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Why Health Policy Reforms Fail: Implementation Barriers in South Africa's National Health Insurance

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Abstract: Major public policy reforms in developing and middle-income states frequently falter not at the design stage, but during implementation. In South Africa, the National Health Insurance (NHI) represents one of the most ambitious post-apartheid policy reforms, aimed at advancing universal health coverage through a single-payer system. Despite sustained political commitment and extensive policy development, progress in implementing the NHI has been slow and uneven. Existing scholarship on the NHI has largely focused on financing models, constitutional debates, and health equity outcomes, with comparatively limited attention to the public administration and policy implementation conditions shaping reform feasibility. This article addresses this gap by examining the policy implementation barriers constraining the rollout of the NHI, with particular attention to governance arrangements, administrative capacity, and intergovernmental coordination within South Africa's public sector. The study adopts a qualitative research design, drawing on document analysis and semi-structured interviews with key informants from government, civil society, academia, and the private health sector. The analysis is guided by Policy Implementation Theory and institutional perspectives to assess the alignment between policy ambition and administrative capability. The findings reveal that NHI implementation is undermined by weak policy–administration alignment, fragmented accountability across government spheres, bureaucratic inertia, uneven institutional capacity at provincial and district levels, and ambiguities within the policy and legislative framework. These constraints are further reinforced by the persistence of a dual public–private health system, which complicates coordination and operational integration. The article recommends strengthening intergovernmental coordination mechanisms, clarifying implementation authority, and investing in administrative and managerial capacity as preconditions for large-scale policy reform. It concludes that the challenges facing the NHI are primarily institutional and administrative rather than technical or financial. The study contributes to the scholarship on public administration and policy implementation by positioning the NHI as a case of implementation failure rooted in state capacity constraints, offering transferable insights for the governance of complex social policy reforms in middle-income countries.

Keywords: National Health Insurance (NHI); Universal Health Coverage (UHC); Health Equity, Health Access; Policy Implementation; Structural Barriers; Institutional Capacity; Governance.

Introduction and Background

South Africa's health system remains profoundly shaped by apartheid-era inequalities that institutionalised a dual structure in which a minority of the population accesses a well-resourced private healthcare system while the majority depends on an overstretched public sector (Mkhwanazi 2024:198). These historical inequities are not limited to disparities in service quality and access, but are embedded within more profound structural weaknesses related to health financing, governance arrangements, and institutional capacity across the public health system

(Burger & Christian 2020). Since the democratic transition in 1994, successive governments have pursued an ambitious reform agenda to redress these imbalances and expand access to healthcare. However, despite notable policy advances, persistent structural fragmentation and uneven administrative capacity continue to undermine equity, system performance, and reform sustainability (Munyewende & Rispel 2014)

Early post-apartheid health reforms illustrate the implementation challenges that continue to shape contemporary policy efforts. The introduction of free primary healthcare (PHC) in 1996 marked a decisive break from racially exclusionary policies and significantly expanded service utilisation, particularly among historically marginalised communities (Coovadia, Barron & Peer 2009:829). Yet this expansion exposed enduring systemic weaknesses, including chronic staff shortages, ageing infrastructure, and weak accountability mechanisms within the public sector (Coovadia et al. 2009). Similarly, the National Health Act of 2003 sought to strengthen decentralised service delivery by establishing the District Health System (DHS), intended to improve responsiveness and local accountability. In practice, implementation was uneven, constrained by blurred lines of authority and capacity deficits across national, provincial, and district levels (Nxumalo & Gilson 2023:67–68). These shortcomings were particularly pronounced in rural and under-resourced provinces, reinforcing spatial and institutional inequalities.

Subsequent reform initiatives further underscore the limits of policy ambition in the absence of institutional readiness. The establishment of the Office of Health Standards Compliance (OHSC) in 2013 was intended to strengthen quality assurance and prepare public facilities for accreditation under the (NHI). However, the OHSC has faced persistent constraints, including limited enforcement powers, inadequate staffing, and ongoing infrastructure backlogs across public health facilities (AGSA 2022:16). Auditor-General reports continue to document widespread non-compliance and declining performance in key service areas, raising serious concerns about the capacity of the health system to meet the standards required for effective NHI implementation. These experiences reveal a recurring pattern in South Africa's reform trajectory: while policy frameworks are often well articulated, implementation is undermined by structural and institutional weaknesses.

Despite these implementation challenges, political commitment to the NHI has intensified over time. The African National Congress (ANC) first articulated a vision for universal healthcare access in 1994, formalised NHI as policy in 2007, and progressively advanced the reform through the 2011 Green Paper, the 2017 White Paper, and the passage of the NHI Bill in 2023 (Fusheini & Eyles 2016; ANC 2009). Nevertheless, the reform remains highly contested, with ongoing debates surrounding financing models, governance arrangements, constitutional implications, and the role of the private sector. South Africa continues to operate a deeply unequal two-tiered health system, characterised by stark disparities in financing, service quality, and health outcomes between the public and private sectors (Coovadia et al. 2009:45; Blecher et al. 2011). While the NHI seeks to address these inequities through a single-payer financing mechanism to advance universal health coverage (Munyewende & Rispel 2014), lessons from earlier reforms such as PHC, DHS, and OHSC indicate that expanded access alone is insufficient without parallel improvements in governance, administrative capacity, and institutional coordination (Coovadia et al. 2009; Nxumalo & Gilson 2023).

Notwithstanding formal policy adoption, progress in implementing the NHI has been slow and uneven, reflecting persistent structural and institutional barriers. Governance inefficiencies, weak intergovernmental coordination, duplication of roles, and enduring disparities between health sectors continue to undermine implementation efforts (Nxumalo & Gilson 2023:64; Ditlopo et al. 2011:4). Evidence from NHI pilot sites points to delays, inconsistent progress, and variable outcomes, highlighting systemic fragmentation and capacity deficits within the public administration (NDoH 2017:18; Ataguba 2022:3). While existing scholarship has extensively examined NHI financing models, human rights considerations, and political contestation, comparatively limited attention has been paid to the policy implementation conditions shaping reform feasibility, particularly from a public administration perspective (Benatar 2013; Thomas & Gilson 2017; Rispel & Moorman 2015). This study addresses this gap by analysing the implementation barriers constraining the NHI, with a focus on governance arrangements, institutional coordination, infrastructure readiness, and workforce capacity. By repositioning the NHI as a case of policy implementation failure rather than policy design deficiency, the article contributes to public administration scholarship on state capacity and large-scale reform implementation, while offering insights relevant to debates on universal health coverage in low- and middle-income countries (Ataguba & Akazili 2010; Gilson & Raphaely 2008). The remainder of the paper is structured as follows: the next section outlines the theoretical framework guiding the analysis, followed by a presentation of the research methodology, findings, discussion of the results, and concluding reflections on policy and administrative implications.

Theoretical Framework

This study is grounded in Policy Implementation Theory and Governance and Institutional Theory, which together provide a robust analytical framework for examining why large-scale policy reforms fail during implementation, despite strong political commitment. The NHI reform represents a complex, multi-level policy intervention that requires coordinated action across multiple spheres of government, administrative systems, and institutional actors. In such contexts, implementation outcomes are shaped less by policy intent and more by the interaction between administrative capacity, governance arrangements, and institutional behaviour. By combining these two theories, the study can interrogate both the processes through which policy is implemented and the institutional structures that enable or constrain its effective execution.

Policy Implementation Theory provides the primary analytical foundation for understanding the gap between policy formulation and policy outcomes. Classic implementation scholars argue that policy failure frequently occurs not because of flawed design, but due to weaknesses in execution, coordination, and administrative capacity. Pressman and Wildavsky (1973) demonstrate that implementation is vulnerable to breakdown when policies involve multiple decision points, actors, and institutions conditions that are clearly evident in South Africa's NHI reform. Sabatier and Mazmanian (1989) further emphasise that successful implementation depends on clear objectives, adequate resources, and alignment among implementing actors, all of which remain uneven across national, provincial, and district health authorities (Ditlopo et al. 2011). In the NHI context, persistent workforce shortages, intergovernmental misalignment, and infrastructure deficits illustrate how structural weaknesses undermine implementation despite sustained political support (Parsons 1995; Rispel & Moorman 2015). Policy Implementation Theory, therefore, enables this study to systematically analyse how administrative fragmentation, bureaucratic inertia, and weak coordination translate policy ambitions into implementation failures.

Complementing this perspective, Governance and Institutional Theory explains how decision-making structures, accountability arrangements, and entrenched institutional norms shape implementation outcomes over time. South Africa's health system is characterised by overlapping mandates, uneven provincial capacity, and blurred lines of authority, which generate coordination failures and weaken accountability mechanisms (Harrison 2010; Rispel 2015). From an institutional perspective, these challenges are not merely technical but are embedded within enduring organisational routines and power relations. Institutional path dependency further entrenches these dynamics, as historical arrangements reproduce themselves and resist reform (Pierson 2000). In the case of the NHI, the persistence of a two-tier health system comprising a powerful private sector and a historically under-resourced public sector illustrates how institutional legacies constrain integration and reform efforts (McIntyre & Ataguba 2012). Governance and Institutional Theory thus highlights that NHI implementation is not only an administrative exercise, but also a contest over authority, resources, and institutional control.

Together, Policy Implementation Theory and Governance and Institutional Theory provide a coherent and complementary framework for analysing the NHI as a case of implementation failure rooted in state capacity and institutional constraints. Policy Implementation Theory focuses attention on how administrative processes, coordination mechanisms, and capacity deficits disrupt execution, while Governance and Institutional Theory explain why these weaknesses persist despite repeated reform efforts. This combined framework enables the study to move beyond descriptive accounts of policy challenges and instead offer a theoretically grounded explanation of how institutional fragmentation, weak governance, and entrenched administrative practices undermine the feasibility of complex social policy reforms. In doing so, the study contributes to public administration scholarship by demonstrating how large-scale reforms such as the NHI are ultimately shaped by the interaction between implementation processes and institutional structures, rather than by policy design alone.

Literature Review: International and South African Experiences of NHI and UHC Implementation

Comparative experiences of NHI and UHC reforms demonstrate that successful health policy reform depends less on policy intent and more on institutional capacity, governance arrangements, and implementation feasibility. The United Kingdom's NHS, established in 1948, is frequently cited as a landmark social policy achievement and a foundational model for universal access (Gorsky 2015). However, its creation was neither technocratic nor consensual; it faced strong resistance from medical professionals concerned about income loss and professional autonomy (Light 2003:26). Political leadership proved decisive, with negotiated compromises securing broad professional buy-in (Light 2003:26). While the NHS significantly expanded access regardless of income, long-term sustainability challenges emerged due to rising medical costs, fiscal constraints, and persistent waiting times, which in turn allowed private provision to coexist alongside the public system (Rivett 2014; History of Medicine 2014; Doyle & Bull 2000). These dynamics

underscore that even mature UHC systems remain vulnerable to implementation pressures rooted in governance, fiscal capacity, and institutional negotiation.

The United States presents a contrasting case, illustrating how fragmented governance and political contestation can impede universal reform. Repeated efforts to introduce comprehensive UHC were blocked throughout the twentieth century due to resistance from professional groups and political elites (Palmer 1999; Baum & Kernell 2001). Incremental reforms, including the introduction of Medicare in 1965 and subsequent expansions through the Medicare Modernisation Act of 2003, improved access for specific population groups but stopped short of universal coverage (Dowdal 1997; King 2013; Olivier, Lee & Lipton 2004:283). The Affordable Care Act (ACA) of 2010 further expanded coverage through mandates, subsidies, and regulated exchanges while retaining a pluralistic insurance model (Supreme Court 2011). Nevertheless, persistent political opposition, regulatory complexity, and rising costs have continued to limit reform consolidation (Popik 2014). The US case highlights how fragmented institutional arrangements and contested authority structures undermine coherent policy implementation, even in high-capacity states.

Mixed public–private systems such as those in Canada and Australia offer additional insights into the governance challenges of integrating multiple actors within UHC frameworks. Canada's predominantly tax-funded system operates through decentralised provincial governance, with physicians functioning as independent contractors and regional authorities enjoying significant autonomy (Marchildon 2013:19). Australia's Medicare similarly guarantees universal access based on need, yet private insurance continues to play a substantial role, covering approximately half of the population (Johar et al. 2012; Cheng, Joyce & Scott 2013). While these dual arrangements help distribute service demand and enhance system resilience, they also raise persistent equity concerns. These experiences demonstrate that the coexistence of public and private sectors is not inherently problematic, but requires strong regulatory capacity, clear accountability frameworks, and effective intergovernmental coordination to prevent inequitable outcomes.

African experiences with NHI and UHC reforms further reinforce the centrality of institutional capacity and governance effectiveness. Ghana's NHIS, introduced in 2003, expanded access through a mixed financing model combining VAT, payroll deductions, and individual premiums, particularly benefiting low-income groups (Blanchet et al. 2012:425; Chrismal & Aridam 2020:1894). However, coverage remains uneven, with persistent challenges related to financial sustainability, delayed provider payments, and governance inefficiencies (Agyepong & Adjei 2008:152; Chrismal & Aridam 2020:1894). Rwanda's Mutuelles de Santé achieved rapid coverage expansion exceeding 90% by 2010 through strong political commitment, decentralised governance, and donor support, although concerns regarding long-term sustainability, quality of care, and donor dependence persist (Lu et al. 2012; Chemouni 2018:109). Kenya's NHIF reforms and UHC pilots similarly reveal progress constrained by governance inefficiencies, limited coverage among informal workers, and corruption risks (Maina & Kirigia 2016; Munge & Briggs 2014:705, 708). Nigeria's NHIS illustrates the consequences of weak institutions and limited fiscal commitment, with coverage remaining below 10% and heavy reliance on out-of-pocket payments (Onoka et al. 2013; Obikeze et al. 2013:22; Adewole et al. 2015:93). Collectively, these cases demonstrate that political commitment alone is insufficient; implementation success depends on institutional coherence, administrative capacity, and sustained governance reform.

Within South Africa, the literature consistently identifies structural fragmentation, infrastructure deficits, and governance weaknesses as key constraints on effective UHC implementation. The health system operates across national, provincial, and local spheres and remains sharply divided between a public sector serving the majority and a private sector catering to a wealthier minority (Maphumulo & Bhengu 2019; Arhete & Erasmus 2016; Ataguba & McIntyre 2012). Although primary healthcare is free, hospital services remain partially subsidised, exposing many households to out-of-pocket costs (Passchier 2017; Smith & Nkosi 2021:102–103). Approximately 20% of South Africans utilise private healthcare due to perceived quality and efficiency advantages (Ataguba & McIntyre 2012; Statistics South Africa 2023), reinforcing inequities and sustainability concerns. Infrastructure gaps, particularly in rural areas, including dilapidated facilities, equipment shortages, and human resource constraints, further undermine service delivery (Smith & Lee 2018:42; WHO 2010:15; Brown & Williams 2017:88; Kumar & Patel 2020:80; Malakoane et al. 2020). Governance and financial constraints including weak leadership, corruption, fiscal mismanagement, and poor intergovernmental coordination compound these challenges, threatening NHI feasibility and fiscal sustainability (Andrews & Pillay 2005; Coovadia et al. 2009; Mabaso 2020; Baleta 2012; Marais & Petersen 2015; Solanki et al. 2022). Taken together, the literature suggests that South Africa's NHI implementation challenges are fundamentally administrative and institutional in nature, aligning with broader international evidence that large-scale health reforms succeed or fail based on governance capacity rather than policy ambition alone.

Methodological framework

This study is grounded in a social constructivist epistemology, which holds that policy realities, institutional practices, and implementation outcomes are socially constructed through interactions, interpretations, and power relations within specific governance contexts (Haralambos & Holborn, 2008:793). From this perspective, policy implementation is not a linear, purely technical process, but a negotiated, context-dependent phenomenon shaped by institutional norms, administrative routines, and stakeholder interpretations. This orientation is particularly appropriate for analysing the implementation of South Africa's NHI, a complex, multi-actor reform unfolding across multiple spheres of government and organisational settings. Consistent with this epistemological grounding, the study adopts a qualitative, interpretive case study design in which the NHI is treated as a single, embedded case within a multi-level governance and institutional system. The qualitative approach is appropriate because the study seeks to explain how and why implementation barriers emerge and persist within public sector institutions, rather than to measure outcomes statistically. The design integrates exploratory, descriptive, and explanatory elements to surface implementation dynamics and link observed barriers to Policy Implementation Theory and Governance and Institutional Theory. Deductive reasoning engages established theoretical frameworks as sensitising lenses, while inductive reasoning allows empirical insights to emerge from stakeholder accounts and documentary evidence (Blaikie 2010:95; Gabriel & Lester 2013:23), ensuring theoretical sensitivity without imposing rigid causal assumptions.

In recognition of potential internal biases associated with qualitative inquiry particularly verbal (interview-based), textual (policy and documentary sources), and digitally mediated data the study incorporated deliberate safeguards to enhance analytical neutrality and credibility. Methodological triangulation was employed by integrating semi-structured interviews with systematic document analysis, enabling cross-verification between stakeholder narratives and formal policy, legislative, budgetary, and oversight records. Reflexive awareness was maintained throughout the research process to limit normative assumptions about reform success or failure. Analytical decisions were documented through a transparent audit trail that recorded coding iterations, theme refinement, and theoretical integration, thereby strengthening confirmability. A structured coding framework was applied consistently across all data sources to reduce selective interpretation and confirmation bias. Participants were drawn from diverse institutional locations within the NHI governance chain, enabling systematic comparison of converging and diverging perspectives. These measures collectively strengthened internal validity and ensured that findings reflect analytically grounded patterns rather than isolated perceptions, political positioning, or the researchers' predispositions.

Population and Sampling Strategy

The population for this study comprised actors directly involved in, or exercising oversight over, the formulation, governance, and implementation of South Africa's NHI across the political–administrative system. Consistent with the qualitative, implementation-focused design, non-probability sampling was employed to generate analytically rich insights rather than statistical generalisation. A combination of purposive and limited snowball sampling was used to identify strategically positioned participants with direct knowledge of governance arrangements, fiscal oversight, and implementation constraints (Creswell & Creswell 2018:148). The final sample (N = 10), summarised in Table 1 below, represents a cross-section of legislative, executive, oversight, private-sector, civil-society, and academic actors operating across the NHI governance chain. This diversity was intentionally structured to capture converging and diverging institutional perspectives on implementation feasibility.

Table 1: Sample Composition and Interview Modality

Stakeholder Group	Number of Participants (N)	Interview Modality
Health Portfolio Committee Members (MPs)	3	Online (Microsoft Teams)
Government Officials (Health Sector)	1	Online (Microsoft Teams)
Private Health Sector Representative	1	Online (Microsoft Teams)
Civil Society / NGO Representatives	2	Online (Microsoft Teams)
Oversight Institution (National Treasury)	1	Online (Microsoft Teams)
Academics / Health Policy Experts	2	Online (Microsoft Teams)
Total	10	—

Source: Author's own compilation (2025)

The rationale for the sample size is grounded in qualitative case study principles, where depth, stakeholder positioning, and theoretical sufficiency take precedence over numerical breadth. Given the specialised and policy-sensitive nature of NHI implementation, priority was placed on engaging high-level, functionally relevant actors capable of providing

informed, experience-based accounts of governance fragmentation, administrative capacity, fiscal oversight, and institutional constraints. The objective was not representativeness, but analytical depth within a bounded policy case. Secondly, the determination of ten participants was informed by conceptual saturation and cross-institutional triangulation. During iterative data collection and analysis, recurring patterns stabilised across stakeholder categories, with additional interviews reinforcing rather than expanding core themes related to coordination gaps, policy–administration misalignment, capacity limitations, and accountability risks. The adequacy of the sample is therefore justified by theoretical sufficiency, stakeholder diversity, and the study's ability to generate analytically transferable insights into NHI implementation dynamics, rather than by statistical inference.

Data Collection Methods

This study employed multiple qualitative data collection methods to generate rich, triangulated evidence on the implementation of South Africa's NHI. Consistent with the study's interpretive, implementation-focused design, data were drawn from semi-structured interviews and systematic document analysis, enabling the integration of experiential accounts with formal policy and governance records (Smith 1997:216; Kumar 2014:17; Ajayi 2017:3–4). The use of complementary methods strengthened analytical depth and enhanced the credibility of findings by allowing convergence and contrast between what policy actors *experience in practice* and what policy texts and official records *formally prescribe*. Together, these methods are well-suited to examining complex policy reforms where implementation outcomes are shaped by administrative processes, institutional rules, and intergovernmental dynamics rather than by observable outputs alone (Creswell 2009:25).

Semi-Structured Interviews

Primary data were collected through semi-structured interviews, which enabled an in-depth exploration of participants' perspectives on NHI implementation, governance coordination, and institutional constraints. Interviews are particularly suitable for policy implementation research because they enable respondents to articulate their interpretations, experiences, and judgements in their own words, thereby revealing meanings that are often obscured in formal policy documents (Alshenqeeti 2014:40; Bryman 2016:465). Semi-structured interviews were selected over structured, unstructured, narrative, and fully open-ended formats because they offer a balance between analytical consistency and flexibility. While a common interview guide ensured comparability across respondents, the semi-structured format allowed for probing and clarification of issues as they emerged during discussion (Kvale & Brinkmann 2009). This was essential given the complexity and political sensitivity of NHI implementation. All interviews were conducted online via Microsoft Teams at mutually convenient times, lasted approximately 30–40 minutes, and were audio-recorded with participants' consent. Interviews were conducted in English, and no translation was required.

Document Analysis

To complement interview data and strengthen analytical rigour, the study also employed systematic document analysis. Document analysis is a qualitative method that involves the careful examination and interpretation of written materials to generate empirical insights and contextual understanding (Bowen 2009:28). In this study, document analysis served two purposes. First, it provided contextual and historical insight into the evolution, objectives, and regulatory architecture of the NHI. Second, it enabled triangulation by comparing formal policy intentions with stakeholder accounts of implementation realities. The documents analysed included constitutional and legislative texts, national policy frameworks, government reports, budget and audit documents, international institutional reports, academic literature, and civil society submissions related to the NHI. Analysing these documents enabled the study to identify consistencies and discrepancies between policy design and implementation practice, thereby strengthening its capacity to explain implementation barriers within South Africa's health governance system.

Data Analysis Strategy

Data were analysed using a theory-informed thematic analysis to systematically identify, interpret, and explain patterns related to policy implementation barriers in South Africa's NHI. The analysis followed an iterative and reflexive process consistent with qualitative best practice, enabling movement between empirical material and the study's analytical frameworks (Braun & Clarke 2006). Interview transcripts and documentary sources were first subjected to familiarisation and open coding, during which segments of text were coded inductively to capture recurring issues, meanings, and implementation experiences expressed by participants. This initial coding phase was followed by axial coding, in which related codes were clustered into higher-order categories that reflected governance arrangements, administrative capacity, coordination mechanisms, and institutional constraints. In the final phase, selective coding was employed to integrate empirically derived themes with Policy Implementation Theory and Governance and

Institutional Theory, allowing the analysis to move beyond description toward explanation. This approach ensured that findings were both grounded in participant accounts and analytically linked to established public administration scholarship, thereby strengthening explanatory depth and theoretical coherence.

Documentary data were analysed in parallel with interview data to support analytical triangulation and to contextualise stakeholder perspectives within formal policy and governance frameworks. Legislative texts, policy documents, audit reports, and budget reviews were examined to identify stated objectives, implementation arrangements, accountability mechanisms, and reported performance outcomes. These documents were coded using the same thematic framework applied to the interview data, enabling a systematic comparison between the *policy as designed* and the *policy as implemented*. This comparative logic was particularly important for identifying discrepancies between formal institutional mandates and operational realities, a core concern in policy implementation research (Schurink & Auriacombe 2010:449). By integrating interview and documentary evidence within a single analytical framework, the study enhanced internal consistency and reduced the risk of privileging either official narratives or individual perceptions.

To ensure transparency and analytical rigour, the relationship between empirical data, analytical themes, and theoretical constructs is summarised in Table 2. The table demonstrates how raw data were progressively abstracted into themes and linked to the study's theoretical foundations, supporting the credibility and traceability of the analytical process.

Table 2: Data Analysis Framework Linking Empirical Codes, Themes, and Theory

Data Source	Initial Codes (Illustrative)	Analytical Themes	Theoretical Link
Interviews (MPs, officials, CSOs, experts)	Weak coordination, unclear mandates, capacity gaps, delays	Intergovernmental fragmentation	Policy Implementation Theory
Interviews & Documents	Role duplication, compliance focus, administrative inertia	Bureaucratic and institutional constraints	Governance & Institutional Theory
Policy and Legislative Documents	Ambiguous authority, overlapping legislation	Policy–administration misalignment	Policy Implementation Theory
Audit & Budget Reports	Resource constraints, weak oversight	State capacity and accountability failures	Governance & Institutional Theory
Civil Society Submissions	Trust deficits, participation gaps	Stakeholder exclusion and legitimacy	Governance & Institutional Theory

Source: Author's own compilation (2025).

This structured analytical strategy ensured that the study's findings were not only empirically grounded but also theoretically interpretable. By explicitly linking data to analytical themes and theoretical constructs, the analysis advances an explanation of NHI implementation barriers as the product of institutional arrangements, governance dynamics, and administrative capacity constraints, rather than isolated technical shortcomings. This approach supports the study's broader contribution to public administration and policy implementation scholarship by demonstrating how qualitative analysis can generate transferable insights into the governance of complex social policy reforms.

Trustworthiness and Rigour

Trustworthiness was ensured through the application of established qualitative criteria of credibility, dependability, confirmability, and transferability. Credibility was enhanced through sustained engagement with interview and documentary data and through systematic comparison of perspectives across legislative, executive, oversight, private sector, civil society, and academic actors, thereby reducing the likelihood that partial institutional narratives would shape conclusions. Dependability was supported by a clearly articulated research design, transparent sampling logic, and systematic documentation of data collection and analytical procedures. Confirmability was reinforced by grounding interpretations in traceable empirical evidence, with findings demonstrably linked to coded interview

segments and documentary materials. Transferability was strengthened through rich contextual description of South Africa's governance and institutional environment, enabling analytically transferable insights for comparable large-scale policy reforms in middle-income contexts, without claims of statistical generalisation.

Ethical Considerations

Ethical clearance for the study was obtained from the University of Johannesburg Research Ethics Committee prior to data collection, ensuring compliance with institutional and national ethical standards for research involving human participants. All participants received an information sheet detailing the purpose, objectives, procedures, and ethical safeguards of the study, and provided informed consent before participation, with the right to withdraw at any stage without penalty.

Findings

Weak Policy–Administration Alignment

A central finding of this study is the persistent misalignment between NHI policy ambition and administrative reality, which participants identified as a fundamental barrier to practical implementation. While the NHI is articulated as a transformative reform at the legislative and policy level, respondents consistently described a gap between high-level commitments and the operational guidance available to implementing actors. Participants across various roles, including political, administrative, and oversight, noted that policy objectives are often communicated in broad, aspirational terms, without sufficient translation into concrete administrative processes, implementation timelines, or clearly defined responsibilities. This disconnect has created uncertainty within public administration, particularly at provincial and district levels, where officials are expected to implement reforms without clarity on how policy intent should be operationalised in practice. As one participant observed, *"The policy sounds very clear at the top, but once it reaches the departments, it becomes difficult to know what exactly must be done and by whom"* (P3).

Participants further highlighted that legislative progression has not been matched by implementation readiness, creating pressure on administrative systems that are already stretched. Several respondents described the passage of the NHI Bill as creating expectations of imminent rollout, despite unresolved questions around systems, staffing, and operational authority. This has contributed to what participants characterised as reform fatigue within the bureaucracy, where officials are required to prepare for implementation without adequate resources or institutional support. A government official noted that *"we are being told to prepare for NHI, but there is no clear operational plan that tells us what preparation actually means at our level"* (P6). Members of Parliament echoed this concern, acknowledging that political momentum has at times outpaced administrative preparedness, with one stating, *"There is a strong political push, but the administrative machinery is not yet aligned to carry it through"* (P2).

The misalignment between policy formulation and administrative execution was also reflected in the limited vertical coherence across various government spheres. Provincial and district actors reported receiving policy directives without accompanying adjustments to budgets, staffing norms, or reporting systems, constraining their ability to act meaningfully on NHI-related mandates. This resulted in uneven interpretation and implementation readiness across jurisdictions. Civil society respondents similarly pointed to the absence of clear feedback loops between implementers and policymakers, noting that implementation challenges identified at operational levels rarely informed subsequent policy refinement. As one civil society participant explained, *"the people who are supposed to implement are not always part of the conversation when policies are finalised, so the same problems repeat themselves"* (P8). Collectively, these findings suggest that weak policy–administration alignment has led to uncertainty, uneven preparedness, and implementation inertia, thereby undermining the feasibility of translating NHI policy commitments into effective administrative action.

Fragmented Governance and Intergovernmental Coordination Failures

A second major finding concerns persistent governance fragmentation and weak intergovernmental coordination, which participants identified as a critical constraint on NHI implementation. Respondents consistently reported that responsibilities related to health governance and NHI rollout are dispersed across national, provincial, and local spheres without sufficiently clear lines of authority or coordination mechanisms. This has resulted in overlapping mandates, duplication of functions, and uncertainty regarding decision-making power. Participants described a system in which accountability is diffused across institutions, making it difficult to determine where responsibility for implementation, progress or failure ultimately resides. As one oversight participant explained, "everyone is involved, but no one is fully accountable, because the mandates overlap and decisions get passed around" (P9).

Participants from provincial and administrative backgrounds highlighted that vertical coordination between national and provincial spheres remains weak, particularly in relation to planning, budgeting, and reporting for NHI-related activities. Several respondents noted that national policy directives are often issued without adequate consultation or alignment with provincial capacities and priorities, leading to uneven implementation readiness across provinces. A provincial-level participant stated that "national sets the direction, but provinces are expected to implement without having real input into how feasible those decisions are on the ground" (P6). This lack of coordination was reported to generate tension between spheres of government, with provinces perceiving NHI-related responsibilities as additional burdens rather than integrated reforms supported by shared planning and resources.

Horizontal coordination challenges were also evident, particularly between health departments and other key institutions involved in financing, oversight, and regulation. Participants indicated that limited coordination between departments responsible for health, finance, and public administration has slowed decision-making and constrained implementation coherence. One participant observed that "health cannot implement NHI on its own, but the coordination with Treasury and other departments is not as seamless as it needs to be" (P4). This fragmentation was further compounded by the absence of strong coordinating structures capable of resolving disputes, harmonising timelines, or aligning institutional incentives across departments and spheres.

Civil society and parliamentary participants additionally pointed to uneven implementation across provinces as an outcome of fragmented governance arrangements. Differences in administrative capacity, leadership stability, and political commitment were reported to result in varied interpretations of NHI preparedness and progress. A Member of Parliament noted that "what you see in one province is not the same in another, and that tells you coordination is weak" (P1). Participants emphasised that without coherent intergovernmental coordination frameworks, the NHI risks reproducing existing inequalities rather than addressing them. Overall, the findings suggest that fragmented governance structures and weak coordination mechanisms have created systemic obstacles to NHI implementation, resulting in inconsistent progress, diluted accountability, and a stalled momentum for reform.

Uneven Institutional and Administrative Capacity

A third major finding of the study is the presence of significant disparities in institutional and administrative capacity across the health system, which participants consistently identified as a major barrier to the effective implementation of NHI. Respondents across all stakeholder groups emphasised that the ability to plan for, manage, and operationalise NHI-related reforms varies considerably between institutions and across provinces. These capacity differences were described not only in terms of financial resources, but also in relation to managerial competence, human resource availability, and administrative systems. Several participants noted that while some provinces and facilities may be able to engage with NHI readiness requirements, others lack even the basic institutional infrastructure necessary to absorb additional reform responsibilities. As one academic participant stated, *"you cannot implement the same policy in institutions that are at very different levels of capacity and expect the same results"* (P7).

Participants highlighted human resource constraints as a particularly acute dimension of uneven capacity. Shortages of skilled administrative and managerial personnel were reported to limit the ability of institutions to engage with complex policy requirements such as accreditation processes, contracting arrangements, and compliance reporting. In several cases, respondents described situations where clinical staff were required to take on administrative responsibilities due to the absence of dedicated management personnel, further straining already overstretched systems. A public sector participant explained that *"there are facilities where the focus is still on basic service delivery, and there is simply no capacity to deal with the additional administrative demands that NHI brings"* (P5). These constraints were reported to be more pronounced in rural and historically under-resourced provinces, reinforcing existing spatial and institutional inequalities.

In addition to human resource limitations, participants identified infrastructure readiness and administrative systems as uneven and, in some cases, inadequate for supporting the implementation of NHI. Respondents noted that weaknesses in information systems, procurement processes, and facility infrastructure constrain the ability of institutions to meet required standards and timelines. Oversight participants indicated that repeated audit findings related to infrastructure maintenance, equipment availability, and record-keeping reflect deeper institutional weaknesses rather than isolated compliance failures. As one oversight respondent remarked, *"you cannot talk about implementing NHI when basic systems like infrastructure, information, and maintenance are still not functioning properly"* (P9). Collectively, these findings suggest that uneven institutional and administrative capacity has created differential readiness across the health system, limiting the feasibility of a uniform NHI rollout and contributing to stalled implementation at multiple levels of governance.

Persistence of Public–Private Sector Fragmentation

A further key finding of the study is the continued fragmentation between the public and private healthcare sectors, which participants identified as a major structural barrier to NHI implementation. Respondents consistently described South Africa's health system as operating through two parallel and weakly integrated systems, each governed by different incentives, capacities, and accountability mechanisms. This fragmentation was reported to complicate efforts to operationalise the NHI, particularly in relation to service purchasing, provider accreditation, and contracting arrangements. Participants noted that, despite policy intentions to integrate public and private provision under a single financing framework, there remains limited clarity on how such integration will function in practice. As one participant remarked, *"on paper the NHI brings the two systems together, but in reality they still operate separately, with very little alignment"* (P4).

Participants from both public and oversight institutions highlighted trust deficits and uncertainty as key factors contributing to ongoing fragmentation. Private sector actors were described as sceptical about the administrative capacity of the state to manage large-scale purchasing and reimbursement systems, while public sector respondents expressed concern about the negotiating power and profit orientation of private providers. This mutual distrust was reported to slow engagement and limit meaningful collaboration around NHI implementation processes. A civil society participant observed that *"there is still a lot of suspicion on both sides, and without trust, integration becomes very difficult"* (P8). Several respondents indicated that uncertainty around reimbursement mechanisms, pricing, and contractual obligations has discouraged private providers from fully engaging with NHI planning processes.

The persistence of fragmentation was also evident in unequal power relations between sectors, which participants described as shaping the pace and direction of reform. Respondents noted that the private health sector's financial and organisational strength enables it to influence policy debates and resist aspects of reform perceived as threatening to existing business models. At the same time, public sector institutions were described as struggling to assert regulatory authority due to capacity constraints and governance weaknesses. A parliamentary participant stated that *"the private sector has more leverage and more resources, so integration is not a neutral process it is shaped by power"* (P2). These dynamics were reported to contribute to stalled negotiations, contested policy interpretations, and incremental rather than transformative change.

Participants further indicated that the lack of clear operational frameworks for integration has reinforced fragmentation at the implementation level. Respondents described uncertainty regarding accreditation criteria, contracting processes, and dispute resolution mechanisms, which have limited practical experimentation and learning. In the absence of clear guidance, institutions were reported to default to existing practices rather than engage proactively with NHI-related reforms. As one academic participant noted, *"without clear rules of engagement, both sectors retreat to what they already know, and that sustains the divide"* (P7). Overall, the findings suggest that the persistence of public–private sector fragmentation reflects not only technical challenges but also institutional inertia, power asymmetries, and unresolved governance questions, all of which constrain the implementation of an integrated NHI system.

Weak Accountability, Oversight, and Feedback Mechanisms

The final major finding of the study concerns weak accountability, oversight, and feedback mechanisms, which participants identified as a key factor sustaining implementation challenges within the NHI reform process. Respondents consistently reported that while formal oversight structures and reporting requirements exist, these mechanisms are often compliance-driven rather than learning-oriented, limiting their effectiveness in supporting adaptive implementation. Participants noted that monitoring processes tend to focus on procedural compliance and documentation rather than on identifying systemic bottlenecks or enabling corrective action. As one oversight participant explained, *"there are many reports and audits, but very little changes as a result of what is found"* (P9).

Participants further highlighted that feedback loops between implementers, oversight bodies, and policymakers remain weak, resulting in repeated identification of the same problems without meaningful resolution. Several respondents indicated that challenges raised by provinces, facilities, or pilot sites are not systematically fed back into policy refinement or administrative redesign. This has contributed to a perception that implementation challenges are acknowledged but not acted upon. A government participant observed that *"the same issues come up year after year, but there is no mechanism that forces a response or adjustment"* (P6). Civil society respondents echoed this concern, noting that stakeholder inputs and oversight findings often have limited influence on decision-making processes, reinforcing frustration and disengagement.

Accountability was also reported to be undermined by diffused responsibility and limited consequences for implementation failure. Participants described an environment in which responsibility for delays or poor performance

is dispersed across multiple institutions, making it difficult to assign accountability or enforce corrective measures. Several respondents noted that performance management systems rarely link implementation outcomes to incentives or sanctions, reducing pressure for institutional change. A parliamentary participant remarked that *"when things don't move, it is hard to say who must be held responsible, because everyone can point elsewhere"* (P1). This diffusion of accountability was perceived as contributing to implementation inertia and weakening the momentum of reform.

Finally, participants indicated that lessons from NHI pilot initiatives and oversight exercises are insufficiently institutionalised, limiting opportunities for learning and adaptation. Respondents noted that while pilot sites generate valuable insights, these lessons are not consistently translated into system-wide improvements or revised implementation strategies. An academic participant stated that *"pilots are meant to help us learn, but the learning does not always travel beyond the pilot sites"* (P7). Overall, the findings suggest that weak accountability, limited feedback mechanisms, and the absence of structured learning processes have allowed implementation challenges to persist, thereby reinforcing structural barriers across the governance, capacity, and coordination dimensions of the NHI reform.

Discussion of Findings

The findings of this study reinforce a central argument in public administration scholarship: ambitious social policy reforms are frequently undermined not by flawed policy intent, but by weak alignment between political ambition and administrative capability. South Africa's NHI reform mirrors earlier post-apartheid health reforms such as free primary healthcare, the District Health System, and the establishment of the Office of Health Standards Compliance where expansionary policy commitments were introduced into institutional environments characterised by uneven capacity, weak accountability, and fragmented governance (Coovadia et al. 2009; Nxumalo & Gilson 2023; AGSA 2022). While the NHI represents a more comprehensive and system-wide intervention, the persistence of these structural conditions suggests a path-dependent reform trajectory in which implementation constraints are reproduced across policy cycles rather than resolved. This finding supports the view that policy reform in highly unequal and institutionally fragmented systems requires not only legislative innovation but sustained investment in administrative alignment and institutional readiness (Mkhwanazi 2024).

Interpreted through Policy Implementation Theory, the study demonstrates how the NHI exhibits many of the classic conditions associated with implementation failure in complex policy environments. As Pressman and Wildavsky (1973) and Sabatier and Mazmanian (1989) argue, policies that involve multiple actors, decision points, and levels of government are particularly vulnerable to breakdown when objectives are ambiguous, coordination is weak, and administrative capacity is uneven. The NHI's slow and inconsistent progress reflects these dynamics, with governance inefficiencies, intergovernmental misalignment, and capacity disparities constraining implementation despite strong political commitment (Ditlopo et al. 2011; Rispel & Moorman 2015). Rather than representing isolated administrative shortcomings, these challenges highlight systemic weaknesses in how large-scale reforms are implemented within South Africa's public sector. The study thus contributes empirically to implementation scholarship by illustrating how policy ambition can outpace institutional capability in middle-income contexts, producing implementation inertia rather than transformation.

Governance and Institutional Theory further illuminates why these implementation challenges persist over time. The South African health system operates within entrenched institutional arrangements shaped by historical inequalities, overlapping mandates, and uneven provincial capacity (Harrison 2010; Rispel 2015). The persistence of a dual public–private health system exemplifies institutional path dependency, where existing power relations and organisational routines resist integration and reform (McIntyre & Ataguba 2012; Pierson 2000). Rather than facilitating coordination, governance structures often diffuse accountability and dilute authority, enabling actors to deflect responsibility for implementation failure. This institutional configuration helps explain why lessons from earlier reforms such as DHS decentralisation and OHSC accreditation have not been translated into stronger implementation readiness for the NHI (Nxumalo & Gilson 2023; AGSA 2022). The study thus advances governance theory by demonstrating how institutional fragmentation and power asymmetries actively shape the pace and direction of reform, rather than serving as passive constraints on the process.

When situated within international and comparative literature on NHI and UHC, the South African case aligns closely with experiences in both high-income and African contexts. Comparative evidence from the United Kingdom, United States, Canada, Australia, Ghana, Rwanda, Kenya, and Nigeria shows that political commitment alone is insufficient to guarantee successful reform; rather, implementation outcomes hinge on governance coherence, regulatory capacity, and institutional coordination (Gorsky 2015; Light 2003; Marchildon 2013; Agyepong & Adjei 2008; Chemouni 2018; Munge & Briggs 2014). South Africa's experience is distinctive not because its challenges are unique, but because

they are intensified by extreme inequality, intergovernmental complexity, and a powerful private health sector (Coovadia et al. 2009; Blecher et al. 2011; Ataguba & McIntyre 2012). By foregrounding implementation dynamics rather than financing or constitutional debates, this study contributes to comparative UHC scholarship by positioning South Africa's NHI as an instructive case of how institutional context conditions reform feasibility in low- and middle-income countries (Ataguba & Akazili 2010; Gilson & Raphaely 2008).

Overall, the study makes both theoretical and empirical contributions to the fields of public administration and health policy scholarship. Theoretically, it strengthens the application of Policy Implementation Theory and Governance and Institutional Theory to large-scale social policy reform, demonstrating how implementation failure emerges from the interaction between administrative processes and institutional structures rather than from policy design alone. Empirically, it contributes a governance-oriented analysis of the NHI that shifts the debate beyond normative commitments to equity and universalism, toward the practical conditions required for implementation within the state. By repositioning the NHI as a case of implementation failure rooted in state capacity and institutional fragmentation, the study provides a framework for understanding why ambitious reforms repeatedly stall in similar governance contexts. These insights are directly relevant to ongoing debates on universal health coverage, public sector reform, and state capacity in South Africa and other middle-income countries that are pursuing transformative social policies under conditions of deep inequality and institutional constraints.

Policy Implications for Strengthening NHI Implementation

The findings of this study contribute directly to improving the National Health Insurance programme by identifying the governance and institutional conditions that must be stabilised to enhance implementation feasibility. First, by demonstrating that implementation barriers are rooted in fragmented authority, uneven administrative capacity, and weak coordination mechanisms, the study shifts reform focus from policy articulation to institutional sequencing. This implies that NHI improvement requires phased implementation aligned with differentiated provincial readiness, rather than uniform national rollout. Second, the identification of policy–administration misalignment underscores the need for operational clarity, including clearly delineated roles for national and provincial actors and harmonisation among the NHI Bill, the National Health Act, and the PFMA. Third, evidence of accountability and oversight weaknesses suggests that strengthening transparency mechanisms within the NHI Fund, including integrated reporting systems and cross-sphere fiscal monitoring, is essential to reduce governance risk and build public trust. By foregrounding these institutional priorities, the study provides actionable insight for policymakers seeking to enhance reform durability, reduce implementation inertia, and improve the long-term sustainability of universal health coverage in South Africa.

Conclusion and Recommendations

This study examined the implementation of South Africa's NHI from a public administration and governance perspective, addressing a gap in scholarship that has largely prioritised financing models and normative commitments to equity over the administrative and institutional conditions that shape reform feasibility. Drawing on Policy Implementation Theory and Governance and Institutional Theory, and grounded in qualitative evidence from key stakeholders and documentary analysis, the study demonstrates that the central challenges confronting the NHI are institutional and governance-related rather than primarily technical or financial. Successive reform cycles in South Africa have introduced ambitious frameworks into an implementation environment characterised by fragmented authority, uneven capacity, weak coordination, and limited accountability. The NHI represents the most comprehensive iteration of this reform trajectory, yet the findings indicate that it continues to reproduce longstanding structural weaknesses. By repositioning the NHI as a case of policy implementation failure rooted in state capacity constraints rather than policy design inadequacies, the study contributes empirically to public administration scholarship and advances understanding of reform trajectories in complex governance systems.

From a theoretical standpoint, the study extends Policy Implementation Theory by illustrating how multi-level, multi-actor reforms become vulnerable when policy ambition exceeds institutional capability. Governance and Institutional Theory further explain why these challenges persist despite political commitment, as entrenched institutional arrangements, overlapping mandates, and historically produced power asymmetries shape reform outcomes in durable ways. Implementation failure, therefore, emerges not from isolated administrative shortcomings but from the interaction between reform design and deeply embedded governance structures. This theoretical integration provides analytical insight into why large-scale social policy reforms in middle-income countries frequently encounter recurrent implementation barriers despite strong legislative foundations.

The findings generate several practical implications for the future implementation of the NHI. Strengthening policy–administration alignment is critical to ensure that legislative advances are accompanied by operational clarity, sequenced implementation frameworks, and clearly delineated responsibilities across government spheres. Enhancing governance coherence and formalised intergovernmental coordination mechanisms is essential to reduce duplication and blurred accountability. Targeted and differentiated investment in administrative capacity, including managerial competence, systems strengthening, infrastructure maintenance, and leadership stability, must be prioritised to address uneven readiness across provinces and institutions. Furthermore, improving public–private integration and institutionalising learning-oriented accountability systems would reduce uncertainty, build trust, and enable adaptive reform processes.

In deriving these conclusions, deliberate safeguards were applied to mitigate internal bias and ensure responsible inference. Triangulation between interview data and documentary sources enabled cross-verification of stakeholder claims against formal policy, legislative, and oversight records, reducing reliance on single-source narratives. The analysis followed a structured thematic framework, ensuring that interpretations emerged systematically from coded data rather than from normative assumptions about reform success or failure. Divergent perspectives across stakeholder groups were actively compared to avoid privileging dominant institutional voices. Conclusions were therefore grounded in recurring patterns observable across multiple data sources and theoretical lenses, rather than isolated statements or politically situated positions. Importantly, the study does not claim causal generalisation; instead, it offers analytically transferable insights bounded by the case context. By explicitly linking empirical themes to established implementation and governance theories, the research strengthens the credibility, transparency, and analytical defensibility of its conclusions.

Taken together, the study underscores that the long-term viability of the NHI depends not on further policy articulation, but on confronting deep-seated governance fragmentation, institutional inertia, and capacity constraints. Addressing these structural conditions is essential for translating reform ambition into operational reality. By foregrounding governance coherence, administrative readiness, and institutional learning, the study offers policy-relevant and theoretically grounded insights for South Africa and other countries pursuing universal health coverage through complex, system-wide reforms under conditions of inequality and institutional fragmentation.

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