GOOD GOVERNANCE AND THE IMPLEMENTATION OF NATIONAL HEALTH INSURANCE IN THE PUBLIC HEALTH SECTOR: A CASE OF SOUTH AFRICA

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Abstract

For years it has been argued that implementation failure is one of the main reasons why policies do not yield the results expected. In South Africa, a version of this argument, which often features, is that good policies are drawn up but then not implemented. Government failure is a reality. Just as corporations survive according to whether they make good decisions, so to governments fall or are re-elected on whether they make good decisions. General argument in governance literature is that a wide variety of developments have undermined the capacity of governments to control events within the nation state. As a consequence the state can no longer assume a monopoly of expertise or of the resources to govern.

Keywords: Good Governance, Public Policy, Policy Implementation, Accountability, National Health Insurance

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Introduction

The issue of poor service delivery and ineffective policy implementation regarding healthcare has received considerable critical attention of late. Dr Manto-Tshabalala-Msimang (Department of Health 2000) claimed that since 1994, the post-apartheid government and the Department of Health have developed and implemented a number of policies and pieces of legislation that impact directly and indirectly on the delivery of health services. South Africa has some of the world`s best policies, yet sometimes struggle with their implementation.

Pre 1994, public health services were fragmented to perpetuate discrimination. The system was founded on an apartheid ideology that was characterised by racial and geographical differences. The people, who needed health services the most, were denied such services. The dawn of democracy promised freedom and expectation of a better life for all as espoused in the 1994 Election Manifesto of the African National Congress. After 18 years, South Africa is still grappling with the remnants of apartheid and the challenges of transforming institutions and promoting equity in the health sector.

For many years it has been argued that implementation failure is one of the main reasons why policies do not yield the results expected. In South Africa, a version of this argument, which often features, is that good policies are drawn up but then not implemented. Meyer and Cloete argue that 'bad implementation' has been a major obstacle to progress in developing countries' (Meyer and Cloete 2006: 301). The government insists that the policy framework is transparent and well-defined and that what is needed is effective implementation. Regrettably, the transition of policy into practice is more complex than the perceived judgement of government. Critical concerns regarding issues about how policy can be effectively implemented and who should be responsible for implementing policy is one of major concern.

Ham and Hawkins (2003: 86) claim that the implementation of policies as a means of improving services in the health sector will vary depending on the degree of consistency between the values embedded in these policies and those held by actors in the system. Decisions on service delivery, policies and the implementation thereof, should be guided by constitutional requirements which aim to:

− Take steps to progressively realise the rights of everyone to have access to health care services;

− Promote and protect the right of children to basic health care services;

− Ensure that no-one is refused emergency medical treatment (sections 27(1) (a), (2) and (3) and section 28(1) (c) of the Constitution of the Republic of South Africa – 1996).

According to Cloete (1998: 159), policy making is a prerequisite in the provision of goods or services. Officials within the public health sector concerned with the formulation and the implementation of policy must always be aware of techniques that may be used to improve the performance of the actions involved. Policy making involves identifying needs, preparing legislation, and analysing existing policies

whilst policy implementation involves setting missions/objectives/goals, planning, programming, marketing of policy missions/objectives/goal and identifying and reporting shortcomings.

Good Governance as a Normative Concept of Governance

Chhotray and Stoker (2009) contend that the growing interest in governance is precisely because established institutional forms of governance appear under challenge and new forms appear to be emerging. Newman (2001: 11-12) in Fenger and Bekkers (2007: 16) writes that the general argument in governance literature is that a wide variety of developments have undermined the capacity of governments to control events within the nation state. As a consequence the state can no longer assume a monopoly of expertise or of the resources to govern, but must rely on a plurality of interdependent institutions and actors drawn from within and beyond government.

Hyden, Court, and Mease (2004) identify six fundamental principles that are widely accepted by researchers and governance stakeholders in developing and transitional societies around the world, 1) participation - the degree of involvement by affected stakeholders, 2) fairness - the degree to which rules apply equally to everyone in society, 3) decency - the degree to which the formation and stewardship of the rules is undertaken without humiliating or harming people, 4) accountability - the extent to which political actors are responsible to society for what they say and do, 5) transparency - the degree of clarity and openness with which decisions are made, and 7) efficiency - the extent to which limited human and financial resources are applied without unnecessary waste, delay or corruption.

A number of multilateral organisations including the International Monetary Fund (IMF), the World Bank and the United Nations Development Programme (UNDP) have deliberated on the elements of good governance. As the experiences of these organisations vary, so too, do their perceptions of what constitutes good governance. The IMF (2005: 1) suggests that good governance ensures the rule of law, improves the efficiency and accountability of the public sector, and tackles corruption. The UNDP (2005: 12) characterises good governance as participatory, transparent, accountable, effective and equitable. It promotes the rule of law and ensures political, social and economic priorities are based on consensus in society and that the voices of the poorest and most vulnerable are heard in decision-making.

Kofi Annan (1998: A21) recognised good governance as ensuring respect for human rights and the rule of law, strengthening democratization and promoting transparency and capability in public administration. In 1992 the World Bank argued that

good governance was an essential compliment to sound economic policies and although not easy to offer a simple definition of good governance it is possible to argue that corruption among government officials would destroy the fundamental basis of good governance. On the other hand poor governance is characterised by corruption and mismanagement which drain a countries resources and present a significant barrier to development and a lack of information exchange with citizens which prohibits public participation. (Alsayed, 2008: 78). According to the World Bank, some of the symptoms of poor governance include, 1) failure to make a clear separation between what is public and what is private, thus a tendency to divert public resources for private gain, 2) failure to establish a predictable framework of law and government behaviour conducive to development, 3) excessive rules and regulations which impede the functioning of markets and encourage rent-seeking, 4) priorities inconsistent with development, resulting in misallocation of resources, and 5) excessively narrow based or non-existent decision-making.

Government failure is a reality. Pound (1995: 81) points out that just as corporations survive according to whether they make good decisions, so to governments fall or are re-elected on whether they make good decisions. Pound argues that governance failure does not stem solely from bad managers, but emanate also from culture, behaviour, personalities, politics and motivation within the organisation. This statement is supported by Lumumba (2011: 41) who states that bad governance are decision making processes that are devoid of proper thinking processes and governance supported by weak institutions.

Dahl's (1971) definition of democracy is based on two essential elements namely political participation and public contestation. The former refers to the chance of all citizens to have a meaningful impact on the selection of both personnel and policies. The latter by contrast, concerns the supply of politics. There has to be meaningful competition of candidates for public office and policy solutions. These two elements define the essence of modern democracy. When it comes to inclusiveness a participative democracy aims at including the maximum number of citizens in public decision-making processes. Yet, only small minorities of people are actually interested in getting involved in democratic institutions (Talpin, 2011: 100 - 102). According to Doorenspleet (2002: 56) political regime is considered as democratic when it fulfils the requirements of inclusiveness.

Good Governance and Accountability

The concept of accountability and good governance cannot be overemphasised where accountability is considered the cornerstone of democracy. Druke (2007: 61) suggests that accountability is not

restricted to public governance - it is the basic principle of regulation and expectation in all social relations arguing that accountability is essential for the legitimacy of governance. In keeping with the argument of inclusiveness Druke states that citizens have the right to good governance based on the premise that the public administration must deliver high quality social services and allow participation in political processes. Saarenpää (2002: 10) points out that this is an old term given that the prevailing mentality was that citizens were subjects of government and the process of guiding governments towards serving the citizenry was overlooked. Druke (2007: 62) makes it clear that accountability is an important feature of good governance, not only in the sense of effective bureaucracy but also in the sense of democratic governance. He mentions that accountability facilitates good governance insofar as active involvement of citizens in transparent decision-making shapes good governance. This statement brings one to the understanding that citizens have a right to take an active part in governance and to have public services of good quality.

The African Development Bank (ADB) has identified five elements of good governance, 1) accountability is defined as the imperative to hold public officials, individuals and organisations charged with a public mandate, accountable to the public for actions and decisions from which they derive their authority. It also means establishing criteria to measure the performance of public officials, as well as oversight mechanisms to ensure that standards are met, 2) transparency is defined as public access to knowledge of the policies and strategies of government. It requires that public accounts are verifiable, that provision is made for public participation in government policy-making and implementation, and that contestation over decisions impacting on the lives of citizens are allowed for, 3) fighting corruption is seen by the ADB as a key indicator to commitment to good governance, a critical area for managing scare resources, 4) participation is a process whereby citizens exercise influence over public decisions. It should focus on the creation of an enabling regulatory framework and economic environment in which citizens and private institutions can participate in their own governance, generate legitimate demands and monitor government policies and actions, and 5) legal and judicial framework in which laws, regulations and policies that regulate society are clear, fair and consistently applied through and objective and independent judiciary. An effective legal framework promotes the rule of law, respects human rights and protects private capital flows (ADB, 1999: 2-3).

Governance and Its Actors

Crucial to governance concepts is the increasingly important role of non-state actors, among them multinational corporations, NGOs and social movements. A narrow definition of non-state actors formulated by Judge (1995) claims that NGOs mediate between the state and its citizens taking over essential functions pertinent to sustain democratic culture. These non-state actors can be categorised into firms and industrial groups on the one hand and NGOs and civil society on the other hand. Both these categories appear on the world stage and appear to take over governance (Abbott and Snidal, 2009: 506). Whereas traditional governance comprises mandatory laws and regulations, centralised authority and bureaucratic expertise, governance encompasses soft law, state orchestration and broad participation characterised by decentralised authority and dispersed expertise (Abbott and Snidal, 2009: 520). The emerging collaboration of diverse actors enable pursuing common goals while combining complimentary competencies along with sharing expertise, capacities, resources and commitment (Abbott and Snidal, 2009: 526).

Given the growing involvement of non-state actors in governance helps to lower the pressure on the state, it has also been linked to a number of governance failures (Taulbee, 2000). According to Howe (1998) decreased transparency and accountability are among the most frequently noted problems with the growing role of non-state actors in governance. According to Kennett (2008: 210) one way in which the emergence of governance is challenging established norms and decision-making arrangements is with the dissolution of state sovereignty and clear lines of responsibility. While under governmental arrangements political responsibility rests with the legislative and executive, in governance it is distributed among a multiplicity of public and private actors. Since these actors cooperate in the making and implementation of policies, no singe actor can be held responsible for the outcomes of this process.

Challenges of Health Disparities

The public service as a whole in South Africa prior to 1994 was characterised by poor quality of services, ineffectiveness and lack of commitment. The system was founded on an apartheid ideology that was characterised by racial and geographical differences. For those living in poor rural communities, access to healthcare was difficult. The first democratic election in April 1994 was an important landmark in the history of South Africa. Effectively, an end to white minority political rule was initiated and replaced by the adoption of a progressive constitution. In particular, section 27 (1) of the Constitution of the Republic of South Africa (Act 108 of 1996) states that: everyone has the right to access healthcare services.

Sarkin (1999) points out that South Africa's human rights record is appalling, largely due to

apartheid which affected almost every sphere of South African life, including access to healthcare. In the past, where healthcare was available it was delivered in a discriminatory manner. During the first five years of democratic governance much progress has been made to combat the legacy of apartheid and deliver equitable health to all South Africans. The first democratic parliament passed a number of new, often controversial pieces of legislation supported by regulations aimed at ensuring a more accessible and cost-effective healthcare system. However, in many cases, legislation was driven without adequate consultation and negotiations, which led to resentment on the part of the affected parties. Unfortunately, the increase in health legislation has been hampered by a shortage of skilled personnel in health law which in turn has inhibited the evolution of a coherent health law structure at both national and provincial levels. The health sector is still a long way from providing the population with proper health services. According to Coovadia, Jewkes, Barron, Sanders and McIntyre (2009) the country is plagued by four major health problems namely; 1) HIV/AIDS and TB, 2) maternal, infant and child mortality, 3) non-communicable diseases and 4) injury and violence.

A chronic misalignment of resources between the public and private sectors is perhaps the most common criticism of the healthcare system in South Africa. The need to address the inefficient and inequitable distribution of resources between these two sectors relative to the population served by each is a significant challenge. There is more than twice as many hospital beds per beneficiary of private hospital services as there are for those dependant on the public sector. The disparities are even greater in relation to health professionals where pharmacists in the public sector serve between 12-30 times and each generalist doctor in the public sector serves 7-17 times more people than those in the private sector. There is a six fold difference in the number of people served per nurse, and a 23 times difference in the number of people served per specialist doctor working in the public sector in South Africa.

Reform in the public health sector was necessary to redress the past imbalances that existed (ANC General Council on NHI 2010: 13).

Lack of funding in the health sector is compounded by severe human resource shortages. According to the ANC (2010: 10) there is a serious misdistribution of health workers in the country, with 60% serving 85% of the population using the public health sector. Most of the health workers work in urban areas while there is a serious shortage in the rural areas. Nurses form the backbone of the healthcare system and yet they are in short supply. This is largely due to a number of factors including cuts in provincial budgets and the closure of nursing colleges which has resulted in fewer nurses being trained. But, even those who were trained do not all

go to practice in this country. Some leave the country to seek greener pastures in countries such as Saudi Arabia, Canada, Australia and the United Kingdom.

Linked to the issue of nurses is the shortage of medical practitioners and all other allied professionals. Access to quality healthcare for the majority of South Africans using the public health sector is negatively affected by inadequate supply of medical practitioners and allied professionals. Many migrate to developed countries citing reasons such as crime, deteriorating conditions in the public sector, better pay abroad and active foreign recruitment. These are challenges that the state must address if South Africa is to retain the doctors that it trains at R780 000 per doctor (Breier and Wildschut, 2006).

The shortage of key health professionals is being experienced at a time when the size of the population dependent on public health services has been increasing, and the burden of ill-health among the population primarily due to the HIV/AIDS epidemic is increasing. This has placed incredible strain on public sector health services, and on the staff who work in public sector facilities (ANC General Council on NHI, 2010: 11).

Another challenge facing the public health sector is the shortage of drugs at public health facilities especially AIDS drugs and the ability to access medicines at lower prices. The private sector on the other hand has an over-supply of pharmacies resulting in pharmacies being located in close proximity to one another in urban areas. The rural population on the other hand has little or no access to pharmacies. This misdistribution is the result of the disproportionate healthcare financing system. Despite government efforts to reduce the prices of medicines in the private sector, they remain unaffordable to the majority of South Africans (ANC General Council on NHI 2010: 11).

An added challenge is translating health policies into practice. Meyer and Cloete (2006: 301) argue that bad implementation has been a major obstacle to progress in developing countries – a comment which this chapter argues is applicable to South Africa. While the government insists that the policy framework is transparent and well defined, regrettably the translation of policy into practice is more complex than the statements of the government. There remain critical issues about how policy can be effectively implemented and who should be responsible for implementation.

In the NHI Policy Proposal - Republic of South Africa (2009), it is stated that the rationale for introducing NHI is to remove the current tiered system where those with the greatest need have the least access and have poor health outcomes. The Taylor Committee Report of 2002 provides a vision for the transformation of healthcare reform. The Taylor Report (2002: 101) recommends that South Africa shift towards a NHI system based on multiple funds and a public sector-related environment. This is

an essential document on healthcare reform and the recommendations are still being applied.

Past Attempts at NHI

The Green Paper on NHI - Republic of South Africa (2011) states that the history of healthcare reform actually dates back more than 80 years. NHI was recommended in 1935 for whites. However, the proposal was never taken forward. The World Health Organisation (WHO) (2000:13) reveals the attempted introduction of a National Health Service in South Africa in the 1940s, stating that a scheme for a national health service similar to the British model was recommended in South Africa in 1944. Such a scheme was to consist of free healthcare and a network of community centres and general practitioners as part of a referral system, but it was not implemented. The Green Paper mentions that, during the period 1942-1944, a commission led by Dr Henry Gluckman, called the National Health Service Commission, was set up. It proposed the implementation of a National Health Tax to ensure that free health services be provided to all South Africans. The Gluckman Commission proposals were accepted by the government led by General Jan Smuts; however, it was decided to implement them as a series of measures rather than in a single phase. Advances from the Gluckman Commission process were reversed after the National Party (NP) government led by General DF Malan was elected in 1948 (Phillips, 1993: 1037- 1039).

The Green Paper confirms that by the early 1990's interest had again turned to the prospect of introducing some form of mandatory health insurance. After the 1994 elections, there were numerous policy initiatives that considered either social insurance or NHI. According to the Healthcare Finance Committee of 1994, it was recommended that all formally employed individuals and their immediate dependents should form the core membership of Social Health Insurance (SHI). This would eventually be expanded to cover other groups over time. It was proposed that a comprehensive set of services be covered under such a system and that both public and private providers be involved (Doherty, McIntyre and Gilson, 2003: 47 - 58). The 1994 Finance Committee was followed by the 1995 Commission of Enquiry on NHI which fully endorsed the recommendations of the Health Finance Committee. In 1997, the SHI Working Group developed the regulatory framework that resulted in the enactment of the Medical Schemes Act in 1998. This Act was meant to regulate private health insurance. However, the level of coverage for the national population has remained below 16 percent and is only affordable to the relatively well-off (Gilson, Doherty, McIntyre, Thomas, Brijlal, Bowa and Mbatsha, 1999: 4).

The White Paper states that Professor Vivienne Taylor was appointed in 2002 by the Department of Social Development to chair the Committee of Enquiry into a Comprehensive Social Security for South Africa following principles outlined in the White Paper. The Commission proposed that there should be mandatory cover for all those in the formal sector earning above a given tax threshold and that contributions should be income related and collected as a dedicated tax for health. The Committee further recommended that the state should establish a national health fund through which resources would be routed to public facilities through the government budget process.

The Department of Health established the Ministerial Task Team on SHI in 2002 to implement the recommendations of the Taylor Committee. The task was to draft an implementation plan with proposals on how to advance towards SHI. In addition, the team had to create supporting legislative and institutional mechanisms to influence the long-term result in the enactment of legislation of NHI in South Africa. However, the path to achieving universal coverage was not widely supported resulting in the supporting proposals being stalled. The Ministerial Advisory Committee on NHI was established in August 2009. The committee was tasked with providing the Minister of Health and the Department of Health with recommendations regarding the relevant health system reforms relating to the design and roll-out of NHI. This was to carry forward the resolution passed at the ruling party's (ANC) conference in December 2007 in Polokwane.

Proposal for NHI

Given the specific burden of disease that plagues South Africa it is necessary for the formulation of a National Health Insurance (NHI) system. The proposed NHI according to McIntyre (2011) is about attaining a universal health system which means that everyone enjoys financial protection from high healthcare costs; and everyone is able to access good health services. The reality however for millions of South African citizens is that they do not receive appropriate healthcare from the public health sector. NHI is intended to address this reality.

A Green Paper outlining the government's broad policy proposals for NHI was released in August 2011. The significant inequity in healthcare delivery to the South African population makes it essential that government arrives at a solution that is equitable and sustainable. Therefore, the green paper was seen by many as a welcome document. It forms part of a multi-faceted approach which includes infrastructure and improving human resources. The proposals have been reviewed and supported by the National Planning Commission (Sunday Times 2012: 12).

There is little doubt that the NHI will require funding 'over and above current budget allocations to public health', funding options are identified as payroll tax, surcharges on taxable income and increased Value Added Tax (Republic of South Africa 2012a: 25). The longer term depends on further uncertainties, related to 'institutional reforms and health service delivery capacity', a statement implying better performance if not referring to it directly. There are also risks because of the amount of money entailed. Public health services now stand at about 4% of Gross Domestic Product and could reach 6% by 2025 (Republic of South Africa 2012b: 81). Performance management will have to be effective to ensure that value for money is attained. An Office of Standards Compliance has been established in the Department of Health to 'improve monitoring and raise standards across all health facilities'; it will eventually become an independent public body (Republic of South Africa 2012b: 84).

Led by Dr Aaron Motsoaledi, the Minister of Health since 2009, the NHI proposal is a plan to redirect the public health system. According to the Minister for the NHI to succeed there are two critical things that the country must do:

*"Improvement of quality of service in public hospitals must be non-negotiable and pricing of healthcare in the private sector must be tackled equally seriously" (*Department of Health media statement by the minister of health on NHI, 2011).

Pointing out that only 16% of the population have private cover (medical aid), Dr Motsoaledi argues that a system is needed to provide better healthcare for all citizens (Department of Health 2012: 14). These sentiments were echoed in the recently released National Development Plan which points to a 'crumbling health system and a rising disease burden' requiring major reform, including better management at institutional level (Republic of South Africa, 2012c: 51).

The proposals entail a system of contributions for universal care to be paid in advance of an illness. The broad plan is for these contributions to be made by individuals (presumably families), employers and the state. There is no doubt that this effort represents a significant attempt to redistribute both the payment for, and the availability of, healthcare: 'An important consideration is that the revenue base should be as broad as possible in order to achieve the lowest contribution rates and still generate sufficient funds to supplement the general tax allocation to the NHI (Republic of South Africa 2011: 35). A similar reform is currently being introduced in Kenya so that low income and unemployed Kenyans may have better access to healthcare (Adera 2012: 10).

The green paper makes it clear that NHI is a long-term project that will be rolled out over 14 years. The first five years will focus on building the health sector and preparing for NHI. The paper states that the primary phases of NHI will focus on improving the services of the public healthcare system. The green paper introduces the start of a complete transformation of the country's health system which would begin in a pilot phase in 11 districts. In an interesting article titled "health within a comprehensive system of social security: is national health insurance an appropriate response"? A keynote address by the previous minister of health, Dr Tshabalala-Msimang (2008: 7-8) revealed that it took Germany close to 100 years to achieve an inclusive social health system. On the other hand, it took South Korea only 12 years to cover the whole population, including the poor and the unemployed. Dr Tshabalala-Msimang mentioned that solidarity is a crucial foundation for healthcare financing (general tax and compulsory health insurance) where some countries such as the United Kingdom (UK) and Sweden chose the tax route while others such as France and Germany have chosen the insurance route.

On the 22nd March 2012, Dr Motsoaledi announced the 11 districts where the NHI pilot programme will be rolled out. The 11 districts represent a district in each of the nine provinces, with three sites identified in KwaZulu-Natal. Motsoaledi mentioned that two districts were identified in KwaZulu-Natal because it has the second largest population in the country and it has the highest burden of disease. According to Motsoaledi, the programme was to begin on the 1stApril 2012 because it coincides with the beginning of the financial year (Department of Health Government Information, 2012).

This marks the start of the three phases of the NHI, which will be implemented over 14 years where the first phase will focus on the strengthening of primary healthcare and service delivery. The districts were selected according to their demographic composition, their socio-economic situation and burden of disease. The selected NHI pilot districts per province are:

- Eastern Cape – OR Tambo;
- Mpumalanga – Gert Sibande;
- Limpopo – Vhembe;
- Northern Cape – Pixley ka Seme;
- KwaZulu-Natal – uMzinyathi, uMgungundlovu and Amajuba;
- Western Cape – Eden;
- North West – Dr K Kaunda;
- Free State – Thabo Mofutsanyane; and
- Gauteng – Tshwane.

The pilot tests are the building blocks for the successful implementation of NHI. The programme will focus on the most susceptible sectors of the country and aims to strengthen the operation of the public health system. The National Development Plan takes the view that, for the pilot phase to work well, the following are needed: more personnel, new forms of managerial authority and stronger statutory structures for community representation (Republic of South Africa 2012c: 52).

It is intended that doctors in private practice will be instrumental in strengthening the success of the government's proposed NHI. According to the Minister of Health, the Department of Health (DOH) will guarantee the payment of private general practitioners, who work in public clinics in the NHI pilot districts. However, the NHI has not been universally welcomed by those who benefit from the status quo. This is one of the reasons why the debate has become quite heated, as noted by a distinguished Australian health economist who observed much of the anger and resistance coming from the private medical schemes and healthcare providers (Mooney 2011: 3).

Encouraging foreign doctors to work in rural areas could reduce staff shortages. However, the Health Professions Council of South Africa tends to be slow to register these doctors. Staff appointments take up to 5 months to be approved. The government has the prime responsibility of ensuring access to healthcare for all, especially for the most vulnerable groups. It is important for government to ensure that services are brought closer to the people and the communities be made aware of services being rendered pertaining to how, when and where. The government must ensure that hospitals and clinics have fully equipped offices with staff who display the necessary knowledge and skills.

Conclusions

From the beginning of the 21st century good governance principles have been practiced all over the world, based on the concept of reinventing government, implementing policy changes and instilling good practices. As a policy approach good governance is aimed at increasing the public sectors efficiency and citizen satisfaction from having a responsible and committed government. From a global perspective good governance is aimed at learning and sharing knowledge among scientists, practitioners and policymakers.

South Africa is building a better understanding of what NHI is and why it must be implemented. There will probably remain many who question the policy for good and bad reasons, so continued consultation and dialogue by all players in society will be essential. The National Department of Health (NDoH) has agreed on a timetable for implementing the NHI, which is ambitious by international standards, but definitely possible. This review has shown that there has been good progress in many areas but in others there is still considerable work to be done. It will take time for these major changes in the financing and delivery of services to impact on people's lives. Universal coverage is no longer a dream for the country and if all players work together it will become an increasing certainty. NHI is only a funding mechanism and not a general panacea for South African healthcare – delivery is essential and

will need careful examination in the existing South African context of poor public health systems. Therefore, the many failings in our health system are based on design faults that continue to entrench inequities, disparities in health outcomes and unfairness in access to quality healthcare. With such a big policy change we are likely to encounter implementation challenges.

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