THE ROLE THAT CAN BE PLAYED BY THE HWSETA TO SUPPORT THE NATIONAL HEALTH INSURANCE PROGRAMME

BY

QAQAMBA MATHA

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17 Bradford Road
Bedfordview
Gauteng
South Africa

P.O. Box X15
Gardenview
2047
Tel: +2711 607 6900
Fax: +2711 616 8939

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The views expressed in this report are that of the author and not that of the HWSETA.

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Written by:

Qaqamba Matha
Researcher

Edited and Approved:

Bulelwa Plaatjie
Executive Manager: RIME

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Abbreviations and Acronyms

ATR	Annual Training Report
AUO	African Union Organisation
CCMDD	Centralised Chronic Medicine Dispensing and Distribution system
CEO	Chief Executive Officer
DHET	Department of Higher Education and Training
DCSTs	District Clinical Specialist Teams
GP	General Practitioner
HPRS	Health Patient Registration system
HWSETA	Health and Welfare Sector Education and Training
HR	Human Resource
HRD	Human Resource Development
ICRM	Ideal Clinic Realisation and Maintenance
ISHP	Integrated School health programme
LMIP	Labour Market Intelligence Partnership
KZN	KwaZulu-Natal
NHI	National Health Insurance
NQF	National Qualification Framework
NDOH	National Department of Health
NDP	National Development Plan
OD	Organisational Development
PSET	Post School Education and Training
PHC	Primary Health Centre
PPP	Public-Private Partnerships
PP	Public Partnerships
SVS	Stock Visibility System
SAHR	South Africa Health Review
SSP	Sector Skills Plan
SETA	Sectorial Education and Training Authority
UNDP	United Nations development programme
UHC	Universal Health Coverage
WSP	Workplace Skills Plan

WHO	World Health Organisation
WBPHCOTs	Ward-based Primary Healthcare outreach team

EXECUTIVE SUMMARY

1. Introduction

Globally, continued epidemics and the spread of diseases are demanding that all nationals put measures in place to ensure access to healthcare for the welfare of their citizens. As such, chapter 10 of the 2012 National Development Plan (NDP) vision 2030 on promoting health highlights the importance for South Africa to have Universal Health Coverage (UHC). In the drive to achieve Universal Health Coverage by 2030, as per the NDP, the NDOH has formulated a National Health Insurance (NHI) Bill, which is a health financing system that is designed to pool funds to provide access to quality and affordable personal health services for all South Africans. This bill seeks to harmonize access to quality health care and to bridge the gap between South Africa's private and public health-care sector (*white paper - NHI, 2017*).

This study therefore aims to identify the skills needs in each districts where NHI has been piloted; so as to tailor sustainable skills support intervention for implementation by the HWSETA.

The objectives of the study are as follows:

- To provide an understanding about the South African National Health Insurance Programme
- To identify the essential skills needed for the effective implementation of the NHI Programme
- To identify interventions required for an effective implementation of the NHI Programme

2. Research Methodology

The study was explanatory in nature which helped to interrogate the problem more with lessons to learn. Overall, the study utilized qualitative methods. The target population of this study were the eleven district offices of Primary Health Centres (PHC) of the NHI pilot project, as well as the NHI war room and NDOH.

Pilot district Site	Province		Pilot district Site	Province
OR Tambo	Eastern Cape		Vhembe	Limpopo
Thabo Mofutsanyane	Free State		Gert Sibande	Mpumalanga
Tshwane	Gauteng		Pixley ka Seme	Northern Cape
uMgungundlovu	KZN		Dr. Kenneth Kaunda	North West
uMzinyathi	KZN		Eden	Western Cape
Amajuba-	KZN *(this was the additional site included by KZN provincial government.)*		NHI war room	National
NHI War room	National		NDoH	National

Availability sampling was used to get each NHI site to respond to the study. Out of the 11 pilot sites, the NHI war room and NDOH, only 3 pilot sites and the NHI war room actually participated in the study. The pilot sites that participated included; the Eastern Cape OR Tambo Pilot site, the Gauteng-Tshwane Pilot site, and the KZN-uMzinyathi Pilot site. Semi-structured interviews were used as the primary research collection instrument. The Secondary data collection technique that was used is the documentary review. Thematic analysis was used in this study to pinpoint, examine, and record patterns within data for both document review and primary data analysis.

3. Discussion of Findings

The findings of the study are discussed in line with the objectives of the study as follows:

Objective 1: Understanding the South African National Health Insurance Programme

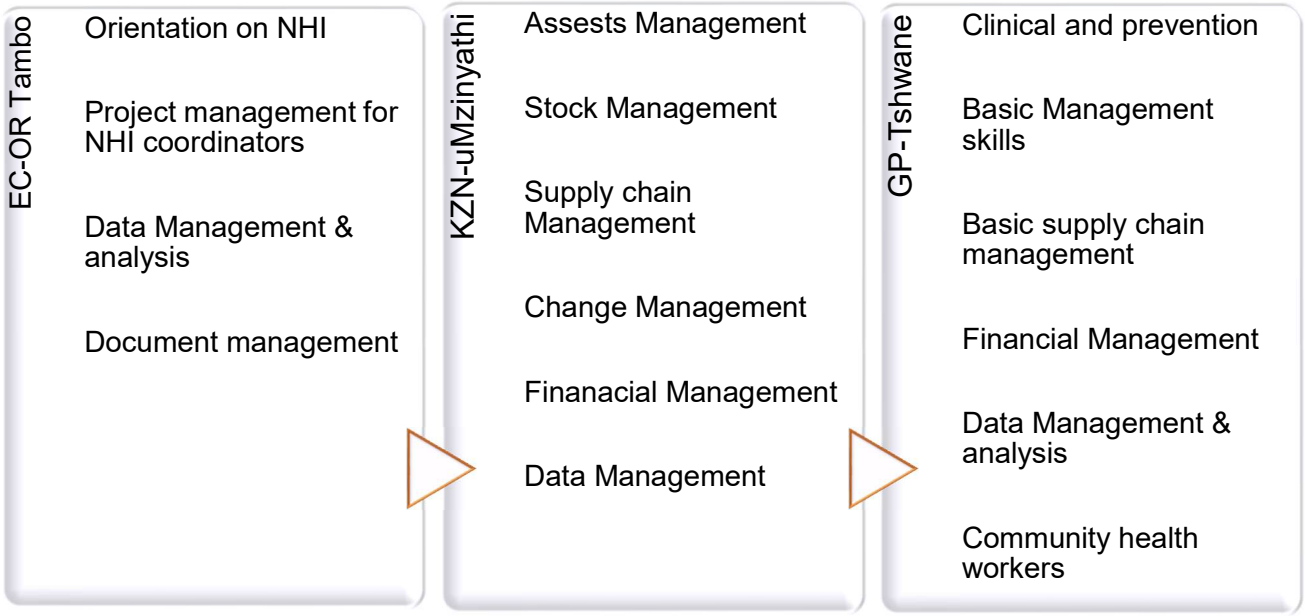
The NHI is being implemented by the NDOH through a gradual process, over three phases. Phase one was from 2012 to 2017, and it focused on piloting health system strengthening (HSS) initiatives; the establishment of the NHI Fund and key institutions; and the moving of central hospitals to the national sphere. Phase 2 was from 2017 and will end in 2022. It will focus on ensuring that the NHI Fund is fully functional and has the required management and governance structures so that the purchase of services and population registration can begin (Green paper on NHI,2011). This involves passing the NHI Bill, which was introduced last year, and making amendments to several pieces of legislation

(Green paper on NHI,2011). Phase 3 of NHI, will be from 2022 to 2026. It will signal the introduction of mandatory prepayment and the contracting of accredited private hospital and specialist services as well as the finalisation of the Medical Schemes Amendment Act (Green paper on NHI,2011).

Objective 2: Identifying the essential skills needs for the effective implementation of the NHI

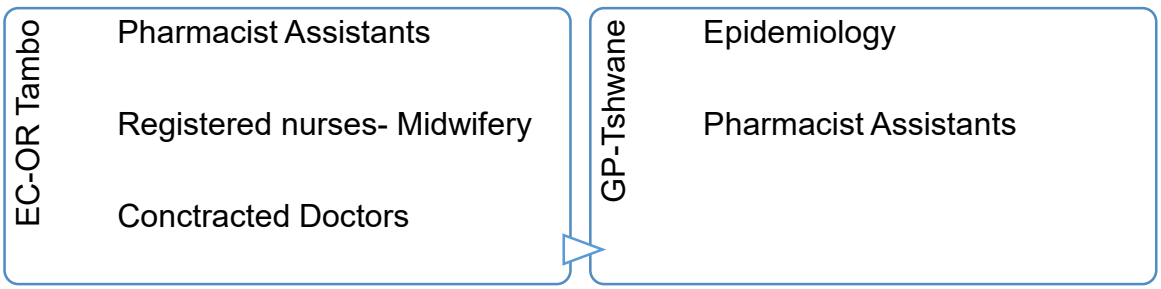
The following are the critical skills required for the implementation of NHI yielded by the study:

Chart 3: Critical Skills for the NHI Programme based on the NHI Pilot Sites



The following are the scarce skills required for the implementation of NHI yielded by the study:

Chart 4: Scarce skills for the NHI Programme based on the NHI Pilot Sites



Given the functionality of the NHI, the system relies more on contracting the General Practitioners (GP's) and specialist at the Primary Health care level. In the Eastern

Objective 3: Identifying interventions required for an effective NHI Programme

Interventions are presented in line with skills needs in each pilot sites region as follows:

Chart 5: OR Tambo identified skills intervention:

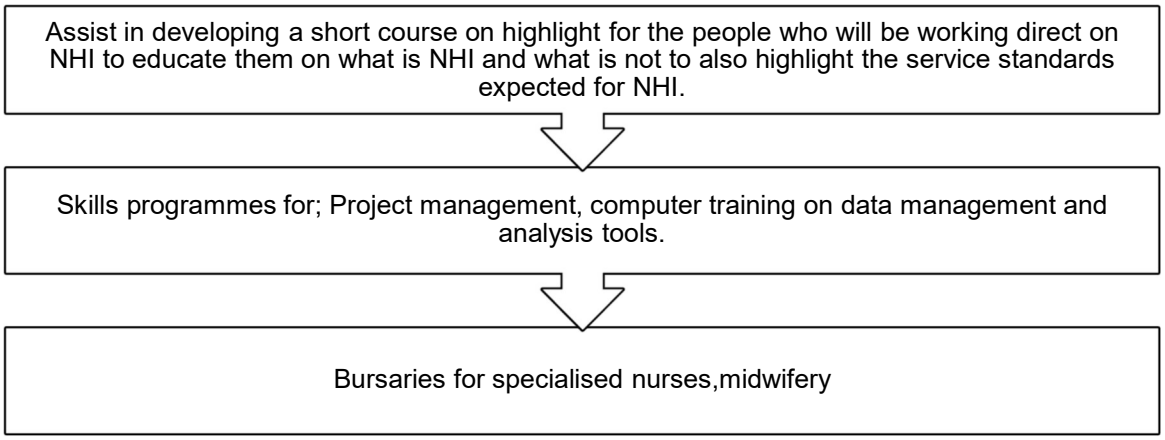


Chart: 6 uMzinyathi Identified Skills Interventions

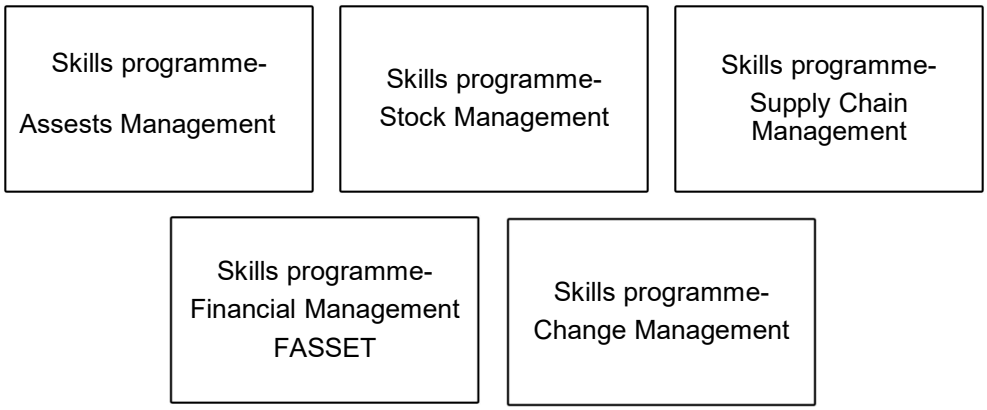
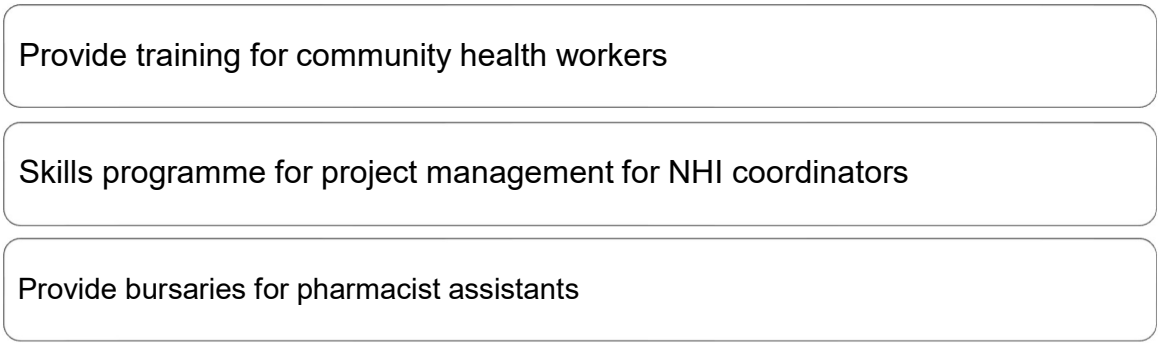


Chart 7: GP-Tshwane identified skills interventions



4. Conclusion and recommendations

In conclusion, the research study identified some gaps as far as skills development is a concerned in the areas where NHI was piloted. It has been showed that HWSETA needs to properly partake in closing the identified gaps. More effort is needed on ensuring that the people in different primary health facilities are educated about what is NHI and what is not NHI to ensure proper service delivery and proper skills planning.

It is therefore recommended that:

- The HWSETA supports the bridging of the skills gap and addressing the critical skills identified in the pilot sites visited.
- The HWSETA needs to have a decentralized partnership approach with districts than having it with the National department, due to inefficient information (financial) flow across the system.
- The HWSETA needs to have partnerships with districts with a specific time frame and required outputs explicitly stating the skills development needs.
- The HWSETA needs to identify possible working partnerships to ensure effective implementation of the NHI.

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Introduction

Globally, continued epidemics and spread of diseases are demanding that all nationals put measures in place to ensure access to health care for the welfare of their citizens. As such, chapter 10 of the 2012 National Development Plan (NDP) vision 2030 on promoting health highlights the importance for South Africa to have Universal Health Coverage (UHC). It also highlights the key perspectives to be considered when assessing the public health system where Human Resources, infrastructure and governance came out strongly. This means that in order to have an effective universal health coverage the above need to be addressed in our public health system. The NDP (2012) also puts emphasis on primary health care which has been widely neglected yet it is the backbone of universal health coverage, as it has been emphasized globally.

Furthermore, research shows us that Japan was the first country to introduce UHC and Rwanda can be used as an example of how all countries at all income levels can make progress towards UHC. For instance, Rwanda has significantly advanced health coverage with its community -based health insurance (CBHI) program. In this programme, funds are used to help, subsidise healthcare for the citizens and clinic functionality. This allows citizens to access care and pay for services based on a tiered premium system according to socio-economic standing. In the drive to achieve universal health coverage by 2030 as per the NDP the NDOH has formulated a National Health Insurance (NHI) Bill, which is a health financing system that is designed to pool funds to provide access to quality and affordable personal health services for all South Africans. NHI derives its mandate from Section 27 of the Bill of Rights of the Constitution of the Republic of South Africa in which a commitment is made by the State to take reasonable legislative and other measures to achieve the progressive realization of the right to health care (*white paper-NHI, 2017*).

This bill seeks to harmonize access to quality health care and to bridge the gap between South Africa's private and public health-care sector (*white paper - NHI, 2017*). A notable feature of the history of the South African healthcare system has been fragmented both within the public health sector and public health sectors. During the apartheid era, health

facilities were racially segregated; curative and preventive services were separated by the Public Health Amendment Act of 1897. It was a time where the Gluckman Commission (1942-44) attempted to redirect the health system by recommending universal coverage. However, this was not achieved due to the huge segregation in the delivery of health services.

1.2 Problem addressed by the study, and aim and objectives of the study

The health sector in South Africa has been affected by the legacy of maldistribution due to poor skills of many healthcare personnel, which has compromised the ability to deliver key programs. Despite 60% of the health budget being spent on human resources, the staffing crisis at the district level remains a challenge and persists (Bheekie & Bradley, 2016). Also, evaluation studies conducted by the South African Health Review (2018), Ruiter (2017) and the NDOH (2017) identified factors hindering the effective implementation of NHI to include lack of human and financial resources, lack of skills and insufficient mechanisms to monitor progress. It has therefore become important for the HWSETA to determine the role that it she can play to support the implementation of the NHI.

This study therefore aims to identify the skills needs in each districts where NHI has been piloted; so as to tailor sustainable skills support intervention for implementation by the HWSETA.

The objectives of the study are as follows:

- To provide an understanding about the South African National Health Insurance Programme
- To identify the essential skills needed for the effective implementation of the NHI Programme
- To identify interventions required for an effective implementation of the NHI Programme

It is against this background why the research is being undertaken.

1.3 Overview of the research report

This report consists of 5 chapters, which provide methodology used to conduct the study, findings yielded by the study, and recommendations to address challenges identified in the programme. Below is a summary of what each chapter entails:

- Chapter 1 - Introduced the research study
- chapter 2 - Contextualizes Universal Coverage.
- Chapter 3 - Outlines the methodology, which includes the research design, sampling, data collection, analysis, and ethical considerations.
- Chapters 4 - Presents an interpretation and discussion of the findings, and in the last chapter,
- Chapter 5 – Provides conclusions to the study, makes recommendations, and explains how findings will be translated into information and then disseminated.

CHAPTER 2: CONTEXTUALIZING THE NHI IN SOUTH AFRICA

2.1 Introduction

This section contextualizes the applicability of essential skills in answering what? (definition), and how questions (relevance) to the study. It also highlights the conceptions and perceptions of NHI linking it back to how it fits into the supply and demand in our sector. It further highlights the theoretical framework which has been constructed from the literature review.

2.2 Definitions and concepts - essential skills

For the purpose of this study, the word essential can be used interchangeably with “hard to fill vacancies (HTFV) and critical skills” depending on the level of exploration. For example, different people use this word interchangeably as well, it through unpacking the reasons where one can be able to see if they are referring to "Hard to fill vacancies (scares skills)” or critical skills. Hard to Fill vacancies (scares skills) refers to an absolute or relative demand for skilled people to fill occupations as classified on the Organising Framework for Occupations (OFO), (DHET Dictionary, 2019).

Concerning the Sector Skills Plan (SSP), the following key points are what quantifies the HTFV. For instance, one of the clearest indicators of skills shortages is vacancies that remain unfilled for long periods despite employers' active recruitment efforts. Whereas “critical skills” means those capabilities needed within an occupation (DHET Dictionary, 2019). These are often referred to as soft skills or top up skills. The following part will provide a linkage between the abovementioned essential skills together with the understanding of the conceptions and perceptions of NHI with the demand and supply for

our sector. In order to see how HWSETA can best play its part in the implementation of NHI.

2.3 Conceptions and perceptions of the NHI

As mentioned in chapter 1 NHI is a health financing system that is designed to pool funds to provide access to quality affordable personal health services for all South Africans irrespective of their socio-economic status (*white paper - NHI, 2017)*. NHI represents a substantial policy shift that will necessitate a massive reorganization of the current health care system, both public and private. The reports from the health system's trust highlight a need for South Africa to have universal health coverage. Organizations such as, World Health Organisation (WHO) and the United Nations have also called for Universal Health Coverage (UHC) which on their term means “nobody should be left behind” (Coovadia, Jewkes, Barron, Sanders, 2009 et al), (Shi, 2017).

UHC is a set of objectives that health systems pursue; it is not a scheme or a set of arrangements in the health system. Making progress towards UHC is not inherently synonymous with increasing the percentage of the population in an explicit insurance scheme (WHO,2013) and (Shi, 2017). In NHI your socio-economic status will not matter but your health needs will determine what form of service you get.

It aims to provide equity and social solidarity through the pooling of risks and funds. It will create one public health fund with adequate resources to plan for and effectively meet the health needs of the entire population not just for a selected few (Shi, 2017). The current two-tier healthcare system has several problems including inequity, hospital-based care, high cost, poor outcomes and inefficiency (Ricardo, 2012). Which requires our collaborative effort to act urgently in addressing the issues.

2.4 Perceptions of NHI

Much debate has taken place around the proposed NHI Bill. At the advent of tabling NHI in parliament different stakeholders from civil society, private funders, providers and the general public at large have different perceptions on NHI. Some believe the government is being too ambitious. Some private providers show some support on NHI up to a certain

extent. For instance, Chief Executive Officer (CEO) of Mediclinic in southern Africa, “private hospitals could help with, reducing the backlog of hip and knee replacements by doing a percentage of these procedures at lower tariffs, by acquiring pharmaceutical items and prostheses at state tender prices, and by using available capacity in private hospitals” (City Press, 2019).

Additionally, Richard Friedland, Netcare group CEO, also shows some support on NHI he said, "South Africa can't build a community and economy without proper access to quality healthcare for everyone" (City Press,2019). This means that private providers are willing to work with the department of health to create a sustainable future.

Whereas on another side the Private funders (medical aids) are showing some discomfort on NHI especially on the fact that medical aids medical schemes will not be able to provide cover for services that are covered by the NHI. Discovery medical aid (2019) believes that the above-mentioned stance on medical aids highlights on the bill is not policy sound. Meaning it does not give people the right to purchases their services instead they are being boxed into one.

As much as there are some uncertainties on NHI at this moment, the researcher is of the view that we need UHC, with the current inequalities that exist in the health sector this could be beneficial to everyone, especially at a grass-root level. However, the question would then be is South Africa ready? will we ever be ready? Evidence by various authors such as Dizon (2018), and Ruiter (2018) show that it can be done by first addressing the current problems in our health system. Sadly, 25 years into democracy we are still talking about poor governance and lack of human resources in our health system.

Understanding the objectives of the study, together with contextualizing the applicability of essential skills in answering what? (definition) And the how questions (relevance) to the study. Also understanding the conceptions and perceptions of the NHI. The following part will highlight how the above fit to supply and demand to take into consideration how HWSETA can assist in the implementation of NHI.

2.5 Understanding the demand and supply

Skills planning remains predominantly complex due to the continued existence of intricate multiple dynamic interrelationships between the education system and the economic system (Statistics on Post-School education and training,2014). In which skills are utilized as a central input into production and supporting inclusive economic growth. There have been several efforts towards planning for skills needs in South Africa this is also evident by the amount of work done by various Sector Education Training Authorities (SETAs) across the sectors. Nonetheless, the efforts were seen too fragmented and the performance of the skills planning mechanism has not been effective as evidenced by persistent skills shortages (Skills planning Report, 2018).

For instance, concerning the HWSETA, SSP on hard-to-fill vacancies data both the public and private health sectors suffer from a shortage of skills. As for highlights in the table below.

Table:1: Hard-to-fill vacancies/Scarce Skills

Occupations	Private	Public	Total
Registered Nurse (Disability and Rehabilitation)	50	1271	1321
General Medical Practitioner	10	888	898
Registered Nurse (Medical)	780	47	827
Nursing Support Worker	1	714	715
Enrolled Nurse	480		480
Registered Nurse (Critical Care and Emergency)	79	314	393
Midwife	45	233	278
Clinical Nurse Practitioner	71	197	268
Registered Nurse (Child and Family Health)	10	239	249
Hospital Pharmacist	36	208	244
Registered Nurse (Medical Practice)	12	212	224
Ambulance Officer	0	170	170
Physiotherapist	70	94	164
Medical Diagnostic Radiographer	38	93	131

Occupations	Private	Public	Total
Dietician	14	96	110
Retail Pharmacist	106		106
Specialist Physician (General Medicine)	8	96	104
Registered Nurse (Operating theatre)	48	55	103

Source: HWSETA SSP, 2019.

Table 3 shows us the high shortage of registered nurses and medical practitioners. Both these are seen to be very critical for NHI for instance for all clinics in SA to be NHI accredited they need to have a General Medical Practitioner and a Registered nurse amongst other things. At this stage, it is unclear if the government will continue to contract General Medical Practitioner once NHI is fully functional. Even though, the White paper,2017 highlights only the contracting of a specialist. This means that we might need more general Medical practitioners working fulltime for NHI facilities, which some need to be accredited NHI facilities.

There is another study done by HWSETA, (2019) on the extent and nature of the decline of supply of nurses in SA. Which highlights that a high number of skilled nurses are living SA. This again is another worrying sign since nurses are set to play a critical role in NHI. This shows us the complexity of skills planning. Meaning SA might need to review the strategy/approach used for skills planning, to be more futuristic than reactive.

There is also a national list on occupations in high demand compiled by the Department of Higher Education and Training (DHET;2018) which the HWSETA SSP concedes with. The list was compiled through various stakeholder engagements with the industry and scanning of government strategies and policies for economic growth and development.

The table below highlights occupations in high demand for our sector. These occupations were categorized into three levels of demand, namely the highest demand, higher demand, and high demand. These levels of demand indicate that all these categories have high demand but there is a variation among them and that occupation in the highest group scored in the top group on the statistical index that was used when consolidating the list. In this list, the researcher only highlights those occupations that are proven to be critical for NHI.

Table:2: Occupations in high demand

Occupation	OF Code	Level of Demand
Medical Laboratory Technician	321201	Highest
Childcare worker	531101	Highest
General Medical Practitioner	221101	Higher
Hospital Pharmacist	226201	Higher
Retail Pharmacist	226203	Higher
Social Worker	263507	Higher
Health and Safety Manager	121206	High
Biochemist	213106	High
Microbiologist	213108	High
Registered Nurse (Aged care)	222102	High
Registered Nurse (Child and family health)	222103	High
Registered Nurse (Community Health)	222104	High
Registered Nurse (Critical care emergency)	222105	High
Registered Nurse (Developmental disability)	222106	High
Registered Nurse (Disability and Rehabilitation)	222107	High
Registered Nurse (Medical Practice)	222109	High
Registered Nurse (Mental Health)	222110	High
Registered Nurse (Operation theatre)	222111	High
Registered Nurse (surgical)	222112	High

Source: (DHET, 2018)

One should ask themselves What does this mean for NHI? Looking at the table above we can see some skills shortage gaps that need to be addressed. Especially with the advent of NHI and what does this mean to the contribution of HWSETA. Having seen from the above the current skills gap identified in our sector, which most of these gaps are seen to be very critical for NHI. The following part will look at the current HWSETA contribution as per the (HWSETA SSP, 2019).

2.6 Sectoral priority occupations (PIVOTAL), 2019

The following table will highlight a brief summary of the HWSETA contribution to the above-identified needs.

Table 3: Sectoral Priority Occupations

Occupation	Qualification	SETA Intervention	Quantity Needed	HWSETA Supported
Hospital Pharmacist	Bachelor of Pharmacy	Bursary	244	100
	FETC: Pharmacist Assistance	Learnerships		250
	NC: Pharmacist Assistance	Learnerships		250

Occupation	Qualification	SETA Intervention	Quantity Needed	HWSETA Supported
Ambulance Officer	Bachelor of Emergency Medical Care	Bursary	170	39
Medical Diagnostic Radiographer	Diploma in Diagnostic Radiography	Bursary	131	100
	WIL	WIL		122
Occupational Therapist	BSc in Occupational Therapy	Bursary	90	20
Registered Nurse (Disability and Rehabilitation)	Bachelor of Nursing Sciences	Bursary	1321	150
	Diploma in Nursing: Community, Psychiatry and Midwifery	Bursary		300
	Diploma in General Nursing: Bridging	Learnerships		325
General Medical Practitioner	Bachelor of Medicine and Bachelor of Surgery	Bursary	898	200
Registered Nurse (Medical)	Advanced Diploma in Medical and Surgical Nursing	Learnerships	827	250

Source: HWSETA SSP (2019).

With the different skills gap highlighted above, one can ask is all this enough. Will these interventions highlight above be able to fully address the overall gap? The answer to the above questions "No", due to funding constraints that the HWSETA is faced with, it cannot address all of them at the same time.

2.7 Overview of Determinants Skills Development entries and output

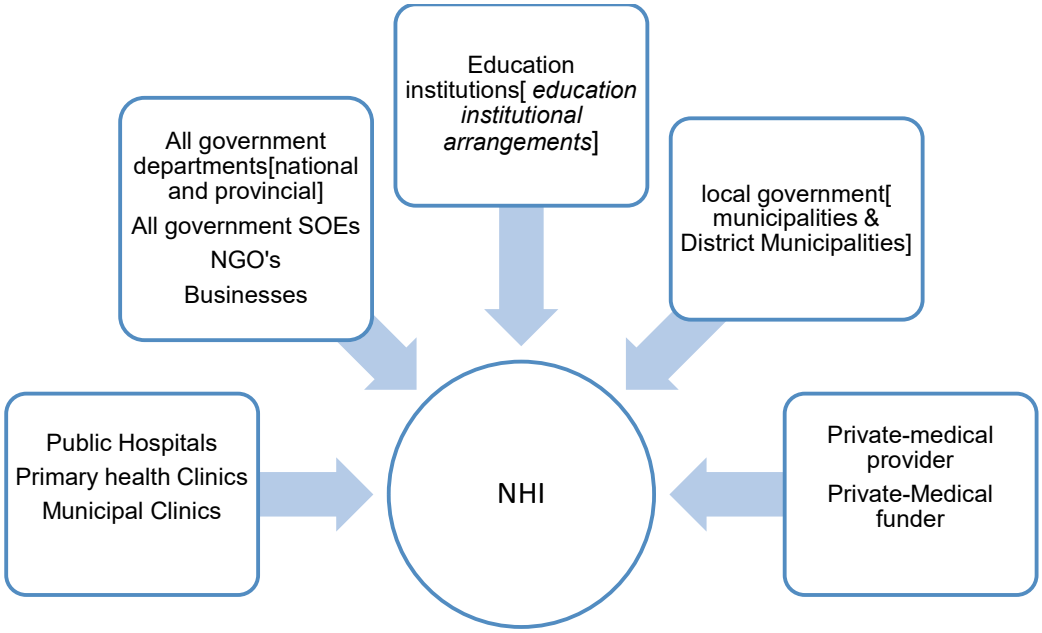
This part will highlight the determinants of skills development entries and output linking it back to the discussions highlighted in previous sections. In the same way, the study is looking at NHI how we need to understand the determinants of skills development output. Such as, looking at what should happen in different levels of skills planning. This section will look at how institutional arrangements can assist in addressing the skills gap. For instance, some of the problems we have in skills planning are a result of poor institutional arrangements.

Institutional arrangements are the policies, systems, and processes that organizations use to legislate, plan and manage their activities efficiently and effectively coordinate with

others to fulfill their mandate (UNDP,2017). For instance, arrangements between the high school, tertiary and industries on the outputs should be in place. Blom, (2011) highlights that the Post-school education system is at a compromised state due to a lack of institutional arrangements. This creates a disjuncture between the output and the need identified by industries. Furthermore, Blom, (2011) cited in Bheekie, Bradley (2016) states that some of the problems the county has on skills planning are results of how our government responds to those gaps. Ignoring various important role players in the process. As it stands if the pass rate at a high school level is 37.6%, but to gain entry at medical school you need anything above 60% where are we going to get more medical doctors?

A recent study done by statistics SA (2019) indicated that only 29% of matriculants passed with a bachelor pass, bachelor pass allows you to gain university access. This means NHI might be fully functional with some of the critical skills gaps not being addressed. The problems faced are very complex, however, some can be resolved through a system thinking approach. Having highlights the impact institutional arrangements have on skills planning the following part will highlight a theory that can be used to unpack the problem and ensure that NHI skills gaps are addressed. For instance, the table below will highlight the stance of this approach in this study. It highlights all-important stakeholders that have an impact on the success and failure of NHI implementation. All these stakeholders below have a direct and indirect contribution to ensuring a smooth implementation for NHI.

Chart:1: System thinking



Source: Researchers' notes (2019).

Firstly, we cannot ignore the complexity of South Africa's health system, with regards to the inequalities that exist within the system. Secondly, as mentioned above, we cannot even ignore the complexity of skills planning. From issues of governance, systems, institutional arrangements, change, etc. Therefore, it is important for HWSETA when trying to contribute to NHI, to appreciate the fact that NHI cannot be effectively implemented in the absence of the highlighted stakeholders. The department of health cannot effectively implement NHI on its own. Hence the need for a system thinking approach when dealing with the issue under study.

Additionally, HWSETA needs to appreciate the magnitude of the system and the fact that it would need some assistance from other skills authorities for an impactful contribution to NHI. For instance, from the different components highlights some areas are out of the Health sector domain strategically. Another typical example would be "infrastructure" we cannot ignore the fact that for NHI to be effectively implemented we need proper infrastructure, human resources, and systems in place.

2.8 Global context on universal coverage

This section will provide an overview of the global context on universal coverage, as to how far are developing countries in the fulfilment of the sustainable development goals on universal coverage. It will start by highlighting the current context of universal coverage on countries like Japan and Rwanda. Then further highlight the lesson learned from the Rwanda benchmarking exercise on their Community-Based Health which is basically NHI in our context. As highlighted above universal health coverage is part of our developmental goals, this means that all countries that are in signatory with the United Nations are obliged to meet this target of providing universal coverage to all its citizens.

2.9 Universal coverage in Japan

It is important to note that Japan was the first country to respond to the call for UHC and they have tried to champion this call as per the SDG goals. Huge progress has been made in this regard as far as UHC is a concern. On the evaluations that have been done in Japan on UHC the following success stories were highlighted. UHC is not an overnight process but a systematic one(WHO, 2019). It requires all government departments, state organs, and multimillion companies to work together in ensuring this is achieved. The research further highlights that an effort to expand health coverage may be limited by the availability of financial and human resources (WHO, 2019).

It went further and demonstrated that human resource has a huge impact on achieving UHC. By making reference to the recent study conducted in Japan by the Health, labour and welfare Ministry that by 2025 Japan could need up to 270 000 nurses which in actual fact for effective UHC it will need up to 2.02 million nurses by 2025(*The Japan Times*, n.d.). Furthermore, the world bank report has highlighted that the issue of shortage of human resources is a global crisis especially in the era where countries are on a road to achieve UHC. This means that to fully cover the entire population human resources needs to be addressed across board systematically.

For instance, this is demonstrated, in the time it took for Japan to fully cover the entire population. With this, we can see that for the effective implementation of UHC we need financial resources and human resources more. Above all, the research also highlights the need to consider private and public partnerships and public and public partnerships. Hence the above sections put more emphasis on the system thinking approach.

The following part will highlight the lesson learned in the Rwanda UHC. Research shows that Rwanda can be used as a lesson that the country does not need to have a high income to fully implement UHC.

2.10 Universal coverage in Rwanda

In Africa, Rwanda refers to its UHC as a Community based health insurance (CBHI) which has its origins on the mutual aid and community solidarity value systems that are deeply engrained in the fabric of its society (Rwanda National Strategy, 2017). The scheme has grown from its humble beginnings from 1999 with a coverage rate of 7% in the three pilot districts, currently, coverage is at about 100% (Rwanda National Strategy, 2017). As a result of this and the government's firm commitment to its expansion, Rwanda's CBHI is one of the most successful CBHI schemes in Africa thus far (Gates notes,2018). This came with a lot of amendments to the then existing legislation to accommodate CHBI in their context.

The key success of this CHBI is that everyone has access to health care regardless of their social status. Also, in all this process their systems are interlinked and functioning as per the ideal functionality of NHI highlighted in chart 1.

However, there are some challenges that they are currently faced with which include the following:

- shortage of human resources such as nurses, doctors, and specialists.
- Capital in flights as people seek care outside the country since they do not have enough specialists.
- Long waiting period for specialized services

This again shows us the complexity of skills planning and that shortages of skills are a global issue. Which requires countries to continually skill and upskill their people in order to fully respond to societal health needs.

2.11 Lesson learned from Rwanda benchmarking exercise

As mentioned above Public-Private partnership (PPP) and public partnership (PP) have been overemphasized. As much as HWSETA is a skills development authority for the health sector it needs to bring into play other skills development role players to support NHI skills development initiatives. For Instance, we see the importance of technology and financial management in the whole NHI system. This will require a systematic PPP and PP which is what Rwanda is excelling in.

2.12 Conclusion

The above discussion has outlined how the contextualization and application of essential skills. Further linking back, the current challenges of skills planning and how they can be addressed. By highlighting the systems thinking approach as a useful approach to use when trying to address the skills gaps concerning NHI for effective implementation. By putting emphasis on the usefulness of having functional PPP and PPP in place. Lastly, it also highlights how other countries are doing as far as UHC is concerned with a lesson to learn for our NHI.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This section highlights and describes the research design and methods that have been employed in this research to select a sample, collect and process data, and then analyse empirical evidence. To assist us in providing answers to the research questions that this study intends to answer.

3.2 Research Methodology

The study was explanatory in nature which helps to interrogate the problem more with lessons to learn. According to Jajoo & Malu,(2014) cited in Bryman,(2012) explanatory research is grounded in theory. Explanatory studies go beyond description and attempt to explain the reasons for the phenomenon that the descriptive study only observed. In an explanatory study, theories are used to represent the forces that caused a certain phenomenon to occur. Overall, the study utilized qualitative methods. The qualitative research strategy is a systematic subjective approach used to describe life experiences and situations to give them meaning (Inghan-Broomfeild, 2014). Qualitative research can provide complex textual descriptions of how people experience a given research issue (Inghan-Broomfeild, 2014).

3.3 Target Population and Sampling

A study population is a group of individuals from a general population who share the same characteristics (Bryman, 2012).The target population of this study were the eleven district offices of Primary Health Centres (PHC) of the NHI pilot project, as well as the NHI war room and NDOH. Table 4 outlines the pilot sights and also the representatives of each of the sights or department.

Table 4: Target Population

Pilot district Site	Province	Representatives	Motivation
OR Tambo	Eastern Cape	HR director or HRD Manager, SDF, Head of Department	At a Strategic level in the Pilot Site
Thabo Mofutsanyane	Free State		
Tshwane	Gauteng		
uMgungundlovu	KZN		
uMzinyathi	KZN		
Amajuba-	KZN *(this was the additional site included by KZN provincial government.)*		
Vhembe	Limpopo		
Gert Sibande	Mpumalanga		
Pixley ka Seme	Northern Cape		
Dr. Kenneth Kaunda	North West		
Eden	Western Cape		
NHI war room	National	Advisor to the President on Social Policy	At a Strategic level in the NHI war room and leading the NHI consultations from the presidency
NDoH	National	National NHI Coordinator, HR Deputy Director-General,	At a Strategic level in the Pilot Site

Concerning the above, a detailed breakdown of representation is as follows:

- 11 Primary Health Centre offices- represented by 11 facility managers,
- The National Department of Health represented by 11NHI Coordinators comprised by 6 NHI coordinators, 2 District Managers, 2 Department of health Manager [Directors] and 1 Advisor to the president on social policy.

Availability sampling was used to get each NHI site to respond to the study. This type of sampling relies on data collection from population members who are conveniently available to participate in study. The reason for choosing the above respondents was because they were all at the managerial level and their expertise and experiences was beneficial in answering the objectives of the study. However, out of the 11 pilot sites, the NHI war room and NDOH, only 3 pilot sites and the NHI war room actually participated in the study. The pilot sites included; the Eastern Cape OR Tambo Pilot site, the Gauteng-Tshwane Pilot site, and the KZN-uMzinyathi Pilot site. The response rate did not compromise the study as it was

qualitative in nature and therefore did not seek to generalise findings. Below is a brief description of the Pilot Sites that participated in the study:

- Eastern Cape Province was estimated to have an area of 6 880 967 km² with 20.8% of the population living in OR Tambo District (Census,2011). The huge population has very limited medical aid coverage, and province-wide 89.2% of the population depend on government health services. Poverty, unemployment, education, housing, access to piped water and sanitation are the social determinants of health that characterize the Eastern Cape Province. This pilot site is one of the Largest ones which sees about 65 000 patients annually (Eastern Cape Department of Health Annual Report,2018). However, issues of human resource are a great concern for this area as the highly skilled individual continue to migrate to more urban areas due to minimal economic development in this area.
- KZN has the second largest population with 11,4 million people (19,7%) with an area covering about 94,361.32 km² (Census,2011). 571,650 of the population are living in uMzinyathi of which 93% are rural and uninsured heavily depend on state health services (Census,2011). uMzinyathi is an underdeveloped rural environment with little economic. Close to one-third of the district population is dependent on Social Grants. According to Ngobese (2017) this area is considered to one of the areas with high vacancy rate as more and more professional migrate to urban areas.
- GP has the largest population with 12,27 million people with about 18 176 km² (Census,2011) 2,921 million of the population are living in Tshwane. Tshwane is one of the districts in the country with a high percentage of the population with medical insurance coverage (Tshwane profile report). The human resource aspect of this area remains unclear.

3.4 Methods for Data Collection

This section documents the actual procedure and the methods employed in this research to collect, process, and analyse empirical evidence. Broadly, this section details the process of data collection, from the development of data collecting instrument to actual data collection involving ethical considerations.

For the study, semi-structured interviews were used as the primary research collection instrument, which allowed the respondent to answer without being presented with implied choices (Taylor & Bogdan 2015:64).

The benefit of this instrument is that it also allows the study participants to answer on their terms, voicing their views, values, knowledge, and experiences (Taylor & Bogdan 2015-:65). The Secondary data collection technique that was used is the documentary review, which involved extracting data from documentary material by reading and analyzing.

3.4.1 Development of a data collecting instrument

Given the nature of the study, the following were used:

- Document review and analysis on what is NHI
- Semi-structured interviews with the following NHI pilot site representatives:
    - HR managers in representative districts,
    - NDOH coordinators on NHI and
    - the Advisor to the President on Social policy.

This assisted in generating an understanding about the NHI and the essential skills needed for the effective implementation of NHI.

3.4.2 Ethical considerations

The following ethical considerations were put in place;

- The researcher was committed to the code of ethics and demonstrate honesty and integrity throughout the research process.
- Informed consent was obtained from all participants
- The study adhered to the HWSETA research protocol.

3.5 Data analysis

Data analysis is a process of examining data to come up with important information to use (Wotela, 2016). Thematic analysis was used in this study to pinpoint, examine, and record

patterns within data (Bryman, 2012). This method of data analysis was used for both document review and primary data analysis.

3.6 Limitations of the study

The only limitation of this study was the level of participation by the target population, which relied on the availability of representatives of the NHI pilot sites, NHI war room, and the NDOH that was at 31%. The only hindrance expected from this is if there are skills needs that are unique to the pilot site that did not participate. Such skills needs will be sought when the HWSETA enters into partnerships to support the NHI. As thus the limitation will be managed to not negatively affect the outcome of this research study.

3.7 Conclusion

In conclusion, this chapter has given a brief definition of the research methodology used. It further outlined the data collection methods used and how empirical data was analysed. Above all, the overall strategy of the method used in the study, how it was utilized and the rationale for utilizing it has been outlined.

CHAPTER 4: THE INTERPRETATION AND DISCUSSION OF FINDINGS

4.1 Introduction

Data for this study was collected using the qualitative data collection methods as described in Chapter 3. Once the data was collected, the researcher prepared the information by taking all recorded data and inserting it in a transcript for easy analysis. Additionally, data were grouped into themes that were identified in Chapter 2, critical and scarce skills. This chapter presents an overview of the data collected. It is presented by first outlining the background to the NHI Pilot sites visited, which included EC-OR Tambo, KZN- uMzinyathi, and GP-Tshwane, followed by the research findings and analysis, to respond to the aim of the study and its research objectives.

4.2 Presenting and Interpretation of the results

The findings derived from the research study are presented in line with the objectives of the study, as follows:

Objective 1: Understanding the South African National Health Insurance Programme

To address the first objective of the study, government legislations such Green paper on NHI, white paper on NHI and various reports on NHI were reviewed. These documents describe the NHI as a health financing system that is designed to pool funds to provide access to quality and affordable personal health services for all South Africans. These documents explain that the NHI is being implemented by the NDOH through a gradual process, over three phases. These three phases were set to be implemented over a period of five years each, as follows:

Phase 1 of the NHI Implementation

The first phase began, from 2012 and ended in 2017. It focused on piloting the health system strengthening (HSS) initiatives and establishing the NHI Fund and key institutions (Green Paper on NHI,2011), which focused on the primary health care.

These interventions included the following, refer to table 5 below:

Table 5: NHI interventions

Intervention	Description of the intervention
Ward-based Primary healthcare outreach Team (WBPHCOTs),	Provision of promotive and preventative healthcare to households;
Integrated School health programme (ISHP)	Provision of a range of health promotion and preventive services to school-going children at schools.
General practitioner (GP)	To increase the number of GPs at PHC facilities to improve the quality and acceptability of care.
Ideal Clinic Realisation and Maintenance (ICRM)	This model aimed to increase the quality of services through the establishment of minimum standards.it is important to note that for all piloted PHC they had to meet the ideal clinic standard before qualifying to be a pilot site.
District Clinical Specialist Teams (DCSTs)	Responsible for supporting clinical governance and undertaking clinical work, research and training.
Centralized Chronic Medicine Dispensing and Distribution (CCMDD) system	Aimed to improve the distribution of medicines to patients through the provision of chronic medication at designated pick-up points (PUPs) closer to the communities in the pilot districts.
Health Patient Registration system (HPRS)	The goal of a fully electronic patient record-keeping system but has commenced with the capturing of patient data and the generation of electronic files.
Stock Visibility System (SVS)	Aimed to improve the oversight of stock through an electronic stock monitoring system, thereby reducing stock-outs by allowing for appropriate and timely ordering.
Infrastructure projects	To improve health infrastructure.

(Genesis Analytics, 2019)

These interventions implemented during this phase were mainly funded by direct conditional grant to provinces. There were other funding mechanisms that aided the process (Genesis Analytics, 2019). The NDOH established workstreams to develop and refine NHI related policy and incorporate feedback from the phased NHI implementation (Genesis Analytics, 2019). Unfortunately, the conditional grants were stopped in some provinces, which meant that they had to find means of ensuring continuity of the programme.

It is important to note that the NHI pilot's sites were made up of 11 pilot districts, one in every province, with the exception of KwaZulu-Natal (KZN) which had three pilot sites, solely funded by the province itself. Furthermore, these NHI sites were intended to become sites for innovation & testing throughout the implementation of NHI phase one. The sites referred to are tabulated as follows:

Table:6: NHI Pilot Sites

	Pilot district Site	**Province**
1	OR Tambo	Eastern Cape
2	Thabo Mofutsanyane	Free State
3	Tshwane	Gauteng
4	uMgungundlovu	KZN
5	uMzinyathi	KZN
6	Amajuba	KZN *(this was the additional site included by KZN provincial government.)*
7	Vhembe	Limpopo
8	Gert Sibande	Mpumalanga
9	Pixley ka Seme	Northern Cape
10	Dr. Kenneth Kaunda	North West
11	Eden	Western Cape

Source:(Genesis Analytics, 2019)

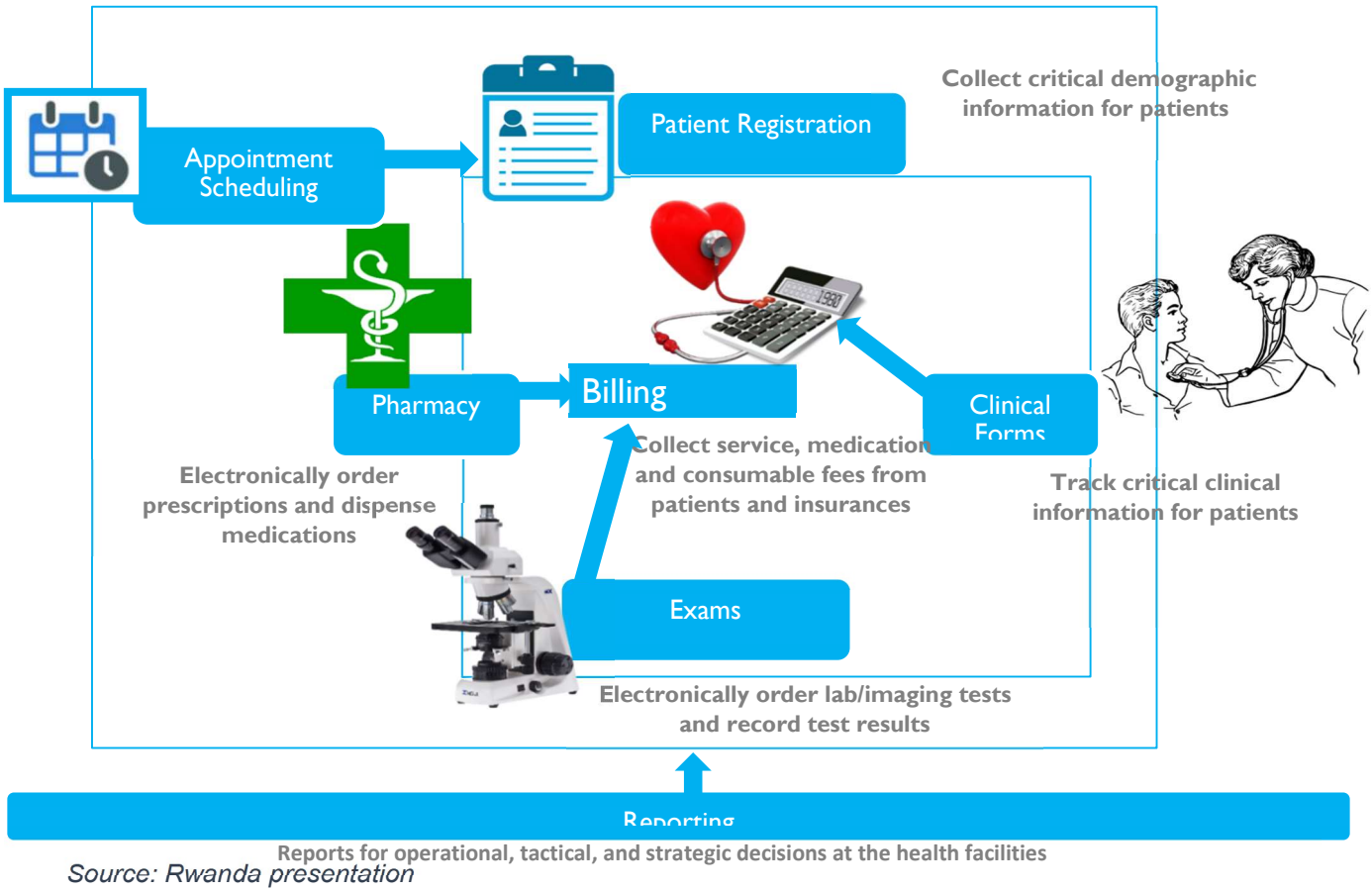
Upon rolling out phase one, evaluation studies were conducted by various evaluators such as the SAHR (2018), Ruiter (2017) and NDOH (2017). Through these evaluations, the NHI coordinators in all districts, District Managers and Facility Managers were interviewed. The aim of these evaluations was to find the state of readiness or progress for the implementation of NHI.

The findings of these evaluations communicated mixed feelings on the success of the project, due to some limitations. For instance, the evaluation reports by the NDOH, (Genesis Analytics, 2019) and by (*SAHR 2018South Africa health system*, n.d.) highlighted that in areas where successful stories were identified it was due to the following factors, strong political will, adequate human resource, financial resource, good coordination, and good monitoring systems were in place. However, there were some challenges across the pilot districts where unsuccessful stories were identified which included; lack of human and financial resources, lack of coordination and insufficient mechanisms to monitor progress.

These evaluations further identified that given the nature of NHI which relied more on the usage of technology, some pilot sites had some issues with registering the patients due to inadequate use of computers, data management soft wares and poor connection in those sites. This compromised progress in some sites as they were unable to track progress as far as patient registration was concerned. Registration is the entry point for anyone to benefit from the NHI services. Registration did not only help the patients, it helped the facility to know how much stock they had, how many Doctors, Pharmacists, and Nurses were needed to service patients. As a result poor registration management had a negative impact on the financials of the NHI system.

The following part highlight the ideal functionality of NHI patient registration.

Chart 2: NHI patient registration



Source: Rwanda presentation

The outcome of the above mainly ensured that data entry was managed in a proper manner and continuous monitoring and stock management were done in a simpler way in order to increase transparency between the patient, doctor and the financial management of the system.

Phase 2 of NHI implementation

Phase 2 of the NHI, started from 2017 and will end in 2022. It focuses on ensuring the NHI Fund is fully functional and has the required management and governance structures so that the purchase of services and population registration can begin. This involves passing the NHI Bill, which was introduced in 2019, and making amendments to several pieces of legislation (Green Paper on NHI,2011).

Phase 3 of the NHI implementation

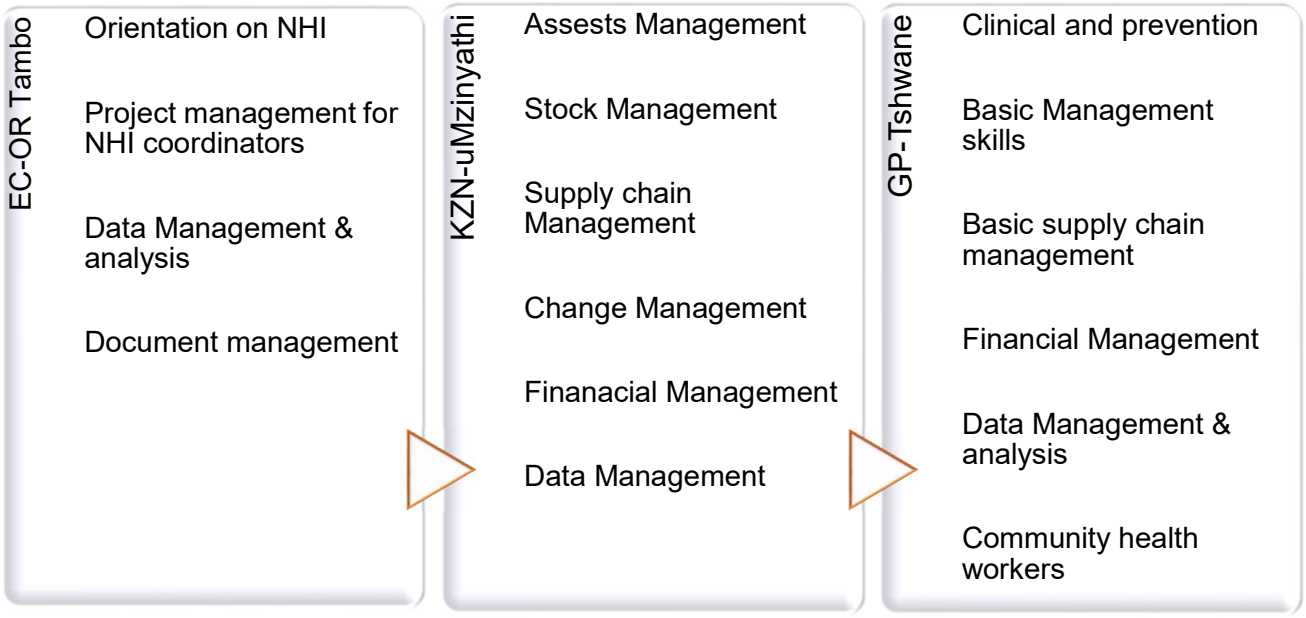
Phase 3 of the NHI, will begin from 2022 and run through to 2026. This phase will signal the introduction of mandatory prepayment and the contracting of accredited private hospital and specialist services, as well as the finalisation of the Medical Schemes Amendment Act.

Objective 2: Identifying the essential skills needed for the effective implementation of the NHI Programme

This section of the report provides an overview of the primary data collected from representatives of the NHI pilot sights. This part highlights those essentials skills needed for effective implementation of NHI. As mentioned in chapter 2 for the purpose of this study essential skills include both the critical skills ***"top-up skills"*** and Scarce skills identified through ***"hard to fill vacancies"*** *from the Workplace Skills Plans.*

The following are the critical skills required for the implementation of NHI yielded by the study:

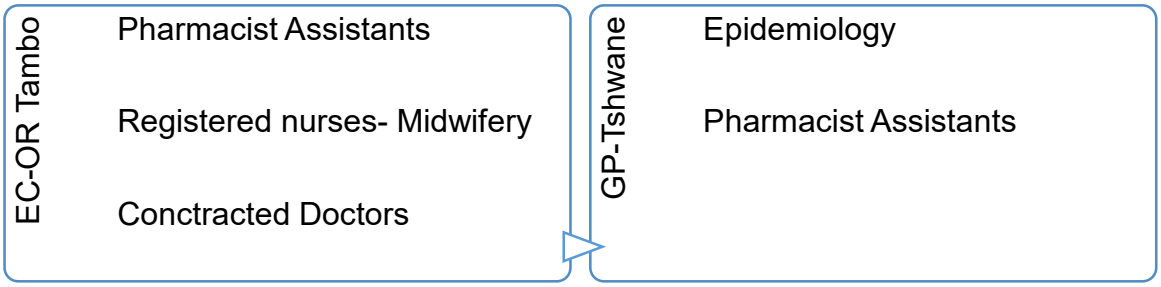
Chart 3: Critical Skills for the NHI Programme based on the NHI Pilot Sites



The above-mentioned critical skills needs may be offered in the form of a short course for the existing personnel. Without these they are unable to implement NHI effectively.

The following are the scarce skills required for the implementation of NHI yielded by the study:

Chart 4: Scarce skills for the NHI Programme based on the NHI Pilot Sites



Given the functionality of the NHI, the system relies more on contracting the General Practitioners (GP's) and specialist at the Primary Health care level. In the Eastern

Cape, the GP's have been contracted to assist in servicing the people in the pilot site. However, the problem came after the pilot period has elapsed where the Provincial Departments were advised to budget for the contracting. This added more financial burden in the Eastern Cape Department of Health finances, which resulted in some GP's withdrawing from NHI Pilot site, for they were not paid on time. Also Registered Nurses, Midwifery Nurses, and Pharmacists did not want to work in rural areas, yielding a finding on the effect of geographical areas on the NIH Pilot programme. However, it is important to note that the geographical problem is a global problem due to those areas not being economically developed. Until when there is economic development in those areas this issue will remain unresolved.

The Tshwane NHI Pilot site identified the specialisation in epidemiology as a scarce-skills for the effective implementation of the NHI Programme. Epidemiology was important as the region required the identification of patterns and determinants of health and disease conditions. For the primary health centre to respond effectively to the needs of Tshwane region, it was also discovered that another scare skill was the Pharmacist Assistance as most preferred to work for the private sector than the public sector. This scarcity was worse for Primary Healthcare.

Objective 3: Identifying Interventions required for an effective NHI Programme

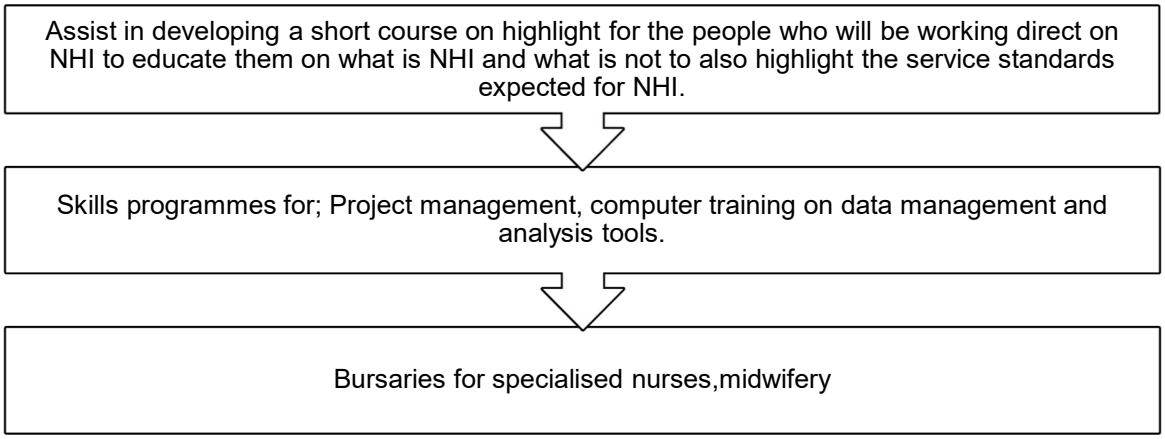
After all the identified skills gaps have been highlighted above this part will address the "so what part". For instance, now we know the current skills gap in those NHI pilot sites visited this part will highlight the possible position for HWSETA. Specific to those sites that were covered by the study.

The following section highlights the skills development interventions for NHI for each region.

The Eastern Cape Region

Interventions for this region are presented in chart 5 as follows:

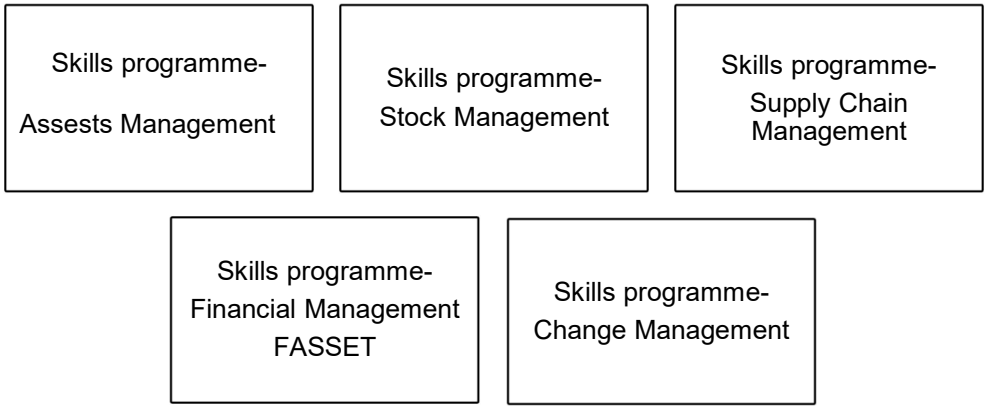
Chart 5: OR Tambo identified skills intervention:



The Kwa Zulu-Natal Region

As highlighted above it shows how system thinking is important for effective implementation for NHI. As shown on the interpretation of the results of how the KZN -uMzinyathi pilot site shows the need for partnering with a SETA for skills development intervention. This means that HWSETA will need to initiate a partnership with other skills development authorities in ensuring that the gaps identified in KZN -uMzinyathi pilot site can be addressed.

Chart: 6 uMzinyathi Identified Skills Interventions



Source researchers' notes (2018).

Gauteng Region

The following chart highlights the skills development interventions for the Tshwane pilot site.

Chart 7: GP-Tshwane identified skills interventions

Provide training for community health workers
Skills programme for project management for NHI coordinators
Provide bursaries for pharmacist assistants

Source Researchers notes (2018).

As highlighted above in Chapter 2 the conceptual theory suggests the application of systems thinking approach when dealing with NHI. Even for the above-mentioned skills intervention to work will require a system thinking approach even on areas where possible partnerships have been highlighted.

Currently, the Presidency, working with the Ministry of Health, is set to ensure the implementation of an overarching National Quality Implementation Plan (NQIP), for South Africa. The Plan seeks to transform existing service delivery challenges into learnings and opportunities for quality improvement and to pull together the quality of care initiatives into a coherent 5-year plan. This plan is set to alleviate the concerns raised around NHI.

The overall objective of the Plan is to ensure the best possible outcomes for the South African health system, as reflected in improved health status, satisfied patients and staff and the best use of resources. This can be achieved through quality assurance and improvement strategies. HWSETA is funding the capacity-building aspect of this project.

From the above list that the key essential skills do not entail fall under the HWSETA's domain. Hence, there is a need for a system thinking approach when dealing with NHI for the effective implementation of NHI.

4.3 Conclusion

The above sections have highlighted an overview of what is NHI. Above all, we saw the complexity of skills planning which might need to be addressed by proper systems in place to ensure ongoing skilling and upskilling.

CHAPTER 5: CONCLUSIONS, RECOMMENDATIONS, AND DISSEMINATION OF RESULTS

5.1 Introduction

In summary, on-going collaboration across the board is needed even from the Skills development authorities. Also, institutional arrangements also play a positive role in bridging the supply and demand gap. Given the mandate of HWSETA, it is expected to take a leading role to support the NHI as far as skills development is concerned, working in collaboration with other important stakeholders. This can be done by using the information in chapter 2 on the possible partners in formulating functional partnerships.

5.2 Conclusions

In conclusion, as highlights above, there are still some gaps as far as skills development is a concern in the areas where NHI was piloted. It has been showed that HWSETA needs to properly partake in closing the identified gaps. As mentioned above, this can only work if the system thinking approach is applied when dealing with the issue under study. Most importantly more effort is needed on ensuring that the people in different primary health facilities are educated about what is NHI and what is not NHI to ensure proper service delivery and proper skills planning.

5.3 Recommendations

It is recommended that:

- The HWSETA supports the bridging of the skills gap and addressing the critical skills identified in the pilot sites visited.
- The HWSETA needs to have a decentralized partnership approach with districts than having it with the National department, due to inefficient information (financial) flow across the system.
- The HWSETA needs to have partnerships with districts with a specific time frame and required outputs explicitly stating the skills development needs.

- The HWSETA needs to identify possible working partnerships to ensure effective implementation of the NHI.

5.4 Disseminating of the results

The results findings would be disseminated as follows;

- Research findings to be presented in the RIME/SDP committee
- Report to be published on the HWSETA website
- Report to be shared with the Labour Market Intelligence partnership (LMIP) repository housed at the Department of Higher Education and Training
- To be shared with the Department of Higher Education and Training for the Post school education and training (PSET) research bulletin.

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