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Challenges in Medical Ethics:

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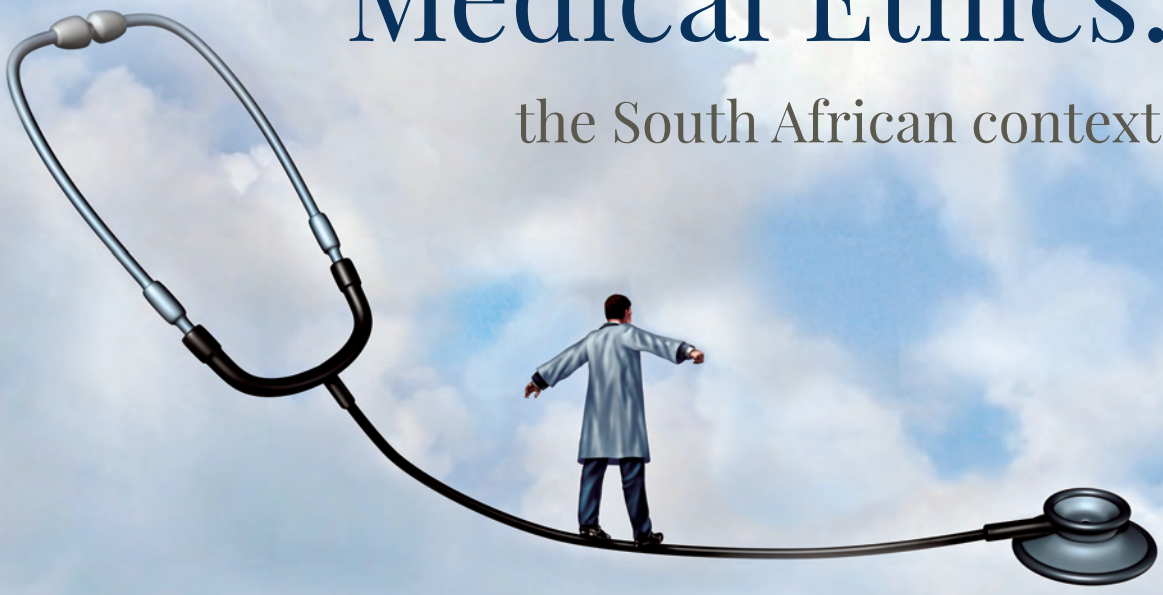

Editors:
Chris Jones, Mariana Kruger, Juri van den Heever & Anton van Niekerk

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2

Universal Health Coverage, National Health Insurance, and Sustainable Workforce

Mariana Kruger

Keywords: equity; fairness; health care workforce; national health insurance (NHI) policy; right to health; sustainable; universal health coverage (UHC)

2.1 INTRODUCTION

Everybody has a right to health, which can be achieved by implementing access to universal health coverage (UHC), a key concept of the current century according to the World Health Organization (WHO) (Ottersen et al., 2014; WHO, 2014). Good health will ensure the pursuit of a wide range of life plans, which will affect all aspects of life such as education, income, and happiness (Daniels, 2008). Poor health is associated with limited well-being and often needs large payments for health services, impacting negatively on financial security. WHO encourages all countries to develop strategies to provide affordable, quality health care to their population (Ottersen et al., 2014; WHO, 2014).

The pursuit of health for all has been the important message since the 1978 Declaration of Alma-Ata (Declaration of Alma-Ata, 1978). Subsequently, several other documents stress the importance of health such as the Bangkok Statement on UHC in 2011 (*The Lancet*, 2012) and the recent global call to implement UHC (Barron & Koonin, 2021). UHC benefits society in general as improved population health impacts positively on country development. For example, healthy children learn better, while healthy adults contribute through their productive lives to economic growth. Investment in the health of a nation has therefore enormous benefits for the country.

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UHC is defined as "all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for these services" (Ottersen et al., 2014; WHO, 2014). UHC includes curative, preventive, rehabilitative, palliative, and promotive services (58th World Health Assembly, 2005; WHO, 2010). For effective UHC, the whole health system should be strengthened by improving service provision, ensuring adequate human-, physical- and financial resources, as well as good governance (WHO, 2000). The pursuit of UHC must be aligned with other strategies to improve social determinants such as housing, employment, education, and environment and should be aligned with the strategy of UHC implementation (Rio Political Declaration on Social Determinants of Health, 2011; WHO, 2008).

All countries must make judgements about what health care interventions they should implement to address their local health care needs. This does not mean all possible health services will be provided, as these services are subject to existing resource constraints. According to the WHO, countries should advance three dimensions in health care, namely expanding priority health services, including all people, and reducing out-of-pocket health care expenses (Ottersen et al., 2014; WHO, 2014). Numerous countries have embarked on the implementation of access to UHC, with the assistance of the WHO with implementation.

This chapter aims to address the following crucial questions: (1) Which services should be prioritised for expansion; (2) who should be included first; (3) how to move to prepayment; and (4) how to ensure fairness. Equity is especially of crucial importance. The actions taken by South Africa to move towards UHC will be discussed, as well as the planned South African NHI. Lastly, the need for a sustainable health care workforce will be discussed as this is crucial in the rollout of UHC and a major constraint in South Africa.

2.2 EXPANSION OF PRIORITY SERVICES

Health is an important good for society, but it is not the only good needed and there are always competing interests for the available resources. Choices must be made regarding priorities in health to ensure reasonable access to these resources. To justify these choices, decision-making should be based on good evidence and sound rationale (Daniels, Porteny & Urritia, 2016). Unfair distribution of resources must be limited with improvement in health equity. Safety, efficacy, and cost-effectiveness are usually assessed in the priority setting of health interventions but may not be enough according to Daniels et al. (2016), as they argue that there should also be "accountability for reasonableness" which include

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decisions that are transparent, relevant to resource allocation, can be revised with new evidence emerging, and enforceable (Daniels, 2008).

Health care service expansion necessitates the categorisation into high priority-, medium priority- and low-priority health care services (Ottersen et al., 2014; WHO, 2014). Criteria to be used in ranking such services include cost-effectiveness, protection against financial risk, and prioritising the worse-off. The key question for a country is which services should be expanded first and is best based on the burden of disease in the country. Significant morbidity and mortality causes of the population are important to consider. Interventions implemented should be population-based rather than based on individual services (WHO, 2010). In this context, both communicable and non-communicable diseases must be included with good reasons that are transparent to ensure public trust with accountability and corruption prevention (Glassman & Chalkidou, 2012). Successful prioritisation of health services has been implemented in the United Kingdom, Denmark, Sweden, Norway, and the Netherlands and common in their priorities are the objectives to improve population health with fair distribution of health services and proven cost-effectiveness (Sabik & Lie, 2008).

Cost-effectiveness is measured as either quality-adjusted life years (QALYs) saved, or disability-adjusted life years (DALYs) prevented (Gold, Stevenson & Fryback, 2002; Murray, 2012). Both QALYs and DALYs assist in developing a framework for priority setting and are utilitarian in nature with the aim to maximise benefit in society. Although useful in planning health services, critique of using QALYs and DALYs include the following: (1) priority cannot be given to the worse-off; (2) there may be discrimination against those with limited treatment options; and (3) cannot account for qualitative differences in outcome. To ensure fairness, countries need to find ways to overcome these issues and ring-fence budget allocation and services for certain predefined conditions affecting the worse-off or those with limited treatment options (Pinxten et al., 2012).

2.3 INCLUSION OF ALL/MORE PEOPLE

A key issue with implementation is to determine who should be included first as it is unlikely to be the whole population when embarking on UHC (Ottersen et al., 2014; WHO, 2014). The priority setting should probably address the needs of marginalised or low-income groups, rural populations, and other disadvantaged groups in terms of access to health care or coverage, especially in line with the burden of disease in a specific country. As mentioned above, the focus should be on groups rather than individuals, taking into consideration the conditions that affect the disadvantaged groups and should result in a reduction

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of inequalities of service coverage of the whole population (Jamison et al., 2013). It is important that all vulnerable groups of the population are included through a progressive implementation of UHC. In the process, health care workers must recognise human rights with a zero tolerance for discriminatory attitudes, while policymakers need to ensure the establishment of respectful services with effective dialogue between communities and health care providers (Tangcharoensathien et al., 2018).

2.4 REDUCTION OF OUT-OF-POCKET EXPENSES

Out-of-pocket payments for health services are common in many low- and middle-income countries, especially in Africa (Derkyi-Kwarteng et al., 2021). For impoverished communities, such payments cause a lack of access to health care, as often the out-of-pocket expenses place an enormous burden on the financial budget of the family with them refusing to seek such services, leading to a delay in diagnosis which in turn worsens the underlying condition. Only when these out-of-pocket expenses are less than 20% of health expenditure is the worsening of financial status prevented (WHO, 2010). Compulsory prepayment during the implementation of UHC is essential in the creation of a central fund to assist with prepayment of health care services. It is especially important to initially eliminate out-of-pocket expenses for high-priority services and to allow the worse-off to gain early access to these services (Ottersen et al., 2014; WHO, 2014). This compulsory prepayment must be in line with the increased income of households or individuals.

2.5 FAIRNESS AND EQUITY

Key ethical issues in UHC include fairness of distribution of health careservices with equity in access to health care (Frenz & Vega, 2010). Both fairness and equity address the benefit distribution and societal burdens (Ottersen et al., 2014; WHO, 2014). Fair access to health care services, however, should be based on need and not on the ability to pay. For fair distribution, the worse-off groups should be prioritised, and their health care needs must determine the services to be provided. However, in this context, utility should also be considered as only using worse-off as a single factor may lead to futile treatment without benefit, while others with less severe illnesses may potentially benefit more. It is therefore crucial to combine fair opportunity with utility to determine access to health care resources for society in general (WHO, 2014). But, fair contribution entails that prepayment is based on the ability of individuals to pay, and not on their health

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care needs. A fair equitable health care system will ensure that all have equitable access to these health care services, regardless of their prepayment contribution.

2.6 UHC SHOULD MAXIMISE BENEFITS

A cardinal aim of UHC is to maximise benefits for the whole population. These can be additional life years or improved quality of life. Cost-effectiveness is very important in this context as the benefits generated must justify the resources used. Benefit maximisation and fairness often go together as the sum of health benefits should also benefit those with the least access to health care or are worse-off (Jamison et al., 2013). The worse-off can be with regard to health, socio-economic status, well-being, or service coverage. However, the fairest of actions may not always maximise benefit. A good example is when the provision of health care services is prioritised for the rural population, but this may be too costly for a country, leading to prioritising the urban population first as it is more cost-effective (Chopra, Campbell & Rudan, 2012). Where the two objectives diverge, the WHO guideline suggests that countries should investigate alternative policies to achieve both objectives (Ottersen et al., 2014; WHO, 2014).

2.7 SUGGESTED WHO STRATEGY AND PATHWAYS

As mentioned above, the proposed steps to be undertaken should include (Ottersen et al., 2014; WHO, 2014):

1. Categorise health care services into priority categories. Aspects to take into consideration include the provision of priority to the worse-off persons, the cost-effectiveness of the interventions, and protection against financial risk.
2. Expand the high-priority health care services to all persons in the country, especially with the elimination of out-of-pocket expenses. Over a period of time, the compulsory prepayment should increase with a pooling in a central fund.
3. Ensure that the disadvantaged groups do gain access, especially low-income, marginalised, and rural people.

To ensure fairness, unacceptable trade-offs should be avoided, including the expansion of low- or medium-priority services prior to universal cover for high-priority services, the prioritisation of services resulting in small health benefits, the prioritisation of well-off groups with health cover before those impoverished groups without health cover, and to only include those that can contribute to the universal health fund (Ottersen et al., 2014; WHO, 2014).

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Good governance, monitoring, and accountability in a UHC strategy are crucial to ensure success. Countries should carefully consider indicators to monitor the UHC process and invest in robust health information systems that can generate the necessary information needed to inform health policies that are linked to the priority-setting process, health outcomes, and protection of the central fund and coverage, while demonstrating equity and fairness.

2.8 SOUTH AFRICAN CONTEXT WITH REGARD TO UHC

Africa as a continent and South Africa specifically are faced with high burdens of infectious diseases such as multi-drug resistance tuberculosis and AIDS, as well as high mortality rates, malnutrition, and chronic non-communicable diseases (Modjadji, 2021). Furthermore, impoverished communities suffer more from diseases, including both communicable and non-communicable diseases (Ataguba, Akazili & McIntyre, 2011; Wong et al., 2021). This is further complicated by existing major inequalities within South Africa with regard to socio-economic status and access to health care services as part of the historical legacy of apartheid (Molepo, 2021). Health expenditure and resource allocation during the apartheid years have favoured the white population with most of the black population having far less allocated to them for health care (Harris et al., 2014). The health system has also favoured capitalist ideals, namely those who can pay have access to quality health care (Price, 1986).

The current South African health system is divided into a private and a public sector. This dual structure still has an unequal nature, whereby the more affluent members of society utilise private health care, whereas the majority rely on the under-resourced and overburdened public sector (Burger & Christian, 2018). About 16% of the population is served by the private sector versus 84% served by the public sector which has limited resources and is poorly managed. Also worsening the inequity is the fact that 30% of the health care workers serve the public sector versus 70% serving the private health care sector (Labonté et al., 2015). The health care worker shortage in the public sector is especially due to low remuneration, poor working conditions, and lack of career development versus the private sector with superior remuneration and working conditions (Rispel et al., 2018). Added to this, there is the 'brain drain' with health care workers emigrating (Labonté et al., 2015).

Since the change to a democracy in 1994, South African government spending is divided equally between the two sectors (Rispel, 2016). Current public health care is decentralised into the provinces with National Treasury providing the funding as conditional grants (Pauw, 2021). The allocation is based on the indivi-

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dual provincial risk characteristics, as well as health care facilities capacity (Roos, 2020). As medical costs are increasing in South Africa, private health care is becoming unaffordable, while quality health care access is compounded by an increasingly high unemployment rate and poor economic growth (Burger & Christian, 2018; Pauw, 2021; Tshoose, 2015).

2.9 SOUTH AFRICAN NATIONAL HEALTH POLICY

According to the World Bank, 9% of South Africa's gross domestic product (GDP) has been spent on health care in 2019, but by global standards return on investment is poor as demonstrated by the still existing health care inequalities mentioned above (World Bank, 2019a). Due to this inequity in health care and resource allocation, the South African health care system should be completely transformed with a focus on UHC (Giaimo, 2016).

The National Health Policy was introduced in May 1994 with a focus on both medical care and healthy lifestyles as the first steps in the improvement of health care for all with the introduction of the Primary Health Care (PHC) facilities to prevent disease, promote health, and provide primary health care (WHO, 2019). The National Health Act 61 of 2003 documents current national health policy and one of the major positive outcomes of this policy is the successful extensive antiretroviral treatment programmes implemented in South Africa (Hassim, Heyman & Honermann, 2008; Pauw, 2021).

As the roll-out of UHC is challenging with no single way to implement it, due to country differences in disease profiles, the South African government is embarking on an incremental process of UHC implementation through the improvement of public health infrastructure and services with subsequent improved public trust (Pauw, 2021; WHO, 2021).

2.10 NATIONAL HEALTH INSURANCE (NHI)

South Africa passed the National Health Insurance Bill in 2019 as a strategy to provide UHC to the South African population (National Health Insurance Bill, 2019) and is establishing National Health Insurance (NHI), which aims to provide affordable and high-quality health services for all South Africans (Navarro, 2007; Pauw, 2021; WHO, 2021). The NHI is a funding mechanism for the provision of health care for the whole population (Mash, 2020a; Pauw, 2021). The NHI will initiate a prepayment system with a public fund to cover health services to prevent personal expenditure on health care (NHI Bill, 2019). This funding mechanism will ensure that free health care services are provided if

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obtained from health care practitioners who meet predefined quality criteria and are registered for the NHI. The division of health funding between private and public sectors will be minimised, while the National fiscus will be responsible for obtaining funds from reallocation of medical scheme tax credits, the general tax revenue, a payroll tax (to replace current medical aid contributions), and a surcharge on personal income tax. The NHI funds will purchase medicines, health care services, and other related health products.

As the main aim of the NHI is to address the inequality in health care provision with improved quality health care to the whole population, it will cover health care services for South African citizens and permanent residents, refugees, and all children, regardless of origin (Mash, 2020a & 2020c). Other groups such as asylum seekers and illegal migrants will only be covered for emergency and notifiable diseases. All South African citizens will be required to register for the NHI, regardless of whether they have a medical aid or not. Patients will have freedom of choice regarding their primary health care provider and not be limited to either public or private sector (Mash, 2020b).

Both the current public and private health care sectors will serve as service providers, with a prescribed health care pathway. As PHC is the cornerstone of the NHI, the South African government plans to contract private health care providers in Contracting Units for Primary Health Care (CUPs). These CUPs will be combined with PHC to promote both prevention of disease as well as practice curative medicine (NHI Bill, 2019). The plan is to form District Health Management Offices to ensure good access to health care on a local level. The whole process of implementation needs good health service organisation and coordination, as well as restructuring of public health finances – both posing bureaucratic challenges that must be addressed to ensure success (Michel et al., 2020).

The implementation of the NHI will be in three phases and the first phase has been the piloting of the NHI in ten PHCs with mixed successes (Genesis Analytics, 2019). These mixed successes are due to the existence of a strong political will with adequate human and financial resources in certain PHCs, while crucial challenges for the less successful implementation in PHCs are the lack of effective planning, limited resources, and poor communication with weak coordination and monitoring. Phase two is currently being introduced with the passing of the NHI Bill with amendments to existing legislation that may affect the implementation and the establishment of the NHI (NHI Bill, 2019). The third phase will implement resource allocation and the aim is to have all South Africans included into UHC by 2030 (BusinessTech, 2020b; NHI Bill, 2019).

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The Minister of Health will be responsible for governance of the NHI while the National Department of Health will determine health policy and strategy. The NHI fund will be managed by a board of 11 members, who will be appointed by the Minister of Health, but nominated through public participation (Mash, 2020a; NHI Bill, 2019). Several advisory committees will provide guidance regarding the benefits to be covered, what payments should be for, and participation of stakeholders. Provincial health departments will oversee the services provided in their provinces, while existing private medical schemes will have to cover the health care services not covered by the NHI.

The South African Values and Ethics for Universal Health Coverage (SAVE-UHC) Working Group has developed a framework to use in South Africa for health priority-setting (Blaauw et al., 2022; Krubiner et al., 2022). There are 12 domains in the framework of which the first four are commonly used in health priority-setting, namely burden of disease, expected health benefits and harms, cost-effectiveness analysis, and budget impact. They describe a further eight ethical domains, namely respect and dignity, equity, ease of suffering, impact on safety and security, maintaining important personal relationships, impact on personal finances, solidarity, and social cohesion. A diverse group of stakeholders have accepted this framework.

There are currently major debates about whether NHI can be implemented effectively in South Africa as the policy is vague about what health services will be covered and what the tax individuals will have to contribute to the NHI (Pauw, 2019). Concerns about the roll-out of the NHI include issues such as corruption, poor leadership, poor management, and weak governance (Molepo, 2021; Rispel, 2016). The situation is further worsened by the infrastructure degradation, the lack of fully functional PHC facilities, limited resources, especially human resources in the public sector and a huge burden of disease (McIntyre, Doherty & Ataguba, 2014).

Learning from the experience of UHC implementation in Ghana, it is important to note that health care inequality is not reduced if participation is voluntary and not part of the tax system, as health care is still unaffordable for 60% (Kipo-Sunyehzi et al., 2020). South Africa therefore will introduce a tax-based NHI contribution, based on the ability of persons to contribute according to income (Pauw, 2020).

The Solidarity Research Institute conducted a survey in October 2019 to determine the health care workers' understanding and readiness to implement the NHI (Welthagen, 2019). The findings conclude that nearly 80% have an unfavourable opinion with apprehension whether government can ensure payment of

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health care services. The South African public is also not sure that government can deliver or successfully implement the NHI without corruption (Sekhejane, 2013). The Institute of Risk Management in South Africa reports that the government's inability to prevent corruption, public distrust in the health sector, inadequate service delivery, and inadequate number of health care workers pose major threats to the successful implementation of UHC through the NHI (Institute of Risk Management, 2020).

2.11 SUSTAINABLE HEALTH CARE WORKFORCE IN SOUTH AFRICA

The success of UHC access is crucially dependent on an adequate health care workforce (Rispel et al., 2018). This health care workforce includes all persons whose actions are intended to improve health, namely physicians, nurses, pharmacists, dentists, and other allied health care workers (dieticians, occupational therapists, physiotherapists) and support staff (Rispel, 2018; Soucat, Scheffler & Ghebreyesus, 2013). The health care workforce will include individuals working in either public or private sectors or on a voluntary basis. A sustainable health system needs balanced labour market dynamics with the right level of education. Core indicators of a sustainable health care workforce include the health worker density, the distribution by occupation or specialisation in regions including sex distribution, and the annual graduates of health care professions (number of graduates per 100 000 population per annum) (WHO, 2018).

2.11.1 Core indicator 1: Health care worker density in South Africa

The calculation of health care workers is easy to determine as these workers are registered with their professional boards and are used to compare the density of health care workers of different countries. The density is especially useful to monitor whether the workforce can provide the planned health care coverage. The most complete data exists for physicians, nurses, and midwives, but all other categories should be taken into account such as pharmacists, laboratory personnel, health managers, technicians, and others. The most recent health care worker density in South Africa is reported as 0.79 physicians per 1 000 people, while nurses and midwives are reported as 1.3 per 1 000 people by the World Bank (World Bank, 2019a, 2019b). This is in great contrast compared to the United Kingdom with a density of 5.82 physicians per 1 000 people, where existing UHC access through NHS is successfully implemented (World Bank, 2019c). However, even the South African reported density may be inaccurate as current data is obtained from the absolute numbers of health care professionals registered with their respective professional boards in South Africa, but it does not specify

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whether they are actively practising in South Africa, as many emigrating health care workers remain registered in South Africa (Rispel et al., 2018).

Although South Africa is currently in the top five countries in Africa with regard to the density of health care workers per 1 000 of the population, it is necessary to improve the density to achieve success with the rollout of UHC access. Rispel et al. (2018) recommend that a mapping should be done regarding the health care workforce capacity needs in all regions of South Africa (Rispel et al., 2018). Such a mapping exercise will assist in the planning of improving health care workforce density in regions currently underserved in South Africa and should take into consideration those health care workers actively working in South Africa and not rely on registration numbers from professional health care boards.

2.11.2 Core indicator 2: Health care worker distribution by occupation/specialisation/region/sex

Although South Africa is at the top when it comes to density, this is unfortunately not the case in the public health sector, especially in rural communities (BusinessTech, 2020a; South African Department of Health: Annual Report, 2017; WHO, 2018). For example, there are currently 16.5 medical specialists per 100 000 of whom 7 per 100 000 are employed in the public sector versus 69 per 100 000 in the private sector, while the Western Cape has 25.8 medical specialists per 100 000 versus the more rural Limpopo with 1.4 per 100 000 (BusinessTech, 2020a).

The National Department of Health aims to develop and implement staffing norms and standards for health facilities as part of the strategy towards UHC, based on the Workload Indicators of Staffing Need (WISN) method of the WHO (South African Department of Health: Annual Report, 2017; WHO, 1998). This method includes assessment of the health care worker's workload with time spent on each workload component in the different regions of a country. Unfortunately, the National Department of Health has only used the WISN method to address human resources in the health care sector and to date this method has not resulted in the planned improvement with existing inability to meet the targets for human resources improvement in primary health care (Rispel et al., 2018; Mabunda et al., 2021).

One of the major obstacles is the unaffordability to achieve the recommended health care workforce with appropriate distribution according to the WISN method. Other limitations include the major dependency on accurate annual service statistics with possible overreporting or underreporting and insufficient assessment of needs in rural regions. Improvements can perhaps be achieved

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through a combination of the WISN method with needs-based human resources planning methods for health care in the different regions (Birch, 2015). Such methods should include investigation into epidemiological changes regarding disease profile and regional needs, demography of health care workers, as well as their education and their productivity (ASSAf, 2018). According to Mumbauer et al. (2021), workplace conditions and remuneration packages are more important in employment decisions than location or employment sector in South Africa. Workplace condition improvements, together with the aforementioned health care worker density mapping exercise, may assist in the strategic planning and recruitment of staff to underserved areas in South Africa and a more equitable distribution of health care workers.

2.11.3 Core indicator 3: The annual number of health care graduates per annum

It is crucial to monitor the annual output of health care graduates in relation to the population per annum. Such data will assist in addressing the needs regarding all cadres, the underserved regions, and the number of foreign-trained graduates will indicate what needs exist to ensure self-sufficiency (WHO, 2018).

According to the Academy of Science of South Africa's (ASSAf) 2018 report, health care workers' education is excellent in South Africa, but is hampered by weak coordination, fragmented funding streams, inadequate infrastructure, inadequate clinical teaching platforms, lack of clinical teachers, and a decrease in health care workers pursuing careers in academic health sciences (ASSAf, 2018). Furthermore, health care student selection is hampered by a great variability in school education quality, poor career guidance, and inequity in financial and staff support at universities. The internship experience may negatively impact on the vision of future workplace choices. However, it seems that the compulsory community service programmes for health care workers have led to positive professional development.

The ASSAf report (2018) recommends that health care worker selection must use a broader set of criteria than currently used to attract a greater variety in culture and skills. Health care education should focus on addressing the existing inequity in health care access with a focus of support for the primary health care sector and increased supply of health care workers to rural areas. The existing academic institutions need strengthening to ensure an increase in the number of training health care professionals, utilising both the private and public sector. There is also a need for retaining training staff in academic institutions. A way forward is to implement a long-term national plan for the expansion of health care workforces through education with a pro-active strategy to retain the services

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of these graduates in South Africa through workplace improvements and remuneration packages, with opportunities for continual professional development and active mentoring in the workplace (Kovacs et al., 2017). This development of a sustainable workforce is, however, linked to improvement of other socio-economic circumstances such as job creation with reduced unemployment, improved housing and education, and other socio-economic factors that will improve the general well-being of the South African population and cannot be done in isolation, however, this is outside the scope of this chapter.

2.12 CONCLUSION

As health care is the right of every individual, governments should implement a UHC system to ensure equity in access to health care. The implementation of the NHI is, according to the South African government, the only potential way to achieve UHC for all persons with equity in the health sector. In countries where UHC has been successfully introduced, the population's health has improved, which has led to an improvement in the overall economy. However, the South African government needs to address the concerns of the South African population by ensuring transparency, clarity regarding public concerns, improve access to resources, especially sustainable human resources, and good governance with prevention of corruption. The roll-out of UHC should also be linked to other social determinants of health namely employment equity, housing, and education.

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