Politics of health transitions: Policy evolution from the National Health Act to National Health Insurance for equitable access to health services

S Banda

orcid.org 0000-0001-7625-4610

Dissertation accepted in fulfilment of the requirements for the degree *Master of Arts in Political Studies* at the North-West University

Supervisor: Dr S Motloung

Co-supervisor: Ms N Modise

Graduation: May 2026

Table of Contents

ACKNOWLEDGEMENTS

This dissertation has been one of the most challenging and greatest experiences of my life. The journey has been emotionally taxing, while providing me with great academic experience and teaching me patience. I am deeply grateful to God the Almighty for carrying me this far. None of this would have been possible without Him. “He gives wisdom to the wise and knowledge to those who have understanding” (Daniel 2:21). Indeed, it is through His grace that I was able to preserve and complete this study.

I extend my sincere gratitude to my supervisors, Dr. Sysman Motloung and Ms. Naledi Modise, for their unwavering support and belief in my academic potential. Thank you for your patience, encouragement, and constructive feedback during the research process. Your guidance sharpened my academic writing and critical thinking skills, and your mentorship made this journey less daunting and more enriching.

I would also like to express my heartfelt appreciation to my academic mentors: Dr. Seshupo Mosala, Natalie von Meullen, and Mamello Bila. Your consistent support and encouragement have pushed me to do better and aim higher. Thank you for opening the doors of knowledge, offering guidance through difficult academic decisions, and reminding me of my capabilities when I doubted myself. Your dedication to mentoring has shaped my growth not only as a scholar but also as an individual.

To my beloved family, thank you for being the foundation of my life. To my mother, Letta Banda, and my sisters, Masentle and Phindile Banda, your endless love, support, and belief in me, especially when others did not, have carried me through the most difficult times. You have been my anchor, and this achievement is as much yours as it is mine.

To my dear friends Refiloe Mxhotyelwa, Theressa Batsane, Lebohang Nkosi, Nokuphela Mokhothu, Lerato Mashile, Mbalentle Fatsha, and Sanelisiwe Matshali, thank you for walking beside me through my academic and personal journey. Your words of encouragement, laughter, and prayers have kept me motivated. *Ngibonga ubukho benu empilweni yami.*

Lastly, I would like to extend my sincere appreciation to North-West University for the postgraduate bursary that made my studies possible. Your support has been vital in allowing me to pursue my academic dreams without the weight of financial burdens.

DEDICATION

I dedicate this work to my late father, Abufane Ntshasa, my late sister, Amanda Banda, and all my family members. Let this work be a gentle reminder that it is possible to dream, to soar beyond limitations, and to rise even when the odds are against you. "*If you are able, then you are capable"* because ability, when met with determination, can overcome even the greatest challenges.

ABSTRACT

This study examines the politics of health transition in South Africa, focusing on the evolution of health policy from the National Health Act (NHA) of 2003 to the National Health Insurance (NHI), with particular emphasis on equitable access to health services. Using a qualitative approach underpinned by the constructivist paradigm, this study employs a comparative case study analysis of the NHA and NHI to evaluate their intentions, implementations, and outcomes in addressing inequitable health care access. Data were gathered through document reviews. The findings highlight leadership deficits, inadequate financing, systematic inefficiencies, and weak integration between the public and private sectors as central barriers to equity.

It contributes to scholarship by illustrating how governance, justice, and participation intersect with health policy and offering a framework for aligning health systems with democratic values and social justice imperatives. The study concludes that equitable health care in South Africa can only be achieved through intentional reforms that dismantle the dual health system, strengthen state accountability, and ensure that the principle of equity is put into practice as well as in policy.

Keywords: Health care, health politics, National Health Insurance, National Health Act, South Africa, social justice.

CHAPTER ONE: CHALLENGES OF EQUITABLE ACCESS TO HEALTH SERVICES IN THE CONTEXT OF NHA AND NHI IN SOUTH AFRICA

1.1 Introduction and background to the study

An interdisciplinary subject of study, commonly referred to as “health politics” or “politics of health”, analyses the effect of political and social authority on people's health (Navaro *et al.*, 2006). Health politics deals with comprehending politics, not just as governance, but as a public society and a method of power and dispute. It encompasses multiple perspectives, from health sociology to international relations; thus, broader knowledge of politics emerges at all societal levels (Carpenter, 2012:290). Therefore, political decisions may significantly influence public health outcomes and individual well-being (Borrel *et al.*, 2007). Political decisions and factors surrounding health care access and affordability can determine whether individuals benefit from necessary medical care without incurring financial hardship.

Health care access refers to people’s ability to acquire affordable health care services (Gulliford *et al.*, 2002:186). The establishment of universal health care systems and health insurance programmes has a direct impact on health care access and treatment. The government has a duty to ensure patient safety and ethical standards by regulating health care providers (Republic of South Africa, 2008). For example, the United States of America has been using the Patient Protection and Affordable Care Act (PPACA) to overhaul the U.S. health care system and extend health insurance coverage to millions of uninsured Americans (Shaw *et al.*, 2014).

South Africa’s history demonstrates a close connection between politics and health, with colonial and apartheid laws enforcing racial segregation in health care. These laws created inequalities, with health care resources disproportionately allocated to ‘white’ hospitals, leaving ‘black’ hospitals overcrowded and underfunded (Coovadia, 2005:818; Solomon *et al.*, 2020:29). Ambulance services, health care staff, and expenditure on health were divided along racial lines, favouring white communities, while Black communities received minimal care, resulting in major health disparities (Brauns & Stanton, 2016). Apartheid's impact on health led to extreme morbidity and mortality among Black South Africans.

This was evident in 1981, when the Bantustans accounted for 27% of all tuberculosis (TB) cases; but TB infections among white people dropped by half during the 1970s (Brauns & Stanton, 2016:25-26). Life expectancy varied greatly across races, with white people living an average of 70 years compared to 55 years for Black people in 1980 (Kon & Lackan, 2008:2273). Health services catered primarily to the needs of the apartheid state, prioritising white communities and leaving Black South Africans with inadequate care (Brauns & Stanton, 2016).

This separation in health care changed with the attainment of democracy in 1994 in South Africa. To move away from the apartheid-era health system, the African National Congress (ANC) unveiled the first National Health Plan, a sectoral strategy with a deep commitment to social justice and fairness (Burger, 2000:45). This plan recognised that health encompasses fair economic and social development and the provision of medical care. According to Christian (2020:50), within the framework of the Reconstruction and Development Programme (RDP), the National Health Plan received top priority because it would address the racialised socioeconomic inequities in the health services. The government proposed strategies for the health sector that adhered to the RDP's guiding principles, including that the health sector should contribute to equity by creating a single, integrated health system (National Department of Health, 1997).

These principles are also reflected in the Constitution of the Republic of South Africa, Act No. 108 of 1996, and the National Health Act [NHA] No. 61 of 2003 (NHA, 2003). Considering that the Constitution and other regulations assign certain duties and responsibilities regarding health services to local, provincial, and national governments, the NHA establishes a structure for an organised, uniform health system (Hassim *et al.*, 2008). “The objectives of NHA Section 2(a) include i) establishing a national health system; ii) setting out the rights and duties of health care providers; and iii) protecting, respecting, promoting, and fulfilling the rights of the people of South Africa” (NHA, 2003).

The Constitution (RSA, 1996), Section 27 (1) a), provides that “everyone has the right to have access to health care services, including reproductive health care.” Moreover, Section 27(2) provides that “the state must take reasonable measures, within its available resources, to achieve a progressive realisation of each of these rights,” and

(3) “no one may be refused emergency medical treatment” (RSA, 1996). In this sense, it is important to investigate the delivery of health care within the constraints of the state's existing social and economic structures.

To this effect, the government decentralised health care into national, provincial, and district health systems. South Africa introduced universal health coverage through the National Health Insurance Act 20 of 2023 (NHI), which extends to private health sector institutions to improve service delivery and the availability of health care for all socioeconomic categories (Michel *et al.*, 2020; RSA, 2024). The objectives of the NHI Section 2(a) are for the state “i) serving as the single purchaser and single payer of health care services to ensure the equitable and fair distribution and use of health care services; ii) ensuring the sustainability of funding for health care services; and iii) promoting equity and efficiency in funding by pooling of funds and strategic purchasing of health care services, medicines, health goods, and health-related products from accredited and contracted health care service providers” (NHI, 2019). This model mirrors a global example, such as Rwanda’s community-based health system, which successfully covered 90% of the populace and minimised the financial burden of fatal health care, particularly for the less privileged members of society (Binagwaho, 2012).

1.2 Problem statement

Despite South Africa’s efforts to reform its health system through the NHA and NHI, equitable access to quality health care remains a persistent challenge. Equitable health care access is hindered by an overburdened and under-resourced public health service that serves the majority, while the well-resourced private service serves only a few. Structural inefficiencies, inadequate funding, leadership failures, weak management, workforce shortages, and geographic disparities further undermine equitable access to health care.

Poor stewardship, ineffective management structures, and a lack of accountability create gaps between policy and practice (Michael *et al*., 2019:3). Such dysfunction undermines the goals of both the NHA and NHI, jeopardising their full implementation and exacerbating disparities in health care access (Mataka *et al.*, 2020; 7). Leadership failure is evident in the lack of management boards and ineffective clinic committees (Anasel *et al*., 2023; Malakoena *et al*., 2020). Furthermore, hospitals and clinics in the Gauteng and Mpumalanga Provinces face severe dysfunction due to inadequate leadership and weak management

(Naidoo, 2009; Witters *et al*., 2024; Pasha, 2015). Poor management practices have centralised decision-making, particularly in the Free State, hindering local health systems (Malakoena *et al*., 2020). These are marked by dysfunctional services in provinces such as North West, producing i) delays in medical care, ii) staff shortages, iii) outdated infrastructure, iv) inadequate methods for disease control and prevention, and vi) limited access to quality health services (Young, 2016; de Villiers, 2021; Mmadi & Sithole, 2019; Cilliers, 2024).

1.3 General research questions

To what extent do the NHA provisions and NHI policy implementation address structural inefficiencies, funding constraints, and leadership challenges in promoting equitable access to quality health care in South Africa?

Answering this question requires an assessment of the political factors that make the legislative framework dysfunctional.

1.4 Specific research questions

To measure the success of the NHA provisions and NHI implementation for equal access to health care services, this study poses the following questions:

- What are the challenges of inequitable access to health care services in South Africa?
- To what extent does the state of access to health services reflect the NHA and NHI provisions?
- What reform strategies are required to strengthen the implementation of the NHA and NHI to minimise disparities in health care access?

1.5 Research objectives

In enhancing the success of NHA provisions and NHI implementation for equal access to health care services, the study will:

- identify factors that affect access to and cause dysfunctional health services in the context of the NHA and NHI,
- explain the social justice philosophical justifications for equitable access to health care services,

- compare the NHA and NHI provisions against the state of access to health services in South Africa, and
- propose reform strategies to strengthen the implementation of the NHA and the NHI, ensuring equitable access to health services and improving functionality through strong leadership and management.

1.6 Theoretical framework

Social justice is a political and theoretical concept centered on promoting fairness in interactions among individuals within society, ensuring equal access to resources, opportunities, and societal benefits (Said, 2021). Historically, social justice began to receive greater attention in the 1970s, largely due to the ground-breaking contributions of American political philosopher and ethicist, John Rawls. Nearly 50 years ago, his book 'A Theory of Justice' (Rawls, 1971) offered a comprehensive explanation of the theory of social justice (Rawls, 1971). Rawls' (1971) theory of social justice was influenced by contractualism, a framework rooted in the principles of freedom, equality, and moral respect for individuals, as advocated by John Locke, Jean-Jacques Rousseau, and Immanuel Kant (Joseph, 2020). By applying social justice in this study, the public sector can design more equitable policies and interventions to advocate for vulnerable people. The social justice theory draws linkages between i) leadership and inequality (Singh *et al.*, 2023); ii) conditions of equality (Beauchamp, 1976), iii) social dysfunctionality (Ruger, 2004), and iv) power distribution (Buettner-Schmidt & Lobo, 2012). Rawls's Theory of Social Justice asserts that all individuals should have the right to extensive fundamental liberties that others enjoy in society (Rawls, 1971). This principle highlights that fairness and equality of opportunity can influence environments where people are treated with respect and have freedom (Heyen, 2023). This could minimise disparities within the organisation or society by ensuring that any advantage uplifts those most disadvantaged (Rawls, 1971; Bhugra *et al.*, 2022). In the realm of health, social justice fundamentals uphold equitable access to health care as an essential human entitlement (Ruger, 2004:1077).

Social justice theory asserts that effective leadership strives for an effective public health system (Lewis, 2019). Social justice asserts that functionality is a fundamental principle, and that stakeholders and clinic committees should work together to achieve equitable health care (Bodenheim, 2005:66). Based on the need to reduce disparities

in health care services and promote better social and economic development, the social justice theory contends that the state must provide health care services (Bodenheim, 2005:66). This means that social justice measures the distribution of resources based on equality and need (Bell & De-Shalit, 2002; Jackson, 2005). In this case, each group is handled for allocation as if it were an individual. The government's requirement to offer health care is founded on the belief that the private sector tends to place a high premium on health services. This eventually excludes poor or marginalised people in society who need critical health care. Therefore, the state's involvement is a balancing act to ensure the physical and mental integrity of citizens. Hence, the relevance of comparing the NHA and NHI is the extent to which health care policies address the differences in health service access between various socioeconomic groups (Bhurga & Tribe, 2022).

1.7 Research methodology

This comparative case study method is about the known provisions of the NHA to reform the health sector, including the lesser-known NHI implementation, which intends to enhance equitable access to health services. The comparative case approach examines the NHA and NHI in South Africa. This comparison will show similarities and differences in the NHA provisions and NHI implementation, to enhance access to health care (Azarnia, 2011).

1.7.1 Research paradigm

There are four paradigms to use when conducting research: i) constructivism; ii) pragmatics; iii) post-positivism; and iv) advocacy and participation (Galifa, 2018:71-74). As far as the four paradigms are concerned, the most used paradigm is the interpretive (constructivism) paradigm, which assists researchers in describing and comprehending real-life problems from the point of view and descriptions of the affected people. The study relies on a constructivist research paradigm, which will help describe and understand the politics of health in the implementation of the NHA and the NHI. The constructivist research paradigm is helpful in identifying the meanings of experiences, which can then guide and enhance medical practice (Burns *et al*., 2022).

The study considers truth (ontology) about inequitable access to health services as determined by the physical aspects of facilities and human resources, and the values influenced by the NHA and NHI (David & Fisher, 2018:22, 25). Moreover, how people

experience and attach meaning to their health access standards, as the epistemology (getting to know), is validated through personal accounts and official reports on health services. This implies that both objective and subjective narratives are equally valuable. This comparative case study research provides insights into the lived experiences and perceptions of those impacted by access to health services. This study cannot manipulate axiology (values) regarding equitable access to health because they are reflected in the everyday interactions of people and health institutions. Therefore, this study will explore attitudes and biases expressed in language or descriptions that people and institutions use to portray access to health (Rehman, 2016:52).

1.7.2 Research design

The analytical scope of this study is limited to comparing the implementation of the NHA and NHI to determine their effectiveness in promoting equitable access to health care in South Africa. This is a comparative case study research format to draw the relationship between the NHA provisions and NHI implementation and the levels and quality of access to health care services (Befani, 2020). The benefits of diagnostic case research include: i) assisting with discovering the main root cause of a problem; ii) assisting with identifying the main factors that initially contribute to the problem; and iii) assisting with developing solutions that are tailored to the main problem (Befani, 2020:335). This way, the researcher can compare the health problems and planned solutions, both in the past and present. The researcher can provide the depth of the health system issues and recommend solutions for the NHI's success.

1.7.3 Research method

A qualitative approach will be employed to carry out an in-depth analysis (Holstein, 2011:403-406) of the NHA and NHI implementation and the state of access to health care in a real-life context. In essence, the study compares dominant problems, i.e., the state of the health sector before and after the implementation of the reforms through the NHA and NHI. Hence, the comparison helps formulate comments about the efficiency of health policies. The characteristics of qualitative research include i) diagnosing factors that affect access to health services and why they are dysfunctional in the context of the NHA and NHI; ii) using philosophical justifications [world views,

personal opinions, and framings] of social justice and fair access to medical services; iii) describing the state of health care services and how people experience them; and iv) providing solutions or theorising successful interventions to promote better health care (Nassaji, 2015; Setswe *et al.,* 2016).

The NHA and NHI are health services entities that are the unit of comparative analysis (Ragin, 2008). At the same time, equitable access is the unit of observation [variable] (Sedgwick, 2015). The nature of the stated research questions makes this comparative case study an appropriate research design, which fits into the problem statement and theoretical argument about dysfunctional health services and systemic inefficiencies in the implementation of the NHA and NHI.

Dysfunctional health care manifests through overburdened and under-resourced public health services, in addition to structural inefficiencies, lack of funding, and poor leadership. This contrasts with the well-resourced private health care that reflects a functional health care system with structural efficiencies, adequate funding, and effective leadership and management. Therefore, using various data sources is indispensable for the validity and reliability of findings. Using multiple lenses reveals and clarifies numerous aspects of the phenomenon (Baxter, 2008:547).

1.7.4 Data collection tools

The study used a document review of secondary data gathered by different individuals about access to health services. This will help provide a narrative and an in-depth understanding of the barriers faced by different populations in accessing health services. In-depth understanding comes from debates about NHI and NHA in governmental and non-governmental institutional reports, legislation, academic publications, and newspaper reports (Taherdoost, 2021:11). These documents are available from the North-West University library repository, Google Scholar, and newspaper publications such as The Citizen and the Daily Maverick. Government legislation and policy discussions from the Parliamentary Monitoring Group (PMG) portal will be vital to present verbatim expressions of lawmakers in the debates around the NHI and NHA about health access.

1.7.4.1 Purposive selection of cases

For empirical analysis, the study investigates Tambo Memorial Hospital in Gauteng, Enhlanzeni Local Clinic in Mpumalanga, Mafikeng Provincial Hospital in North West, and Pelonomi Tertiary Hospital in the Free State. These institutions are selected because they appear to have the main characteristics of dysfunctional leadership, failure, and weak management (West *et al.,* 2021; Witters *et al*., 2024; Malakoena *et al*., 2020). Understanding unequal access to health care services demands comparing the NHA with the NHI. This is because the NHA sets the legal framework for the delivery of health services, involving the responsibilities and rights of health care providers and those receiving care (Hassan *et al*., 2008), while the NHI is aimed at overhauling the health financing system to guarantee equal accessibility to health care for all citizens (Matsotso & Fryaat, 2013).

The NHA is interested in developing guidelines for health care delivery, including matters such as patient rights, the standard of care, and the regulatory environment (Hassan *et al*., 2008). On the other hand, the NHI seeks to eradicate financial obstacles to access by pooling resources to achieve universal health coverage (Setswe *et al.,* 2016). Using an analysis of the interaction between these two legislative tools, we can understand how financial and structural procedures worsen or alleviate health inequities. This comparison offers insights into how health reforms could potentially be maximised in achieving fundamental universal fairness in the delivery of health services, by revealing the gaps and overlaps in policy execution that impact equitable access.

1.7.4.2 Data analysis and interpretation

A view-difference-view comparative analysis approach helps clarify systematic differences and “the causal process in the creation” of unequal access to health services (Azarian, 2011). The analysis of public health through the comparison of NHA and NHI would reveal meanings about the quality of health services as effective, preferable, or useful (Bolbakova *et al*., 2020:2), which would further help theory building of solutions about social justice in health care (Azarian, 2011). The social justice theoretical criteria of equality and inequality in access to health are also vital for comparison. Table 1 below is a framework of analysis that will confirm changes and

continuities in the state of health services in South Africa through the lens of social justice. The table presents the theoretical assumptions of social justice theory and compares how the NHA and NHI align with them.

Social justice principles	NHA provision	NHI implementation
Leadership quality	Absent	"Section (5). A board member is appointed for a term not exceeding five years, which is renewable only once, and must (a) be a fit and proper person and (b) have appropriate technical expertise, skills, and knowledge or experience in health care service financing, health economics, public health planning, monitoring and evaluation, law, actuarial sciences, information technology, and communication" (NHI, 2019).
Vulnerable groups	"Section 4(3). Subject to any condition prescribed by the Minister, the State, and clinics must provide a) pregnant women and lactating women, and children below the age of six, who are not members or beneficiaries of the	"Section 4(3). All children, including children of asylum seekers or illegal foreigners, are entitled to basic health care services as provided for in section 28(1)(c) of the Constitution" (NHI, 2019).

	medical scheme with free health service" (NHA, 2003).	
Functional institutions	"Section 25(2). The head of a provincial department must, by national health policy and the relevant provincial health policy, in respect of or within the relevant province, i) facilitate and promote the provision of port health services, comprehensive primary health services, and community hospital services" (NHA, 2003).	"Section 38(2). The Health Products Procurement unit must be located within the Fund and is responsible for the centralised facilitation and coordination of functions related to the public procurement of health-related products, including but not limited to medicines, medical devices, and equipment" (NHI, 2019).
Affordability	"Section 90(1) a). Fees to be paid to public health establishments for health services rendered" (NHA, 2003).	"Section 8(1). A user of the Fund is entitled to receive the health care services purchased on his or her behalf by the Fund from an accredited health care service provider or health establishment, free at the point of care" (NHI, 2019).

1.7.4.3 Limitations of the study

The study's qualitative methodology has certain limitations, even though it enables a thorough examination of the NHA and NHI implementations and their effects on access to health care (Holstein, 2011). The research's significant dependence on journal articles rather than interviews could be a concern, but that does not invalidate the

study's views and conclusions, because the researcher consults institutional reports from reputable organisations. The researcher opted not to use interviews because of the time and resource limitations to cover the geographic spread of Gauteng, Mpumalanga, North West, and Free State provinces. Desktop research can grant the researcher access to valuable information from experts and residents, including other cases for theoretical and data triangulation. Therefore, the method does not undermine the validity of the study.

1.7.4.4 Ethical Considerations

There will be no ethical dilemmas and potential conflicts of interest, as the study was strictly limited to collecting data from secondary materials. A desktop study will be conducted, so the study will not have human participants. Therefore, the informed consent process was not followed. The researcher has a moral and professional obligation to be ethical even when the research participants are unaware (Gajjar, 2013:9-10). Therefore, this study will not manipulate secondary data to represent anyone or an organisation in a bad light; instead, if an organisation is in a bad light, the researcher will commit to reporting data as it is presented. It is of paramount importance to hold oneself accountable to provide an excellent scientific study. In this case, the researcher will not take facts at face value but corroborate them with other sources to establish their validity and reliability. The codes of ethics guide researchers (Resnik, 2015). The researcher will avoid plagiarism by compiling data ethically, such as by providing full citations of works taken from other people (David, 2015).

1.8 Literature review

Health care access refers to the availability and sufficient supply of services for all individuals (Guilford *et al.*, 2002:186). Irrespective of different levels of social advantages, the provision of health should be equal. Financial barriers impact health outcomes, as social, economic, and educational differences frequently cause or contribute to racial disparities (Williams *et al.*, 2016:35-37). This point of view is relevant to the research study, highlighting the complementary nature of the policies between NHA and NHI. The NHI aims to provide equity and social solidarity through the pooling of risks and funds. Limited or no access to health care is caused by i) poor service, ii) shortage of skilled workers, iii) long waiting hours, iv) limited resources, and

vi) geographical accessibility of health care facilities in all countries of the African continent (Chinyakata *et al.*, 2021). This book is relevant to the study, as it answers the problem statement of the research. Health services are dysfunctional because of leadership failures (poor stewardship) and weak management.

The South African health system is described as a two-tiered system. Public health and private health make up the two tiers of the system (Olive, 2024). This book is relevant to the study, as it provides a more comprehensive view of the state of health in South Africa. Conmy (2018) contends that the private sector is composed of voluntary health insurance programmes, or access to health care schemes that are meant to keep out Black South Africans. He states that these programmes were developed for white individuals who did not want to access health care together with the Black population (Conmy, 2018). This statement is relevant to the study, as it presents the impact of apartheid on Black communities. Shisana agrees that public sector spending is still out of control and primarily benefits the Black majority. This neglects and unequally distributes opportunities for early prevention and care (cited by Delobelle, 2013:160). This study is relevant to the research, as it gives an overview of the state of the health system in South Africa.

The successful implementation of NHI will necessitate a reform in the delivery and management of health services, with an emphasis on improving the quality of care provided in both the public and private sectors. To do this, the health care system will be reorganised. Primary health care will be a part of the health care system's restructuring, by i) re-engineering the Ideal Clinic Model's implementation; ii) forming the National Health Commission; iii) changing management practices; and iv) involving government hospitals. This covers public health and leadership issues (Day & Zondi, 2019). This study is relevant, as it gives a clear answer to the study's problem statement. Evaluating human resources in the health sector and taking prompt, crucial initiatives to correct the critical matters about human resources that the South African health care system is presently facing are essential for the NHI to be successful (Rispel & Barron, 2012:632). This statement is relevant to the study, as it will help with the successful requirements for NHI. Moving forward, it can be beneficial for the NHI procedure if the government recognises private providers as important actors in the NHI rollout, and collaborates quite closely with them (Ngwaru *et al.*, 2019:38). This

statement is relevant to this study, as it also can help with requirements for the success of NHI.

There are interesting observations to make concerning the NHA objectives below.

- “establishing a national health system,
- setting out the rights and duties of health care providers,
- protecting and promoting the rights of the people” (NHA, 2003).

compared to the NHI objectives

- “single purchaser and single payer of health care services to ensure the equitable and fair distribution and use of health care services
- ensuring the sustainability of funding for health care services” (NHI, 2019).

There is essentially no need to speak about the health policies as moving from the NHA to NHI as if one were abandoning the NHA. Instead, the NHA introduced the health system that outlines the rights and duties of health care practitioners, as well as promoting the rights of the public who access health services. Rather than eradicate the NHA, the NHI seeks to secure funding and sustainability of the health system and services.

Previous studies, such as Naidoo and Mokoena (2024), focus on the factors that hinder the effective implementation of the building blocks for NHI. Others, like Gidword et al. (2019) discuss primary health care delivery models for uninsured, low-income earners during the NHI transition. Some research explores the visions, challenges, and potential solutions for NHI, while others, like McQuoid-Mason and Dada (2006), examine the NHA and its implications for family practice. Additionally, Maphela (2023) analyses Section 363 of the NHA (61 of 2003) regarding the management of human remains from the perspective of funeral directors. However, none of these studies addressed what the proposed research focuses on, the politics of health transition from the NHA to NHI, and how this transition aims to increase access to health services.

1.9 Significance of the study

The study examines the NHA and NHI in the provision of health services in South Africa. These policies exist to provide universal access to quality health care for all South Africans, as enshrined in the Constitution. However, the NHA does not say anything about leadership quality, and my study aims to contribute to that. If we were to improve leadership in public health care service delivery and in all provinces, there would be better integration of services and policy implementation.

The political aspect of health in society is one of the main topics of my research, and by combining social power and political analysis with an examination of the health and health care systems, one can better comprehend the obstacles that stand in the way of reducing health disparity and inequality. It criticises public health for depoliticising the health system and health, by modernising them to the point of removing them from public participation. As a result, the medical community and business community acquire control over the public, enabling them to define health and, consequently, its political significance. The integration of political science and public health research aims to understand the unique relationships between politics and this field of policy, to ascertain the politics of health. The study's contribution will be disseminated through academic journal publications and conference presentations, thereby enriching scholarly discourse on governance of health in South Africa.

1.10 Chapter layout

Chapter 1: The core challenges of inequitable access to health care services in the context of the NHA and NHI. This chapter describes the background, focus, and rationale of the study. A brief outline of objectives, research questions, research model, and methodology is provided.

Chapter 2: The social justice theoretical justification for equitable access to health care services. This chapter concentrates on the literature study concerning research completed on the quality of the health care system in the context of NHA and NHI, social justice philosophical justifications for equitable access, and possible successful requirements for NHI.

Chapter 3: The state of access to health services compared to the NHA and NHI provisions. This evaluates the impact of the NHA and NHI on access to health care.

Chapter 4: Research Methodology and findings. This chapter presents the findings, methodology, and results of the study.

Chapter 5: Strategies strengthen the implementation of the NHA and NHI to reduce health care disparities. This chapter presents strategies to strengthen the implementation of NHA and NHI. It also presents the conclusion of the study and the contribution to the field.

1.11 Summary

The research examined the past connection between political organisations and health care delivery systems. The apartheid system based its fundamental structure on racial segregation through the legal enforcement of two health care systems. The health care system under apartheid established a system that gave preference to white people and communities, with superior services, while Black South Africans were relegated to under-resourced and inadequate care. The study also examined the post-apartheid unified health plan, which emerged as a solution to dismantle the existing health care system, and apartheid-era health structures, and promote decentralisation across national, provincial, local, and district levels. However, despite these reforms, the South African health care system remains fundamentally two-tiered; the Constitution's recognition of health as a right does not automatically solve existing barriers that block people from obtaining medical services. The post-apartheid era continues to face ongoing difficulties because of its broken service systems. Leadership failures and weak managerial capacity, and the ongoing difference between sound policy design and poor implementation, continue to be grappled with.

CHAPTER 2: THE SOCIAL JUSTICE JUSTIFICATIONS FOR EQUITABLE ACCESS TO HEALTH SERVICES

2.1 Introduction

The previous chapter explored the challenges associated with achieving equitable access to health care within the framework of the NHA and the NHI in South Africa. The social justice theory serves as the core principle because it creates fairness in health care through equal access and actively fights against system-based inequalities that impact disadvantaged social groups. The solution to these disparities needs urgent implementation because it will lead to better health outcomes and proper medical treatment for all people. A society that is just needs to provide equal health care access to all citizens, because this ensures everyone can reach life fulfilment without facing health-related challenges.

The following section develops the social justice theory as a method to analyse the case for equal health care availability. The purported justifications will be useful to analyse contestations about equitable health care in South Africa, including the rationale for health transitions in South Africa's policy landscape. The social justice assumptions will also guide empirical analysis of the state of health care and build the case for effective leadership and management. The chapter outline starts with a view on historical and global health inequities, which is a premise for philosophical justifications for justice, extending to the right to health. The quality and functionality, or lack thereof, of health services determine the extent of disparities in health care accessibility among different population groups. Counterarguments on social justice also affect evaluations of health equity. The final section of the chapter study presents an evaluation of different strategies that governments use to achieve health equality.

2.2 An historical and global context of inequality

The historical and worldwide health care inequality patterns stem from enduring socioeconomic systems that determine who receives medical treatment (Safaei, 2007). Health outcomes between low-income and high-income nations have been negatively affected by globalisation and colonial heritage, and uneven power relationships (Tugwell, Robinson & Morris, 2007). The existing economic differences between countries lead to additional income gaps, which prove that health outcomes

depend on socioeconomic position (Safaei, 2007). The apartheid regime in South Africa established two separate health care systems, which gave better treatment to white people but denied essential care to Black people, and this dual system continues to affect their health services (Whyle & Olivier, 2023). The long-term effects of political events create enduring links between health outcomes, institutional discrimination, and economic disadvantage (Gray & Vawda, 2013).

Health disparities throughout the world show a distinct relationship with both national income levels, educational standards, and gender, and urban development (Gray & Vawda, 2013). Ruger and Kim (2006) performed comparative research that showed that industrialised countries keep significant health disparities because their health outcomes stem from their established national policies and social structures. McGillivray Dutta and Markova (2009) show that deprivation indices offer a better understanding of health inequality, because they assess poverty through methods that go beyond income differences in countries with diverse poverty patterns. The authors Townsend, Phillimore, and Beattie (2023) demonstrate that the North-South divide in England replicates global South patterns of health inequality, because these disparities become embedded in local development structures.

The health disparities that continue to exist stem from social and structural factors, which include housing conditions, educational access, employment opportunities, and discriminatory practices (Gray & Vawda, 2013). According to Crear-Perry et al. (2021), maternal health disparities in the United States stem from racism, gender discrimination, social inequality, and insufficient policy support. Williams McKinney and Cheskin (2024) studied the ways social inequalities between food deserts, poor urban planning, and low-income levels generate differences in obesity. Glen (2025) states that clinical practice needs to implement upstream thinking to handle health disparities by finding and treating the root structural causes. Gilboe and Curran (2025) establish in their research that justice stands as a core principle that must take precedence when addressing social determinants that affect health outcomes. Benfer (2015) demonstrates this perspective through his research, which proves that health justice requires solutions for social system-based inequalities.

The operation of health systems creates structural injustice, which leads to health disparities. Bergen and While (2005) analyse how community health street-level

bureaucrats encounter institutional barriers that prevent them from achieving policy objectives, thus creating an 'implementation deficit.' The South African case study by Murphy and Moosa (2021) shows that NHI faces the same challenges that front-line managers deal with when they must handle various responsibilities, and work under insufficient resources and poor governance structures that block the progress of reform. The study shows political commitments fail to match system capabilities, which supports Khanal et al. (2023) in their assessment of Nepal's NHI programme through its unmet policy goals, because of inadequate institutional power and insufficient accountability mechanisms.

The Scandinavian nations present an alternative system through their universalist policies and welfare programmes, which have succeeded in reducing health inequality (Khanal *et al*., 2023). Vallgarda (2007) describes the Scandinavian public health system as a system based on social solidarity, preventive care, and egalitarian policy principles. The author Cherkasov (2023) explains that Scandinavian social policy universalism exists as an actual system of institutional arrangements that ensures continuous access to benefits throughout a person's life. Mehrara (2020) demonstrates that Norway continues to experience difficulties between its universalist principles and social obstacles that block immigrant integration and lead to geographic inequalities. The authors Carey, Crammond, and De Leeuw (2015) suggest a "proportionate universalism" approach, which provides universal interventions at appropriate scales and intensities to meet individual needs for achieving both equity and universality.

The evaluation of health systems through frameworks now includes these principles as part of global policy strategies for equity. Luoto et al. (2013) analyse worldwide evidence-based frameworks to demonstrate that interventions need to match local conditions, available resources, and community involvement for successful implementation, which supports the need for grassroots participation. Caunic (2019) supports the need to expand evaluation of health system performance by incorporating social indicators, governance, and resilience metrics in addition to clinical results. Mpofu et al. (2014) report showed that Botswana built monitoring and evaluation systems that enhanced decision-making and accountability in resource-constrained environments through political as well as technical measurement approaches.

The global frameworks show that countries need to turn their general promises into detailed plans that work to achieve justice and support inclusivity. The research by Mayhew (1999) reveals that Ghana's sexual and reproductive health services encounter difficulties in policy execution because of persistent structural obstacles and independent service delivery frameworks. The solution to health inequality demands an integrated method that unites historical understanding with social fairness and consistent policies, and strong assessment systems. Yearby (2022) states that attempts to reduce disparities will not succeed because they do not incorporate a justice perspective, which would stop ongoing inequality from persisting.

2.3 Philosophical foundations of justice

The study of ethics, political philosophy, and legal philosophy examines justice as their core fundamental principle (Muller & Edward, 2023). The standard serves as a tool to assess behaviour, laws, public policies, and justice systems, and their underlying reasons for being considered unjust. Traditionally, justice is one of the four cardinal virtues alongside temperance, prudence, and fortitude; sometimes it is even reckoned as the most important among them. It is “the first virtue of social institutions” (Rawls, 1971:77) to set a framework of entitlements where individual rights to freedom, opportunity, and resources may conflict (Miller, 2001). Resource distribution and decision-making processes between people or groups heavily depend on justice, according to Bell and De-Shalit (2002). The theory of justice operates through the logic of social justice, political justice, economic justice, environmental justice, and legal justice. The logic requires society to establish complete equality in economic, political, and social domains for all people (Jackson, 2005). Molenkamp (2022) states that justice requires equal resource distribution for all people while promoting diversity, human rights, and equity.

2.3.1 Justice as fairness

Fairness is the first concept in the theory of justice (Rawls, 1971). Justice as fairness posits that a just society is one where fundamental rights and opportunities are equal for all, and inequalities are only justifiable if they benefit everyone, especially the least well-off (Wenar, 2008). It is about ensuring reasonable public policy outcomes when balancing rights and responsibilities, including circumstances and needs (Schneider

et al., 2021). Fairness also has a significant implication within the political arena, especially in social justice movements. Disparities in health care access reflect a broader social injustice and necessitate equitable health outcomes despite socioeconomic and historical advantages (Buettner-Schmidth, 2012).

2.3.2 Justice as equality

Equality as the second concept of justice implies opening opportunities and access to resources for everyone in society (Wenar, 2008). The background, identity, and status or condition of a person should not affect their ability to access or be denied public values (Ruger, 2008). Human dignity exists because equality removes all obstacles that prevent people from reaching their complete potential. People should have access to three main life opportunities, which are health, education, and employment. These are vital for achieving one's life aspirations. This is about reducing differences between the poor and the rich. At a policy level, reducing differences necessitates recognising differences by creating measures to support the marginalised and disadvantaged in society. People with disabilities, for example, could be unable to work or deliberately excluded from working and earning an income because of their condition; hence, the relevance of equity. Equity is about supplying resources tailored to one's specific needs (Braverman & Gruskin, 2003), such as giving a prosthetic to an amputee and prenatal care to a pregnant mother who cannot afford it. Thus, equity-orientated policies, particularly those targeting systematic barriers, are crucial to achieving social justice (Molenkamp, 2022). Justice functions as an essential foundation of a fair society rather than being equivalent to charity, according to Jackson (2005).

2.3.3 Justice in the allocation of values

Allocation of values (redistribution) is the third concept of justice concerning the fair distribution of benefits and burdens for society's stability and harmony (Colquitt *et al*., 2015). Perceptions among some groups in society that they are being excluded or discriminated against [being treated unfairly] in the allocation of public values could lead to unrest and strife (Velasquez *et al*., 1990). Public values refer to the benefits and outcomes that society or the public gains from the government policies, services, or actions (Benington, 2011). Justice, therefore, is not just a moral or ethical idea but

a fundamental component of a stable and equitable society, influencing laws, policies, and public sentiments (Rawls, 1997).

2.3.4 Justice as protection

Protection is the third concept of justice conveyed through the punishment of wrongdoers (retribution) to hold them accountable for their actions, which violate legal and moral principles in society. A just society requires consequence management to address the social instability caused by inequality, corruption, and discrimination, according to Kraynak (2018). The three policy areas of human rights, safety, and well-being create ongoing discussions about justice. These protective measures aim to defend people from all types of harm and discriminatory actions, which encompass physical, emotional, and psychological abuse, instead of only concentrating on punishing the perpetrators. Justice creates protective systems that safeguard both security and dignity. Rawls (2008) identifies privacy, speech, political participation, freedom of movement and belief and religion, and association, as essential freedoms that must be safeguarded to establish a fair society. Protection as justice minimises people's vulnerability and marginalisation because of their race, gender, or socioeconomic status.

2.3.5 Justice as restitution

Reparation is the fourth concept where justice serves a restorative function. This category is about repairing the effects of discrimination and inequality. Modern conceptions of social justice prioritise addressing historical discrimination and improving conditions for marginalised groups (Ogar & Akpan, 2016). Reconciliation and deliberation are common modalities of restorative justice instead of retribution. This allows for affirmative action policies and safety net programmes, including environmental protection policies as a matter of justice, where communities cannot lead a happy life (eudemonia) without a clean environment. In this regard, diversity becomes a key principle, advocating for the representation of communities within both government and business sectors, and aiming for a genuinely inclusive society (Molenkamp, 2022).

2.3.6 The relevance of social justice principles in health services

The social justice function of levelling the playing fields within society spans areas from health care and shelter to education and recreational opportunities, yet often remains uneven across socioeconomic divides (Rousseau, 2016; Molenkamp, 2022). Hence, modern democracies have constitutions that govern economic structures, adhering to the principle of fair opportunity. In this light, justice demands that any inequality benefits all, especially the least advantaged, maintaining equality as the baseline from which any further distribution must enhance the overall welfare (Rawls, 1971). Through these guiding principles, justice sustains moral order and shapes policies and social systems, driving a collective commitment to a fairer and more inclusive world. This implies

> i) the assessment of individual well-being; ii) the evaluation and assessment of social arrangements; and iii) the design of policies and proposals about social change in society (Robeyns & Byskov, 2025).

The above principles inform the capability approach to health access, which is based on two normative claims: "first[ly], the freedom to achieve well-being is of primary moral importance and, second[ly], well-being should be understood in terms of people's capabilities and functionings" (Robeyns & Byskov, 2025).

Therefore, being healthy is a capability, something a person can achieve if they work at it, which involves activities. Critically, there should be no hindrances to a person acting to achieve their desired state of health, while 'functioning' refers to the actual state of being healthy (the achievement of a healthy state). Therefore, there should be resources available (freedom) to enable people to be what they want to be. Such resources include the freedom to access a health facility and practitioner (health services). In this regard, people should have the opportunity to access health services without the impediment of money, or lack thereof. Beyond mere access to health services, it is essential to imagine that people can use health services for preventive means, such as early diagnosis, instead of reactive treatment when ailments have occurred. People can live longer, not just be healthy, when managing chronic ailments. They can be more socially engaged and economically productive due to the lack of sickness-induced downtime. The general community can be resilient to pandemics, avoid unnecessary disabilities, and enjoy holistic wellness.

2.4 The right to health care as a human right

The right to health is enshrined in several international declarations, most notably the Universal Declaration of Human Rights (United Nations, 1948). Every nation under the International Covenant on Economic, Social, and Cultural Rights must guarantee health care access to all its citizens (United Nations, 1966). In the African context, the African Charter on Human and Peoples' Rights affirms every individual's right to health (African Union, 1981). The worldwide agreements have effects on national laws and policy frameworks that extend throughout different continents. For example, Mexico's constitution guarantees the right to health protection under Article 4 (Constitution of Mexico, 1983). The United States Constitution does not contain specific health-related provisions, but the Affordable Care Act established legal structures to provide health care access to all citizens (U.S. Government, 2010). Section 3 of Canada's Health Act affirms the principles of public administration, comprehensiveness, universality, portability, and accessibility (Government of Canada, 1985). The preamble to the Constitution of France includes a right to health protection (French Government, 1946), and the United Kingdom ensures universal health coverage via the National Health Service Act (UK Government, 2006).

China's Constitution commits to developing public health services for all (NPC of China, 1982). Australia ensures access to health care through the Health Insurance Act 1973, which underpins the Medicare system (Australian Government, 1983). Egypt's Constitution, under Article 18, affirms health care as a right for every citizen (Arab Republic of Egypt, 2014), and Israel guarantees health access through the National Health Insurance Law of 1995 (State of Israel, 1995). The Nigerian Health Act lays out a legal framework for the delivery of health services, and Rwanda's Constitution recognises health as a basic right under Article 41 (Republic of Rwanda, 2003). The policies demonstrate a unified dedication to health rights through their implementation of different health care systems. The right to access health care exists because of the principle that ensures equal health care services for every person. The definition of 'equitable access' refers to a health care system that gives all people equal access to services without discrimination based on their social status or where they live. The study defines 'universal access' and 'equitable access' as equivalent terms because they focus on providing equal access to health care services. Outka (2015)

supports the moral duty to offer health care services as a basic right for all people, according to Gibbard (1984b), who suggests that policies need to establish a fundamental level of care for every individual.

The right to health care for all people stands as a necessity for achieving equity, since it ensures everyone can access medical services without regard to their financial situation or geographical location (Tramp & Collins, 2020). Moten et al. (2012) demonstrate the real-world effects of the unavailability of health services through an HIV patient's case in Tanzania.

> "My family has already purchased a coffin for me," Naeema explained, enervated though she was. "The medicine we got from the local clinic has not helped. I am getting worse. We have spent almost all of our money going to regional hospitals to get a diagnostic test and request government-subsidized medicine. My parents have sold everything we had, our crops, our land, and our livestock to pay for my medicine. My family does not have any more money or even enough food to eat." Naeema was HIV-positive, and due to a lack of diagnostic capabilities or availability of antiretroviral treatments (ARTs) in her village of Kibosho in Tanzania, she had been bed-bound for more than three months after the onset of her symptoms, when she first arrived at the clinic.

The World Health Organisation (WHO) underscores that universal access should guarantee safe, effective, and affordable health services tailored to each country's needs, especially for vulnerable populations (WHO, 2017). Mubaiwa (2018) supports this by highlighting that universal health care encompasses availability and the equitable utilisation of health resources without barriers. According to Evans et al. (2013), universal access hinges on three dimensions: i) physical accessibility, ii) financial affordability, and iii) acceptability, which must be integrated to ensure comprehensive, equitable health care access. From the literature, the key aspects of equitable access are accessibility/availability, affordability, acceptability, and quality.

Affordability links with the justice principle of fairness in that health services should be accessible to everyone, using subsidies for disadvantaged people and universal health coverage. Availability links with the social justice principle of redistribution. This entails having enough health care facilities to achieve optimal, timely results (Reily, 2021). It is the ability "to reach, use, or visit a service and a method of approaching, reaching,

or entering a place" (Levesque *et al*., 2013:32). Entering a place means removing geographic barriers, in that no one should be too far from the reach of health services (Abatemarco *et al*., 2020; Rosenberg, 2014). The modern adage of 'leaving no one behind' applies in this regard, hence taking health services to the people through intervention programmes that visit remote communities.

Acceptability links with the justice principles of protection and reparation, as health services are made culturally appropriate and without discrimination. It is about structural arrangements and the capacity to align health services with the diverse needs of individuals (Salkever, 1976; Donabedian, 1973). Acceptability presents a moral burden on the state to implement health measures to protect disadvantaged groups from preventable diseases and harm. This justifies the government's supply of basic health care for all. Quality links with the justice principle of equality, where all people ought to get the same health service. This includes the same medical practitioner, health facility, medication, and treatment, without discrimination on socioeconomic status, age, or gender. This ensures a fair chance of good health for all, even ensuring that the marginalised groups get better health services than they would afford on their own (Ruger, 2004). The justice principle of reparation is also enabled through quality health care. This is where equitable access to health addresses the historical injustices of those communities that were neglected for political and discriminatory reasons.

Justice and the right to health are intertwined, facilitating the social justice objectives of removing discrimination, oppression, and informational, financial, physical, and systemic barriers in health care services (Gold, 1988; Rawls, 1971). Justice demands that government and health care practitioners promote health (Hixon *et al*., 2013). This would lead to societal well-being and overall quality of life, which is the objective of good governance and ideal societies. Hence, ethical leadership manifests in policymakers and health institutions that advocate for equitable access to health care. Such leadership is committed to building a health care system that addresses individual rights and collective responsibilities (Daniels, 2001; Rhodes & Silver, 2012). Additionally, the role of professional health care practitioners, particularly nurses, in advancing health equity has been widely recognised (Rudner, 2021).

2.5 The significance of functional health services

Functional health services relate to efficiency, which is about “minimum wastage of resources in the achievement of health care objectives” (National Department of Health, 2020). It is about ensuring health outcomes through detailed functional specifications integrated with operational processes (Greenes, Collen, & Shanon, 1994; Kolodner, 1994; Christensen & Grimsmo, 2005; Ouhbi *et al*., 2017; Parasaie *et al*., 2024). Electronic health communication and mobile health applications are popular considerations for building functional health services (Kolodner, 1994; Christensen & Grimsmo, 2005; Greenes *et al*., 1994). The authors emphasise that health information systems require efficient data entry methods, presentation systems, and streamlining. Taguri (2008) explains that health care access and efficiency require modern health services to adopt patient-centred care models, which provide integrated, accessible services. The patient-centred models operate through state and donor funding, which supports health centres, clinics, and public health agencies that provide care to underserved communities (Hennessey, 2013; Lenihan *et al*., 2007). Mobile clinics in remote geographic communities are part of the patient-centred care models. But funding and staff shortages are common challenges of community clinics, which justifies the need for state subsidies (Grimilda, 1993; Cruz-Gomez *et al*., 2018). The shortage of health care workers causes operational inefficiencies, which ultimately result in lower patient care quality.

The delivery of functional health services depends on two essential components, which are infrastructure and facilities. The delivery of health services depends on buildings, equipment, electricity, roads, emergency transport systems, and water and sanitation facilities, in both private and public facilities, and non-governmental organisations (NGO) network operations (Moten *et al*., 2012). The WHO documented in 2020 that developing nations experience significant health infrastructure deficiencies because they do not possess essential medical equipment and core infrastructure (WHO, 2020). Health care facilities in these countries encounter two main service delivery problems, because 60% of facilities do not have adequate sanitation, and 50% of facilities function without reliable electricity (WHO, 2020). The World Bank (2021) reports that sub-Saharan health care facilities face equipment and

staffing shortages, which mainly affect rural areas, and create barriers to essential services, resulting in elevated maternal and child death statistics.

The Chinese government invested its funds to improve health care delivery through facility construction, digital health system implementation, and rural health care service expansion after the 2003 SARS outbreak (Yip *et al.*, 2019). China established the New Rural Cooperative Medical Scheme to enhance both health insurance coverage and medical facilities in underserved rural areas (Yip *et al.*, 2019). The Cuban health care system functions with restricted resources to provide community-based primary care services that include preventive care and local medical services (Keck & Reed, 2012). The health care system of Cuba bases its operations on primary care services, home-based medical visits, and clinic accessibility for every community (Keck & Reed, 2012).

The United States has top-tier health care facilities, but unequal health care access exists because of economic differences and its broken health care structure (Tikkanen & Abrams, 2020). The United States' rural areas face ongoing challenges because hospitals are shutting down while health care professionals remain scarce, which restricts patients from receiving urgent and specialised medical services (Bai & Mehrotra, 2020). The nation produces conflicting results, because India built many health care facilities throughout the past decades, but rural areas still encounter challenges in accessing modern medical facilities and skilled medical staff (Patel *et al.*, 2015). The Ayushman Bharat scheme, which the government initiated in 2018, works to enhance health care facilities while safeguarding the most at-risk populations; however, it has not eliminated the existing gap between urban and rural health care delivery (Niti Aayog, 2021). The health infrastructure of Mozambique struggles to develop because public health facilities operate without basic resources, access to dependable power, water access, and the required medical equipment (WHO, 2022). The nation faces its most severe infrastructure problems in rural areas because these locations have restricted health care availability due to their distant locations and insufficient transportation networks (Riddle *et al.*, 2021). International aid, together with government partnerships, has backed community clinics and emergency response operations for the last few years (UNICEF, 2021). The World Bank (2021) indicates that health infrastructure requires both equitable distribution and policy integration to achieve universal health coverage as per global agreements.

2.5.1. The role of strong leadership in enhancing functional health services

The research by Seims et al. (2012) shows that health care team leadership and management development result in improved health service delivery and higher patient visit rates (Bahreini *et al*., 2021; Gilson & Daire, 2011). Engaging effectively within health teams, fostering motivation, and implementing strategic goals are critical for increasing patient throughput and improving service utilisation (Bahreini *et al*., 2021). Leaders who are effective will support new plans and oversee the execution of health care initiatives (Gilson & Daire, 2011). AL-Haddad and Psych (2003) found that health care leaders need to link administrative tasks to medical service delivery, based on their research. Leaders need to grasp both health care management and patient clinical requirements, according to these experts. Leaders who handle resources and deliver patient care at the same time create an organisational system that delivers superior patient care through effective resource management. The outcome would produce a specialised workforce that delivers better patient care while showing decreased burnout symptoms (Firth-Cozens & Mowbray, 2001; Plesk & Wilson, 2001). The authors base their argument on the fact that health care organisations operate as intricate systems that require leaders who can manage both clinical operations and organisational results. Leadership requires adaptability to handle all the different components that exist in health care facilities.

The research by Kakeman et al. (2020) describes essential competencies for hospital managers. These include evidence-based decision-making, operations management, knowledge of health care environments, interpersonal skills, leadership, managing change, and professionalism. The development of these competencies leads to better organisational productivity and service quality, and sustainable health care systems. The framework provides a full leadership effectiveness model that extends past the limits of operational and clinical competence. Rather, it involves the ability to navigate complex organisational environments, foster collaboration, and lead teams through change. Budak and Kar (2014) support the identified competencies through their research, which shows that health care organisations need strategic leadership to handle financial constraints and patient care responsibilities.

Gilson (2007) examines the appropriate role of leaders in health inequality reduction through his research, which demonstrates that health care system stewardship

demands leaders who actively combat health care disparities. This theme of equity is also central to the work of Mutale et al. (2017), who demonstrate the positive impact of leadership training on health system performance in Zambia. The research shows that district health managers who receive training in leadership and management skills become more effective decision-makers and better resource managers, which results in enhanced community health results. Gilson (2007) explains that health care leadership requires both resource management and social determinants of health solutions in low-income health care settings. Leadership training and capacity-building programmes function as vital tools to establish health care equity because they enable leaders to create solutions for the underserved population's needs (Triggle, 2015). Bradley et al. (2015) highlight that health care leaders need to manage operational requirements of these service delivery models while ensuring financial stability.

2.6 Structural and health inequalities

Health inequalities manifest through unfair distribution of health facilities and discrimination in terms of access to services (National Department of Health, 2020:14). Multiple factors, including structural elements, geographical position, socioeconomic conditions, and cultural aspects, determine how people in resource-deprived areas access medical care. Visagie et al. (2015) studied health care accessibility in the Western Cape Province of South Africa to show that transportation problems, insufficient staff numbers, and poor facility conditions create major barriers for patients to access care. Bhatti (2005) supports this finding through his study of health care access challenges in Pakistan's District Attock, which shows that health unit distribution and availability create barriers to health care services. The author supports the need for more health care facilities in underserved areas because they believe that insufficient infrastructure and logistical barriers prevent people from accessing health care services. The health care system faces multiple structural barriers because of insufficient funding, insufficient facilities, and insufficient health care staff who work in rural areas (Visagie *et al.,* 2015; Osadolor *et al*., 2022).

The combination of transportation problems and extended waiting times functions as a physical obstacle, which prevents patients from accessing medical care (van Gaan & Dent, 2018). The rural areas of India experience inadequate health outcomes because patients need to travel extended distances to health care facilities through

restricted road systems (Patel *et al.,* 2015). The remote location of Aboriginal communities throughout Australia creates an obstacle that prevents them from accessing specialised medical care and emergency services, according to the AIHHW (2020). The combination of severe winter conditions and remote locations in rural Canada makes it difficult for patients to access medical facilities (Kulig *et al.*, 2011). The inadequate road infrastructure and health care systems that are concentrated in urban areas of sub-Saharan Africa's low-income countries lead to higher death rates among rural mothers and children (Peter *et al.*, 2008).

The existing barriers to health care access become more severe because of economic conditions that include poverty levels, educational inequalities, and insufficient health coverage (Osadolor *et al.*, 2022; Nnoyelu & Nwanko, 2014). The various elements that influence health care access create different patterns of access for different population groups throughout the country. People with disabilities in rural areas face unequal health care access because social discrimination, physical barriers, and insufficient medical services prevent them from getting proper care (Dassa *et al.*, 2018). Dassa *et al.* (2018) demonstrate how these obstacles generate challenges for disadvantaged groups, since disability tends to enhance existing obstacles. The study by Islam and Kamal (2021) shows that economic differences between social groups lead to health care service gaps, which block marginalised populations from receiving essential medical care.

The rural-urban divide in access to health care is also addressed in Sop and Messi's (2022) study of health care facility access in the Bali-Nyonga Sub-Division of Cameroon. The authors show that rural patients must overcome two major obstacles, which include travelling long distances to health care facilities and a lack of suitable transportation systems, according to Grut *et al.* (2012). The authors describe the same difficulties that disabled people face in rural areas in South Africa. The authors agree that rural health care access problems stem from inadequate transportation systems and insufficient medical facilities, which require policy solutions to enhance health care facility numbers and transportation networks (Sop & Messi, 2022; Grut *et al.*, 2012). Kiwanuka et al. (2008) confirm this requirement, because Uganda faces financial and logistical challenges that mainly affect impoverished areas, so policymakers should focus on geographical issues to achieve health care equity.

Rust and de Jagger (2010) show in their research that South African hospitals achieve better staff satisfaction and health care quality through their leadership and governance systems. Murray and Cope (2021) show that leadership stands as a primary factor that determines patient safety, because poor leadership creates negative effects on health care outcomes. Gilson and Daire (2021) build upon this by studying governance problems in South African health care, while proposing that better leadership would help fix systemic flaws to enhance health care delivery. The process of resource mobilisation and service delivery requires effective governance to achieve accountability and health service equity. South Africa has faced continuous challenges to improve health care accessibility for disadvantaged groups since 1994 (Christian, 2014).

Health care access depends on socioeconomic status, yet racial differences emerge in perceptions of health care accessibility, because Black, coloured, and Indian people show more optimistic views than white individuals do (Lallo *et al.*, 2004). The service delivery system presents the biggest obstacles for lower-income groups, because it determines their service access through availability, accessibility, affordability, acceptability, and adequacy (Scheffler *et al.*, 2015). The health care system creates obstacles for disabled people because of environmental factors and institutional barriers, and social and personal elements (Mji *et al.*, 2017). The research shows that South African health care delivery faces inherent challenges because of ongoing social and economic inequalities, which prevent equal access to health care. Aikman (2019) identifies multiple systematic problems in South Africa's health care system, which he explains as a complex disorder caused by weak policy execution, insufficient staff numbers, poor management, and insufficient health care facilities. The study by Malakoaene et al. (2020) supports these results by analysing the Free State health care system, which shows similar weaknesses that affect health service delivery. The organisation drives health care system transformation through structural changes that improve resource management and staff development, and facility maintenance.

2.7 Counterargument on social justice and equitable health access

From a policy perspective, health care ought to be “directly and permanently accessible without undue barriers of cost, language, culture, or geography” (NDoH, 2020:14). Health care access receives different perspectives from libertarianism and

liberalism, and democratic socialism (Pereira, 1990). The free-market system should control health care delivery according to libertarian principles, because it respects personal freedom above all else (Pereira, 1990). The liberal perspective supports social safety nets because equitable health care access stands as a fundamental requirement for building a just society (Giles & Liburd, 2007). Democratic socialism supports universal health care as a basic human right because it implements a collective strategy to reduce health inequality (Wronka, 2016).

The ethical study of health equity uses three main approaches, which include utilitarianism and Rawlsian justice, and Sen's capability approach (Amir *et al.,* 2024; Rawls, 2009). The pursuit of maximum happiness through utilitarianism sometimes leads to conflicts with both individual rights and justice principles (Giles & Liburd, 2007). According to Gibbard (1984), health care policies should create general welfare improvements while protecting all population groups from substantial harm. The health care system should work to eliminate social disparities while creating equal treatment for all patients, according to Peter and Evans (2001). The high costs of implementing universal health care programmes create concerns about their sustainability. Traditional cost-effectiveness studies fail to show how health interventions affect distribution patterns and resulting inequality reduction (Dukhanin *et al*., 2018; Hixon *et al*., 2012).

The evaluation of policies needs to move beyond efficiency metrics because equity stands as an essential outcome measure. The absence of state-provided quality health care leads people from better-off backgrounds to seek medical care through private facilities. The Bangladeshi health care privatisation process, according to Rahman (2022), has made health disparities worse for disadvantaged social groups. The analysis of the European health care system by Abbing (2010) shows that universal health care systems with strong social safety nets and universal access produce superior health outcomes and decreased social inequalities. The author demonstrates that heavy dependence on private health care systems creates problems that require a balanced strategy that combines equity with efficiency (Abbing, 2020; Rahmna, 2022). Triggle (2015) demonstrates through his NHS research that health care leaders need to make challenging financial decisions that protect service quality in environments with limited resources. Bradley *et al.* (2015)

build upon this concept by demonstrating how management teams can use their influence to enhance health care systems worldwide. Health care systems require effective management practices, which include financial oversight, resource allocation, and strategic planning, to achieve better performance and sustainability. The leadership framework developed by Kakemam *et al.* (2020) and Bahreini *et al.* (2021) includes financial management and sustainability as essential competencies that support their earlier findings.

2.8 Policy approaches towards equitable health care

Sreenivasan (2007) defines health access as a core element of equality because he demonstrates that unequal health care access creates new social inequalities that block people from achieving their life objectives. Marmot (2015) states that health care service disparities between different social groups make existing social inequalities worse, particularly in areas with low-income levels. Maeda *et al.* (2014) studied eleven case studies to demonstrate that universal health coverage implementation leads to inclusive development through equal access to affordable quality health care, which reduces health disparities based on income and geographic location. The research conducted by Lagomarsino *et al*. (2012) demonstrated that Ghana and Thailand achieved better service coverage and reduced health care expenses for their citizens through their investments in primary health care and financial protection systems, which included free care for the poor and national insurance programmes. The study by Balabanova *et al*. (2013) stresses that proper governance systems with accountability functions must exist to guarantee that health reform programmes benefit marginalised communities. The research findings showed better access to equity, together with decreased patient costs and wider health system inclusiveness (Maeda *et al.,* 2014; World Health Organisation, 2010).

Ikegamis (2014) studied Japan's UHC system of adaptive health policies, which support long-term health care delivery for all citizens. The system provides universal population coverage because it operates under legal requirements and risk group fund pooling mechanisms, as described by Ikegamis (2014). Japan depends on its national uniform fee schedule to control medical expenses, prevent price increases, and ensure all citizens can access health care (Campbell & Ikegamis, 2009). To protect equity, co-payments are capped, and subsidies are provided for the elderly and low-

income groups (Tamiya *et al.*, 2011). Japan focuses on preventive care and scheduled health screenings because these methods help detect health issues before they become severe (Hashimoto *et al.*, 2011). In response to demographic ageing, Japan introduced a long-term care insurance (LTCI) scheme in 2000, which supports home-based and institutional care for the elderly (Tsutsui & Muramatsu, 2005). Japan has achieved elevated life expectancy and reduced infant mortality rates, and universal health care access for all social groups through the implemented interventions (Ikegamis, 2014; Matsuda, 2019).

Different methods exist to achieve universal health coverage throughout the world. The UK delivers free care services through government-operated facilities (Chang *et al.*, 2011), while Germany's system is funded by public insurance that covers private services (Blumel & Reinhardt, 2015). The South Korean health care system operates through two separate systems, which combine universal health coverage that covers 60% of medical expenses with private insurance that covers 40% of costs (Palaniappan *et al.*, 2019). Brazil provides complete inclusion through its health care system, which offers free services to all residents, including undocumented immigrants (Casto *et al.*, 2019). The Universal Coverage Scheme (UCS) of Thailand has proven successful by offering complete health services to all residents at low direct costs, which has decreased social health inequalities and protected people from financial risks (Tangcharoensathien *et al.*, 2018). Similarly, Cuba has long championed an equitable health system that is built on community-oriented primary care, which emphasises prevention and strong doctor-patient relationships, resulting in impressive health indicators despite economic constraints (Keck & Reed, 2021). Research shows that universal health care accessibility depends on three essential factors, which include political commitment, robust primary care networks, and sufficient public financial support.

Multiple African countries have started large-scale health service reform programmes to improve equal health care access throughout their entire territories. The Mutuelles de Santé health insurance model in Rwanda has reached more than 90% population coverage, which shows that community-based financing systems decrease health care costs and improve basic health care availability (Lu *et al.*, 2012). The National Health Insurance Scheme (NHIS) of Ghana functions as a fundamental system for

universal health coverage but faces operational challenges when delivering its services (Alhassan *et al*., 2016). The Linda Mama programme operates as a maternal health programme in Kenya, which delivers free medical services to mothers while working to reduce maternal and newborn deaths and improve health care availability (Waithaka *et al*., 2020). The programmes demonstrate that regional stakeholders have united to establish an equal health care system which addresses monetary obstacles and operational problems (Lu *et al*., 2012).

South Africa bases its health reform strategies on social justice principles through primary health care services that follow the Alma-Ata principles to fight against apartheid-created health disparities (Rispel, 2016). The NHI serves as a key initiative for South Africa to connect health services with universal coverage while advancing social equity (Shisana *et al*., 2019). The implementation of these reforms produces broad social effects because UHC serves as a fundamental requirement to achieve Sustainable Development Goals (SDGs) (WHO, 2018). The WHO has established UHC as the essential foundation to achieve SDGs, which concentrate on health and poverty reduction, and inequality reduction (WHO, 2018). The initiative backs health care systems that prioritise primary care, tackle social determinants to reduce health disparities, and boost economic and social development.

Kingson and Cornman (2007) view UHC as a basic human right, which would lead to better health care services and decreased total health care expenses. Marziale (2016) emphasises nurses as essential professionals who need to tackle social and economic challenges to reach UHC. Yet, as Alter *et al.* (2011) suggest, universal access to health care does not automatically eliminate health disparities, because their Canadian research showed that disadvantaged social groups received more services, yet their health status deteriorated, which requires early intervention for behavioural risk factors. Tramp and Collins (2020) explain that UHC works to build a fair health system that supports people and promotes enduring development. The achievement of universal access serves as a base, but equal access needs to address structural barriers through complete primary care services, which foster social unity and community health (WHO, 2017).

2.9 Summary

The chapter investigated social justice methods for health care service equity through an analysis of how justice theory and health care accessibility principles function in South Africa's health sector. The NHA and NHI systems were designed to improve health care equity, yet their effectiveness requires solutions to socio-economic and structural barriers that include financial stability, geographic access, and resource distribution. Social justice requires policy changes and complete dedication to reduce health inequalities caused by social determinants of health for achieving health equity.

CHAPTER 3: THE STATE OF ACCESS TO HEALTH SERVICES COMPARED TO THE NHA AND NHI PROVISIONS

3.1 Introduction

The previous chapter explored the social justice theory and policy approaches towards equitable health care. The NHA and NHI are based on social justice principles because they aim to provide equal health care services to all South Africans. The NHA provides the legal framework for structured and uniform health systems at all levels of government, while the NHI is a specific mechanism for financing and delivering health care services. Weak governance and ineffective leadership in a dual health system have hindered progressive policy goals and equitable service delivery.

The first section of this chapter presents an international perspective of health services, which opens into the analysis of health policy effectiveness in delivering access to health care. The political evaluation of NHA and NHI provisions confirms priorities, and the pattern of inequalities based on resource distribution. The health reforms have increased public participation in the operations of health systems.

3.2 Health care reform in South Africa

The health care system of South Africa under apartheid provided excellent care to white people but insufficient care for Black communities (Benatar, 2003; Coovadia *et al.*, 2009; Michael *et al.*, 2020). Black communities faced major barriers to obtaining proper medical care because rural areas lacked sufficient health care facilities and services, according to Chopra and Sandra (2004). The apartheid regime's intentional disregard for Black health needs left the new government to deal with a broken health care system, which maintained severe structural disparities (Coovadia *et al.*, 2009). The post-apartheid government faced significant challenges in dismantling the system because it needed to distribute health care resources equally through a framework that had denied access to most people (Prince, 1994; Rensburg, 1999). The first health care reforms faced two major challenges because society had ignored health care requirements; at the same time, it required a fast implementation of a structured system.

The NHA provisions have always reflected the government's intention to establish a national health system that incorporates the private and public health sectors within available resources (RSA, 2003: s2(a)i). The intention is the progressive realisation of the constitutional right of access to health care. Section 4 of the NHA provides for free health services in public health establishments. Even though section 3(3)b of the NHA suggests that people with medical aid cannot use public health facilities, this clause is not implemented to exclude them (Ramaphosa, 2024b). Because of the free health care policy, there are more foreign nationals accessing health services. This has led to political fallout between foreigners and the residents, who complain about "the pressures on public services, including overburdened clinics and exhausted health care workers." But "members of the public are urged to raise such concerns through lawful and appropriate channels" (Mnukwa, 2025; Letlape, 2025). The modernised South African health structure has attracted foreign nationals from countries where health systems have collapsed.

In line with the NHA objectives of decentralised, equitable, inclusive, and efficient management of health services, the current South African health system structure is made of ward-based outreach teams, traditional health practitioners, primary health care clinics, community health centres, and district hospitals as the first tier of general health care (NDoH, 2020:7). This system is based on a referral process from the primary to specialised health facilities, depending on the care and intervention needed. The health system includes emergency ambulance and planned patient transport services, which are accessible without exposing users to financial hardship (NDoH, 2020:5). The government implemented Community Health Workers (CHW) to serve patients within their households. This reduces the burden on people waiting long hours or travelling to health facilities for treatment. The CHWs had visited 17 916 505 households by March 2024 (NDoH, 2024:24; 43). These CHWs provide preventive and promotive care, including early detection and referral services. Service integration has achieved progress, yet structural barriers such as leadership instability, insufficient staff, and inadequate management systems have blocked the expansion of successful programmes (Mayosi & Benatar, 2014). The health care system faces severe difficulties throughout the entire country, but rural areas experience the most extreme problems because their medical facilities operate at maximum capacity (Maphumulo & Bhengu, 2019).

Figure 3.1 below shows the referral system in health care, and the place of the private sector as an alternative where the public sector is failing. The private sector provides convenient and specialised services that are not easily accessible in the public sector.

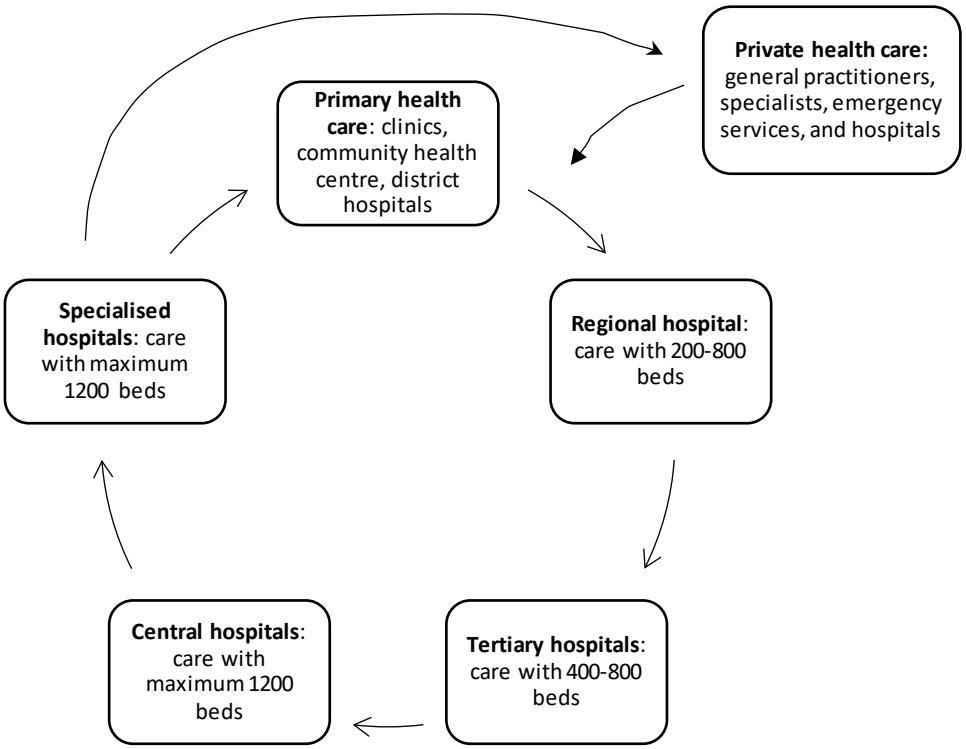

Figure 3.1: South African health care referral process (adapted from NDoH, 2020:7-8, 15).

The NHA objectives of cooperative governance and management for health policy and service delivery remain the biggest challenge of the South African health system, where there is endemic misallocation of resources (Ramaphosa, 2024b). Public sector leadership and care providers faced major challenges when moving young patients from paediatric to adult care because of conflicting policies and insufficient training (Kung *et al.*, 2016). These challenges were also confirmed in the HIV/AIDS epidemic, because the state had failed to create an adequate response system during the early 2000s (Rensburg, 2014). Weak institutional leadership and poor coordination were recurring in South Africa's health care. This enabled NGOs to take charge of HIV/AIDS intervention work (Simelane & Venter, 2014). However, the NGO intervention added to the problem of insufficient coordination between government and civil society organisations, which resulted in duplicated and fragmented service delivery systems (Knijn & Slabbert, 2012). The early years of post-apartheid South Africa saw policy

discussions focus on how to transform the functions of public and private health care organisations (De Beer, 1986). Prince (1996) states that the government planned to increase public health care services, yet private interests maintained dominance because of their financial power and institutional influence. Benatar (1997) states that the public system reform efforts were restricted because of limited funding and weak administrative control, which mainly affected rural areas that required the most assistance. The main obstacle to UHC access stems from an unsustainable health care funding system, which is worsened because of inadequate leadership in resource management (Ataguba, 2010). The NHA introduction aimed to spread services across different areas, but its execution showed that provincial health departments lacked sufficient operational capacity (Hassin *et al*., 2008). The existing gaps between the two systems were both technical and managerial in nature, which demonstrated a recurring pattern of poor governance that continued from one administration to the next.

Over the years, the government has implemented the NHA objectives of a uniform national health system, as seen through Figure 3.1. But some challenges exist in that there is no unified record management system, as a person must create a new file each time they visit a different health establishment. Talks about digital records and a file management system are underway (Botha *et al*., 2024), as in the Emerging South African National Health Information System: Strategies, Approaches and Experiences (NDoH & CSIR, 2020). There is some small integration with the private sector, in that patients can be taken from a public to a private health establishment to cover the needs that public facilities cannot provide. There is some evidence of cooperative governance for health policy and service delivery moving from national to local spheres. The health system is decentralised but not sufficiently equitable. Management practices need improvement, and public participation needs to be enhanced. The NHA's objectives of an integrated private and public health service, along with shared responsibility to implement health plans, drive the impetus to implement the NHI.

The gradual implementation of the NHI for UHC and promoting social solidarity through cross-subsidisation is now in effect. President Cyril Ramaphosa challenged

the misconception that the private health sector is independent of government in its operations and financing.

> Firstly, the training of doctors, nurses, and other health care personnel who work in both the public and private sectors is subsidised by the state. Secondly, as an employer, the state pays billions of Rands annually in subsidies for employees who are members of the various public sector medical aid schemes. Thirdly, taxpayers claim tax rebates for medical aid expenses amounting to approximately R37 billion. This is the money the state should earn in taxes, which it foregoes to subsidise private health care. We therefore have a situation where the state both directly and indirectly helps to fund a private health care sector that serves only a minority of society. Access to private health care through medical aids is also costly for users. It is said that without the tax rebate, private health care would not be affordable to the majority of users. Medical aid contributions are increasing faster than inflation. At the same time, benefits are being reduced. As the 2016 Health care Market Inquiry found, private health care services and medical scheme cover are frequently overused without clear improvements in health outcomes. The resources that are spent both by the state and private individuals can therefore be more efficiently used to build a single, unitary health care system that serves all. Some people have claimed that the NHI will signal the end of private health care. To the contrary, the NHI aims to use the respective strengths and capabilities of both the private and public health sectors to build a single, quality health system for all. South Africa's private health sector has world-class expertise and is a major source of domestic and foreign investment. The public sector, too, has numerous centres of excellence and is staffed by well-trained, experienced personnel. The NHI Fund will procure services from accredited public and private service providers for every person in need of health care. The NHI will be a lifeline for millions of poor South Africans whose resources will be freed up for other essential needs. It will also alleviate the burden on those who are increasingly paying more in medical aid premiums for increasingly fewer services. There may be different views on how NHI will be progressively implemented; the reality we must confront is that the current health care system is unsustainable. Access to quality, decent health care should not depend on one's ability to pay. The current situation does not serve the poor, does not serve the middle class, and does not serve the country. With careful planning, effective oversight and monitoring, and the strategic allocation of resources, we can achieve universal health coverage. Working together in partnership, as both the public and private sectors, we can make the dream of quality health care for all a reality (Ramaphosa, 2024b)

The above excerpt can be summarised by how it expresses the principle of justice in access to health care. First, the state invests in the training of health practitioners. Second, as an employer, the state subsidises medical aid fees for employees in public institutions, and the state provides tax rebates for medical aid members. Third, despite so much fiscal input for the use of medical aids, there are fewer people benefiting from them, the medical aid cover quickly runs out, and its cost is increasingly unaffordable, forcing people to use public health establishments. That people pay more for medical aid and get fewer services in return is a great injustice. Fourth, the state is losing a lot of money within the health system that does not improve health outcomes. Hence, there is a need to ensure efficient use of resources for the benefit of all. And lastly, it admits that people need to be protected and enabled to access health care. The current health care system is unsustainable because only people with money can access quality health care.

The NHI intends to eradicate the stark inequalities that determine who receives adequate health care and who suffers from neglect (Ramaphosa, 2024a). The NHI pilot study (NDoH, 2019) covered interventions at ten Primary Health Care (PHC) facilities (clinics and community health centres) in one district, for all 9 South African provinces. KwaZulu-Natal (KZN) had interventions in two districts. Under this project, ward-based outreach teams served 12 million households. Just over 4.3 million learners were screened in the school health programme, and 1507 establishments were updated to ideal clinic status. In this programme, between 2012 and 2017, 504,803 learners had various health problems and were referred for treatment, while 130 establishments were renovated for improved patient experience. Twenty million patients were registered on the health patient registration system in 2,968 PHC facilities, along with the implementation of the stock visibility system in 3,167 clinics to reduce medicine shortages. Workload indicators for staffing needs, contracting of 330 general practitioners on the NHI, and access to doctors at facilities had improved. Common challenges in the NHI pilot revealed a lack of governance and coordination, as there was poor communication and fragmentation from the national to the local sphere. In addition, some districts operated in silos without alignment with the NHI; this means the NHA's objective of decentralisation could be undermined and negatively affect access to health. There were persistent staff shortages in PHC, and

a lack of team supervisors and leaders for outreach teams, due to poor human resource capacity and frozen posts.

Michael et al. (2020) propose that the NHI would create a smoother transition process through unified national standards, but this method requires successful facility-level leadership and accountability systems to work effectively. Health disparities between age groups increase when health care facilities are managed by pools, because it creates disruptions in patient treatment flow (Michael *et al.*, 2020; Von Fintel & Richter, 2019). These gaps are not only medical but also administrative, as weak management fails to create the support necessary for adolescent health care. Solutions to youth health care inequality require leaders who can unite services with developmental requirements (Richter, 2019). Weak management and supervisory systems have led to an ineffective public health sector with insufficient resources, by contrast with the private sector (Mahomed *et al.*, 2017). Rensburg (2021) explains that public hospitals require strategic leadership to implement reforms, because they operate with different financial management systems from private hospitals. Katuu (2018) advocates for a governance system that merges universal health coverage principles with decentralised management to create a more responsive health care delivery system. The lack of such a leadership structure change will maintain existing gaps between the public and private sectors, which will block progress toward both fairness and maximum output.

Fusheni and Eyles (2016) support the district health system (DHS) model as a method to implement universal health coverage in regions with limited access to health care. The National Department of Health makes decisions from a centralised position, which opposes the principles of local empowerment and leadership (Fusheni & Eyles, 2016). Young (2016) adds that while public-private partnerships (PPPs) could improve efficiency, their success depends on transparent leadership and regulatory accountability. Ghobadian et al. (2004) show that PPPs work effectively under specific circumstances, yet they state public leadership failures can lead to profit goals exceeding equity values. Multiple barriers exist in developing inclusive policies because organisations need to build leadership competencies that enable successful policy execution. Well-intentioned reforms have suffered from poor management practices that need urgent leadership reform to succeed.

3.2.1 Leadership deficiencies negate health sector reforms

In the Free State province, multiple operational problems in health care facilities, such as Pelonomi Tertiary Hospital, have resulted from inadequate management approaches that created insufficient staff numbers and communication breakdown (Malakoane *et al*., 2020; Journal News, 2025). The political leaders of provincial health departments have encountered ongoing difficulties because patronage networks and inadequate accountability systems prevented vital reforms from taking place (Malakoane *et al*., 2020). Young (2016) made a similar observation about the need for effective facility-level leadership for improved resource optimisation and patient-centred service delivery goals. Rensburg (2021) supports this view but adds a warning that the lack of leadership will erode financial inputs meant for improved public health care delivery. The Health Ombud (2025) investigated Helen Joseph Hospital in Johannesburg and found systematic mismanagement, dangerous patient care, and a lack of accountability. Like Rensburg (2021), the Health Ombud (2025) warned that health care equity will not become a reality without immediate changes to leadership practices and following established governance principles.

3.2.2 The NHI for comprehensive leadership and fiscal structural reforms

The NHI proposal offers the most complete solution to handle these institutional problems by creating a single system for payment and service organisation (Surrender, 2016). Van den Heever (2016) explains that NHI aims to pool resources and redistribute them to historically neglected areas, with equity at the core of its design. The success of NHI depends on having effective leadership at all levels of the health care system, according to Van Ransburg (2014). Meyer et al. (2017) recognise the potential of the NHI policy yet warn that current administrative problems could harm its operational success. The pilot districts face existing implementation challenges because of inadequate planning, confusing communication, and insufficient leadership, which have caused delays in their progress (Vearey *et al*., 2017). The NHI vision shows promise, but it faces the same management issues that have affected health care since the beginning of the 1990s.

Gilson and Daire (2011) define leadership as more than administrative control, because it requires leaders to build trust, develop institutional strength, and maintain

organisational accountability. The authors emphasise that sustainable health system reform requires leaders who can achieve performance improvements throughout the entire health care system, starting from clinics up to national policy levels (Gilson & Daire, 2011). Stefl (2008) states that leadership development requires institutional backing to produce qualified professionals who can manage intricate situations and reach desired results. Malakoane et al. (2020) show that bad governance practices lead to poor patient outcomes, which makes leadership change necessary. South African health leadership management needs a fundamental transformation for the NHI and other reforms to achieve their goals of equity and quality (Conmy, 2018).

3.3 South Africa's health service priorities contrasted with those of other countries

Most countries that implement an NHI policy, like South Africa, primarily aim for UHC (Marten *et al*., 2014). However, South Africa's progress has been slow in comparison to its peers. The Unified Health System (SUS) of Brazil created UHC through constitutional rights, which resulted in better health care availability (Castro *et al*., 2019). The main distinction between Brazil and South Africa stems from their different levels of political dedication to health equity through their governmental frameworks (Castro *et al*., 2019). The decentralised health administration system of Brazil allows local governments to deliver health care services, which leads to quicker responses and better local control (Castro *et al*., 2019). The decentralisation approach in Thailand achieved success by improving both community-based planning and service delivery systems (Tangcharoensathien *et al*., 2018). The NHI system of South Africa operates as a centralised model, which puts at risk the current service delivery functions of provincial and district authorities (Katuu, 2018). The implementation of successful reforms requires both local capacity and autonomy, as shown by international examples (Van den Heever, 2010).

The organisational design of institutions determines the success of reforms, but it must be matched with viable financial systems. The general taxation system of Thailand served as the funding mechanism for UHC because it provided a progressive and sustainable method of financing (Tangcharoesathien *et al*., 2018). The publicly funded systems in Canada depend on tax revenue and shared resources to provide UHC without causing financial difficulties (Birn & Nixon, 2010). The South African financing

system continues to be debated, because NHI faces two major barriers of affordability and sustainability due to low tax revenue and budget limitations (Michael *et al.*, 2020). Health care reforms become impossible to achieve because there is no established funding system (Van den Heever, 2010).

The current state of health outcomes in different countries shows how past events have formed the basis for their present health status. Canada and Sweden achieved political stability during their system-building era, which allowed them to establish continuous paths to reform (Usher, 2015). The health system of South Africa operates based on apartheid-established inequalities, which produce ongoing service differences between different racial and geographic areas (Katuu, 2018). The current structural inequalities need their own distinct solutions, which go beyond the scope of policy adjustments. The achievement of health reform success requires identifying historical legacies that must be actively removed (McPake & Mills, 2000).

Human resource constraints further complicate South Africa's health reform efforts. The public health care system faces reduced delivery of quality care because rural areas and underserved regions lack sufficient health professionals (Michel *et al.*, 2020). Brazil launched the family strategy to expand its workforce through the deployment of doctors, nurses, and community health workers at primary care facilities (Castro *et al.*, 2019). The Thai government established programmes which encouraged medical personnel to work in remote areas, to improve health care service delivery throughout the country (Tangcharoensathien *et al.*, 2018). South Africa can use these models to create employee retention plans, which will help build a strong workforce for NHI delivery.

Preventive care is the essential factor of successful worldwide health reform. The Cuban health care system achieves exceptional results with minimal resources because it bases its operations on primary and preventive care (Zahid *et al.*, 2021). Brazil and Thailand established primary health care as the base of their UHC systems, which led to better population health outcomes and decreased health care expenses (Castro *et al.*, 2019; Tangcharoensathien *et al.*, 2018). The South African health care system bases its policy on primary care, but the funding and implementation focus on curative services (Michel *et al.*, 2020).

3.4 The legal and policy framework for health services

The South African Constitution reflects a rights-based approach to health services. Health care is a justiciable socio-economic right and obliges the state to take active steps to ensure its realisation. Section 27(1)(a) provides that everyone has the right to have access to health care, while Section 27(2) mandates the state to take reasonable legislative and other measures, within its available resources, to progressively realise these rights (RSA,1996). The state maintains its emergency obligations through Section 27(3), which prohibits any refusal of urgent medical treatment. These provisions are anchored in the founding values in the Bill of Rights, which apply to all laws, and bind the legislature, executive, judiciary, and all organs of the state to promote them (RSA, 1996: s8).

Fairness and equality are the first category values for equitable access to health care without unjust discrimination (RSA, 1996: s9 (3)). There must be substantive fairness for redistributive measures to ensure that historically disadvantaged groups enjoy equal access to quality health services (Harris *et al.*, 2011). Any form of discrimination in health care is not allowed; this means there should be identical treatment for everyone. The issue of non-discrimination has animated political discourse about the necessity to include undocumented foreign nationals in public health care (SAHRC, 2025). These ideals exist in a context of non-ideal conditions of insufficient funding for public health care, which means the government provides health services in an incremental manner based on available resources (RSA, 1996: s27 (2)).

The distribution of health care resources is the second value category, for fairness, equality, and dignity (RSA, 1999: s10). The allocation of health care resources through affirmative measures is legislated, without which it would be near impossible to address health inequalities (Ngwena, 2000; McIntyre & Mooney, 2007). As in politics, where authoritative allocation of values is a norm, the state distributes health resources for preventive and curative medical services to all citizens. This is where the state fulfils its mandate to protect citizens (RSA, 1996, s7 (2)). Without such protection, citizens are exposed to discrimination, neglect, and exploitation in health services (Ngwena & Cook, 2007).

Against this background, protection fulfils the imperative of restitution as a third value category for those citizens who have been systematically excluded from health services. Restitution is central to healing the divisions of the past (RSA, 1996: preamble, s8, s27; Coovadia *et al*., 2009). The NHI is one of the vital tools to ensure restitution and close the gap between private and public health care, and even geographic disparities in resource distribution affecting rural communities (National Department of Health, 2017). When operationalised, restitution enables framing human dignity in health care as a component of individual well-being. The Constitution frames well-being broadly through the right to dignity (RSA, 1996: s10; s27), a component identified by the ease of access to health care, acceptable treatment, and affordability for each person (CESCR, 2000; London, 2008). It is also important to assess social conditions concerning which the legal framework is meant to transform.

South Africa is committed to building a developmental state and shaping inclusive health services (RSA, 1996: s195; NDoH, 2017). The legal and policy reforms are intended for this purpose. The policy intention of the NHA was the main reference for quality health care in the post-apartheid era. It unified private and public health services into a single system, thus minimising chances of discriminatory practices and inequality (SAHRC, 2025; Hassim *et al*., 2008). The NHA authorised the Minister of Health to coordinate national policy, oversee service delivery, and uphold core standards for health services, monitoring, and clinical governance (Lourens, 2012). The Act, along with the Medical Scheme Act, contributes to achieving universal coverage (Strode *et al*., 2014). But the ambition of a fully developed health system is hindered by capacity constraints. More than creating a new funding model for health services, the NHA is more of a structural framework for governance and regulation of health services.

The NHI is more of a financial framework for a unified health care system (NDoH, 2011; Naidoo, 2012). The NHI essentially addresses the problem of an affluent minority who enjoy private health care through private health providers (Matsoso & Fryatt, 2013). It provides financial protection and restitution (Heunis *et al.,* 2019), as well as cost-effectiveness through a single-payer system and risk-pooling in health services (Wilkinson *et al*., 2022; Day & Zondi, 2019). The NHI in South Africa is comparable to some international cases of health care financing (Christmals & Aidam,

2020). Ghana has a National Health Insurance Scheme (NHIS), which improved health care access, although there are concerns about its sustainability (Blanchet, Fink & Osei-Akoto, 2012). The NHIS in South Korea proved successful through its administrative capacity to handle large enrolment numbers and single-payer operations (Shin, Cho, & Guallar, 2016). There were complexities of balancing private insurance and public financing in Taiwan's NHI (Liu & Chen, 2002), which threatened to reintroduce inequalities if not well-regulated.

The NHA was established to ensure the delivery of equitable, accessible, and quality health care services in South Africa (RSA, 2003). The foundation of the post-apartheid health system depends on this act, which creates a full legal framework to unite public and private health care services under one unified system (Hassim *et al*., 2008). The Minister of Health must follow this law by delivering health services, creating national health policies, and maintaining service quality through National Core Standards (Lourens, 2012). Health care facilities use these standards to monitor quality and enforce clinical governance (Lourens, 2012). The Act faces challenges during its implementation because rural provinces have varying levels of development, as they lack sufficient resources and experience financial inequality (Amollo, 2009). The Act functions as part of a system, with the Medical Scheme Act, to create accessible health care services for every citizen (Strode *et al*., 2014).

However, the NHA was not designed to create a new financing mechanism for health care but to provide a structural coordination, which is unlike the NHI policy, which aims to transform financing and access mechanisms (NDoH, 2011). The NHI, as introduced in the 2011 Green Paper, envisions a single-payer system that funds comprehensive health services for all South Africans, irrespective of socioeconomic status (Naidoo, 2012). The system resolves the existing gap between public and private health care delivery, because private care facilities receive most of the total health expenditure from patients from the minority population (Matsoso & Fryatt, 2013). The NHI system maintains the NHA's goals, but it uses mandatory prepayment and risk pooling to achieve financial protection, according to Day and Zondi (2019). The programme focuses on removing past health care inequalities created by apartheid and made worse by growing economic differences (Heunis *et al.,* 2019). The NHI system runs a

purchasing and contracting function that obtains health care services at both affordable costs and high-quality standards (Wilkinson *et al*., 2022).

The transition from the National Health Agency (NHA) to NHI financing aligns with worldwide progress toward UHC, which uses specific knowledge from international health care systems (Christmals & Aidam, 2020). The NHIS of Ghana achieved higher health care usage rates after its introduction, but the system faces ongoing problems with financial stability and equal access to care (Blanchet, Fink, & Osei-Akoto, 2012; Atofoe, Akota, & Nyarko, 2017). The lessons learned from this system are vital for South Africa because they enable the country to manage public service delivery demands relative to institutional operational capacity (Christmals & Aidam, 2020). The NHIS of South Korea operates a single-payer system, which proves that a well-developed administrative framework, combined with information management systems, enables successful enrolment and claims processing for big health care programmes (Shin, Cho, & Guallar, 2016). The fragmented structure of South Africa's health system hinders the claim processing efficiency of the NHIS (Wilkinson *et al*., 2022). The Taiwanese NHIS shows how public funding systems encounter problems when combined with private insurance, because uncontrolled supplemental insurance creates fresh social inequalities (Liu & Chen, 2002).

3.5 The state of health access in South Africa

The South African health system has 1,805 (52%) governance structures out of 3,472 PHCs. 2,046 of these facilities hold the Ideal Clinic status (NDoH, 2024:43). The South African Human Rights Commission (SAHRC) notes that 82 out of 100 people do not have access to medical aid and rely on the public health system.

> "South Africa remains an unequal society, where the quality and type of services people receive tend to be influenced significantly by their socio-economic status and ability to access services, regardless of the level of need for care. The majority of people in South Africa depend on public health care facilities to access their right to health care services" (SAHRC, 2025).

The health outcomes and service delivery between provinces show significant differences, because the Eastern Cape and Limpopo provinces perform poorly, because of failing infrastructure and inadequate funding, which mainly affects rural

areas (Ewing *et al.*, 2020; Potgieter *et al.*, 2021). The Western Cape demonstrates a superior health system performance because its provincial leadership maintains strong control and distributes resources effectively between urban and peri-urban areas (Rispel, 2016; Stuckler *et al.*, 2011). The economic core of South Africa encounters two major problems because public hospitals operate at full capacity, while service delivery between private health care in affluent areas, and insufficient public health care in disadvantaged urban zones remains inconsistent (Benatar, 2013; Gavaza *et al.*, 2012). The Free State has shown persistent maternal health challenges linked to the understaffing and late emergency referrals in rural clinics (Hlafa *et al.*, 2019; Visagie & Schnedier, 2014).

The South African health system faces ongoing public-private divisions, which affect health care delivery, because the public sector provides care to 80% of people, yet receives less than 50% of total health care funding (Gavaza *et al.*, 2012). The private sector operates medical facilities in the Johannesburg, Durban, and Cape Town urban areas to provide premium health care services to insured patients, which perpetuates social inequality (Coovadia *et al.*, 2009; Mooney & McIntyre, 2008). Public hospitals, including Chris Hani Baragwanath in Soweto and Doza Nginza in the Eastern Cape, operate at high capacity while facing resource shortages due to their overloaded conditions, which demonstrate the major differences between public and private health care systems (Van den Heever *et al.*, 2021).

The urban-rural divide produces major differences between urban and rural areas, because rural areas in Limpopo, Eastern Cape, and Mpumalanga lack basic services such as piped water, clinic sanitation, and electricity access (Potgieter *et al.*, 2021; Visagie & Schneider, 2014). The distance between rural residents and emergency care facilities leads to preventable deaths and inadequate chronic disease management, because people cannot access medical services (Neely & Ponshunmugam, 2019; Tollman *et al.*, 2008). Urban areas located near services develop similar conditions of poverty as rural areas, because their high population density and insufficient municipal services create similar living conditions to rural areas in the Gauteng and KZN peri-urban regions (Ngene *et al.*, 2023).

The working poor and rural residents face major financial challenges to obtain health care because they lack funds to reach clinics and have medical expenses that public

facilities cannot provide (Ataguba *et al.*, 2011). The practice of paying medical expenses directly from personal funds creates severe financial difficulties for people without medical insurance, because it drives them into deeper poverty (Gavaza *et al.*, 2012; Hirschowitz *et al.,* 1995). The financial instability affects rural families and women-led households, elderly people, disabled individuals, and those with ongoing medical conditions (Kalepini, 2000; Benatar, 2013). The most vulnerable populations, including children under five, elderly people, disabled individuals, and HIV/AIDS patients, experience the worst effects of health care system breakdowns in both rural and urban areas (Gaede & Verseeg, 2011). The insufficient maternal and child health care services in rural KZN and Mpumalanga lead to avoidable child deaths and high levels of stunting (Tollman *et al.*, 2008). The inner city of Johannesburg denies health care services to migrants and homeless people, while they also face xenophobic treatment and documentation issues (Sifunda *et al.*, 2006; Ngene *et al.*, 2023). The prison system contains an overlooked population, which KZN correctional health workers demonstrate through their work to show the insufficient mental health and chronic care services in facilities (Sifunda *et al.*, 2006).

The shortage of health care workers and their uneven distribution between provinces create service delivery problems that affect rural areas more severely, because these regions struggle to keep skilled staff (Rose & Janse van Rensburg-Bonthuyzen, 2015; Dovey, 2002). The distribution of doctors and nurses between urban private hospitals and rural areas creates an uneven provider-to-population ratio, which benefits areas such as Sandton and Cape Town's southern suburbs, but leaves Vhembe and Alfred Nzo districts with only one health care provider for every 5000 residents (Potgieter *et al.*, 2021). The implementation of incentive programmes and training initiatives has brought limited progress, but these efforts have not resolved the fundamental problems related to rural housing conditions, and insufficient educational facilities and professional support systems (Visagie & Schneider, 2014).

The Eastern Cape faces a major challenge in delivering equitable health care because many clinics lack power supply and refrigeration systems for vaccines (Ewing *et al.*, 2020). The physical infrastructure in urban areas shows better development, but health care facilities experience severe overcrowding, ageing infrastructure, and maintenance problems that reduce their operational capacity (Ngene *et al.*, 2023). The

post-COVID recovery period revealed digital infrastructure shortcomings because rural clinics lack the capability to use telemedicine or electronic health records, which perpetuates systematic exclusion (De Groot & Lemanskii, 2021; Mbunge, 2020).

Leadership, together with policy implementation, functions as a key mechanism to handle these complex situations, yet governance failures, including corruption, weak oversight, and poor intergovernmental coordination, have blocked advancement (Van den Heever *et al.*, 2021). The Western Cape demonstrates better policy implementation skills among provincial departments, yet the Free State and North West in the Mafikeng Provincial Hospital face ongoing financial management and procurement system failures (Van Ryneveld *et al.*, 2020; Whyle & Olivier, 2023; Masike & Mahomed, 2025). The resulting service delivery gaps create lasting inequalities that separate urban from rural areas and different provinces from each other (Benatar, 2013; Coovadia *et al.*, 2009).

3.6 Public opinion and citizens' engagement in health services

Health reforms that aim to establish universal health coverage depend heavily on how the public views these changes. Research determines how well reforms get implemented and accepted (Krupnikov & Levine, 2019). Across the world, it is demonstrated that when there is public trust, along with system inclusiveness and perceived fairness between health care providers and patients, people tend to back health reform initiatives when they trust health authorities and believe these changes benefit their community (Blanco-Mancilla, 2013; Krupnikov & Levine, 2019). The success of health policies depends on public trust, because any lack of confidence leads to policy resistance and unmet objectives (Blanco-Mancilla, 2013). The apartheid legacy in South Africa has created enduring social inequalities that generate ongoing public distrust toward public institutions (Coovadia *et al.*, 2009). According to Gabardine, Tefe, and List (2022), public trust and perception serve as fundamental factors that will determine the success of NHI policy implementation for universal health access.

The world now recognises participatory governance and citizen involvement as fundamental elements for democratic health reform success (Marston, Renedo & Miles, 2020). People function as stakeholders who help determine those institutions

that provide them with health care services. Research shows that countries that link health system transformations to public expectations through co-production practices achieve better outcomes (Batalden *et al.*, 2016; Ocloo & Matthews, 2016). The involvement of citizens in policy development, service delivery, and local oversight systems builds ownership and legitimacy, which enhances both short-term adoption and long-term maintenance of programmes. The process of participation needs to deliver actual results instead of creating false appearances (Marston, Renedo & Miles, 2020). Marston, Renedo, and Miles (2020) warn that single-instance consultations and poorly managed forums result in superficial citizen involvement, which makes people feel disregarded or deceived. The South African public has criticised the NHI programme because it failed to involve communities in meaningful discussions (Setswe & Witthuhn, 2013). The research conducted by Tandwa and Dhai (2020) revealed that patients at the central hospital lacked understanding about NHI goals because of insufficient public dialogue and civic education initiatives.

Health reform initiatives need continuous and inclusive participation from the public to achieve meaningful impact (Baradin *et al.*, 2016). Public participation in health care requires more than just consultation, because it needs to establish systems that enable feedback and negotiation, and ensure accountability, according to Popay (2008). The South African health care system can leverage community-based health systems, including ward-based outreach teams and clinic committees, to enhance public engagement (Setswe & Witthuhn, 2013). These mechanisms need proper backing from resources and political backing to achieve their intended goals. The absence of these elements prevents marginalised communities from influencing health policies which directly affect their lives (Coovadia *et al.,* 2009). Setswe and Wittuhn (2013) note that health programmes which start with community empowerment tend to succeed, because they establish trust through grassroots involvement, which connects national targets to community-specific needs.

Any health system requires trust as its base, but this essential element remains highly vulnerable. According to Gilson (2003), trust in health care exists between patients and health care providers at the personal level, and between health care institutions and their citizen population. The South African public sector faces ongoing distrust because of prolonged periods of discriminatory treatment, combined with public sector

corruption and operational inefficiencies (Harris *et al.*, 2011). The dual health care system between public and private sectors weakens trust, because many citizens believe the system benefits the affluent while neglecting the disadvantaged population. The public doubts that NHI will solve fundamental systemic issues because they see the programme as a theoretical redistribution without practical solutions (Benatar, 2007).

The success of NHI depends on rebuilding trust through both words and sustained improvements in public health care service quality (Day & Zondi, 2019). The process of trust restoration requires direct acknowledgement of the actual health care experiences that patients have faced. Research indicates that patients who receive respectful treatment from health care providers tend to access public health services and endorse health system changes (Elwyn *et al.*, 2012). The development of interpersonal trust between patients and health care providers leads to increased institutional trust over time (Gilson, 2003). The post-apartheid South African health care system needs to establish both relational care and community-based accountability to rebuild trust, because health institutions operated as tools for discrimination in the past (Setswe & Witthuhn, 2013). The authors Gabardine, Tefe, and List (2022) warn that neglecting trust development will probably intensify past traumas, which will push people away from participating in the NHI implementation process.

People form their opinions about future health care based on their current experiences with medical services. The research conducted by BMC Public Health (2020) revealed that numerous South Africans doubt the NHI will solve their current problems, including extended waiting times, insufficient medication, and unqualified medical staff. The public worries that fundamental system problems will continue to exist under different names, according to their current concerns. According to Gilson (2003), a health system achieves legitimacy through both its promise of fairness and its actual practice of fair treatment for patients. The lack of visible and systematic solutions to these problems will make NHI appear as an enlarged version of current system failures, according to Van Eijk and Steen (2014).

3.7 Political, economic, and institutional dynamics in health care

South Africa's health policy implementation results from multiple factors, which include political elements, ideological beliefs, institutional backgrounds, and economic conditions, that influence reform design and delivery to citizens (Gilson, 2019). The current decision-making environment is shaped by political institutions that maintain historical frameworks from colonial and apartheid times, which affect both policy development and actor conduct (Whyle & Olivier, 2024). These legacies are deeply institutionalised and thus limit the flexibility of government actors to shift directions in health reforms, such as NHI, despite popular and technical support for transformation (Surrender, 2014). The state needs more than political determination to establish policies during this current period. The inherited institutions direct resource mobilisation and coordination activities that establish the system's structure (Gilbert & Gilbert, 2004). The historical practice of fragmented service and exclusion has created enduring institutional weaknesses that should guide the development of health policies for delivering equitable health care (van Niekerk, 2024). The political discourse in post-apartheid South Africa supports equity and universal access, yet actual implementation faces challenges because of institutional barriers and past relationships (Whyle & Olivier, 2024).

The political economy perspective shows how different groups of actors, including politicians, health officials, and civil society members, determine which health policies will move forward, or get changed or blocked (Gilson, 2019). The political leadership supports NHI principles, although strong opposition has emerged from two main groups: those who wish to protect their existing benefits and the established systems that produce social inequality (Ansah *et al.*, 2024). The reform process becomes more complex because private health providers, trade unions, and bureaucrats pursue distinct goals that affect both the speed and the standard of implementation (Surrender, 2014). The implementation of evidence-based policymaking faces challenges because political factors frequently take precedence over technical recommendations, which results in the restriction of research influence on effective health policy development (Liverani, Hawkins & Parkhurst, 2013). This politicisation of evidence results in suboptimal outcomes, particularly when reforms are symbolically endorsed but not meaningfully implemented on the ground (Ansah *et al.*, 2024). The

system of democratic governance enables more people to participate in decision-making, but it creates policy stagnation because different groups cannot find common ground within established institutional structures (Ulriksen & Plagerson, 2017). The path of health reform implementation depends on both the vertical linkages between national and provincial governments and the horizontal connections between stakeholders (Brynard, 2009).

The economic situation of South Africa affects health policy delivery, because it creates social disparities and requires different funding levels (Maphumulo & Bhengu, 2019). Public health systems deal with two major health issues because their limited funding creates problems for rural and underdeveloped areas (Gilson *et al.*, 2003). Progressive policy implementation becomes difficult because of insufficient medical resources, insufficient personnel, and substandard facilities (Maphumulo & Bhengu, 2019). The state must choose between maintaining economic stability and funding social services, because high fiscal pressure leads to insufficient health initiative funding, according to Gros (2015). The post-apartheid economic policies implemented fiscal conservatism, which limited state redistribution power and made it difficult to establish NHI (Gilson, 2019). The division between economic choices and health policy discussions results in extra challenges that make it difficult for sectors to coordinate their planning effectively (Modisenyane, Hendricks & Fineberg, 2017). Different areas show economic disparities, which prove that health targets fail to create lasting solutions because national policies use different methods (Ulriksen & Plagerson, 2017).

The economic limitations create challenges for health care delivery, because they affect the human resources for health, which are necessary for providing quality care and executing reforms (Gilbert & Gilbert, 2004). Health care staff distribution between urban regions and private medical facilities demonstrates how health care systems maintain existing social disparities, which result in unequal health policy results (Maphumolo & Bhengu, 2019). The implementation of health information systems with restricted capabilities and independent monitoring systems hinders tracking progress, which hinders policy adaptation and knowledge acquisition (Gilson *et al.*, 2003). The Departments of Health, Finance, and Public Service maintain independent operations, which Surrender (2014) states creates obstacles for the integrated planning that NHI

needs for success. The government sector faces problems with repeated work efforts and unassigned responsibilities because of its disorganisation, which causes delays in service delivery and makes it hard to identify responsible parties (Brynard, 2009). The implementation problems stem from institutional design issues, which prevent collaborative governance rather than insufficient capacity (Ulriksen & Plagerson, 2017). The study of institutional fragmentation requires analysis of its technical aspects together with its political nature, which stems from historical and present-day arrangements (Whyle & Olivier, 2024).

The existing health care financing system, together with the service delivery structure, acts as a barrier for South Africa to achieve universal health coverage (Gilson, 2019). The dual system allows private health care to serve a limited number of people while using the most health resources, creating new social inequalities that violate the NHI principles (Surrender, 2014). Risk pooling and redistributive resource reforms face political opposition from powerful private sector entities, who consider these changes as threats to their business interests (Ansah *et al*., 2024). The political aspect of redistribution disputes emerges from fundamental power struggles, which simultaneously attack both institutional power and its basis of legitimacy (Gilbert & Gilbert, 2004). Public health policies emerge from political actor negotiations about resource distribution within institutional frameworks (Liverani, Hawkins & Parkhurst, 2013). The implementation of available technical solutions faces political obstacles that stem from policy changes, leadership transitions, and disagreements between stakeholders (Whyle & Olivier, 2024). The research shows that institutional and political alignment functions as a vital element that enables policy documents to become actual implemented practices (Gilson *et al*., 2003).

3.8 Summary

South Africa's pursuit of universal health coverage through the NHI reflects a bold vision, but faces structural, financial, and leadership challenges that undermine its success. Comparative experiences from Brazil, Thailand, and Canada highlight the importance of decentralised governance, sustainable financing, and strong public trust. The enduring legacy of apartheid, coupled with fragmented service delivery and limited intersectoral collaboration, further complicates reform. Effective leadership, evidence-informed policymaking, and investment in primary care are crucial for

realising the NHI's transformative goals. Without these foundational elements, policy intention risks falling short in practice. Global lessons demonstrate that health equity is achievable with long-term commitment and systematic alignment. South Africa must enable these insights in its reform to ensure a more just and sustainable health system.

CHAPTER 4: RESEARCH DESIGN, METHODOLOGY, AND FINDINGS

4.1 Introduction

The previous chapter presented the NHA and NHI, South Africa's programme for universal health coverage, by examining its wide-ranging objectives together with its multiple organisational and financial obstacles. The three countries, Brazil, Thailand, and Canada, demonstrate that decentralised governance systems, combined with sustainable funding and public trust, are essential for effective governance. The system of apartheid, along with its non-functioning services and weak intersectoral coordination, continues to block progress. The NHI requires strong leadership, together with evidence-based policies and sufficient funding for primary health care to achieve its goals. The policies face a high risk of failure because of these missing elements, although research shows that dedicated health systems with strategic planning can achieve equity in health care delivery.

This chapter conducts a comparative evaluation between NHA and NHI to determine how their provisions match the current health service delivery in South Africa. The research draws its conclusions from purposively selected institutional cases as units of analysis viz; Tambo Memorial Hospital (Gauteng), Enhlanzeni Local Clinic (Mpumalanga), Mafikeng Provincial Hospital (North West), and Pelonomi Tertiary Hospital (Free State). The chapter contains two separate sections. The research methodology section presents the data sources that were used for the study. The second section presents the findings. The section examines the implementation gaps and mismatches, governance challenges, and the provincial government's roles in health reform, public trust, and stakeholder influence.

4.2 Research methodology and data sources

The research employs qualitative methods to conduct an in-depth examination of South African health access challenges (Mwita, 2022). The qualitative approach was best suited to focus on policy evolution. The research evaluates how NHA provision affects the implementation of NHI. The study follows the comparative case study. The research studies the selected cases by examining their unique characteristics and environmental contexts (Mwita, 2022). The research seeks to establish the extent to which South African health reform policies fulfil the constitutional right to health care

access. The research utilised secondary sources, which included academic journal articles from Health Policy Planning, Social Science & Medicine, and the Journal of Health Policy and Management. The research incorporated international policy reports from the WHO, together with comparative case studies from other nations, to place South African health reforms within worldwide policy developments.

The research relies on document analysis of policy instruments, including the NHA and NHI bills and white papers, and the National Department of Health annual reports, to study legislative intent, policy design, and governance structure evolution. The research uses existing data from Statistics South Africa and the National Department of Health to analyse health service accessibility and payment systems and identify existing inequalities. For analysis, a view-different-view comparative analysis approach was applied, which helped clarify systematic differences between the NHA and NHI (Azarian, 2011). The research used a comparative approach to study the two policies through their objectives and management structures, and their fairness components. The analytical approach combined legal, empirical, and comparative methods to understand factors of the political economy in health policy changes and their effects on service delivery equity.

4.2.1 Sampling techniques

The research employed purposive sampling. Purposive sampling is especially useful for thoroughly examining complicated phenomena, since it deliberately chooses units such as people, situations, or cases, based on their significance to the research issue (Rhai & Thapa, 2015). Purposive sampling relies on judgement or subjective sampling (Rhai & Thapa). The selected hospitals in South Africa are among the other aspects that determined case judgement. Pelonomi Tertiary Hospital in the Free State and other various hospitals in Gauteng and Mpumalanga are marked by dysfunctional service (West *et al.*, 2021; Pasha, 2015). Leadership failure is evident by the lack of management boards, as seen in the Free State and North West (Young, 2016; Anasel *et al.*, 2023; Malakoena *et al.*, 2020). Other information included selecting information-rich literature on challenges of health care, and comparisons of NHA and NHI. Purposive sampling was used to select government documents, Google Scholar, and Journal articles to address the topic of the study.

4.2.2 Data analysis

The data gathered was presented as main themes drawn from research objectives and research questions. The view-difference-view comparative analysis was applied. The study compared NHA and NHI to reveal the quality of health as either less effective or less useful. A table was used to present theoretical assumptions of the social justice theory and a comparison of NHA and NHI. The entire data gathered from the research questions was gathered according to the following themes, to guide: (a) core challenges of inequitable access to health care, (b) social justice theoretical justification for equitable access in the context of NHA and NHI, and (c) requirements for functional health services through leadership.

4.2.3 Limitation and delimitation

The main limitation of this study is that it was a desktop study, and the researcher was not physically present at the hospitals selected for empirical analysis. However, the researcher thoroughly conducted scientific analysis and mainly used documents that were already published.

4.3 Research findings

4.3.1 Findings based on stated research questions

This section ascertains the veracity of the answers generated when operationalising the research questions. The key findings from the literature review provide an understanding of the NHI and NHA implementation in South Africa. The section shows consistent political will to implement a unified health system. There are also challenges related to governance and leadership coordination, and resource constraints.

4.3.1.1 The core challenges of inequitable access to health care services in the context of the NHA and NHI

This study demonstrates that South Africa faces ongoing health service inequality based on affordability, medical coverage, and proximity to well-resourced hospitals. However, South Africa has a good primary health ecosystem, with clinics located in many communities, including rural areas. Despite these efforts to roll out health care resources to various communities, the main problem is the acceptability of treatment

or services in public health care (Ohonba *et al.*, 2023). There is the issue of long waiting times and a shortage of medicine. The NHA and NHI are instrumental in balancing the distribution of doctors between the private and public health care facilities, especially for residents in rural communities (Ohonba *et al.*, 2023:4; Coovadia *et al.*, 2009). Notably, South Africa improved its UHC coverage, from 28/100 people having access to health care in 2000, and 71/100 people had access as of 2021 (Swanepoel, 2024). The NHA requires decentralisation and expansion of health services; however, implementation challenges, funding shortages, and weak management have prevented its effectiveness, resulting in persistent barriers to health care (Hassin *et al.*, 2008).

Current delivery issues arising between formulation and implementation of policies testify to the fact that the NHIS experiences an unpredictable course in overcoming established structural obstacles (Van Rensburg, 2014). The broken nature of the health-care system in the South African context poses a major obstacle since the well-established private sector is serving a minority group of medical-aid subscribers, and the under-established sector is serving over 80% of the population (Benar, 2003; Gavaza *et al.*, 2012). This two-tier system contributes to the socioeconomic injustice, with the urban privatised facilities that have all the modular amenities serving a small group of patients, as opposed to rural state-funded facilities that face endemic staffing, funding, and equipment issues (Mooney & McIntyre, 2008). The NHA strives to incorporate health care services; its efficiency is still hampered by the weak ability of the provincial health sector and the absence of strong intergovernmental regulation (Gilson & Daire, 2011). Similarly, the NHI is also aimed at the reduction of the financial gaps via the pools of resources, though its future looks rather unpromising because of the shortage of resources and organisational issues in the state system (Van den Heever, 2016).

There are other obstacles to accessing health care, because rural areas and peri-urban regions have a lower quality of roads and increased distances of travel, as well as poor transport infrastructure (Patel *et al.*, 2015; Sop & Messi, 2022). The provinces of Limpopo and Eastern Cape in South Africa demonstrate the extreme nature of these problems because patients must travel extensive distances to reach under-equipped facilities that are without power or vaccine storage capabilities (Ewing *et al.*, 2020;

Potgieter *et al.*, 2021). The NHA's goal for service equity remains unfulfilled because underfunded provinces lack the necessary infrastructure development (Visagie & Schneider, 2014). The NHI establishes equal funding but fails to resolve the practical challenges of rural infrastructure development, which threatens to leave health care accessibility in a poor condition (Meyer *et al.*, 2017).

Socioeconomic inequalities, together with geographical barriers, function as the primary factors that determine health care accessibility for South African citizens. The combination of poverty, unemployment, and the absence of medical insurance prevents numerous people from receiving proper medical care when health care facilities are present (Ataguba *et al.*, 2011; Osadolor *et al.*, 2022). The financial costs of medical care for low-income families reach catastrophic levels because they must pay for transportation, diagnostic tests, and unavailable medications, which drives them further into poverty (Hirschowitz *et al.*, 1995; Gavaza *et al.*, 2012). The NHA establishes access rights, but financial obstacles prevent many people from receiving health care services, especially women-led families and senior citizens (Kalepini, 2000). The current administrative problems in NHI pilot districts demonstrate how the system remains vulnerable to unequal financial protection distribution (Vearey *et al.*, 2017).

The gap between urban and rural areas intensifies social inequalities. The quality of health care in affluent suburban areas stands in contrast to informal settlements; urban residents can easily access services, but rural populations stay isolated from essential services (Benatar *et al.*, 2013) because of overcrowding and insufficient municipal services (Benatar, 2013; Coovadia *et al.*, 2009). The NHA has failed to eliminate socioeconomic exclusion patterns, which created spatial inequities between different areas of the country (Rispel, 2016). The NHI's resource pooling mechanism will enhance macro-level equity, but it will not solve existing urban-rural infrastructure gaps, which will maintain current inequalities (Van der Heever *et al.*, 2021). The research shows that health worker shortages and uneven distribution patterns create significant challenges for rural areas. Most doctors and nurses work in urban areas and private health care facilities, while rural districts, including Alfred Nzo in the Eastern Cape and Vhembe in Limpopo, face severe health care provider shortages,

with some areas having one provider for every 5,000 patients (Potgieter *et al.,* 2021; Rose & Janse van Rensburg-Bonthuyzen, 2015).

The NHA attempted to solve workforce distribution problems through service requirements and training initiatives, yet health care providers continue to leave their positions because of inadequate rural housing, insufficient educational facilities, and insufficient professional backing (Visagie & Schneider, 2014). The NHI faces a high risk of maintaining existing workforce imbalances, because equal health care financing does not automatically lead to equal distribution of health care providers (Malakoane *et al*., 2020). Research demonstrates that leadership and governance systems play a crucial role in determining how people access health care services. Research evidence demonstrates that health care delivery at Pelonomi Tertiary Hospital in Free State and Mafikeng Provincial Hospital in North West province suffers from inadequate leadership, poor accountability, and widespread corruption (Malakoane *et al*., 2020; Whyle & Olivier, 2023; West *et al*., 2021; Masike & Mahomed, 2025). The NHA created a governance structure for decentralisation, yet weak institutional capabilities, together with political favouritism, resulted in poor implementation outcomes (Christian, 2014). The NHI faces identical risks to the NHA because its equity-focused design depends on robust leadership and transparent governance systems to achieve effective resource pooling and distribution (Van den Heever, 2016). Policy intentions will remain unfulfilled because of inadequate leadership reform, which allows health inequities to persist even with existing legal protections (Gilson & Daire, 2021).

The HIV/AIDS pandemic demonstrates how inadequate leadership creates major obstacles for achieving health equity. The South African government's delayed response during the early 2000s forced NGOs to take over service delivery, which resulted in service duplication and system fragmentation (Rensburg, 2014; Simelani & Venter, 2014). The integration of HIV-care services has not eliminated structural barriers, which include insufficient staff numbers, inadequate management systems, and poor coordination between services, especially in rural settings (Mayosi & Benatar, 2014; Maphumulo & Bhengu, 2019). The health system governance problems prevent the NHA from achieving its goals through inadequate leadership, which makes it uncertain whether the NHI will succeed under similar governance conditions (Meyer *et al*., 2017). The research findings show that structural inequalities

are expressed in a variety of dimensions. The geographical location, socioeconomic status, cultural background, and political environment have interactions that determine access to health care.

The empirical results show a multidimensional nature of structural inequities across the board. These injustices are the effect of a combination of geographical, socioeconomic, cultural, and political factors that combine their effects to determine access to health care, for example, people with disabilities living in rural areas of South Africa who are faced with a combination of stigma, lack of physical access, and insufficient health care services (Dassa *et al.*, 2018). Though the NHA considers vulnerable populations, it does not take active interventions to break these layered barriers, and the NHI will not work as an intervention to escalate exclusion outcomes without being tailored to meet overlapping vulnerabilities (Islam & Kamal, 2021). All these points imply that equity cannot be achieved through changing the fiscal status, but through additional culturally sensitive and context-based policies (Mji *et al.*, 2017).

Inequities in the provision of services are further exaggerated by provincial heterogeneity in governance and the provision of health services. Western Cape stands in constant contrast to other provinces, and this result could be explained by stronger governance and distribution of resources; but Eastern Cape and Limpopo are still in a disadvantaged state, being continuously subject to under-investment and degradation of their infrastructure (Rispel, 2016; Ewing *et al.*, 2020). Although Gauteng, the economically leading province, may also suffer overcrowded state hospitals and inconsistency in service delivery, inequity in the economy is not reserved for provinces that are not doing well in governance, where the institutions are also sub-optimal (Gavaza *et al.*, 2012). The lack of centralised actions between governments has also hindered the application of consistency of standards in equitable care, even though the NHA provides the national standards of equitable care, and the lack of proper governmental coordination has diminished the likelihood that the NHI scheme would eliminate these provincial injustices, unless the governance frameworks are fortified (Van Ryneveld *et al.*, 2020).

The results support the continuum of financial barriers as one of the possible determinants of inequity, especially among people who lack medical care. Medical service out-of-pocket expenses push vulnerable households into poverty; the same

impact is even greater in rural areas, where the economic burden is further enlarged by transport costs and shortage of medicine (Ataguba *et al*., 2011). This fact contrasts with the mandates of the NHA equity, which implements universality regardless of the financial ability of an individual; however, the factor of cost is decisive in health-care usage (Scheffler *et al*., 2015). Even though the NHI scheme was formulated to eliminate financial exclusion, the first pilot programme already indicates delays and ineffective pooling of resources, and this suggests that financial reforms, if left alone with no additional managerial reforms, cannot survive to provide equitable access (Vearey *et al*., 2017). Lastly, it is shown that the root cause of inequitable access in the South African health care system lies in the sphere of failures in governance and leadership, namely, poor oversight, corruption, and patronage, which bring down even those plans that have the best intentions. This is best exemplified by the 2025 Health Ombud report about Helen B. Joseph Hospital, which reported institutional poor governance, lack of accountability, and dangerous omissions in patient care (Health Ombud, 2025). Even though the NHA offers a roadmap on accountability, its enforcement has failed due to the lack of provincial leadership; in the same vein, the NHI is also at a similar risk of collapsing unless leadership potential is strengthened immediately (Rensburg, 2021). To build sustainable equity, the health-leadership paradigm needs to be radically changed, and accountability, integrity, and professional competence must represent the driving forces behind reform (Gilson & Daire, 2011; Conmy, 2018). Without these changes, differences in access to health care will probably not disappear, even in response to financial or legal intervention.

4.3.1.2 The social justice theoretical justifications of equitable access to health care

The concept of justice is a theoretical pillar that supports equitable health access to health care services, which assumes care as a moral and political right instead of a privilege and imposes upon societies the responsibility to protect it (Muller & Edward, 2023). Within social institutions, justice plays the supreme role in a way that creates a normative system that balances the claim to health with other claims and limited resources (Miller, 2001). As a framework put into practice, justice comes to be realised in terms of fairness, equality, protection, redistribution, and restitution; therefore, recognising health care as a human right and as an aspect of social justice (Molenkamp, 2022). This implies that these philosophical underpinnings support the

need to implement fair models in health care systems that consider issues of inclusion, non-discrimination, and sensitivity to the needs of disadvantaged groups (Wenar, 2008).

The principle of just health care is based on the theories of fairness presented by Rawls, who argues that everyone should receive similar rights and opportunities in the health care system, and that the remaining gaps can only be tolerable when addressed for the benefit of the less fortunate (Rawls, 1971). This argument explicitly underlines the premise that the health care law must be designed to tackle the socioeconomic inequalities in health outcomes, which, if otherwise unaddressed, are indicative of other structural injustices (Buettner, 2012). Fairness also applies to the realm of public policy, according to which redistributive tools, including subsidies, social-insurance programmes, and purposive measures, that seek to target the vulnerable groups, are deemed to be necessary in ensuring that no citizen is left without the means by which their well-being can be attained (Schneider, 2005; Molenkamp, 2022). The notion of fairness, therefore, acts as a point of intersection between normative political theory and the delivery of health services in practical terms, to create a point of connection between abstract ideas and the practical implementation of policies.

Equity, which strongly relates to the notion of fairness, is a concept that acknowledges that no one person should have less access to health care services based on identity, socioeconomic status, or historical disadvantage (Ruger, 2008). In that regard, equality requires the eradication of systemic inequalities that often deny marginalised groups the opportunity to access key services so that they can participate in activities that are critical to a good life, such as health, education, and work (Braveman & Gruskin, 2003). In the health care sector, it is admitted that equal treatment is not enough, but equity-based approaches, according to which resources are distributed depending on the needs of a person, are necessary to achieve true equality in outcomes (Molenkamp, 2022). Equality can move beyond theory to being a practical ground in redistributive health policies by targeting specific resources, such as prosthetics to amputees, or prenatal services to those who are pregnant.

The empowerment of resources, as the phenomenon of redistributive justice, also supports the need to have equitable access to health services and promotes the importance of distributing the social goods, such as health care, fairly (Colquitt *et al*.,

2015). An unfair distribution of health services creates the perception of being ostracised and, in the end, compromises social solidarity and trust in state institutions (Benington, 2011). In this view, fair health care distribution can be seen as not only a morally good but also a practical responsibility to ensure the continuation of harmony and social legitimacy in society (Rawls, 1971). This is why governmental players are encouraged to create health systems that are balanced between prevention and curative services, but still prioritise the most vulnerable population, ensuring equal distribution of resources according to the constitutional and ethical requirements of human dignity and equality (McIntyre & Mooney, 2007; RSA, 1996).

Justice as protection further removes the argument of fair health care of the obligation to protect a person against harm, discrimination, and marginalisation (Kraynak, 2018). The protective aspect involves not only avoiding the infringement of rights but also working proactively to create conditions beneficial to health, including safety, security, and access to essential facilities (Ngwena & Cook, 2007). In the health care system, this principle is the basis of measures such as patients' rights charters, anti-discriminative laws, and regulatory control over the activities of the public and private providers, so that provision that meets the standards set in the Constitution is ensured (RSA, 1996; Ngwena, 2000). The safety element of justice, therefore, amplifies the rationale as to why governments should not only provide health services but also make sure they are culturally aware and responsive to the demands of a heterogeneous population base (Salkever, 1976; Donabedian, 1973).

The principle of restitution, when it comes to the imbalance in access, also contributes to equitable access by resolving historical discrimination and the presence of structural inequities in health care systems (Ogar & Akpan, 2016). History has created deeply ingrained inequalities in health care access based on race, gender, geography, or class, which such policy needs to address in the present (Coovadia *et al.*, 2009). Restitution justifies projects such as affirmative action in health care resource distribution, NHI schemes, and targeted rural and historically disadvantaged community programmes (NDoH, 2017). Through restitution, the health system will no longer be involved in charity or short-term relief, but instead, through repairing injustices, it will end up creating a more inclusive and coherent society (Molenkamp, 2022). These principles of justice, when incorporated into health

systems, are in line with global and national human-rights discourses that entrench the right to health as a universal right (United Nations, 1948; African Union, 1981). It is realised through equitable access, where the affordability, availability, acceptability, and quality of health care are delivered (AAAQ) (Evan *et al.*, 2013; CESCR, 2000). Affordability appeals to justness in requiring subsidies and making services universally accessible to the needy, whereas availability appeals to redistribution by increasing facilities and services in tattered neighbourhoods (Reily, 2021; Levesque *et al.*, 2013). Protection and restitution are associated with acceptability, which needs cultural sensitivity and steps of redressing past discrimination, and quality is associated with equal standards of treatment and care (Ruger, 2004; Donabedian, 1973). The justice model and the human-rights approach meet in achieving equitable access, and therefore, it is both an ethical necessity and a legal requirement (Gold, 1988; Hixon *et al.*, 2013).

Finally, the social-justice theoretical justification of equal access to health care possesses the basis of the understanding that health is a human capacity as well as a social good, needed to achieve well-being and to be a member of society (Robeyns & Byskov, 2025). Health care deprivation increases vulnerability, puts poverty on firm ground, and destroys human dignity, but access to equality can foster resilience, productivity, and social cohesion (Moten *et al.*, 2012; Mubaiwa, 2018). Justice thus requires not merely erasing the financial, geographical, and systemic obstacles to health care, but rather proactively having structures in place so that they enable inclusion towards participation in the health care opportunities (Rawls, 1971; Rhodes & Silver, 2012). In this light, equitable access to health care is not merely a health policy concern but a social justice imperative, central to democratic governance, ethical leadership, and the building of just societies (Ruder, 2021).

4.3.1.3 The state of access to health services compared to the NHA and NHI provisions

NHA provisions for equitable access to health care include to i) establish a uniform national health system that integrates public and private sectors; ii) promote cooperative governance for health policy and service delivery; iii) ensure decentralised, equitable, and efficient management through sound management and

public participation; and iv) promote shared responsibility among public and private health practitioners to implement health plans.

NHI provisions for access to health care include i) achieving universal access; ii) establishing a single purchaser and payer for health services; iii) ensuring financial protection through mandatory prepayment and risk pooling; iv) eliminating fragmentation in health financing and purchasing services, medicines, and products; v) promoting social solidarity through cross-subsidisation; and vi) enhancing efficiency and accountability in health care funding and services.

4.3.2 Findings from institutional case studies

This study operationalised a comparative case study approach to explore health major health reforms in South Africa. The NHI and NHA influence health access and determine perceptions about justice and inequality. Grounded in a constructivist paradigm and driven by a social justice lens, the study probed how policy intentions intersect with political, institutional, and managerial realities. With the NHI and NHA as units of analysis, Tambo Memorial Hospital in Gauteng, Enhlanzeni Local Clinic in Mpumalanga, Mafikeng Provincial Hospital in North West, and Pelonomi Tertiary Hospital in the Free State were incorporated as embedded institutional sub-cases. They were purposively selected because government reports, scholarly analyses, and media investigations had identified persistent problems with leadership instability, infrastructural deficits, managerial weaknesses, and service-delivery pressures. Their inclusion enabled the study to examine how national policy commitments translate into operational realities in different provinces, strengthening analytical generalisation rather than statistical representativeness.

4.3.2.1 Tambo Memorial Hospital (Gauteng)

Tambo Memorial Hospital, one of Gauteng's oldest medical facilities, is a provincial hospital. It employs roughly 1100 people and has about 640 beds (PMG, 2025). The hospital serves more than a million people in Benoni, Boksburg, and a portion of Germiston (Naidoo, 2009; PMG, 2025). A 2017 evaluation commissioned by the hospital declared the building was deemed “an occupational hazard” and “unfit for human habitation’’ (Molelekwa, 2022). Some parts of the building have an unpleasant odour, and a significant portion of the infrastructure remains inadequate and continues

to compromise service delivery (PMG, 2025). Large patient loads put an extra burden on ageing equipment, raising the possibility of malfunctions and outages.

In 2023-2024, the hospital recorded 164,456 headcounts by the ninth month of the financial year. The number rose to 180 595, in the same year of 2024-2025, reflecting a growing burden of care (Mashel, 2025). Budgetary constraints further limit the hospital's ability to address infrastructure and equipment needs. These challenges undermine the aim of NHA regarding a safe and functional health care environment, while threatening compliance with NHI accreditation standards, which require facilities to meet quality and infrastructure benchmarks with the NHI fund (NHI, 2023).

4.3.2.2 Enhlanzeni Local Clinic (Mpumalanga)

Enhlanzeni Local Clinic is situated in Mpumalanga is characterised by primary health care facilities serving a large population, particularly in the rural areas. Access to health care service at clinics is constrained by lengthy wait periods, and the attitudes of health care professionals and the educational backgrounds of patients for health care utilisation (Metiso & Mboweni, 2025). Operational challenges include frequent staff meetings during service hours, responding to emergencies, and a lack of personnel, all of which disrupt continuity of care. In addition, the lack of grievance procedures, which left patients unaware of delays (Lefafa, 2023). Low patient satisfaction has been linked to attitudes that hinder access to and use of health services, including rude treatment, especially from nurses, and a lack of interpersonal skills among health care professionals (Metiso & Mboweni, 2025). A shortage of medication or a doctor's absence also prevented some people from accessing the program (Lefafa, 2022). These challenges undermine NHA's primary health care mandate, which emphasis accessibility and continuity of care (NHA, 2023). Furthermore, as clinics must fulfil minimum quality criteria to operate as contracted providers within the NHI system, quality standards and a bad patient experience pose obstacles to NHI accreditation (NHI,2023).

4.3.2.3 Mafikeng Provincial Hospital (North West)

Mafikeng Provincial Hospital is a regional and specialised referral hospital serving Ngaka Modiri Molema District across five sub-districts. The sub-districts include Mafikeng Local Municipality, Ratlou Local Municipality, Ramotshere Moiloa Local

Municipality, Ditsobotla Local Municipality and Tswaing Local Municipality (Yes Media, 2026). Several issues plague Mafikeng Provincial Hospital, including malfunctioning and broken medical equipment, lengthy surgical wait times, and a persistent lack of qualified nursing personnel (Lefafa, 2025). Complex systemic deficiencies affect the hospital. Poor planning, budgetary strains, procurement delays, and management shortcomings seem to be the main causes of the hospital's problems (PMG, 2025). The NHA's requirements for operational provincial health services are weakened by these difficulties. Mafikeng's weak administrative capacity raises questions regarding institutional readiness for accreditation, indicating a gap between national policy aspirations and provincial implementation competence, even though NHI procurement reforms aim to centralise and streamline purchasing (NHI, 2023).

4.3.2.4 Pelonomi Tertiary Hospital (Free State)

Pelonomi Tertiary Hospital is located inside the Mangaung metropolitan region in Bloemfontein, South Africa, and functions as a referral for Xhariep district. The Xhariep district serves around 125,000 while Manguang metropolitan region serves about 850,000 people (Mangalie, Khaliq & Jassen, 2025). The hospital has faced persistent challenges, such as inadequate infrastructure, lengthy wait times, and a lack of proper equipment (Democratic Alliance, 2018). Severe shortage of physicians, nurses, specialists, ambulance personnel, and community health workers further undermines service delivery (Mchoari, 2022). Lack of employees lowers the standard of treatment that patients receive. The freezing of funded and open positions worsens workload pressure staff burnout, long wait times, patient rejection, and low staff morale (Mchoari, 2022).

The systemic failure contributes to rising medical negligence claims against the state, because of these errors the expenses of preventable lawsuits take money away from the population's access to health care (SAHRC, 2022). Many of the issues jeopardise the provision of high-quality health care to the public and limit the hospital's capacity to meet NHI accreditation requirements, which call for steady human resources, operational infrastructure, and consistent service quality to be eligible as an NHI service provider (NHI, 2023). They also jeopardise the hospital's ability to fulfil NHA obligations regarding proper staffing and care quality.

4.3.2.5 Cross case examination.

Across the four facilities, recurring governance failures were evident, although they manifested differently by level of care. Tambo Memorial and Pelonomi hospitals both large referral institutions struggled with procurement delays and overcrowding, while Enhlanzeni Clinic faced chronic staffing shortages and weak referral networks. Mafikeng Hospital reflected compounded governance failures and infrastructure decay. These patterns suggest that while the NHA provides a uniform regulatory framework, provincial administrative capacity mediates actual access outcomes. The emerging NHI model therefore confronts uneven institutional baselines that threaten equitable rollout

4.3.3 Critical considerations

The South African health system bears several indicators. First, historical and structural inequality, which entails the impact of apartheid discrimination in health services that are still visible today and have led to the stark public-private health care divides. In this case, the problems of health care efficiency are deeply structural, not simply administrative and financial. The NHI seems to target this fundamental issue to ensure a functional health system. An unequal distribution of resources between the private and public health sectors reproduces inequality in health care. Secondly, community participation and trust in governance. People expect public health care standards to mirror those of the private sector. In practice, these expectations are untenable because the private health sector serves fewer people, and its service standards are better than those of the public health sector. Thirdly, infrastructure and capacity gaps are an issue that receives government attention. However, little progress has been made. There were only three newly built PHCs in the 2022/2023 financial year nationally: Boegoeberg Clinic in the Northern Cape, Thengwe Clinic in Limpopo, and Balfour CHC in Mpumalanga (NDoH, 2024:46). These infrastructure and capacity gaps entrench urban-rural disparities. The report further states that 30 hospitals were constructed or revitalised, which does not clarify how many of these are newly built.

4.3.3.1 Comparative analysis of the NHA and NHI provisions versus reality

The comparison between the NHA and the NHI highlights clear tension between policy provision and implementation realities, particularly about equity, financing, and health system capacity. Although both policies are supposed to achieve equitable access to health services, the heterogeneous results are achieved due to the different structural designs and the areas of focus (RSA, 2003). The NHA was developed as a regulatory system that is aimed at integrating health services that were dispersed, and the financing mechanism presented by the NHI introduces a system that very clearly deals with inequities in the allocation and access of resources (Hassim *et al.*, 2008). However, these two policies have not been applied uniformly, especially in rural and under-resourced provinces, which highlights the issue of bringing ambitious legal and financial frameworks to concrete health-system results (Amollo, 2009; Heunis *et al.*, 2019).

One of the existing areas of disagreement between the NHA and the NHI is the approach that the two systems adopt, concerning financing and redistribution. In contrast to the NHA, which focused on governance and supervising mechanisms, but failed to implement a special financial system to address the past injustices (Lourens, 2012), the NHI proposes mandatory pre-payment and risk-pooling developments that allow poor people and the sick to cross-subsidise each other, making the principle of equity be put into tangible fiscal equivalents (Day & Zondi, 2019). Although progressively designed, there has been a concern in terms of the administrative capability of the NHI Fund to handle large claims, especially considering the ethereal structures of the information systems and poor institutional capacities that define South Africa (Wilkinson *et al.*, 2022). The example of Ghana with its NHIS, and Taiwan with a national scheme, are also international case studies that demonstrate how one of the key elements of sustainability is a sound governance and technological framework, which has not yet been fully secured in South Africa (Blanchet, Fink & Osei-Okoto, 2013).

The loss of human resources further reveals the disparity existing between the policy provisions and reality on the ground. NHA acknowledged the necessity of having a trained health workforce, but did not have the aspect of expanding the workforce and distribution in an equitable manner (RSA, 2003). The NHI, on the other hand, puts a

strong emphasis on planning its human resources, suggesting prompt initiatives to train, hire, and keep health workers in under-serviced regions (Heunis, Mofolo & Kigozi, 2019). However, the ongoing uneven geographical distribution of health specialists demonstrates that the given provisions have not yet produced significant changes, particularly in rural provinces, where the lack of health professionals is still a problem (Day & Zondi, 2019; Matsoso & Fryatt, 2013). The unwillingness of professional bodies to be involved and the lack of clear implementation plans, also complicate workforce reforms, which have proven challenging in Ghana in terms of the NHIS implementation, where equity was undermined due to an urban bias (Christmals & Aidam, 2020).

The NHA has developed a hierarchical system of oversight in governance using provincial and district bodies, but responsibility has been lost in the system; hence, inefficiencies and uneven quality of care have ensued (Hassim *et al.*, 2008; Lourens, 2012). Strategic buying is one of the interventions offered by the NHI that would enable the fund to deal directly with accredited providers and avoid provincial intermediaries (Wilkinson *et al.*, 2022). This has changed in line with reforms in the world health systems, such as purchasing, as a means of bringing about efficiency and accountability in France (Rodwin, 2003). However, the low quality of the infrastructure and the capacity to administer the fund in South Africa imply that the gains of such changes might not be as practical as the benefits of such reforms are assumed to be (which can be seen through the inefficiencies in procurement and resource distribution to date) (Heunis *et al.*, 2019; Christmals & Aidam, 2020).

Another area of provisions that are very different compared to reality is service-delivery models. NHA focused on regulatory scrutiny, which provided minimal guidelines on the pathways of integration leading to fragile service fragmentation that persists (Hassim *et al.*, 2008). In its turn, the NHI suggests referral pathways and a gate-keeping mechanism that could enhance efficiency, decrease the use of specialists that are not necessary, and enhance primary health care (NDoH, 2011; Wilkinson *et al.*, 2022). Nevertheless, the inadequate facilities in primary care and the poor infrastructure of referral systems are still present in the South African public health system, leading to further concerns about the viability of integrated care with the NHI (Heunis *et al.*, 2019). The experience of South Korea and France has shown that only through well-

established primary-care systems are gate-keeping models efficient, and South Africa has not gone far at all (Shin, Cho & Guallar, 2016).

Equity remains a central theme in both policy frameworks, yet outcomes on the ground reveal persistent disparities. The NHA is a law that stipulates the principle of a fair distribution of care; however, it lacks a tangible financial redistribution initiative to realise the vision (Hassim *et al*., 2008). It is here that the NHI was specifically conceived, and it makes use of tools of cross-subsidisation and risk-pooling, which were meant to address the inequity that was institutionalised by the policies of apartheid. However, with the high levels of income inequality in South Africa, it is extremely doubtful if the redistribution on a large scale can be effectively implemented politically and administratively (Matsoso & Fryratt, 2013). Evidence offered by other countries around the world shows that equity-based health financing reforms require strong political determination; examples are provided by the successful experiences of Canada and Britain, which have adopted the strategy of aligning the financing reforms with the progressive regulatory frameworks in a cascading manner (Hacker, 1998). In South Africa, by comparison, the chronic nature of political rivalry and fiscal limitation has hampered the durability needed to actualise the equity objectives into practice (Shisana *et al*., 2019).

The comparison analysis also highlights the central role of universal governance structures and social determinants in influencing the outcomes of health policies. Even though the NHA and the NHI programmes have their foundations based on the ideas of equity and universal access, structural inequities, including poverty, geographic non-equivalence, and poor health facilities infrastructure, still limit their performance (Visagie *et al*., 2015). The best way to achieve this is shown by empirical evidence of other settings, including Rwanda, where Mutuelles de Santé is applied, Thailand, where Universal Coverage Scheme is implemented, and other places where such programmes register distinct improvements in inequities, due to strong political dedication to primary health care and financial protection mechanisms (Tangcharoeňsantien *et al*., 2018). In South Africa, on the other hand, the existence of systemic inefficiencies and an intricate imbalance of resources implies that policy aspirations commonly surpass the ability of the institutions to deliver, which eventually

destroys the transformative potential of both the NHA and the NHI (Rispel, 2016; Wilkinson *et al*., 2022).

4.4 Summary

Empirical evidence suggests that despite the NHA and the NHI representing progressive ideas of universal health care, the implementation of the policies is limited because of the ongoing inequalities. These include the urban-rural disparities, social-cultural stratification, unequal distribution of human resources, lack of infrastructure, and scarcity of social faith. The needy groups, therefore, will not be adequately served as intended by the policy. As is widely seen in the comparative study of the experiences of countries internationally, there is no enduring political goodwill, sound governance institutions, or involvement of the community that would bridge the gap between the policy offerings and the actual experiences of citizens. The factors can be viewed as critical activities of how articulated commitments can be translated into practice. To sum it up, unless South Africa takes care of these systemic gaps, the country's aspirational goals of equity and universality of health care will be solely imaginary. That is why there is an urgency to attempt to implement health reforms into a strong social-justice system to turn the policy rhetoric into tangible benefits.

CHAPTER 5: STRATEGIES TO STRENGTHEN THE IMPLEMENTATION OF THE NHA AND NHI TO REDUCE HEALTH CARE DISPARITIES

5.1 Introduction

The previous chapter analysed the aspect of health care access in South Africa in terms of social justice, where the concepts of fairness, equality, distributive justice, protection, and restitution provide the theoretical and practical grounds for the realisation of equity in health systems. It graphically portrayed that, despite the progressive accounts of universal health coverage espoused by the NHA, as well as the NHI, the presence of structural inequalities such as urban-rural gaps, socioeconomic status, unequal allocation of the health workforce, lack of infrastructural facilities, and diminishing citizen confidence still stands to frustrate their success. Comparative insights also indicated that, without good governance, a good political determination, and the same level of community involvement, the transformational objectives of equity are but just a mirage instead of reality.

Building on this foundation, the current chapter shifts to focus on strategies to strengthen the implementation of the NHA and NHI to reduce health care disparities. It explores practical measures based on the findings stated in the research questions. In doing so, the chapter aims to identify actionable pathways for ensuring South Africa's health reforms not only advance universal health coverage but also align with the broader social justice imperative of addressing historical and structural inequalities in access to health care.

5.2 Strategies to strengthen the implementation of the NHA and NHI

5.2.1 Leadership, Accountability, and System Stewardship

A central problem identified in South Africa is that both the NHA and the NHI policy outline the governance arrangement but fail to create binding accountability for results. This has left what Mkhwanazi (2024) calls a ‘‘last mile gap’’ between policy and practice, and where delivery on the ground is uneven and provincial execution is poorly enforced (Mkhwanazi, 2024). To close this, South Africa must move beyond soft guidance and embed statutory performance contracts for provincial and district managers tied directly to NHI purchasing criteria such as facility accreditation, ideal

clinic standards, and referral compliance. If contracts are linked to financing and renewal of authority, stewardship shifts from aspirational policy to enforceable governance. Scholars such as Mokoena, Tsoeu-Nisani, and Mphahlele (2024) argue that such contracts, coupled with public reporting, drive a culture of accountability that is currently absent in the public sector (Mokoena *et al.*, 2024).

The second solution is to operationalise the Second Presidential Health Compact (2024-2029) as the backbone of the NHI rollout. Objectives already established in the compact, such as medicine access, employee retention, and wait-time reductions, are already idealistic aims, though they will not happen unless they are formally connected to the financial systems of requirements and accreditation programmes. The current lack of alignment between central policy intent and local implementation can be addressed significantly by sharing quarterly dashboards that vividly discuss target achievement, as well as by enforcing remedial measures if a performance disparity begins to form. According to scholars like Mukwena (2022), without a transparent performance system, South Africa will merely repeat the same cycle, where health reforms will be celebrated in politics, and the changes are powerless in practice (Mukwena, 2022). The suggested approach makes stewardship both data-based and transparent and hence strengthens equality and trust in society. The paragraph on the international experience also confirms the viability of such a solution. An example is when Rwanda adopted the compact-based system, where local governments were seen as responsible for service provision by means of Imihigo performance contracts that inculcated the use of health indicators. Reputational and financial repercussions of these contracts were seen to exceed financial cost impacts that eventually yielded quantifiable results in immunisation and maternal health outcomes (Akpuh, 2022). Following the example of Rwanda, South Africa would be able to make its compacts stronger by cascading down explicit responsibilities, starting with the Presidency, down to separate clinics, therefore making accountability perpetual and enforceable. This plan directly strives to deal with the current problem of soft accountability, which can restructure stewardship into a viable force towards equity.

Scholars highlight that strong leadership has a central role in the reduction of health-care inequalities, since it aids leaders in addressing not just organisational inefficiencies, but wider social causes of ill-health (Gilson, 2007). Leadership in South

Africa has very often been reactive, as opposed to being strategic, which has contributed to corruption and misappropriation of resources (Matso & Fyraytt, 2013). To overcome these gaps, there is a need to enrich leadership models that anticipate responsibility and fairness, hence making it possible to convert the NHI and NHA targets to practical reforms. South Africa has been undertaking competency-based leadership training programmes to help managers have the necessary tools required to do away with the complexities presented by the health care environment. Kakeman et al. (2020) set forth evidence-based decision-making, management of resources, and change management as key skills that health care leaders must have.

5.2.2 Equity-Directed Financing and Strategic Purchasing

The results also indicate that even though the NHI embraces a pooled financing system, it does not have any meaningful redistributive purchasing features, and hence it allows the resource distribution to continue along historical extended lines rather than responding to the regions that are in most need. According to Solanki (2024), NHI purchasing will focus on deepening existing injustices unless a properly expressed redistribution plan is developed (Solanki, 2024). In addressing this risk, South Africa should adopt a risk-adjusted, needs-based capitation policy on primary health care that is based on weighting variables (that include rurality, poverty levels, and disease burden) and diagnosis-related group (DRG) payment by hospitals. This would ensure that under-served districts are allotted higher funding to that area, hence directly contradicting the findings of the geographic inequalities in the data.

In addition to this, embedding accountability in the financing architecture would be through the formation of purchaser-provider contracts that stipulate minimum waiting time, medication availability, and adherence to the referral form. As Kahn notes, strategic purchasing achieves efficacy only in cases where there are quantifiable service requirements in the contract, and in those cases where performance disbursements are contingent upon performance instead of the old allocation trends (Khan, 2025). An experimental implementation of the model can be seen in the deployment of district-level purchasing hubs, which would oversee contracts both in public facilities and in eligible private providers. Also, the release of an annual equity-impact report outlining the demographic groups that have attained better access at the

district and income-quantile levels would resolve the issue of financial transparency and make the redistribution operation publicly apparent.

Thailand's Universal Coverage Scheme demonstrates the feasibility of this approach. Thailand introduced capitation for PHC and DRGs for hospitals, alongside strong accreditation and auditing, which successfully compressed inequities and expanded access (Tangcharoensathien *et al.*, 2020). South Africa could adapt this by piloting equity-weighted purchasing in high-deprivation districts before scaling up nationally. Analysts argue that starting with pilot projects balances ambition with fiscal capacity, while making redistribution rules explicit would address current concerns that the NHI lacks clarity on how funds will redress inequalities (Reuters, 2024). In short, equity-directed financing strategies directly tackle the problem of 'funding inertia' and reorient financial flows towards the least advantaged, aligning with the justice principle identified in the findings.

5.2.3 Infrastructure, facilities, and health systems' readiness

The findings also revealed that structural inequalities are deeply tied to geographical barriers and poor-quality infrastructure, especially in rural areas. The NHA mandates facility planning, and the NHI outlines accreditation standards, but neither provides a clear national infrastructure plan with timelines and a financing mechanism. As Naidoo (2022) argues, equity cannot be achieved when people in rural communities must travel 50–70 kilometres to access basic needs (Naidoo, 2014). Therefore, a critical strategy is the development of the National Health Infrastructure Revitalisation Plan, linked to NHI accreditation, which ensures that facilities meet minimum structural standards (e.g., electricity, water, ICT, maternity wards). Without this, universal access remains aspirational rather than real.

A complementary approach is adopting public-private infrastructure partnerships (PPPs) to accelerate upgrades. While South Africa has some PPP experience in tertiary hospitals, these have not been scaled to primary and district facilities. PPPs are effective only when embedded in strong regulation and transparent contracts that prioritise public good over profit (Nkosi & Maseko, 2023). Public-partnering health insurance (PPP) is one solution to address the issue of infrastructure shortages, as well as the financial limitations of the country, through NHI accreditation. An example

can be found in the Ayushman Bharat Scheme in India, where there were massive investments in the refurbishment of over 150,000 Health and Wellness Centres, and thus focused on the improvement of infrastructures and the introduction of information-communication technology (ICT) to strengthen the provision of primary healthcare (Kumar *et al*., 2020). Similarly, Rwanda has also shown that financing of rural health centres by donors can help to increase access to care and better health outcomes (Binagwaho *et al*., 2021). Based on this, South Africa can implement similar measures by integrating infrastructure development with equity-based planning that focuses on historically disadvantaged provinces such as the Eastern Cape, Limpopo, Mpumalanga, and Northern Cape.

5.2.4 Strengthening Human Resources for Health

One of the main gaps that was found in the analysis is the shortage and imbalance of health professionals, especially in rural provinces. Although the NHA outlines functions of human-resource planning, and the NHI framework also mentions the procedures of accreditation, neither tool provides a legally binding tool to keep skilled personnel in those spheres where they are needed most. According to Rispel et al. (2021), there is an urban bias in workforce distribution in South Africa, which leads to insufficiency in rural facilities and undermines the opportunity to access care equally (Rispel *et al*., 2021). In response, it should be integrated into the policy by including mandatory, service-based incentives, including speedy career paths and rural hardship reimbursements, to NHI contracts, making redistribution not an aspiration, but an obligation.

Secondly, the shortage of staff might be addressed with the help of the expansion of task-shifting models. There is empirical evidence that nurse-led and community health worker (CHW) programmes are effective at offering care for maternal health, HIV, and chronic conditions on a large-scale basis (Schneider & Nxumalo, 2023). However, these cadres are still not well recognised and well assimilated into the official NHI service system. The concept of making CHWs a true component of the network of contracted providers, including remuneration and performance indicators, would reinforce the primary care provision and decrease the workload of overstretched doctors and specialists. The use of this approach is directly dependent on the discovery that marginalised communities are disproportionately affected by structural

inequalities; the professionalisation of CHWs provides a concrete channel for reducing the service gap.

The examples from the international experience enlighten the feasibility. An example of such an initiative that was able to expand an educated workforce to the rural population, the Health Extension Programme in Ethiopia, was able to achieve significant improvements in the health outcomes of mothers and children by training many CHWs (Berhanu *et al.*, 2022). Similarly, the Family Health Strategy in Brazil implements CHWs in multidisciplinary teams, with implications for infant mortality and inequity in health (Castro *et al.*, 2019). South Africa can follow these examples and integrate CHWs into NHI agreements at the respective levels by making them a permanent part of the human-resource planning approach rather than a temporary solution.

5.2.5 Harmonising Public and Private Health Sector Delivery

The findings reveal that there has been a sharp divide between the public and the private sectors of the health system, with only 16 per cent of the medically insured population receiving world-class care in the private sector and the rest having to rely on the chronically underfunded and overstretched state-funded facilities. Though the gaps are to be filled with the NHI, one must not overlook insufficient intentional, specific actions that may result in a situation where the status quo will be left intact. According to Rispel and Moorman (2022), unfair distribution of the resources instils injustice in the system, where the popular institutions are overcrowded, and the medical institutions are under-utilised by the disparate population (Rispel & Moorman, 2022). Accordingly, one of the key measures is the introduction of a common system of service delivery that can be applied to both industries. With the NHI, accreditation standards must mandate that all providers (both public and private) achieve the same standards on staffing ratios, waiting times, the availability of necessary drugs, and patient-safety measures. Such a strategy would avert the revival of a two-level system under one financing structure.

A second plan would be to establish a uniform system of pricing and reimbursement of services that are paid by the NHI. Currently, the cost of tariffs in the private sector is higher than that of the public sector; as such, it poses affordability issues (Coovadia

et al., 2019). Through embracing a national tariff schedule, the NHI fund would guarantee the payments of private providers at a level of parity with the function of the governmental establishment to offer similar services, as this will foster parity in the provision. According to Pillay and Barron (2020), the NHI is vulnerable to financial sustainability when prices are not regulated, since even with the established guidelines, a private hospital can still implement exorbitant rates (Pillay & Barron, 2020). An openly regulated reimbursement system would not only ensure the sustainability of the fund but also ensure that patients get the same standard of care irrespective of the care arrangement.

Lastly, promoting inter-service-delivery partnerships may coordinate quality in the health system. To illustrate, a public-private partnership could be that of the private specialists on rotation in the district hospitals based on an NHI contract, and the training and mentorship of the public clinicians in the private institutions. This cross-sector cooperation would address the lack of an even distribution of experience and create the spirit of common standards. Setswe (2021) argues that the benefits of the two systems, the government and the corporate one need to be used to overcome mistrust and inefficiencies that have degraded the reform (Setswe, 2021). That way, the NHI would not just be an act of financial pooling, but it would work towards eliminating the quality gap, so that all South Africans, regardless of their wealth, would be enjoying equal access to quality services under one unified system.

5.3 Conclusion

This study has examined the persistent health care disparities in South Africa, focusing on the implementation of the NHA and the proposed NHI. The empirical results prove that, despite the declared goals of the NHA of equity of access, structural inequalities have deep roots. There has been a dominant lack of effective leadership, and an unending division between citizens and the private health care industry has acted to curb substantive gains. Practically, most of the South African population is still dependent on the publicly available facilities that are regularly over exploited, and a relatively small group of people can receive high-quality treatment in the system of privatised care. These disparities directly violate the constitutional provision of right-to-health as a primary human right, hence the desperate necessity for massive reforms. The study, therefore, aimed to develop effective measures to readjust the

NHA or the NHI systems to prevent failure points in the system, and reduce health care inequalities.

One of the main conclusions of the analysis is the most significant role of strong, responsible leadership. According to the data, poor stewardship has undermined the efficacy of health service delivery, whereas ineffective accountability measures have allowed unrestricted inefficiencies. Empowerment of decision-makers, performance monitoring and targeted training on improving leadership capacity would help to improve resource allocation, the governance processes, and accountability, thus establishing a more equal basis of health care provision. This suggestion agrees with the argument put forward by Gilson (2007), stating that equity depends on leaders who not only act as administrators but as custodians of justice, who are committed to reconfiguring systems in favour of the most vulnerable. In addition to that, the focus on leadership aligns with other discourses in political science about governance, and the competence of a state to provide the necessary public goods is inherently connected with the legitimacy of this state.

The evidence provided empirically clearly shows that sustainable health-system reform is conditional on effective and sound financial management. Without the effective allocation of resources, the NHI is made vulnerable to collapse amidst mounting cost pressures; or, in other cases, it will have the effect of entrenching the already-existing inequities. Open budgets and uniform reimbursement systems will mean that both the public and the private provider will play on a level playing field, and this will counter the two-tier health-system dynamics, which has always supported inequality. To the policymakers, this brings in the political-economic aspect of the health system reform; redistributive financing does not only increase the fiscal soundness of the NHI but also the legitimacy of the government, by linking the act of fairness to the government. In the case of communities, fair financing means that disastrous health spending will be minimised, and households will be placed in a position to pull themselves out of the vicious circle of poverty caused by poor health.

Thirdly, the research determines the community as invaluable to reform implementation. One of the main barriers was the public distrust which arose from the historical exclusion of the communities in decision-making. Participatory strategies, based on the institutionalisation of participative methods, including community health

councils or local accountability systems, are therefore needed to enhance inclusivity. This observation adds to the body of studies on political science, since it confirms the essence of participatory governance in policy legitimacy. Like Habermas (1996), the research suggests that legitimacy is strengthened when the citizens make use of deliberation practices. The NHI should be more than a technocratic design, and be seen as a socially owned initiative, which is co-designed with the population with whom it is intended to work.

Fourthly, one of the fundamental inequities has been found to be the continuation of a bifurcated system, whereby the privatised care continues to flourish as the state facilities deteriorate. The study suggests that standardisation of service levels and creation of models of collaboration should be used to guarantee equal care across the board, regardless of the sector. This is a direct response to the debate in political science on the fair state-market relationship, showing how government control over the activities of the private sector could support the social-justice goal. The role of the South African government on such harmonisation is that it legitimises the government as a guarantor of fairness, and to communities, it annihilates the view that only the wealthy have access to high-quality care.

Geographic and quality disparity is compounded by the lack of infrastructure, especially in rural areas. The research suggests that it should focus on the allocation of funding to modernised facilities, dependable supplies, and increasing digital health technologies to address such gaps. Through the incorporation of Rawlsian notions of justice, the study will argue that institutional restructuring should improve the lives of the least privileged, hence the promotion of fairness. Further, the analysis places health care reform in the context of wider political legitimacy and democratic governance discourse and provides insights into how emerging democracies might incorporate the values of justice, accountability, and inclusiveness in their health systems.

In conclusion, this study establishes that achieving equitable health care in South Africa requires more than a policy framework; it demands strong leadership, equitable financing, community participation, harmonisation of public and private services, and robust infrastructure development. These policies directly address the systemic issues found within the empirical data and offer a realistic plan on how to improve the work

of the NHA and the NHI. To the government, such actions will greatly restore the constitutional commitments and enhance credibility among citizens. To communities, they map a course of increased trust, dignity, and achievement of health care as a basic human right. Finally, the research benefits both the health and political science literature, showing that health-system reform needs to be theorised as the project of creating a fair and inclusive society, to achieve equity and justice as realities.

REFERENCES

Abbing, H.D., 2010. Social justice and health care systems in Europe. Eur. J. *Health L.*, 17:217.

Abebe, S.M., Teshome, D.F., Molla, D.G., et al. 2022. Decentralized health governance and its effect on health service delivery in Ethiopia. *Health Policy and Planning*, 37(3):345–356.

Abrahams, G.L., Thani, X.C. & Kahn, S.B., 2022. South African public primary health care services and challenges: considerations during the COVID-19 pandemic. *Administratio Publica*, 30(2): 63-85.

Addaney, M., 2019. Women and Minority Rights Law in Africa*: Reimagining Equality and Addressing Discrimination*.

African Union, 1981. African Charter on Human and Peoples' Rights. [Online] Available at: https://au.int/en/treaties/african-charter-human-and-peoples-rights [Accessed 15 March. 2025].

Agyepong, I.A., Abankwah, D.N.Y., Abroso, A., Chun, C., Dodoo, J.N.O., Lee, S., and Wang, C., 2016. The "universal" in UHC: a scoping review of the inclusion of informal workers in universal health coverage. *Health Policy and Planning*, 31(8):1042–1054.

Aikman, N., 2019. The crisis within the South African health care system: A multifactorial disorder. *South African Journal of Bioethics and Law*, 12(2):52-56.

Akpoghome, T.U., 2018. Examining the protection of health care access and delivery by the National Health Act 2014*. Advances in Social Sciences Research Journal,* 5(6).

Akpuh, H. 2022. Political economy and governance of health financing reforms. (Used here to frame stewardship/purchaser issues via secondary citations).

Albertyn, C. and Goldblatt, B., 1998. Facing the challenge of transformation: Difficulties in the development of an indigenous jurisprudence of equality. *South African Journal on Human Rights*, 14(2):248-276.

Almgren, G., 2017. Health care politics, policy, and services: a social justice analysis. *Springer Publishing Company*.

Amri, M., Jølstad, B. and Bump, J.B., 2024. Health equity and distributive justice: views of high-level African policymakers. *BMC Medical Ethics*, 25(1):151.

Anasel, M., Kapologwe, N. & Kalolo, A., 2023. *Leadership and Governance in Primary Health Care: An Exemplar for Practice in Resource Limited Settings*. 127. Taylor and Francis. https://library.oapen.org/handle/20.500.12657/61002 Date of access: 20 Oct.2024.

Anderson, J.M., Rodney, P., Reimer-Kirkham, S., Browne, A.J., Khan, K.B. & Lynam, M.J., 2009. Inequities in health and health care viewed through the ethical lens of critical social justice: Contextual knowledge for the global priorities ahead. *Advances in Nursing Science*, 32(4): 282-294.

Anderson, Pitchforth, E., Edwards, N., Laderwick, H., McGuire, A. and Mossialos, E., 2022. *United Kingdom*: *Health System Review*. Health system in Transition, 24(1): 1-194.

Arab Republic of Egypt, 2014. Constitution of the Arab Republic of Egypt. Article 18. [Online] Available at: *https://www.constituteproject.org/constitution/Egypt*_2014.pdf [Accessed 10 Apr. 2025].

Ataguba, J.E. 2020. COVID-19 pandemic, a war to be won: understanding its economic implications for Africa. *Applied Health Economics and Health Policy*, 18(3): 325–328.

Ataguba, J.E., 2010. Health care financing in South Africa: moving towards universal coverage. *Continuing Medical Education*, 28(2): 74-78.

Ataguba, J.E.O. & Goudge, J., 2012. The impact of health insurance on health-care utilization and out-of-pocket payments in South Africa. *The Geneva Papers on Risk and Insurance-Issues and Practice,* 37:633-654.

Australian Government, 1983. Health Insurance Act 1973 – Medicare. [Online] Available at*:* https://www.legislation.gov.au/Series/C2004A01714 [Accessed 04 Apr. 2025].

Awoonor-Williams, J.K., Phillips, J.F., & Bawah, A.A. 2020. Scaling up health system innovations: Community-based Health Planning and Services (CHPS) in Ghana. *Health Research Policy and Systems*, 18(1): 27.

Azarian, R., 2011. Potentials and limitations of comparative method in social science. *International Journal of Humanities and Social Science*, 1(4):113-125.

Bahreini, R., Gholizadeh, M., Gedik, F.G., Yousefi, M. & Janati, A., 2021. Components of contributing conditions to strengthen health system management and leadership capacity building: a systematic review and decision-making framework. *Leadership in Health Services,* 34(4): 527-545.

Bai, G. and Mehrotra, A., 2020. U.S. rural hospitals are facing a crisis: rising closures and declining access to care. Health Affairs Blog. [Online] Available at: https://www.healthaffairs.org/do/10.1377/forefront.20200218.220051/full/ [Accessed 18 Apr. 2025].

Balabanova, D., McKee, M. and Mills, A. 2013. *Good Health at Low Cost 25 Years On: What Makes a Successful Health System? London*: London School of Hygiene & Tropical Medicine.

Balding, C., 2005. Strengthening clinical governance through cultivating the line management role. *Australian Health Review*, 29(3):353-359.

Bali, S., Singh, A., & Dey, A. 2020. Telemedicine: India's eSanjeevani initiative. *Journal of Family Medicine and Primary Care*, 9(9): 4533–4537.

Bambra, C., Fox, D. & Scott-Samuel, A., 2005. Towards a politics of health. *Health Promotion International*, 20(2): 187-193.

Banerjee, A., Mullainathan, S. & Hanna, R., 2012. *Corruption* (No. w17968). National Bureau of Economic Research. *http://www.nber.org/papers/w17968*

Barasa, E., Nguhiu, P. and McIntyre, D., 2018. Measuring progress towards Sustainable Development Goal 3.8 on universal health coverage in Kenya. *BMJ Global Health*, 3(3), p.e000904. *https://gh.bmj.com/content/3/3/e000904*

Barasa, E.W., Manyara, A.M., Molyneux, S. and Tsofa, B., 2017. Recentralization within decentralization: *county hospital autonomy under devolution in Kenya*. *Plos One*, 12(8), p.e0182440. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0182440

Batalden, P., Batalden, M., Margolis, P., Seid, M., Armstrong, G., Opipari-Arrigan, L., and Hartung, H., 2016. Coproduction of health care service. *BMJ Quality & Safety*, 25 (7):509-517.

Baxter, P. & Jack, S. 2008. Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, 13(4): 544-559.

Beauchamp, D.E., 1976. Public health as social justice. *Inquiry*, 13(1): 3-14.

Befani, B., 2020. Quality of quality: A diagnostic approach to qualitative evaluation. *Evaluation*, 26(3):333-349.

Bergen, A., & While, A., 2005. 'Implementation deficit'and 'street-level bureaucracy': policy, practice and change in the development of community nursing issues. *Health & social care in the community*, 13(1):1-10.

Bell, D.A. & De-Shalit, A. eds., 2002. Forms of justice: *Critical perspectives on David Miller's political philosophy*. Rowman & Littlefield Publishers.

Benatar, S., 2013. The challenges of health disparities in South Africa. SAMJ: *South African Medical Journal*, 103(3):154-155.

Benatar, S.R., 1997. Health care reform and the crisis of HIV and AIDS in South Africa. *New England Journal of Medicine*, 337(14):1031-1035.

Benfer, E.A., 2015. Health Justice: A Framework (and Call to Action) for Eliminating Health Inequity and Social Justice. *Am. UL Rev*.., 65:275.

Benington, J. 2011. From private choice to public value. In Benington, J., & Moore, MH (eds). 2011. *Public value*: *Theory and practice.* New York, NY: Palgrave Macmillan, 31-49.

Benjamin, G.C. 2015. Health equity and social justice: a health improvement tool. grant makers in health views from the field. *https://www.gih.org/files/FileDownloads/Health%5FEquity%5FSocial%5FJustice%5FAPHA%5FMay%5F2015.pdf*

Bhatti, M.A., 2005. Geographical patterns of access and utilization of the basic health unit in District Attock. *Journal of Liaquat University of Medical and Health Sciences,* 44(2):48-53.

Bhugra, D., Tribe, R. & Poulter, D., 2022. Social justice, health equity, and mental health. *South African Journal of Psychology*, *52*(1):3-10.

Binagwaho, A., Hartwig, R., Ingeri, D. & Makaka, A., 2012. Mutual health insurance and the contribution to improvements in child health in Rwanda. Rotterdam: International Institute of Social Studies: Erasmus University. *https://aec.afdb.org/sites/default/files/2019/12/04/mutual_health_insurance_and_the_contribution_to_improvements_in_child_health_in_rwanda.pdf*

Birn, A.E. & Nixon, S., 2010. Canada's health care system: a relevant approach for South Africa? SAMJ: *South African Medical Journal*, 100(8): 516-520.

Blanchet, N.J., Fink, G. and Osei-Akoto, I., 2012. The effect of Ghana's National Health Insurance Scheme on health care utilisation. *Ghana Medical Journal*, 46(2):76-84.

Blanco-Mancilla, H., 2013. Citizen Engagement in Public Health Service Delivery: From Collaboration to Accountability. In: *Non-Governmental Public Action and Social Justice*. London: Palgrave Macmillan: 159-180.

Block, M.A.G., 1997. Comparative research and analysis methods for shared learning from health system reform. *Health Policy*, 42(3):187-209.

Bolbakov, R.G., Sinitsyn, A.V. & Tsvetkov, V.Y., 2020, November. Methods of comparative analysis. *In Journal of Physics: Conference Series* 1679(5):052047.

Borrell, C., Espelt, A., Rodriguez-Sanz, M. & Navarro, V., 2007. Politics and health. *Journal of Epidemiology & Community Health*, 61(8): 658-659.

Bradley, E.H., Taylor, L.A. & Cuellar, C.J., 2015. Management matters: a leverage point for health systems strengthening in global health. *International journal of health policy and management*, 4(7): 411.

Brauns, M. & Stanton, A, 2016. Governance of the public health sector during apartheid: The case of *South African of Governance and Regulation/Volume*, 5(1):23-30.

Braveman, P. and Gruskin, S., 2003. Defining equity in health. *Journal of Epidemiology & Community Health*, 57(4):254-258.

Brondeel, R., Weill, A., Thomas, F. & Chaix, B., 2014. Use of health care services in the residence and workplace neighborhood: the effect of spatial accessibility to health care services. *Health & place*, 30: 127-133.

Brunello, G., 2021. The provision of Health care in the United States before and after the introduction of the Affordable Care Act*. A comparative institutional analysis of OECD countries*. http://hdl.handle.net/10579/19801

Budak, F. & Kar, A., 2014. The importance of strategic leadership in health care management. *IIB International Refereed Academic Social Sciences Journal*, 5(15):155.

Buettner-Schmidt, K. & Lobo, M.L., 2012. Social justice: A concept analysis. *Journal of Advanced Nursing*, 68(4): 948-958.

Burger, R. & Christian, C., 2020. Access to health care in post-apartheid South Africa: availability, affordability, acceptability. *Health Economics, Policy and Law*, 15(1):43-55.

Burns, M., Bally, J., Burles, M., Holtslander, L. and Peacock, S., 2022. Constructivist grounded theory or interpretive phenomenology? Methodological choices within specific study contexts. *International Journal of Qualitative Methods*, 21, p.16094069221077758.*https://journals.sagepub.com/doi/abs/10.1177/16094069221077758*

Callahan, J.L., 2010. Constructing a manuscript: Distinguishing integrative literature reviews and conceptual and theory articles. *Human Resource Development Review*, 9(3): 300-304.

Campbell, B., 2021. Social justice and sociological theory. *Society,* 58(5):355-364.

Campbell, J.C. and Ikegami, N. 2009. 'The Art of Balance in Health Policy: Maintaining Japan's Low-cost, Egalitarian System', *Cambridge University Press*.

Campos, P.A. & Reich, M.R., 2019. Political analysis for health policy implementation. *Health Systems & Reform*, 5(3):224-235.

Carey, G., Crammond, B. and De Leeuw, E., 2015. Towards health equity: a framework for the application of proportionate universalism. *International journal for equity in health*, 14(1):81.

Carey, G. and Crammond, B., 2015. Systems change for the social determinants of health. *BMC public health*, 15(1):662.

Caron, D.D., Fitzpatrick, J., and Slye, R.C., 2003. Republic of South Africa v. Grootboom. Case No. CCT 11/00. 2000 (11) BCLR 1169 and Minister of Health v. Treatment Action Campaign. Case No. CCT 8/02. *American Journal of International Law*, 97(3):669-680.

Carpenter, D., 2012. Is health politics different? *Annual Review of Political Science*, 15:287-311.

Castelyn, C., 2024. Leadership in healthcare during a pandemic: *for a systems leadership approach. Frontiers in Public Health*, 12:1361046. *https://www.frontiersin.org/articles/10.3389/fpubh.2024.1361046/full*

Castro, M.C., Massuada, A., Almeida, G., Menezes-Filho, N.A., Andrade, M.V., de Souza Norohna, K.V.M., Rocha, R., Macinko, J., Hone, T., Tasca, R. and Govanella, L., 2019. Brazil's unified health system: the first 30 years and prospects for the future. *The Lancet,* 394(10195):345-356.

Chandanabhumma, P.P. & Narasimhan, S., 2020. Towards health equity and social justice: An applied framework of decolonization in health promotion. *Health Promotion International,* 35(4):831-840.

Chang, J., Peysakhovich, F., Wang, W., & Zhu, J., 2011. The UK health care system. *The United Kingdom*, 30: 2019**.**

Chatterjee, R., Suy, R., Yen, Y. & Chhay, L., 2018. Literature review on leadership in health care management. *Journal of Social Science Studies*, 5(1):38-47.

Chinyakata, R., Roman, N.V. & Msiza, F.B., 2021. Stakeholders' perspectives on the barriers to accessing health care services in rural settings: A human capabilities approach. *The Open Public Health Journal*, 14(1).

Chopra, M. and Sanders, D., 2004. From apartheid to globalization: Health and social change in South Africa. *Hygiene and Tropical Medicine*, 98(4):238-244.

Christensen, T. & Grimsmo, A., 2005. Development of functional requirements for electronic health communication: preliminary results from the ELIN project. *Informatics in Primary Care*, 13(3).

Christmals, C.D. & Aidam, K., 2020. Implementation of the National Health Insurance Scheme (NHIS) in Ghana: lessons for South Africa and low- and middle-income countries. *Risk Management and Health care Policy*, 1879-1904.

Colquitt, J.A. & Rodell, J.B., 2015. Measuring justice and fairness. *The Oxford handbook of justice in the workplace,* 1: 187-202.

Conmy, A., 2018. South African health care system analysis. *Public Health Review*, 1(1).

Coovadia, H., Jewkes, R., Barron, P., Sanders, D. & McIntyre, D., 2009. The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*, 374(9692):817-834.

Cornwall, A., & Shankland, A. 2013. Engaging citizens: Lessons from building Brazil's national health system. Social Science & Medicine, 96, 221–229.

Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M.R., Neilson, E. and Wallace, M., 2021. Social and structural determinants of health inequities in maternal health. *Journal of women's health,* 30(2):230-235.

Cruz-Gomes, S., Amorim-Lopes, M. & Almada-Lobo, B., 2018. A labour requirement function for sizing the health workforce. *Human Resources for Health*, 16:1-12.

Cuadrado, C., Crispi, F., Libuy, M., Marchildon, G. and Cid, C., 2019. National Health Insurance: a conceptual framework from conflicting typologies. *Health Policy*, 123(7):621-629.

Daniels, N., 2001. Justice, health, and health care. *American Journal of Bioethics*, 1(2): 2-16.

Daniels, N., 2008. Justice and access to health care**.** *https://plato.stanford.edu/eNtRIeS/justice-health careaccess/*

Dassah, E., Aldersey, H., McColl, M.A. and Davison, C., 2018. Factors affecting access to primary health care services for persons with disabilities in rural areas: a "best-fit" framework synthesis. *Global health research and policy*, 3:1-13.

David, B., 2015. What is ethics in research & why is it important?

Davies, C. & Fisher, M., 2018. Understanding research paradigms. *Journal of the Australasian Rehabilitation Nurses Association*, 21(3):21-25.

Day, C. & Zondi, T., 2019. Measuring national health insurance: Towards universal health coverage in South Africa. *South African health review*, 2019(1):55-68

Day, C., Gray, A. and Padarath, A., 2015. Health and related indicators. In: Padarath, A., King, J., English, R. and Day, C. (eds). *South African Health Review 2015*. Durban: Health System Trust.

Day, G.E. & Leggat, S.G., 2015. Leading and managing health services: An Australasian perspective. *Cambridge University Press*.

De Beer, C., 1986a. The South African disease: Apartheid health and health services. *Africa World Press*.

De Beer, C.H., 1986b. Privatization of health services in South Africa: a debate in the making. *Social Science & Medicine*, 22(5):503-507.

De Groot, J. and Lemanski, C., 2021. COVID-19 responses: infrastructure inequality and privileged capacity to transform everyday life in South Africa. *Environment and Urbanization*, 33(1):255-272.

de Villiers, K., 2021. Bridging the health inequality gap: an examination of South Africa's social innovation in the health landscape*. Infectious Diseases of Poverty,* 10:1-7*.*

Delobelle, P., 2013. The health system in South Africa. Historical perspectives and current challenges. South Africa in focus: *Economic, political and social issues*: 159-205.

Democratic Alliance (DA). 2018. *Pelonomi Hospital's crumbling infrastructure shows how NHI is doomed to fail,* 2018 July. [Online]. Available at: https://www.da.org.za/2018/07/pelonomi-hospitals-crumbling-infrastructure-shows-how-nhi-is-doomed-to-fail/ (Accessed: 5 Feb. 2026).

Doherty, J., Kirigia, D., Okoli, C., Chuma, J, Ezumah, N., Ichoku, H., Hanson, K., and McIntyre, D., 2018. Does expanding fiscal space lead to improved health sector funding in developing countries? *And South Africa Global Health Action*, 11(1):1461228.

Donabedian, A., 1973. Aspects of medical care administration: s*pecifying requirements for health care*.

Dookie, S. and Singh, S., 2012. Primary health services at the district level in South Africa: a critique of the primary health care approach. *BMC Family Practice*, 13: 1-4.

Dukhanin, V., Searle, A., Zwerling, A., Dowdy, D.W., Taylor, H.A. & Merritt, M.W., 2018. Integrating social justice concerns into economic evaluation for health care and public health: A systematic review. *Social Science & Medicine*, 198: 27-35.

El Taguri, A., 2008. Essential concepts in modern health services. *Libyan Journal of Medicine*, 3(3):1-12.

Elwyn, G., Frosch, D. and Kobrin, S., 2012. Implementing shared decision-making: consider all the consequences. *Implementation Science*, 7(1):114.

Federal Government of Nigeria. 2014. National Health Act. [Online] Available at: *https://www.health.gov.ng/index.php/documents/policies?download=344:national-health-act-2014* [Accessed 02 Apr. 2025].

Feldstein, M.S., 1971. A new approach to national health insurance. *The Public Interest*, 23:93.

Firth-Cozens, J. & Mowbray, D., 2001. Leadership and the quality of care. *BMJ Quality & Safety*, 10(suppl 2): ii3-ii7.

Foucault, M., 2014. The politics of health in the eighteenth century. *Foucault Studies*, 113-127.

Fraser, N. 2019. *The old is dying and the new cannot be born: From progressive neoliberalism to Trump and beyond*. Verso. (Applied for the parity-of-participation justice lens).

French Government, 1946. Preamble to the Constitution of the Fourth Republic. [Online] Available at: *https://www.conseil-constitutionnel.fr/en/constitution-of-4-october-1958* [Accessed 10 Apr. 2025].

Fusheini, A. & Eyles, J., 2016. Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision. *BMC Health Services Research*, 16:1-11.

Gabardine, T., Tefe, G. and List, I., 2022. Understanding community perspectives on South Africa's National Health Insurance*. African Social Science Network*, 17(2):112-119.

Gajjar, D., 2013. Ethical consideration in research. *Education*, 2(7):8-15.

Garrett, L., 2017. The challenge of global health. *In Global* Health Routledge.

Gasper, D., 2002. Is Sen's capability approach an adequate basis for considering human development? *Review of political economy*, 14(4): 435-461.

Gavaza, P., Rascati, K.L., Oladapo, A.O. and Khoza, S., 2012. The state of health economic research in South Africa: a systematic review. *Pharmacoeconomics,* 30(10):925-940.

George, G., Quinlan, T., & Reardon, C. 2019. Human resources for health: A needs and gaps analysis of HRH in South Africa. Human Resources for Health Journal, 17(1): 22–31.

Ghobadian, A., Gallear, D., O'Regan, N. and Viney, H., 2004. *Public-private partnership*: *policy and experience*. Palgrave Macmillan.

Gibbard, A., 1984a. Basic justice and health care. In: R.M. Veatch, ed. Ethical Issues in Health Care. Boston: *Jones and Bartlett*: 66–76.

Gibbard, A., 1984b. Health care and the prospective Pareto principle. *Ethics*, 94(2):261-282.

Gilboe, S. and Curran, L., 2025. The Role of Justice in Addressing the Social Determinants of Health. *International Journal of Social Determinants of Health and Health Services: 27551938251321973*.

Gilson, L. & Daire, J., 2011. Leadership and governance within the South African health system. *South African Health Review*, 2011(1): 69-80.

Gilson, L., 2003. Trust and the development of health care as a social institution. *Social Science & Medicine,* 56(7):1453-1468.

Gilson, L., 2007. What sort of stewardship and health system management is needed to tackle health inequity, and how can it be developed and sustained? *A literature review.*

Girdwood, S., Govender, K., Long, L., Miot, J. & Meyer-Rath, G., 2019. Primary health care delivery models for uninsured low-income earners during the transition to National Health Insurance: perspectives of private South African providers. *South African Medical Journal*, 109(10):771-783.

Goergen, H. & Schmidt-Ehry, B., 2004. The concept of the district health system (DHS). *The District Health System*, 27.

Gold, M., 1998. Beyond coverage and supply: measuring access to health care in today's market. *Health Services Research,* 33(3 Pt 2):625.

Gordon, T., Booysen, F. & Mbonigaba, J., 2020. Socio-economic inequalities in the multiple dimensions of access to health care: the case of South Africa. *BMC Public Health*, 20:1-13.

Government of Canada, 1985. Canada Health Act. R.S.C., 1985, c. C-6. [Online] Available at*: https://laws-lois.justice.gc.ca/eng/acts/c-6/* [Accessed 10 Apr. 2025].

Gray, A. and Vawda, Y., 2013. Health policy and legislation. *South African Health Review,* 2013(1):1-14.

Greenes, R.A., Collen, M. & Shannon, R.H., 1994. Functional requirements as an integral part of the design and development process: summary and recommendations. *International journal of bio-medical computing*, 34(1-4):59-76.

Grimaldi, P., 1993. Latest Medicare benefit: FQHC (Federally Qualified Health Center) services. Health care Financial Management*: Journal of the Health care Financial Management Association*, 47(1):34-36.

Gruchy, T.D. and Vearey, J., 2020. “Left behind”: why implementing migration-aware responses to HIV for migrant farm workers is a priority for South Africa. *African Journal of AIDS Research*, 19(1):57-68.

Grut, L., Braathen, S.H., Mji, G. & Ingstad, B., 2012. Accessing community health services: challenges faced by poor people with disabilities in a rural community in South Africa. *African Journal of Disability*, 1(1):1-7.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R. & Hudson, M., 2002. What does' access to health care ‘mean? J*ournal of health services research & policy*, 7(3):186-188.

Habermas, J. 1996. Between Facts and Norms. *MIT Press*.

Hacker, J.S., 1998. The historical logic of national health insurance: Structure and sequence in the development of British, Canadian, and US medical policy. *Studies in American Political Development*, 12(1):57-130.

Harris, B., Goudge, J., Ataguba, J.E., McIntyre, D., Nxumalo, N., Jikwane, S. and Chersich, M., 2011. Inequalities in access to health care in South Africa. *Health Policy and Planning*, (26)1:102-123.

Hashimoto, H. et al., 2011. ‘Cost containment and quality of care in Japan: is there a trade-off?*’ The Lancet*, 378(9797): 1174–1182.

Hassani, A., Gilson, L. and Mills, A., 2008. *Health Policy and systems research*: a methodology reader. Alliance for Health Policy and Systems Research.

Hassim, A., Heywood, M. & Honermann, B. eds., 2008. The National Health Act 61 of 2003: A guide. SECTION27.

Haverinen, J., Keränen, N., Falkenbach, P., Maijala, A., Kolehmainen, T. & Reponen, J., 2019. Digi-HTA: Health technology assessment framework for digital health care services. *Finnish Journal of eHealth and eWelfare*, 11(4):326-341.

Health care.gov. 2010. Patient Protection and Affordable Care Act 111-148. *https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf*

Health Ombud, 2025. *Report on the conditions and leadership of Helen Joseph Tertiary Hospital*. Pretoria: Office of Health Standards Compliance.

Hennessy, J., 2013. FQHCs and health reform: up to the task? Nw*. JL & Soc. Pol'y, 9: 122.*

Heunis, C., Mofolo, N. and Kigozi, G.N., 2019. Towards national health insurance: Alignment of strategic human resources in South Africa. *African Journal of Primary Health Care and Family Medicine*, 11(1):1-7.

Heyen, D.A., 2023. Social justice in the context of climate policy: systematizing the variety of inequality dimensions, social impacts, and justice principles. *Climate Policy,* 23(5):539-554.

Hixon, A.L., Yamada, S., Farmer, P.E., & Maskarinec, G.G., 2013. Social justice: The heart of medical education. *Social Medicine*, 7(3):161-168.

Hoffman, S.J., Røttingen, J.A., Bennett, S., Lavis, J.N., Edge, J.S. & Frenk, J., 2012. Background paper on conceptual issues related to health systems research to inform a WHO global strategy on health systems research. *Health Systems Alliance*.

Hollstein, B., 2011. Qualitative approaches. The SAGE *Handbook of Social Network Analysis,* pp.404-416.Islam, A. & Biswas, T., 2014. The health system in Bangladesh: challenges and opportunities. *American Journal of Health Research*, 2(6):366-374.

Ikegami, N., Yoo, B.K., Hashimoto, H., Matsumoto, M., Ogata, H., Babazono, A., Watanabe, R., Shibuya, K., Yang, B.M., Reich, M.R. and Kobayashi, Y., 2011. Japanese universal health coverage: evolution, achievements, and challenges. *The Lancet,* 378(9796):1106–1115.

International comparison source: Tangcharoensathien, V., et al. 2020. Financial risk protection and universal health coverage in Thailand: achievements and challenges. *The Lancet*. (Used for capitation/DRG purchasing example) *https://www.econstor.eu/handle/10419/127007*

Irlam, J., Euripidou, R., Phomane, M. & Rangunwala, A., 2022. The just transition and health in South Africa. *South African Health Review*, 2022(1):1-7.

Irlam, J., Kaplan, R., Ndwaphi, N., Mcgain, F., and Rehfuess, E.A., 2023. *Greening South Africa's Health system: environmental health impacts of coal and the role of the National Health Insurance.* BMJ Global Health, 8(1): e011167.

Islam, M.S. and Kamal, M.M., 2021. Factors Contributing to Inequality in Access to Urban Health Service Delivery in Low Resource Setting Country of Bangladesh.

Jackson, B., 2005. The conceptual history of social justice. *Political Studies Review,* 3(3):356-373.

Jeon, Y.H., Merlyn, T. & Chenoweth, L., 2010. Leadership and management in the aged care sector: a narrative synthesis. *Australasian journal on aging*, 29(2): 54-60.

Journal News, 2025. *Pelonomi hospital staff down tools. Journal* News, 27 June. Available at: https://journalnews.co.za/news/pelonomi-hospital-staff-down-tools (Accessed: 22 January 2026)

Joseph, R., 2020. Toward a pragmatic understanding of Rawls' social justice theory in social work: A critical evaluation. *Journal of Human Rights and Social Work*, 5(3):147-156.

Kakemam, E., Liang, Z., Janati, A., Arab-Zozani, M., Mohaghegh, B. & Gholizadeh, M., 2020. Leadership and management competencies for hospital managers: a systematic review and best-fit framework synthesis. *Journal of Health care Leadership*, 59-68.

Kaswa, R., & von Pressentin, K. 2025. Primary health care strengthening through the lens of health care systems thinking. South African Family Practice, 67(1): a6039.

Katuu, S., 2018. Health care systems: Typologies, framework models, and South Africa's health sector. *International Journal of Health Governance*, 23(2):134-148.

Keck, C.W. and Reed, G.A., 2012. The curious case of Cuba. *American Journal of Public Health,* 102(8): e13–e22.

Keeton, C., 2010. Bridging the gap in South Africa. *Bulletin of the World Health Organization, 8*8(11).

Khan, R. 2025. Building credibility for South Africa's National Health Insurance through contracting with the private sector. *The Lancet Regional Health – Africa,* 36:100967.

Kingson, E.R. and Cornman, J.M., 2007. Health care reform: universal access is feasible and necessary. *Benefits quarterly*, 23(3).

Kiwanuka, S.N., Ekirapa, E.K., Peterson, S., Okui, O., Rahman, M.H., Peters, D. & Pariyo, G.W., 2008. Access to and utilization of health services for the poor in Uganda: a systematic review of available evidence. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 102(11): 1067-1074.

Knaul, F.M., González-Pier, E., Gómez-Dantés, O., García-Junco, D., Arreola-Ornelas, H., Barraza-Lloréns, M., Sandoval, R., Caballero, F., Hernández-Ávila, M., Juan, M. and Kerswell, C., 2012. The quest for universal health coverage: achieving social protection for all in Mexico. *The Lancet*, 380(9849):1259–1279.

Knijn, T. & Slabbert, M., 2012. Transferring HIV/AIDS Related Health care from Non-governmental Organizations to the Public Health care System in South Africa: *Opportunities and Challenges. Social policy & administration*, 46(6):636-653.

Kolodner, R.M., 1994. Functional workstation requirements: clinical perspectives. *International Journal of Bio-Medical Computing*, 34(1-4):115-121.

Kon, Z.R. & Lackan, N., 2008. Ethnic disparities in access to care in post-apartheid South Africa. *American Journal of Public Health*, 98(12): 2272-2277.

Kraynak, R.P., 2018. The origins of "social justice" in the natural law philosophy of Antonio Rosmini. *The Review of Politics,* 80(1): 3-29.

Krupnikov, Y. and Levibe, A.S., 2019. Political Issues, Evidence, and Citizens' Engagement: The case of Unequal Access to Affordable Health Care. *The Journal of Politics*, 81(2):385-398.

Krupnikov, Y., & Levine, A. 2019. Cross-cutting messages and political identity. *Journal of Politics*, 81(3):920–933.

Kulig, J.C., Kilpatrick, K., Moffitt, P. and Zimmer, L., 2011. Rural health in Canada. *Canadian Journal of Nursing Research*, 43(2):5-11.

Kulig, J.C., Penz, K., Karunanayake, C., MacLeod, M.L., Jahner, S. and Andrews, M.E., 2017. Experiences of rural and remote nurses assisting with disasters. *Australasian emergency nursing journal*, 20(2):98-106.

Kung, T.H., Wallace, M.L., Snyder, K.L., Robson, V.K., Kalombo, C.D., Bekker, L.G. & Mabud, T.S., 2016. South African health care provider perspectives on transitioning adolescents into adult HIV care. *South African Medical Journal*, 106(8):804-080.

Lagomarsino, G., Garabrant, A., Adyas, A., Muga, R. and Otoo, N., 2012. 'Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia', *The Lancet*, 380(9845):933–943.

Lefafa, N. 2023. *How Mpumalanga Health is addressing clinic challenges*. Medical Brief, 28 June. [Online]. Available at: https://www.medicalbrief.co.za/how-mpumalanga-health-is-addressing-clinic-challenges/ (Accessed: 3 Feb. 2026)

Lefafa, N. 2022. *Report finds some improvement at Mpumalanga clinics, but serious challenges remain*. Spotlight NSP, 28 June. [Online]. Available at: https://www.spotlightnsp.co.za/2022/06/28/report-finds-some-improvement-at-mpumalanga-clinics-but-serious-challenges-remain/ (Accessed: 3 Feb. 2026).

Lefafa, N. 2025. *After a damning report, health dept says issues at Mafikeng Provincial Hospital are being addressed*. Spotlight NSP, 12 November. [Online]. Available at: https://www.spotlightnsp.co.za/2025/11/12/after-a-damning-report-health-dept-says-issues-at-mafikeng-provincial-hospital-are-being-addressed/ (Accessed: 3 Feb. 2026).

Lega, F., Prenestini, A. & Spurgeon, P., 2013. Is management essential to improving the performance and sustainability of health care systems and organizations? A systematic review and a roadmap for future studies. *Value in Health*, 16(1): 46-51.

Lenihan, P., Welter, C., Chang, C. & Gorenflo, G., 2007. The operational definition of a functional local public health agency: the next strategic step in the quest for identity and relevance. *Journal of Public Health Management and Practice*, 13(4):357-363.

Letlape, K. 2025. ActionSA Reveals Health Department's Blind Spot-on Foreign Nationals in Public Healthcare. https://www.actionsa.org.za/actionsa-reveals-health-departments-blind-spot-on-foreign-nationals-in-public-healthcare/

Levesque, J.F., Harris, M.F. and Russell, G., 2013. Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. *International journal for equity in health*, 12:1-9.

Liverani, M., Hawkins, B. and Parkhurst, J.O., 2013. Political and institutional influences on the use of evidence in public health policy. A systematic review. *PloS one*, 8(10): e77404. *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0077404*

Lloyd, B., Sanders, D. & Lehmann, U., 2010. Human resource requirements for National Health Insurance: perspectives on national health insurance. *South African Health Review*, 2010(1):171-178.

London, L., 2008. What is a human-rights-based approach to health, and does it matter? *Health and human rights*, .65-80.

Lu, C., Chin, B., Li, G. and Murray, C.J.L., 2012. Limitations of methods for measuring out-of-pocket and catastrophic private health expenditures. *Bulletin of the World Health Organization,* 87(3):238–244.

Lucas, T., 2020. Health consequences and correlates of social justice. *The Wiley encyclopedia of health psychology*, 223-230.

Macinko, J. and Harris, M.J., 2015. Brazil's Family Health Strategy—delivering community-based primary care in a universal health system. *New England Journal of Medicine*, 372(23):2177–2181.

Madden, R., Fortune, N. and Gordon, J., 2022. Health statistics in Australia: what we know and do not know. *International journal of environmental research and public health*, 19(9):4959.

Maeda, A., Araujo, E.C., Cashin, C., Harris, J. and Zuvanic, L., 2014. *Universal Health Coverage for Inclusive and Sustainable Development:* A Synthesis of 11 Country Case Studies. Washington, DC: World Bank.

Mahomed, S., Sturm, A.W. & Moodley, P., 2017. A comparison of private and public sector intensive care unit infrastructure in South Africa. *South African Medical Journal*, 107(12):1086-1090.

Malakoane, B., Heunis, J.C., Chikobvu, P., Kigozi, N.G. & Kruger, W.H., 2020. Public health system challenges in the Free State, South Africa: A situation appraisal to inform health system strengthening. *BMC Health Services Research*, 20:1-14.

Malakoane, B., Heunis, J.C., Chikobvu, P., Kigozi, N.G. & Kruger, W.H., 2020. Public health system challenges in the Free State, South Africa: A situation appraisal to inform health system strengthening. *BMC Health Services Research*, *20:*1-14.

Mangalie, B.L., Khaliq, O.P. and Jassen, A., 2025. The assessment of preventive measures in infants admitted with acute diarrhoeal disease to Pelonomi Tertiary Hospital in Bloemfontein, South Africa. *South African Medical Journal,* 115(4):48-54.

Maphela, B., 2023. An Analysis of Regulation 363 of the National Health Act (61 of 2003) Regarding the Management of Human Remains from the Perspective of Emerging Funeral Directors. *African Journal of Governance and Development*| *Volume*, 12(2):21.

Maphumulo, W.T. & Bhengu, B.R., 2019. Challenges of quality improvement in the health care of South Africa post-apartheid*: A critical review. Curationis*, 42(1):1-9.

Marmot, M., 2015. The Health Gap: *The Challenge of an Unequal World*. London: Bloomsbury Publishing.

Marston, C. Renedo, A. and Miles, S., 2020. Community participation is crucial in a pandemic. *The Lancet*, 395(102380):1676-1678.

Marten, R., McLintrye, D., Travassos, C., Shishikin, S., Longde, W., Reddy, S., and Vega, J., 2014. AN assessment of progress towards universal health coverage in Brazil, Russia, India, China, and South Africa (BRICS), *The Lancet*, 384(9960):2164-2171.

Martínez-Gonzalez, M., Monreal-Bosch, P., Perera, S. & Olid, C.S., 2016. Public Health care Organizations: Leadership or Management? Athenea Digital. *Revista de pensamiento e investigación social*, 16(3):245-257.

Masike, M. and Mahomed, O., 2025. Leadership Challenges in a Resource-Constrained Health Care System in South Africa's North West Province Case Study. *Journal of Healthcare Leadership*: 831-842.

Mash, R., Ogunbanjo, G., Naidoo, S.S. & Hellenberg, D., 2015. The contribution of family physicians to district health services: A national position paper for South Africa. *South African Family Practice*, 57(3):54-61.

Mashel, L. 2025. *Hospital responds to complaint about equipment. Boksburg Advertiser,* 20 January. [Online]. Available at: https://www.citizen.co.za/boksburg-advertiser/news-headlines/2025/01/20/hospital-responds-to-complaint-about-equipment/ (Accessed: 4 Feb. 2026).

Matsi, M.M., 2015*. Views and Perceptions of Health care Workers on the National Health Insurance at Pietersburg-Mankweng Tertiary Hospital, Limpopo Province* (Doctoral- dissertation). *http://policyresearch.limpopo.gov.za/handle/123456789/1260*

Matsoso, M.P. & Fryatt, R., 2013. National Health Insurance: the first 18 months. *South African Medical Journal*, 103(3):156-158.

Matsuda, R. (2019) 'Sustainability and reform of Japan's health system', *Japan Medical Association Journal*, 2(3):245–250.

Mayosi, B.M. & Benatar, S.R., 2014. Health and health care in South Africa—20 years after Mandela. *New England Journal of Medicine*, 371(14):1344-1353.

McGillivray, M., Dutta, I. and Markova, N., 2009. Health inequality and deprivation. *Health Economics*, 18(S1): S1-S12.

McIntyre, D. and Mooney, G., 2007. The *economics of health equity*, xvi: 276. *https://www.cabidigitallibrary.org/doi/full/10.5555/20093032126*

McIntyre, D., 2010. National Health Insurance: Providing a vocabulary for public engagement: perspectives on national health insurance. *South African Health Review*, 2010(1):145-156.

McLaren, Z., Ardington, C. and Leibbrandt, M., 2013. *Distance as a barrier to health care access in South Africa.*

McLaren, Z.M., Ardington, C. and Leibbrandt, M., 2014. Distance decay and persistent health care disparities in South Africa. *BMC Health Services Research*, 14:1-9.

McPake, B. and Mills, A., 2000. What can we learn from international comparisons of health systems and health system reform*? Bulletin of the World Health Organization*, 78:811-820.

McQuoid-Mason, D.J. & Dada, M.A., 2006. The National Health Act: some implications for family practice. CME: *Your SA Journal of CPD*, 24(1):12-14.

Metiso, N.F. and Mboweni, S.H., 2025. Barriers and Enablers of Health Services Utilisation in Rural Communities of Nkomazi Sub-District in Mpumalanga Province, South Africa: A Quantitative Community Survey. *Health Services Insights*, 18:11786329251356931.

Meyer, J.C., Schellack, N., Stokes, J., Lancaster, R., Zeeman, H., Defty, D., Godman, B. & Steel, G., 2017. *Ongoing initiatives to improve the quality and efficiency of medicine use within the public health care system in South Africa*: a preliminary study. Frontiers in Pharmacology, 8: 751.

Michel, J., Chimbindi, N., Mohlakoana, N., Orgill, M., Bärnighausen, T.W., Obrist, B., Tediosi, F., Evans, D., McIntryre, D., Bressers, H.T. & Tanner, M., 2019. How and why policy-practice gaps come about: a South African Universal Health Coverage context. *Journal of Global Health Reports*, *3*:1-32.

Michel, J., Obrist, B., Bärnighausen, T., Tediosi, F., McIntyre, D., Evans, D. & Tanner, M., 2020. What we need is health system transformation and not health system strengthening for universal health coverage to work: Perspectives from a National Health Insurance pilot site in South Africa. *South African Family Practice*, *62*(3).

Michel, J., Tediosi, F., Egger, M., Barnighausen, T., McIntyre, D., Tanner, M. & Evans, D., 2020. Universal health coverage financing in South Africa wishes vs reality. *Journal of Global Health Reports*, 4, e2020061. https://www.joghr.org/article/13509-universal-health-

Miller, D., 2001. Principles of social justice. *Harvard University Press.*

Mkhwanazi, T. 2024. Assessing the NHI in South Africa: Policy formulation, stakeholder engagement and implementation challenges. *European Journal of Medical and Health Research*, 2(6): 198–215.

Mmadi, P.J. and Sithole, S.L., 2019. The state of public healthcare facilities in South Africa: Some reflections on service delivery. *Development Trends in Modern Africa*. Publisher: *Centre for Democracy, Research, and Development* (CEDRED).

Mndzebele, S. & Matsi, M., 2016. Perspectives and experiences of health care workers on the National Health Insurance at tertiary hospitals in the Limpopo Province, South Africa. PULA: *Botswana J Afr Stud,* 30(1):123-30.

Mnukwa, M. 2025. Government on blocking of access to healthcare services. *https://www.gov.za/news/media-statements/government-blocking-access-healthcare-services-05-jul-2025*

Mochoari, R. 2022. *Concern over safety at Free State healthcare facilities*. Spotlight NSP, 13 April. [Online]. Available at: https://www.spotlightnsp.co.za/2022/04/13/concern-over-safety-at-free-state-healthcare-facilities/ (Accessed: 3 Feb. 2026).

Modisenyane, S.M., Hendricks, S.J.H. and Fineberg, H., 2017. Understanding how domestic health policy is integrated into foreign policy in South Africa: a case for accelerating access to antiretroviral medicines. *Global health action*, 10(1); 1339533.

Mokoena, M., Tsoeu-Nisani, L., & Mphahlele, M.2024. Accountability as a driver of public service reform. *International Journal of Public Leadership*, 20(2):155–169.

Mokoena, S.V. & Naidoo, P., 2024. Factors that hamper the effective implementation of the building blocks for National Health Insurance in South Africa. *SA Pharmaceutical Journal*, 91(2):45-51.

Mollenkamp, D., 2022. Social justice, meaning, and main principles are explained. *Investopedia.*

Molelekwa, T. 2022. *Decaying infrastructure at Tambo Hospital still putting patients and health workers at risk.* Spotlight NSP, 16 November. [Online]. Available at: https://www.spotlightnsp.co.za/2022/11/16/decaying-infrastructure-at-tambo-hospital-still-putting-patients-and-health-workers-at-risk/ (Accessed: 2 Feb. 2026).

Moten A, Schafer DF, & Montgomery E.2012. A prescription for health inequity: Building public health infrastructure in resource-poor settings. *J Glob Health*, 2(2):020302. doi: 10.7189/jogh.02.020302.

Mueller, J., 2017. OP92 Addressing Challenges of Implementing a Health Technology Assessment Framework in South Africa. *International Journal of Technology Assessment in Health Care*, 33(S1):41-42.

Murphy, S.D. and Moosa, S., 2021. The views of public service managers on the implementation of National Health Insurance in primary care: a case of Johannesburg Health District, Gauteng Province, Republic of South Africa. *BMC Health Services Research*, 21(1):969.

Murray, M. and Cope, V., 2021. Leadership: Patient safety depends on it! *Collegian,* 28(6): 604-609*.*

Mutale, W., Vardoy-Mutale, A.T., Kachemba, A., Mukendi, R., Clarke, K. & Mulenga, D., 2017. Leadership and management training as a catalyst to health system strengthening in low-income settings: Evidence from the implementation of the Zambia Management and Leadership course for district health managers in Zambia. *PLoS One,* 12(7): e0174536*.* *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0174536*

Naidoo, A. 2009. *Trends in adult medical admissions at Tambo Memorial Hospital, Gauteng, between 2005 and 2007*. Unpublished MMed dissertation. University of the Witwatersrand, Johannesburg.

Naidoo, S., 2012. The South African national health insurance: a revolution in health-care delivery! *Journal of Public Health*, 34(1):149-150.

Naidoo, P., Koch, H.E., Anderson, J., Ghela, P., Govender, P., Hoosen, N., and Khan, H., 2014. Accessibility for persons with mobility impairments within an informal trading site: A case study on the markets of Warwick, South Africa. *African Journal of Disability*, 3(1):1-9.

Naledi, T., Barron, P. & Schneider, H., 2011. Primary health care in SA since 1994 and implications of the new vision for PHC re-engineering. *South African Health Review*, *2011*(1):17-28.

National Department of Health (NDdoH). 2019. Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot

Districts in South Africa*, Evaluation Report, Final*. NDOH10/2017-2018. *https://www.health.gov.za/wp-content/uploads/2020/11/nhi-evaluation_evaluation-report.pdf*

National Department of Health (NDoH). 2006. *Our health, our care, our say: A new direction for community services* (Vol. 6737). The Stationery Office.

National Department of Health (NDoH). 2011. National Health Act (61/2003): Policy on National Health Insurance. Government Gazette, Vol. 554, No. 34523.

National Department of Health (NDoH). 2015. National health insurance for South Africa: towards universal health coverage. *Government Gazette*, 1230: 1-97.

National Department of Health (NDoH). 2020*. National Department of Health. Referral Policy for South African Health Services and Referral Implementation Guidelines;* National Department of Health: Pretoria, South Africa, 2020.

National Department of Health (NDoH). 2025. Annual report 2023/24 RP190/2024 ISBN: 978-1-77997-100-5 NDoH-Annual-Report-2023-24.pdf

Navarro, V., Muntaner, C., Borrell, C., Benach, J., Quiroga, Á. Rodríguez-Sanz, M., Vergés, N. & Pasarín, M.I., 2006. Politics and health outcomes. *The Lancet*, 368(9540): 1033-1037**.**

Neely, A.H. and Ponshunmugam, A., 2019. A qualitative approach to examining health care access in rural South Africa. *Social Science & Medicine*, 230:214-221.

Nevondwe, L. & Odeku, K.O., 2014. Financing the national health insurance scheme of South Africa: opportunities and challenges. *Journal of Social Sciences*, 39(1): 9-18.

News24. 2023. Tambo Memorial: The horror hospital where the sick fear to go. (Date of Access: 16 Nov.2022). *https://www.news24.com/citypress/news/tambo-memorial-the-horror-hospital-where-the-sick-fear-to-go-20230806*

Ngwaru, T., Fanoe, W., Harrison, S., Davén, J., Blecher, M.S., Khanna, N. & Matsebula, T., 2019. National Health Insurance: vision, challenges, and potential solutions. *South African Health Review*, 2019(1): 29-42.

Niti Aayog, 2021. Health System for a New India: Building Blocks – Potential Pathways to Reforms. [Online] New Delhi: Government of India. Available at: *https://www.niti.gov.in/sites/default/files/202110/Health_System_for_a_New_India_Complete_Report.pdf* [Accessed 03 March. 2025].

Njoroge, M., Zurovac, D., Ogara, E.A., et al. 2021. Uptake and equity of a digital health insurance platform (M-TIBA) in Kenya. BMJ Global Health, 6(4), e004309.

Nnonyelu, N. & Nwankwo, I.U., 2014. Social determinants of differential access to health services across five states of southeast Nigeria. *European Scientific Journal.*

NPC of China (National People's Congress of China). Constitution of the People's Republic of China. Article 21. [Online] Available at: *https://www.constituteproject.org/constitution/China_2018.pdf [Accessed 10 Apr. 2025].*

Nsibande, D., Doherty, T., & Jackson, D. 2021. Task shifting in sub-Saharan Africa: Lessons from HIV and maternal health. *BMC Health Services Research*, 21, 876.

Ocloo, J. and Matthews, R., 2016. From tokenism to empowerment: progressing patient and public involvement in health care improvement. *BMJ Quality & Safety*, 25(8):626-632.

Ogar, J.N. & Akpan, B.S., 2016. Historical Perspective on Social Justice. *STM Journals,* 6(3):7.

Ohonba, A., Kirsten, F., & Mkhize, B. (2023). Aa Perceived unmet needs in health care as inequality indicators: Evidence from South Africa. *EDWRG Working Paper Number* 05-23.

Okorafor, O.A., 2012. National health insurance reform in South Africa: estimating the implications for demand for private health insurance. *Applied health economics and health policy*, 10:189-200.

Oliver, G., 2024. The National Health Insurance (NHI) and Women: *making the case for the socialization of accessing health services from a policy perspective*. https://uwcscholar.uwc.ac.za/items/d7b16488-eeb6-43f0-9c71-43b925c57f2c

Osadolor, O.O., Osadolor, A.J., Osadolor, O.O., Enabulele, E., Akaji, E.A. & Odiowaya, D.E., 2022. Access to health services and health inequalities in remote and rural areas. *Janaki Medical College Journal of Medical Science, 10*(2):70-74.

Ouhbi, S., Idri, A., Hakmi, R., Benjelloun, H., Fernández-Alemán, J.L. y Toval, A., 2017, April. Requirements for a mobile personal health record to improve cardiovascular health care services. *In Proceedings of the Symposium on Applied Computing* (557-562).

Outka, G., 1975. Social justice and equal access to health care. *Perspectives in biology and medicine,* 18(2):185-203.

Pagaiya, N., & Noree, T. 2019. Thailand's experiences with rural recruitment and retention of health care workers. *Bulletin of the World Health Organization*, 97(6):417–422.

Paim, J., Travassos, C., Almeida, C., Bahia, L., and Macinko, J., 2011. The Brazilian health system: history, advances, and challenges. *The Lancet*, 377(9779):1778–1797.

Pan, J. and de Oliveira Dias, M., 2024. Health care in Brazil: An Overview. *British Journal* of Multidisciplinary and Advanced Studies, 5(2):69-89.

Parsaei, Z., Jangi, M., Tahmasebian, S. & Ehteshami, A., 2024. Functional and Nonfunctional Requirements of Virtual Clinic Mobile Applications: A *Systematic Review. International Journal of Telemedicine and Applications,* 2024(1), 7800321.

Patel, V., Parikh, R., Nandraj, S., Balasubramaniam, P., Narayan, K., Paul, V.K., Kumar, A.S., Chatterjee, M, and Reddy, K.S., 2015. Assuring health coverage for all in India. *The Lancet*, 386(10011):2422-2435.

Pauw, M. 2022. Understanding South Africa's pending NHI. *Health Systems Global Blog*. (Used to highlight operational clarity gaps).

Peter, F., 2001. Health equity and social justice. *Journal of Applied Philosophy*, 159-170.

Peters, D.H., Garg, A., Bloom, G., Walker, D.G., Brieger, W.R. and Rahman, M.H., 2008. Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences,* 1136(1):161-171.

Phasha, F.G., 2015. *Management of public hospitals in Waterberg District* (Limpopo Province) (Doctoral dissertation, University of Limpopo). *http://ul.netd.ac.za/bitstream/handle/10386/1234/phasha_fg_2015.pdf?sequence=1&isAllowed=y*

Pieterse, M., 2010. *Legislative and executive translation of the right to access health care services.* Law, Democracy & Development, 14.

Pihlainen, V., Kivinen, T. and Lammintakanen, J., 2016. Management and leadership competence in hospitals: a systematic literature review. *Leadership in Health Services*, 29(1):95-110.

Plsek, P.E. & Wilson, T., 2001. Complexity, leadership, and management in health care organizations*. BMJ,* 323(7315):746-749*.*

Popay, J., 2008. Community engagement to address the wider social determinants of health: a review of evidence. *London: NHS Health Development Agency.*

Potgieter, N., Heine, L., Ngandu, J.P.K., Ledwaba, S.E., Zitha, T., Mudau, L.S., Becker, P., Traore, A.N., and Barnard, T.G., 2023. High burden of co-infection with multiple enteric pathogens in children suffering with diarrhoea from rural and peri-urban communities in South Africa. *Pathogens*, 12(2):315.

Parliamentary Monitoring Group (PMG). 2025. Committee meeting: 27067. [Online]. Available at: https://pmg.org.za/committee-meeting/27067/ (Accessed: 3 Feb. 2026).

Parliamentary Monitoring Group (PMG). 2025*. Report of the Select Committee on Social Services:* An oversight visit to Gauteng Province, 24-28 February 2025. [Online]. Available at: https://pmg.org.za/files/250328scsocialreport.pdf (Accessed: 3 Feb. 2026).

Preda, A., and Voigt, K. 2015. The Social Determinants of Health. Why should we care? *The American Journal of Bioethics*, 15(3):25-36.2015.

Price, M., 1994. The impact of political transformation in South Africa on public/private mix policy debates*. Health Policy and Planning, 9(1): 50-62.*

Ragin, C.C. 2008. *What is Qualitative Comparative Analysis*?

Rahman, R., 2022. Private sector health care in Bangladesh: Implications for social justice and the right to health care. *Global public health*, 17(2): 285-296.

Rai, N. and Thapa, B., 2015. A study on purposive sampling method in research. Kathmandu: Kathmandu School of Law, 5(1):8-15.

Ramaphosa, C. 2024a. Remarks by President Cyril Ramaphosa on the signing of the National Health Insurance (NHI) Bill. 15 May.

Ramaphosa, C. 2024b. One step closer to affordable quality health care for all. 20 May *https://www.thepresidency.gov.za/node/8149*

Rammila, D., 2023. Evaluating the potential impact of National Health Insurance on medical scheme members' rights to have access to health-care services in South Africa. *Law, Democracy and Development*, 27: 360-391.

Rawls, J., 1971. *Theory of justice*. Cambridge (Mass.).

Rawls, J., 2008*. Lectures on the history of political philosophy*. Harvard University Press.

Reilly, M., 2021. Health Disparities and Access to Health care in Rural vs. Urban Areas. *Theory in Action*, 14(2).

Rensburg, R., 2021. Health care in South Africa: How inequity is contributing to inefficiency. *The Conversation*, 6.

Republic of Rwanda, 2003. Constitution of the Republic of Rwanda. Article 41. [Online] Available at: *https://www.constituteproject.org/constitution/Rwanda_2015.pdf* [Accessed 10 Apr. 2025].

Republic of South Africa (RSA). 1994. Constitution of the Republic of South Africa, 1993 (Vol. 8). *Creda Press for the Government Printer, Pretoria*.

Republic of South Africa (RSA). 2017. *White Paper on National Health Insurance for South Africa: Towards Universal Health Coverage*. Pretoria: Department of Health.

Republic of South Africa (RSA). 2024. National Health Insurance Act. *Government Gazette,* 707(50664)-97 https://www.gov.za/documents/acts/national-health-insurance-act-20-2023-english-afrikaans-16-may-2024

Republic of South Africa, Department of Justice and Constitutional Development (2008) Patient Rights Charter. Available at: https://www.justice.gov.za/vc/docs/policy/patient%20rights%20charter.pdf [Accessed: 22 January 2026].

Rhodes, R., Battin, M. & Silvers, A. eds., 2012. Medicine and social justice: essays on the distribution of health care. *Oxford University Press*.

Ridde, V., Druetz, T., Pires, R. and Haddad, S., 2021. Health system resilience in Mozambique: case studies of disease control and responses. *BMJ Global Health,* 6(10): e006507.

Rights, C., 2000. *The right to the highest attainable standard of health*: 08/11/2000. E/C. 12/2000/4. (General Comments).

https://www.graduateinstitute.ch/sites/internet/files/2020-11/GC14%20CESCR.pdf

Ringard, Å. Sagan, A., Saunes, I.S., & Lindahl, A.K. 2021. Norway: Health system review. *Health Systems in Transition*, 23(2):1–234.

Rispel, L.C. and Barron, P., 2012. Valuing human resources: key to the success of a National Health Insurance System. *Development Southern Africa,* 29(5):616-635.

Rispel, L.C., Ditlopo, P., White, J. and Blaauw, D., 2021. Methodological considerations in establishing and maintaining longitudinal health workforce studies: Lessons learned from the WiSDOM cohort in South Africa. *Global Health Action,* 14(1):1996688.

Rispel, L. & Moorman, J., 2010. Health legislation and policy: Context, process, and progress: Reflections on the Millennium Development Goals. *South African Health Review,* 2010(1): 127-142.

Rispel, L.C., 2016. Analysing the progress and fault lines of health sector transformation in South Africa. *South African Health Review, 2016*(1):17–23.

Robeyns, I., & Byskov, MF. 2025. The Capability Approach. Stanford Encyclopaedia of Philosophy.

Rodwin, V.G., 2003. The health care system under French national health insurance: lessons for health reform in the United States. *American journal of public health*, 93(1):31-37.

Rose, A. and Janse van Rensburg-Bonthuyzen, E., 2015. The factors that attract healthcare professionals to and retain them in rural areas in South Africa. *South African Family Practice*, 57(1):44-49.

Rosenberg, M., 2014. Health geography I: Social justice, idealist theory, health, and health care. *Progress in human geography*, 38(3):466-475.

Rousseau, J.J. 2018. *The Social Contract. Createspace* (Original work published 1762

Rousseau, J.J., 2016. Social Justice and Equity. *People, Planet, and Progress Beyond* 2015, 2:251-263.

Rudner, N., 2021. Nursing is a health equity and social justice movement. *Public Health Nursing,* 38(4):687-691.

Ruger, J.P., 2004. Health and social justice. *The Lancet*, 364(9439):1075-1080.

Ruger, J.P. and Kim, H.J., 2006. Global health inequalities: an international comparison. *Journal of epidemiology & community health,* 60(11): 928-936.

Rust, A.B. & de Jager, J.J., 2010. Leadership in public health care: Staff satisfaction in selected South African hospitals. African Journal of Business Management, 4(11): 2277.

Said, M.Y. and Nurhayati, Y., 2021. A review on Rawls Theory of Justice. *International Journal of Law, Environment, and Natural Resources*, 1(1):29-36.

Salkever, D.S., 1976. Accessibility and the demand for preventive care. *Social Science & Medicine* (1967), 10(9-10):469-475.

Schiff, T. and Rieth, K., 2012. Projects in medical education: "Social Justice in Medicine" is a rationale for an elective program as part of the medical education curriculum at the John A. Burns School of Medicine. *Hawai'i Journal of Medicine & Public Health*, 71(4 Suppl 1):64.

Second Presidential Health Compact 2024–2029. 2024. *Presidency of the Republic of South Africa*.

Schneider, H., Olivier, J., Orgill, M., Brady, L., Whyle, E., Zulu, J., San Sebastian, M., George, A., and Chaminuka Collective, 2021. The multiple lenses on the community health system: implications for policy, practice, and research. *International Journal of Health Policy and Management*, 11(1):9.

Seims, L.R.K., Alegre, J.C., Murei, L., Bragar, J., Thatte, N., Kibunga, P. & Cheburet, S., 2012. Strengthening management and leadership practices to increase health-service delivery in Kenya: an evidence-based approach. *Human resources for health*, 10:1-7.

Stews, G. and Witthuhn, J., 2013. Community-based health programmes and health promotion in South Africa. *Journal of Public Health in Africa*, 4(1), e6

Setswe, G., Muyanga, S., Witthuhn, J. & Nyasulu, P., 2015. Public awareness and knowledge of the National Health Insurance in South Africa. *Pan African Medical Journal*, 22(1).

Setswe, G., Witthuhn, J., Muyanga, S. & Nyasulu, P., 2016. The new national health insurance policy in South Africa: public perceptions and expectations. *International Journal of Health care Management*, 9(2):77-82.

Shaw, F.E., Asomugha, C.N., Conway, P.H. and Rein, A.S., 2014. The Patient Protection and Affordable Care Act: opportunities for prevention and public health. *The Lancet*, 384(9937):75-82.

Shelp, E.E., ed. 2012. *Justice and health care*, vol. 8. Springer Science & Business Media.

Shenaaz, G.A.N.I., 2023. A Critical Review of the Sustainability of South Africa's Health System, Users' Satisfaction and Key Performance Scores. *International Journal of Environmental, Sustainability, and Social Science*, *4*(3):927-942.

Shisana, O., Rehle, T., Louw, J., Zungu-Dirwayi, N., Dana, P. & Rispel, L., 2006. Public perceptions on national health insurance: moving towards universal health coverage in South Africa. *South African Medical Journal*, 96(9):814-818.

Simelane, S. and Venter, W., 2014. The NGO sector and HIV/AIDS in South Africa: Historical perspectives and current trends. African Journal of AIDS Research, 13(3):245–255.

Simelela, N.P. & Venter, W.D.F., 2014. A brief history of South Africa's response to AIDS: history of HIV in SA-Progress towards the Millennium Development Goals. *South African Medical Journal,* 104(3):249-251.

Singh, G., Cribb, A. and Owens, J., 2023. Leadership from below, change from within revitalizing medical professionalism through social justice. *BMJ Leader*, 7(Suppl 2): p.e000817. *https://bmjleader.bmj.com/content/7/Suppl_2/e000817.abstract*

Singh, V., Sarbadhikari, S.N., Jacob, A.G. and John, O., 2022. Challenges in delivering primary care via telemedicine during the COVID-19 pandemic in

India: a review synthesis using a systems approach. *Journal of family medicine and primary care,* 11(6):2581-2588.

Sithole, H.L., 2015. An overview of the National Health Insurance and its possible impact on eye health care services in South Africa. *African Vision and Eye Health*, 74(1): 6.

Solanki, G.C., Wilkinson, T., Myburgh, N.G., Cornell, J.E. and Brijlal, V., 2024. South African healthcare reforms towards universal healthcare-where to next? SAMJ: *South African Medical Journal*, 114(3):13-16.

Solomon, M., Moncado, J., Latouf, M., Bierlich, M., Polidori, G., Chen, L. & Sauttter, D., 2020. A Health Care System Divided: How Apartheid's Lingering Effects Harm South African Maternal Health. *McGill Journal of Global Health*, 9(1): 27-44.

Sop, M.D.S. & Messi, B.E., 2022. Factors affecting access to health care facilities in a rural Community: The case of Bali-Nyonga Sub-Division, Cameroon. *Journal of the Cameroon Academy of Sciences,* 17(3):235-253.

South African Human Rights Commission (SAHRC). 2025. Media Advisory: Who is entitled to access to health care in South Africa? *https://www.sahrc.org.za/index.php/sahrc-media/news-2/item/4347-media-advisory-who-is-entitled-to-access-to-health care-in-south-Africa*

South African Human Rights Commission SAHRC. Access to health. *https://www.sahrc.org.za/home/21/files/FINAL%20Access%20to%20Health%20Care%20Educational%20Booklet.pdf*

South African Human Rights Commission (SAHRC). 2022*. FS Health dept under pressure following SAHRC visit,* 20 July. [Online]. Available at: https://www.sahrc.org.za/index.php/sahrc-media/news/item/3192-fs-health-dept-under-pressure-following-sahrc-visit (Accessed: 3 Feb. 2026).Sreenivasan, G. 2007 ‘Health care and equality of opportunity’, T*he Hastings Centre Report,* 37(2): 21–31.

State of Israel, 1995. National Health Insurance Law. [Online] Available at: *https://www.health.gov.il/English/Pages/HomePage.aspx* [Accessed 01 Apr. 2025].

Surender, R., Van Niekerk, R. & Alfers, L., 2016. Is South Africa advancing towards National Health Insurance? The perspectives of general practitioners in one pilot site. *South African Medical Journal*, 106(11):1092-1095.

Swanepoel, D. 2024. Is South Africa getting healthier? Inclusive Society Institute Occasional Paper 4/2024 https://www.inclusivesociety.org.za/post/is-south-africa-getting-healthier

Taherdoost, H., 2021. Data Collection Methods and tools: Tools for research; a step-by-step guide to choosing data collection techniques for academic and Business Research Projects. *International Journal of Academic Research in Management (IJARM),* 10(1):10-38.

Tamiya, N. et al. 2011. 'Population ageing and health care expenditure in Japan: for sustainable health care financing', *The Lancet*, 378(9796): 1051–1052.

Tamiya, N., Noguchi, H., Nishi, A., Reich, M.R., Ikegami, N., Hashimoto, H., Shibuya, K., Kawachi, I., and Campbell, J.C., 2011. Population ageing and wellbeing: lessons from Japan's long-term care insurance policy. *The Lancet*, 378(9797):1183-1192.

Tandwa, L A., and Dhai, A., 2020. Public engagement in the development of the National Health Insurance: a study involving patients from a central hospital in South Africa. *BMC Public Health*, 20:1584.

Tangcharoensathien, V., Patcharanarumol, W., Kulthanmanusorn, A., et al. 2020. The COVID-19 response and Universal Health Coverage in Thailand. *International Journal of Health Policy and Management*, 9(10): 466–474.

Tangcharoensathien, V., Witthayapipopsakul, W., Panichkriangkrai, W., Patcharanarumol, W. and Mills, A., 2018. Health systems development in Thailand: a solid platform for successful implementation of universal health coverage. *The Lancet*, 391(10126):1205–1223.

Tikkanen, R. and Abrams, M.K., 2020. U.S. health care from a global perspective, 2019: Higher spending, worse outcomes? The Commonwealth Fund. [Online] Available at: *https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019* [Accessed 18 Apr. 2025].

Triggle, N., 2015. Strong leadership is needed to ensure the NHS makes savings. *Nursing Management-UK*, 22(5).

Townsend, P., Phillimore, P. and Beattie, A., 2023. *Health and deprivation: inequality and the North*. Routledge.

Tromp, J. & Collins, S., 2020. Universal health care, but not universal access? *European journal of preventive cardiology*, 27(1):75-78.

Tsutsui, T. and Muramatsu, N., 2005. 'Care-needs certification in the long-term care insurance system of Japan', *Journal of the American Geriatrics Society*, 53(3):522–527.

West, R.L., Lippman, S.A., Twine, R., Maritze, M., Kahn, K. and Leslie, H.H., 2021. Providers' definitions of quality and barriers to providing quality care: a qualitative study in rural Mpumalanga Province, *South Africa. Journal of global health science,* 3(1); e1.

UK Government, 2006. National Health Service Act 2006. [Online] Available at: *https://www.legislation.gov.uk/ukpga/2006/41/contents* [Accessed 29 March. 2025].

UNICEF, 2021. Mozambique: Strengthening Health Systems for Women and Children. [Online] Available at: *https://www.unicef.org/mozambique/en/stories/strengthening-health-systems* [Accessed 11 Apr. 2025].

United Nations, 1948. Universal Declaration of Human Rights. [Online] Available at: *https://www.un.org/en/about-us/universal-declaration-of-human-rights* [Accessed 10 Apr. 2025].

United Nations, 1966. International Covenant on Economic, Social, and Cultural Rights. [Online] Available at: *https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights [Accessed 04 Apr. 2025].*

Usher, K.A., 2015. *The politics of health care reform: a comparative analysis of South Africa*, Sweden, and Canada. University of South Africa (South Africa).

Van den Heever, A., 2010. A financial feasibility review of the NHI proposal for South Africa: perspective on the national health insurance. *South African Health Review*, 2010(10:157-170).

Van den Heever, A.M., Dhai, A., Ballot, D. & Vellor, M., 2021. Corruption, leadership, and the corrosion of public health system capabilities in South Africa. Pandemics and Health Care, 1st Edn. Cape Town*: Juta and Company (Pty) Ltd*: 110-125.

Van Eijk, C.J and Steen, T.P., 2014. Why people co-produce: Analyzing citizens' perception of co-planning engagement in health care service. *Public Management Review*, 16(3):358-382.

Van Gaans, D. & Dent, E., 2018. Issues of accessibility to health services by older Australians: a review. *Public health reviews*, 39:1-16.

Van Rensburg, D., 1999. Health and health care in South Africa in transition*: a macro perspective. https://scholar.ufs.ac.za/bitstream/handle/11660/10260/academ_v31_n1_a1.pdf ?sequence=1&isAllowed=y*

Van Rensburg, H.C., 2014. South Africa's protracted struggle for equal distribution and equitable access is still not there. *Human resources for health*, 12:1-16.

Vearey, J.O., Modisenyane, M. & Hunter-Adams, J., 2017. Towards a migration-aware health system in South Africa: a strategic opportunity to address health inequity. *South African Health Review*, 2017(1):89-98.

Velasquez, M., Andre, C., Shanks, T. & Meyer, M.J., 1990. Justice and fairness. *Issues in Ethics*, 3(2): 1-3.

Victora, C.G., Barreto, M.L., do Carmo Leal, M., Monteiro, C.A., Schmidt, M.I., Paim, J., Bastos, F.I., Almeida, C., Bahia, L., Travassos, C. and Reichenheim, M.E., 2011. Health conditions and health-policy innovations in Brazil: the way forward. *The Lancet,* 377(9782):2042–2053.

Visagie, S., Schneider, M., Scheffler, E. and Schneider, M., 2015. The impact of health service variables on health care access in a low-resourced urban setting in the Western Cape*, South Africa. African Journal of Primary Health Care and Family Medicine*, 7(1):1-11.

Von Fintel, D. & Richter, L., 2019a. Intergenerational transfer of health inequalities: exploration of mechanisms in the Birth to Twenty cohort in South Africa. *BMJ Global Health*, 4(5), p.e001828. *https://gh.bmj.com/content/4/5/e001828*

Von Fintel, M. and Richter, L., 2019b. Intergenerational transmission of poverty and inequality: Evidence from the Birth to Twenty Plus cohort in South Africa. *South African Journal of Science*, 115(11/12):1–7.

Weeks, R.V., 2012. Health care services management: A systems perspective. *Journal of Contemporary Management, 9(*1):382-401.

Williams, J.S., Walker, R.J. & Egede, L.E., 2016. Achieving equity in an evolving health care system: opportunities and challenges. T*he American journal of the medical sciences,* 351(1) Bodenheim, 2005:66:33-43.

Witter, S., van der Merwe, M., Twine, R., Mabetha, D., Hove, J., Tollman, S.M, and D'Ambruoso, L., 2024. Opening decision spaces: a case study on the opportunities and constraints in the public health sector of Mpumalanga Province, South Africa. *PloS one*, 19(7): e0304775. *https://dx.doi.org/10.1371/journal.pone.0304775*

Whyle, E.B. and Olivier, J., 2024. Health system reform and path-dependency: how ideas constrained change in South Africa's national health insurance policy process. *Policy Sciences*, 57(3):663-690.

World Bank, 2021. Improving health infrastructure. [Online] Available at: *https://www.worldbank.org/en/topic/health/publication/improving-health-infrastructure* [Accessed 18 Apr. 2025].

World Health Organisation (WHO), 2022. Mozambique: Health System Strengthening. [Online] Available at: *https://www.who.int/mozambique/health-system-strengthening* [Accessed 16 Apr. 2025].

World Health Organisation (WHO). 2010. *Health Systems Financing: The Path to Universal Coverage.* Geneva: WHO.

World Health Organisation (WHO). 2020. Global progress report on water, sanitation, and hygiene in health care facilities: Fundamentals first. [Online] Geneva: WHO. Available at: *https://www.who.int/publications/i/item/9789240017542* [Accessed 01 Apr. 2025].

World Health Organisation (WHO). 2021. Health equity and universal health coverage in Africa: Past progress and future opportunities. [Online] Brazzaville: World Health Organization. Available at: *https://www.afro.who.int/publications* [Accessed 22 Apr. 2025].

World Health Organisation (WHO). 2024. Africa Health Workforce Investment Charter. *https://pesquisa.bvsalud.org/portal/resource/pt/who-376689*

Wronka, J., 2016. Human rights and social justice: *Social action and service for the helping and health professions*. Sage Publications.

Yes Media. 2026. *Ngaka Modiri Molema District Municipality (DC38) – Overview. Municipalities.co.za*. [Online]. Available at: *https://municipalities.co.za/overview/142/ngaka-modiri-molema-district-municipality* (Accessed: 3 Feb. 2026).

Yip, W., Fu, H., Chen, A.T., Zhai, T., Jian, W., Xu, R., Pan, Q., Hu, M., Zhou, Z., and Chen, Q., 2019. 10 years of health-care reform in China: progress and gaps in universal health coverage. *The Lancet*, (39410204):1192 -1204.

Young, M., 2016. Private vs. public health care in South Africa. *https://scholarworks.wmich.edu/honors_theses/2741*

Young, T., 2016. The role of public-private partnership in health care provision in South Africa. *Development Southern Africa*, 33(5):765-790.

Zahid, N., Ahmed, F., Israr, N., Ali, A., Farooq, S., and Syed, M., 2021. The Cuban Health Care System: An Insight. *Asian Journal of Medicine and Health*, 19(1):63-69.