility and patience.

LIST OF ABBREVIATIONS

ANC	African National Congress
ASGISA	Accelerated and Shared Growth Initiative for South Africa
CODESA	Convention for a Democratic South Africa
COSATU	Congress of South African Trade Unions
DA	Democratic Alliance
EFF	Economic Freedom Fighter
GEAR	Growth, Employment and Redistribution
GNU	Government of National Unity
IM	International Monetary Fund
MDGs	Millennium Development Goals
MTS	The Medium-Term Strategic Framework
NDoH	National Department of Health
NEHAWU	National Education, Health, and Allied Workers' Union
NHI	National Health Insurance
NP	National Party
PHC	Primary Health Care
RDP	Reconstruction Development Program
SA	South Africa
SACP	South African Communist Party
SAMA	South African Medical Association
SANCO	South Africa National Civic Organisation
SAPPF	South African Private Practioners Forum
SDG	Sustainable Development Goals
UHC	Universal Health Care
UN DESA	United Nation Department of Economic and Social Affairs
UN	United Nations
UNICEF	United Nations Children's Fund
WDR	World Development Report
WHO	World Health Organization
WPTHS	White Paper on the Transformation of Healthcare systems

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CHAPTER ONE
INTRODUCTION

1.1 INTRODUCTION AND BACKGROUND

"It is my aspiration that health finally will be seen not as a blessing to be wished for, but as a human right to be fought for."- Koffi Annan.

This study is a retrospective analysis of the formulation of the National Health Insurance (NHI) policy in South Africa. Ostensibly, retrospective analysis has been described as instrumental in the study of health systems reform, as it allows for the explanation of the relationship between institutions, policymakers, interests, as well as the actual policy process (Walt et al., 2008). Based on this observation, this research is undertaken for various reasons. Each of these reasons remains vital to the study of health systems reform and findings can contribute significantly to effective policy changes. First, this study aims to analyse how the NHI was formulated and whether critical stakeholders involved in the healthcare system were excluded from the policy formulation phase. Second, it seeks to analyse whether and how healthcare policy formulation has taken place in South Africa as an attribute of bureaucratic and elite-driven decision-making. Last, it aims to show that post-apartheid South Africa's healthcare policies have not achieved the intended outcomes for stakeholders because they were formulated based on previous and existing policies of the apartheid regime. As a result, healthcare policy change is characterised by incremental path-dependence that is informed by previous policy decisions.

The year 1993 served as a landmark of change for global health. The World Bank published the World Development Report (WDR, 1993). This report outlined that health systems in developing countries had poor outcomes, they lacked financial and technological resources, and they experienced serious administrative challenges. The report proposed that developing countries should take measures to reform their healthcare systems to align them with the Primary Health Care (PHC) programme. The latter refers to a health systems policy and approach to effective service delivery. The PHC was adopted in the Declaration of Alma Ata in 1978 and was further formalised by the World Health Organisation (WHO) as well as the United Nations (UN). The World Bank served as the first global stakeholder to propose

healthcare reform aimed at improving service delivery. Furthermore, the World Bank report endorsed the notion of equal access to healthcare as a basic right, saying that comprehensive health services should be afforded to all citizens, at an affordable cost with protection against catastrophic health expenditures leading to financial hardship (WDR, 1993).

In 1994, the post-apartheid South African government recognised the need to transform the two-tier healthcare system which traditionally catered to two constituencies namely, the private sector and the public sector (Ataguba et al., 2010:177-180). These two systems provided the same services but differed in respect of service quality. This was the result of historically segregated health policies such as the Public Health Amendment Act of 1897, which organized access to health resources, and which created a fragmented system made up of fourteen departments tasked with providing healthcare based on racial categories and class politics (Toyana, 2013: 11). The main objective of the NHI was therefore to create a unified healthcare system in South Africa to provide redress to historical healthcare imbalances by ensuring that all citizens have access to quality, affordable, and accessible healthcare facilities.

The NHI is defined as a policy which seeks to ensure universal healthcare access to all legal citizens of South Africa (Gqirana,2015: 1). Thus, the NHI must be understood as a policy framework that is aimed at operationalizing section 27(1) of the South African Constitution's Bill of Rights (1996). The Bill of Rights asserts that "everyone has the right to have access to healthcare services including reproductive rights'' (RSA, 1996). Naidoo (2012: 149) argues that the NHI policy represents an innovative financing system that intends to ensure that all South Africans have access to appropriate healthcare which will transform service delivery, management, and the administrative system. Naidoo (2012: 149) argues that the NHI is a "strategic initiative that will address the country's inherent systemic healthcare challenges, as well as ensure that the citizenry has access to an appropriate quality of healthcare services."

1.2 LITERATURE OVERVIEW: THE ANALYTICAL FRAMEWORK

Van Niekerk et al (2001: 95) argue that policy formulation begins when stakeholders identify issues and make demands on policymakers for these issues to be resolved. Public policy can be understood as a written or unwritten government plan that is aimed at addressing issues that confront society and which affect all stakeholders at every level (McBride & Stahl, 2010).

Bezuidenhout (2016: 12) defines a stakeholder as an individual or group that wields a significant amount of power in policy objectives. Shangase (2018: 20) argues that the policy process requires a level of autonomy between the government and stakeholders who have competing interests in the policy process. He adds that the policy process is informed by political authority, and that the influence of stakeholders lies in negotiating and bargaining to ensure that their interests are met. Bezuidenhout (2016: 13) postulates that for a policy to be successful, the principal stakeholder must consider all perspectives through intense stakeholder consultation. In this sense, the decision to include or exclude certain stakeholders during the formulation of public policy relies on the government as the principal stakeholder.

Ike (2009) argues that political, economic, and social factors are key determinants when establishing which stakeholders form part of the policy formulation phase. Wilkund (2005) for example, points out that there may be communication among stakeholders, but this can also serve as a tool of exclusion for other stakeholders. In other words, it can be used by certain stakeholders in pursuit of personal interests and certain preferences. According to Ike (2009), policy formulation requires consultation which serves to address policy problems. It involves a communication process together with economic, social, and power intricacies. This is because stakeholders have different beliefs and perspectives. Hence, the policy formulation phase can be understood through three interactive models which provide different meanings in respect of how policy should be formulated, as well as the way in which stakeholders must be invited to participate in the policy making process.

According to Lelokoana (2015: 22), the three policy formulation models consist of the linear, policy stream, and rounds models. Lelokoana (2015: 22) points out that the linear model infers that policy formulation follows certain steps. Each step considers how the policy begins as well as its expected outcomes. The linear model considers policy formulation to be a rational approach which provides factual data and choices that are needed to suit the perceptions of stakeholders. Lelokoana (2015: 22) argues that the decisions in this model adopt a top-down approach where the process is conducted by bureaucratic professionals. In this sense, the decisions are passed down and prescribed to stakeholders involved with policy implementation.

On the other hand, Kingdon (1995: 3) posits that the policy streams model is based on the idea that political events influence whether a problem that is identified requires the immediate attention of the government or not. This means that the problem can only be resolved according

to the country's political climate. Furthermore, he points out that there are various ideas available for addressing policy problems. Here the stakeholders may present unique solutions that may clash, and as a result, only a few policy solutions are considered. This is also subsequently dependent on the political and social values encompassed by stakeholders. Finally, Lelokoana (2015: 25) demonstrates that the rounds model considers stakeholders to be a central feature of the policy formulation stage. Stakeholders are given the power and authority to make contributions to all policy formulation aspects. He further says that the rounds model promotes transparency and accountability because stakeholders consolidate the policy alternatives together. The policies formulated through this model can therefore be implemented easily. This is because every stakeholder has participated in the formulation process and as a result, all stakeholders have the right of ownership to the policy.

1.3 POLICY FORMULATION IN THE SOUTH AFRICAN CONTEXT

According to Shangase (2018: 216), the historical context of the transition from the apartheid regime to democratic rule in SA was heavily influenced by a negotiated settlement. This was marked by compromises, economic tolerance, and political concessions. This suggests that policy formulation in South Africa was unilaterally informed by a negotiated settlement, which has subsequently constrained future policy making processes. According to Venter & Landsberg (2007: 17), the historical constraints of post-apartheid policy formulation means that policies cannot always meet their outcomes. As a result, they argue, that the ANC government has adopted an incremental approach to policy making. They argue that incrementalism can be understood as a continuation of previous government activities. Cloete et al (2006: 34) argue that the incremental model adopts a form of rationality because policymakers have less time and resources than are required to analyse policy, and to engage with new methods to formulate new policies. Therefore, past policies are accepted as being grounded in legitimacy and as being pragmatic.

According to Shangase (2018: 216), policy change in South Africa indicates incremental path dependence because policy decisions are based on previous policies. The result here is a desire not to disrupt the status quo or the previous hegemonic apartheid ideology. This means that the ANC-led government opted for policy making that would not alienate certain influential stakeholders, and it adopted incremental policy change because it is expensive and difficult to

reverse policy decisions that were adopted previously. According to Hall & Taylor (1996: 941), incremental path dependency is an ideational process that takes a gradual approach. This makes it difficult to change institutional arrangements. For Pierson (2000: 210-211), incremental path dependencies take place when individuals or groups conform to the existing institutional positions, and where actors are trapped on a specific policy path.

Baucus & Hicks (2007) point out that the South African policy formulation process today is elite driven to a large degree. In other words, it is only the bureaucracy and other public officials, who are engaged fully in these processes. According to Horowitz (1989), the policy process in developing countries lacks transparency and it is characterised by limited stakeholder participation and engagement. Shangase (2018: 15) argues that the bureaucracy in developing countries plays a significant role in justifying how decision-making occurs. The bureaucracy thus perceives itself to have the power and authority to justify an elite driven narrative. Heywood (2002: 359) argues that bureaucracies lack transparency, and that as a result, they serve as an instrument for class power. Thus, bureaucracies are perceived as rigid and unresponsive towards the policy perspectives of other stakeholders (Mabasa, 2015: 26). South Africa is not an exception to this practice. Generally, bureaucrats and political elites indoctrinate stakeholders with the assumption that bureaucracies have the ability to make all policy decisions.

According to the Presidency (2020), policy formulation in South Africa begins when the ruling party declares its conference Resolutions, goals and direction. This means that at each conference of the ruling party, the latter debates and decides on its overall vision for the country. Following the Resolutions adopted at the ruling party conference, the Executive in government draws up a policy on a particular identified challenge. This means that the ruling party employs its power to convert party policies into official government policies. During this process, the government's role is to formulate a Green Paper which must be published so as to ensure that various stakeholders such as opposition parties, civil society, the media, as well as non-governmental organisation can debate and negotiate the proposed policy with the ruling party (The Presidency, 2020). Stakeholders can therefore use different opportunities for input, such as attending parliamentary committee hearings, setting up meetings with department heads or the minister, or using the media to apply pressure on the government.

Once the various stakeholders have consulted and discussed a Green Paper, the government department that is responsible for formulating and implementing the policy must draft a White Paper. The latter must include all of the suggestions from the various stakeholders. A White Paper often forms the basis of legislation. When the Minister or the Department decides that a new law is necessary to achieve its objectives and implement its policy, that Department will begin the process of drafting the new law. In its early stages, before a new law has been tabled in Parliament, it is called a draft Bill. Once it has been tabled in Parliament it is called a Bill (The Presidency, 2020).

1.4 HEALTHCARE POLICIES IN THE SA CONTEXT

Post-1994 the challenge of redressing the imbalances and inequalities that characterised apartheid South Africa was the main task of the new democratic government. The healthcare system in South Africa was characterised as a two-tier healthcare system which traditionally catered to two constituencies namely, the private sector and the public sector (Ataguba et al., 2010: 177-180). These two systems provided the same services but differed in respect of service quality. Thus, the post-apartheid government sought to establish new healthcare policies, such as the ANC's National Health Plan of 1994, The White Paper for the Transformation of the Health system 1997, and the National Health Act 61 of 2003. This was an arduous task which involved balancing reform objectives with crafting policy goals and creating new institutions that would serve the purpose of transforming the healthcare system. To legitimise these policies, the country's leadership needed to create a constitution that was inclusive, and which aspired to the values of a democratic state (Chetty, 2007: 3).

The Constitution of 1996, under section 27(1), deeply ingrained that "everyone has the right to have access to healthcare services including reproductive rights (South African Bill of Rights 1996). Consequently, the ANC's National Health Plan of 1994 was formulated to transform the healthcare system as well as existing institutions (Toyana, 2013: 17). Toyana further argues that the ANC National Health Plan of 1994 was institutionalised as the central policy document which influenced the formulation of health policies and decision-making around health in South Africa. It served as a yardstick that could measure the government's success in health policy development (Toyana, 2013:18).

It is worth noting that the ANC's policy objectives were closely linked to the Reconstruction and Development Programme (RDP) of 1994 where health was considered to be a major contributor to the development of South Africa (Chetty, 2007: 3). The RDP served as a policy attempt to devise a set of socio-economic and political policies and practices, aimed at transforming South Africa into a more just and equal country. The ANC's National Health Plan and RDP (1994) were important policy documents which led to the formulation of the White Paper for the Transformation of the Healthcare System in 1997. The latter aimed to reduce inequalities of healthcare service provision which was the result of apartheid regime policies. This policy document also recognised the inadequate infrastructure and disparities between high-income groups who could afford medical care, and low-income groups who could not (NDoH ,1997).

The NDoH (1997) points out that the White Paper for the Transformation of the Healthcare System (1997) aimed to ensure that health resources were to be distributed equally between the rural, and urban areas, as well as between high-income, and low-income groups in an equitable manner. It also aimed to formulate a healthcare financing policy that would serve all groups in South Africa. Recognising the complexities of the healthcare system, the government also crafted the National Health Act 61 of 2003, which promulgated that everyone had the right to access healthcare facilities as obligated by the Constitution (Hassim et al., 2008). Toyana (2013: 20) argues that the Act established the national, provincial, and district healthcare system, together with a framework that would ensure quality service delivery for all citizens. Furthermore, Toyana (2013: 20) points out that the Act provided fertile ground for the National Department of Health to develop relationships with other stakeholders who sought to advance post-apartheid health policies.

Subsequently, all these policies led to the establishment of the NHI. Gqirana (2015: 1) points out that the NHI seeks to ensure universal healthcare access to all legal citizens in South Africa. Naidoo (2012: 149) suggests that the NHI policy represents an innovative financing system that intends to ensure that all South Africans have access to appropriate healthcare which will transform service delivery, management, and the administrative system. This means that the NHI aims to transform the financing of healthcare in pursuit of mitigating against financial risk, eliminating fragmentation, and creating a unified healthcare system in SA. Naidoo (2012: 149) argues that the NHI is a "strategic initiative" that will address the inherent systemic

healthcare challenges, whilst ensuring that the citizenry has access to an appropriate quality of healthcare.

In respect of the origins of the NHI, it is well documented that the 52nd ANC conference in Polokwane, in 2007, served as the landmark for the ruling party to reflect on its governing performance. The report of the ANC conference saw the introduction of Resolutions 53, 54, 55, 57, and 67 which spoke to creating a unified healthcare system and the NHI. Resolution 53 especially expressed that "the ANC will reaffirm the implementation of the NHI by strengthening the public healthcare system and ensuring the adequate provision of funding'' (ANC, 2007). The ANC's conference Resolution 54 expressed that the ANC would ensure that the government implements the NHI. This Resolution also had political implications since it created the expectation that the role of the incoming government, after the general elections of 2009, would be to commence with the implementation of the NHI. Toyana (2013: 39-42) points out that the White Paper of the South African Department of Health, 2017, outlines that the main objective of the NHI is to ensure that there is financial risk protection so that people are not denied access to the healthcare services that they need. In other words, the NHI is intended to serve as a single fund that will integrate all sources of funding into a unified health financing pool that caters for the needs of the population (Toyana, 2013: 39-42).

The NHI is intended to serve as a strategic purchaser that will purchase services for all. It will be an entity that identifies the population's health needs, whilst determining the most appropriate and effective mechanisms towards achieving universal healthcare coverage (UHC). Furthermore, the NHI will be a single payer, tasked with the role of ensuring payments for the entire population. Moreover, it is to be publicly administered, which means that it will be publicly owned through appropriate structures that then become accredited providers on behalf of the entire population.

1.5 MOTIVATION AND CONTRIBUTION OF THE STUDY

In this study, the NHI is perceived to be a policy model which can bridge the gap between the public and private healthcare sectors. The concept of health is linked to the Sustainable Development Goals (SDGs) (particularly goal 3) which aspires to health and well-being for all, and which is a bold commitment to end the epidemics of AIDS, tuberculosis, malaria, and other

communicable diseases by 2030. Similarly, the aim is to achieve universal health coverage and to provide access to safe and effective medicines and vaccines for all. SDG 3 therefore points SA towards human development through a multidimensional approach. This means that SA must accelerate healthcare progress by involving all stakeholders so as to develop healthcare solutions that will work for all members of society.

For this study, the researcher was motivated by the fact that as it stands, there is generally little health policy analysis in respect of policy formulation. Furthermore, few studies have been undertaken in respect of the involvement and non -involvement of local stakeholders in the policy formulation process which led to the establishment of the NHI in South Africa specifically. Therefore, this research will contribute to the knowledge of health policy formulation, and policymaking in general, especially in respect of post-apartheid South Africa's healthcare system. This research is important as it will inform future policymakers on how to better formulate healthcare policies. Furthermore, this study will further develop knowledge on public policy theory so as to provide insights into the intricacies and complexities of public healthcare policy, thereby indicating possible policy alternatives and information which is required for conducting future policy formulation in SA.

It has been suggested that Development Studies represents an ambitious approach to understanding policies and institutions that promote human development so as to address the world's perils (Oyalode, 2005: 37). The researcher was motivated by the fact that the NHI, as a new healthcare policy, is directly linked to the emergence of universal healthcare coverage for all. However, it has been suggested that SA is one of the few countries that still has a fragmented healthcare system. Oyalode (2005: 37) provides that a developing state should pursue goals and reforms without compromising the goal of social welfare for the people. The researcher was motivated by the fact that the formulation of the NHI reflects the government's commitment to taking the lead in resolving the healthcare challenges facing SA. In addition, the NHI is important for South Africa given the fact that the policy is linked to SDG 3 of the United Nations. In this regard, the researcher considered that the study will contribute to the pool of knowledge on public healthcare policy making in developing countries.

1.6 FORMULATION AND DEMARCATION OF THE RESEARCH PROBLEM

According to Heywood (2013: 57), one of the primary functions of government is to formulate and implement policies. This function serves to ensure the development of the state and the protection of its core values. In this vein, the NDoH in SA, as a government department, formulated the NHI, which is defined as a healthcare financing system designed to pool funds to actively purchase and provide access to quality and affordable personal healthcare to all citizens (NDoH, 2017: 3). However, the NHI does not seem to have achieved these expected outcomes. This study will show that the linear model of policymaking is best suited to explain some of the reasons for the policy challenges which the NHI is currently facing. It can be said that the democratic government in SA adopted a top-down approach in the formulation of the NHI. The process was conducted by the bureaucracy and political elites, so that ultimately, the decision was passed down to stakeholders, without consulting them during the process.

Bureaucracies can therefore be perceived as rigid and unresponsive towards the policy perspectives of other stakeholders (Mabasa, 2015: 26). Bauccus & Hicks (2007) point out that the post-apartheid SA policy formulation process has been elite driven. Thus, policy-formulation continues to serve as a mechanism to further exclude certain policy stakeholders. This implies that critical stakeholders in the SA healthcare system are generally excluded from the all-important policy formulation phase. This goes contrary to the fact that SA is supposedly a democratic state that is governed by laws and institutions, which are responsible for the formulation of healthcare legislation and the implementation of policies. These policies are constitutionally driven by the goal of reforming institutions and rectifying historical inequalities in healthcare service provision.

In 2007, to address these challenges, the SA government introduced the NHI. The NHI was adopted by the ANC- led government to unify the healthcare system. Despite having key policy targets, the NHI now faces a range of challenges in the policy implementation phase. This is because new policies such as the NHI, which have been formulated by the post-apartheid government, are potentially constrained by previous policies which were implemented by the apartheid government, as well as by existing policies implemented by the post-apartheid government. It might also be that the healthcare policies which were formulated and implemented by the post-apartheid government largely reflected previous apartheid policies so

as to not disrupt the prevailing status quo. This suggests that healthcare policies that were formulated by the post-apartheid government only achieved first order policy change.

First order policy change means that new policy objectives are like previous policies, and that new policies only achieve incremental and gradual change. Hence, the policy change attained by the NDoH can be characterised as path-dependent in that new forms of policy change come as mere adjustments of prior policies, which are incrementally formulated, and which are based on previous policy decisions which become difficult to dislodge. Furthermore, it can be said that the ANC-led government has adopted an incremental path dependent approach with respect to policy formulation. Cloete et al (2006: 34) define the incremental policy making approach as a continuation of a previous government's policies.

This then results in conservative policy options, as well as the formulation of new policies that are only slightly different from those that preceded them. Moreover, when policies are driven by old government choices, the decisions cannot be reversed. Thus, old policy choices have an influence on new policy choices (Peters, 1999: 63). This suggests that the NHI might be characterised as a form of policy continuity as opposed to policy change. SA has been set on a certain healthcare policy path. It is difficult to alter this path because stakeholders and policies have become institutionalised. As a result, there are great costs for stakeholders who desire policy change, and this affects decisions about future policy choices. This is because policy ideas become locked in the institution and constitute a path that affects new policies, and actors therefore adapt by following a predetermined path which results in policy change and institutional development being incrementally path dependent.

1.7 RESEARCH QUESTION

Main question: How was the NHI developed and formulated by the National Department of Health, and what are the challenges being faced during the implementation phase of the NHI policy in South Africa?

The study is driven by the following secondary/subsidiary questions:

- What are the main factors that affected the formulation of healthcare policies in post-apartheid South Africa?

- How were various stakeholders incorporated or excluded in the policy formulation process and how did stakeholders' interests shape the development of healthcare policies?

- What were the different policy initiatives that fostered the formulation of the NHI in South Africa?

1.8 RESEARCH OBJECTIVES

- To retrospectively analyse how the NHI was formulated by the National Department of Health in South Africa.

- To identify the main factors which affected healthcare policy formulation in post-apartheid South Africa.

- To investigate how historical policy patterns, pose challenges for the NHI, and how policy change has occurred in the healthcare system in South Africa.

1.9 RESEARCH METHODOLOGY

This study employs a retrospective policy analysis of the NHI in South Africa. Retrospective policy analysis is important because it focuses on an outcome that has already occurred at the time when a study is initiated (Kumar, 2005: 99). Retrospective policy analysis investigates specified outcomes by looking backwards at the primary and secondary data arising from previous policy experiences. Furthermore, retrospective analysis serves "as an audit tool for comparison of the historical data with current or future practice" (Patton et al., 1993: 1). Retrospective policy analysis is generally defined as a research method that studies the social phenomenon, as well as the challenges that have already taken place, with the aim of identifying "how and why a policy challenge came about" (Kumar, 2005: 99). Patton et al (1993), point out that retrospective policy analysis prioritises history, as well as the

interpretation of previous policies, to assess whether the espoused policy objectives have been met or not.

Retrospective policy analysis was employed in this study because of the study's focus on a historical policy experience. Thus, the purpose of using retrospective policy analysis in this study assisted the researcher to interrogate how the formulation of the NHI policy was conducted, and why the policy came about. The retrospective analysis therefore allowed the researcher to analyse the complexities of the policy formulation process of the NHI. Patton et al (2016: 23), point out that retrospective policy analysis is best suited for studies that seek to outline how stakeholders are relatively positioned in the policy-making process. This whilst focusing on historical and existing policies. This assisted the study to explain how path dependence and incrementalism have been present in the formulation of South Africa's healthcare policies.

1.10 DATA COLLECTION METHOD

This study employed documents as the primary source of data. The purpose of using documents is related to the study's adoption of retrospective policy analysis. The study was interested in establishing how and why the NHI policy was formulated by the NDoH. According to Kayesa (2018: 1B), documents are descriptive, and they provide a chronological explanation of the policy development process. Documents describe a first-hand account of situations and reflect the policy being studied extensively. Flick (2013: 2-17) argues that ''documents are written records that can possibly inform future action which are drawn up in formal settings". Nieuwenhuis (2007: 82) points out that, "when one uses documents as a data-gathering technique, one will focus on all types of written communications that may provide information of the phenomenon that the researcher is investigating''. Documents offer a means of tracking changes, checking the accuracy of data, and they can offer suggestions on new situations that need to be investigated (Bowen, 2009: 29-30).

In this study, the documents selected were a result of a critical desktop approach. These include primary and secondary document sources. The documents and texts selected were useful in providing an account of the way in which the NHI was established in South Africa by the NDoH. The researcher determined that the primary documents that could provide a useful account of this were the ANC's 2007 Resolution conference document, the 2011 Green Paper

on the NHI and the White Paper on the NHI 2017, as well as speeches and Bills on the NHI from the NDoH. These documents were authored by the government, as well as by the ANC, and were subsequently adopted by government officials. The secondary documents that were published by other scholars, such as journal articles, news articles and specifically opinion pieces published in the Daily Maverick, as well as dissertations written by other researchers, provided an account of the policy formulation of the NHI. The secondary documents analysed, determined the selection criteria of each scholar's understanding of healthcare policies between 1994 until 2018. These documents provide insight on how the ANC and government initiated the process of formulating and implementing the NHI. This in turn provides an understanding on who the main stakeholders were and the institutions that were involved in the policy making of the NHI.

1.11 ETHICAL CONSIDERATIONS

In the planning and execution of this study, the researcher considered the University of Pretoria's ethics, procedures, and guidelines. The study relied on information and data from existing literature, and documents, that were available in the public domain. The researcher ensured that the study appropriately referenced in-text and in the bibliographic list. Additionally, the researcher ensured that the study did not present a biased analysis of the evidence found in the data collected and presented. The researcher verified the authenticity of the documents employed in the study and reviewed them with caution, and nothing was taken at face value. The information was corroborated with other sources to limit the potential of bias associated with documents as the main data source.

1.12 LIMITATIONS OF THE STUDY

This study is based on data collected from primary and secondary documents that were gathered from the public domain. Because of COVID-19 the researcher did not employ the use of interviews to extract more information from public officials, bureaucrats, and political leaders from the ANC on their experiences and knowledge about the approach employed to formulate the NHI. Furthermore, this prevented the researcher from meeting different types of stakeholders to get their perspectives on the NHI too.

1.13 DEMARCATION OF CHAPTERS

Chapter one served as the introductory chapter of this study. It provided the background of the healthcare system challenges faced in South Africa. This chapter also provided an overview of the NHI policy, and it presented the motivation and significance of the study in respect of the discipline of Development Studies. The chapter also positioned the study in public policy analysis, and more specifically the models which have been used to study policy formulation. This whilst noting that historical institutionalism, as an approach, is also able to help us further deepen our understanding of the policy formulation process and its challenges. In addition, chapter one included the methodology section which situated the study within retrospective policy analysis and highlighted the data collection techniques.

Chapter two explores the existing literature on public policy, and policy formulation, from a general perspective. The aim is to locate this study in the public policy context. The literature consulted explores public policy, and it discusses the different theoretical models that guide the policy formulation phase in the policy making process, namely the linear, policy streams and rounds models. This chapter also presents scholarly literature on the roles and types of stakeholders who are involved in the policy formulation phase. It then introduces the approach of historical institutionalism, and the concept of policy change, so as to develop an analysis of policy formulation. Within the same chapter the discussion moves away from the general perspectives of policy formulation and focuses more specifically on the policy formulation phase of the NHI in the South Africa context.

Chapter three examines South Africa's apartheid and post-apartheid healthcare policies. This is achieved by presenting a detailed chronological timeline of the historical background, and the series of events, that triggered the NDoH to formulate the NHI. This chapter relies heavily on primary and secondary documentary sources. The main analytical contribution of this chapter is the introduction of the NHI policy framework, as it is at the centre of healthcare reform in South Africa. This is achieved by analysing the NHI policy and legislation in the context of the NHI Green Paper (2011), and the NHI White Paper (2015–2017). These documents are important because they outline, in detail, the health policy context by emphasising its challenges. This helps us to understand the government's decision to formulate and implement the NHI.

Chapter four draws on the linear model of policy formulation. This chapter endeavours to retrospectively address the question of stakeholder exclusion and inclusion post the policy formulation phase of the NHI. This chapter retrospectively analyses the way in which the ANC and bureaucrats came to recognise the problems faced by the healthcare system. It also analyses how various stakeholders felt after the Green Paper on NHI was published and how they understood health policy problems in SA. Further, it provides insights on how the NDoH is mandated to formulate and implement policies by powerful political elites from the ANC.

Chapter Five draws on the historical institutionalist approach to show that the changes in healthcare policies since 1994 are most likely path dependent, which impedes the fundamental policy shift which was envisaged by NHI. The chapter will show that the NHI policy seems to appear distinct in comparison to previous policies, but the challenge remains that SA has not yet achieved third order policy change. In this regard, this means that the NHI is potentially path-dependent and constrained by previous policy choices.

Chapter Six is the concluding chapter. This chapter provides the analytical findings arising from the preceding chapters, as well as the concluding remarks of the study. This chapter further provides the recommendations based on the literature reviewed.

1.14 CONCLUSION

The aim of this chapter was to provide a detailed introduction to the study, as well as a brief insight of what the study aims to achieve. The chapter highlighted that the study's aim was to retrospectively analyse the policy formulation phase of the NHI and how certain key stakeholders were excluded from this formulation process. The chapter also highlighted that the SA government has formulated different policies aimed at unifying the healthcare system in the country to achieve the overall goal of creating access to healthcare services for all, as well as ensuring that healthcare facilities have the necessary capacity to address the needs of citizens. This chapter argued that these policies have not achieved the desired outcomes. The chapter indicated that historical institutionalism is best suited to provide an account for why policies previously formulated and implemented fail to enact change. The chapter argued that SA is affected by incremental path dependence which has influenced the new proposed NHI policy. The chapter has indicated that the NHI formulation process involved bureaucrats, who

are at the top of government departments, and that these bureaucrats are rigid and unresponsive towards the policy perspectives of other stakeholders. The chapter also provided the problem statement, the research objectives, as well as the methodology employed by the study.

CHAPTER TWO
THE ANALYTICAL FRAMEWORK

2.1 INTRODUCTION

This chapter presents the analytical framework for this study. This chapter provides a literature review on public policy, and it focuses on the policy formulation phase of the policy making process in particular. This is achieved by conceptualising the policy formulation phase within the public policy process to better understand how this phase occurs in policymaking. This includes a discussion of the three policy formulation models introduced in the literature overview namely, the linear, policy streams and rounds models. The chapter presents an overview of the types of stakeholders who are potentially involved in policy making, as well as their influence in the policy formulation phase. The focus here is to consider the potential exclusion and inclusion of stakeholders in the policy formulation phase. Last, this chapter applies historical institutionalism as an approach in public policy analysis to show how path-dependence and incrementalism create challenges for government officials and bureaucrats in achieving policy change.

2.2 POLICY FORMULATION

According to Brooks (1989: 16), public policy refers to the "broad framework of ideas and values in which decisions are taken, and how actions, or inaction, is pursued by governments in relation to some issue or problem". He further contends that policy involves various societal values. Thus, policy, as a statement of intent, emanates from a process of formulation. This involves different stakeholders who have critical roles in shaping the policy outcome (Coning, 2006: 3). Theodoulou & Cahn (1995: 86), argue that policy formulation is the process whereby stakeholders identify steps as to how the problem could be addressed, which tools and instruments could be used, and which institution could best be suited to address the problem. This means that policy formulation involves collecting and analysing data by the principal stakeholder to ensure that there is a result. Roux (2006: 126) argues that policy formulation is "what government decides to do or not do to counter a perceived problem in society". He further points out that policy formulation must deal with the problem, solutions, and timeframe,

to achieve policy goals, conduct cost-benefit analysis, as well as to identify the positive and negative returns of the policy alternative.

According to Cochran & Malone (2005), policy formulation must be understood as a function that involves different stakeholders who gather and produce policy alternatives to ensure that all objectives are met. Thus, policy formulation is characterised by a permanent condition of conflict because of competing stakeholders' interests and power asymmetries in the policy process. According to Turpenny et al., (2015: 7-8), the policy formulation phase comprises different stakeholders that carry with them various political, ideological, and economic interests. Stakeholders are constantly under pressure, because their knowledge on policy issues is informed by different advisors, lobbyists, as well as interest groups. This means that policy formulation occurs when a certain stakeholder has identified policy issues and makes demands for these issues to be resolved based on their own evidence, and proposed policy solutions (Turpenny 2015: 7-8).

2.3 POLICY FORMULATION MODELS

The study of policy formulation is guided by different models and approaches. Explanations of the policy formulation phase comprises three main models, namely the linear, policy stream, and rounds models. Despite their methodological differences, all three models are concerned with explaining how policy formulation is conducted by different governments, institutions, and stakeholders. It is the contention of this study that all three models are relevant to account for how stakeholders behave, and how they inform policy formulation. However, the linear model is best suited to explain how the NHI was formulated by the NDoH in SA.

The linear model explains policy formulation as a function of government officials, bureaucracies, and elite groups. This model assumes that policy formulation is conducted through various rigid steps, with each step having a clear beginning and end (Linder & Peters, 1989). This model argues that bureaucracies and elites are rationally efficient in terms of their functions when carrying out decision making, and that they can transmit policy decisions to society. The linear model provides that there is a hierarchy in decision making, and that decisions are adopted through a top-down approach. This means that the elites and bureaucracy are responsible for passing down decisions to other stakeholders, whilst informing them of policy implementation strategies, as well as the scheduled timelines to meet policy outcomes.

Corkery et al (1995 :13), however argue, that this model privileges certain interests over others, thus leading to an inequality in policy outcomes. In essence, this model assumes that policy makers are rational beings, and that if policies do not achieve what they intended to achieve, this failure can be attributed to a lack of political will, poor management skills and a shortage of technical as well as financial resources.

The linear model privileges the top-down approach since it views bureaucrats and policy makers as the main stakeholders. The top-down approach has been criticised for viewing policy formulation as an administrative process, and for not acknowledging other challenges such as political influence and the complex structures it creates. The top-down approach is also criticised along the lines that it does not examine the details of public policy making, such as how the activities and roles of other stakeholders influence the policy formulation process (May, 1992: 224).

The policy streams model of policy formulation is attributed to Kingdon (1984). The policy streams model suggests that policy formulation involves problems, politics, and policy alternatives, and it highlights that policy comes into existence when these three streams come together. According to Kingdon (1995: 117), the problem stream inherent in this model means that citizens observe their material conditions and demand that the government, and other stakeholders, resolve their policy problems. The problem stream in this model outlines those problems that need to be addressed by stakeholders. Kingdon, (1995: 117) further provides that the politics streams of this model speak to political events that are occurring. These events may include elections, administrative changes in different spheres of government as well as conflict among citizens, and governments. The policy stream model assumes that numerous policy proposals and solutions are involved in decision making which are aimed at resolving problems.

According to Kingdon (1995: 117), in the policy stream, many policy ideas are presented, circulated, and combined by stakeholders. However, only a few of these ideas are adopted based on their technical feasibility, budgetary constraints, as well as political will. The policy stream model is like the linear model, since it also grants preferential access in the policy formulation phase to mid-level government officials and bureaucrats. The policy stream model of policy formulation also assumes that bureaucrats and government officials are rational actors. The model is critiqued by Cairney & Jones (2016: 40), who point out that this model

disregards the reality that citizens can develop credible policy solutions to their problems. Therefore, similarly to the linear model, the policy streams model is critiqued for still considering bureaucrats and elites to be equipped with all the policy solutions available to challenges. Hence, according to this critique, policies formulated through this model are difficult to implement and are mainly pursued for short term gains (Cairney & Jones, 2016: 40).

Finally, in respect of the rounds model, Teisman (2000) points out that policy formulation consists of different rounds, where different stakeholders are invited to participate in the policy formulation phase. In the rounds model, it is assumed that different stakeholders interact to define policy problems, and to bring forward different alternatives. In the rounds model, the principal stakeholder invites other stakeholders, and provides them with scores in each different round, with respect to them providing definitions of the perceived problem and solution. However, the round can change based on the appearance of new stakeholders. Hence, the rounds may change to promote greater participation.

According to this model, the stakeholders involved in the policy formulation phase may not agree on certain policy problems and solutions. This model further assumes that stakeholders have a fixed set of preferences, and that they aim to maximise those preferences by being involved in collective actions, whilst pursuing the maximisation of their policy preferences. This implies that policy decisions are reached in the most efficient manner. The rounds model is attractive in its explanation since it uses both an inclusive and participatory approach, through the different rounds of participation, to ensure that all stakeholders form part of the policy formulation phase. This allows for a more holistic interpretation of policy problems and solutions (Teisman ,1992: 33).

Termeer (1993: 44-51) argues that in the rounds model, policy formulation begins and ends with a clear adoption of problems and solutions from one or more stakeholder. However, Termeer points out that problem definitions and solutions are not seen as final, since policy formulation is a continuous process, over a longer period of several discussion rounds. The rounds model is also voluntarist, since it suggests that policies are the product of a voluntary contract between different stakeholders. Scharpf (1997: 11), provides that policies formulated through the rounds model are most likely to achieve the desired outcomes for stakeholders given that these outcomes are formulated in an environment already replete with institutions.

The rounds model also incorporates the importance of collective action. This ensures that all stakeholders participate in policy making on an issue area which will affect them. When stakeholders bargain at a collective level, stakeholders are said to make rational decisions based on short- and long-term gains.

In summary, the linear model suggests that policy formulation is conducted by the bureaucracy and elites who transmit policy decisions to other stakeholders without consulting them. Policy formulation in the policy stream model is not entirely the domain of bureaucrats, because elites also tend to be more involved in identifying both policy problems and proposing solutions. Finally, the rounds model, unlike the linear and policy streams models, promotes the participation of all stakeholders. This means that all stakeholders are involved in the policy formulation phase.

2.4 STAKEHOLDERS IN POLICY FORMULATION

Ingold (2011) defines stakeholders as individuals or organisations who work together on policy issues, influence decisions, and who coordinate, as well as share, information on policy activities. Stakeholders are also defined as autonomous groups or individuals that provide policy recommendations, and programmes of action, to ensure that the government complies with policy goals to foster development (United Nations Department of Economic and Social Affairs, 2020: 30). According to Turpenny (2015), a stakeholder is "any group or individual who can affect or is affected by the achievement of the organisation's objectives." Sabatier & Weible (2007) point out that stakeholders are groups, institutions, and individuals who wield significant power in determining the policy objectives. Therefore, when reviewing the literature, there are many types of stakeholders who might be involved in policy making. The following section elaborates on some of these stakeholder types.

2.5 TYPES OF STAKEHOLDERS

Government officials

Government officials have the responsibility for introducing policy change where appropriate. According to Lelokoana (2015: 18), government officials have the role of detecting policy problems, as well as other challenges, which affect the citizenry. They are ascribed with power

to decide whether the policy problem requires immediate attention. Therefore, if the policy problem is rendered as a public challenge, government officials have the role of determining the magnitude of the problem. According to Roux (2002: 421), government officials must determine the causes and impact of the challenge to develop knowledge of the policy problem. After officials have mapped out the policy problem, they must identify policy objectives, intentions, and the approaches that will be adopted to meet the objectives. As such, officials and bureaucrats involved in policy formulation, must consider alternative policy solutions, and conduct a cost-benefit analysis of the alternatives available to them.

Bureaucracies

According to Heywood (2002: 359), bureaucracy can be defined as the "administration of the state. Bureaucrats being elected and appointed civil servants who function via rules and procedures of the state." Weber (1968) argues that the bureaucracy seems to rest on three principles. First, offices, which serve as administrative units or departments of the public sector that are responsible for the implementation of rules and procedures of the political elites or governments. These are seen as the instrumental tools of the governing process. In addition, these offices have a clear chain of command, and hierarchies, to ensure that the higher office monitors the lower office. Second, the bureaucracy comprises professional actors because decision-making requires specialisation in different fields of knowledge (Weber, 1968).

Finally, bureaucracies' function on the basis of the division of tasks. This means that responsibilities rest upon officials who have the technical skills, merits, and qualifications that are required to assume authority in the office. Weber (1968) further provides that bureaucrats function on the basis of impersonal rules. Thus, bureaucrats are informed and constrained by the type of political regimes that guide the institutions. However, Heywood (2002) criticises the bureaucracy and he argues that it incorrectly diagnoses how people must be governed. Thus, it is conservative, because it promotes a culture of conformity, and rigid control so that it is unresponsive to the needs of the general citizenry. He further argues that bureaucracies in the modern period lack accountability, they are self-serving, inefficient and function through secretiveness (Heywood, 2007).

The court of law

Roux (2002: 421), contends that "once policymakers have formulated a policy, the policy must be authorised by the court of law''. This means that stakeholders in the field of law must assess whether the policy complies with the country's constitutional obligations. This means that legal professional's study how public policy is formulated and processed through different courts as well as the administration of the state. This is achieved by studying previous rulings and laws that have been passed by the government to ensure that public policy is formulated in line with existing laws and legal provisions (Taylor, 2008).

Interest groups

According to Hanekom (1987: 80**),** interest groups are also important stakeholders in the policy-making process. Interest groups can display collective unity, they can gather society's needs, and they register those needs on the government's agenda. Therefore, interest groups "serve as a mouthpiece for specific community groups in society" (Hanekom 1987: 80). According to Cloete & Meyer (2006: 113), interest groups use mobilisation and limited resources to strengthen their power, and they can influence policy making through written and oral modes of representation.

Political parties

Political parties are also among the stakeholders involved in the formulation of public policy. Political parties refer to a group of people who share ideological intentions and who attempt to gain control of state resources, or to serve as leaders in government departments (Patton, 1989: 81). In addition, "political parties are social organisations, whose principal objective is to place their avowed leaders into the offices of government. Political parties therefore recruit and nominate prospective governmental officials. The minimal observable requirements for classification as a political party consists of two roles: nominees for government offices, and voters who make up a party-in-the-electorate" (Goldman, 1983: 4). A political party that wields significant power in any state tends to influence its deployed members in government to formulate policies that align with the party's manifesto and guidelines. This means that political power ensures that political parties place their interests onto the policy agenda. This further means that political parties serve as stakeholders that can influence the activities of public policy and content. In this sense, political parties serve as principal agents for engagement, and debates, and they influence how public resources must be allocated to different societal

challenges. Furthermore, political parties have a set of preferences, and they maximise those policy preferences (Goldman, 1983: 4).

The private/ business sector

The private sector is another stakeholder in the policy-making process. This is because it is a major contributor to economic development. Fred (2003: 63), points out that the private sector provides investments to society, economic outputs, and employment. Furthermore, the private sector contributes to sustainable development and innovation. According to Fred (2003: 63), the private sector has economic power, and elite support, which provides it with the ability to influence policy making. This also means that the private sector influences public policy making through direct financial contributions, as well as providing expertise and knowledge to assist in policy drafting and setting.

The Media

The Media forms part of the stakeholders in policy making. It plays a vital role in disseminating information on public policy problems. This is achieved using its resources such as radio and social networks, as well as television. According to Fischer (1991), the media provides citizens with information to ensure that the latter effectively participate in public policy issues and other matters which affect them. Fischer further adds that the media also assists the government to disseminate information about public services. Fischer (1991) points out that the media informs the general citizenry about the success and failure of the government as well as public policy challenges. She further adds that the media can provide a platform where citizens and leaders can discuss issues. This means that the media has the role of being a mediator between the governors and the governed.

Citizens

According to Lindblom (1986), citizens play a vital role in shaping public policy. This means that citizens are custodians of public policy, and that the government must consider their views when deciding on matters that have implications for them. Therefore, individuals and groups, involved in the policy making process must formulate policies which take what citizens desire into consideration. This is imperative because the government must minimise civic unrest and protests. According to Anderson (1979), citizens provide the government with power through

voting, and hence they can vote out governing political parties should their policy programmes fail to progressively realise the needs of citizens.

Elites

Elites are further stakeholders in policy formulation. According to Abbink & Salverda (2013: 4), elites are a social minority, or group, within a given society, whereby these social minorities or groups assume a position of superiority within the social hierarchy. North et al., (2006), postulate that elites enjoy economic, political, and social prestige in comparison to the general citizenry. This means that elites possess special skills, and they have access to economic opportunities, as well as institutional positions. This provides them with power to constitute public policy problems. This prestige also allows elites to inform policy decisions, as well as the allocation of resources in society. Elites are defined by, "the relative power they exercise, or are accorded, in society, and elites include all influential individuals in a society who occupy a position of authority and seek to preserve this privileged status" (Abbink & Salverda, 2013: 1). Elites employ their relative ascribed power to determine what ideas should form part of the policy agenda, or not. Elites do not always exercise power. Rather they employ or incentivise bureaucracies to conduct policy activities on their behalf. In this sense, elites use their economic and social status, as well as intellectual capabilities to maximise their policy interests. Furthermore, the policy outcomes emanating from elite decision-making reflect their own interests, because they can influence the policy making process (Abbink & Salverda 2013: 4).

2.6 THE EXCLUSION OF STAKEHOLDERS IN POLICY FORMULATION

According to Clarkson (1995), in the development of policy, there is a risk that certain stakeholders may be excluded in the policy formulation phase by the principal stakeholder responsible for initiating the policy process. The exclusion of stakeholders begins when governments decide to formulate programmes without considering the inputs of other stakeholders. It ends when governments implement the policy programme without taking the inputs of other stakeholders into account. This is because the principal stakeholder and other stakeholders, are influenced by their interests, and are always looking for new ways to maximise their policy preferences. Peterson (2009: 31), argues that the stakeholders' competing interests might influence the policy instruments, and the regulatory mechanisms of the institutional design of the policy environment. As such, the principal stakeholder may employ

structures to constrain the behaviour of other stakeholders to ensure that proposed policy outcomes are not affected by their interests. This means that the principal stakeholder enjoys a certain degree of autonomy, and in certain policy making scenarios, can constrain other stakeholders from making significant inputs required to effectively resolve other problems.

By excluding certain stakeholders from the policy formulation phase, the principal stakeholder, who assumes the responsibility for initiating the policy formulation phase, recognises power relations in existing institutions, policy environments, and the power asymmetries between stakeholders. Power must be understood as a resource, and it refers to the capacity of the individual or group to use it as a means of attaining their needs (Giddens, 1984). According to Statham (2006), policy formulation is conducted by bureaucrats, through hierarchies, with a linear approach, and power is held in the hands of a privileged few. This means that the principal stakeholder does not distribute power and decision-making authority to all stakeholders (Fischer, 2003).

As indicated earlier, the linear model of policy making explains the policy formulation phase as the consequence of decision making by elites and bureaucrats, who deliberately create a policy to solve a problem based on their needs and understandings (Lelokoana, 2015). This view suggests that other stakeholders are potentially excluded from the policy formulation phase because bureaucrats and elites control the flow of information, and because they derive their power through this top-down approach. Furthermore, bureaucrats and elites can exclude other stakeholders, transmit information to society, and implement policies, without consulting other stakeholders. These policies are then accepted because elites, as well as bureaucrats, have a reputed network of power and influence. This further means that the process of excluding stakeholders from participating in the policy formulation phase is influenced by the power that the government, bureaucrats, and elites hold. The interests and behaviour of stakeholders excluded from the policy formulation phase also determines how the policy will perform.

Calculating policy benefit and loss is difficult, and it is presumptuous to assume that all stakeholders always have complete information in the policy formulation phase. This stems from the understanding that the time and financial resources required to conduct policy formulation is limited. As such, other stakeholders are not prioritised in the policy formulation phase. This also means that the principal stakeholder may include experts who understand the problem well, and who have the power to influence the policy, rather than inviting multiple

stakeholders. Moreover, institutions may influence and reinforce the idea that not all stakeholders must participate in the policy formulation phase to ensure that fewer resources and less time is consumed during this phase. This might be aimed at ensuring that other stakeholders adjust their expectations on the policy outcomes, as well as the benefits that come from forming part of the policy formulation phase (Lelokoana, 2015).

2.7 THE INCLUSION OF STAKEHOLDERS IN POLICY FORMULATION

According to Bryson (2004 :3), it is well documented that the inclusion of stakeholders in the policy formulation phase serves as a means for collecting data that relates to the needs, perceptions, and interests of the general citizenry. This becomes vital for achieving informed policy objectives. According to Silva et al (2019: 4), the inclusion of stakeholders in the policy formulation phase must be understood as a conversation between stakeholders which allows for the introduction of different perspectives on how to formulate new policies and reflect on grey areas. The rounds model of policy formulation better accounts for inclusivity in policy formulation, since it argues that policy formulation is a response by stakeholders to the challenges in the local context. As such, this ensures that all stakeholders are consistently involved in collective action. The inclusion of stakeholders serves to ensure that all stakeholders provide certainty, and information, to other stakeholders so as to ensure that policies are strategic, and respond well to policy challenges (Bryson, 2004: 3). Furthermore, the rounds model of policy formulation accommodates the inclusion of stakeholders, so that they take strategic policy preferences, and make strategic calculations, so as to ensure that the policy goals meet needs.

Draai &Taylor (2009: 114), argue that the inclusion of stakeholders in the policy formulation phase also serves as an open, accountable, and transparent process through which individuals, and groups, can influence policy objectives. Hall adopts a similar argument for the inclusion of stakeholders in the policy process. He suggests that inclusive policy making reflects collective action (Hall, 1993: 278). He further adds that inclusive policy making ensures that stakeholders undergo policy learning. He defines policy learning as a learning approach in public policy, which serves to ensure that stakeholders learn from past policy experiences to ensure that they can formulate appropriate policy objectives. Hall (1993: 278) further adds that, policy learning serves to discourage stakeholders from formulating policies that are based on political allegiance, thus ensuring that stakeholders make informed adjustments in policy goals.

This stems from the understanding that the formulation of public policies relies heavily on learning experiences derived from other policy initiatives.

The inclusion of stakeholders further ensures that policy formulation is detailed, and that it offers objectives, with strategies, on how implementation will be realised (Hogwood & Gunn, 1984). Therefore, inclusive policy making ensures that there are links between all the steps in the policy cycle. It also prevents elites from building policy agendas, and from formulating policies that do not fully recognise the problems. Furthermore, the inclusion of stakeholders ensures that many problems effectively get on the agenda to ensure that bureaucrats and leaders, within institutions, do not deny the existence of serious problems (Hogwood & Gunn, 1984).

2.8 HISTORICAL INSTITUTIONALISM IN POLICY FORMULATION

Historical institutionalism emphasises the importance of understanding structural institutional origins, and for examining how institutions perpetuate inequality between stakeholders by privileging certain ideas, interests, and assumptions over others (Thelen, 2002: 92). Institutions are defined as laws and conventions that govern behaviour, and which can transform the state (Thelen, 2002: 92). Furthermore, institutions enjoy a degree of autonomy, which in certain instances, allows them to constrain decision-making as well as policy change. Historical institutionalism posits that the relationship between the state and institutions is sticky and rigid. According to Pierson (2000: 252), actors within institutions are prone to act in accordance with previously established institutional or policy paths because of the high costs associated with deviating from previously established paths. This suggests that actors tend to follow the same path. Hence, the more likely they are to follow previous policy directions.

Historical institutionalism also asserts that policies formulated through institutions only achieve incremental change over a prolonged period (Thelen, 2002: 92). The autonomy of institutions over the state can potentially increase because the state provides authority to institutions to resolve policy problems. As such, institutions, and privileged stakeholders, are said to make decisions based on short-term, as opposed to collective gains. States therefore usually find themselves in a lock-in situation, whereby the policy decisions adopted by institutions in the past may be too costly to exit. This explains the continuation of unfavourable institutional structures and policy designs (Pierson, 2000). Therefore, policy ideas become

locked in the institutions and develop a path that affects policy making (Thelen, 1999: 385). As a result, actors adapt their decision-making pattern by following a previously determined path which results in the institutional reform process being path dependent.

According to Hall (1993), institutions are formal in terms of their design. Therefore, the laws governing them cannot be changed casually. New institutions are said to come with higher costs. Historical institutionalism further accounts for historical development and path-dependency. Historical institutionalism assumes that institutional and policy change is dependent on a particular sequence of events, and a particular context of state history. According to Pierson (2000), political events occur from similar conditions and consequences which come from small, contingent events, whereby the course of action of other events is difficult to reverse. Historical institutionalists foreground that small events may not be so small, and that they can go on to further influence future policies (Pierson, 2002).

Pierson (2000) further points out that politics is a form of collective action. Actors within the different political contexts tend to adapt as to how they must behave according to the demands of institutions. Furthermore, institutions possess legacies of historical struggles, which tend to influence how actors define their policy interests and objectives. Therefore, historical institutionalists argue that history, and previous events, shape political choices and policy outcomes (Thelen 1999: 381). Moreover, policy choices adopted when an institution was created, or when a policy was formulated and implemented, will have a continuation, and further determine the nature of new policies. According to Peters (2012: 71), this may be regarded as path dependency which makes it difficult to change policy choices and to reform institutions. In essence, historical institutionalism is concerned with explaining why policy interests are costly to shift. It also emphasises the unintended consequences which are generated by policymakers and existing institutions that formulate public policy. However, historical institutionalism does cater for critical junctures in historical events, whereby institutional change does occur, thus ensuring that the institution might move onto a radically new trajectory (Pierson, 2004, 33).

2.9 POLICY CHANGE

The challenge with changing public policy is that public policy is dependent on decisions which are taken by the principal stakeholder (Lester & Stewart, 1996: 136). Policy change is defined as the "replacement of one or more existing policies with one or more other policies." According to Cairney (2012: 30), policy change must be assessed, since actors are always tackling policy problems that require decisions. In public policy however, there is a great degree of policy change that might not take place, given that stakeholders may prioritise political stability. This is a result of stakeholders using their power and influence to preserve the status quo (Howlett, 2009). The need to maintain the status quo stems from the observation that society constantly undergoes changes and competition whereby stakeholders, hoping to maintain the prevailing status quo, are involved in a power struggle with those seeking to disrupt existing institutions, as well as policies. As such, path dependency, within historical institutionalism, regards the stakeholder who has power and authority to govern established institutions, as being able to formulate policies that are dependent on previous policy activities, so as to maintain this status quo. Furthermore, these stakeholders adopt policy decisions that are difficult to reverse. This means that radical policy change is constrained because path-dependency informs the outcomes of policy activities (Marier, 2013).

Hall (1993) provides that policy change is made up of three modes, namely, first order policy change, second order policy change, and third order policy change. However, despite their differences, all three modes are concerned with how to construe the relationship between stakeholders and institutions, and how to explain the process whereby policies change. First order policy change explains that stakeholders formulate policies to initiate institutional reform. This mode assumes that stakeholders formulate policy goals that are like previous policy activities, and that the policy instruments do not change. Instead, the policy instruments are adjusted to fit the policy context. According to Peters (2012:91), first order policy change refers to 'layering' whereby previous policy objective persist, but new actors and ideas are introduced. Second order policy change assumes that policy formulation is dependent on a particular situation, and a particular context inherited from the past. According to Hall (1993), second order change introduces new policy instruments, and it applies change in policy techniques. This means that new policy interpretations and ideas enter the institutions replacing others. However, actors within the institution tend to make policy changes to fit previous institutional and policy paths. Therefore, change may not always be possible (Peters, 2019: 92).

This infers that policy change does not occur, despite changes in the new policy objectives or the environment. In this case, stakeholders focus on policy stability. This too is an example of path dependence, since this type of change is a result of self-reinforcing effects, whereby the costs of exiting a certain policy path increases over time. This further suggests that policy ideas become locked in the institution and develop a path that affects future policies.

According to Lindblom (1979: 520), first and second order policy change reflects incremental-path dependence. As such, first and second-order policy change does not intend to disrupt the dominant status quo, but rather it adheres to the existing paradigm to ensure that there is policy continuity (Hall, 1993). This means that policies are in a lock-in situation, where the previous decisions made by stakeholders are too costly to exit. This further means that policy change is dependent on a particular historical choice. As a result, policies are path-dependent, and stakeholders are unable to achieve third order change. This is because policies do not contain shifts in objectives. Rather, policy goals are merely adapted to the existing policy, or new policies are formulated.

Third order policy change implies a radical change of policy goals and instruments to ensure that the new policy which is introduced disrupts the existing status quo (Howlett & Cashore, 2009). Third order policy change rejects old institutional approaches to public policy making. It emphasises that institutions must be reformed to establish new power relations and ideas that will determine the new policy paradigm. Third order policy change seems to appear during critical junctures where there are new windows of opportunity for policy formulation. Greener (2001), defines a critical juncture as a period of significant change which enables policy change and institutional reform.

Third order policy change provides that policies and institutions are punctuated by crises which force them to bring about change. Furthermore, the external environment serves as a source of change, and it creates a crisis which breaks old institutions and policies. This ensures that stakeholders battle over the formulation of new policies and designs. However, once the institutions and policies have been reformed, it is also impossible to transition back to previous institutional designs and policy goals because these changes are difficult to reverse (Greener, 2001). In essence, critical junctures are produced by ‘shocks’ which present stakeholders with an opportunity to implement new policy goals and to discover new ideas that can be entrenched in the new institutions which they establish.

2.10 CONCLUSION

This chapter explored the literature surrounding public policy, and especially what this literature had to say about the policy formulation phase of the policy making process. This was achieved by conceptualising the policy formulation phase with the view to better understanding how this phase occurs in policymaking from a general perspective. This chapter included a discussion of the three policy formulation models proposed by the literature namely, the linear, policy streams and rounds models. There was a discussion on stakeholders, and different types of stakeholders, who might influence the policy formulation phase significantly. The chapter further included a discussion on the role of stakeholders to outline how their exclusion, as well as inclusion has an impact on the policy formulation phase. This chapter introduced historical institutionalism as an approach to public policy analysis to show how path-dependence and incrementalism create challenges for government officials and bureaucrats in achieving policy change. Historical institutionalism was deemed to be helpful since it provides an analytical tool to specifically analyse the formulation of the NHI policy. Furthermore, historical institutionalism is considered attractive when analysing how path dependence occurs and why policy change hardly takes place in new institutions.

CHAPTER THREE

HEALTHCARE POLICY FORMULATION IN SA: THE CASE OF THE NATIONAL HEALTH INSURANCE (NHI)

3.1 INTRODUCTION

The aim of this chapter is to contextualise the origins of the NHI in SA. This chapter presents a detailed chronological timeline to provide the historical background, and the series of commissions, policies, legislation, and events, that prompted the NDoH in SA to formulate the NHI. It especially highlights the policy formulation process of the NHI. This chapter relies on evidence that is extracted from primary and secondary sources. The chapter begins by discussing significant Commissions which previously investigated challenges that faced the healthcare system in SA namely, the Loram, Gluckman, and Snyman, as well as the Browne Commissions, which served as a blueprint for the origins of the NHI. This is followed by a discussion of historical healthcare policies and legislation, namely the ANC National Health Plan (1994), WPTHS (1997), and National Health Act 61 (2003). This chapter also highlights the economic policy shifts that influenced healthcare policy formulation in SA. Finally, this chapter explores the broad goals and ideas of the NHI. This will be achieved with reference to the NDoH Green paper on NHI (2011) as well the White Paper on NHI (2015-2017).

3.2 HEALTHCARE POLICIES AND LEGISLATIVE DOCUMENTS OF THE APARTHEID REGIME

In April of 1994, South Africa became a fully democratic state. In 1996, the ANC led government, together with a small group of political parties, formed an administration of national unity. Parliament later adopted the new Constitution and the Bill of Rights in 1996 which formally expressed the need to redress the inherent legacy of underdevelopment, as well as the challenges that had persisted in the country's healthcare system (Coovadia et al., 2009: 819). It was recognised by the post-1994 government that the apartheid regime had formed a healthcare system that was segregated and fragmented. This served to perpetuate inequality among South African citizens. According to Coovadia (2009: 819), the apartheid healthcare system perpetuated inequality using discrimination based on racial classification. Historically, the British colonial government had implemented the Public Health Act 4 of 1883, and the

Public Health Act 4 of 1897, to institutionalise racial segregation in the healthcare system. These types of legislation excluded the black African population from the healthcare system. (Du Toit, 2017: 15).

In 1910, the Union of South Africa was established. As a result, healthcare policies required the integration of British and Dutch healthcare practices. The integration of these two practices toward healthcare set down specific criteria for access to healthcare facilities (Du Toit, 2017: 17). The government of the time implemented the Public Health Act, 36 of 1919, which created racial fragmentation in the public healthcare sector whilst empowering the private healthcare sector to develop. The Union government justified this two-tier healthcare system through the Public Health Act, 36 of 1919. This ensured that the black African population was excluded from utilising healthcare facilities that were reserved only for the white population. The Native Areas Act, 21 of 1923, served as another legislative document which dictated that the black African population would only receive curative services. This meant that the black African population was not allowed to receive preventative medicine. As such, the decision by the Union government to prevent the black African population from obtaining preventative medicine reflected their concerns about the threat supposedly posed to white people by the black African population during the Spanish influenza (Maharaj, 2020). In reality however, whereas, ‘‘diseases (such as the bubonic plague at the time) were associated with the black African population, it was mostly the white population contracting the disease’’ (Du Toit, 2017: 13-14). One might suggest therefore that the Native Areas Act, 21 of 1923, unreasonably authorised the removal of the Cape’s black African population upon the outbreak of disease.

Subsequently, Act 21 of 1923, initiated the urban, and rural divide, to contain the spread of the Spanish influenza. Furthermore, this Act ensured that black African patients did not have access to healthcare facilities in designated white areas. Within the first year of the Spanish influenza, over 300 000 South Africans died. More importantly, the death of labourers placed immense pressure on the struggling economy of rural reserves, which prompted the Union government to initiate the Loram Committee in 1928. This was made up of representatives from the Union medical services, to resolve the public healthcare sector challenges amicably.

However, attempts by the Loram Committee to address challenges in the healthcare sector, such as the training of Natives in Medicine and Public Health, the establishment of state subsidised programmes for African doctors, together with the creation of rural units to be

managed by African health assistants and nurses, proved ineffective. At this time, the Union government rejected the proposals of the Loram Committee since the latter questioned the legitimacy of the Union's healthcare policies (Seedat, 1984: 23). Furthermore, the Union government was insistent that it would not accept that black Africans could be trained as doctors. For the Union government, the Loram Committee proposals were considered tantamount to competition for white doctors, as the training of black Africans, as doctors, would affect the authority of white medical doctors and personnel. Following the rejection of the Loram Committee report, the Gluckman Commission was established in 1942 (Du Toit, 2017: 17).

The Gluckman Commission subsequently established that the healthcare system in South Africa was uncoordinated, it lacked resources, and that the private healthcare sector was unregulated. Furthermore, the healthcare system had failed to prioritise curative medical care over preventative care (Du Toit, 2017: 18). In 1944, the Gluckman Commission began preparing recommendations for the Union government. The Gluckman report provided that the government must reduce private healthcare costs and that it should develop a decentralised healthcare system to ensure improved efficiency and quality of services. The Gluckman report further outlined that the government must ensure free healthcare service provision for citizens that was to be financed by a mandatory health tax system. The Commission also recommended "the implementation of a National Health Tax to ensure that health services could be provided free at the point of service for all SA citizens with the objective of bringing health services within reach of all sections of the population, according to their needs, and without regard to race, colour, means or station in life"(Toyana, 2013: 14).

The Gluckman Commission recommendations were welcomed by the SA government led by General Jan Smuts. However, Smuts pointed out that these recommendations must be implemented in a series of steps, rather than in a single phase. Regrettably, the process of implementing these recommendations was reversed by the apartheid government when it came to power in 1948 led by General DF Malan. The apartheid government favoured the privatisation of healthcare. In this regard, the apartheid government wanted to ensure that the black African population did not have access to adequate healthcare service, and as a result, the racially segregated healthcare system was further maintained.

The country's health system therefore remained unequal and ineffective. The Group Areas Act, 41 of 1950, was then promulgated to further legitimise the exclusion of the black population from urban areas. This further served to prevent black Africans from obtaining healthcare in white areas, and white doctors were prevented from practicing in black areas. More frustratingly, the Reservation of Separate Amenities Act, 43 of 1953, was implemented by the apartheid government. The latter served as a mechanism to separate black and white people. This Act was aimed at controlling 'space' on a racial basis by legalising the segregation of healthcare services. Furthermore, this policy instrument separated black people according to tribes, which also meant that black people were restricted from urban areas and were thus relocated to the homelands. The homelands were self-governed territories, and the traditional leadership of each designated area was responsible for the provision of healthcare services (Du Toit, 2017).

The Reservation of Separate Amenities Act ,43 of 1953, deemed white people as superior and therefore entitled them to advanced healthcare facilities which were characterised as a two-tier one i.e., the private and public healthcare system. According to Shisana and Simbayi (2002: 46), the public healthcare facilities for the black African population were under-funded and overwhelmed. This is because the apartheid government's approach to policy making was largely one of protectionism and of promoting the interests of Afrikaner capital (Shisana & Simbayi, 2002: 46). According to Du Toit (2017: 17), due to a lack of legislative regulation, private healthcare costs increased for the white population. As a result, the rising medical costs in the private healthcare sector were placing financial pressures on the white minority group. This prompted the apartheid government to establish the Snyman Commission in 1960.

To resolve the rising medical costs that were facing the private healthcare sector, the Snyman Commission conducted an investigation and discovered that the "legislation governing the patenting of medicine was a cause of the increasing prices" (Du Toit, 2017: 18). The Snyman Commission recommended that the Minister of Health at the time should regulate the sale of medicine by assuming the responsibility of issuing medical trade licenses. In June 1965, the Minister of Health published the Drugs Control Act, 101 of 1965. This Act promulgated that medicines must be evaluated by the Drugs Control Council before placing them on the market so as to ensure that medical drug provision was regulated. However, these policy recommendations were not fully implemented by the Ministry of Health.

Although these recommendations were not fully implemented by the Ministry of Health, they did influence the formulation of the Medical Schemes Act, 72 of 1967. This Act aimed to regulate private healthcare sector costs by providing minimum benefits to those who used the private healthcare system (Du Toit, 2017: 19). However, this Act came at a time when the apartheid government had aligned its policy objectives to neoliberalism, which prioritised the privatisation of health. Thus, the Act was seen at the most relevant and appropriate policy to adopt since it enabled different white elites to own private clinics, and hospitals, and to employ medical professionals of their own choice (Coovadia et al., 2009: 10). As a result, this Act was unsuccessful, and it further resulted in the fragmentation between the public and private healthcare sectors.

In May 1977, the apartheid government published the National Health Act, 63 of 1977, which provided that the state was not responsible for healthcare provision, thus placing the burden on the individual (Du Toit, 2017). This implied that healthcare was a privilege as opposed to a social or public good. Furthermore, Du Toit (2017: 17-10), argues that the National Health Act of 1977 placed an additional burden on the individual, as out-of-pocket payments were necessary to obtain healthcare service in the country. Subsequently, the apartheid government adopted the idea of privatisation which held that individuals were responsible for their own healthcare needs.

According to Nkosi (2020), structural and racialised inequalities were perpetuated in the South African healthcare system, as the apartheid regime had embraced racism as well as neo-liberalism, as the governing ideology for South Africa. In addition, ‘‘healthcare was one facet of the many socio-economic inequalities which had become institutionalised by the racial segregation introduced by colonialism and then manifested under the apartheid regime. The political unrest and movement towards a democratic and equal society brought more focus to socioeconomic inequalities, such as in access to health care services” (Du Toit, 2017: 19). This violence and social unrest were too great for the apartheid government to address in its effort to restore stability in South Africa. For example, in 1984, the then ANC president, Oliver Tambo, declared a people’s war to render South Africa ungovernable. He also announced that the ANC intended to overthrow the rule of apartheid. This was further linked to the armed struggle programme of action initiated by the ANC, which aimed to intensify the freedom struggle against the apartheid government.

In September 1984, violent conflict erupted between the black African population and the apartheid government. This immediately impacted negatively on the apartheid government's day-to-day operations. The apartheid government responded in a heavy handed way in response to the demands of the black African population involved in the protests (Houldsworth, 2016: 5). As the situation worsened on the ground throughout the 1980s, international condemnation of the apartheid government escalated. In December of 1989, the UN General Assembly voted unanimously to pass Resolution 202 A (XXI) of 16 December 1966. The declaration provided that apartheid was destructive and that it was a crime against humanity. It also called for the SA government to establish a non-racial democracy (Hirsch, 2008). Furthermore, South Africa faced rejection by many countries globally due its political system at the time. This led to the country's inability to attract foreign direct investment, and eventually led to the total exclusion of South Africa from global financial markets.

3.3 THE TRANSITION PHASE: POLICY FORMULATION IN POST-APARTHEID SOUTH AFRICA

In February 1990, President F.W. De Klerk initiated processes to stabilise and bring peace to the country. President De Klerk's mandate was to perform a peacebuilding role, which included the unbanning of all political parties, the drafting of an interim constitution, the ending of violence and attacks on civilians, and the creation of an enabling environment for the first democratic elections (Hirsch, 2008). In September 1991, the National Peace Accord (NPA) was signed by 27 political parties, which made provision for negotiations, and for preventing violence. It also set down the specific criteria for mediation, to address issues related to justice. The NPA further made provision for the Convention of a Democratic South Africa (CODESA) aimed at drafting the new South African Constitution, specific criteria for elections, and the establishment of peace in the country. Finally, on 27 April 1994, South African conducted elections for a new government. The ANC was able to win the elections. This led to two fundamental changes in South Africa, namely the transition from apartheid rule to democracy, and the formation of the Government of National Unity (GNU).

The Government of National Unity (GNU) was led by the ANC, and it reflected on the economic challenges that were inherited from the apartheid regime. At the time, the ANC was aware that all levels of government and institutions needed to be reformed, and that new policies needed to be implemented to facilitate inclusivity and reform. Therefore, it was quite

evident that SA required comprehensive reform programmes and policies that were globally competitive. The GNU also aimed to dismantle the economic legacy of the apartheid government whilst ensuring that public policies distributed social goods to the citizenry (Hirsch, 2008). Following extensive consultation between the ANC -alliance, academia and other stakeholders at the time, the Reconstruction and Development Programme (RDP) policy document was formulated and introduced in SA. The RDP was a development policy that attempted to rectify the conditions left by the apartheid government. Its main priority was to implement programmes that would meet the basic needs of the poor in SA (Terreblanche, 1999).

The RDP aimed to promote service delivery, and to ensure that there was a transformation of all sectors, and especially the healthcare system, based on the ANC's National Health Plan of 1994. The ANC National Health Plan was one of the ANC's first major healthcare policy documents since the signing of the Freedom Charter in 1955. The Plan set out that, "a preventive health scheme shall be run by the state'' (ANC's National Health Plan , 1994). Furthermore, the democratic government recognised that the deficiencies in the healthcare system were a result of apartheid legislation. The ANC National Health Plan policy document was supported and ratified by the World Health Organisation (WHO), and the United Nations International Children's Emergency Fund (UNICEF) in 1994.

The ANC's National Health Plan further emphasised the importance of ensuring that the state provide free medical care and hospitalisation for all, with special care for mothers and young children. The ANC's National Health Plan of 1994 asserted that it was committed to transforming the country's health system by redressing social and economic injustices to ensure that all South Africans enjoyed their human and political rights, such as access to quality and decent healthcare services (ANC National Health Plan, 1994). The ANC's National Health Plan of 1994 emphasised the importance of wider community participation, accountability, and transparency. Furthermore, it stressed that the democratic government would become the central coordinator of healthcare service delivery in the country. It was suggested that this would culminate in institutional and policy reform to develop the healthcare system. The ANC -led government suggested that vulnerable groups were a priority for the Health Plan which further proposed an investigation into the possibility of creating an NHI.

The core elements of the ANC's National Health Plan also focused on a strategy towards Primary Health Care (PHC), which entailed community participation, equity, health promotion, and interventions aimed at transforming healthcare for the poor, an integrated referral system, as well as developing a team of professionals who had biomedical and social skills (ANC National Health Plan, 1994). In its National Health Plan for SA, the ANC declared that adopting all these principles, and the PHC approach, was in line with international standards. More importantly, this was aimed at strengthening community services and the development of the District Health System (ANC National Health Plan, 1994). The district level was considered as the level of government where healthcare policies and programmes of reform were to be implemented.

In 1994, the then Minister of Health, appointed a committee of inquiry that would investigate the possibility of the NHI. This Committee made recommendations to phase out private healthcare funding within a period of five to ten years. It is in the same year that the RDP was published by the ANC. It was anticipated that the healthcare system would be tailored to cater for all the citizens of the country, especially those who were previously excluded, and that the system would be holistically restructured to ensure that there was equality, equity, and access to healthcare for all (ANC,1994). Attempts to redress the challenges of the healthcare sector however proved ineffective, and the objectives of the ANC's National Health Plan were not fully implemented. This is because the ANC-led government lacked the necessary public administration institutions that would carry-out this task, as well as a lack of finances. However, the ANC's National Health Plan did serve as an important guideline for future policies, and especially the RDP.

As indicated earlier, in November 1994, the RDP was launched by the ANC-led government. The RDP policy set out to address economic challenges that were inherited from the apartheid government. The RDP was designed to integrate South Africa into the international economy by establishing a strong domestic economy that addressed the issues of poverty and the provision of basic needs (ANC, 1994: 9). Recognising the inequality that existed in the healthcare system, the RDP set out to restructure the healthcare system in South Africa to ensure that it was improved, and that citizens were afforded quality healthcare provision (RDP, 1994:5). Overall, the RDP was formulated by the post-1994 government to transform all sectors.

However, there was a recognition by the government that economic development was linked to profit maximisation and privatisation (Magubane, 2004). As a result, the ANC led government endorsed neo- liberalism and formulated the Growth, Employment and Redistribution (GEAR) economic policy in June 1996. The aim of the new macro-economic policy was to implement the objectives of the RDP. The GEAR policy outlined that its primary objective was to accelerate economic development, and to counter inflation by creating a new tax system that would prevent financial loss for the government. The GEAR policy aimed to manage exchange rate depreciation, liberalise the exchange rate, and to consolidate industrial policies by lowering tariffs to stimulate economic development (Heintz, 2003).

The policy shift from RDP to GEAR was met with criticism from trade unions and certain members of the ANC. Each broadly expressed that the government could not be led by the private sector, nor could the latter be expected to deliver services (Bond, 2000). This would result in the gap between the poor and rich being intensified. Nkosi (2020: 101) further says that GEAR, as a neoliberal economic policy, affected the public healthcare sector, as the government had to cut funding. GEAR prioritised private healthcare, and the government of the time removed the ideals of developing universal healthcare coverage. This meant that GEAR further entrenched the two-tier healthcare system.

It is said that the decision by the ANC-led government to formulate GEAR represents a strange case of policymaking. GEAR prioritised privatisation. However, in response to this in 1997, Dr. Nkosazana Dlamini-Zuma, a former Minister of Health in South Africa, together with the ANC, introduced the White Paper for the Transformation of the Health System (WPTHS). This document presented policy objectives aimed at unifying the healthcare sectors. It provided a set of strategies that aimed to ensure that South Africa progressively moved towards healthcare provision that was based on need, together with approaches aimed at ensuring that all South African citizens acquired quality healthcare services (NDoH White Paper, 1997). The WPTHS further emphasised the importance of incorporating all stakeholders, including women, children, and vulnerable groups into identifying community needs, and monitoring the delivery of healthcare delivery (NDoH White Paper, 1997). In many ways this was consistent with the World Health Organisation's (WHO) Alma-Ata declaration of 1978 which stated that stakeholders were important in shaping healthcare policy outcomes and in ensuring that Primary Health Care (PHC) is achieved in different communities (WHO, 1978).

The WPTHS further highlighted that a key objective of the government was to distribute healthcare resources equitably, and to establish healthcare financing policies to promote equality between the groups in different geographical settings. The WPTHS also outlined that it aimed to decentralise the management of healthcare services through the introduction of a district health system. The latter would ensure that healthcare and financial resources were distributed to each community by district managers (NDoH, 1997). The WPTHS articulated the possibility that a health insurance approach would be investigated to complement these healthcare objectives.

The WPTHS also emphasised that SA required a unified national health system to transform the two-tier healthcare system. The NDoH adopted Primary Health Care (PHC) as an initiative for reforming the healthcare system. The NDoH's mission was to ensure that there was leadership and proper guidelines for the National Health System which was regarded as important to promote and monitor health for all SA citizens, and to ensure that facilities provided effective services through the PHC approach. Furthermore, the latter emphasised equity, and a strong commitment to universal access, and comprehensive primary healthcare services (Coovadia et al., 2009). The WPTHS also outlined that reforming the healthcare system required new structures, with skilled people, to ensure effectiveness and efficiency with regards to managing the healthcare system. (Brauns, 2016). Therefore, human resource development was seen as a crucial element for the implementation of healthcare reform policy in SA. As a result, the WPTHS set out a framework that would ensure that healthcare personnel received adequate training to ensure that citizens attained effective healthcare services.

However, the attempts by the NDoH over this period proved to be ineffective. At this time, South Africa was firmly entrenched in privatisation since GEAR served as the macro-economic policy between 1996 and 2000. As a result, privatisation, profit maximisation, and commercialisation were prioritised over the provision of public goods (Habib, 2004). In this sense, the SA government acknowledged that the two-tier healthcare system was being reinforced, and that healthcare was a commodity. In addition to the preceding interventions, in 2002, the government acknowledged that it had failed to transform the healthcare system or to uplift the public healthcare sector. As a result, the Department of Social Development set up the Taylor Committee of Inquiry in 2002 (Brauns, 2016: 75). The Committee was instructed to perform a research role, which included the exploration of strategies that would establish a Social Health Insurance, as well as the possibility of formulating legislative and institutional

mechanisms aimed at creating an enabling environment for Universal Health Care (UHC) in South Africa.

In March 2002, the Taylor Committee presented its major recommendation. This recommendation provided that the state should create a mandatory tax system aimed at ensuring that those who could not afford medical care were to be supported by the state. The Taylor Committee of inquiry further proposed that the state should establish a national health fund that would allow healthcare resources to be distributed by the government. Furthermore, the Taylor Committee reported that the public healthcare sector was overwhelmed and that it was severely affected by budget cuts. The Taylor Committee of inquiry reported that GEAR had contributed to the decline of healthcare funding, leading to staff shortages in the public healthcare sector. The staff shortages had also affected administration and the actual delivery of public healthcare services.

According to Brauns (2016: 76) however, the recommendations of the Taylor Committee to create legislative and institutional reform, and to advance South Africa towards UHC and NHI, proved ineffective. Since the private healthcare system was expensive, and only catered for a minority group, the NDoH feared the possibility of criticism resulting from the private sector. It thus became difficult to even discuss reforming the healthcare system, and instead maintaining the two-tier healthcare system became the preferred approach by the SA government. Also, at this time, South Africa's public administration, as well as bureaucrats, lacked the necessary networks and resources for implementing these recommendations. In addition, the South African economy had not achieved the adequate economic growth required to carry-out these recommendations. Furthermore, the macroeconomic policy of GEAR emphasised capital accumulation without considering the needs of the poor and working class (Nkosi, 2020). Nkosi further points out that at the time, “working-class households earned inadequate salaries, and therefore could not afford basic goods and healthcare services from the private sector” (Nkosi, 2020).

Another significant document which attempted to shape the South African healthcare system was the National Health Act, 61 of 2003. The objective of this Act was to assign duties to the different management spheres in the public healthcare system, (which include national, provincial, and district management) to ensure the separation of powers between each sphere of government (National Health Act 61, 2003). In essence, the National Health Act established

the structures for delivering healthcare services for the entire population by further ensuring a relationship between the NDoH and the private and public healthcare sectors. The Act also stressed that the Minister of Health should establish a relationship between the private and public healthcare sectors to provide regulations to coordinate these two sectors so as to ensure that adequate healthcare service delivery was achieved (National Health Act 61, 2003). The National Health Act proposed a code of conduct to govern the NDoH in the different kinds of policy processes and day-to-day activities that took place in its respective facilities and departmental units (NHA, 2003).

In practice, the National Health Act 61 of 2003, was also considered as legislation providing for the establishment of the National Health System and District Health System. The Act was considered as a legislative document responsible for establishing governance structures and institutions for the provision of healthcare service. It further provided that the NDoH was responsible for policy implementation, and for issuing guidelines for the different provinces. The National Health Act further aimed to effect change in the healthcare system through the establishment of the National Consultative Health Forum made up of different stakeholders in the healthcare system, and the Minister of Health was to utilise the Forum to provide stakeholders with information on national health matters.

By the end of 2005, the National Healthcare Act 61 had failed to meet some of its objectives. Although it achieved its other goals, it failed to achieve the intended reform of the healthcare system. The persistent challenge of access to quality healthcare services contributed to growing calls for the government to play a larger role in reforming the public healthcare system and to pursue a new policy that would unite the two-tier healthcare sector. The calls for change signalled the government to move towards creating the NHI. Despite the challenges that were addressed by the National Health Act 61, the latter did not live up to the expectations of the government, and universal access and reform opportunities of the healthcare system were missed. By the end of 2006, the unequal resource allocation for the two-tiered healthcare system had deepened. For example, it is shown that the private healthcare sector continued to benefit from the national health budget on an unequal ratio, despite the fact that the private healthcare sector was only servicing 16 percent of the population (Nkosi, 2020).

The challenge now facing the SA government was its failure to provide resources to both the public and private healthcare sectors. The government therefore emphasised that the challenges were too great, and that this required both sectors to work together to meet the healthcare demands of all citizens. Regardless of the challenges that were created by prior economic and healthcare policies, the ANC-led government went ahead and further formulated the Accelerated and Shared Growth Initiative for South Africa (ASGISA). ASGISA was introduced in early 2006 by the then Deputy President Phumzile Mlambo-Ngcuka . At the time, the SA government was looking for new ways to reform institutions and to initiate new ways to share growth. ASGISA built on the core objectives of a developing democratic state and integrated growth projects (The Presidency, 2006). However, during this period, private healthcare provision had increased. At the same time, the different provinces overspent their healthcare budgets. As a result, there was an increase in unemployment rates, and healthcare workers that were meant to serve the public healthcare sector moved to the private healthcare sector.

As a result, the government had become concerned about the challenges facing the public healthcare sector, especially since that sector had failed to retain skilled workers. The government also realised that the public healthcare economy lacked the necessary expertise for sustainable growth, given the fact that more healthcare personnel had moved to private healthcare facilities, whilst others had moved abroad (The Presidency, 2007). Regardless of these challenges, by the end of 2007, there was an improvement between governance and institutions. However, there was great concern by the government that departments lacked the capacity to implement programmes of reform fully. Therefore, the government emphasised that SA required a new policy that would be fully implemented to improve the healthcare system (The Presidency, 2007).

In December 2007, the ANC began preparing for its 52nd national conference in Polokwane. The conference served as a platform for the leadership of the ruling party to assess its performance and to decide on new policy alternatives that could alter the political landscape of the country at a rapid speed. The internal differences of the ANC, which included the failure to improve service delivery, rampant corruption, and infighting, as well as factionalism, culminated in the defeat of the Thabo Mbeki faction and the ascendance of Jacob Zuma to the presidency of the ruling party (Gordin, 2008: 238-239). The rationale by some ANC leaders

was that the removal of Thabo Mbeki was an attempt to remedy the wrongdoings in the movement and to reconnect it to its Freedom Charter aspirations and ideology. Therefore, the election of Zuma was assumed to be a victory for the left-wing alliance and the victory of the values of socialism over neoliberalism.

The newly elected ANC leadership at Polokwane expressed that: “we are only at the beginning of a long journey to a truly united, democratic and prosperous society, based on the principles contained in the Freedom Charter” (ANC Policy Conference, 2007). The ANC political transition raised expectations that there would be radical policy shifts which would usher South Africa onto a new development path. Consequently, the ANC's National Conference resolved to prioritise education and health for the next government administration. In respect of the NHI, conference resolution numbers 53, 54, 55, and 67 referred to the challenges of the healthcare system. Resolution 53 explicitly expressed that the "ANC will reaffirm the implementation of the NHI by strengthening the public health care system and ensuring that there is adequate provision of funding" (ANC Policy Conference, 2007). Resolution 54 provided that the "ANC led government should develop a reliable single health information system" (ANC Policy Conference, 2007).

Furthermore, the leadership of the ANC declared that the government must find innovative ways to regulate the increasing premiums of medical schemes and private care costs to ensure that healthcare was affordable. The increasing medical schemes costs meant that patients were burdened by out-of- pocket payments. Furthermore, it was indicated that private medical schemes only catered “for 8.8 million people in a country with a population of approximately 58 million people” (Nkosi, 2020: 126). This meant that the ANC leadership in 2007 reinforced the idea that the government must regulate and set medical care prices, particularly in the private sector. This was supported by an ANC statement from the conference which expressed that: “the next elections agenda will be to ensure that when the new government is elected in 2009, the ANC-led government will push for NHI implementation” (ANC,2007).

Following the Polokwane conference, the ANC began gearing up to the 2009 general elections. The ANC was seeking to gain legitimate state power through this election by convincing the country that it was committed to the prospects of the National Democratic Revolution (NDR) to serve as “a progressive ideology with radical ideas of governing the ANC” (Venter, 2012: 33). This resulted in the ANC winning the elections at a national level with 65,89% of the vote

in 2009 (IEC, 2009). This was followed by the appointment of Dr. Aaron Motsoaledi as the Minister of Health of South Africa on the 11May 2009. In his first address to parliament on the 3 June 2009, the Minister expressed that the NHI was important and that stakeholders in the healthcare sector should cooperate with the government.

He further defined the NHI as a "system of Universal Health Care that guarantees each citizen health insurance because, the current healthcare system is dysfunctional" (NDoH, 2009). In an effort to carry out their administrative duties, the ANC-led government introduced the Medium-Term Strategic Framework (MTSF) in July 2009. This served as the government's guiding document for the period 2009-2014. According to the Department of Health (2010), this document encompassed the electoral mandate. The task of the administration was to "improve the nation's health profile and access to basic health service, as well as the progressive realisation of universal healthcare coverage" (NDoH, 2010). This document included the Department of Health's ten-point plan which prioritised the following, inter alia, the implementation of the NHI, improving the quality of health services, and strengthening research and development. Furthermore, it provided that to achieve free healthcare for all, it would be important to improve human resources, development, planning, as well as management (MSTF, 2009). In addition, the Department of Health had a role to ensure that infrastructure was developed and that facilities were upgraded, especially in the public healthcare sector.

The Medium-Term Strategic Framework further emphasised that the government must improve citizen's health profiles, and worker's skills, and to promote universal access to basic healthcare services (MTSF, 2009). It further held that the two-tiered healthcare system must be overhauled. Regarding the NHI, the MTSF (2009) provided that there must be the development of institutional and organisational structures so as to start implementing the NHI. Chapter Five of the South African Constitution Bill of Rights (1996) expresses that, ''Ministers are responsible for the powers and functions of the executive assigned to them by the President". Furthermore, they are "accountable collectively and individually to Parliament for the exercise of their powers and the performance of their functions'' (SA Constitution, 1996). It was against this backdrop that Dr. Aaron Mostoaledi established an NHI technical team within the NDoH that would guide the implementation phase of the NHI. This team was made up of 27 members of the ministerial advisory committee, and it was established according to the National Health Act 61 of 2003. The team had the role of preparing the 2011 Green Paper on NHI and for

finalising policy recommendations to produce the White Paper on NHI 2015-2017. Furthermore, this team was tasked with developing the 2018 NHI Bill which had to go to cabinet for final approval.

3.4 THE NHI AND ITS POLICY OBJECTIVES

The NDoH released the Green Paper on the NHI in August 2011. This policy document contended that the plural healthcare system was unsustainable, ruinous, very costly, and extremely curative (NDoH, 2011). The document further pointed out that it is irrefutable that the SA healthcare system is affected by the quadruple burden of disease, and a shortage of human resources, specifically in the public healthcare sector (NDoH, 2011: 7-10). This document outlined that the NHI serves as legislation to establish free healthcare services for all. According to the NDoH Green Paper on NHI (2011: 15), the rationale for implementing the NHI in South Africa was to eradicate the existing inequalities in the healthcare system. This was to ensure that the majority of poor citizens, without access to healthcare facilities, could access them.

Furthermore, the NDoH envisioned that implementing the NHI would ensure that people had access to quality healthcare services, and that the government would provide financial risk protection against unforeseeable healthcare household expenditure. In addition, the NHI would ensure that people were financially subsidised to improve funding contributions which were linked to an individual's ability to pay, and that everyone would have a defined comprehensive package of health services. This also meant that any person who required medical care would gain access to any healthcare sector of choice for free (NDoH Green paper NHI, 2011). As a strategy to attain UN SDG (3), the NHI stressed that Primary Health Care (PHC) is important because it presents the tactics that are necessary for fighting against the quadruple burden of disease-causing rapid mortality and morbidity (NDOH Green Paper on NHI, 2011). The NHI further provides that PHC requires facilities that are more accessible, and which offers all essential services to vulnerable communities.

After the NHI White Paper (2015) was published by the NDoH, an amended NHI White paper was published in June 2017. This was ratified by the former Minister of Health, Dr Aaron Motsoaledi. According to the NDoH White Paper NHI of 2017 (2017: 9). the NHI is a health financing system that is designed to pool funds to provide universal access to quality,

affordable personal health services for all South Africans based on their health needs, regardless of their socio-economic status. NHI would be implemented through the creation of a single fund that would be publicly financed and publicly administered. The health services covered by NHI would be provided for free at the point of care. NHI would also provide a mechanism for improving cross-subsidisation in the overall health system. As a result, the funding would be linked to an individual's ability-to-pay, and benefits from health services would be in line with an individual's need for health care.

It can be said that the NHI policy presents a broad socio-economic vision for South Africa which covers a wide range of issues, whilst also addressing healthcare challenges. The White Paper on the NHI (2017: 9) outlines the following. First, universal access. This means that all South Africans will obtain the healthcare services that they need, and that they will benefit from financial risk protection. They will also not be exposed to financial hardship. This is because the provision of healthcare will be based on need, and not on socio-economic profiles. Second, mandatory prepayment of healthcare. This means that in order for the Department of Health to implement the NHI it will require additional taxes.

The White Paper on the NHI 2017 outlines that the "NHI will be financed through mandatory prepayment which is distinct from other modes, such as voluntary prepayment, and out-of-pocket payment"(NDoH White Paper on NHI, 2017). This further means that the NHI will regulate broker fees, subsidise lower earners, and ensure that extra medical costs are paid to facilities based on the individual's income. Third, the NHI offers comprehensive services. This means that the "NHI 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" (NDoH Green Paper on NHI, 2011). This further means that the NHI will develop an integrated system aimed at meeting the healthcare needs of families, and communities within their local settings. In addition, healthcare services will be delivered through referral systems, and will include all levels of care, namely primary, secondary, tertiary and quaternary health care services (NDoH White Paper on NHI, 2017).

Further features of the NHI include financial risk protection. This means that the NHI will ensure that individuals and households do not suffer financial hardship, and that they are not deterred from accessing and utilising needed health services. This involves eliminating various

forms of direct payments such as user charges, co-payments, and direct out-of-pocket payments to accredited health service providers (NDoH Green Paper on NHI, 2011). Also, the NHI is a single fund. This refers to integrating all sources of funding into a unified health financing pool that caters to the needs of the population. Additionally, the NHI proposes a single payer. This refers to the government being responsible for paying all health care costs on behalf of the population. Furthermore, the NHI will serve as a strategic purchaser. This means that government will "purchase services for all, and that there should be an entity that actively utilises its power as a single purchaser to proactively identify population health needs and to determine the most appropriate, efficient and effective mechanisms for drawing on existing health service providers" (NDoH White Paper on NHI, 2015: 10).

The NHI further outlines a sizable number of core principles, inter alia: the right to access health care, social solidarity, healthcare as a public good, affordability, and efficiency, effectiveness, and appropriateness (NDoH White Paper on NHI, 2017: 10-11). It is therefore clear that the NHI policy attempts to be a comprehensive framework of healthcare reform and broader development in South Africa. The White Paper also asserts that the NHI will be introduced in three phases over 14 years. Phase one of the NHI's implementation began in 2012 and it was completed in 2017. This phase encompassed a wide array of reforms that entailed policy and legislative reforms at facilities, the strengthening of public healthcare systems through decentralising hospital management, implementing primary care, as well as improving quality assurance and service delivery (NDoH White Paper, 2017: 85)

The NDoH White Paper on NHI (2017: 86) asserted that phase two of NHI implementation would resume in 2017 and conclude in the 2021 budgetary year. This phase intended to, inter alia: purchase services to be funded by the NHI, mobilise additional resources, and to establish a fully functional NHI fund. Moreover, this phase aimed to establish the NHI Fund Management and Governance Structures. The NHI Fund will be governed by the NHI Commission. Therefore, an NHI Commission will be created together with the appointment of a management team, as well as a stakeholder Representative Forum (NDoH White Paper on NHI, 2017: 86). The final phase is the full implementation of the NHI health system. This phase aims to begin in 2021 and to end in 2025. The main target of this phase is to ensure that there is a contributory system, and that general tax will serve as the source of the NHI's revenue.

Furthermore, the NDoH envisages that the NHI will be fully implemented, with public healthcare infrastructure being developed, so that all groups and individuals in South Africa will be able to benefit from the NHI health system. Furthermore, the NDoH White Paper on NHI (2019: 71) outlines that, "South Africans that have been registered with the NHI system will be issued with an NHI card linked to the Department of Home Affairs smart identification system". With regards to financing, the NDoH White Paper on NHI (2015: 71) says that the NHI aims to, "pool funds for personal health services". This will be done to eliminate fragmentation, and to minimize financial risk as well as to ensure subsidisation. Thus, the NHI will serve as a national pool of funds that will actively purchase healthcare services for the entire population (NDoH White Paper on NHI, 2015: 71).

The NHI policy also acknowledges that existing institutions are weak, and it provides that they need to be improved. Because the NHI fund will be publicly administered, it will be governed through legislation, and it will serve as "an autonomous public entity with demarcated functions, roles, and responsibilities, governance structures, and accountability mechanisms" (NDoH White Paper on NHI, 2015: 72). In addition, the NHI will be managed at a national level. This means that the NDoH will be responsible for purchasing medical goods, undertaking auditing and risk management, maintaining the health demographic of the population, and conducting research and analysis. This will be achieved through the creation of specific units which include planning and benefits design, price determination and accreditation, a purchasing, contracting, and procurement unit, as well as a provider payment unit. Furthermore, there will be a performance monitoring unit, and a risk and fraud prevention unit (NDoH White Paper on NHI, 2015: 72).

The NHI also intends to attain a level in the healthcare system that will promote efficiency, and effective service delivery. This will be achieved through evidence-based interventions in both healthcare sectors. It also aims at upgrading and strengthening under-resourced and strained public healthcare facilities to improve performance and healthcare outcomes (NDoH White Paper on NHI, 2015: 72). The NHI also intends to serve as comprehensive policy that adopts an appropriate, innovative health service delivery model, that will meet the needs of citizens.

Regarding the governance of the NHI, the NDoH (2015: 72) states that "there will be appropriate governance mechanisms" (NDoH White Paper on NHI, 2015: 72). This means that the NHI Commission will be tasked with providing oversight, and ensuring that there is

accountability, as well as transparency, to protect the interests of the citizenry. The Commission will be made up of experts from various fields, as well as selected citizens, who will also serve as representatives. Furthermore, the Commission will report to Parliament annually, whilst the NHI Fund must prepare all its financial statements that must be audited by the Office of the Auditor-General, and these must be made known to the public (NDoH White Paper on NHI, 2015).

The ANC held another national elective conference in December 2017, where the NHI was once again discussed. The conclusion of the conference was that the ANC- led government will implement the NHI. Subsequently, the NHI Bill of 2018 was the last document drafted in this regard by the SA government. The NHI Bill describes the policy strategy, and it simultaneously amends the existing legislation that governs the medical aid schemes. Furthermore, the Cabinet committee met with President Ramaphosa, on Wednesday, 30 May 2018. The Cabinet voted in support of the NHI Bill, thereby approving the last piece of legislation of the NHI policy and system. (Nkosi, 2020). The ANC-led government was subsequently involved in several engagements with the National Treasury to ensure that this institution was provided with its own autonomy. The NHI Bill only lays down the specific legal criteria for establishing an NHI fund, which will purchase the required services from accredited public and private healthcare providers. The NHI Bill does not however provide any information about how the NHI system will be financed, and the government declared that financing will be determined by the National Treasury.

The NHI Bill, and the Medical Schemes Amendment Bill 2018, both reiterated that the SA government will provide financial protection for all citizens from the costs of accessing quality healthcare services, to no cost at any point (NDoH, 2018). The NHI Bill was therefore taken as the last policy statement of the government, which emphasised the importance of the role of the Minister, the Department of Health and medical aid schemes. This offers a new governing approach to the existing healthcare system, and it attempts to further deepen the possibility of redressing the challenges inherited from the apartheid government. The Bill also made it clear that the SA government is committed to achieving the goal of UHC for all citizens through better governance. Furthermore, the Bill provides that good governance serves as the cornerstone of achieving policy goals. Therefore, the Bill translated all NHI papers into approved interventions by Cabinet, and it also placed central importance on the need to employ more human resources required to implement policies, reduce corruption, and the

mismanagement of healthcare funds, as well as ensuring that there is coordination between the different healthcare departments and institutions (NDoH, 2018).

3.5 CONCLUSION

Chapter Three has traced the history of the origins of the NHI in South Africa. The findings from the Loram, Gluckman, and Snyman, as well as the Browne Commissions, which served as a blueprint for the origins of the NHI commissions, provided a deeper understanding of the healthcare system challenges faced by South Africa before and during the apartheid era. These commissions further outlined that the South Africa healthcare system has always required reform to ensure that citizens obtain access to quality healthcare services. Furthermore, the ANC National Health Plan (1994), WPTHS (1997), and National Health Act (2003) policy documents were introduced by the post-apartheid government to redefine the healthcare system and to introduce an early sense of universal healthcare coverage. Even though the NDoH has not fully achieved the implementation of these policy objectives, there is a compelling argument that the need to reform has, and remains, a legitimate effort at ensuring quality healthcare services. Subsequently, this chapter presented the broad goals and objectives of the NHI. This was achieved by extracting information from primary sources derived from NDoH Green and White Papers on NHI. Using these documents in this context has highlighted the importance on why the SA government aims to reform the healthcare system, whilst also improving the general well-being of citizens, and perhaps the healthcare system as a whole.

CHAPTER FOUR

APPLYING THE LINEAR MODEL OF POLICY FORMULATION TO ANALYSE THE ORIGINS OF NHI

4.1 INTRODUCTION

The purpose of this chapter is to retrospectively analyse the formulation phase of the NHI policy making process. It offers an analytical account of some of the issues that were identified in the policy formulation phase of the NHI to highlight the exclusion of different types of stakeholders as well as the top-down approach to policy formulation which was adopted by the NDoH in the formulation phase of the NHI policy. The chapter draws on the analytical framework presented in previous chapters, as well as the scholarly literature, that explained policy formulation, stakeholders, as well as the historical stages of healthcare policy formulation in SA. This chapter will show that the policy formulation phase of the NHI in South Africa was highly influenced by bureaucrats from the NDoH, and the ANC, as the governing party, in South Africa. Furthermore, it will show that other stakeholders had little influence on the decisions of the ANC, as a political party, and ANC as the government, to formulate the NHI.

4.2 THE FOUNDING PHASE OF NHI AND THE EXCLUSION OF STAKEHOLDERS

The linear model of policy formulation can best account for the way in which the NHI was formulated in SA. The literature which explores the complex relationship between policy formulation and politicians, as well as bureaucracies, has been underpinned by the Weberian understanding of bureaucracy. A bureaucracy is made up of elected and appointed civil servants who function via the rules and procedures of the state (Weber, 1968). In the SA context, the ANC- led government has a unique method for formulating its public policies and for addressing the needs of the country. The process begins when the ANC's top officials identify social problems in different communities or sectors, and the development of a policy agenda mainly occurs at ANC National Conferences. At the ANC policy and elective conferences, it is only the members of the organisation who have the basic democratic right to elect party leaders and to formulate policies (ANC Constitution, 1994: 19). In ANC

constitutional terms, it is only branches of the ANC, that dominate conferences, who are permitted to make policy decisions, which are then adopted at a national conference, which serves as the supreme rule, and which controls the ANC.

The ANC's 52nd conference in Polokwane in 2007, served as the platform for the liberation movement to reflect on its performance and to decide on strategic public policies. In Resolution Number 52, education and health were recognised as, "the main priorities of the ANC for the next five years" (ANC, 2007). The bureaucrats that were selected by the ANC's top officials problematised the current two-tier healthcare system in SA. The bureaucrats pointed out that the two-tier healthcare system was inconsistent and uncoordinated with regard to access. Furthermore, the ANC pointed out that this was untenable since private healthcare was becoming expensive, and that the government lacked the capacity to develop effective public healthcare facilities to meet the healthcare needs of SA citizens. Thus, the NHI, at the time was seen as the most appropriate policy to adopt. It was understood by ANC leaders to be a comprehensive response to the conditions affecting the healthcare system. Furthermore, the implication of adopting these Resolutions meant that the political agenda of the ANC would be to ensure that the officials deployed in the NDoH would begin preparing for the implementation of the NHI.

Therefore, the policy formulation process of the NHI was spear-headed by the ANC and its selected bureaucrats. This is consistent with the view that party politics plays a significant role in the policy formulation process, and that this often determines how policy activities will be carried out. Notably, the national and provincial elections in SA in 2009 coincided with the NHI policy development timeframes. This meant that each government department and the ANC, viewed the NHI as important for electoral purposes. As such, the NHI had to be aligned with the government's developmental agenda, based on the ANC's manifesto of 2009. In this respect, public policies in SA are formulated to achieve what the manifesto of the ANC dictates, and the policy preference is often based on affiliation. Hence, the ANC Election Draft Manifesto of 2009 outlined that the NHI sub-committee, under the leadership of Dr. Zweli Mkhize, (who was responsible for conducting research on NHI), must find new strategies that would ensure that the new healthcare policy would be fully implemented over the proposed timeframes. Dr. Zweli Mkhize, as the head of the NHI sub-committee, was responsible for recruiting stakeholders for the NHI's implementation. He established a task team led by Dr. Shisana, which was tasked with the responsibility of developing a policy proposal for the sub-

committee, and the National Executive Committee of the ANC. Hence, the NHI was included in the ANC's National and Provincial Manifesto (ANC Draft Election Manifesto, 2009: 1). The NHI Task Team, under the leadership of Dr. Shisana, completed its task and handed over the policy proposal to the sub-committee.

During a meeting held between Dr. Zweli Mkhize, and other National Executive Committee members of the ANC, Dr. Mkhize expressed deep concern over the consequences that would result from the deterioration of the public healthcare sector, and the rising costs in the private healthcare sector. Therefore, the NHI policy proposal was adopted by the National Executive Committee and the NHI sub-committee. Dr. Mkhize responded to both committees by stating that "we are expecting attacks from opposing political parties, the media, and business, and we further anticipate resistance and opposition on the NHI's implementation" (ANC Draft Election Manifesto, 2009: 2). Mkhize's response to the NHI policy proposal suggests that the policy formulation process was restricted to ANC political elites and bureaucrats with no input from civil society, the media, the private sector, as well as other political parties. This means that different types of stakeholders were excluded during the policy formulation process.

Regardless of Dr. Mkhize's anxieties over anticipated stakeholder reactions, the NHI sub-committee established the NHI Campaigns Committee, which was comprised of ANC members, employees from the Office of the Secretary-General of the ANC, and staff members from Luthuli House, (who are involved with organising and mobilising), as well as the Media and Communication team of the ANC. Furthermore, other members of the NHI Campaigns Committee were from the Policy Institute and Political Education & Training unit of the ANC. Additionally, committee members included other political stakeholders that remain aligned to the ANC, namely the South African Communists Party (SACP), and the Congress of South African Trade Unions (COSATU), as well as the South African National Civic Organisation (SANCO).

All of this suggests that the ANC employed a top-down approach to the policy formulation process of the NHI. As indicated, the top-down approach to policy formulation does not include a great number of stakeholders but rather creates an environment whereby decisions are passed down to others without consulting them. This means that in its origins, the NHI lacked a holistic perspective from all stakeholders, and that it was possibly only formulated to serve the political interests of the ANC. Furthermore, the establishment of the NHI Campaigns Committee (which

mainly included members of the ANC) suggests that priority in policy making was given to cadres of the ANC who advanced specific policy interests of their party, and the need to implement the NHI.

During his State of the Nation Address in 2010, President Zuma announced his government's intention to implement the NHI to address the inequities in the healthcare system. Since improving healthcare delivery was also aligned with the sustainable development agenda, the then Minister of Finance, provided that the state would work towards reforming the healthcare system by ensuring that it was financed. Furthermore, the finance minister stated that the government would develop close relations between the public and private healthcare systems to ensure that the introduction of NHI was successful (Gordhan, 2010: 17). Furthermore, the Minister of Health at the time, further emphasised that the NHI was important for ensuring that there was provision for universal access to quality healthcare for all citizens. The government had thus committed itself to ensuring that all SA citizens have access to equal healthcare services.

The government proposed that the NHI would be implemented over a timeline of fourteen years. Furthermore, new hospitals and clinics would be built to meet demands, and existing healthcare facilities would be improved, and used to full capacity. Furthermore, the then Minister of Health declared that the envisaged NHI was in line with the democratic government's visions of ensuring equity in access to affordable, quality health services that would be cost-effective and close to all citizens (Gordhan, 2010: 17). According to Waters (2009), this was the first time that Members of Parliament had heard of the NHI initiative. This further suggests that other Members of Parliament were not effective or influential in guiding the then government in respect of the NHI. This is because, ostensibly, a policy decision had already been taken, and it was only taken to Parliament for approval with the confidence that most members were aligned to the ruling party anyway and were willing to support it. However, stakeholders from private sector organisation were taken by surprise, and they vowed that they would not support the policy until the government clarified the NHI.

4.3 CRITICISM AND ARGUMENTS RAISED BY DIFFERENT TYPE OF STAKEHOLDERS

Compared to its predecessors, the NHI is the most fiercely challenged healthcare policy in post-apartheid South Africa. It was seen by many Members of Parliament as the imperfect policy to have been adopted by government. As a result, the NDoH and ANC received heavy criticism about the NHI policy formulation phase. At the same time, the NHI had been formulated to balance the heavy demand that was placed on government by SDG 3, which required the NDoH to reassure foreign investors, as well as international donors, that it would meet SDG 3 by 2030. In terms of its formulation, the NHI was not discussed openly, in that it lacked stakeholder participation and consultation. In the NHI case, a key feature was the closed nature of its formulation process, which was coordinated by ANC members, and thus formulated by people who shared similar beliefs in respect to the kind of healthcare policy the government should adopt. Furthermore, the same ANC members who drafted the ANC's Conference Resolutions, formed part of the same technical team that researched the NHI.

To make matters worse, the NDoH had not released a Green Paper on NHI to allow other stakeholders to understand what the NHI entailed. At this point it became obvious that the ANC had arrived at an impasse. This was because the role played by the NDoH during the policy formulation process was unclear and bureaucrats could not explain some of the Resolutions that the ANC had adopted. The NDoH had not published the Green Paper on NHI. As a result, the NDoH was not able to translate or convey what was agreed upon during their consultations with the ANC. Despite all of this, in his speech to the National Assembly as Minister of Health in 2009, Dr. Motsoaledi declared that the NDoH would implement the NHI (Motsoaledi, 2009). According to Kabwe (2019), this showed dangerous levels of political power, and this reflects the idea that when something originates from the top, no other citizen stakeholder has the authority to overturn it. As expected, Dr. Motsoaledi received criticism following his announcement of the NHI. Stakeholders are important in the policy implementation phase, and therefore also have a role to play in the policy formulation phase. This means that the perceptions and responses of stakeholders in the finalisation process of the NHI cannot be ignored. This section of the study will therefore provide the submissions made by different stakeholders in respect of the NHI policy formulation process.

Political parties

Dr. Mostoaledi presented the NHI as an alternative to resolving the challenges facing the country's healthcare system. The policy formulation phase of the NHI was questioned by various political parties. The Democratic Alliance (DA), as the leading opposition party, opposed the NHI plan proposed by the ANC. The DA questioned the need for a new healthcare policy and stated that it would not support any policy initiative that required funds to be overspent by ANC cadres (Waters, 2009). The DA expressed the view that the new NHI policy should be taken seriously, but they raised legitimate concerns about the implications of the NHI and its impact on the private healthcare sector. Furthermore, the DA questioned whether there were no other alternatives that could be implemented to address the numerous problems in the healthcare system. Additionally, they argued that they resisted the idea of the NHI because it was imposed by ANC cadres, and those deployed in government, without proper consultation, and without considering the inputs of other political parties (Waters, 2009).

The DA also added that the NHI policy should be endorsed by all stakeholders through adequate consultation, and that all polices should be formulated based on the values of a participatory democracy. In a press statement, the DA stated that "we must fix the problems of the health system on the ground, without massive expenditure on more bureaucracy, and we will fight to ensure that South Africans do not bear the brunt of another ANC spending extravaganza which delivers little" (Waters, 2009). The DA further argued that the government should not focus on policy formulation and implementation that would become impossible, given that there was a shortage of healthcare employees in the country. The DA further argued that the NDoH must focus on reviewing the role played by hospitals managers, as well as structures that govern the public healthcare system. The DA also suggested that the ANC must change its attitude towards the private healthcare sector (Waters, 2009).

Furthermore, the DA also added that the NHI is not relevant to SA because the private healthcare sector is not responsible for the poor healthcare outcomes in the country. The DA further outlined that the NHI was formulated by the ANC to privilege the interests of the public healthcare sector over the private healthcare sector. In addition, the DA stated that the public healthcare sector is faced by challenges that have been created by the maladministration of the apartheid regime as well as the new democratic government (Waters, 2009). The African Christian Democratic Party (ACDP), as a minority opposition party, argued that the NHI project entailed huge administrative and maintenance costs. It also argued that the ANC could

have explored other alternatives that could ‘‘reduce taxation of companies so that they, together with the employees, can contribute towards medical savings schemes’’ (ACDP, 2009).

However, there were mixed emotions about the NHI. In his speech as the General Secretary of the SACP, in 2009, Dr. Blade Nzimande declared that citizens who have financial privilege must contribute to the NHI, as this will ensure that the disadvantaged SA citizens will benefit from the NHI (SACP Central Committee Report, 2009). Dr. Nzimande also emphasised that business elites would oppose the idea of the NHI as it would affect their profits, and they would also ‘‘sabotage the implementation of NHI’’ (SACP Central Committee Report, 2009: 3). Furthermore, Magaxa and Manamela, who were leaders of the Young Communist League (YCL) at the time, maintained that ‘‘the NHI will mean better facilities, more hospitals, and more clinics. It will mean more accessible and more affordable health services, especially for people in the rural areas and the townships. It will mean quality healthcare for all’’ (SACP, 2009: 3).

Trade Unions

According to the South African Health Review (2019: 49), the formal inclusion of stakeholders in formulating the NHI only occurred when the NDoH hosted a conference on NHI, titled “Lessons for South Africa”. According to the South African Health Review (2019: 49), the NDoH met with stakeholders for the first time in 2011, only after the Green Paper on NHI was published. It is said that this meeting merely served as a consultative process to speed up the drafting of the White Paper on NHI. In the consultative meeting, the trade union movement COSATU, an alliance partner of the ANC, expressed the view that the NHI is important since it creates ‘‘an organised class-conscious worker-centred mechanism for a socialist mode of healthcare production (free healthcare) within one (single-tiered) public healthcare sector-led healthcare system’’ (Nkosi, 2020: 120). Although COSATU and NEHAWU were in favour of NHI, they have subsequently not exercised much power regarding its implementation because they felt that the NDoH should carry out the entire policy making process (Nkosi, 2020).

According to Usher (2015), Dr. Molefe, a representative of the NDoH, indicated that COSATU and NEHAWU were involved in certain aspects of formulating the NHI but only to a certain degree. Dr Molefe was of the view that the involvement of trade unions in government activities results in the politicisation of state affairs which creates an enabling environment for trade

unions to advance personal interests. Usher (2015) further indicates that Dr. Schoeman, a professor of social policy, specialising in inequality, at the University of the Witwatersrand, also argued that the trade union movements were absent in the discussions of NHI. This indicates that although COSATU has shown support towards the NHI, it has not fully engaged government on the implications of this policy on the working class.

Private sector organisations

The South African Private Practitioner Forum (SAPPF) was also amongst the stakeholders who submitted their concerns about the NHI Green Paper. The SAPPF is an organisation for private medical specialists who work in the private healthcare sector, and it has 2 500 members. This organisation argued that the NHI was formulated by political elites and bureaucrats who had their own agenda and who did not take into consideration the true challenges that face the healthcare system in South Africa (Helen Suzman Foundation, 2011: 3). They argued that "to simply criticize the private sector distracts attention from the most pressing concern facing the health sector i.e. the dire state of public health" (Helen Suzman Foundation, 2011: 03). The SAPPF argued that the NHI Green Paper lacked clear information on fundamental policy areas. For example, the SAPPF raised concerns over "the continuing role of the private health care system, with specific detail pertaining to the role of private medical schemes and the nature, function, operation and models of the intended public- private partnerships" (Helen Suzman Foundation, 2011: 3). Furthermore, they stressed that the policy position of the NHI was more theoretical, with little information on the type of funding model that the government aimed to use to finance the NHI.

The SAPPF emphasised that the NDoH had shifted the blame onto the private healthcare sector with regards to the rising medical costs to justify the importance of the NHI. The SAPPF also argued that the policy formulation phase of the NHI did not consider the principles of good governance, namely accountability, transparency, and consultation, as well as failing to create an enabling environment for citizens to express their concerns over the proposed NHI (Helen Suzman Foundation, 2011: 3). The SAPPF also emphasised that bureaucrats from the NDoH assumed that they were acting in the interests of everyone, whilst in fact they excluded stakeholders from the important policy formulation phase. Furthermore, the SAPPF stated that it would not support a policy that aims to marginalise the private healthcare sector, thus

deeming the NHI as unreasonable, and driven by the ANC's political agenda (Helen Suzman Foundation, 2011: 13).

The SAPPF also argued that the challenges faced by the public healthcare sector were a result of poor service delivery. According to Matsoso and Fryatt (2013), stakeholders from the private sector, especially pharmaceutical companies, highlighted that the proposed timelines for the implementation of the NHI were hastily planned. This concern, raised by stakeholders from the private sector in SA, confirms that policies formulated in a top-down fashion "are often made on the basis of perception, stored conventional wisdom, and attitudes of particular interest groups or bureaucratic interests, to which some partial technical analysis and information, whenever available, are added in the form of a brief technical memorandum written hurriedly at very short notice" (Corkery et al., 1995: 13). This further suggests that bureaucrats often adopt policy decisions without conducting research or understanding the possible consequences of their decisions.

It is said that the NHI will affect private institutions that are responsible for the supply chain of healthcare products. Therefore, it is potentially pharmaceutical companies (as the biggest service providers in the healthcare system) who will determine whether certain policy objectives of the NHI will be met (Econex, 2013). Stakeholders, such as Medi-clinic, from the private healthcare sector, also emphasised that the government had not fully recognised its own lack of capacity, and that the NHI is likely to require substantial financial and technical assistance. This will create dependence on the WHO and the IMF for financial aid (Hlophe, 2013). Mediclinic argued that the NHI Green Paper must provide information on the "cost implications of NHI, personnel definition and features of the benefit package, and the role of private schemes in the future" (Hlophe, 2013: 38).

According to the Helen Suzman Foundation (2011), the South African Medical Association (SAMA), represented by Trevor Terreblanche, agreed that universal access to healthcare for all SA citizens was important. SAMA was of the view that SA has a healthcare system that is fragmented and not ideal for addressing the prevailing healthcare challenges (Helen Suzman Foundation, 2011). SAMA further proposed that SA needs to discuss funding mechanisms for ensuring healthcare delivery. SAMA also stated that healthcare had to be paid for by 'someone' because there is nothing called free healthcare. Furthermore, SAMA expressed the view that SA needs to focus on developing funding, because an NHI system that lacks financial capacity

would lower the quality of the healthcare system, and negatively affect citizens who benefit from medical aid schemes (Helen Suzman Foundation, 2011). Additionally, SAMA emphasised that the public healthcare sector lacks the capacity to carry out healthcare provision in SA. This view however was met with great resistance from Dr. Rudiger Kech (Director of Ethics, Equity, Trade and Human Rights from the WHO), he argued that the NHI is aimed at fast tracking Universal Healthcare Coverage and that it serves as an innovative approach towards social transformation (Helen Suzman Foundation, 2011).

Dr. Kech further emphasised that stakeholders involved in the healthcare system in South Africa must develop solutions which reduce conflict. Furthermore, Dr. Theodore Kutzin from the WHO, also emphasised that all countries must develop policies and financing mechanisms that will ensure that citizens have access to healthcare so that they are not exposed to financial burdens. He further expressed the view that all stakeholders must participate in the policy making process to improve governance (Helen Suzman Foundation, 2011). Bureaucrats from the NDoH, specifically Dr. Molefe, argued that consultation with stakeholders was delayed because of conflicting views on the nature of the healthcare system. Dr. Molefe argued that those from the private sector resisted the NHI because they wanted to protect their sector. According to Dr. Molefe, private practitioners have a profit-making agenda. He pointed out that, "they are the biggest beneficiaries of the current system and if we come with a single payer system their role will be diminished" (Usher, 2015: 87).

Michelle David, the director of the Norton Rose Fulbright law firm, expressed the view that the NHI will not be accepted by stakeholders, private donors, and private hospitals (Nkosi, 2020: 129). She further expressed that most private practioners would emigrate in the case where the NHI dictates to practioners what to charge, whilst also setting tariffs for them. According to Dr. Broomberg, the CEO of Discovery Health, the NHI proposed by the ANC did not provide a proper approach on how it would strengthen the public healthcare system. He further argued that the NDoH had not taken into account the challenges of the healthcare system and that the NHI must investigate the reality facing private access to healthcare (Discovery Health, 2011). In addition, Dr. Broomberg provided that, "there is significant risk of multiple unintended consequences, which may impact negatively on the realisation of the objectives of the NHI policy" (Discovery Health comments on NHI Green Paper, 2011).

However, Dr. Broomberg later indicated that Discovery Health would support the healthcare reform initiatives that were being undertaken to guarantee quality healthcare services for all South African citizens. He argued that Discovery Health would engage with any stakeholder that sees the importance of reforming the healthcare system. Furthermore, Discovery Health stressed that the private healthcare sector also plays a role in shaping healthcare outcomes, and that it should always be engaged when the government is looking for new ways to transform the healthcare system. He further added that, "we are supportive of structural change that assist in strengthening and improving the healthcare system for all South Africans, and we are committed to assisting where we can in building it, and making it workable and sustainable, seeking to ultimately strengthen both the public and private healthcare systems for all South Africans''(Discovery Health , 2018). He further provided that "while the NHI is a huge, complex, and multi-decade initiative and a considerable amount of debate and effort would be required to make it workable" (Discovery Health, 2018). Dr. Broomberg also emphasised that the company would engage with other stakeholders to monitor developments in relation to NHI Bills and would also engage its members with the relevant developments (Discovery Health, 2018).

Academia/elites

Professor Heever, who serves as a health economist at the University of Witwatersrand, Johannesburg, argues that the NHI was formulated without conducting a proper institutional analysis (Hlophe, 2013). He further argued that the bureaucrats from the NDoH did not conduct a situational analysis of the institutional failures, and existing structural design, of the South African healthcare system. Professor Heever concluded by stating that the NDoH must consider developing a new policy document that is based on different perspectives and which would holistically address the challenges in the healthcare system (Hlophe, 2013). Heever, also pointed out that the targets proposed by the NHI were unrealistic, as the five-year timeline plan for each implementation phase was not enough to see positive results, and that the government would still require better capacity to develop effective institutions (Usher, 2015).

Joe Veriava from the Wits School of Public Health, was more concerned about the operations as opposed to the technicalities of the NHI. He stated that, "in SA, our hospitals are not coping, make no mistake about it" (Helen Suzman Foundation, 2009: 17). He emphasised that SA must implement the NHI to ensure that the healthcare system benefits all the citizens of SA. In

addition, he argued that integrating the healthcare system would promote universal healthcare as well as reaffirm SA's commitment to section 27 of the Constitution, which guarantees that every citizen must have equal access to health care. He also pointed out that funding, and economic constraints, prevented the government from fulfilling that basic right. Therefore, he concluded by stating that the government and private sector must develop a partnership in order to ensure that citizens are offered what they were promised in a democratic state (Helen Suzman Foundation, 2009).

Professor Di McIntyre, a healthcare economist from the University of Cape Town, argued that "there are three alternative sources from which finances to fund Universal Coverage in health can be mobilised, these are voluntary prepayments; mandatory prepayments or out-of-pocket payments" (NDoH, 2011: 42). Furthermore, she pointed out that the existing healthcare system in South Africa is expensive, given the fact that people still make prepayments and out-of-pocket payments to obtain healthcare services. She concluded by stating that SA must limit this and move towards UHC for all.

The media

Another significant stakeholder that was vocal about the NHI was the media. For example, in article published on the 18 June 2018 by The Star titled 'Knives of out for Motsoaledi', Sifile and Mashaba provided that there is a pressure group, that fiercely called for the dismissal of Mostoaledi as the Minister of Health. The article reflects that this pressure group was made up of different medical practitioners who were disapproving of the NHI policy, and that they were requesting the Government to review the new NHI system. Sifile and Mashaba (2018), state that the pressure group criticised public healthcare management and the NHI presentation made to the Cabinet by Dr. Motsoaledi. Amilcar Juggernath, a member of the pressure group said that 'they are a collective that will take a stand in the quest for better healthcare '(Sifile & Mashaba, 2018). Furthermore, the pressure group stated that the NHI policy was "unresearched and did not address the real challenges of the healthcare system and that the NHI lacked transparency and that it was not even supported by the National Treasury because the costs of implementing the NHI were too great" (Sifile & Mashaba, 2018).

4.4 THE NHI AND THE LINEAR MODEL

The NHI is a key example of how the linear model can explain policy formulation. According to Gqirana (2015: 1), in 2007, the then ANC leadership suggested that the government should undertake a continuum of steps, including formulating new healthcare policies, so as to resolve the rising medical costs in the private healthcare sector, as well as the multiple challenges facing the public healthcare sector. Therefore, the NHI emerged in SA following the ANC's realisation that the healthcare system was facing challenges, and that the two-tier healthcare system divided people based on their economic status. In the policy formulation of the NHI, the ANC used the traditional approach of handpicking certain bureaucrats to decide on policies.

Upon a close retrospective analysis of the NHI's formulation, the linear model was identified as the best one suited to provide an account for the way in which the NHI was formulated. The literature on policy formulation explores the complex relationship between policy formulation, the government, and different types of stakeholders in society. First, the policy formulation surrounding the NHI, highlights the role played by the ANC, as a political party. The ANC has great influence in policy formulation in SA and it also determines the type of policy that must be adopted. Following the ANC's 52nd national elective conference held in Polokwane, in 2007 the NHI was adopted because ANC leaders believed that SA's two-tier healthcare system contributed to the prevailing healthcare challenges, and that in many ways this was orchestrated and perpetrated by the legacy of apartheid, as well as healthcare policies that failed to reform the healthcare system after 1994. Members of the tripartite alliance (SANCO, SACP & COSATU) at the ANC conference, confirmed the growing concern that the two-tier healthcare system was chaotic, and that government must implement section 27(1) of the Constitution to meet its obligation of ensuring that all citizens have access to quality healthcare services.

The issue with the formulation of the NHI however is that it lacked the participation of different types of stakeholders because they were not affiliated with the ruling party. This means that policy decision making is reserved for cadres of the ANC who advance specific interests and needs. Furthermore, because the ANC is the dominant political party with an overwhelming majority, what the ANC decides in its gatherings later translates into government policies. This suggests that policy making is an activity of political elites from the ANC, and that the NHI policy formulation process was a closed-door process. It was coordinated by the ANC's top leaders, and a group of handpicked individuals, who were entrusted by the then Minister of

Health and the President. This further shows that the policy formulation process of the NHI was conservative and restricted, with no stakeholder involvement. This is consistent with the linear model of policy formulation which suggests that political elites engage in top-down decision making, which is exclusionary, and only involves a select number of bureaucrats.

A few days after the 2007 conference was concluded, the ANC published its Resolutions and conference report whereby the NHI was introduced. The report of the ANC conference witnessed the introduction of Resolutions 53, 54, 55, 57, and 67 which spoke of creating a unified healthcare system and the NHI. Resolution 53 especially expressed that, "the ANC will reaffirm the implementation of the NHI by strengthening the public healthcare system and ensuring the adequate provision of funding'' (ANC, 2007). ANC conference Resolution 54 expressed that the ANC would push for the implementation of the NHI. The report did not provide much more detail and depth. The report was essentially a summary of what was discussed by the leadership and membership of the ANC. However, this Resolution also had political implications since it created the expectation that the role of the incoming government, after the general elections of 2009, would be to commence with the implementation of the NHI. On 11 May 2009, President Jacob Zuma appointed Dr. Aaron Mostoaledi as the Health Minister. A month after the release of the ANC's NHI proposal document, the Minister of Health, Dr. Motsoaledi, was mandated by President Zuma to appoint a team and committee that would evaluate the healthcare situation and formulate the NHI Green paper.

Dr. Aaron Mostoaledi subsequently established an NHI technical team within the NDoH, which would guide the implementation phase of the NHI. This team was made up of 27 members of the ministerial advisory committee, and it was established according to the National Health Act 61 of 2003. The individuals that were selected by the Minister included academics from some South African universities, public servants who lead the Department of Health in different provinces, and policy makers from the NDoH who are experts in the field of healthcare policy (NDoH, 2009).In the early stage of formulating the NHI, stakeholder engagement was limited. This implies that different types of stakeholders did not participate in the policy formulation phase. This became a form of exclusionary policy making because other stakeholders could not exercise their responsibilities i.e., deciding, planning, and playing a part in plans that affected their lives and interests.

As indicated earlier in this chapter, different stakeholders expressed their concerns in respect of NHI since most of them felt excluded from the policy discussion. Irrespective of these stakeholder concerns, the Ministerial Task Team for NHI, continued to prepare the 2011 Green Paper and to finalise policy recommendations. According to Hlophe (2013), stakeholders from private sector organisations, and political parties such as the DA, accused Minister Motsoaledi of handpicking people to consult on NHI. In addition, because members of the NHI Task Team continued to formulate policy documents without consulting different types of stakeholders. The Task Team members considered themselves as rationally efficient in terms of their functions when carrying out decision making, and they were confident that they could transmit policy decisions to other people.

In 2011, the Task Team on NHI, published the Green Paper on NHI, and the recommendations were accepted by the Minister of Health. Once the Green Paper was made available in the public domain, different stakeholders were able to review and comment on it. The ANC reaffirmed its support for NHI, and it advocated for the implementation of the policy as a solution to address the healthcare challenges. Furthermore, the Green Paper on NHI formulated by the Task Team, stated that the NHI would be introduced in three phases over 14 years. This is further evidence that the elites and bureaucracy were responsible for passing down decisions to other stakeholders whilst informing them of policy implementation strategies only later, as well as the scheduled timelines to meet policy outcomes (Corkery et al ,1995: 13). The NHI was thus presented to other stakeholders as a non-negotiable policy. Many stakeholders questioned this, and they emphasised that the approach adopted in the policy formulation process privileged certain interests of the ANC over other stakeholders, thus leading to an inequality in policy outcomes.

Some stakeholders from the private sector, such as Discovery Health, were not against the NHI. Rather, they argued that ‘we are supportive of structural change that assists in strengthening and improving the healthcare system for all South Africans’ (Discovery, 2018). However, this meant that stakeholders first had to accept what was being proposed by the NDoH through the Green Paper on NHI. This further indicates that the NHI was formulated using a top-down approach. There was extensive consultation within the tripartite alliance, particularly the labour union COSATU. However, the Task Team and subcommittee of the NHI, did not permit certain leaders of the tripartite alliance to read and comment on the contents to offer suggestions on how the NHI could benefit the labour force.

When finally acknowledging the importance of stakeholder consultation, the NDoH reviewed its approach in 2011, whereby the department hosted a conference on NHI, titled, 'Lessons for South Africa'. This platform served as a consultative process to refine the policy position to move towards the drafting of the White Paper on NHI. This engagement with stakeholders did shed some light on the reasons as to why the NDoH did not include all stakeholders. For example, Dr. Mabane, a representative from NDoH, was questioned as to why the Green Paper was formulated behind closed doors. She responded by saying that ''the media does not understand what a green paper is, they seem to think that a green paper must provide a comprehensive and detailed overview of policy, but this is not true''(Usher,2015). She went on to say, ''A green paper is a broad policy direction. It tells you that this is the direction the country is moving towards, so you may not find all the detail that you want. Even in the White Paper, you may not find the minutest detail, because that will come in the implementation plan'' (Usher, 2015). Whereas stakeholders welcomed this consultation conference, they argued that the NHI was not discussed openly, that and it lacked participation and consultation, and that it was not subjected to public opinion. Instead, they argued that it was formulated by ANC cadres, and the Task Team. Many stakeholders from the private sector argued that they were caught off-guard by the ANC-led government announcement of NHI (Discovery, 2018). The NHI Task Team and the NDoH continued to work towards drafting the White Paper on NHI without involving stakeholders.

Minister Mostoaledi had requested that the White Paper on NHI be completed timeously as it would help address the questions on NHI that stakeholders were asking of him (Nkosi, 2020). In particular, he believed that the White Paper would offer a way to restore the credibility and confidence of stakeholders in the NDoH. The White Paper represented a different approach from the Green Paper since it went through numerous drafting stages between 2015 and 2017. The final White Paper was in fact shaped by what stakeholders had highlighted in the consultation meeting of 2011. However, stakeholders were not contributors to the final White Paper. The final White Paper on NHI was published in 2017. The White Paper operationalised the original Green Paper document, and it conceptualised how the government would begin to implement the NHI (Nkosi, 2020). The NHI White Paper was considered by stakeholders from the private sector to be incoherent and lacking in a clear statement on how the government would unite the healthcare system. They argued that there was no clear understanding on how the government would achieve the objectives set out in the White Paper (Bezuidenhout, 2016).

After the finalisation and publication of the White Paper in 2017, the NDoH was responsible for preparing the NHI Bill. Following the ANC National Conference, held in NASREC in 2017. The ANC voted unanimously to fully implement the NHI. Further agreements between the leadership of the ANC, and government officials, led to the drafting of the NHI Bill in 2018. The latter was intended to serve as a legal policy framework enabling the government to achieve its goal of implementing the NHI. In May 2018, the Minister of Health, Dr. Motsoaledi, presented the Medical Schemes Amendment Act to Cabinet for ratification and he presented the NHI Bill to be gazetted for public comment. This is when the process of legislating NHI began. Despite criticism from other stakeholders, the National Treasury allocated R4,2 billion to ensure that the government moved towards the implementation of the NHI system (Nkosi, 2020). The decision to implement the NHI was further reinforced after Cabinet approved the Medical Schemes Amendment Bill in 2018. The current NHI Bill however follows the same path of the Green and White Papers because it too represents a top-down approach towards policy formulation because stakeholders once again were excluded from the process.

The pressure group, comprising of healthcare practitioners, and academics, said that the NHI Bill of 2018 was only presented to all stakeholders after it had been approved by Cabinet. The pressure group raised concerns about the unfolding implementation process of the NHI, and it called for the dismissal of the Minister. However, the Minister's response to this concern was more troubling, since he expressed that the people opposing the NHI, and who were calling for his dismissal, were being orchestrated by private sector elites who did not seem to take the challenges facing the healthcare system seriously (Sifile & Mashaba, 2018). The pressure group further argued that the NHI policy was unclear, that it lacked research, and that it was undertaken by the ANC, and the government, to address an immediate crisis with no future alternatives, should this initiative fail. As a result, the pressure group characterised the entire policy making process as ad hoc, with no transparency or credibility. Furthermore, it argued that the National Treasury was the most fervent supporter of the policy, whilst in fact, the public service was on the brink of collapse (Sifile & Mashaba, 2018).

The publication of the NHI Bill in 2018, amid this criticism, shows that the ANC-led government continued to apply the top-down approach to policy making by passing down policy decisions to stakeholders, only after the policy document was fully drafted and prepared for implementation. The general citizenry in SA was also only invited by the NDoH to comment on the NHI through public gatherings after the policy was formulated. This was well

highlighted by a participant in the Gauteng NHI hearings, who stated that, "government only invites us to engagements when they have already selected their policy goals" (NDoH, 2021). Overall, it is surprising that throughout all the policy cycles surrounding the NHI, the ANC, and the NDoH, barely mentioned the importance of including stakeholders before publishing these documents. In essence, the policy formulation phase of the NHI shows that a top-down decision-making approach dominated the process. The inputs from different stakeholders such as, civil society and private sector organisations was, not considered. Therefore, these stakeholders felt excluded, and correctly suggested that the NHI policy did not represent their interests.

In SA, the Minister of Health, is politically and constitutionally mandated to introduce new administrative, institutional, and policy reforms, and to ensure that the health department is capable of delivering healthcare services. On this account, one can argue that it is the Minister of Health, together with bureaucrats, who must finalise policy formulation and implementation in the healthcare system and to prevent outside interference. However, due to party loyalty, and the influence of the ANC in policy formulation, one cannot conclusively determine whether the failure to include other stakeholders was informed by the NDoH or by the ANC. It is also difficult to downplay the challenges facing government departments. The ANC's insistence on its own policy objectives, and the use of public policy for campaign purposes, often hinders collective decision making.

As a result, policy formulation, as a long-term activity, was not prioritised by the NDoH. The linear model of policy formulation suggests that information is derived by bureaucrats at very short notice, and policy decisions are taken by the latter without proper and extensive understanding of the possible consequences of their decisions. With this in mind, policies formulated through the linear model, "are often made on the basis of perception, stored conventional wisdom, and attitudes of a particular interest groups or bureaucratic interests" (Cockery et al., 1995: 13). In fact, during the whole policy formulation process, an increasing amount of power was concentrated in the hands of the Minister, and even provincial and local health department leaders became more dependent upon him. Policy issues and planning were solely the responsibility of the Minister.

The linear model approach to policy making might argue that the private sector concerns had more to do with curbing the ANC-led government's hegemony in influencing public policy

making. One might argue that the concerns raised by private sector organisations confirms the possibility that the ANC-led government was serving its own political agenda, thus being unwilling to engage with stakeholders. This implies that the top-down decision-making approach employed by the ANC-led government created policy making which did not consider the inputs of all stakeholders. The linear model of policy formulation sees people as recipients of policies that are formulated by political elites and bureaucrats (Lelokoana, 2015). In this model, stakeholders are informed about policy decisions which are essentially handed down to bureaucrats for implementation, based on the schedules and procedures set by political elites. This is consistent with a central tenet of the linear model of policy formulation which emphasises the exclusionary aspects of policy formulation, and which examines how the principal stakeholder privileges certain interests over others, thus leading to an inequality in outcomes. In the context of the NHI, the NDoH was not a neutral broker among stakeholder competing interests, but rather a principal stakeholder which promoted the implementation of the NHI to pursue specific interests.

It can be argued that the policy formulation process of the NHI in SA was conducted by bureaucrats who are part of a politicised administrative system which serves to carry out the mandate of the ANC. This further suggests that the role of bureaucrats in the NDoH is obfuscated by a partisan politics. As such, policy formulation in South Africa is formulated through the ANC hierarchy, and policy is then passed down to bureaucrats who draft policy documents and then pass them down to other stakeholders for adoption and implementation. Therefore, the activation of stakeholders, only once policy and legislative documents have been published, (with no clear consensus and agreements with these types of stakeholders), serves to undermine the NDoH's efforts to resolve the criticisms raised against it (Hlophe, 2013).

According to Southall (2013), the use of politicised bureaucrats means that political power and hegemony is sustained over time. The need for political elites to maintain hegemony is important because they obtain political gains in the form of re-election and prestige. Bureaucrats, and especially those who support political elites, are provided with financial rewards for formulating policies that suit the interests of these political elites (Southall, 2013). Drawing from the linear model of policy formulation, one can argue that in the SA context, bureaucrats excluded different stakeholders in the policy formulation phase of the NHI because bureaucrats from the NDoH had to prioritise the interests of ANC's National Executive leadership. Leaders of the ANC knew that the Minister of Health could not undertake decision-

making alone. Hence, these leaders ensured that the NDoH acted only after the Polokwane conference. This is when Resolutions bound the leaders of the ANC in government to the organisation's policy position. It was only after the ANC 2007 conference that the NDoH fulfilled its primary responsibility which was requiring bureaucrats from the NDoH to establish the policy papers on NHI.

According to Nkosi (2020), the private healthcare sector focuses mainly on profit maximisation by commodifying healthcare services. He further adds that ''the private healthcare sector wants to expand the limit, to gain control of the South African market, to become monopolists, and to squeeze as much profit as possible out of the South African healthcare economy'' (Nkosi, 2020: 128). Despite the realities around stakeholders' exclusion however, it is important to note that from the inception of democracy, the privatisation of the healthcare sector was a policy goal undertaken by the GNU. Furthermore, while the private healthcare sector has been criticised and labelled as profit driven and neoliberal by various politicians, it is against this backdrop that it was excluded from the policy activities. As shown, the relationship between the public and private sectors has always been characterised by conflict in SA. The linear model might therefore explain that excluding private sector organisations from the policy formulation phase might be a way for the ANC, and the NDoH, to neutralise opposition and to reduce resistance to policy change.

The linear model also suggests that policy formulation is a function of government officials, bureaucracies, and elite groups. This model assumes that policy formulation is conducted through various rigid steps with each step having a clear beginning and end (Linder & Peters, 1989). According to the linear model, bureaucracies and elites are rationally efficient in terms of their functions when carrying out decision making thus allowing them to transmit policy decisions to society. Despite all the criticism against the NHI by other stakeholders, the linear model points out that it is not irrational for bureaucrats to make policy decisions alone. This means that stakeholders should not be shocked when they are excluded, since the linear model says that policy formulation entails a top-down decision-making approach.

The NDoH, as a decision-making institution has the power to formulate policies independently and without succumbing to pressure from other stakeholders. According to Peters (2005:164), institutions are organisational structures that create formal, and informal rules for policy making. Institutions further set the procedures that stakeholders must conform to, and they

encourage the establishment of policies that are suited to meet the needs of the majority. Therefore, the NDoH, as a government institution, has the responsibility and authority to transform healthcare over time. Furthermore, the NDoH enjoys a degree of autonomy from different stakeholders, and in certain instances it can constrain the policy formulation process. Furthermore, the roles and functions of institutions increase over time, and the institution is expected to deliver new results (Pauw, 2021). Therefore, institutions have the right to delegate policy issues to experts to effectively resolve problems facing the state (Ngwenya, 2006). The linear model justifies that the NDoH has the constitutional, and political right to formulate health policies without including stakeholders in the policy making process. This means that the NDoH excluded stakeholders because it had the legitimate power to formulate the NHI, and to ensure that bureaucrats within the NDoH resolve challenges facing the healthcare system.

The linear model provides that there is a hierarchy, and that decisions are adopted through a top-down approach. In the context of SA, decision-making is made through the top-down approach because at the top of the hierarchy, there is the NDoH, followed by nine provincial departments of health and, at the bottom, there are local and district structures (Pauw, 2021: 6). The NDoH has the responsibility of formulating policies, allocating funds, and resources. The provincial departments are responsible for oversight of each of the nine provinces, whilst the local and district levels are responsible for managing health facilities in their respective communities (Pauw, 2021:6). This means that the NDoH, as an institution, is made up of bureaucrats that have expert knowledge, and that they exercise power that is socially accepted. This means that the NHI was formulated in a manner which reflects the hierarchy and the roles of the national, provincial, and local authorities of health in SA.

According to the linear model therefore, the NHI was formulated based on the top-down approach because all three structures of the Department of Health have the responsibility to promote the legitimacy of the institution by formulating and implementing a policy that aligns with the needs of the majority. The linear model essentially explains that stakeholders must not be shocked when they are excluded from the policy formulation phase because the bureaucrats have the primary responsibility to formulate policies, pass down decisions, and to consult with stakeholders only when it is necessary to do.

This means that the political elites, and the bureaucracy that were involved in the policy formulation phase of the NHI have legitimate power, and the responsibility to pass down decisions to other stakeholders, whilst informing them of policy implementation strategies, as well as the scheduled timelines to meet policy outcomes. Consistent with the linear model, one might suggest that the NHI exemplifies how institutions privilege certain interests over others, and the NDoH was not a neutral broker, but rather as an institution promoting institutional policy goals. In this sense, it is unrealistic for stakeholders to assume that bureaucrats always have the time, resources, and information to make comprehensive assessments about the costs and benefits of different policy alternatives which may be presented by other stakeholders.

The linear model suggests that bureaucrats are professional experts who have the ability to identify problems, and to formulate new policies within a pre-existing set of ideas and existing proposals. The linear model might suggest that bureaucrats from the NDoH reached the decision to formulate the NHI because often decision makers must make policy pronouncements immediately in response to emerging challenges. In addition, the linear model would suggest that the ANC applied strong pressure on the NDoH to adopt the NHI, and therefore bureaucrats did not have enough room to consider other policy options. This confirms that there are times when political leaders have a substantial amount of leverage over the policy making process, and that they can ensure that their own policy preferences are considered for implementation.

The linear model might also provide that governments, and politicians are under pressure from international organisations to deliver on policy initiatives, and to meet international targets, to obtain funding, and to meet the conditions for attaining loans. In this sense, the NDoH is accountable, not only to domestic stakeholders, but to the international community as a whole. The logic of the linear model is that stakeholders pursue certain policy initiatives because they are perceived as beneficial and right, as opposed to stakeholders being invited to calculate consequences and expected utilities. Therefore, perhaps excluding other stakeholders from the policy making processes of the NHI, was a way to reduce the costs associated with consultation, and to prevent stakeholders from maximising their preferences whilst, reducing the alternatives on the agenda. In summary therefore, the ability for political elites, and bureaucrats to prescribe rules to stakeholders perhaps was necessary. This is because the NDoH is a formal institution, which is mandated by the electorate, and which has the power to implement legislative, and other measures, directed towards realising socio-economic rights.

4.5 CONCLUSION

The purpose of this chapter was to retrospectively analyse the formulation phase of the NHI process. The chapter demonstrated that the NHI was formulated based on what the ANC political leaders, and bureaucrats from the NDoH conceptualised, as the challenges facing the healthcare system in SA. The linear model of policy formulation helped to show why the policy formulation process of the NHI potentially excluded different stakeholders from the initial discussions of what bureaucrats and leaders of the ANC thought was the problem. This chapter showed how various policy proposals and alternatives related to addressing the challenges facing the healthcare system in SA were passed down to the different stakeholders without consultation. This leads to the conclusion that the ANC, and bureaucrats, developed the NHI policy through a top-down approach. The chapter also showed that the NDoH, as a formal institution, and authority that is responsible for policy making, and the implementer of healthcare policies in SA, was influential in the policy formulation stage of the NHI.

The chapter also demonstrated that despite resistance and objections from various stakeholders within the healthcare system, the government continued to formulate more policy documents on the NHI, whilst pushing for its implementation. This suggests that the NHI policy will be implemented because it has political buy-in and support from bureaucrats. This chapter showed, consistent with the linear model, that the mandate of policy formulation remains in the hand of the ANC, and the NDoH. Therefore, it was rational for the ANC, and the NDoH, to coordinate the policy formulation process of the NHI, and to handpick individuals who were entrusted by the government to draft the Green and White Papers. In addition, this chapter presented that the bureaucrats who were tasked with the role of formulating the NHI were experts in the field of healthcare policy making. Thus, the NHI was formulated by a group of individuals who additionally had the legitimate power and authority to select who must be included or excluded in the policy making process.

CHAPTER FIVE

ANALYSING THE ORIGINS OF THE NHI THROUGH HISTORICAL INSTITUTIONALISM

5.1 INTRODUCTION

This chapter analyses the previous healthcare policies that were adopted in post-apartheid South Africa, leading to the formulation of the NHI. It analyses the circumstances under which these policies originated, and the environment under which these policies were formulated. First, this chapter analyses the RDP, and the ANC's National Health Plan, which were the first policies to be adopted in post-apartheid South Africa in 1994. It is important to analyse these policies closely to trace path dependence and to see how this affects the proposed NHI policy. This chapter will provide a discussion on the type of policy change which was achieved by the democratic government in SA. Second, this chapter will closely analyse the WPTHS, which was the second health policy adopted by the post-apartheid government in 1997. This policy was intended to replace the ANC's National Health Plan. Thus, it is the first example of policy change which differed slightly from that of the ANC's National Health Plan. This will help determine the type of policy change that was brought about by the WPTHS. Furthermore, this chapter analyses the National Health Act 61 of 2003, which was introduced to accelerate transformation, and to unite the private and public healthcare sectors.

This chapter will ultimately show how historical institutionalism is a useful approach for understanding the challenges that face the implementation phase of the NHI today. Historical institutionalism helps policy analysts to understand how societal issues become policy problems in the first place, and how solutions are arrived at by stakeholders, as well as by institutions. This chapter thus argues that the NHI is a result of incremental path dependence, and it contends that the NHI is particularly characterised by first and second order policy change. This is despite the fact that the proposed NHI seems to be presented by the government as new and innovative. This chapter ultimately considers whether this policy is new or whether it is incrementally path dependent, and thus constrained by previous policy choices.

5.2 THE INSTITUTIONAL CONTEXT AND PATHWAY

This chapter employs the historical institutionalist approach, which is nuanced in explaining path dependence, the role of actors, and of ideas in bringing about policy change. In order to understand the process whereby policies and institutions become path dependent, Schreyögg & Sydow (2011), divide the path dependence process into three phases. The first is the preformation phase. In terms of path dependence, this phase is characterised as completely new, and there is no restriction on the scope of action. This means that the first policy actor searches for alternatives from scratch, decisions are not constrained, and the final choice is explained as rational (Arthur, 1989). According to Schreyögg & Sydow (2011: 323), in the second phase of the path dependence process, a new regime takes over. By implication, the policy options decrease, and it becomes difficult for actors to return to the first stage. In this second phase of path dependence, policy decisions depend on luck, and preferences are limited. Therefore, actors do not have many options, and a particular decision that was adopted previously reproduces itself, even though new actors create new policies to reverse it.

According to Pierson (2000: 252), actors within institutions are prone to act in accordance with previously established institutional or policy paths because of the high costs associated with deviating from previously established paths. This suggests that actors tend to follow the same path and are more likely to follow previous policy directions. The third phase of path dependence is characterised by lock-in. Lock-in is characterised as a process of constriction, where new governments or organisations have to adapt to already established paths, because the costs associated with deviation are high (Thelen, 1999). This means that decisions, and established policy practices, tend to reproduce, and all new policy decisions tend to replicate the path. In addition, in this phase, the organisation begins to lose its capability to adapt to new alternatives. Hence, the organisation loses its flexibility, and it becomes confined to a path that creates ineffective solutions (Streeck & Thelen, 2005).

Drawing from the preformation phase of path dependence, one might argue that the colonial regime formulated the Public Health Act, 36 of 1919, as a new policy, and that the decision to implement this policy was not constrained by any factors. As a result, the two-tier healthcare system was established in SA, and it became embedded in the country. The Reservation of Separate Amenities Act, 43 of 1953, was implemented by the apartheid government. The latter served as a mechanism to separate black and white people. This Act was aimed at controlling

‘space’ on a racial basis by legalising the segregation of healthcare services (Du Toit, 2017). The Reservation of Separate Amenities Act,43 of 1953, deemed white people as superior, and therefore entitling them to advanced healthcare facilities which were characterised as two-tier i.e., the private and public healthcare system. As a result, the colonial regime, and the apartheid government, both implemented the two-tier healthcare system without understanding that ‘‘once a decision is made or an action taken, this choice may turn out to be a ‘small event’, which, often unintentionally, sets off a self-reinforcing process’’ (Schreyögg & Sydow, 2011: 323).

Path dependence asserts that previous policy decisions influence new policy decisions, as well as new actors. Hence, since the inception of democracy in South Africa, in 1994, the ANC was tasked with governing the state and formulating public policies that could, amongst other things, reform the healthcare system. During apartheid, SA had an inequitable, racially segregated, and fragmented healthcare system. It was made up of separate healthcare departments in each homeland, and segregation was institutionalised. This allowed Coloureds, Indians, and Whites to have their own healthcare administrators (Coovadia et al., 2009). The administrative fragmentation of the healthcare system meant that each department of health was racialised to reinforce inequalities with respect to funding and service delivery.

Furthermore, access to the public healthcare sector was poorly organised, geographically isolated, under-resourced, as well as poorly managed by its administrators (Coovadia et al., 2009). As such, health was one of those sectors whereby new policies by the democratic dispensation were prioritised. The emphasis of the new government was on the implementation of democratic laws and policies. Healthcare reform was one of the most difficult challenges facing the post-apartheid government. SA was a highly unequal society based on race and class. This extended to healthcare standards, and the allocation of resources between the private and public healthcare sectors which further entrenched this fragmentation.

The first democratic administration, under President Nelson Mandela, introduced measures to create a unified healthcare system for all. The NDoH was one of the institutions mandated to give direction, and to determine policies that would coordinate provincial and local healthcare departments. The NDoH, therefore, became a formal institution made up of bureaucracies and legislative bodies. The NDoH is responsible for health policy making and it is responsible for enforcing policies aimed at resolving challenges that face the healthcare system, and it

therefore encourages the establishment of a single healthcare system in SA. Therefore, the NDoH, as an institution, was regarded by the government as the department which would oversee matters related to development planning, and which would more specifically handle policy formulation processes, standards, and procedures so as to ensure functional healthcare service across all spheres of government. At that time, however, the NDoH was still a nascent institution that had not yet developed, nor had it institutionalised governance mechanisms. At the time, the NDoH did not satisfy the criteria of being institutionalised. It was still in the process of setting standards of behaviour against which the public and private healthcare sectors should conform. Additionally, the NDoH had not developed governance structures to address the healthcare challenges that were facing the country. Furthermore, the NDoH was still establishing new democratic laws and policies for governing the healthcare system.

Furthermore, the NDoH lacked resources in terms of qualified policy makers as well as funding. Therefore, the transition period from apartheid to democracy was critical in determining policy and institutional reform. It can be said that the transition period had ambitious goals that were unattainable, considering the economic and political conditions facing the country at the time. In essence, the transition from apartheid to democracy has been labelled as a passive revolution, as it mainly focused on bringing stability and continuity to the country after the 1994 elections (Satgar, 2008). A passive revolution is the "reinforcement or reproduction of a hegemonic project through the adoption of policies and discourses designed to forestall and at the same time adopt the demands of the marginalised, yet without bringing the marginalised groups into the historic ruling bloc, in an effort to preserve the essential aspects of social structure" (Satgar, 2008: 3).

It seems that the new government had no knowledge of the consequences that would be brought about by the negotiated settlement, which to a great extent constrained policy formulation. The negotiated settlement meant that policy formulation became dependent on the provisions of CODESA (Shivambu, 2015). The CODESA agreement itself can be labelled as path dependent, given that it paid attention to pre-existing institutional commitments. One might argue that the CODESA settlement granted the apartheid regime institutional power to coordinate and organise South Africa, and thus prevent the democratic government from immediately dissolving the two-tier healthcare system. The failure to secure economic power placed constraints on the new government, and largely hindered it from reforming institutions. According to Shivambu (2015), the failure to obtain economic power ensured that power was

shared among elites. This was aimed at ensuring that elites protected their private property, and advanced capital accumulation (Shivambu, 2015). This resulted in a situation whereby economic power, and ownership of state resources, were concentrated in a few hands, and control by certain individuals, who were only interested in protecting their elite status, and interests.

The political negotiations were a balancing act, and the concessions agreed upon by political leaders at the time created a country that continued to be shaped by the legacy of apartheid (Butler, 2004). The negotiated settlement, therefore, triumphed in determining the country's policy making, whilst safeguarding elite interests that reigned supreme over society's socio-economic needs (Shivambu, 2018: 94). In the context of healthcare, this means that the post-apartheid elites continued to benefit from the existing nature of the country's healthcare system. Historical institutionalism might argue that the CODESA privileged certain interests over others, thus leading to inequality of outcomes. In this sense, the NDoH is a product of the negotiated settlement which adopted the function of reforming the healthcare system, whilst at the same time, the transition period ,1990 to 1994 laid the foundation for continuity of the two-tier healthcare system.

Therefore, one could argue that the NDoH kept the two-tier healthcare system because it was deeply entrenched in the decisions made by the apartheid government. The democratic government had to adapt to the idea of having two separate healthcare sectors because it was difficult to reverse the choices adopted by the apartheid government. This means that prior historical decisions, policy choices, and institutional factors in the country have become difficult to reverse. The healthcare policies formulated post-1994, were not readily implementable, as the economic, and social, as well as the political conditions of the state were not stable. The government in 1994, lacked the required administrative capacity to implement socio-economic policies, and the new actors within the NDoH, that were responsible for the implementation of healthcare policies, were inefficient, and they did not have the experience to build effective healthcare facilities. In the SA context, this meant that policy change would initially occur as a result of minor incremental adjustments, and policy alternatives, which were based on political concessions (Shangase, 2018). Thus, one can argue that policies were set up for failure. As a result, SA continues to oscillate between allegations of the ANC government failing to bring policy change, and of only introducing new policies when existing policies fail (Shangase, 2018).

5.3 THE ANC's NATIONAL HEALTH PLAN AND RDP 1994

One of the first healthcare policies that presented an opportunity for the NDoH to demonstrate its ability to change the healthcare system, was the ANC's National Health Plan of 1994. It was at this time that the SA government had called for the implementation of a unified healthcare system. This was guided by PHC which was aimed at ensuring that all citizens had access to quality healthcare services. It was expected that the NDoH would rise to the challenge, especially in respect of section 27(1) of the South African Constitution's Bill of Rights (1996). It was through the ANC's National Health Plan that the government recognised the importance of developing a single comprehensive, tax funded, healthcare system organised at provincial and district levels (ANC, 1994).

The ANC's National Health Plan proposed free Primary Health Care (PHC) and services for all who utilised public healthcare services. In addition, through the ANC's National Health Plan and RDP, there was to be greater access to public healthcare facilities. As such, between 1994 and 1998, the democratic government established 500 new clinics which catered for over five million citizens (Lodge, 2002). However, the use of the public healthcare facilities came with greater challenges, such as the shortage of medical supplies, overcrowding, and the abuse of minimal healthcare resources. As a result, the public healthcare sector could not address the demands of citizens (Van Rensburg, 2012: 128). Despite the challenges facing the public healthcare sector, the government supported the commercialisation of health by reducing spending on the public healthcare system, and by deregulating the private healthcare sector, so as to ensure that private hospitals were developed, and that medical aid schemes were able to provide those who could afford to pay medical aid fees with funds. Thus, the SA government was supporting the commercialisation of health by reducing spending on public health.

Path dependency suggests that continuity leads to ineffective consequences (Hall, 1993). Rather than the NDoH removing the two-tier healthcare system in SA, the NDoH supported the commercialisation of health and the reduction of spending on public health. Pierson (2004) emphasises that institutions and public policies become more difficult to change the longer they proceed in the same direction. As more people benefit and invest in the status quo, it becomes more difficult and costlier to change the policy direction. In this regard, the NDoH supported the private healthcare sector, and by cutting public healthcare expenditure, it promoted the two-

tier healthcare system, thus helping the private healthcare system to grow thus increasing the latter's ability to function in the long term.

One might suggest that the post-apartheid government increased the costs of deviating from the two-tier healthcare system, by supporting the commercialisation of healthcare. A historical institutionalist approach might suggest that the NDoH pursued individual gains by maintaining the two-tier healthcare system, and that the actors from the NDoH are now trapped in a lock-in situation were decisions that were made in the past influence the current healthcare reform process. In this sense, the ability of the NDoH to affect policy change is restricted by past activities, and institutional reform is hampered by the NDoH's inability to unite the private and public healthcare sectors.

The ANC's National Health Plan (as an extension of the RDP) was also confronted by additional challenges. The SA government lacked the administrative capacity to fully implement the RDP, as well as the ANC's National Health Plan. This is because state administrators, who had the responsibility for implementing policies, lacked the necessary skills and experience required to implement public policies. The failure of administrators resulted in service delivery backlogs and the lack of provision of healthcare services to communities (Blumenfeld, 1996). The government had set up the RDP office in the office of the President which was headed by Minister Jay Naidoo. This led to confusion. Government officials were not sure if this was a Ministry, or a mini department, which had authority over other government departments. This is because the RDP did not fully address the institutional design, functions, or authority of other institutions (Hirsch, 2005).

The ANC's National Health Plan, and the RDP, served as the new policies aimed to reform the healthcare system. These two policies led to a degree of strengthening of the healthcare system, and thus making the need to reform the NDoH more important. Thus, the first reformative path in 1994 was the formulation, and implementation, of the ANC's National Health Plan, and the concept of universal healthcare access for all, as well as the creation of healthcare benefits. Path dependence however can be identified in the formulation and implementation of the ANC's National Health Plan. In 1997, the SA healthcare system was characterised by a continuation of the two-tier healthcare system, which was implemented through the Public Health Act, 36 of 1919, and the Reservation of Separate Amenities Act,43 of 1953.

However, there was a degree of incremental restructuring of the two-tier healthcare system at all levels (especially in the public healthcare sector). For example, there was greater access to public healthcare facilities (Lodge, 2002). However, overall, the healthcare system remained characterised by apartheid access, and affordability patterns that divided the system into two. Path dependence suggests that previous policy outcomes are reinforced, even when reform policies, in general, are determined to establish new institutions, ‘‘while they rarely give attention to the deinstitutionalisation of old institutions so that they are not replaced but rather complemented by new ones” (Streeck & Thelen, 2005).In this regard, both the RDP, and the ANC’s National Health Plan, served as reform policies, but they did not deinstitutionalise the two-tier healthcare system. According to Streeck & Thelen (2005), institutions and policies tend to persist not only because they perform certain functions, but because they also serve certain interests. In this regard, the ability of the NDoH to effect change in the two-tier healthcare system through the National Health Plan, and RDP was restricted to decisions that were adopted during the transition period, and in the CODESA negotiations between 1990-1994.

In the context of RDP, the different Ministries and government departments faced difficulties in achieving policy objectives because policy makers had little knowledge on governing the state at the time (Shangase, 2018). This led to poor economic performance, and the government began to cut expenditure on critical sectors such as healthcare, and education (Hirsch, 2005). In 1996, the government accepted its failures and realised that it lacked the necessary capacity to implement the RDP. However, this also meant that the other objectives of the ANC’s Health Plan were impossible to implement, given that the RDP (as the umbrella policy), had failed. This meant that the ANC’s National Health Plan of 1994 had to be discarded. Subsequently, both policies were discarded, and new policies were formulated. Path dependent policy making is not open to many interpretations. This means that the two-tier healthcare system that was introduced by the colonial regime and, maintained by the apartheid government, became difficult to dislodge. In addition, both the Public Health Act, 36 of 1919, and the Reservation of Separate Amenities Act, 43 of 1953, are still shaping the healthcare system given the fact that the two-tier healthcare system persists in SA. Under these circumstances, the ANC’s National Health Plan could not reform the two-tier healthcare system to create a single healthcare system.

Significantly, when the ANC's National Health Plan, and RDP, were introduced in 1994, these policies were regarded by the government as the ones that would achieve equal healthcare rights for all; ensure universal access to healthcare, and overhaul the two-tier healthcare system (Coovadia et al., 2009). There was however a recognition that reforming the healthcare system was also linked to economic development. In this regard, SA adopted neoliberal economic policies, as the country also had to reintegrate itself into the global economy. In this regard, the NDoH prioritised privatisation, profit maximisation, and commercialisation, over the provision of public goods (Habib, 2004). In this sense, the SA government acknowledged that the two-tier healthcare system was being reinforced, and that healthcare was a commodity. This meant that the SA government valued the private healthcare sector over the public healthcare sector. (Taylor, 2001). This means that at this point, policy change in SA was significantly influenced by the ideas that were available to policy makers, with the latter adopting policy alternatives that were consistent with a neoliberal ideology.

Whilst the ideas of privatisation, marketisation, and the commercialisation of health might have tacitly served to legitimise the private healthcare system, they certainly did not satisfy the ideas of the RDP and ANC's National Healthcare Plan. One might only suggest that the benefits to be derived from maintaining the two-tier healthcare system exceeded the costs of creating an alternate single healthcare system (Pierson, 2000). This means that policy options became narrowed to the idea of privatisation, commercialisation, and the marketisation of healthcare, to the extent that policy makers did not seem to have to have a choice but to implement policies that would achieve incremental change. This means that policy change and institutional reform occurs at a slow pace, and change is established through combining old, and new policies (Parker & Parenta, 2008). Incremental change therefore also makes policy change path dependent, since this type of change does not tamper with earlier policy decisions. One might suggest that policy makers did not overhaul the two-tier healthcare system through the RDP or the ANC's National Health Plan. This is consistent with path dependent contexts, whereby it is difficult to bring about full transformation (Hall, 1993).

5.4 ANALYSIS OF GEAR 1996, WPTHS 1997, AND NATIONAL HEALTH ACT 61 OF 2003

GEAR was subsequently formulated by the ANC government, after it was recognised that reforming the healthcare system was linked to economic development. GEAR was the macro-economic policy that was introduced in 1996 by the Department of Finance. GEAR was introduced at a time when the country's currency was depreciating, foreign exchange was low, and poor economic growth made it impossible to meet social investment demands. Whereas GEAR was built on the goals outlined by the RDP, according to Heintz (2003), GEAR was also aimed at restoring the confidence and credibility of the SA economy, improving economic growth, and ensuring that the government focused on socio-economic targets. However, according to Nkosi (2020: 101) GEAR, as a neoliberal economic policy, negatively affected the public healthcare sector, as the government had to cut funding. GEAR prioritised private healthcare, and the government of the time removed the ideals of developing universal healthcare coverage. This meant that GEAR further entrenched the two-tier healthcare system. GEAR proposed a set of policies towards the rapid liberalisation of the economy through the relaxation of exchange rate controls, trade liberalisation, regulation, deficit reduction, and strict monetary, and fiscal policies to stabilise the rand, as well as the country's economy (Heintz, 2003).

As such, GEAR did not replace the RDP. Rather, GEAR represents a form of first order policy change whereby the principal policy goals, and policy instruments, remain unchanged, whilst a new policy was adjusted to suit the needs of the prevailing circumstances (Heintz, 2003). According to Naidoo (2005), however, GEAR failed to ensure that basic service needs were met, and the policy significantly reduced access for people to healthcare. Dr. Floyd, a health economist from the University of Cape Town's Health Economics Unit argues that, GEAR caused more damage than reparation for the health sector. When asked about the failure of the health sector, she said, ''As far as I'm concerned, the damage was done during the period of GEAR when the real per capita spending in the public health sector declined, and I mean we lost a decade. So, in 2005 I think we had got back to the level of real per capita expenditure that we were at in 1996. So, the GEAR policy had a massive impact. I mean the government had to restrict its expenditure etc. and the social sectors got hit, especially the health sector'' (Usher, 2015: 58).

Furthermore, GEAR's neoliberal approach led to a tight fiscal budget which meant that the equity goals of the RDP and National Health Plan failed. Van Rensburg (2012: 13), points out that this led to a step-back in the health reform agenda, and the development of the public healthcare sector. GEAR prioritised the privatisation of the healthcare system, as opposed to overhauling and creating a single healthcare system. This means that GEAR did not commit to transforming the country's healthcare system, or to ensuring that the government became the central coordinator of healthcare service delivery as provided for by the RDP, and the ANC's National Health Plan. As a result, there was further unequal resource distribution in the two-tiered healthcare system. The cost of implementing free healthcare for all did not align with the neo-liberal standards of GEAR. This meant that the private sector was receiving more finance from the state, and thus more resources within the two-tier healthcare system (Van Rensburg , 2012).

It is thus safe to say that GEAR did not introduce any radical policy change in the healthcare system. According to Peters (2019: 92), radical policy change occurs when the fundamental ideas, and the meaning of the institution, are entirely changed by political actors. In the SA context, one might argue that GEAR could not change the idea of the two-tier healthcare system, or the NDoH's ability to overhaul it. According to Thelen (2000: 259), political actors tend to adapt and to follow a predetermined path. Thelen also emphasises that the process of ''positive feedback mechanisms, as a reason of why the power privileges of certain groups reinforce within institutions and also the other way around, why other groups continue to be marginalised'' (Thelen,1999: 394). According to Heintz (2003), GEAR did not practically address the relationship between the private and public healthcare sectors. In this regard, it is safe to say that GEAR privileged the interests of the private healthcare sector, whilst the public healthcare sector continued to be marginalised, because the NDoH adapted to and followed the path of a two-tier healthcare system.

It was within this context that the NDoH formulated the White Paper for the Transformation of the Healthcare System of 1997 (WPTHS). The WPTHS was built on the goals outlined by the ANC's National Health Plan. The WPTHS emphasised the importance of unifying the healthcare system, fast-tracking primary health care (PHC), and moving SA towards Universal Healthcare Coverage (UHC). Furthermore, it provided a set of strategies that were aimed at ensuring that all SA citizens acquired quality healthcare services. However, the WPTHS was also merely characterised by minor adjustments, and it was layered with previous commitments

which were outlined in the ANC's National Health Plan. The goals that were outlined in both the ANC's National Health Plan and the WPTHS, included that the government will distribute healthcare resources, and it will establish healthcare financing policies to promote equality between the groups in different geographical settings. In addition, both these policies articulated the possibility that a health insurance approach would be investigated to complement these healthcare objectives. In addition, these two policies also emphasised that SA required a unified national health system to transform the two-tier healthcare system (ANC National Health Plan, 1994; NDoH White Paper, 1997).

Here again, path dependency is notable, because the NDoH, as an institution, introduced a new policy intervention that was layered with previous commitments. This is even though the WPTHS was presented as a revised policy of the ANC's National Health Plan. Whereas the ANC's National Health Plan was presented as being new, the WPTHS represents incremental policy change because it merely improved on previous ideas set out by the ANC's National Health Plan. As a result, the WPTHS yielded first order policy change, whereby the ANC- led government and the NDoH, had made small changes to the new policy. Therefore, bureaucrats within the NDoH attempted to fit the WPTHS policy into a previous policy path. At this stage, radical change is unlikely to happen. This is because the cost of breaking the two-tier healthcare system had increased over time, which has made it more difficult for the NDoH to bring about change.

The ANC's National Health Plan, and the WPTHS, represented continuity as opposed to policy change, because the two-tier healthcare system was deeply entrenched in SA and it was difficult to alter this path because the political leaders had institutionalised the two-tier healthcare system through the ANC's National Health Plan, the RDP, and GEAR. As a result, policy making became incremental, cautious, and routinised so that third order policy change could not be triggered. Rather, there was only first order policy change because the WPTHS had successfully converted the ANC's National Health Plan into a formal policy. The policy goals of unifying the healthcare system, fast-tracking primary health care (PHC), and moving SA towards Universal Healthcare Coverage (UHC) which remained consistent. According to Hall (1993: 280), first and second order policy change is incremental, and policy makers only make small changes to policies. First and second order policy changes are incrementally path dependent, whereas radical change, fundamentally changes the institutions, and a paradigm shift occurs (Hall, 1993: 280). First and second order policy change arises when existing older,

and new policy alternatives, are layered over with previous policy choices. In this regard, the ideas of unifying the healthcare system, fast-tracking primary health care (PHC), and moving SA towards Universal Healthcare Coverage (UHC) enabled policy continuity. In order for major policy change to be introduced, policy makers need to wait for a critical juncture, or a conjuncture, to introduce new policy initiatives (Wilsford, 1994). For example, Wilsford applies the notion of ‘‘exogenous shocks such as a war or international economic crisis that serves as a critical juncture that sets a country onto a new path’’ (Wilsford, 1994).

According to Van Rensburg (2012: 132), the WPTHS effectively converted the ANC’s National Health Plan into a formal policy which led to the National Health Bill. This in turn led to the National Health Act 61 of 2003. This new Act set out to, “regulate national health and to provide uniformity in respect of health services” (Van Rensburg, 2012: 135) through the establishment of a National Health System, encompassing both public and private health care services, which would provide people with affordable, quality health services. Furthermore, the Act outlined the duties of health providers, health workers, health institutions, and the beneficiaries of health. Perplexingly however, these policies preserved the two-tier healthcare system. The traditional analysis of historical institutionalism provides that many policy and institutional arrangements are path dependent, and they are sustained to limit change (Thelen & Streeck, 2005). This was also evident in the National Health Act 61 of 2003, where the NDoH adopted the key proposals from the ANC’s National Health Plan, and the WPTHS. In this regard, historical institutionalism might suggest that the proposals from the ANC’s National Health Plan and the WPTHS were formalised and could not be changed arbitrarily. Because the costs of exiting from certain policy initiatives increases over time, the NDoH preferred to persist with the existing policy objectives (Pierson, 2000).

The amendments that led to the National Health Act 61 of 2003, are similar to the ANC’s National Health Plan, and the WPTHS. Pursuant to the goals of the former and the latter, the NDoH, through the National Health Act 61, introduced the importance of cooperative governance and management, to establish uniform procedures of quality healthcare delivery. To reach these amended goals, the NDoH advocated for healthcare stakeholders to assume joint responsibility. This would entail cooperation between public and private healthcare professionals, and this would mean creating space on the budget to spend on healthcare. For the government to be able to create space for healthcare, the Minister of Health had to prioritise, and determine, who was eligible for access to primary healthcare services. Therefore, the

NDoH adopted the National Health Act 61 of 2003 as a new healthcare legislative document following the challenges faced by its predecessors. Thus, combining the objectives from the previous policies, and introducing amendments to a new policy, serve as what Hall (1993) identifies as the concept of layering, and first order policy change.

The above refers to a policy scenario whereby the broader goals and instruments do not change, but the policy goals are adjusted (Hall, 1993). The National Health Act 61 of 2003, did not fundamentally depart from the policy goals of the ANC's National Health Plan, the RDP, or the WPTHS. The National Health Act aimed to establish a National Health System encompassing both public and private health care services which would provide people with affordable, quality health services (Coovadia et al, 2009). Furthermore, the Act outlined the duties of health providers, health workers, health institutions, and the beneficiaries of health. However, the National Health Act did not have the ambition of dismantling the two-tier healthcare system, and therefore did not provide the NDoH with further competence to unite the public and private healthcare sectors. Rather, it was focused on providing the private and public healthcare sectors with guidelines by which both sectors should act in (Ngwenya, 2006).

With the National Health Act 61 of 2003, the ''new'' main policy goal was to regulate national health, and to provide uniformity in respect of health services. This means that the changes which were made were adjustments, as opposed to replacements of previous policy objectives. There was no creation of a new policy instrument, which would signal third order policy change. Therefore, one can argue that the decision to formulate the National Health Act 61, was a result of previous policy experiences, which could not achieve their intended outcomes. Furthermore, the National Health Act was implemented to ensure that the outcomes of previous policies were incrementally achieved. As a result, ''the policies, laws, and structures that perpetuated unequal access to healthcare services, as part of maintaining separate amenities, homelands, and tri-cameral policies were dismantled in favour of a unified, but decentralised, system with one national department and nine provincial departments'' (Ngwenya 2006: 81).

On the one hand, one could argue that the idea to regulate national health, and to provide uniformity in respect of health services, indicates second order policy change. Furthermore, the removal of fourteen departments of health indicated some reform, and the National Health Act did provide some changes in the two-tier healthcare system. However, the National Health Act also remained characterised by limitations, and opportunities for overhauling the two-tier

healthcare system because it followed first and second order policy change. It is reasonable to argue that the National Health Act therefore produced incremental, as opposed to third order, policy change.

This shows that the policy areas of the NDoH have achieved small incremental changes over the years. Changes to certain apartheid policies and legislation have affected change so that people can now access certain healthcare facilities in the public healthcare sector. However, the policy changes that have been made by the NDoH have not reformed the entire healthcare system. The overall objective, and the idea of Universal Healthcare Coverage for all, as well as unifying the private and public healthcare sectors, which was clearly outlined in the ANC's National Health Plan, WPTHS, and the National Health Act 61, has not been achieved by these policies. Rather than creating a single healthcare system, both the private and public healthcare sectors emerged. The idea of the two-tier healthcare system demonstrates that ideas tend to become locked-in within an institution when it is being created, and due to reinforcing mechanisms, changes to the policies and institutions become difficult.

The healthcare reform agenda in SA corresponds with Hall's (1993) idea of first and second order policy change. This complicates the implementation of future policy, as there is little evidence that existing policies or ideas have changed. This implies that the policy formulation process in SA is path dependent and impedes unifying the healthcare system. This means that the ideas embedded in the ANC's National Health Plan, RDP, and GEAR, the WPTHS, as well as the National Health Act 61 of 2003, resemble path dependence as they reproduce the same outcomes, and reinforce the existing status quo, thus making change less likely. In order words, the persistence of the two-tier healthcare system continues, and renders the whole process of policy change more difficult.

Overall, the policy change that has been experienced over the years represents incrementalism on the part of policy makers and the NDoH. The latter's efforts to implement policies to address the ongoing healthcare challenges have been drawn from previous policies. The introduction of the WPTHS, and the National Health Act 61, served as a form of incremental change because policy layering in both policies chose not to tamper with the prevailing status quo in the healthcare system. This represents second order policy change, which relates to the alteration of policy goals without radically changing the policy (Hall, 1993). The healthcare policies formulated in SA between 1997, and 2003, were aimed at overhauling the two-tier healthcare

system. However, they were implemented in a way that so as not to alienate the private healthcare sector, but rather to maintain the two-tier healthcare system.

The introduction of the WPTHS, and the National Health Act 61 of 2003, in many ways represent policies that have been aligned with the goals of both the RDP, and ANC's National Health Plan. The WPTHS, and National Health Act 61 of 2003, were not necessarily new since they maintained the objective of addressing the healthcare inequalities institutionalised by the apartheid government. Furthermore, the processes of policy change in SA are constrained by the provisions which originated from the negotiated settlement, and the transition period. This suggests that the SA government has been compelled to formulate new policies based on previous commitments to avoid removing the prevailing status quo. Therefore, any fundamental change will come ''from small incremental adjustments, and policy outcomes which tend to be concessions, and incoherent'' (Shangase, 2018: 222).

The formulation of the RDP, and ANC's National Health Plan, as well as the ideas surrounding the WPTHS, and the National Health Act 61 of 2003, are policies and interventions which have become deeply entrenched within an institutional and policy environment that has not challenged previous paths, and ideas. Therefore, they have buttressed incremental change, whereby new policy ideas are layered over with previous commitments (Parker & Parenta, 2008: 610). Therefore, these ideas have become enduring, and difficult to replace as the development of new ideas takes a period of time. One might argue that the colonial regime formulated the Public Health Act, 36 of 1919 as a new policy, and the decision to implement this policy was not constrained by any factors (Schreyögg & Sydow, 2011). As a result, the two-tier healthcare system was established in SA, and it became embedded in the country. Whilst the apartheid government maintained the two-tier healthcare system through the Reservation of Separate Amenities Act, 43 of 1953. In addition, when the democratic government took over there was already a two-tier healthcare path established by the colonial regime which was maintained by the apartheid government. In SA, the concept of path dependence reveals that decisions that were taken by the colonial regime, and the apartheid government may, have had unintended, and irrational consequences given the fact that the two-tier healthcare system persists in the democratic dispensation (Thelen, 1999).

This implies that the democratic government in 1994 merely adopted the established two-tier healthcare system. In the democratic dispensation, new policies, such as the ANC's National

Health Plan, the RDP, GEAR, and the WPTHS, as well as the National Health Act 61 of 2003, were all formulated and implemented. However, all these policies have reproduced the same outcome, and they have not overhauled the two-tier healthcare system. Consequently, all of these healthcare policies, which have been implemented by the democratic government, incorporate and maintain the two-tier healthcare system that is in conflict with the original objective of removing it. As a result, historical institutionalism provides that institutions and policies are highly formalised in terms of structures and cannot be changed easily. One might suggest that the costs of removing the two-tier healthcare system have increased over the years, and the NDoH tends to engage in incremental policy making in order to more slowly reform the healthcare system.

GEAR, and the WPTHS as well as the National Health Act 61 of 2003, ensured that there was a continuity of the two-tier healthcare system. Within GEAR, there were severe constraints with effecting third order policy change, and reforming the healthcare system proved to be limited because of fiscal challenges at time, and the SA government had prioritised privatisation of healthcare (Hirsch, 2008). Therefore, it is the contention of this study that post-apartheid healthcare policies are marked by a high degree of path dependency. This is because new policies such as the NHI, which have been formulated by the post-apartheid government, are constrained by previous policies which were implemented by the apartheid government, as well as by existing policies implemented by the post-apartheid government. Furthermore, the healthcare policies formulated and implemented by the latter were altered so as not to disrupt the prevailing status quo. This suggests that healthcare policies that were formulated by the post-apartheid government only achieved first order policy change.

5.5 NHI AND PATH DEPENDENCY

The ANC's own internal processes, such as policy conferences, are critical for enabling the bureaucracy to discuss and effect new institutional reform, as well as policy change. In December 2007, at its national elective conference in Polokwane, the ANC reaffirmed its commitment to addressing the challenges facing the SA healthcare system. This was a result of the party facing criticism from many members that social development was happening at too slow a pace in the country. As such, the ANC, at Polokwane, prioritised health and it committed to ensuring better health services, whilst reducing the inequalities perpetuated by

the two-tier healthcare system. Therefore, the NHI was considered by the ANC and the government, as a policy that would transform the two-tier healthcare system.

The move towards the NHI policy signals Hall's (1993) understanding of policy learning which asserts that policy makers believe that old policy ideas can be replaced by new ones. The NHI recognises that SA's two-tier healthcare system was fragmented prior to 1994, and that there had been a failure to reform and bring about an equitable healthcare system. The rationale for introducing the NHI was to unify the two-tier healthcare system to ensure that those with the greatest demand had access to healthcare facilities. The primary goal of reforming the healthcare system can be regarded as a form of layering in the NHI. It may be argued that the policy goal of the ANC to reform the two-tier healthcare system has not been altered. Consequently, there has been no paradigmatic shift that would constitute third order change. The goal of reforming the two-tier healthcare system has been presented through various policies such as inter alia, the ANC's National Health Plan, the RDP, the WPTHS, and the National Health Act 61 of 2003, as well as the proposed NHI.

The inclusion of the idea to unify the public and private healthcare sectors is an example of what Thelen (1999: 385), and Pierson (2000:259) describe as ideas becoming locked in an institution. The policy, therefore, develops with the previously established path, which is also why the policy objective remains within all policies. As a result, all these policies tend to produce the same outcome, which in the SA context, is incremental change. This is because the SA healthcare system is characterised by significant apartheid continuities when it comes to access, and the provision of services. Overall, policy change is always influenced by ideas that have been available for periods of time, and policy makers operate within existing frameworks. Therefore, policy makers adjust policy goals according to the ideologies that they have been exposed to the over years (Hall, 1993). In the SA context, the two-tier healthcare system has persisted for a long period of time because of the strong fragmentation between the public and private healthcare sector, as well as the constant curtailing of financial allocations (Sehring, 2009).

In the South African context, the NDoH adopted the NHI following the failure of the WPTHS to unify the healthcare system. However, policy makers did not alter the policy goals of the WPTHS. Rather they combined the policy goals of the WPTHS, with the objectives of the proposed NHI. These include: ensuring the right of access to healthcare, as stated in the

Constitution, promoting equitable care, which is affordable, and minimising administrative structures across all spheres of government, whilst ensuring that there is sufficient cross-subsidisation between the poor and rich, as well as the sick and healthy (NDoH White Paper , 2017). Policy makers tend to maintain policy goals because institutions are formalised in terms of structures and rules, and they cannot be changed arbitrarily. This means that the NDoH has kept the goals of promoting equitable care, which is affordable, and minimising administrative structures across all spheres of government, because these goals are a constitutional obligation, and they are further entrenched through the National Health Act 61 of 2003. Furthermore, policy makers understand that the costs of changing an institution, or policy increase over time (Pierson, 2000). This means that in SA policy makers prefer to maintain the two-tier healthcare system, whilst strategically moving towards long-term change through incremental action.

The NHI is continuing with the objectives of previous healthcare policies because the costs of creating a policy, which is more capable of reforming the healthcare system in SA , are too high. One might only suggest that the benefits to be accrued from creating an alternate healthcare system, with more effective healthcare service delivery, exceeds the costs of sustaining the two-tier healthcare system. Furthermore, one might argue that the costs of sustaining the two-tier healthcare system are high because of unequal resource allocation between the private and public healthcare sectors. Overall, the idea of 'unifying' the private and public healthcare sectors has been a recurring attempt by the NDoH to create a single healthcare system. The need to unite the public and private healthcare system indicates the concept of the layering of ideas, as opposed to changing them fundamentally (Peters, 2019). Either way, the idea of unifying the private and public healthcare sectors was present in the RDP, the ANC's National Health Plan, and the WPTHS, as well as the National Health Act 61 of 2003.

The formulation of the NHI, and the idea of unifying the private and public healthcare sectors forms part of what has been called the ''reform agenda'' in South Africa. This idea became entrenched in the RDP, the ANC's National Health Plan, and the WPTHS as well as the National Health Act 61 of 2003, and it is now present in the NHI. This indicates incremental change, not radical policy change, and it emanates from what Parker & Parenta (2008: 810) exemplify as the side-by-side existence of old policy ideas which are simply layered over new policy interventions. Incrementalism is an approach that prescribes a small, peaceful move

away from the current order, and it employs tested strategies (Andersen & Mortensen, 2010: 3). This means new policies and objectives are formulated based on previous policy objectives, and policy makers incrementally adjust these policies in order for them to fit the prevailing circumstances (Andersen & Mortensen, 2010: 3).

In the path dependence processes, policy makers also tend to engage in incremental policy making, and radical change is never really considered important in the process (Robinson et al., 20007). The focus of policy makers responsible for the NHI therefore is to ensure a reduction in out-of-pocket payments, whilst reducing deficit, and wasteful expenditure in the public healthcare sector. Incrementalism is useful for making short-term changes in public policy whilst slowly implementing long-term plans (Hall, 1993:279). In the SA context, during his speech at the Inaugural National Conference of the Health Professions Council of South Africa, in 2019, the Minister of Health, Dr. Zweli Mkhize expressed that the UHC is fundamentally difficult for all countries to implement, and that the SA government will implement the NHI in incremental phases so as to ensure greater cooperation with the public, and also to allow other departments to assist in developing public healthcare infrastructure (Mkhize, 2019).

This is in line with Hall's (1993), notion of how incrementalism is useful for making short-term changes in public policy, whilst slowly implementing long-term plans. However, the idea of implementing the NHI in incremental phases is counter intuitive to the central premise of third order policy change which requires that a new policy departs from the existing status quo and that the dominant current order is discredited by a new policy (Hall, 1993). A historical institutionalist approach would suggest that Dr. Mkhize proposed an incremental path for the implementation phase of the NHI, because he is aware that the decisions that were adopted previously by the NDoH come with financial, and political costs.

The idea of 'unifying' the private, and public healthcare sectors, has been a recurring effort by the NDoH to create a single healthcare system. However, this signals policy continuity as opposed to third order change. Third order policy change refers to the entire overhaul of the dominant paradigm, whereby the current order is discarded (Hall, 1993). The idea of unifying the private and public healthcare sectors is 'fixed' in all of the healthcare policies that have been formulated by the democratic government. The idea has been failing in the implementation phase because the two-tier healthcare system has become difficult to dislodge.

The notion of having separate healthcare systems remains locked in, and this continues to affect the policy decisions that are taken today. This complicates the implementation of the NHI.

Another idea that is relevant to the introduction of the NHI is that of a District Health System, which was already well established by the time that the NHI Green paper was introduced. According to Brauns (2016: 108), the District Health System was implemented from 1997/8 to ensure that all nine provinces were divided into small administration and service units. It was to ensure that local communities would form part of the planning and organisation of healthcare services. The District Healthcare system advocated for a shift in how healthcare resources were distributed, whilst dismantling the curative and urban biases that were perpetuated by the two-tier healthcare system. As a result, ‘‘from 1996/97 to 1997/98, there was a shift of 8% from hospital services and 10,7% towards district health services’’ (Brauns, 2016: 108). Furthermore, there was the building and upgrading of new clinics in most rural areas, so as to ensure that people had access to public healthcare services (Van den Heever & Brijlal,1997)

Ngwenya (2006:81), posits that the District Healthcare System aimed to implement the concept of Primary Health Care (PHC), and that the government established the District Health System in order to implement PHC. The District Health System aimed to decentralise the management and governance structures as well as promote democratic values in healthcare, so as to ensure that people participated in all healthcare policy making activities. The NHI provides that private and public healthcare providers within each district will be granted full authority and power to manage PHC services, and that they will be provided with support from provincial departments of health. The NHI also outlines that it will strengthen District Health Councils by improving political governance, accountability, oversight, as well as managerial capacity (NDoH White Paper, 2017). However, this policy goal is not new, as it was already implemented through the WPTHS, and the National Health Act 61 of 2003.

The emergence of new ideas being proposed by the NHI, is an example of Hall’s (1993) understanding of second order policy change. This means that previous policy goals are merely amended, and slightly altered, so as to strengthen the new policy (Hall, 1993: 280). Given that these ideas only strengthen PHC delivery, one might argue that they will not bring about third order policy change. This is because radical policy change is unlikely to be triggered by small adjustments brought about by new policy interventions (Hall, 1993). This means that the NHI is bound to follow the same logic as the WPTHS, and the National Health Act 61 of 2003,

because the District Health System has only triggered incremental change. In addition, the idea of the District Health System finding its origins in the WPTHS has been presented as new in the NHI. This means that second order policy change is visible in the NHI. However, second order policy change is incremental, and it leads to path dependence. This means that the NDoH will not likely deviate from the two-tier healthcare system, because the NHI follows incrementalism, which leads to small significant change.

Another idea introduced by the NDoH with respect to the healthcare system and the NHI, was an attempt to create insurance that would offer coverage to all citizens, irrespective of their income. The NHI, therefore, aims to ensure access to healthcare services, and to remove financial hardship from individuals. The changes that have been made through the NHI do strengthen the objective of creating universal healthcare access for all, but this too can be classified as second order policy change. In second order policy change, new policy objectives do not necessarily indicate a significant change at first glance. Rather, it is incremental change, which ensures that policy makers avoid policy blunders by prescribing to the objectives which move away from the current order slowly, but which could result in radical change at a later stage. (Peters, 2019:92).

This means that the idea of creating insurance to cover all citizens, irrespective of their income represents incremental change, in that the NHI will pay for healthcare to ensure that all citizens have access to quality healthcare services (NDoH White Paper, 2017). The proposed insurance through the NHI will lead to changes in the private healthcare sector too, since people will likely shift from out-of-pocket payments, and expensive medical aid covers, and move towards using insurance that will protect them from financial hardship (NDoH White Paper, 2017). According to Hall (1993), incrementalism ensures that policy makers move gradually towards long-term change. This ensures that policy makers attempt to bring about policy objectives that are potentially less path dependent.

Creating insurance for all might mean that the two-tier healthcare system will move along a new trajectory. This is in line with a central tenet of historical institutionalism that there is always room for critical junctures, where significant institutional and policy change occurs. As a result. This creates a point for the institution to move along a new trajectory (Hall et al., 1996: 942-943). The goal of providing insurance for all citizens irrespective of their income might lead to the collapse of the two-tier healthcare system. In addition, the creation of insurance for

all represents second order policy change. For example, creation of insurance of all intends to replace out-of-pocket payments, and ensure that people are covered through the NHI fund. However, second order policy change does not indicate a deeper change, but it moves slowly and might lead to radical policy changes that can affect policy outcomes at a later stage (Peters, 2019).

Another initiative worth considering, is that the NHI proposes to pay public and private healthcare providers on the same basis, whilst expecting the same standard of care from both. However, there is a contradiction here. The NHI policy says that it aims to create a unified healthcare system, but in the Green and White Papers, it maintains that the NHI fund will pay for both public and private healthcare providers. According to Jeffrey (2016: 1), ‘‘the White Paper on the NHI seems to believe that all private health care monies (R189bn in 2016/17) can successfully be diverted to the NHI Fund, giving it (if it were to start this year) an overall amount, together with health revenues of R183bn, of R372bn. This is also close to the minimum that would be needed to give 55 million South Africans cover for some 300 prescribed minimum benefits, at a current cost of R605 per person per month or R396 billion a year. But many people now paying for the sound private medical care of their choice may not be willing to contribute the same amount to the NHI, under which health services are likely to become tardy and often poor. This could fuel emigration among the 480 000 people who currently contribute some 57% of personal income tax. This would greatly erode South Africa’s tiny tax base, making it harder to fund government spending in every sphere’’. This means that policy makers within the institutions introduce new ideas, but at this stage, change is less likely to happen, because new policy interests come with financial and political costs (Peters, 2019: 92).

Another initiative of the NHI Bill is to establish a Board that will enable the full introduction of the NHI, as well as new capacited institutions, with demarcated roles. However, institutions are normally the products of historical development, and path dependency. This means that institutional change depends on particular circumstances, and a context which is inherited from the past (Pierson, 2000). The proposal of the NHI Bill to establish a Board, and new institutions may be difficult. According to historical institutionalism, existing institutions, are formalised and fixed in terms of structures so that they cannot be changed easily. Historical institutionalism also says that the costs of exit increase over time, and actors prefer to continue

with an established institutional design. This is because new institutions also come with high political and financial costs (Pierson, 2000).

In respect of establishing institutions, this was initiated and implemented through the National Health Act 61 of 2003. The idea here was to establish institutions such as hospital Boards that would play the role of oversight in healthcare delivery (NDoH National Health Act, 2003). The aim of establishing Boards was the first step to reforming the public healthcare system, and in ensuring that community members would participate in the planning and organising of health policies in SA. Therefore, the idea of establishing new institutions, and Boards, as proposed by the NHI is an example of layering since the idea of an earlier policy persists, and actors modify it, and combine it with a new policy. This means that the NDoH is continuing with a policy goal that was already gradually implemented by the National Health Act 61 of 2003. Therefore, the reintroduction of this goal in the NHI represents what Hall (1993) describes as first order change which means that policy makers amend already established policy goals rather than replace them.

A tenet of historical institutionalism is that institutional change is dependent on a particular context that is inherited from the past (Hall, 1996). In the context of SA's healthcare system, both the Public Health Act,36 of 1919, and the Reservation of Separate Amenities Act,43 of 1953 was responsible for establishing and maintaining the two-tier healthcare system (Du Toit, 2017). Therefore, according to historical institutionalism, the NHI's ability to bring about third order policy change is restricted by SA's healthcare history and policies. The NHI, therefore represents incremental policy change. The NHI is characterised by path dependency, where the policy objectives from the RDP, the ANC's National Health Plan, and the WPTHS, as well as the National Health Act 61 of 2003, are visible in the NHI policy.

The NHI policy will encounter obstacles since the ideas surrounding the policies originate from previous policies, that could not achieve radical change at the implementation phase. As a result, the NHI is continuing with previous policy goals. This means that ''it is less probable for individuals to deviate from ideas that are already embedded in a policy'' (Pierson, 2000: 257). The NHI is, therefore, more likely to represent policy decisions that change the two-tier healthcare system more gradually. This will however also lead to path dependency. Instead of reviewing the earlier policy interventions that were made before the NHI, the NDoH proceeded to layer the NHI with previous commitments. This can now be regarded as routinised policy

making, whereby the overarching two-tier healthcare system remains unopposed, whilst the new NHI will likely only bring small changes to the healthcare system in an incremental way.

The idea of unifying SA's two-tier healthcare system has not changed fundamentally. Instead, amendments and ideas have been layered upon previous healthcare policies as well as the proposed NHI, because the ideas surrounding the NHI are a demonstration of incremental policy change. Therefore, the introduction of the NHI via layering of new policy goals on top of policy options that have stagnated and become ineffective. In the context of the NHI policy, policy makers maintained all of the goals from previous policies, because the layering of new and old policy goals becomes the logical choice since incremental change allows for the co-existence of the old with the new. This means that the NHI is incrementally built upon historical policy decisions and compromises that have become difficult to dislodge. As a result, policy makers use ideas from a historical context and incremental change becomes a practical solution. When new problems appear, policy makers make gradual adjustments. However, adjusting policy goals whilst maintaining old ideas is incrementally path dependent (Parker & Parenta, 2008: 612).

Finally, the NHI policy does not represent third order policy change. As retrospectively analysed, the NHI does not seem to have changed the policy ideas and techniques that would be required for radical policy change to occur. Considering that the NHI policy shows connections to previous policies, it is reasonable to argue that the development of the NHI indicates first and second order policy change. In this context, path dependence might suggest that the private healthcare sector is powerful enough so that it could challenge the NDoH from deviating from the two-tier healthcare system. One might also argue that policy makers become compelled to retreat from initiating radical policy change. Rather, they engage in forms of policy layering that will not overhaul the two-tier healthcare system entirely. Furthermore, since there are no indications of radical policy change, one can assume that the perception of ideas being locked-in an institution has created a situation, whereby previous policy goals are maintained in new policies. As a result, one might suggest that the NHI was formulated to ensure that there is continuity and stability in the two-tier healthcare system.

5.6 CONCLUSION

This chapter employed the historical institutionalist approach to retrospectively analyse the origins of the NHI, and the ability for the NDoH, as a formal institution, to formulate healthcare policies. This chapter showed that the NDoH found the two-tier healthcare to have been institutionalised by the Public Health Act 36 of 1919, and Reservation of Separate Amenities Act,43 of 1953. Using path dependence, this chapter has argued that it is generally difficult to change policies, as well as institutions, because the financial and political costs associated with reversal are very high. As a result, healthcare policies in SA have proven difficult to change so that , past decisions lead to policy continuity, as opposed to third order policy change. This chapter suggested that the NDoH is a product of a negotiated settlement which led to the inception of democracy in 1994. This chapter has also argued that the NDoH is committed to reforming the two-tier healthcare system, however, it has not been successful, because the policies that have been formulated, and implemented by the democratic government only produce incremental change, as opposed to third order policy change.

The retrospective analysis of the NHI also suggests that this policy might be path dependent. This chapter employed Peter Hall's conceptualisation of the three orders of policy change. This chapter established that policy change in the NHI is consistent with first and second order policy change. This meant that policy makers have made minor changes to some of the policy ideas originally coming from ANC's National Health Plan, the RDP, and the WPTHS as well as the National Health Act 61 of 2003. This chapter showed that incremental change ensures continuity under the prevailing two-tier healthcare system. The ostensible radical change expected from the NHI will not be triggered by first and second order policy change. Therefore, this study has established that previous policy ideas have been layered onto the NHI, thus making the latter path dependent. Therefore, the NHI thus can be characterised as a policy that is constrained by previous policy decisions.

CHAPTER SIX
FINDINGS AND CONCLUSION OF THE STUDY

''We have the means and the capacity to deal with our problems if only we can find the political will''- Koffi Annan

6.1 INTRODUCTION

This chapter provides the conclusion of the study by integrating the literature and data from previous chapters. The main aim of this study was to retrospectively analyse the formulation phase of the NHI by questioning how the NHI was formulated by the NDoH and what the challenges might be that could affect the implementation of the policy in SA. A major observation has been that the NDoH, and the ANC, have over time developed policies and legislation to implement the NHI. The policies leading to the NHI included, the Green Paper (2011) and the White Paper (2015–2017). Additionally, the NHI Bill (2018) sought to establish the NHI fund as a single payer for the entire healthcare system. This chapter provides a summary of the main analytical findings in respect of the policy formulation phase of the NHI. Drawing from the historical institutionalist approach in explaining incremental policy change and path dependence, this chapter will conclude that the NHI is incrementally path dependent and that it will not trigger third order policy change

6.2 KEY ANALYTICAL FINDINGS OF NHI THROUGH THE LINEAR MODEL

The study has established that the SA government, in 1994, recognised the need to transform the two-tier healthcare system which traditionally catered for two constituencies namely, the private and public healthcare sectors. These two systems provided the same services but differed in respect of service quality. This was the result of historically segregated health policies, which organised access based on race and class. As a result, the apartheid regime created a fragmented health system. The ANC- led government recognised that this was contrary to the healthcare approach that it needed to achieve Universal Health Coverage. Considering the challenges facing the healthcare system in SA, the ANC-led government formulated the NHI policy at its 2007 National Elective Polokwane conference.

The study has shown that the reasons for formulating the NHI policy included the need to unify the healthcare system, promote universal healthcare access for all legal SA citizens, and to address the challenges facing the country's healthcare system. Running two separate healthcare sectors was expensive. This required a well thought out alternative policy. This study applied the linear model of policy formulation to retrospectively analyse how the ANC, and the NDoH formulated the NHI. The linear model showed that other stakeholders were excluded from the policy formulation process of NHI. The linear model can explain some of the reasons as to why certain stakeholders were excluded and included in the policy formulation phase of the NHI.

In respect of SA, this study highlighted that the ANC, as a political party, was responsible for initiating the discussion of moving SA towards the NHI. Given the fact that the ANC is the ruling party, the NDoH was compelled to formulate the NHI. As a result, the NDoH failed to identify and select stakeholders, and to then invite them to participate in the policy formulation phase. This led to the exclusion of critical stakeholders, especially those from private healthcare sector organisations, academia, and other political parties, as well as civil society. The stakeholders that were included in the formulation of the NHI were mainly elites from the ANC, and bureaucrats from the NDoH. As a result, excluded stakeholders could not directly exercise their power to influence the policy formulation process. Their inclusion only came about after the Green Paper on NHI was published in 2011.

This means that the ANC and the NDoH only consulted stakeholders when the former was planning to move towards the implementation phase of the NHI policy. In addition, the then Minister of Health further excluded stakeholders by initiating an NHI Task Team without consulting them. The former President of SA, Jacob Zuma, and the Minister of Health, Dr. Aaron Mostoaledi, appointed an NHI Task Team to carry out the research, drafting, and planning activities of NHI. The Task Team was also mandated to investigate implementation strategies for the NHI. Despite subsequent resistance and objections from other stakeholders regarding the NHI, the NDoH exercised bureaucratic power again over these stakeholders when it formulated the White Paper on NHI in 2017.

The study presented that the linear model explains and supports the idea that it is the role of bureaucracies to formulate policies without consulting stakeholders. In the SA context, the linear model would justify the top-down approach of decision making that was applied by the NDoH in the formulation process of the NHI. In the context of the NHI, this study demonstrated

that the NDoH is a formal institution that enjoys a degree of autonomy, and it can decide to invite stakeholders to the formulation phase or not. Furthermore, the NDoH can delegate issues to experts to effectively resolve challenges facing healthcare in SA. As a result, in the policy formulation phase, the NDoH could privilege certain interests over others. By applying the linear model, the study found that stakeholders often accept policy outcomes because they perceive bureaucracies and elites to be rationally efficient in terms of their functions when carrying out decision making, and they believe that are capable of transmitting policy decisions to society.

This study has characterised the policy formulation process of NHI as a failure to conduct broader consultation with other stakeholders. Rather, the ANC, and the NDoH, relied on the knowledge and inputs of appointed bureaucrats. Therefore, the policy formulation of NHI was not inclusive and open. Rather, it was finalised by a small technical task team that included academics from some South African universities, public servants who lead the Departments of Health in different provinces, and bureaucrats from the NDoH who were ostensibly experts in the field of healthcare policy. Extensive consultation with other stakeholders was postponed until government bureaucrats had acquired approval to draft policy documents by the ANC. Furthermore, once the Green and White Papers had been drafted, they were reviewed by ANC structures, and government officials, and only later presented to Parliament. This study, however, demonstrated that the linear model supports this because according to this model policy decisions must be made in a top-down manner, and based on the analysis of bureaucrats and elites. The linear model of policy formulation also helped to explain why the NHI was not guided by an inclusive consultation process but rather was decided upon by the NDoH, and ANC. The linear model further helped to explain where the idea of NHI came from, to show that it was a decision that came as a result of Resolutions 53 and 54 of the ANC's National Conference in 2007.

6.3 KEY ANALYTICAL FINDINGS FROM HISTORICAL INSTITUTIONALISM

This study found that the negotiated settlement that brought democracy to South Africa came with compromises, especially in terms of policy formulation and implementation. The post-apartheid healthcare system became defined by a lack of fundamental policy change despite a host of policies being formulated to ensure such change. This study identified that the post-apartheid government formulated the ANC National Health Plan. This policy was committed

to transforming the country's health system by redressing social and economic injustices to ensure that all South Africans enjoyed their human and political rights, such as access to quality and decent healthcare services. The core elements of the ANC's National Health Plan also focused on a strategy toward Primary Health Care (PHC), which entailed community participation, equity, health promotion, and interventions aimed at transforming healthcare. However, the implementation of this policy was an arduous task given the fact that the new SA government had to restructure the entire healthcare system, and to create new institutions that would serve the purpose of reforming the private and public healthcare sectors.

The challenge that faced the ANC's National Health Plan, alongside the RDP, was that both policies struggled to balance the disparities between the public and private healthcare sectors in the context of access to quality healthcare services for all citizens. The failure to balance the disparities between the public and private healthcare sectors was because the ANC-led government lacked the necessary public administration institutions that would carry out this task, as well as a lack of finances. The main challenge was that this policy was introduced in a country facing social and economic challenges, given the fact that SA was in an economic decline and affected by inequality and unemployment. The ANC's National Health Plan was an extension of the RDP, which means that it was affected by the constraints and failures that had affected the RDP too.

This study outlined that when new policies do not yield the intended results for policy makers, and when the policy only introduces gradual incremental change after a prolonged period, bureaucrats and politicians get frustrated with the policy outcomes. As a result, the trend of the SA government has been to present new policies only once they experience challenges with existing policies in terms of implementing goals and desired outcomes. In the SA context, the RDP and the ANC National Health Plan were only able to yield first and second order policy changes. This does not serve to dislodge the status quo, and it only produces small incremental changes. This study has established that a subsequent policy intervention, following the ANC's National Health Plan, was the WPTHS of 1997. This study argued that the introduction of this latter policy was a clear demonstration of incrementalism as it merely served as a way of attending to the failures of the RDP and the ANC's National Health Plan.

The WPTHS was merely layered with the previous commitments of the RDP and the ANC's National Health Plan. Layering means that policy makers alter the policy instruments without

radically changing the policy goals. This type of policy change may lead to new policy goals or to the adjustment of policy goals. This study showed that the WPTHS was layered with the goals of the ANC's National Health Plan of unifying the healthcare system, fast-tracking primary health care (PHC), and moving SA toward Universal Healthcare Coverage (UHC). However, this yielded first and second order policy change which is incremental. Incremental change means continuity of the status quo since it yields the same results as previous policy interventions. This study established that health policies in SA tend to yield similar results because it is difficult for politicians and bureaucrats to exit the two-tier healthcare system because deviation comes with high political and financial costs.

This study analysed whether the policy goals of the NHI are sufficient to guarantee the reform of the two-tier healthcare system or for ensuring universal healthcare coverage for all. This study concluded that the NHI will only achieve incremental change because there are financial and political difficulties that face the NDoH from deviating from the existing two-tier healthcare system. Drawing from path dependence, this study has revealed that the NHI policy represents only first and second order policy change, because the ideas surrounding the NHI have not changed fundamentally. Instead, policy makers merely make minor amendments and changes in policy ideas, because the layering of new and old policy goals becomes the logical choice since incremental change allows for the co-existence of the old and the new. This means that the NHI has connections to previous policies, so that the type of policy change attainable is path dependent.

6.4 RECOMMENDATIONS

The study recommends that the SA government should formulate and implement policies that will address the issues that face SA, and which also develop a positive relationship with stakeholders from different parts of society. The benefit of having a relationship with stakeholders is that they can all contribute to the debate on the feasibility of the policy. This means that policy formulation and implementation can be effective when different stakeholders express their views in different rounds, and the government is able to capture all views to draft policy documents that will not be opposed. The ANC, and the NDoH, need to develop an inclusive and participatory environment so that different people, and representatives from different spheres of society can participate in the policy making process. It is an important function of a modern democratic state to allow stakeholders in the policy making process

because participation, and inclusion, is a constitutional right, and this ensures that government is accountable, and transparent.

The NDoH, and other government departments, must consider the rounds model for future policy formulation processes. In the rounds model, problem definitions and solutions are not seen as final, since policy formulation is a continuous process, over a longer period of several discussion rounds. The rounds model is also voluntarist since it suggests that policies are the product of a voluntary contract between different stakeholders. In addition, policies formulated through the rounds model are most likely to achieve the desired outcomes for stakeholders given that these outcomes are formulated in an environment already replete with institutions. Information obtained from different people sheds light on the conditions, needs, and experiences of people. This information may ensure that policy makers develop implementable policy alternatives.

The proposed NHI policy is in line with prevailing international conventions, agreements, and the SDG targets. Furthermore, it is important to state that the SA government and other stakeholders must understand that the failure to achieve SDG 3 has implications, as foreign investment carries more weight in developing countries like SA. Therefore, stakeholders' attitudes and conduct in policy making need to change. This must be guided by a sense of collaboration so as to ensure that all global and domestic agreements lead to superior outcomes.

6.5 CONCLUSION OF THE STUDY

In December 2007, at the 52nd National Conference of the ANC, which was held in Polokwane, the ANC adopted Resolutions 53, and 54 to implement the NHI system. The ANC leaders further instructed the cadres deployed in government, specifically bureaucrats from the NDoH, to take forward the task of implementing the NHI policy. This study established that the execution of the NHI policy in SA has followed a top-down approach, which has led to the exclusion of critical stakeholders from policy formulation in respect of the healthcare system, and the top-down approach applied by bureaucrats in formulating the NHI documents. The study has shown that the power of the ANC as a political party in SA, affects the way stakeholders are included or excluded and prioritised in policy activities. This limits the role that stakeholders play in the policy making process in the country.

In closing, the study retrospectively showed that South Africa's healthcare policies are incrementally path dependent. New policies are only slightly different from old policies. This demonstrates the reality that despite having good laws and policies in place, South Africa still faces poor implementation of these policies. This is due to public policies remaining stuck on a specific historical path, coupled with the fact that institutions remain rigid. The study argued that new healthcare policies, such as the NHI, are layered with the objectives of previous policy choices. This means that the NHI is constrained by previous policy choices, and it is only able to produce incremental policy change.

The study analytically illustrated that new policies tend to be stagnant and ineffective since they only produce first and second order policy change. The NHI is also being introduced by the NDoH into a society that remains untransformed and characterised by institutions that are not themselves reformed to establish change in the healthcare system. It was revealed that the NDoH is a product of a negotiated settlement. This study provided that the democratic government had no knowledge of the consequences that would be brought about by the negotiated settlement, which to a great extent constrained policy formulation. As a result, it will take time to effect policy change that is required to dislodge the prevailing two-tier healthcare system. It was suggested in this study that Development Studies represents an ambitious approach to understanding policies. and institutions that promote human development so as to address the world’s perils. Therefore, this study demonstrated that Development Studies has the potential to finding solutions to different problems, and most importantly help government to develop policies that will be successful at the implementation phase.

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