

**Managing Human Capital for National Health Insurance: A Case of Nursing
Capacity in the North-West Province**

by

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Master in Business Administration degree

in the

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DEDICATION AND ACKNOWLEDGEMENTS

I dedicate this research study to the diligent and committed men and women nurses in South Africa in general, and in the North-West Province in particular. Their perseverance under strenuous working conditions and resilient fortitude has made a tremendous contribution towards the institutionalization of an efficient human capital and an effective healthcare system in South Africa.

I extend my special admiration and appreciation of nurses who still value their profession as a calling and continue to uphold the virtues of dedication and commitment to their work.

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ABBREVIATIONS/ACRONYMNS

AG	Auditor-General
BRICS	Brazil, Russia, India, China, and South Africa
CAPAM	Commonwealth Association for Public Administration and Management
COSATU	Congress of South African Trade Union
DENOSA	Democratic Nursing Organization of South Africa
GDP	Gross Domestic Product
GNI	Gross National Income
GPs	General Practitioners
HCM	Human Capital Management
HDI	Human Development Index
HHC	Healthcare Human Capital
HRH	Human Resources for Health
HRM	Human Resources Management
ISHCM	International School of Human Capital Management
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organization
IMF	International Monetary Fund
IT	Information Technology
NGOs	Non-Governmental Organizations
NHI	National Health Insurance
NHIS	National Health Insurance Scheme
NHSO	National Health Security Office
NWP	North-West Province
OOP	Out-of-Pocket
OECD	Organization for Economic Cooperation and Development
PHC	Primary Health Care
RSA	Republic of South Africa
SANC	South African Nursing Council
SAMRC	South African Medical Research Council

SHRM	Strategic Human Resources Management
SHRM	Society for Human Resources Management
STATSA	Statistics South Africa
UC	Universal Coverage
UDHR	Universal Declaration of Human Rights (UDHR)
UHC	Universal Health Coverage
UNO	United Nations Organization
USD	United States Dollar
WHO	World Health Organization

ABSTRACT

Access to healthcare has become one of the most contentious issues in South Africa, where the two-tier healthcare system has made it almost impossible for ordinary citizens to have equitable access to healthcare, as they cannot afford to pay for it. Such polarized healthcare access implies that only those who can afford to pay will have access to the best healthcare facilities and amenities in the country. It is against this background of deprivation and inequitable healthcare access that the South African government introduced the National Health Insurance (NHI) as the primary means of ensuring that every citizen has equitable access to healthcare, irrespective of their financial, economic, or social standing in society (ANC General Congress, 2010).

The aim/purpose of this study is to examine whether or not the proposed National Health Insurance (NHI) policy is realizable, given the existing human capital dynamics within the public health sector in South Africa. Desktop document review and analysis was the preferred research design and methodology opted for in the study. In that regard, the study was qualitative and exploratory – considering also that the NHI is a relatively novel health policy initiative by the State. The exploratory aspect of this fundamentally qualitative study was most suitable for the document analysis approach, as it is preparatory for further studies on the research topic (Burns & Grove, 2009).

The key research findings essentially relate to the results or outcomes of the study, on whose basis the recommendations and conclusions were derived (Babbie & Mouton, 2001:4, 563). The document/content analysis approach was exploratory in that it focused on the feasibility of the NHI in the context of the existing nursing staff challenges. In that regard the main findings indicate that there exists a relative degree of an increase in the production of nurses by various nursing institutions. However, the irony emerges insofar as the pervasiveness of attrition/shortages still abound in the totality of the healthcare (nursing and medical) sector, in which there are virtually enormous shortages in specialized areas such as dentistry, pharmacology, nursing professionals, and medical practitioners (Parliamentary Monitoring Group, 2012). Furthermore, the atrocious nurse-to-patient ratio of 203:1 in the country augments to the staff-related challenges that may impair the eventual implementation of the NHI throughout the country.

Key Words and Classification: Universal Health Coverage (UHC); Human Capital Management (HCM); National Health Insurance (NHI).

Classification Code: I130 Health Insurance, Public and Private

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND OF THE RESEARCH PROBLEM

This study is primarily informed by the new healthcare policy that has been adopted by the South African government on universal access to healthcare, which is called the National Health Insurance (NHI). Such a focus and orientation of the study is informed by the introduction of the new healthcare policy referred to as the National Health Insurance. The main focus area of the study therefore, is on the assessment of the management of the nursing human capital and the evaluation of the production of nurses in the North-West province.

Universal Healthcare Coverage (UHC) has been at the centre of the global healthcare debate in the past few years. In its 58th World Health Assembly, member countries were encouraged to move towards achieving universal health coverage. UHC does not only refer to the generation of healthcare funds, but also implies equity in access and guaranteed financial risk protection (Ataguba & Akazili, 2010). Whilst developed countries are advancing and developing innovative ways of implementing UHC, low-income countries and developing countries still face a lot of challenges with regards to healthcare (Haider, 2011). These challenges include infectious diseases, chronic diseases, socio-political challenges, limited resources, lack of administrative capacity, expensive delivery of care, huge populations, and healthcare human resource shortages.

1.1.1 The Role of the State in Directing the NHI Towards Universal Healthcare Coverage (UHC)

The role of the state in driving Universal Health Coverage (UHC) extends well beyond just formulating the framework for its implementation. The measures to implement UHC vary from one country to another. It is at each country's discretion to assess which measures are suitable to meet the particular country's specific healthcare needs and challenges. One of the roles of the state is that of implementing a national health policy designed to ensure universal access to health facilities, goods and services in order that that the masses could enjoy the highest attainable standards of physical and mental health (United Nations, 2000). Furthermore, the state should – within its national health strategy – also utilize resources available to attain defined objectives and formulate cost-effective ways of utilizing these resources.

The conception of the National Health Insurance (NHI) in South Africa demonstrates government's commitment towards ensuring Universal Healthcare Coverage for all citizens. The establishment of the NHI in South Africa demonstrates a paradigmatic shift towards the provision of UHC as a right not only enshrined in the South African Constitution as the duty of

government, but also in the international legislative instruments such as the Universal Declaration of Human Rights (UDHR) and the United Nations' International Covenant on Economic, Social and Cultural Rights (ICESCR) (UNO, 2000).

The NHI has as its founding principles as: *the right to access; equity, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency*; all of which will give effect to the implementation of Universal Healthcare Coverage. It is also the duty and responsibility of the state to formulate legislative frameworks that would guide the direction of the implementation of a National Health Insurance that ensures Universal Healthcare Coverage.

In a country like South Africa, where income inequality has characterized the country's socio-economic profile for years, the orientation towards UHC is just but one attempt towards bridging the gap between the rich and the poor in the country (Ataguba & Akazili, 2010:16). The two-tier healthcare system, together with the high healthcare costs, has for decades deeply deprived the poor people – who constitute the majority of the population – of the right of access to quality healthcare services. NHI is therefore government's healthcare policy initiative towards enforcing the right to healthcare as enacted in the South African Constitution as well as in other international legislative frameworks.

1.2 STATEMENT OF THE RESEARCH PROBLEM

Healthcare provision is a fundamental human right. The World Health Report (2010) outlines Universal Health Coverage as an important factor in enforcing such a right. Notwithstanding that healthcare is a basic human right, it has become a commodity affordable to those with purchasing power, particularly in developing countries. Hellreigel et al. (2008) expound on the need for proper management of human capital, which incorporate management activities such as planning, organizing, leading, and controlling. Kabene et al. (2006), state further that effectiveness and efficiency of human resources practitioners is reliant on the extent of the development of the self-same practitioners.

The researcher is currently employed in the operations department of the Democratic Nursing Organization of South Africa (DENOSA), a nurses' collective bargaining union. The researcher continuously interacts with public policy on health and other related matters. Nurses in the public healthcare setting are exposed to strenuous conditions with limited resources and are under staffed (Wiseman, 2013:46). This situation leads to an unhealthy work environment and predisposes nurses to develop negative attitudes towards both their clients (patients) and the healthcare system itself. The researcher problematizes the efficacy of the public healthcare system and its readiness to implement the proposed National Health Insurance. Since it is the

aim/purpose of the study to examine the feasibility of the proposed NHI, it is inevitable that the availability and readiness of the nursing human capital would come under scrutiny. In this regard then, the rate of production of nurses by the nursing institutions becomes a relevant factor in relation to the implementation of NHI.

The problem statement of this study is therefore premised on the notion that in addition to inadequate nursing human capital, healthcare costs are escalating at a fast rate in many countries, and the working class and poor people in these countries are bearing the brunt of high healthcare costs in the face of the high burden of diseases, and South Africa is no exception (ANC General Council, 2010). Due to the high cost of healthcare, the optimum enjoyment of the right of access to healthcare still remains an ideal for most people across the world, particularly in developing countries. This is particularly the case for people who live in poverty especially in the North-West province and cannot access quality healthcare due to its expensive nature.

1.3 SIGNIFICANCE/JUSTIFICATION OF THE STUDY

The significance of this study is premised on its contribution to the proposed Universal Health Coverage (UHC) trajectory in South Africa, which is called National Health Insurance (NHI). For the relevant decision and policymakers, it is envisaged that the study will provide an overview of the North-West Province's state of readiness (or otherwise) for the NHI upon its implementation. The justification of the study is to inform health policy on possible reforms, to detect unrelated commonalities that may help towards the development and management of health human resource capacity in the North-West province. The NHI policy is a relatively novel initiative in South Africa. Accordingly, the study derives its content mainly from the review of existing data as a precedence of literature remains inadequate.

1.3.1 Discipline-specific Relevance

Health discipline is one of the critical aspects in ensuring the wellbeing of society, therefore the scientific contribute to the body of knowledge on National Health Insurance is envisaged to enrich the management of human capital especially within health systems. This will ensure considerable focus on the realization of the fundamental right to health care of all South Africans as articulated in the 'bill of rights' of the Constitution of the Republic of South Africa. The Act informs that "Everyone has the right to have access to health care services, including reproduction health care" (South Africa, 1996).

Realization of this right to healthcare is dependent on a number of issues, which includes but not limited to the following aspects; human capital management, infrastructure development, financing and funding. The management component forms an integral part of the realization of

access to health care by everyone irrespective of their economic, political, ethic and social background.

1.3.2 Institution-specific Relevance

The study will help the North-West University to acquire and broaden its own intellectual property in the management of human capital on NHI. The chosen pilot site in Dr Kenneth Kaunda district will serve as a test for implementation of the recommendations of this study, thereby allowing the NWU to be profiled positively on its role in contributing to health public policy discourse (Ataguba & Akazili, 2010:16; Roussel, 2006:77).

1.3.3 Practical Socio-economic Benefit to Society

Access to healthcare by all will open doors of all health institutions in South Africa without any prejudicial considerations based on an individual's socio economic status. With that in mind, the escalating burden of disease in South Africa can only be addressed by increasing citizens' access to quality and affordable healthcare. South Africa's constitution instructs government to take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of this right. This constitutional right has been undermined by the commodification of health in South Africa (ANC General Council, 2010).

1.4 AIM/PURPOSE AND OBJECTIVES OF THE STUDY

The aim and objectives of the study were respectively intended to provide both the broader and the more specific intentions of the study. There is a mutual relationship between the purpose (aim) and objectives (specific aims) of a study on the one hand, and the methods of data collection, the research problem, and the research questions on the other hand (Henning, 2005:1). The study investigates the feasibility of the National Health Insurance in relation to the current staff establishment patterns of the nursing human capital. Staff establishment in this context refers to the ratio between the nursing human resource and patient in which the correlation and association between the total numbers of nurses employed at a particular given time against the amount of work to be executed is maintained.

In this study then, the aim/purpose is to examine whether or not the proposed national health insurance policy will be realized, given the existing human capital dynamics within the public health sector in South Africa. The study ascertains whether or not the necessary preconditions, as outlined in the 2005 World Health Organization report, do exist for the successful implementation of Universal Health Coverage.

1.4.1 Research Objectives

Whereas the research purpose refers to the general aim of the study, the research objectives on the other hand refer to the more specific (narrower) intentions of the study in relation to the research tasks to be performed and accomplished (Henning 2005:1; Muller 2004:37). In its narrower orientation, the study specifically focuses on population dynamics, and examines the success of the National Health Insurance in the context of the growing population and the increasing burden of disease. Accordingly, the objectives of the study are:

- To assess the capacity and effectiveness of available human capital in implementing the National Health Insurance;
- To examine the current state of the health human capital in the North West Province; and
- To determine the capacity of nursing institutions to produce the requisite nursing human capital in order to implement the NHI.

1.5 THE RESEARCH PARADIGM

The theoretical perspective/framework of a study provides the researcher with a context for organizing the examination of the identified research problem and the attendant data collection processes (Brink et al. 2010:24). The researcher is able to organize ideas that demonstrate the study as a logical extension of current knowledge by means of organizing a theoretical framework, based on theories, conceptual paradigms, or assumptions.

Research studies are largely based on specific paradigms and establishing boundaries for scientific inquiry; the paradigms themselves could also be influenced by values of the researcher. A research paradigm is described as a system of observing phenomena (for instance, the NHI in the context of universal healthcare coverage and nursing human capital) in a manner that involves a set of philosophical assumptions so as to inform and guide a particular approach to a study (Polit & Beck 2012:736). The current study is located in a naturalistic research paradigm, which argues that reality is multiple, subjective and context-bound (Polit & Beck 2012:12). The research paradigm in this study therefore, is largely premised on the generic qualitative tradition or paradigm, which seeks to assist the researcher in describing and understanding events, actions and processes in their naturalistic contexts (Creswell 2009:195). Such a paradigm provided a clear set of concepts, principles, and rules for carrying out the research (Ulin, Robinson & Tolley 2005:12).

Whereas paradigms and conceptual/theoretic frameworks contextualize (provide a research approach or boundaries) a study, research assumptions provide the value-free principles according to which the research paradigm, approach, or boundaries were guided or arrived at.

Van der Walt & Van Rensburg (2010:22) illuminate further that assumptions are basic principles that are assumed to be true, without proof or verification. Assumptions could be ontological (patterned sets of the researcher's view of reality); epistemological (assumptions about knowledge of reality); axiological (assumptions inspired by appreciation of the researcher's collective efforts during the entire research process; or rhetoric (assumptions based on the researcher's art of persuasion in respect of writing and speaking to a particular audience) (Van der Walt & Van Rensburg, 2010:22).

In this study, methodological assumptions provided the foundational terrain of the theoretical approach (paradigm/perspective) to the research topic and its concomitant research problem. Methodological assumptions themselves are based on 'particular ways of knowing about reality' (Van der Walt & Van Rensburg, 2010). Accordingly, combined inductive and deductive perspectives and principles/assumptions provided the context for this study's theoretic framework. In this particular instance, the study will test the relationship between sustainability and improved access to healthcare. Inductive and deductive methods are not mutually exclusive, as data collection may be turned into a set of concepts which may be tested through experimentation. The exclusivity is evident in the establishment of pilot sites for NHI. According to Gray (2008), the adopted theoretic approach above entrenches a more 'truth seeking' and 'perspective seeking' methods. 'Truth seeking' methods tend to adopt a more experimental or quasi-experimental approaches, while 'perspective seeking' methods tends to be more interpretivist and to generate qualitative data.

The relationship is to be treated as tendencies rather than as laws (Crotty, 1998). Furthermore, the inductive approach accumulates and analyses data to compare the relationship that emanates from the accrued variables. The initiative by the state to ensure access of health across race and class barriers has elements of socialist theoretic perspective as it advocate for cross subsidization through taxation by those who can afford.

1.6 THE PRE-CONDITIONS AND ENABLERS OF UNIVERSAL HEALTHCARE COVERAGE

In its 2005 technical report, the World Health Organization (WHO) tabled preconditions for the successful implementation of UHC. It clearly pronounced that "For a successful implementation of UHC, certain preconditions have to prevail; and these include among others, the following enablers: availability of infrastructure, skilled healthcare human resources, a sound tax administration, a transparent public financing of healthcare, and monitored and effective health spending".

1.6.1 Availability of Infrastructure

It is essential for countries moving towards UHC to invest in infrastructure (Hongoro & McPake, 2004). Most developing countries have a challenge of inadequate, outdated, and dilapidated infrastructure. Investment in infrastructure should therefore be considered as a precondition for adopting a UHC strategy.

1.6.2 Shortage of Health Human Capital

The shortage of skilled healthcare human capital is a global challenge (Cooper et. al., 2011:2). Both developed and developing countries do experience shortages of nurses and doctors within their healthcare systems. It is critically essential that a UHC strategy should entail a clear strategy and plan outlining expected outputs in relation to the production of anticipated skilled healthcare professionals. The severity of the challenge however, differs from one country to another, with developing countries affected more than developed countries. Notwithstanding the country-to-country idiosyncrasies, South African healthcare human capital is not as corroded when compared with other developing countries ;especially some in Africa.

George (2012:9) argues that approaching the shortage of health human capital entirely from a perspective of numbers, only deprived the much-needed strategic intervention as it may be a shortfall on allocation and distribution as a result of poor planning and organizing. This argument suggests a relationship between the production of the correct skill and attrition of staff on the one hand, and retention of human capital and the ever-changing demands on the health services on the other hand.

1.6.3 A Viable Tax Administration

The state of the economy in a country determines the particular country's ability to generate sufficient revenue (Wiseman, 2013:66). It is therefore essential for governments shifting towards a UHC strategy to have a cogent and viable tax administration regime in order that the tax effort is effectively managed into generating strong tax revenue base.

1.6.4 Transparent Public Financing of Healthcare

Finance is one of the key elements to be considerations in any healthcare system (Ataguba & Akazili, 2010:90). Therefore, in adopting a UHC strategy, governments should ensure that financing public health is well managed and planned as it enhances public expenditure management and accountability. Budgetary allocations should be linked to the health system's performance, so as to develop a clear mechanism of accountability.

1.6.5 Monitored and Effective Health Spending

Strategies to guard against wasteful expenditure and corrupt tendencies in hospitals and healthcare facilities are also key considerations in ensuring a successful implementation of a viable UHC strategy (Du Plessis, 2012:14). Such strategies would gain the support and confidence of the population towards the system.

1.7. RESEARCH QUESTIONS

In this study, the research questions have been articulated in close relationship with the research problem, the research objectives, as well as the data collection methods. In this regard, the following constitute the main research questions of the study.

1.7.1 Primary Research Question

- Does the North-West Province have sufficient nursing human capital/capacity to implement and sustain the National Health Insurance policy successfully?

1.7.2 Secondary Research Question

The study will further respond to the following secondary questions:

- Having discussed the pre-conditions of Universal Healthcare Coverage such as Infrastructure, Financing and Human Resources, how ready is the North-West Province to implement NHI in the context of the identified pre-conditions?

1.8. ETHICAL CONSIDERATIONS

In research, ethical considerations refer to the professionally binding research etiquette (including values, norms, and behaviour) to which the researcher has to adhere in the execution of a study, especially where fieldwork and research participants are involved (De Laine, 2000:2-5). The following ethical considerations contributed to the professionalization of the study's execution between the researcher and the participants. However this study does not involve any collection of data through fieldwork and therefore is based on review of existing secondary data.

Special permission was requested and obtained from the Research Ethics Committee of the North-West University prior to this research being undertaken. In order to ensure the study's authenticity and legitimacy, a signed statement of declaration was written by the researcher as a commitment to the study's compliance with all ethical requirements. A special consideration was made to ensure that the sources of data used in this study are credible and reputable.

1.9. RESEARCH DESIGN AND METHODOLOGY

Some researchers use the terms 'research design' and 'research method' as two distinct, but symbiotically related concepts, while others regard the two terms as synonymous – that is, referring to the same idea Mouton (2001:55). In this study, the two terms are used

complementarily as two distinct but interrelated concepts. The research design of a study is regarded as 'the management plan' of the particular study (Henning, 2005:142). Furthermore, the research design relates to the broader course of action or plan of how the study was executed, in that it outlines the processes followed in resolving the research problem as articulated by the researcher (Mouton, 2001:56, 114). On the other hand, the research methodology of a study refers to the specific tools or instruments in meeting the purpose and aim of the study on one hand, and the research problem and research process on the other.

The current study is a purposive, desktop theoretical research review in its nature. Accordingly, the research has followed a content analysis/document review approach using secondary data; and in terms of which the basis of the literature review rested on an in-depth critique of available relevant sources on the subject. No sampling was performed and the research outcomes are informed by the data analysis process.

1.10. ORGANIZATRIION OF CHAPTERS IN THE STUDY

Chapter 1 of the study focused on the broader overview of the research topic, as well as the means by which data was collected for the enhancement of the study's findings and its concomitant validity, reliability, and credibility.

Chapter 2 reviewed literature on most aspects of the research topic and will not only focus on NHI and HRM alone but will also include; the challenges and successes, and the Constitutionality of NHI/UHC in South Africa and the Current State of NHI/UHC in the North-West Province. It will further explore lessons learnt from the international experiences relevance to South Africa and the NWP.

In Chapter 3 the researcher expounded on the research methodology of this study which includes research design and further explains data collection method. In enhancing integrity of the study, valuation of rigor of the study will be engaged through interrogation of trustworthy elements of the research which are credibility, validity, reliability and confirmability of the study. Justification of the chosen methodology will also be dissected to validate the study methodology.

Chapter 4 provided the context for the analysis and interpretation of all data collected. The discussions engendered a comparative and narrative account in relation to the stated objectives of the study.

Chapter 5 concludes the study and highlights the recommendations that could be applied for further studies in the realm of NHI development and implementation.

CHAPTER 2

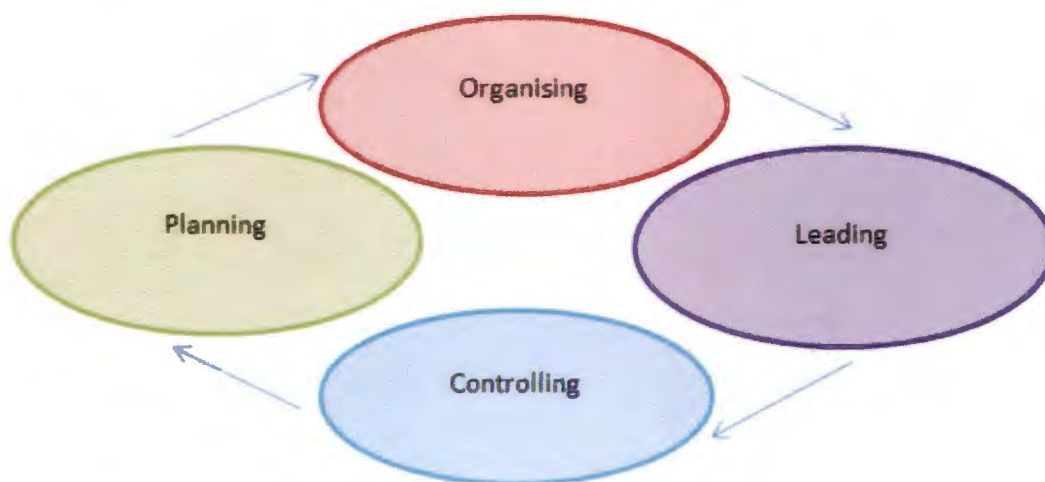
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the consulted literature on the management of human capital in the North West province. The most pivotal themes to emerge from the consulted literature were: Human Capital; Human Resources Management; and National Health Insurance. It is important to define some of these key concepts, in order to clarify the context within which the study is articulated.

Proper management is an integral part of the success of businesses, as it provides an added advantage in the highly competitive business environment. Hellreigel et al. (2006:9), contend that management “can be used to refer to the tasks and activities performed by a manager”. The concept of ‘management’ comprises of four basic tasks: planning, organising, leading, and controlling; all of which are illustrated in Figure 2.1 below:

Figure 2.1: The Four Basic Management Tasks



Source: Hellreigel et al. (2008)

The above-cited four basic management tasks begin at the planning phase, and are then integrated into the organizing, leading and controlling phases.

The production of nurses in the North-West Province has to be informed by an intensive planning and capacity of human resources to address and control nurse attrition, especially the increasing migration of nurses in particular from rural to urban areas. Organizing is an essential management activity as it allows for proper allocation of the relevant human capital, especially in ensuring that all healthcare facilities are adequately resourced in both human and physical terms. Adequate and available nursing human resources and infrastructure reinforces an

environment and context within which viable healthcare facilities could flourish. Hongoro and McPake (2004) argue that human resource is the heart of the health system and a critical component in health policy. Leading and controlling aspects of management will ensure efficacy of human capital to successfully implement National Health Insurance.

Reddin's three dimensional theory of management expresses the three important areas of focus in management (Roussel et al., 2006:170). The first area is a method that measures the influential and effective action of managers. This method is referred to as "situational demand". Based on this focus area, managers' activities are, to a larger or lesser extent, influenced by the environment within which they operate. The healthcare infrastructure and the conditions within which nurses in the North-West Province are exposed, will determine the extent to which the province is able to manage its human resources talent. In most instances the reason for failure to retain nurses is informed by the unwelcoming conditions that such nurses are exposed.

The second focus area is referred to as the 'task- and relationship orientation'. This dimension of leaders is modeled around the Ohio State studies, which focused on leadership behaviour. The study highlights 'consideration' and 'initiating structure' as the two critical aspects of leadership behaviour (Daft, 2008:495).

The third element of Reddin's model focuses on measuring 'managerial effectiveness'. Hellreigel et al. (2008), have highlighted managerial effectiveness as an essential tool to an organization's overall success. An effective manager should be able to perform one of the line managers' effective managerial competencies. Hellreigel et al. (2008:22), describe 'competency' as referring to "combination of knowledge skills, types of behavior, and attitude that contribute to personal effectiveness".

McIntyre et al. (2003) agree that sustainability has a wide-ranging definition and is "multifaceted as it includes financial sustainability, that is, the mobilization of resources combined with improvement in allocative and technical efficiency, as well as political acceptability and health system organizational capacity". In order to ensure sustainable National Health Insurance, the North West Province needs to guarantee enough budget and competent managers who will ensure effective and efficient use of allocated budgetary resources. Securing an adequate budget will also create conducive pre conditions for the successful implementation of NHI.

2.2 STRATEGIC HUMAN RESOURCES MANAGEMENT

The employment of human resource management is the most proven approach and a critical component of ensuring the prevalence of efficient and effective healthcare human capital. Strategic human resource management embraces all the four elements of management

(illustrated in Figure 1) in ensuring that a viable company achieves its vision. Grobler et al. (2006) define strategic human resources management (SHRM) as human resources management (HRM) activities addressing an assortment of people-related issues within an organization. The issues being addressed should be pertinent to the business strategy of the particular organization. The above definition identifies an important link between HRM activities and an organizational business strategy.

This research study interrogates the need for strategic human resources management intervention in managing human capital. Human resources practitioners are no longer considered as administrators. Their function has transcended this administrative role to provide expertise in the leveraging of human capital (Du Plessis et al., 2012).

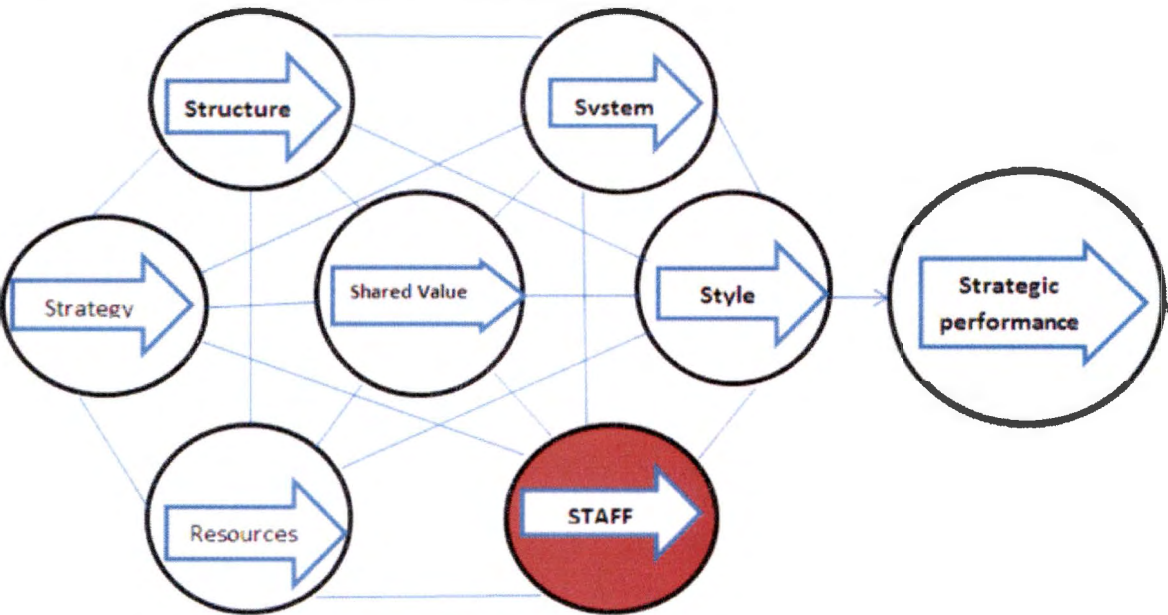
Richard and Johnson (2001) highlight the three important human resources practices for organizational performance in the context of SHRM. These practices are employee turnover, productivity, and financial turnover. This argument places SHRM as an essential tool that enables organizations to achieve their optimal performance goals. The case for North West province to successfully implement NHI is dependent on strategic Human resource for productivity and effectiveness.

On the other hand, Colbert (2004:341) argues that SHRM is based on two dominant assertions, which advocate that “organizational resources are of critical importance” and that “the firm’s HRM practices are instrumental in developing the strategic capability of its pool of human resources”. The central idea of Colbert’s SHRM proposition is premised on the motivation of employees by means of clearly set expectations and well defined goals. Hellreigel et al, (2008:289) argue that goals affect motivation in two ways: “by increasing the amount of effort that people choose to exert, and by directing or channeling that specific effort”. This theory of motivation embraces several key principles that include “designing enriched jobs, clarifying performance expectations, and providing rewards which employees value, giving feedback, and ensuring equitable treatment”. All the above definitions highlight aspects of integration between SHRM and organizational strategic objectives as a value adding mechanism. Becker and Huselid (2006) outline the two main differences between traditional HRM and SHRM. According to the latter two authors, SHRM focuses on organizational performance and the role of HRM system as a solution to business, while traditional HRM is mainly concerned with isolated individual practice approaches.

Higgins (2005) contends that there is a need for organizational entities to reformulate and adjust their existing strategies to meet the need of a changing and more complex business environment. There is even much greater need for the execution of these evolving strategies, and therefore, “the overall direction and performance of an organization is the responsibility of top managers” (Hellreigel et al., 2008:15). Higgins (2005) further argues that “strategic performance” is an envisaged outcome, in addition to the original McKinsey 7’S model. The latter will only happen when all aspects of the model are aligned and work in a convergent manner towards focusing the strategic execution efforts.

Furthermore, there should be proper coordination of activities within the NHI healthcare facilities, especially when the NHI needs to achieve its envisaged strategic objective. The North West province should align its departmental activities based on the ‘eight S’ model as outlined below (Hellreigel et al., 2008).

Figure 2.2: Hellreigel’s 8’S Model of Organizational Activities



Source: Hellreigel et al. (2008)

The proposition of aligning organizational activities highlights the need to align strategic objectives of healthcare facilities with human resources aspects. Such a paradigm further propounds the case that employees are an important component in an organization. Furthermore, an interesting study by Becker and Huselid (1999:290) highlighted elements of the *value-added* HR function, and focused on three key themes as outlined below.

Table 2.1: The Three Key Value-added Themes of the HR function

Themes	Elements
1. A corporate strategy and management culture that is appropriately aligned and supportive.	The foundation of a value-added HR function is a business strategy that relies on the people as a source of competitive advantage and a management culture that embraces that belief. (1999:290)
2. An HR function characterized by operational and professional excellence.	A value-added HR function will be characterized by operational excellence, a focus on client service for individual employees and managers, and delivery of these service at the lowest cost (1999:295)
3. HR managers that are effective business partners and an HR function to support that role.	A value-added HR function requires HR managers that understand the human capital implications of business problems and can access or modify the HR system to solve those problems (1999:296)

Adapted from Becker & Huselid (1999)

The current study asserts that HR is on the one hand a significant strategic and value adding function in an organization, while on the other hand, it is also a business partner with “the performance enhancing dimension of the HRM system” (Becker & Huselid, 1999:298). The concept of “human resource as a business partner” is also well illustrated by the Ulrich model of HR. The Ulrich model entails the four key Human Resources roles as illustrated below.

Figure 2.3: Ulrich’s Model of HR



Source: Becker et al. (2001)

Ulrich advocates the fact that human resources is an integral part of business success and should be considered as a pillar that advances a business's strategic objectives. NHI success is therefore mainly reliant on viable and effective human resource management.

Another view of strategic human resources management argues that core organizational values are important in SHRM, and there must be nurturing of such values and ensure that "they are consistent with the strategic direction of the business" (Harris & Ogbonna, 2001:157). It is therefore important for NHI to embrace the views proposed by the above two authors, to an extent that these views form part of the organization's strategic trajectory.

2.3 HUMAN CAPITAL AND TALENT MANAGEMENT

Adequate human capital is central to the successful implementation of human capital management. The International School of Human Capital Management (ISHCM) defines human capital management as "a term which is used to describe an organization's multi-disciplined approach to optimizing the capabilities and performance of its management and employees". Correctly skilled and diverse health personnel are the key drivers that will ensure that an organization achieves its strategic objective (Du Plessis, 2012)

The serious shortage of nurses in the North-West Province is detrimental to the effectiveness of the proposed National Health Insurance. The failure to produce enough nurses, especially in the rural areas of the province, is a writ large manifestation of a short-coming in the planning and controlling phases of the management process.

According to Nel et al. (2008:648), human capital provides the effective achievement of a company's strategic objectives, and ensures a positive impact of these objectives on an organization's success. There is a direct link between organizational success and the particular organization's strategic objectives, according to which human capital is inextricably linked to the concept of 'value adding'. Grossman (2000) contends that health forms a fundamental aspect of human capital; hence the assertion that health is a durable capital stock that yields an output of healthy work time. The latter view advocates that a healthy workforce can perform optimally.

Mincer (1974) uses the schooling and post-schooling proposition as the two key elements of human capital. The skill and competencies that are acquired during schooling, and the post-schooling experience attained constitute the basis of human capital investment. Nel, et al. (2008), further argue that organizations use human capital to evaluate the impact of human resources functions. The metrics used evaluate progress within the organization, the effects of any change, and the 'value adding' aspect of the human resources function.

Talent management has become a central part of organizational success. Therefore, organizations seeking to sustain a competitive advantage have moved quickly to develop systems to leverage the value of knowledge for this purpose. Lewis and Heckman (2006:140) identify the key components of talent management as the ability of an organization to identify or recruit, develop and retain talent. According to Maslach, Schaufelli, and Lieter (2001), employee engagement is characterised by energy, involvement, and efficacy; which is the direct opposite of the three burnout dimensions of exhaustion, cynicism and inefficacy.

According to a 2008 survey conducted by the Society for Human Resources Management (SHRM), different HR practitioners identified talent management as the leading HRM aspect. The table below illustrates the outcomes of the 2008 survey referred to above.

Table 2.2: Outcomes of the SHRM's 2008 Survey

Priorities for Human Resources Practitioners		Today (n = 517)	Future (n = 504)
1.	Managing talent	48%	52%
2.	Improving leadership development	52%	45%
3.	Managing demographics	16%	34%
4.	Delivering on recruiting and staffing	46%	33%
5.	Managing change and cultural transformation	34%	31%
6.	Enhancing employee commitment	28%	26%
7.	Transforming HR into a strategic partner	25%	25%
8.	Improving performance management and rewards	21%	21%
9.	Managing globalization	9%	20%
10.	Managing work/life balance	23%	20%
11.	Managing diversity	20%	19%
12.	Becoming a learning organization	10%	15%
13.	Measuring HR and employee performance	14%	15%
14.	Mastering HR processes	15%	10%
16.	Restructuring the organization	16%	9%
17.	Providing shared services and outsourcing HR	7%	8%
18.	Managing corporate social responsibility	5%	6%

***Note:** Table represents U.S. respondents. Percentages do not total to 100% as respondents were allowed multiple choices. Respondents were asked to select the four most important topics in 2007 and in the future (2010-2015). Data sorted in descending order by the 2010-2015 data.*

Source: BCG/WFPMA/SHRM (2008)

According to Lewis and Heckman (2006), another element of talent management is employee retention. Fitz-Enz (1997) investigated the nuances related to employee retention, and observed that the average company loses approximately R1 million with every ten managerial and professional employees who leave the organization. Elaborating further on the salience of talent management, Blass (2007) articulate the following enterprise perspective on talent management indicated below. The Planning phase as part of the management process will be interrogated to ensure that there is adequate human capital that is able to embrace the demand of NHI. This phase will ensure proper implementation of talent management initiative with special attention to human resource forecasting.

Organizing and Leading phases will focus on allocation of human resource against the growing burden of disease in particular and NHI health demand in general.

Table 2.3: An Enterprise Perspective on Talent Management

Perspective	Core belief	Recruitment and Selection	Retention	Succession Planning	Development Approach
Competitive	Keep talent away from the competition	Pay the best so you attract the best. Poach the best from the completion.	Good people like to work with good people. Aim to be employer of choice	Geared towards retention – letting people know what their target jobs are.	Both planned and opportunistic approaches adopted. Mentors and used to build loyalty.
Process	Include all Processes to allow talented people to excel and optimize	Competence based consistent approach.	Work life balances processes & intrinsic factors that make people feel they belong.	Routine review process based on performance review cycle.	PDP's and development reviews as part of performance management; intervention as needed.
HR Planning	Right people in the right jobs at the right time.	Target areas of shortage across organization. Numbers and target approach.	Turnover expected, monitored and accounted for in plans.	Detailed in-house mappings for individuals.	Planned in cycle according to organization needs and requirements.
Developmental	Accelerate the	Ideally only	Clear	Identified groups	Both planned and

Perspective	Core belief	Recruitment and Selection	Retention	Succession Planning	Development Approach
	development of high potential.	recruit at entry point and develop.	development path and plans to lock high potential into career paths.	will be developed for each level of the organization.	opportunistic.
Cultural	Belief that talent is needed for Success.	Look for raw talent. Allow introduction from in-house.	Allow people the freedom to demonstrate their talent, and succeed and fail	Develop in-house if possible, if not look outside.	Individuals negotiate their development Path, with Coaching & mentoring.

Source: Blass (2007)

Lake (2000) acknowledges that in spite of knowledge now being recognized as one of an organization's most valuable assets, most organizations lack the supportive systems required to retain and to leverage the value of that very knowledge. Organizations cannot afford to be passive towards knowledge management and hope that people are acquiring and using knowledge, and that sources of knowledge are known and accessed throughout the organization.

Healthcare facility managers need to be correctly skilled in order to relate well with the continuously changing work environment. Failure to adjust would result in insufficient management support and compromise performance – thereby leading to non-achievement of an organization's strategic objectives. One of the factors attributed to non-achievement of an organization's strategic objectives is the appointment of some of the line managers through a political process of deployment which does not always guarantee that the deployed official possesses the correct skills for the position to which they are appointed. This process of political cadre deployment has created huge managerial inefficiency, especially in government institutions.

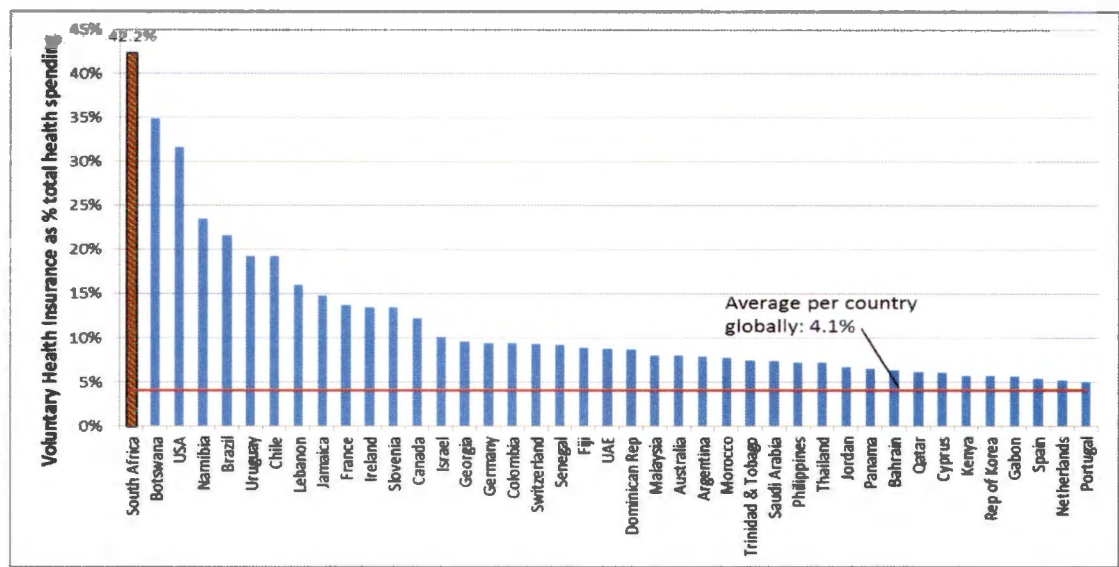
2.4. THE CURRENT STATE OF NHI AND UHC IN SOUTH AFRICA: CHALLENGES AND SUCCESSES

In its twenty year review, the South African government stated that; "Although South Africa spends about 8.5 percent of GDP on healthcare, the country has poor health outcomes, compared with other countries with similar, and in certain instances lower, national income and health expenditure per capita. This is attributed to two main factors. The first is the gross inequality where 5 percent of GDP is spent on 16 percent of the population while the remaining 3.5 percent

of GDP is spent on 84 percent of the population. The second factor is the high cost of healthcare in the private sector.” (Presidency, 2014:61).

South Africa has the most skewed distribution of health finance in the world, as illustrated below.

Figure 2.4: Countries’ Population Against Health Spending



Source: WHO estimates for 2012, countries with population > 600,000

The success of NHI is also dependent on the political will of the leaders and therefore comparative analysis from other countries with similar conditions like those in South Africa will be sort to make a case and draw lessons that will assist South Africa to achieve the envisaged access to health care.

2.5 THE CONSTITUTIONALITY OF NHI/UHC TO HEALTH IN SOUTH AFRICA

Section 27 of the South African Constitution reiterates that “Everyone has the right to have access to: health services, including reproductive health; sufficient food and water; and social security, including, if they are unable to support themselves and their dependents, appropriate social assistance” (RSA Constitution, 1996). Section 27 of the self-same constitution states furthermore that: “The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights and that ‘no one may be refused emergency medical treatment’”.

The NHI serves as a tool to realize the enjoyment of the right of access to healthcare for all. The NHI is therefore guided in its implementation by the provisions of this legislative framework. The National Health Amendment Bill of 8 November 2011 is the first piece of proposed

legislation, published after the release of the NHI Green Paper. The above-cited Bill is the forerunner to the development of a legislative framework aimed at implementing the policies and structures envisaged in the NHI proposal.

According to this Bill, all public and private healthcare centres should obtain accreditation from the Health Standards Office. The establishment of this office follows the government's commitment to the improvement of the quality of healthcare in South Africa's public health facilities, and the strengthening of the country's health system through enhanced accountability. The Bill envisages the establishment of the Office of Health Standards Compliance as a juristic person, with the intention of protecting and promoting the health and safety of users of health services by monitoring compliance "by health establishments with norms and standards prescribed by the Minister in relation to the national health system and ensuring consideration, investigation and disposal of complaints relating to non-compliance" (Section 78 (a)(b) of the National Health Amendment Bill of 8 November 2011) .

The envisaged intention of the NHI in South Africa is to improve access to quality healthcare services, whilst providing financial risk protection against health related catastrophic expenditure for the whole population (NHI Green Paper, 2011). The NHI will provide access to a defined comprehensive package of health services through accredited and contracted public and private providers. Contrary to the current system, which is more curative than preventive, the NHI will strongly emphasize its focus on health promotion and prevention services by means of primary healthcare at community and household levels. The following are the seven principles by which the NHI will be guided:

- The right to access;
- Social Solidarity;
- Effectiveness;
- Appropriateness;
- Equity;
- Affordability; and
- Efficiency.

From the list of the NHI principles above, it could be inferred that the NHI-based healthcare system is aimed at the social transformation of a healthcare system that promotes universal coverage for quality and affordable healthcare.

There are a number of perspectives in the development literature on Universal Health Coverage, all of which outline equity and accessibility as key to UHC implementation. According to the World Health Organization, universal healthcare coverage is the progressive development of a

health system into one that ensures that everyone has access to quality health services. In such a system, everyone is accorded protection from financial hardships linked to accessing health services. Furthermore, proponents of UHC argue that it provides access to key promotive, preventive, curative, and rehabilitative health interventions for all citizens at an affordable cost, and thereby achieving equity in access (WHO, 2005).

The World Federation of Public Health Associations defines UHC as “access to key health interventions, to promote, prevent, cure and rehabilitate all members of society and to do so at an affordable cost” WFPHA (2007).

The International Labour Organization (ILO) on the other hand, refers to universal social health protection coverage as “effective access to affordable healthcare of adequate quality and financial protection in case of sickness (ILO, 2007). According to ILO, this definition of UHC refers to the coverage of social health protection with regards to the size of the population that has access to health services, and the extent to which costs of the defined health services are covered such that costs do not serve as a barrier to quality healthcare service. The major thrust of these definitions or perspectives highlight the following aspects of universal health coverage: population coverage, prevention of disease, promotion of health and rehabilitative services, as well as equity of access.

2.5.1. Health as a Fundamental Human Right

As an enforceable basic human right, health is recognized in a number of international instruments, including The United Nations Universal Declaration of Human Rights (1948), which outlines health as an enforceable and fundamental human right. The Declaration states that “Every human being is entitled to the enjoyment of the highest attainable standard of health through numerous complementary approaches such as the formulation of health policies, or the implementation of health programs developed by the World Health Organization, or the adoption of specific legal instruments” (United Nations, 2000). The Universal Declaration of Human Rights further states that “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services’. It is clear that from these documents, the right to health contains freedoms and entitlements. The logical question then, is: What does this (notion of an enforceable and fundamental human right) imply in practical terms? Who is to be held accountable in the event that it is violated?

The enforceability of this right is a potential pathway to advance UHC. In its Economic and Social Council, the United Nations Organization (UNO) states that health is a fundamental

human right, and is indispensable for the availability and exercise of other human rights. The right to health is an inclusive right that extends beyond appropriate healthcare, and includes the underlying determinants of health such as: access to safe drinking water and adequate sanitation, healthy occupational environmental conditions and access to health-related education and information – including on sexual and reproductive health (United Nations, 2000). The right to health contains both freedoms and entitlements. Freedoms include the right to control one's health, including the right to be free from non-consensual medical treatment and experimentation (United Nations, 2000). Entitlements also include the right to a system of health protection that provides equality of opportunity for people to enjoy the highest attainable standard of health (United Nations Special Rapporteur, 2008). From the various health paradigms explicated above, it is evident that the right to health entails a broad concept that could however, be specified.

2.6 THE CURRENT STATE OF NHI/UHC IN THE NORTH-WEST PROVINCE

The Gini Coefficient Index 2012 report has confirmed South Africa as the leading countries with the highest income inequality in the world. North-West province is no exception with high unemployment rate and increasing burden of disease. Both the unequal socioeconomic conditions of the majority of South Africans and the burden of disease in the country necessitate a shift from the two-tier healthcare system to universal coverage, in order to ensure that society has access to decent healthcare services. The rationale of the NHI is premised on the elimination of the current two-tiered health system in which those with the greatest need to healthcare services have the least access, and consequently have poor health outcomes (NHI Green Paper, 2011).

Du Toit and Van Tonder (2009) outline that the Gini coefficient increased from 0.57 in 1992 to 0.70 in 2008. It improved to 0.65 in 2010, but this figure is way above the Organization for Economic Cooperation and Development (OECD) average of 0.32. The high levels of socio-economic disparities can be observed in all areas of social development.

South Africa is currently rated number 118 out of 187 countries on the 2014 Human Development Index report. This is disconcerting, considering the amount of money spent on health services in the past few years.

2.7. LESSONS LEARNT FROM THE INTERNATIONAL EXPERIENCES: RELEVANCE TO SOUTH AFRICA AND THE NORTH-WEST PROVINCE

Whereas South African NHI is a newly invented healthcare system, other countries have since implemented such a system within their countries' healthcare policies. This includes middle-income countries that are at par with South Africa in terms of economic development, high-

income countries as well as low income countries. Each of these countries has had its own experiences and challenges with the implementation of UHC, and lessons could be learnt from such countries by the South African government as well as other countries that intend to move towards UHC. Whilst countries differ with regards to economic levels and profiles, contexts within which UHC is formulated and implemented also differ and are country-specific. It is therefore important that countries that are yet to implement UHC and those in the process of rolling out the UHC system – such as South Africa – learn from the experiences of other countries. Such learning experiences could assist in the avoidance of discrepancies that otherwise would have been avoided in the actual implementation of the NHI. In order to establish a framework for comparison, this study refers to three countries that already have UHC in progress, and have since implemented it. These countries are: South Korea, Thailand and Ghana.

2.7.1. The South Korean Experience¹

South Korea was largely based on a poor agrarian economy with a relatively small medical workforce and a spartan health infrastructure. The health insurance system was based on chaebols as the primary drivers of industrial development, with health insurance considered a major labour benefit. The orientation towards expanding insurance coverage was part of the Korean State's efforts for the industrial development of a publicly funded, but privately driven health sector. Over the years, South Korea has enjoyed remarkable economic and social development. GDP (gross domestic product) per capita is more than six times, and the country has added about six years to its life expectancy since 2000.

South Korea achieved its universal coverage of 98.5% in 2004. The country previously had multiple funding pools derived from its various economic sectors. In 2000, a law was passed for the integration of all funding pools into a single insurer. The latter initiative enhanced equitable healthcare access, and resulted in the highest reduction in out-of-pocket spending as a share of current expenditure on health during the period 2000 to 2009. In the current South Korean health system, NHI underpins universal coverage; with compulsory wage-based contributions and Medical Aids Scheme for the poor; fee for service payment to almost all healthcare service providers remains dominant; and there is an overwhelmingly high level of private provision of healthcare services. The South Korean health system is also considered as one of the most competitive systems in the world. In addition, there is a growing hospital sector with more people going for hospital treatment than clinic-based treatment. Consequently, hospitals and

¹ Case extracted from the Department of Health's Conference on National Health Insurance report, December 7-8, 2011: presentation by Ankit Kumar.

technology are giving an impetus to healthcare spending; so are chronic conditions – with hospitals dealing with rising chronic conditions which can be attended to at clinic level.

The South Korean government has noted with concern some of the major challenges arising from the dominance of fee-for-service as a reimbursement mechanism; the growth of the private hospital sector; and the increase in the number of people with chronic diseases. As a result of this concern, new interventions are being implemented or considered to ensure better provider payment mechanisms – such as DRGs and prospective payments, as well as different payment options.

2.7.2. The Case of Thailand ²

The population of Thailand is about 47 million. General taxation is Thailand's main source of finance for the health system. In 2011, the country spent an estimated US \$79 per capita on its healthcare system. Under the Universal Coverage (UC) scheme, the benefit package contains a minimum negative list and entitles the population to a comprehensive package of outpatient and inpatient care, preventive and promotive healthcare, an essential drug list, high cost care, ART, and zero co-payments. The UC scheme contracts with public and private provider networks of primary care (of which more than 95% were public, due to geographical monopoly) and primary care givers. Providers are reimbursed by means of capitation for outpatient services and DRGs under global budget for inpatient services. The UC scheme is managed by the National Health Security Office (NHSO) which was legally established as an independent public agency. The NHSO head is the Secretary-General, who is appointed by a governing board. The NHSO employs about 800 (eight hundred) competent staff members, and has no role on revenue collection. Additional technical expertise and support are mobilized from outside research institutions. The government implemented a number of reforms to improve health infrastructure and human resources. In the area of human resources, one of the key interventions was the institutionalization of compulsory community service for all categories of health professionals. As a result of these interventions, the following positive results were recorded within a very short period of time:

- Population per bed increased as a result of accelerated expansion of health infrastructure;
- As a percentage of income, out of pocket (OOP) health expenditure was reduced by 18% prior to 2008, and has subsequently grown even lower;
- Patient utilization improved as a result of capitation implementation;
- The patient admission rate increased mainly due to the roll-out of the DRG system;

² Case extracted from the Department of Health's Conference on National Health Insurance report, December 7-8, 2011: presentation by Dr Viroj Tangcharoensathien.

- The incidence of catastrophic health expenditure declined significantly;
- Household health impoverishment declined after implementation of universal coverage policy formulations.
- Spending in health increased at about the same rate as the total economy at a ratio of 3.5-4%;
- A major achievement is the health share by household payment, which has reduced over time, while the public share consistently increased to almost 75% in 2007; and

A decreasing trend in the rich-poor gap in health payment is largely due to a reduction in the OOP burden shouldered by the poor households.

The above-cited low-income scheme was introduced when the Gross National Income (GNI) per capita was 390 USD, considering that the community-based health insurance scheme was introduced in 1983 when GNI was 760 USD. The occurrence of the Asian economic crisis in 1997 had an adverse impact on the ability of Thailand to progress rapidly towards universal health coverage. However, universal health coverage was eventually achieved, despite the GNI per capita of less than 2000 USD, when other richer countries could not reach universal coverage.

The UHC was implemented when the Thai health system was developed to a state of readiness. Willingness on the part of political leadership played a critical role, but real direction was adequately guided by evidence and a huge role of health systems capacity, professional ethos supported by locally generated evidence for policy (re)formulation, fostering political / financial commitment and ensuring minimum catastrophic health spending, as well as impoverishment for the population. Reaching universal coverage in health requires real political and financial commitment. There should be a resilient and dedicated leadership cadre. Furthermore, responsive health systems are the foundation for successful universal coverage implementation. There are three synergistic driving forces from which South Africa must draw as it implements the NHI:

- 1. Intelligence:** Evidence navigates direction and guides systems designs;
- 2. Outcomes-based:** Responsive politics and financial commitments translate universal coverage politics into tangible outcomes for the population; and
- 3. Citizenship Participation:** Citizens hold politics and governments accountable and responsive.

It is important that there is a policy champion with sufficient political power to sustain the policy reform process. Based on some critical factors from the Thailand experience, South Africa could learn some valuable lessons on the development and implementation of the NHI. The involvement of grassroots organizations will help to create a needed civic movement that could prove pivotal in the progress towards implementation of the NHI in South Africa.

2.7.3. The Ghanaian Experience³

Since its independence from colonial rule in 1957, Ghana has undergone several policy change eras on healthcare financing. These changes included the free healthcare era, the cost recovery era that was commonly referred to as the cash-and-carry system, and more recently the Ghana National Health Insurance scheme. The current universal healthcare system in Ghana was started prior to 1999 with two district pilot schemes that were eventually formalized from 2003 with the passage of the National Health Insurance Act of 2003. Solidarity and Cross-subsidization became the two foremost guiding principles and cornerstones of the Act.

The main sources of funding for the National Health Insurance (NHIS) are premiums and registration fees supplemented by a 2.5% mandatory contribution from formal sector worker pension contributions and a 2.5% Health Insurance levy that is added to address the funding gaps. The benefit package covers 95% of commonly occurring diseases, and health services are provided by predominantly public sector providers, private sector GPs, NGOs and faith based organizations.

The dominant reimbursement mechanism was fee-for-service in the initial stages of implementation. Presently, the NHIS is proposing to implement capitation for GPs and DRGs for hospital level care. The major challenges that the NHIS faces in its operations is the lack of adequate Information Technology (IT) capacity to handle increased volume, utilization and claims, as well as a weak communication strategy to update stakeholders on new developments. Nonetheless, NHIS has rolled out a major programme to expand and enhance its IT capabilities through the implementation of four regional offices to support improved claims processing and provider reimbursement.

2.8. CONCLUSION

The literature in this study managed to highlight and reviewed all the aspects of the research topic. The researcher focused on understanding NHI and HRM, including SHRM. The Current State of NHI and UHC in South Africa with its challenges and successes together with the Constitutionality of NHI/UHC in South Africa is clearly interrogated. The focus of the review also included assessment of the current state of NHI/UHC in the North-West Province. Lessons learnt from the international experiences with specific relevance to South Africa and the NWP were interrogated.

The following chapter focuses on the research design and methodology used in interacting with data in this study.

³ Case extracted from the Department of Health's Conference on National Health Insurance report, December 7-8, 2011; presentation by Mr. Kwesi Eghan.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter provides a description and justification of the research design and methodology used in the study, as well as a brief description of the ontological and epistemological assumptions of the study. In this study, research design and research methodology are viewed as two distinct, but inter-related research concepts. Research methods relate to the specific techniques used by researchers to structure a study and to gather and analyse information relevant to the research questions and associated research problem in order to obtain the desired (but not pre-determined) outcomes of the study (Polit & Beck, 2012:12). Both the research design and research methodology were instrumental in achieving the study's objectives and the evidence on which the findings and recommendations are acted on.

3.2 The Document/Content Analysis Research Design Method

Henning (2004:3) contends that "the quest for understanding and in-depth inquiry" is the main aspect that distinguishes qualitative models from quantitative paradigms, which focuses mainly on control of components. The qualitative research design methodology – as indicated in Section 1.11 (p. 9) of this study – is the purposive, desktop theoretical research review in its nature, and was intended to examine whether the proposed NHI will be realized, given the current nursing human capital challenges and dynamics in the public health sector in the country. Accordingly, the researcher further conducted a content review and analysis of the emerging themes, trends and practices on the implementation of the NHI internationally from secondary data sources. Such an orientation enabled the researcher to obtain multiple insights and perspectives on the corpus of knowledge pertaining to the research topic, as well as possible gaps identified by other scholars in this field of knowledge (Hyett et al., 2014).

Content analysis and document review were undertaken concurrently in accordance with the proposition by McDaniel and Gates (2008:496). Content analysis also facilitated the breaking of data into comparable themes, principles, or concepts; structural or process features/patterns; tendencies; and associations or experiences. The secondary data sources contributed to the formulation of the critical aspects of the research project, such as the literature review; the research problem and its background; the research questions; and research methods and designs – all of which benefitted from the reviewed documents. A critical analysis of the reviewed documents concerning existing literature constituted a critical part of the entire research process. In this study, the review of relevant literature pertaining to the research topic provided further

provided different researchers' and practitioners' views and perspectives on the NHI (Babbie & Mouton, 2001:218).

Secondary data used in this study was obtained electronically from reliable institutions such as the Department of Health, SAMRC, SANC, and WHO. In its quest to examine the feasibility of the NHI (in respect of the current nursing staff challenges), the study invariably tests the validity and justification of the reasons advanced for the introduction of NHI by its proponents, as well as advancing a better understanding of the rationale of such a radical policy stance. The North-West Province is used as a point of reference (and not as a case study) to assess the accessibility of healthcare to all members of society, irrespective of their social, political, or economic standing. Furthermore, the document analysis assesses the implementation phase of National Health Insurance and the management process employed in the country generally and in the North West province in particular. In this case, the research on NHI focuses mainly on conceptual issues that involve analysis of the actual health problems which the South African healthcare system has experienced.

Limiting the document review to the North West Province prevented the study from broadening its scope, as the NHI is still in the nascent developmental and piloted implementation stages in different parts of South Africa. The North-West Province's peculiar healthcare idiosyncrasies lend the province comparable to other provinces in the country. The study by the South African Medical Research Council (2014) states that the North West mortality profile for the year 2010 is based on an estimated 43,072 total deaths. Of these, 20,358 (47.3%) were females and 22,714 (52.7%) were males. For all persons (males and females together), HIV/AIDS and TB deaths accounted for the highest proportion of provincial deaths (43.8%) followed by cardiovascular deaths, which accounted for 19.1% of deaths. This statistical information makes the North-West province a relevant and conducive point of reference at which the document analysis could be focused insofar as assessing the feasibility and likely implementability of the NHI. The prevailing health conditions, including the increasing staffing challenges in the North-West Province, also informed on the extent of issues generated by means of the document analysis. The following table (Table 3.1) depicts the concurrent document review/analysis and (qualitative desktop-driven) data collection processes.

Table 3.1: The Concurrent Document Analysis and Data Collection Processes

Design Type	Purpose	Focus	Methods of Data Collection	Methods of Data Analysis
Content analysis and document review	Identify and understand experience, meaning, or perception from textual information	Visual, and behavioural	Observation; Document Review and Analysis	Categorization; Characterization; Synthesis

Source: McDaniel and Gates (2008: 496)

3.2.1 Justification of the Document Analysis Approach

The appraisal and critical analysis of the existing literature on the NHI has further advanced the refinement of the pertinent research questions. The review of relevant documents was also helpful in the information gathering stages to support existing data, and to validate the researcher's interpretation of data with the prevailing body of knowledge on the research topic. The results accruing from the collected data will be discussed in the context of relevant literature conducted by other researchers in the fields of marketing and advertising, as well as public participation. Furthermore, the review of relevant documents on the research topic may address one or more of the following aspects, depending on the research questions being posed (Babbie & Mouton, 2001:218):

- Theoretical background: past, present or future;
- Acceptable practice; previous or contemporary;
- Methodology and/or research methods;
- Previous findings;
- Rationale and/or relevance of the current study;
- Distinguishing what has been achieved from what still needs to be done;
- Discovering important variables relevant to the topic;
- Identifying relationships between ideas and practice;
- Establishing the context of the topic or problem;
- Rationalising the significance of the problem;
- Understanding the structure of the subject;
- Relating ideas and theory to application;
- Identifying methodologies and techniques that have been used; and
- Placing the research in a historical context to show familiarity with state-of-the-art developments.

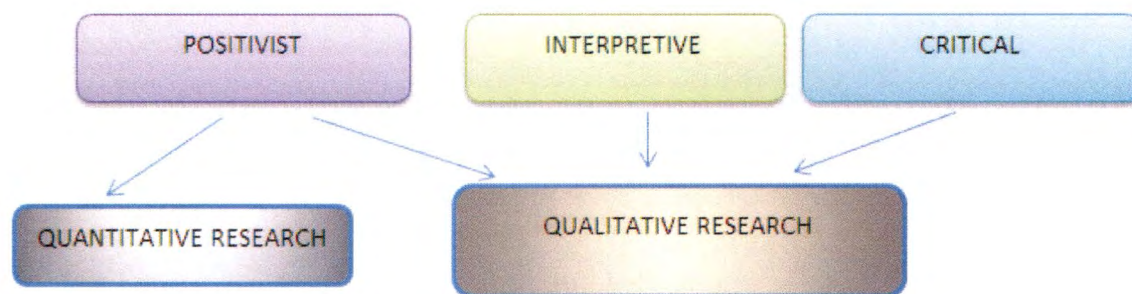
3.2.1.1 The Ontological and Epistemological Premises of the North-West Province as a Point of Reference

The inductive and deductive theoretic methods (referred to in Section 1.5) advocate that reasons be advanced to construct reality and test the form of that knowledge of reality (Denzil & Lincoln, 1998). The ontological approach to the examination of the North-West Province's capacity to implement the proposed NHI gave rise to the researcher's investigation of "possibilities, limits, structure, method and truthfulness" of ensuring successful implementation of NHI (Denzil & Lincoln, 1998). Guba and Lincoln (1998) contend that the sources of knowledge must be established and need to be tested. In grounding the epidemiology of the study, the researcher used valid and reliable secondary data from reputable sources. Such data was also tested against existing literature on the NHI and universal health coverage.

According to Denzil and Lincoln (1998:17), epistemology interrogates the following aspects, among others: "How reality can be known; the relationship between the knower and what is known; the characteristics, the principles, and the assumptions that guide the process of knowing; the achievement of findings; the possibility of that process being shared and repeated by others in order to assess the quality of the research; as well as the reliability of those findings". These criteria assisted the researcher in reviewing different sources of secondary statistical data regarding the number of nurses produced in the North-West Province; the attrition rate; the population of professional nurses in the nine provinces; the ratio of professional nurses per 100 000 population; the production of nurses in the country, the North-West Province's health workforce; and the vacant posts v/s filled-in posts in the North-West Province.

De Gialdino (2011) articulates succinctly that within the domain of epistemology, the interpretative pattern is the foundation of qualitative research, as illustrated below. Quantitative research concerns itself more with positivist theory, while qualitative embraces positivist, interpretive, and critical thinking theories. Figure 5 below is an illustration of de Gialdino's interpretative pattern.

Figure 3.1: The Interpretative Pattern of de Gialdino's (2011) Epistemological Framework



Source: de Gialdino (2009)

The quantitative aspect of research on the one hand, is more concerned with the positivist aspect; while qualitative research is broader and also interrogates critical and interpretative aspects of the research. Qualitative research on the other hand, is grounded on the epistemology of known subject and has two essential components: “cognitive interaction” and “construction of corporative knowledge” (de Gialdino, 2011). The researcher interacted cognitively with data and analyzed it in order to construct an input on the policy direction of the proposed NHI.

3.3 ENHANCING THE INTEGRITY OF THE STUDY

The overall plan for addressing the research question, including specifications for enhancing the study's integrity, obtaining answers to the questions being studied, and for handling some of the difficulties encountered during the research process was achieved by means of a research design whose data collection and data analysis processes were primarily qualitative (Burns & Groove, 2009:218). The current study is a purposive, theoretical research review in its nature, and desktop research became the fundamental data gathering mechanism. The integrity and quality of the study was maintained by means of adhering to strict management of the data collection process involving the concepts of validity, credibility, and reliability as quality assurance mechanisms.

3.3.1 Validity

In research, the validity of a study is determined by the extent to which the study accurately achieves its stated aims and objectives (Gibbs, 2007:93-94). Additionally, validity accounts for the study's closeness to its truth value (Myer & Karim, 2007:155). In the current study, validity was established by means of assessing the capacity and effectiveness of available nursing human capital in the North-West province to ensure implementation of the National Health Insurance. This was through interrogation of the existing data from reliable sources. Further examination of the current state of the nursing human capital in the North West Province; an determination of the

capacity of nursing institutions to produce the requisite nursing human capital in order to implement the NHI through nurse attrition and output at institutions of higher learning.

Soy (2003) states that the following aspects of validity (construct validity, internal validity, and external validity) are critically important and need to be ensured in order to obtain the credibility and reliability of a study. Construct validity refers to the selection of the most appropriate measurement tool for the phenomenon or phenomena being studied, in this specific case, NHI and universal health coverage. In this study, efficacy of the measurement tool is to be determined by the extent to which it illuminates on the effective management of nurses in the North-West Province, as well as the assessment of the production rates and levels of nurses in all training institutions in the province. Internal validity is mostly used as a tool to triangulate data (Soy 2003). Most of the data used, especially from the South African Nursing Council, was collected through arbitrary registration of nurses after completion of their studies. Such data was used to inform the human resource for health (HRH) strategy which the researcher has consulted in verifying data.

On the other hand, external validity refers to the extent to which the data could be adequately applied (transferred or generalized) beyond the circumstances of the specific case (in this case, the North-West Province) to more general situations (Soy, 2003). In this study, the triangulated information gathered across different sources assisted in informing the HRH plan.

3.3.2 Credibility

Credibility refers to the researcher's confidence in the truth value of the accumulated data and its analysis or interpretation. Credibility involves two aspects, namely: executing the study itself, and taking steps to demonstrate the truthfulness of the findings and recommendations to external readers (Polit & Beck, 2008:39). Furthermore, credibility is achieved by employing more than one source of data, data collection. In this study, credibility was established by ensuring that both primary and secondary sources of literature were consulted. Information from desktop research buttressed the information and knowledge accumulated empirically and from primary sources.

3.3.3 Reliability

Reliability/dependability refers to the extent of consistency or accuracy with which the research instrument measures the correctness of the collected data (Gibbs, 2007:100). Furthermore, reliability implies that a degree of repeatability could be achieved in the event of the same study being conducted elsewhere under the same conditions that prevailed at the original research site (Katzenellenbogen & Joubert, 2007:9; Soy, 2003).

In this study, the reliability of nurses' and other relevant nursing-related data and information was established from the South African Nursing Council, on account of the fact that it is binding

that all nurses should register with the South African Nursing Council after completion of their studies, prior to practicing as career or professional nurses.

3.3.4 Confirmability

Confirmability is a quality assurance mechanism for ensuring that the research results reflect a true account of the research participants' shared knowledge with the researcher. The concept of confirmability is the qualitative researcher's concern for objectivity. Confirmability ensures that steps are taken to ascertain as far as possible that the study's findings are the result of the accurate experiences and ideas of the participants, rather than the characteristics and preferences of the researcher (Shenton, 2004:72). Confirmability is further referred to as the objectivity or neutrality of data (Polit & Beck, 2006:363).

3.4 CONCLUSION

This chapter expounded on the qualitative desktop document content analysis study research design used in this study. The researcher intriguingly outlined some conceptual justification of the document analysis approach and delineated the ontological and epistemological premises thereof.

In enhancing the integrity of the study, the researcher further outlined different element of data collection process. The data collection process used in this study involved the elements of validity, credibility, and reliability as quality assurance mechanisms. Strict adherence to management of this process was maintained throughout.

In this study, confirmability was established by means of ensuring that all data collected was from reliable and credible sources and further tested against existing credible academic research bearing the same data. A range of demographic and epidemiological methods were applied in secondary analysis of data obtained. The following chapter will present and interpret data of this study. It will analyse and stimulate discussion that will respond to the research questions.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1 INTRODUCTION

This chapter presents data and its analysis in relation to both the objectives of the study, as well as the research methods and processes as a whole. While the data collection process itself was fundamentally desktop-based, triangulation by means of empirically-generated evidence ensured that the research process and methods collectively embraced both the qualitative and quantitative research approaches.

4.2 DATA ANALYSIS PERSPECTIVES

The purpose of data analysis, regardless of the type of data or underlying research tradition, is to organize, to provide structure, and to elicit meaning from the data (Polit & Beck, 2012:463). Data analysis occurred simultaneously with data collection (Polit & Beck, 2012:463). Yin (2003) articulates that there are essentially five data analysis techniques, namely: pattern matching; linking data to propositions; explanation building; time-series analysis; logic models; and cross-case data synthesis. The “linking data to propositions” and “explanation building” data analysis techniques were deemed to be the most appropriate methods used in the current study. A combination of the latter two approaches was achieved by means of the presented data on the output of nurses in the North-West Province, against the proposition of the growing burden of disease due to the high demand of accessibility to quality healthcare in the province. Logically, the accessibility to quality healthcare would require a proportional increase in the training of relevantly qualified nurses – therefore increasing the nursing human resources capacity in the province and the country as a whole.

To some degree, the study also focused on the extent to which the pursuance of the NHI could be sustained in the broader context of universal healthcare coverage in South Africa. In this regard, the strategic management of health human resources is fundamental, and needs to be the focal point in ensuring viable outcomes. Taking into consideration the challenges with the current two-tier healthcare system, South Africa’s transition towards NHI required a tremendous amount of policy groundwork to be undertaken. This required a lot of stock-taking of the healthcare system in order to establish areas that needed to be developed to ensure that the NHI addresses the healthcare challenges and improvement of the country. The following are the identified pilot site for NHI in South Africa.

Table 4.1: Selected Pilot Districts and Respective Population Figures

Province	District	Total Population Based on STATSA 2010 Population Estimates
Eastern Cape	OR Tambo	1 353 349
Mpumalanga	Gert Sibande	944 694
Limpopo	Vhembe	1 302 107
Northern Cape	Pixley ka Seme	192 157
*Kwa Zulu Natal	UMzinyathi	514 840
*Kwa Zulu Natal	uMgungundlovu	1 066 150
Western Cape	Eden	558 946
North West	Dr K Kaunda	807 752
Free State	Thabo Mofutsanyane	832 172
Gauteng	Tshwane	2 697 423
Total Population		10 269 590

Source: SANC (2013)

*KwaZulu-Natal will pilot two districts due to high population and high burden of disease

4.3 POSSIBLE UHC CHALLENGES AND SUCCESS FACTORS

A committed process to the implementation of NHI as an aspect of universal health coverage will necessarily result in the trajectories and desirable outcomes mentioned below.

4.3.1 Lack of Data on the Supply and Demand of Nurses

In order to ensure proper, efficient and effective human capital management, the unavailability of reliable data on the supply and demand of nurses should be viewed as a matter of priority. The South African Nursing Council mainly keeps records of all registered nurses, and other related data and information concerning the supply and demand of nurses in the country is unavailable from its databases. The South Africa healthcare system is nurse-centred in that nurses are in the majority of the healthcare services provision category, especially in the rural areas. In addition, nurses are the ones running the healthcare facilities. A survey conducted by the South African Institute of Race relations in 2010 indicated that South Africa had 56% (14,351) of doctors' posts unfilled, while the unfilled nursing jobs accounted for 46 percent (44, 780). The latter state of affairs unequivocally demonstrates the need for proper human capital planning and control.

The former Minister of Finance highlighted the need to increase the health budget in his February 2014 budget speech by stating that: "We have spent R39 billion on 1 879 hospitals and other health facility projects, and R26 billion is allocated over the MTEF period ahead". The

difference between expenditure and outcomes indicates that there are underlying structural problems associated with poor health provision.

4.3.2 Overall Strengthening of the Healthcare System

The improvement, expansion and revitalization of public healthcare infrastructure and services are critical to the realization of universal health coverage and the reduction of inequalities in the realm of access to health. Therefore, a parallel health systems strengthening plan will need to be developed to assure infrastructure maintenance, improvement and expansion (capital cost) and service provision (recurrent cost).

4.3.3 Output of Nurses from Higher Education Institutions

The production of Nurses in South Africa is largely produced at both public and training institutions. It must be noted that the nursing profession has different categories which are professional nursing, enrolled nursing and auxiliary nurse. Training that is offered at higher education institutions is mainly for the attainment of professional nursing and nursing specialization.

Table 4.2 below illustrates the production of nurses at various training institutions throughout the country between 2004 and 2013. It can be noted that the North-West province indicates that the general production of nurses in the North West province has been growing constantly between 2005 and 2010. However, a decline in 2011 (234) from 2010 (327) raises a concern especially in relation to the much needed nursing human capital to curb the scourge of raising burden of disease.

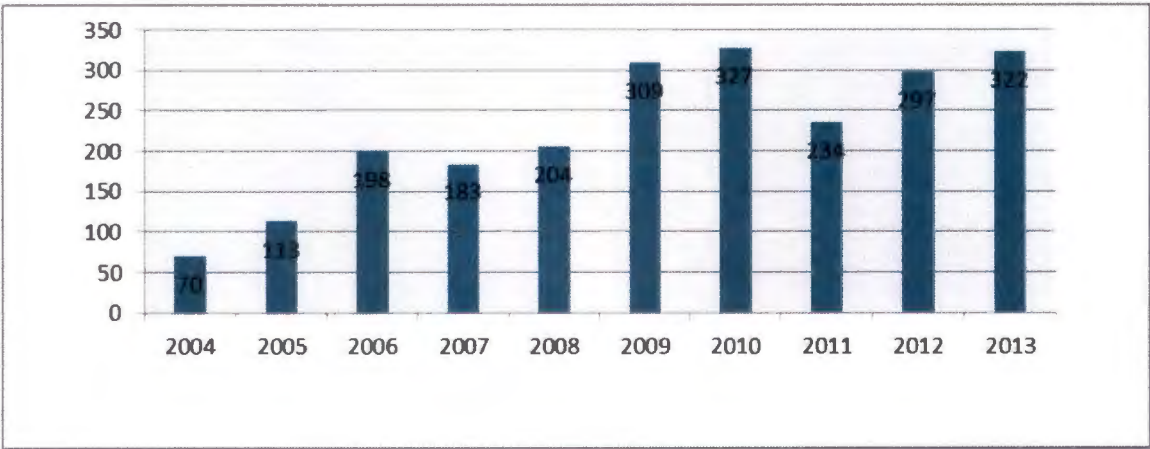
Table 4.2: Output of the Four-Year Nursing Programme at all Institutions (2004-2013) in the Public Sector

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Limpopo	114	142	114	185	224	234	207	248	339	220
North West	70	113	198	183	204	309	327	234	297	322
Mpumalanga	95	52	112	64	72	1	216	140	120	197
Gauteng	368	356	413	521	701	577	784	663	757	793
Free State	79	76	76	100	61	146	182	174	147	174
Kwa Zulu Natal	441	243	429	647	464	448	555	570	604	586
Northern Cape	19	11	24	19	33	14	62	56	3	0
Western Cape	176	160	233	265	241	310	269	301	456	420
Eastern Cape	354	360	428	358	371	599	364	580	502	549

Source: South African Nursing Council 2013]

Figure 4.1 below is a graphic presentation of the output of the nursing professionals studying for the four-year programme between the years 2004 to 2013 across the North-West province. The statistics is for all nursing education institutions.

Figure 4.1: Output of Nursing Professionals in the North-West Province: 2004-2013



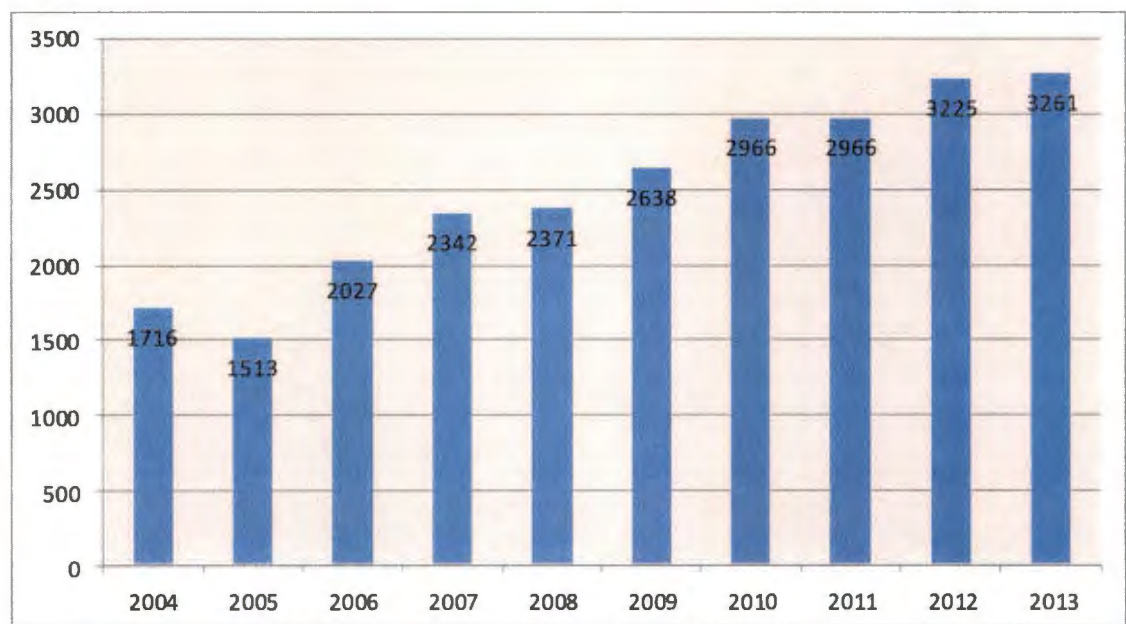
Source: SANC (2013)

The graph above shows an overall increase in nurses’ production over a period of time. However, the trend also shows a drop in production after every three years. The pattern of growth follows a decline on the third year. In 2007 there was a drop then a slide upward movement up to 2010. Another drop in 2011 from 327 nurses produced in 2010 to 234 nurses in 2011. There was an upward movement again up to 2013. It could be concluded that the next figures will decrease due to the “yo-yo” trend as demonstrated by the graph above. This

interpretation is informed by the pattern matching; linking data to propositions; and explanation building’ techniques as expounded by Yin (2003).

The graphic presentation of the data above clearly paints a picture that the 2014 and 2015 output will be lower than 322 nurses produced in 2013. This provincial trend warrants a statistical comparison with the national of trend.

Figure 4.2: Output of Nursing Professionals Across South Africa: 2004-2013



Source: SANC (2013)

The graph shows an ascending growth pattern from 2004 through to 2013 except for a drop in growth in from 1 716 nurses produced in 2004 to 1 513 produced in 2005. It can also be noted that the year 2010 and 2011 produced equal number of nurses at a total of 2 966

In comparing the ‘yo-yo’ trend observed in the North-West province against the steady ascending growth trend of national statistics, it can be concluded that North-West province presents an unstable and gloomy picture especially against the grow burden of disease profile in South Africa.

In its National Health Insurance Policy Paper (2011), the Department of Health (DOH), states that South Africa suffers from the quadruple burden of disease. This term describes the prevalence of the four main types of illnesses in the country, namely: HIV/AIDS; Maternal, Infant, and Child Mortality; Non-Communicable Diseases; as well as Injury and Violence.

The DOH acknowledges that the country’s deaths associated with the above-mentioned categories of diseases are higher than in most middle-income countries. This is evident in the levels of maternal mortality rate which has increased from 81 to 400 (per 100,000) between 1997 and 2005. Child mortality has decreased; however, it remains high at 68 (per 1000 live births).

Other developing economies have managed to lessen the number of child deaths. The tables below capture the recent stats on health performance. The table below indicates and compares the health statistics of BRICS (Brazil, Russia, India, China, and South Africa) countries.

Table 4.3: Selected Health Statistics, BRICS Countries: 2010-2014

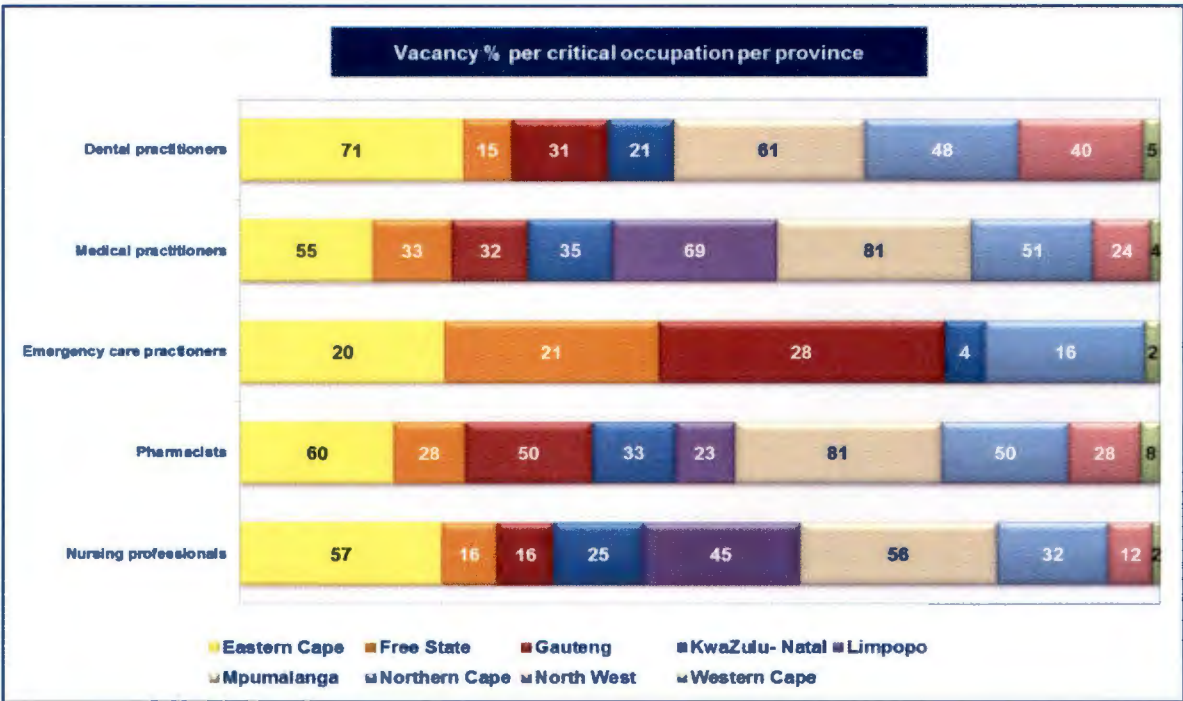
Indicator	Brazil	Russian Federation	India	China	South Africa
Total population (millions)	193.7	140.8	1 198	1 353	50.1
Total expenditure per capita (PPP in \$)	943	1 038	132	309	862
Total expenditure on health as % of GDP	9.0	5.4	4.2	4.6	8.5
General government expenditure on health as per % of total government expenditure	6.1	8.5	4.1	10.3	9.3
Life expectancy at Birth					
Males	70	62	63	72	54
Female	77	74	66	76	55
Both	73	68	65	74	54
Infant mortality rate (per 1000 live births)	17	11	50	17	43
Under 5 mortality	21	12	66	19	62
Adult mortality rate 15-59years (per 1000 population)					
Male	205	391	250	142	521
Female	102	144	169	87	479
Both	154	269	212	166	496
Maternal mortality ratio (per 10 000 births)	58	39	230	38	410
Distribution of year of life lost by causes (%)					
Communicable	20	11	52	15	79
Non Communicable	56	64	35	35	15
Injuries	25	25	13	19	6
Prevalence of HIV among adults aged 15-49 (%)	0.6	1.0	0.3	0.1	17.8
Prevalence of TB (per 100 000 population)	50	132	249	138	808
Tobacco smoking 15+ (%)					
Male	19.4	70.1	33.2	59.5	29.5
Female	12.0	27.7	3.8	3.7	9.4

Source: DOH (2015), Minister of Health Presentation to COSATU National Health Committee, March 2015.

4.3.4 Various Indicators on Shortage of Nurses in South Africa

The World Health Report (2006) has identified that sub-Saharan Africa has a critical shortage of nursing human capital. In order to meet the expected threshold, and reverse the adverse nursing human capital trends, a vacancy rate of about one hundred and forty percent (140%) needs to be seriously addressed. The table below is a vivid illustration of the nursing human capital vacancy rates per nursing category.

Table 4.4: Vacancy Rates per Occupation



Source: Parliamentary Monitoring Group – Annual Reports for 2010/2011

The 2010/2011 annual report of the Parliamentary Monitoring Group indicates that the Eastern Cape and Mpumalanga were the leading provinces with 57% and 56% vacancy rates respectively, while the North West at 12% and the Western Cape at 2% had the least number of vacancies respectively. With regard to the dental practitioners' vacancy rate, the North West Province's was among the highest. Notwithstanding the dire vacancy rates in the various provinces, policy determinants could still be established to ameliorate the situation and its attendant imbalances.

Day and Gray (2008) highlight a typology of four imbalances according to which the shortage and distribution of human capital in a healthcare system could be probed. The imbalances are typically based on the area of specialization; type of training institution; geographic location of the healthcare facility; and demographic factors such the socio-economic status of the majority of healthcare recipients in a particular area.

4.3.5 Improved Staffing of the Healthcare System

There is an urgent need for a reassessment and restructuring of the public nurse education system. The urgency is even more precipitated by the uncoordinated closure of nursing colleges, with the disastrous consequences leading to the reduced production of nurses in general, and professional nurses in particular. The public sector should resume its role of training nurse managers and nurse leaders. The provinces and the districts should take the lead in this regard.

The fact that South Africa still experiences problems of inequalities in the education system, inadvertently leads to the production of a very limited pool of learners with relevant grades and an appropriate combination of subjects that direct and orient learners towards opting for nursing as the ultimate profession of choice.

There is a need to identify assess, and advertise, vacant posts, as well as consider the establishment of new posts such as nursing specialists. The state of nursing vacancy rates is of such national importance that the AG's (Auditor-General's) 2012 report attests to nursing vacancy rates as one of the major impediments to service delivery in the healthcare sector. The North-West continue to be among the provinces that suffers the vacancy due its rural nature.

The table below shows the number of nursing post (vacant and filled) across the country.

Table 4.5: Vacant Posts in Relation to Filled-in Posts in South Africa

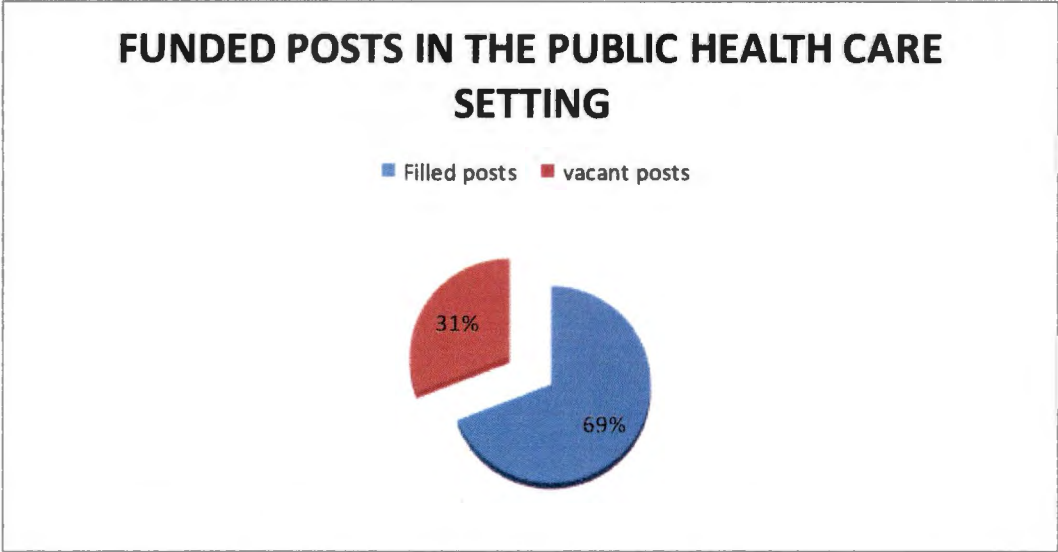
Total number of post	Vacant posts	Filled posts
419 237	129 506	289 731

Source: Parliamentary Monitoring Group – Annual Reports for 2010/2011

The pie chart below illustrates the percentage of filled-in nursing posts against the vacant posts; that is, the vacancy rate of critical human capital within the healthcare system in all the nine provinces of South Africa.

With the 31% vacancy rate of unfilled posts in the healthcare sector, it means that the system only functions with about two third of its staff establishment, and that reduces acceptable nurse-patient ratios; especially for bedside-confined patients.

Figure 4.3: The State of Funded Posts in the Public Healthcare Sector



Source: Parliamentary Monitoring Group, Annual Reports for 2010/2011

The fact that the North West province is predominately rural and therefore may not be the province of choice in attracting and retaining professional skills will be among the disadvantaged in enticing the much needed nursing human capital. It can then be argued that the 31% vacancy rate is very high and therefore poses a threat to successful implementation and sustainability of NHI. The total work force in the province confirms the threat for a positive case of NHI realization.

Table 4.6: North-West Province’s Nursing Workforce per 10 000 People

Nurses	Total	Total per 10 000 population
Professional	4179	10.71
Staff and pupil	746	1.91
Nursing Assistants	4305	11.04

Source: HRH Strategy for the health sector 2012/13 – 2016/17

The workforce total above does not paint a healthy picture as they are below the acceptable and therefore do not advocate for the readiness of the North West Province towards NHI. Even in comparing the ratio of professional nurses across province, the North-West Province remains unfortunate. The table below presents comparison of professional nurses across the provinces in South Africa.

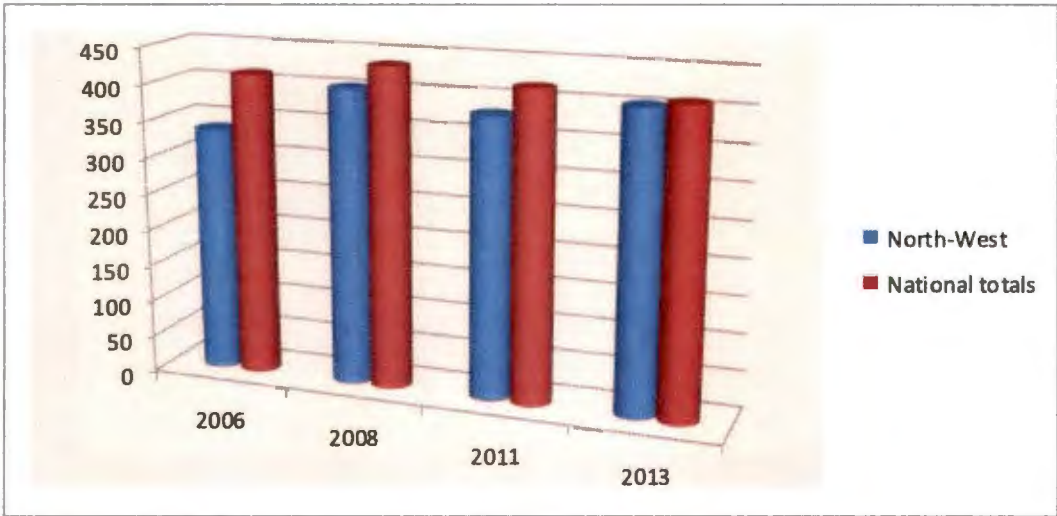
Table 4.7: Ratio of Professional Nurses per 100 000 across the Provinces

Province	2006	2008	2011	2013
Limpopo	303	365	387	524
North West	336	403	381	404
Mpumalanga	289	290	362	616
Gauteng	565	529	404	379
Free State	387	410	324	346
Kwa Zulu Natal	456	492	402	371
Northern Cape	370	339	302	529
Western Cape	543	512	404	375
Eastern Cape	289	328	366	443
TOTAL	414	436	419	411

Source: South African Nursing Council.

The NWP ratio of professional nurses per 100 000 people has always been below the national totals and the graph below vividly shows that the North West Province has always had lesser number of professional nurses against national ratio.

Figure 4.4: Comparison of Professional Nurse Figures: NWP against National Figures



Source: Researcher’s own interpolation, based on Table 4.7 information

Table 4.8: Population of Nurses in all the Provinces within South Africa

Province	Registered	Enrolled	Auxiliaries	TOTAL
Limpopo	524:1	1005:1	598:1	219:1
North West	404:1	1209:1	727:1	214:1
Mpumalanga	616:1	1428:1	1007:1	301:1
Gauteng	379:1	803:1	731:1	190:1
Free State	346:1	1315:1	830:1	206:1
Kwa Zulu Natal	371:1	454:1	855:1	165:1
Northern Cape	529:1	2590:1	972:1	303:1
Western Cape	375:1	963:1	709:1	196:1
Eastern Cape	443:1	1386:1	949:1	248:1
TOTAL	411:1	831:1	780:1	203:1

Source: South African Nursing Council – 2013

4.3.6 Nurse Attrition

The government should consider the reasons attributed to the migration of healthcare professionals to work in other countries. Such consideration should form the basis for improving incentives given to healthcare professionals. The workload of public sector nurses, particular in the rural areas, needs urgent remedial action. One of the remedial efforts suggested in the consulted literature to accelerate healthcare services delivery is that trained nurses working in the private sector should be encouraged to render their professional services to public hospitals on an a sessional basis. Provision of descent residence and competitive salaries should be considered as a strategy to attract nurses to the healthcare facilities in rural areas.

In their report – whose estimation based on “the availability of health workers required to achieve a package of essential health intervention and the millennium development goals” – Wildschut and Mqolozana (2008) highlight the following factors as prominent indicators of the nursing human capital shortage:

- *The desired healthcare worker coverage should be 80% or more; and*
- *An aging workforce – especially the majority professional nurses – should be above (and not below) 40 years.*

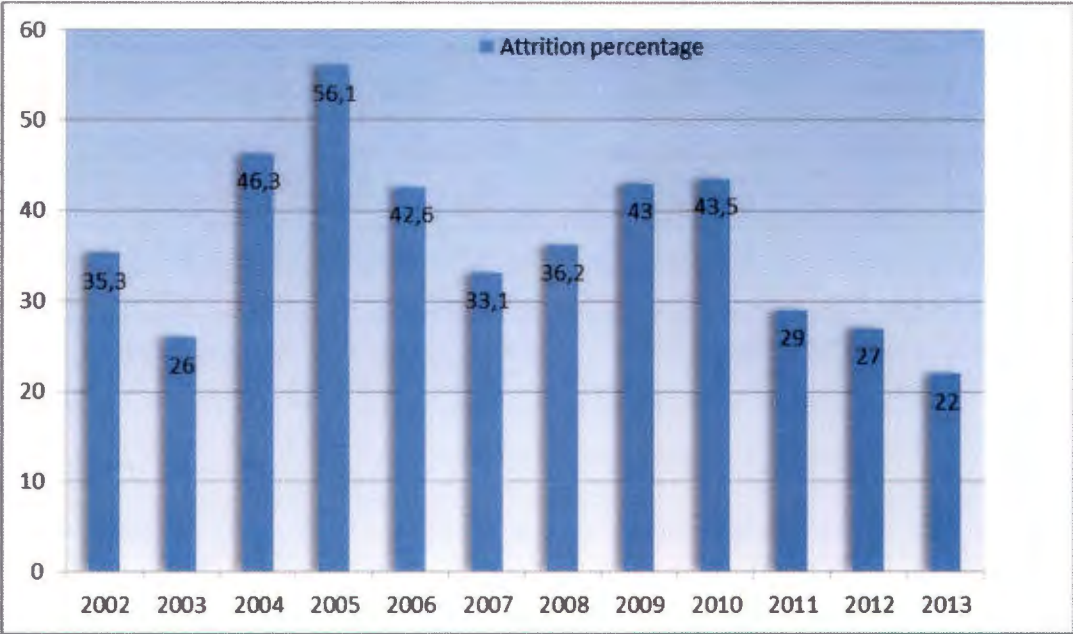
Table 4. 9: Attrition Rate of Nurses in South Africa: 2002-2013

	Total registered	Growth in registration	Total trained (output)	Nurses not registered⁷	Attrition rate⁸
2002	172 869	531	7 501	2 649	35.3%
2003	177 721	4 852	9 101	2 363	26.0%
2004	184 459	6 738	12 687	5 877	46.3%
2005	191 269	6 810	12 852	7 207	56.1%
2006	196 914	5 645	12 265	5 231	42.6%
2007	203 948	7 034	13 236	4 378	33.1%
2008	212 806	8 858	14 118	5 107	36.2%
2009	221 817	9 011	15 910	6 899	43.0%
2010	231 086	9 269	16 318	7 049	43.5%
2011	238 196	7 110	10 064	2 954	29.0%
2012	248 736	10 540	14 395	3 855	27.0%
2013	260 698	11 962	15 331	3 369	22.0%

Source: Econex Health Reform (2013). (*Econex is a specialist economics consultancy focusing on competition economics and other applied economic work*)

The table above reflects the degree of losses of nurses within the health care system in South Africa during the period between 2002 and 2013. This attrition rate is directly linked to management of human capital. The graphic presentation shows an unstable movement in the attrition rate with 2005 experiencing 56.1%, followed by 46.3% in 2004. The lowest percentage was in 2013 at 22%. The pattern reflected in the table above shows a wave fluctuation on whose basis it could be concluded that with 2013 as the lowest percentage point, the next movement will possibly be an upwards.

Figure 4.5: Researcher’s Presentation of Nurse Attrition Rates in South Africa



Source: Researcher’s own interpolation, based on Table 4.10 information

The interpolated information above indicates that between 2002 and 2013, the attrition rate was at its lowest (22%) in 2013 and only at its highest (56.1%) in 2005. Overall, the production of nurses seems to characterize a ‘yo-yo syndrome’ – a pattern or trend of continuous fluctuation.

Table 4.10: Production of Nurses by Various Institutional Curriculum Pathways: 2003-2013

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
University	408	408	400	453	428	460	534	714	670	671	
Colleges	2086	1633	1252	1100	1288	1058	1493	1628	1701	1967	2337
Bridging	1991	1670	1679	1841	2103	2364	2364	2093	2628	2475	2655
Total	4485	3720	3331	3394	3819	3897	4391	4435	4999	5113	5621

Source: South African Nursing Council (SANC) 2013

4.4. CONCLUSION

Analysis and interpretation of data in this chapter was utilized to validate the state of readiness of North-West Province to implement NHI. The study has interrogated the rate at which the province produces its nursing human capital. Furthermore, interpretation of this data has assisted in proven the fact that management of human capital at planning, leading and controlling phases within the NWP does not create a conducive environment for the implementation of NHI and therefore questions the state of readiness of the province.

The overall strengthening of the healthcare system, improved staffing, nurse attrition and retention mechanisms is what is needed to create a fertile ground for NHI. It has surfaced all relevance factors expected to be discussed further and recommendations made on the basis of the accruing discussions. The province is not in apposition to use lessons from developing countries similar to it. The following chapter will give conclusion of the study and further present recommendations.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter presents conclusions drawn from the research process itself, and proposes recommendations for the effective implementation of the envisaged National Health Insurance as a new and viable healthcare policy directive. The data collection, presentation, and analysis processes became the basis on which the conclusions and recommendations were arrived at respectively. The latter processes presented an opportunity to investigate, and described in context, the North-West Province's state of readiness insofar as the implementation of the NHI is concerned.

5.2 STUDY OBJECTIVES AND THEIR REALIZATION

In order to arrive at an objective determination of the conclusions and recommendations of the study, it is necessary to do so in the context of assessing the extent to which the objectives of the study were achieved, or partially achieved. Accordingly, the objectives of the study are:

- To assess the capacity and effectiveness of available human capital in implementing the National Health Insurance;
- To examine the current state of the health human capital in the North West Province; and
- To determine the capacity of nursing institutions to produce the requisite nursing human capital in order to implement the NHI.

The first objective which was to assess the capacity and effectiveness of available human capital in implementing the National Health Insurance; was achieved by means of an international comparative perspective, according to which the researcher embarked on an interrogation and assessment of lessons from other countries in respect of the implementation of universal access to healthcare services. The enabling condition prevalent in those countries provided a cogent case for the successful realization of the NHI in the three countries cited in the comparative framework (Section 2.7 of this study). South Africa in general and the North-West province in particular has almost similar health conditions as found in those countries.

The Auditor-General's report of 2012 is a useful point of reference to determine the capacity and effectiveness of available nursing human capital (or a lack thereof). Table 4.3, Table 4.7 and Table 4.8 – in conjunction with the AG report referred to above – indicate that DURING 2010/2011, the vacancy rate was 69% for the whole country. Furthermore, the NWP experienced a 214:1 ratio of nurse-to-patient, while the South African national average was 203:1. The

picture emerging in this regard suggests that in spite of the perceived overall nursing throughputs, there is also a decline in specific nursing categories. The imbalance between throughput and attrition could therefore compromise the requisite implementation of the proposed NHI.

The study achieved the second objective which was to examine the current state of the health human capital in the North West Province; by means of data analysis, with specific focus on the shortage of nurses in relation to the nurse patient ratios. The interpolated information in Table 4.11 indicates that between 2002 and 2013, the attrition rate was at its lowest (22%) in 2013 and only at its highest (56.1%) in 2005. Overall, the production of nurses seems to characterize a 'yo-yo syndrome' – a pattern or trend of continuous fluctuation. Correspondingly, Table 4.10 indicates that the nursing attrition rate was at its lowest (22%) in 2013 and at its highest (56.1%) in 2005 (Econex Health Reform, 2013). A survey conducted by the South African Institute of Race relations in 2010 indicated that South Africa had 56% (14,351) of doctors' posts unfilled, while the unfilled nursing jobs accounted for 46 percent (44, 780). The latter state of affairs unequivocally demonstrates the need for proper human capital planning and control.

On the other hand, the third objective – which was to determine the capacity of nursing institutions to produce the requisite nursing human capital in order to implement the NHI – was achieved by means of an evidence-based focus on both the attrition and production rates of nurses in the North-West Province. For instance, Table 4.1 and Figure 4.1, and Figure 4.2 collectively demonstrate that, except for 2005 and 2008, the production of nurses by various institutions has shown a relative degree of increase between 2004 and 2013 in both the NWP and the rest of the country. Contrastingly, the 2010/2011 annual report of the Parliamentary Monitoring Group indicates that the Eastern Cape and Mpumalanga were the leading provinces with 57% and 56% vacancy rates respectively, while the North West at 12% and the Western Cape at 2% had the least number of vacancies respectively. With regard to the dental practitioners' vacancy rate, the North West Province's was among the highest. Notwithstanding the dire vacancy rates in the various provinces, policy determinants could still be established to ameliorate the situation and its attendant imbalances. The above situation corroborates the World Health Report (2006) that sub-Saharan Africa has a critical shortage of nursing human capital in the range of .about one hundred and forty percent (140%). The above data indicates that the potential to produce nurses does exist. However, it is in some specific/critical nursing and medical categories that the throughput has to be increased.

5.3 RECOMMENDATIONS

The following recommendations were made on the basis of the accumulated literature including the secondary data and the research process in its entirety. It is the researcher's well considered view that these recommendations could contribute to both the NHI and the UHC as healthcare policy frameworks or plan; as well as improved nursing practice as a mechanism to deliver better and equitable services in the realm of accessible healthcare as a fundamental human right.

5.3.1 Improved Management of Nursing Human Capital

There is an acute need for an improved administration of human capital, with special attention to the planning phase of management. This will ensure that a value proposition strategy is developed, and conducive conditions exist to attract new staff and retain existing nurses. The initial phase will require that appropriate leadership is accorded to the nursing profession by establishing a nursing directorate in the North-West Province. Organization and control at the leadership level will ensure that proper distribution of the nursing human capital is attained in all areas in the province, including the mostly affected rural areas.

5.3.2 Improvement of Healthcare Infrastructure

The plan mentioned in sub-section 5.3 above entails a detailed inventory of both private and public facilities that includes available infrastructure, human resources, and technology in all parts of the country in order to establish the resources needed to deliver quality healthcare services to all the citizens of South Africa. The national health system has to provide services at the different levels of government and the healthcare system, and conduct a needs-based analysis in respect of capacity and both human and material resources. The plan (NHI policy framework) should also be able to identify any gaps for expansion in the event of population increases, in order to better prepare in the refurbishment of depleted facilities and in addressing the increasing disease burden. The envisaged implementation of the NHI entails a programme of facilities revitalization and the construction of new clinics and new hospitals.

5.3.3 Improved Functioning of the District Health Councils

The capacity to deliver quality primary healthcare services is premised on revitalized and adequately financed district health systems and their capacity to meet the needs of the catchment population. Strengthening the Districts Health Councils will improve political governance, managerial oversight, and accountability structures. The District Health Councils focus on improving healthcare service integration; the quality of services offered within facilities and outreach programmes; efficiency and effectiveness; community participation; developmental and multi-sectorial approaches.

5.3.4 Recruitment of Health Workers into South Africa

The recruitment of health professionals into South Africa should be considered as a temporary measure to address the shortage of healthcare workers in the country. The expatriate doctors and nurses should be able to work in their areas of expertise for specific periods, and be required to share or transfer their professional skills and knowledge to residents of this country.

5.3.5 Strengthening the Primary Healthcare Approach

The primary healthcare approach is the core focus in revitalizing and strengthening the South African healthcare system. Such an approach seeks to improve access to quality health services as the first point of entry to the healthcare facilities. The principles of the primary healthcare component of the NHI are contained in Chapter 5 of the National Health Act, which addresses amongst others, the District Health System and the major nuances associated with universal health coverage. The primary healthcare system provides 80% of care needed by the community, while access to secondary and tertiary care occurs on a referral basis.

The composition of the primary care package of services extends beyond mere services that are traditionally provided in health facilities such as clinics, community health centres and district hospitals. Primary healthcare also includes extensive community and home-based programmes. The formation of the outreach teams by means of door-to-door initiatives is intended to focus more on servicing the community's health needs, primary prevention of diseases, as well as rehabilitation. Furthermore, the outreach teams and programmes facilitate inter-sectorial collaboration and community involvement in the latter's health matters.

For the effective implementation and the re-engineering of the healthcare system, the PHC system needs significant involvement of the community at all levels of the health system. This means that the Clinic Committees, Hospital Boards, and District Health Councils need to be strengthened. The re-engineered primary healthcare system should also ensure the availability and access of medicines to people suffering from chronic illnesses including HIV patients. In order to improve compliance, private pharmacies should be contracted and ensure that medicines reach the patients on time, and that the patients understand their medication schedules (ANC General Council, 2010).

5.3.5.1 Task Shifting: The Elephant in the Room?

Task shifting should only be considered in the event of shortage of skilled staff, which often leads to tasks being delegated to workers with lower qualifications, from trained professionals to lay health workers. Health workers' labour unions and other professional associations need to do

their ground work to protect workers against exploitation in accordance with the applicable labour laws.

5.3.5.2 Training of Health Facility Managers

The management of health facilities from primary care to tertiary hospital level requires particular forms of knowledge and skills that need to be recognized and developed by means of health management training. Universities offer a number of out- and in-service programmes of varying duration in this regard.

An alternative possibility should be investigated of complementing universities' initiatives with a new health professional institute with dedicated health management programmes. In the short term, managers from the private and non-health sectors could also be utilized to help improve efficiency and change management. Apprentice or job-shadow arrangements should also be considered to build capacity in the public sector (ANC General Council, 2010).

5.3.6 Plan to Improve the Quality of Service for Public Health Facilities

The degree to which the South African public healthcare services meet the needs of the communities is less than satisfactory. This is due to a number of challenges, including: shortage of healthcare professionals; lack of medical supplies; and lack of medication in hospitals – all of which contribute to poor service provision. The socio-economic conditions of the majority of people in communities also contribute to the increased demand for services, as diseases associated with poor living conditions emerge. The latter trend necessitates the need for the NHI to poignantly address issues of healthcare service provision. By an Act of Parliament, the establishment of the Office of Health Standards Compliance is an attempt by government to improve the quality of service within the envisaged NHI.

5.3.6.1 Institutionalization of the Office of Health Standards compliance

The Office of Health Standards Compliance (OHSC) is established by an Act of Parliament. The OHC will have three units, namely: the inspection unit, the norms and standards unit; and the office of the ombudsperson. It will set norms and standards and undertake the inspection of all health facilities. This process will be undertaken in collaboration with the implementation of quality improvement plans in order to ensure that facilities are ready for accreditation and contracting with the National Health Insurance (NHI Green paper, 2011).

Emphasizing Accreditation Standards

An emphasis on accreditation standards will specify the minimum range of services to be provided at different levels of care. Central to the accreditation is the provision of primary healthcare services that can demonstrate performance linked to health outcomes. This will entail

involvement of competent health and medical staff with appropriate skills (NHI Green paper, 2011).

5.4 RESEARCH LIMITATIONS

The research limitations in this study refer to the extent to which the research topic in its entirety and associated variables may not have fulfilled the resolution of the research problem, its (research topic's) stated objectives and attendant data collection methods – all of which have a significant bearing on the nature of the results and recommendations of the study.

National Health Insurance is a fairly new concept in the South African health policy development and implementation arena. Not much in-depth study was conducted on its (NHI's) sustainability. Consequently, there might also be a lacuna on available literature on the subject matter, especially in South Africa.

The research design and methodology was largely confined to (desktop) document analysis, which focused primarily on the thematically focused analysis of the consulted secondary data sources. The study would have benefitted from a larger scale research method, according to which the scope was broadened to include an empirical component. Not only would the scope for transferability/generalizability be expanded, the involvement of research participants would have provided the social reality of various categories of nursing practitioners and NHI experts in both the public and private health sectors.

5.5 CONCLUSION

The study has tested the relationship between sustainability and improved access to healthcare. The management of the nursing human capital forms an integral part of a successful implementation of the NHI. While most developing countries strive for UHC, it is essential to note that UHC is a process that requires thorough strategic planning and resource availability. Provinces differ in terms of their economic profiles and the burden of diseases. Therefore, the path towards realizing NHI differs from one province to another and it is the duty of the north-West provincial government to enable the readiness with regards to strategic planning to ensure that the province's specific NHI strategy succeeds. It should be noted that South Africa has the potential to realize the healthcare system that is much more equal however the focus of action should be to ensure political commitment and effective management. The researcher's focus on this study was mainly limited to nursing human capital management and therefore wishes to invite further study on the critiquing the financing/ funding model and assessing the needed infrastructure for sustainability of the proposed NHI in South Africa.

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