

RESEARCH ARTICLE

South African National Health Insurance Policy Process 2007-2019: Private and third-sector lessons for BRICS Countries

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Abstract

This paper examines the South African National Health Insurance (NHI) policy process from 2007 to 2019, focusing on the lack of implementation and the limited involvement of the private sector and civil society. Using summative thematic content analysis and applying the Multiple Streams Framework (MSF), the study investigates factors contributing to delays in policy execution. Key findings include challenges in evidence-based policymaking, value judgments, ideological influences, interest group power, misunderstandings of incremental and non-incremental reforms, lack of risk analysis, and compliance issues. The research provides valuable lessons and recommendations for improving NHI policy processes in BRICS countries, emphasising the role of the private and third sectors, regardless of the government's level of involvement. This analysis offers insights into the complexities of achieving universal health coverage (UHC) and the importance of inclusive, collaborative reform strategies.

Keywords: NHI Policy Process, Health Reform, Universal Healthcare, Public Policy, Systematic Rapid Review.

JEL classification: H2, 01, C33, 055

1. Introduction

Cost-effectiveness, governance, and reform are parameters that are critical to achieving universal health coverage (UHC). The interstate association of the Federative Republic of Brazil, the Russian Federation, the Republic of India, the People's Republic of China, and the Republic of South Africa (BRICS) countries, can learn about and cautiously apply health reform policy issues (Gupta and Chowdhury, 2020). While there is notable success reported in Brazil and China in achieving the global goal of UHC, the emphasis on primary health care is more prevalent in South Africa and Russia, while India is still further behind (Rao et al., 2014; Tediosi et al., 2016; Hisham et al., 2018; Gupta and Chowdhury, 2020). Gupta and Chowdhury (2020) state problems in health financing, strengthening primary healthcare, private-public partnerships, and decentralisation. South Africa has decided to address the UHC issue through a National Health Insurance (NHI) policy. The South African NHI policy development process offers significant learning opportunities for BRICS nations and global health policy frameworks about UHC implementation challenges. There are

variabilities in the process of attaining UHC among BRICS countries. For example, Brazil and China achieved substantial progress towards UHC through large public investments and strong primary healthcare systems, but South Africa, together with Russia and India, still face systemic inefficiencies, financial limitations and stakeholder conflicts (Rao et al., 2014; Tediosi et al., 2016). Brazil achieved swift UHC through strong political leadership, while India's fragmented health governance resulted in inconsistent UHC adoption (Gupta & Chowdhury, 2020). The centralised nature of Russia's policy-making generates stakeholder engagement obstacles that parallel South Africa's struggle to achieve harmony between government reforms and private-sector involvement (Hisham et al., 2018). These examples show that sustainable health system reforms depend on designing policies suited to specific contexts and engaging multiple stakeholders through adaptive governance. Examining BRICS countries' political economy related to health policy reveals wider effects on international health governance, necessitating adaptable policy structures to manage various institutional setups and economic limitations.

The World Health Organisation (WHO) defines universal health coverage as "a system whereby all individuals and communities can access the quality health services they need, without suffering financial hardship". The South African healthcare system inherited post-1994 is argued to be skewed by income and geography (Coovadia et al., 2009; Mayosi et al., 2012). Previous frameworks, such as the Refugees Act of South Africa and the 2007 Department of Health circular, stipulate that refugees and asylum seekers, documented or undocumented, can access the same health services and payments as South African citizens. These provisions have strained the healthcare system with the influx of immigrants into South Africa, mostly from neighbouring countries such as Zimbabwe, Mozambique and Malawi (Coovadia et al., 2009; Mayosi et al., 2012; Mayosi and Benatar, 2014; Walls et al., 2016). Additionally, the frequency of non-communicable diseases and the HIV/Aids pandemic in South Africa exacerbates the socio-economic and health challenges (Coovadia et al., 2009; Mayosi et al., 2012; Mayosi and Benatar, 2014; Walls et al., 2016). The Coronavirus Disease (COVID-19) outbreak in December 2019 which was declared a Public Health Emergency by the World Health Organisation, further burdened the South African Health System.

Access to adequate health care is enshrined in the constitution of South Africa unequivocally to all citizens alike (Constitution of South Africa, 1996). However, it is well documented how South Africa's healthcare system suffers from the effects of apartheid, resulting in inequality, and hence is constrained in its ability to fulfil this constitutional right (Coovadia et al., 2009; Mayosi et al., 2012; Walls et al., 2016). Thus, the South African government is correcting these disparities through a government-administered, single-tier Nation Health Insurance (NHI) (McIntyre and van den Heever, 2007; Madore et al., 2015). However, a major criticism cited by many stakeholders is on content, structure, governance, operations and financing of the NHI policy. (Council for Medical Schemes, 2012; Nkosi, 2014; Madore et al., 2015; Mhlaba et al., 2016; Surender et al., 2016; Armstrong et al., 2017). While these concerns are important, they do not provide a critique of the policy process, which is crucial in implementing the policy.

After more than ten years of apparent policy commitment towards the National Health Insurance (NHI), the policy is no closer to concrete implementation. Much was written about the NHI proposals, and little consideration was given to the processes that produced the content and technical design options. Furthermore, while the private and third sectors of South Africa have been vocal about the gaps in the policy processes and the challenges thereof, no systematic review has been provided to the best of our knowledge on their contributions to the NHI and the policy process. However, a systematic assessment of the NHI policy process to date and its potential relationship with the policy outcomes, whether good or bad, has not been conducted. Against the backdrop of the lack of implementation, using multiple streams framework (MSF) as a lens, this paper assesses the NHI policy process to examine the relationship between the process and the resulting policy outcomes. The focus is solely on the NHI policy process from 2007 to 2019

This study aims to explore the South African National Health Insurance (NHI) policy process from 2007 to 2019 and investigates the causes of implementation delays while assessing the influence of private sector and civil society groups. The Multiple Streams Framework (MSF) serves as an analytical tool to examine policy formulation processes which feature competing interests alongside uncertain decision-making contexts (Kingdon, 1984). The MSF suggests policy change takes place when three independent streams—the problem stream, policy stream, and politics stream—come together at a pivotal moment to create policy action opportunities (Zahariadis, 2007). In NHI discussions, the problem stream represents healthcare access inequities and financial limitations (Coovadia et al., 2009), but the policy stream includes different proposals and institutional analysis, according to McIntyre and van den Heever (2007). The politics stream focuses on electoral dynamics, interest group lobbying efforts and governmental decision-making mechanisms (Surender et al., 2016).

By using the MSF, this study demonstrates how interactions between these streams influenced policy outcomes. The framework explains why, despite commitments to universal health coverage, the NHI policy process has faced persistent delays and opposition (Mayosi & Benatar, 2014). Additionally, the MSF helps clarify policy inertia and incrementalism, illustrating how shifts in political leadership and economic conditions impacted NHI reform efforts (Tediosi et al., 2016). Understanding these dynamics offers valuable lessons for other countries facing similar health system reform challenges.

2. Methods and Materials

A qualitative case study approach explored the South African NHI policy process (2007 – 2019). The method uses secondary data from existing data from the dataset instead of primary research (Cheng and Phillips, 2014; Ruggiano and Perry, 2019).

2.1 Protocol, inclusion and exclusion criteria

The inclusion criteria for all these articles were consistent with those used for all the academic literature. Nevertheless, the first check for inclusion was whether the title contained any search terms specified below. Second, inclusion criteria were based on whether the content answered any of the questions relevant to the composition of the different elements of the theoretical framework, as presented in Figure 3 below. If they did not, they were excluded. These, in turn, seek to answer the main research question and the sub-questions and ultimately achieve the research objectives. Another exclusion criterion was the language. All articles not in English (two) were excluded. The last exclusion criterion was if the file was corrupt (one).

The academic literature included peer-reviewed journal articles. The documentation provided information-rich political, contextual, social, cultural and economic data. Articles were included if the titles and abstracts contained search terms. This was done using the search terms elaborated in the data collection and search criteria that follow. Scopus was the central database used for this research article. The reference lists of selected papers were also searched to get more information that might have been overlooked in the selected articles. However, due to financial and time constraints, non-English articles were excluded. Furthermore, articles older than 2007 were excluded (from 2006 going backwards).

2.2 Data collection and search criteria

We conducted an iterative, rapid, systematic literature review to ensure rigour and clarity. All academic literature was searched using the keywords: "South Africa national health insurance" OR "South Africa health reforms" OR "South Africa health reform process" OR "South Africa health policy process" OR "South Africa health policy outcomes" OR "South Africa NHI policy" OR "South

Africa NHI policy process" OR "South Africa national health insurance policy process outcomes" OR "South Africa NHI failure" OR "South Africa policy approaches to health reform". These were searched for in the abstracts and titles. Keywords used in the website search for the titles included: "NHI"; "South African NHI"; and "National Health Insurance".

Furthermore, a Google Scholar search was performed on other academic documents. Their reference lists were also searched for additional relevant literature to address the research questions. The search words used for this literature are path dependency, elite theory, policy process, health reforms, multiple systems frameworks, incrementalism and group theory. Finally, the titles and abstracts were read to eliminate studies irrelevant to answering the research questions. The study admits there are a plethora of articles resulting from the search words used, and not all of them could be explored to achieve the objectives of this study. Therefore, care was taken to focus more on recently published articles that were not more than ten years old. Seminal articles that were older than this were also included. After searching ten to fifteen pages for each search, term saturation was reached, and no new data was discovered. We proceeded to compose the write-up. Most importantly, all titles and abstracts that were deemed irrelevant were excluded. Lastly, not all documents reviewed for full content were used, as they did not directly address the research problem and questions.

2.3 Sampling, screening and selection

For grey and academic literature, searches were conducted and screened according to the inclusion and exclusion criteria described above by a single reviewer (one of the authors). Due to time and financial constraints, no second reviewer was used. For these reasons, the verification for the inclusion of full text according to the inclusion and exclusion criteria was also conducted by one reviewer (one of the authors). Scopus was the database of choice for this research. It provided a database that produced peer-reviewed literature, which we could access. As for the academic literature, titles and abstracts were screened, and only relevant full texts were engaged further. Whereas, for grey literature, full texts were engaged only on the merit of screening the titles of the grey literature against the inclusion criteria for grey literature. The results of the process are shown in Figure 1 below:

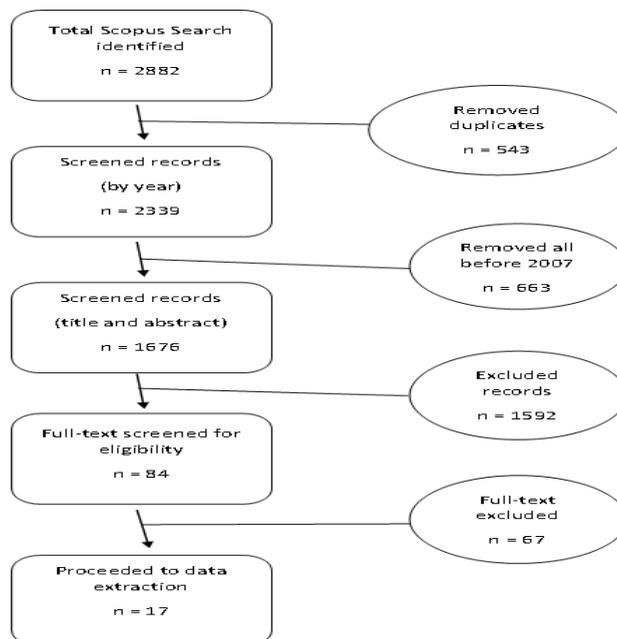


Figure 1. Flow chart for study selection

2.4 Data analysis

We performed a document review consistent with Bryman and Burgess (2002) and Neuman (2011), who argue the importance of assembling and investigating qualitative data to highlight and generate meaning. An adaptation of McMillan and Schumacher's (2014) analysis of data is shown in Figure 2. However, this linear process was iterative throughout the research process.

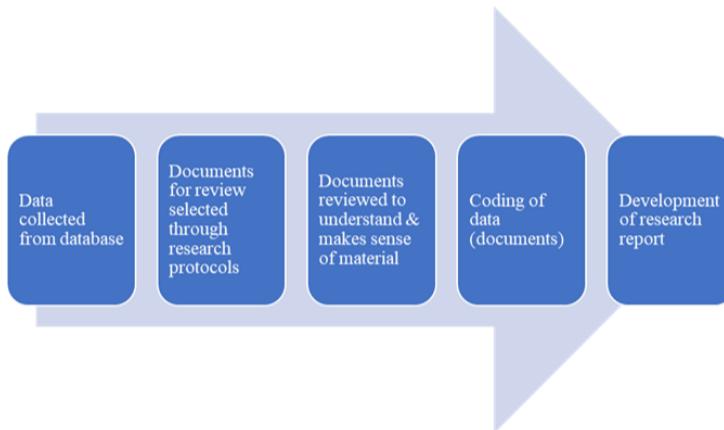


Figure 2. Data analysis process

The questions were generated through coding of various literature on the policy process and questions to ask regarding the policy process (Unit, 2003; World Health Organization, 2005; Maetz and Balié, 2008; Benoit, 2013; Witter et al., 2013; De Leeuw and Peters, 2015; Madore et al., 2016; van Niekerk, 2016). Additionally, this process was facilitated using an Excel sheet with responses to the various categories. These responses were then colour-coded to develop the sub-themes/issues/ drivers. As a result, quotes, summaries and paraphrases were also elucidated, enabling us to derive understanding, values and ideas that were substantial to the research. However, these were guided by the theoretical framework.

3. Theoretical Framework

Kingdon developed the Multiple Streams Framework (MSF) in 1984, which serves as a leading theory for both agenda-setting and policy evaluation processes (Exworthy 2008; Liu et al. 2010; Nowlin 2011; Söderberg & Wikström 2015). MSF stands out for its analysis of the NHI policy process since it offers a detailed understanding of policy development's complex dynamics and fragmentation within South African contexts (Zahariadis, 2007). The MSF examines how different actors, such as policymakers, interest groups, and the media, identify and shape the issue of equitable healthcare access (the problem stream), which plays an essential role in the NHI policy process (Zahariadis, 2007; Walt et al., 2008). It also facilitates the exploration of the policy solutions (the policy stream) put forward by health experts and other stakeholders and the political context (the politics stream) influenced by party politics, legislative turnover, and national mood, all of which play a critical role in shaping the trajectory of NHI (Zahariadis, 2007; Walt et al., 2008). Moreover, the MSF's focus on the "window of opportunity" enables an analysis of the moments when the three streams align, particularly in times of political change, health crises, or shifts in public opinion, which are key to understanding how and when NHI policies may advance or stagnate (Exworthy, 2008; Nowlin, 2011).

Thus, MSF provides a comprehensive framework for analysing the interplay of multiple factors and actors involved in the NHI policy process, making it an appropriate choice for this research. This is summarised in Figure 3.

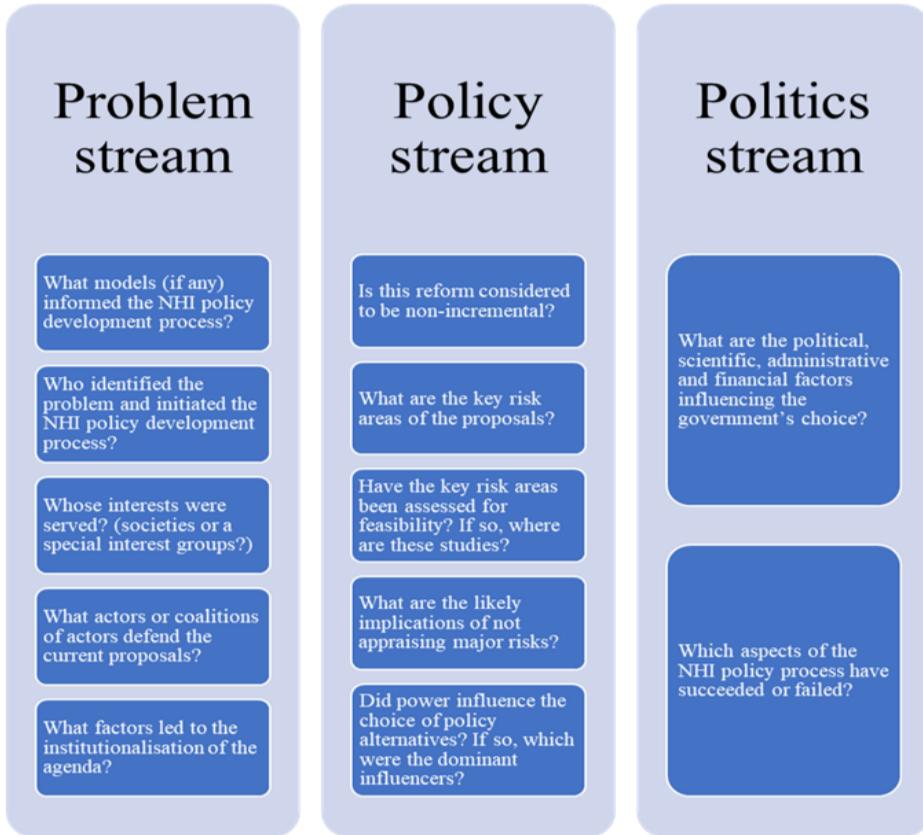


Figure 3. Systematic review of the content of the various documents

4. Brief NHI Overview Within BRICS

Studying South Africa's NHI policy process uncovered critical insights about broader health policy challenges in BRICS countries while identifying shared obstacles and drivers that affect UHC attainability. Brazil has achieved considerable progress in primary healthcare expansion and digital health integration during recent years which provides a useful example for South Africa and other BRICS countries (Andrade et al., 2018; Garcia -Subirats et al., 2022). China's strong healthcare financing systems along with their investment in public health infrastructure led to major progress in UHC which provides beneficial insights for South Africa's NHI policy (Yang et al., 2021). The research positions South Africa's experience within a wider framework to demonstrate how political dedication, stakeholder collaboration and flexible policy systems propel enduring health reform initiatives throughout BRICS nations (Acharya et al., 2014; Michel, Obrist, et al., 2020; Michel, Tediosi, et al., 2020).

Global health policy implications are further evident in the shared challenges of healthcare financing and equitable resource allocation among BRICS nations. Russia's struggle with healthcare funding constraints and India's ongoing efforts to improve access to healthcare services illustrate the critical need for effective health financing strategies and collaborative policy development (Rao et al., 2014; Jakovljević, Lamniso, et al., 2017; Jakovljević, Potapchik, et al, 2022). The study emphasises the necessity of adopting a multifaceted approach to health policy, drawing on successful elements from BRICS countries to address South Africa's unique healthcare challenges. By integrating these comparative insights, the paper contributes to the global discourse on UHC and provides actionable recommendations for policymakers in BRICS nations, aiming to achieve equitable and effective health systems (Sahoo et al., 2023).

5. Results

5.1 Problem Stream

South Africa's party-based electoral system creates a blurred line between party policy and government policy, as political parties often use their manifestos to shape governmental agendas (Brooks, 2004; du Toit & de Jager, 2014). Consequently, party ideologies and value judgments frequently become those of the government. The National Health Insurance (NHI) policy gained traction on the political agenda through arguments advocating that it would reduce healthcare inequality. Key ideologies driving the NHI policy agenda include the constitutional right to healthcare, addressing systemic inequality, fostering social solidarity, promoting efficiency, prioritising health over profit, and leveraging evidence for effective decision-making (Ncayiyana, 2008; Naidoo, 2012; Financial Intermediaries Association, 2019). Surender et al. (2016, p. 1092) further emphasise the political vision of creating an equitable, universal, and integrated healthcare system underpinned by values of social solidarity and redistribution. This was compounded by patronage that overlooked practical considerations to ensure South Africans receive quality healthcare (Preuss, 2016). The document review distinguishes two distinct phases in the NHI's policy trajectory: first, the African National Congress (ANC)-led process beginning with the 2007 Polokwane Conference, followed by the formal government process initiated in 2009 when the South African President confirmed plans for NHI implementation. This progression culminated in the issuance of the NHI Green Paper in 2011 (Mkhwanazi, 2015). The debate surrounding a comprehensive mandatory health insurance system has been ongoing since 1994, and the window for its initiation materialised during this period. Bateman (2010) asserts that NHI emerged on the policy agenda largely through an evidence-based approach, with over 80 studies purportedly reviewed, though the public has yet to see these studies. The Financial Intermediaries Association (2019) contends that contextually relevant policy derives from comprehensive research, with policy initiatives like pilot projects from 2012 constituting the sole publicly accessible evidence of research-driven policymaking.

Despite claims of an evidence-based approach, the NHI's emergence on the policy agenda coincided with a significant political opportunity—the 2009 elections. The ANC's 2007 Polokwane conference acted as a critical juncture, with key stakeholders like the Congress of South African Trade Unions (COSATU) pushing for NHI prioritisation to secure electoral support (Katuu, 2018). Prior to 1994, COSATU had influenced ANC policy through its advocacy for redistributive policies such as the Reconstruction and Development Programme (RDP), which sought to promote social equity (Nevondwe & Odeku, 2014; McIntyre, 2002). The document review underscores how the party-driven process of winning elections paved the way for the institutionalisation of the NHI policy. Following the 2009 elections, a new Minister of Health further propelled the NHI agenda, despite the resistance of opposition parties, academics, labour unions, and non-governmental organisations (NGOs) with competing interests (Business Watch, 2011; Xaba, 2018). Some actors, such as the Dullah Omar Institute (2019) and the Helen Suzman Foundation (2019), aligned their views with the constitutional virtues of the country, while other stakeholders like the Financial Intermediaries

Association of Southern Africa (FIA, 2019) represented the interests of the insurance sector.

The problem stream highlights how ideological commitments and political expediency rather than purely technical or empirical considerations influenced the NHI's emergence on the policy agenda. The MSF framework suggests that aligning problem recognition with political momentum is crucial for successful policy adoption. The MSF framework suggests that problem definition should be comprehensive and supported by empirical evidence to strengthen policy legitimacy. In the case of the NHI, a lack of transparency in problem identification led to contestation among stakeholders, including political opposition, civil society, and professional healthcare organisations. Strengthening policy deliberations with robust empirical data and a consultative approach could mitigate resistance and improve the likelihood of a more equitable and effective healthcare system.

5.2 Policy Stream

The National Health Insurance policy's complexity is apparent in the shift it proposes from a fee-for-service healthcare model to a system where healthcare services are free at the point of delivery (Moosa, Luiz and Carmichael, 2012). This transformation necessitates substantial changes, particularly in managing human resources and healthcare contracts across both the public and private sectors (Naidoo, 2012; Ncayiyana, 2008). The scale of this change underscores the complexity of the NHI policy, as it entails a complete overhaul of the healthcare system, including management structures, the introduction of comprehensive benefits packages, and a focus on primary healthcare (Naidoo, 2012). The policy is not only ambitious but also highly complex, and its implementation will require diverse technical expertise to navigate various challenges related to human resources, financial management, and healthcare provision (FIA, 2019; Mathew and Mash, 2019). Several scholars and stakeholders, such as Cullinan (2015) and Raborife (2016), have highlighted the challenges associated with implementing such a large-scale transformation. While the government insists that NHI will be implemented incrementally, addressing issues like human resource availability, the classification of treatment packages, and ensuring affordability remain critical risks (Mathew and Mash, 2019; McIntyre & Ataguba, 2012). The document review reveals that significant concerns exist regarding the adequacy of consultations, particularly with healthcare professionals, and the lack of transparency surrounding the policy's costing (Malan and Green, 2016; FIA, 2019;). Despite some costing estimates being provided in the 2011 Green Paper, the lack of public access to these figures and the absence of detailed risk assessments signal potential pitfalls in the policy process. As highlighted by Buthelezi (2013), the lack of clarity regarding the allocation and utilisation of funds presents substantial challenges for future implementation. Furthermore, the failure to adequately address risk areas, such as the recruitment of qualified human resources and the feasibility of funding models, threatens the efficacy of the NHI policy. Stakeholders like Editorial Comment (2014) and Mkhwanazi (2015) underscore the government's inability to attract sufficient medical professionals for pilot projects and the mismanagement of funding allocations, which could undermine the policy's long-term viability. Nonetheless, scholars like Koko (2017) and González (2017) assert that despite these challenges, the government remains committed to progressing the NHI policy toward legislative approval.

The policy stream highlights the gap between policy design and practical implementation. The MSF framework suggests that well-developed policy alternatives must be technically feasible and publicly acceptable. The MSF framework emphasises that successful policy adoption requires comprehensive feasibility testing and broad stakeholder buy-in. The NHI process, however, exhibited shortcomings in both areas, leading to resistance from medical professionals, financial intermediaries, and opposition parties (HealthMan, 2019; Psychological Society of South Africa, 2019; South African Medical Association, 2019).

5.3 Politics Stream

The politics surrounding the NHI policy reflect a broader commitment to international health standards and objectives, with some arguing that the fragmented nature of the South African healthcare system should not deter efforts to improve health outcomes (Bateman, 2012). One of the central arguments in favour of NHI is its potential to reduce the financial burden on individuals by providing free healthcare services through a single fund, thus fostering social solidarity and financial risk protection (Kahn, 2016).

Despite these arguments, concerns about the NHI's implementation remain, particularly with regard to transparency and stakeholder engagement. The document review reveals that the Department of Health (DoH) provided the public with opportunities to contribute their perspectives through a consultation process, but Erasmus (2011) argues that these consultations were deficient, focusing more on ideological discussions than constructive feedback. Additionally, the exclusion of key groups, such as psychiatrists and civil society organisations, has been criticised, with Robertson (2016) and Section 27 (2019) emphasising the need for more inclusive decision-making processes.

In terms of human resource preparation, the government has taken steps to ensure adequate staffing for the NHI's implementation, including training programmes and international exchanges for health professionals (Maja, 2012; Child, 2013; Passchier, 2017). However, concerns remain about the governance structures and fund management, as identified by Buthelezi (2013) and Cohen (2019). These challenges are compounded by the legal constraints associated with the NHI Bill, which, in its current form, raises concerns about its impact on private healthcare providers and the economic sustainability of the policy (Ndenze, 2019; van Dalsen, 2019). The NHI policy is situated within a highly complex political context, where competing interests, stakeholder engagements, and economic concerns all intersect. While the government remains committed to advancing the NHI, its success hinges on addressing the significant risks and challenges identified in the policy process.

The politics stream illustrates the significance of political will and stakeholder engagement in shaping policy outcomes. The MSF framework underscores the necessity of aligning political conditions with problem and policy streams for successful policy adoption. A more transparent and participatory approach to stakeholder engagement, coupled with clearly defined governance and financial structures, would enhance policy legitimacy. Ensuring a balanced and consultative political process that accommodates diverse interests while maintaining policy coherence is critical for the successful implementation of NHI.

The findings highlight critical gaps in the NHI policymaking process, reinforcing the need for a more integrated approach within the MSF framework. The problem stream suggests that a stronger empirical foundation is necessary to legitimise problem identification and prevent ideological overreach. In the policy stream, the lack of robust feasibility assessments indicates that greater technical scrutiny and stakeholder engagement are required to refine policy proposals. The political stream underscores the importance of transparent, inclusive consultations to mitigate opposition and enhance policy legitimacy. Addressing these deficiencies would improve policy coherence, facilitate smoother implementation, and enhance the likelihood of achieving equitable healthcare reform in South Africa.

6. Discussion

Political dynamics have strongly influenced the NHI policy process in South Africa through the collaboration between the ruling party and influential labour unions like COSATU. The collaboration between the ruling party and powerful labour unions produced substantial political momentum for the policy but created barriers for key stakeholders including civil society organisations (CSOs), healthcare professionals, and private sector representatives to participate (Preuss, 2016; Bateman, 2010). The marginalisation of certain stakeholders emerges from systemic power imbalances as the foundational elements that structure the policymaking process according to Savard

& Banville (2012). The ruling party's close partnership with COSATU has solidified the NHI as the government's primary reform priority (Ncayiyana, 2008; Naidoo, 2012). Due to the political partnership in place other significant stakeholders such as professional experts and advocates for vulnerable groups received minimal input during policy formulation. The absence of stakeholder participation compromises both the legitimacy and thoroughness of the policy, which diminishes its capacity to handle South Africa's healthcare system complexities (Miller, 2006).

A variety of political and institutional factors account for why key actors remain excluded from the policy process. The historical function of labour unions as a voting bloc for the ruling party led to their prioritisation which granted them substantial influence over the NHI (Schulman, 1975). The ruling party's political supremacy illustrates its wider electoral and ideological pledges through its adoption of the NHI to promote social justice and redistributive policies (Preuss, 2016). The emphasis on political objectives has resulted in insufficient attention to the practical elements of healthcare reform (Bateman, 2010). Healthcare professionals hold essential insights about service delivery challenges which can contribute to creating a feasible and effective NHI. CSOs acting for marginalised and vulnerable groups remain excluded from discussions even though they represent key advocates for fair healthcare access. When diverse perspectives are not included in policy development the resulting framework often serves political goals instead of meeting broad societal requirements (Savard & Banville, 2012).

A thorough examination is necessary to understand the ideological influences and power dynamics behind the NHI policy process. Through its advocacy for social solidarity which aligns with government objectives COSATU facilitated the establishment of NHI as part of the wider political programme (Naidoo, 2012). The focus on redistributive justice is crucial yet elevating political values above practical realities threatens both the durability and effectiveness of the policy (Miller, 2006). The NHI policy process demonstrates a lack of solid evidence-based methodology. The absence of systematic evaluations and financial risk assessments along with independent evaluations demonstrate that political ideologies are shaping the policy rather than empirical research according to Bateman (2010). The NHI's success depends on its foundation in international best practices combined with an understanding of South Africa's specific constraints. A lack of empirical research integration together with unbalanced political ambitions toward practical realities leads to an increased risk of worsening existing inequalities instead of reducing them as Preuss (2016) indicates.

The resolution of these issues requires the establishment of a policymaking process that embraces both inclusion and transparency. The government needs to move beyond one-time consultations and superficial stakeholder interactions instead building sustained and genuine conversations with diverse groups like CSOs, healthcare professionals and private sector representatives. An independent Healthcare Reform Advisory Council that includes broad stakeholder representation will institutionalise inclusive decision-making processes to form policies based on multiple perspectives and experiences. Incorporating independent research institutions into policy-making processes would solidify the evidence base while guaranteeing that decisions reflect up-to-date scientific and empirical discoveries (Bateman, 2010). When decision-makers prioritise inclusion they connect political demands with practical requirements to ensure South Africa's NHI meets the needs of its diverse population.

The apartheid legacy continues to weigh heavily on South Africa's healthcare system by creating significant disparities in healthcare access for its population. The government's comprehensive reform strategy does not account for the benefits of gradual evidence-based adjustments which could lead to a more feasible and enduring healthcare system transformation (Ncayiyana, 2008; Naidoo, 2012). The government's comprehensive reform strategy ignores both the complexity and the scale of the healthcare system's challenges. The realistic and adaptive transition to new reforms requires starting with pilot programmes that initiate small local projects before expanding through evidence-based findings (Savard & Banville, 2012). This approach allows for the resolution of new issues to emerge

while refining policy during rollout and incrementally tackling implementation challenges. The policy implementation will likely fail in achieving long-term success if it proceeds too quickly without establishing adequate foundational support. Implementing an adaptive strategy based on evidence will help overcome the systemic limitations of the health system. Healthcare reform efforts in a country with fiscal restraints demand careful management to achieve long-term sustainability (Schulman, 1975).

Private sector stakeholders, academic institutions and CSOs need to take active roles for the NHI policy to be successfully implemented in South Africa. Private sector actors must actively participate in policy discussions to promote joint efforts with public institutions aimed at improving healthcare delivery and infrastructure alongside innovation and economic sustainability (Miller, 2006). The academic community needs to conduct thorough evidence-based research into the NHI that looks at both its practicability and future effects with attention to financial sustainability and risk management along with healthcare service distribution equity (Bateman, 2010). Independent evaluations and policy analyses conducted by academics will provide decision-makers with empirical data that integrates ideological objectives with realistic limitations (Preuss, 2016). CSOs must actively support the participation of vulnerable populations in healthcare policymaking processes so that these communities' perspectives are included in healthcare access and equity discussions. CSOs need to work alongside other stakeholders to oversee the NHI execution while delivering feedback that reflects direct experiences of those most impacted by healthcare changes (Savard & Banville, 2012). These actors need to focus on maintaining ongoing inclusive discussions and building partnerships across different sectors while advocating persistently to make the NHI a fair and workable policy benefiting all South Africans.

7. Limitations and Areas for Future Studies

The study depends on documented literature which falls short in detailing all the intricate aspects of the NHI policy process. This analysis examines only the years from 2007 to 2019 and therefore excludes any subsequent political changes or institutional developments that impacted the NHI's progression. Subsequent research should evaluate post-2019 developments in NHI policy which involves studying the NHI Bill implementation and its effects to gain a fuller picture of policy evolution. Future research stands to gain from expanding its methodological scope by utilizing primary data sources like stakeholder interviews and fieldwork to achieve a more comprehensive understanding of policy implementation challenges and experiences. Research comparing health reform processes across BRICS nations would enhance comprehension of how South Africa's healthcare policy journey can shape health policy development in varying political and institutional environments. The incorporation of systems thinking theoretical frameworks into future analyses will enable researchers to uncover the interconnections between different healthcare system actors and components to gain comprehensive insights into health policy processes.

8. Summary and Conclusion

Policy formulation for South Africa's NHI between 2007 and 2019 demonstrates how political power structures shaped the process through strong ties between the ruling party and labour unions including COSATU. The political support behind the NHI placed it at the top of government reform priorities but it also led to the sidelining of important stakeholders such as CSOs and healthcare professionals along with representatives from the private sector. The resulting policy aims at redistributive justice but lacks complete input from multiple essential groups which limits its sustainability and effectiveness.

This research reveals critical impacts for both BRICS nations and worldwide health policy development. The South African experience demonstrates how governance reforms must focus on inclusive decision-making processes coupled with active stakeholder engagement. South Africa and its BRICS counterparts must develop deeper engagement methods to strengthen stakeholder

participation. Independent advisory bodies and research institutions need to support a continuous structured engagement process to develop policies that incorporate diverse perspectives and empirical evidence. Establishing a Healthcare Reform Advisory Council with diverse stakeholder representation would institutionalise transparent and accountable decision-making processes that will strengthen both legitimacy and effectiveness for the NHI policy and similar health reforms across BRICS countries.

BRICS countries can learn from South Africa's experiences by tailoring them to their distinct political and institutional environments through recognition of the need to balance political objectives with healthcare system realities. Social justice and equity remain central goals of South Africa's NHI that resonate with numerous BRICS nations. The success of healthcare reforms depends on understanding system complexities and involving stakeholders such as the private sector, academia, and vulnerable populations to achieve their intended goals. BRICS countries stand to overcome transition challenges towards equitable healthcare systems through adaptive evidence-based reforms that utilise pilot programmes and incremental adjustments.

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