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Health Policy in South Africa

From 1994 to now

Towards convergence between public and private health financing

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This paper is one of nine papers prepared for the 1994 to Now Policy Paper Series, prepared for the SALDRU, South Africa at 30 Years of Democracy Conference scheduled for 2-4 April 2025. The papers will be (were) presented at the conference with the aim of contributing to discussions and debates and fostering informed and constructive economic dialogue.

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Executive Director

Health Policy in South Africa: From 1994 to Now

Towards convergence between public and private health financing systems

Andrew Donaldson[1] and Tamar Kahn[2]

Abstract

Optimism about the prospects of better healthcare for all ran high after SA's peaceful transition to democracy in 1994. This policy paper reviews a series of health reforms instituted after the end of apartheid up to the president's assent to the National Health Insurance (NHI) Act 30 years later. It considers which policy interventions have been most significant, the missed opportunities, and the role of various forms of collaboration between the public and private sectors. Given that the ANC's NHI Act faces intense opposition from other political parties within the government of national unity and from other stakeholders intent on litigation, implementation is likely to be delayed. We therefore pose the question: if not NHI, then what? Informed by a series of discussions with experts, we argue that for a return to key steps in the reform path envisaged in the 1990s, seemingly abandoned after 2007. We suggest several ways in which greater collaboration between the public and private sectors should be sought, and in which regulated competition offers scope to improve healthcare in the medium term while contributing to more equal access to health services.

This analysis is based on a review of national legislation, policy documents, peer-reviewed publications, commissioned reports, presentations to parliament and conferences, media articles, and the views of experts in the field. In-depth interviews of up to two hours were conducted with 13 key informants chosen for their experience and insight into health policy development and implementation. They include academic researchers, independent health analysts, and senior figures from the public and private sector.

Keywords: Health systems, health finance, health services regulation, South African health policy

JEL classification: H510; I180

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Executive summary

Introduction

South Africa's transition to democracy in 1994 placed a fragmented, racially divided health system in the hands of the new ANC-led government. It quickly moved to transform the health administrations of 10 homelands and four provinces into a single national department and nine provincial departments, in line with the new constitution. Initial health sector reforms prioritised primary health care and the development of district health services in the public sector, while broadening participation in contributory health insurance schemes that provided access to private sector services. A 1996 policy paper issued by the national department of health, for example, emphasised expansion of the district-based primary healthcare system and proposed a mandatory minimum hospital benefit package to be offered through a regulated competitive health insurance market.

But after 2007, there was a decisive shift in policy and several key elements of the 1997 White Paper on Transformation of the Health System were abandoned. The new approach, culminating in the 2024 NHI Act, envisages a consolidated national health fund under state control rather than a competitive insurance market. The NHI Act implies that prescribed minimum benefits in the medical schemes environment will be replaced by a prohibition on insurance cover for benefits covered by the national insurance plan.

This paper argues that a comprehensive unitary national fund is an unrealistic aspiration, in part because it fails to build on the existing institutional strengths and capabilities of South Africa's public and private health sectors. We draw on key themes in health economics, guidance provided by the Competition Commission's Health Market Inquiry, and experience with public private partnerships to explore options for a pragmatic reform strategy that would both expand health insurance coverage and contribute to easing public health sector resource constraints.

The landscape today – persistence of a dual health system

Thirty years after the advent of democracy, South Africa still has a health system riven by inequalities, with patients' access to care substantially determined by their socio-economic status and where they live. Medical scheme coverage has declined as a share of the population and the public health system confronts a rising burden of disease while budgetary resources are under stress. Patients who rely on the private healthcare sector continue to face increases in medical scheme premiums and out-of-pocket healthcare expenses that outstrip consumer price inflation.

In the context of South Africa's extreme inequalities and disparate access to health services, there is clearly an appeal in the idea of a unitary health system capable of centrally rationing resources to meet health care needs. But it is difficult to describe a credible transition path from South Africa's multi-fund insurance system to a single purchasing authority, or from nine provincial health authorities to a nationally controlled system. The more common approach internationally has been to expand existing insurance coverage while tightening the regulatory framework and targeting fiscal resources to ensure that an equitable healthcare package is available to all.

Analytical perspective

Comparative country reviews reveal that health financing is a *hybrid mix* of systems in all advanced economies. Even where the dominant system is an integrated unitary fund, such as the UK National Health

Service, there are accompanying voluntary supplementary insurance and out-of-pocket payments. In countries with multi-fund competitive insurance schemes, there are also nationally supported programmes to meet special needs. There is considerable variation internationally between "integrated" and "separated" arrangements for funding and providing health services. South Africa's provincial health services are integrated; its private sector arrangements are separated. A strategy for reform has to address questions about how these very different institutional arrangements can adapt over time to changes in regulation or financing arrangements.

In our evaluation of South Africa's shift in health policy, we draw on six broad themes in health economics:

- Distributional and risk-pooling issues
- Information asymmetries and behavioural concern
- Health financing arrangements
- Third-party payer effects
- Market concentration
- Gate-keeping and referral systems.

The concluding sections of this paper return to these themes as considerations in assessing the health reform strategy envisaged in the NHI Act, and possible alternatives.

National health insurance – its policy evolution

One of President Nelson Mandela's first acts after assuming office in 1994 was to introduce free healthcare for pregnant women and children under the age of six. The government embarked on a massive clinic-build programme with a greater emphasis on decentralised management of preventive and primary healthcare. User fees for primary care were largely abolished, as public clinic services were provided free of charge.

In 1995 Health Minister Nkosazana Dlamini-Zuma appointed a Committee of Inquiry into National Health Insurance (NHI). It proposed universal access to a basic primary health care package provided in the public sector while recommending retention of individual choice to use private providers accompanied by a regulated insurance market.

Far-reaching reforms to the medical scheme market were subsequently implemented, reversing its deregulation during the late 1980s and early 1990s. The Medical Schemes Act of 1999 introduced community rating, open enrolment, and a basket of prescribed hospital-based services, later supplemented by a list of chronic conditions, that all schemes were obliged to cover in full.

Building on these reforms, the 2002 report of the Committee of Inquiry into Comprehensive Social Security for SA (the Taylor Committee) set out a four-phase process for achieving universal contributory health cover "based on multiple funds and a public sector contributory environment," involving:

- Consolidation of medical scheme reforms to remove any residual risk-selection and to increase coverage
- Risk-equalisation between medical schemes
- Conversion of the medical schemes tax subsidy into an explicit income and risk-adjusted subsidy
- Mandatory medical scheme membership for higher income groups, accompanied by the development of a subsidised contributory scheme for non-medical scheme members
- Introduction of a Central Equity Fund to make allocations to both public sector health providers and medical schemes based on a risk-adjusted equity formula.

The health department established a task team to implement these recommendations, which included establishing a risk equalisation fund to level the playing field between more than 80 medical schemes and thereby promote competition on efficiency grounds rather than on the number of young and healthy lives they could attract. With effect from 2013, the Treasury amended the tax treatment of medical scheme contributions and medical expenses to shift the tax benefit from higher-income to lower-income beneficiaries.

The reforms initiated in the 1990s and envisaged in the 1997 White Paper comprised the first steps in a longer-term strategy for building a health system that would *combine* public and private financing flows, administrative capacity and service delivery platforms. However, while extensive preparatory work was undertaken, mandatory enrolment and a risk equalisation mechanism were never implemented. The ANC in 2007 resolved instead to pursue a unitary-fund National Health Insurance (NHI) model. This was elaborated in the NHI Green Paper in August 2011, followed by a White Paper in 2015 and a revised White Paper in 2017. Following discussion of a draft Bill in Nedlac and its passage through Parliament, the NHI Act was signed into law in May 2024.

Public discussion of the NHI proposals focused particularly on the Green Paper's indicative cost estimates and the substantial tax increases that would be required. The Treasury's work on health systems reform at this time focused also on the complex institutional changes implied by a transition to a unified fund and separation of pooling, purchasing and provision arrangements. However, the Treasury and the Department of Health failed to reach agreement on publication of this analysis, and it had little impact on the Department's views.

On the role of medical schemes, the ANC's position has hardened over time. The NHI Green paper left space for voluntary medical scheme membership to continue but the NHI Act explicitly restricts medical schemes to offering cover only for "complementary" services not provided under NHI. The shift from a multi-payer system to a single fund is not just a significant change in policy in its rejection of the envisaged role of the established regulated medical schemes, but in the absence of a credible transition strategy is also a much more complex and riskier undertaking.

The Health Market Enquiry

The ANC's decision to pursue NHI aborted work on broadening medical scheme coverage and torpedoed planned amendments to the Medical Schemes Act. As a result the regulatory framework for medical schemes is incomplete, with no mechanism to pool risk between schemes, counter adverse selection or negotiate tariffs collectively. This contributes not just to higher costs but also to a continuing cost spiral and reduced affordability of coverage.

In 2014, the Competition Commission initiated a Health Market Inquiry (HMI) to probe the private healthcare sector's structure and operations and identify potential barriers to competition that might raise costs or hinder patients' access to care. Its 2019 final report provided a detailed and systematic assessment of the private healthcare sector and set out recommendations to strengthen regulation, promote alternative reimbursement mechanisms, encourage multidisciplinary practices and alternative care models and introduce a standardised basic benefit option linked to a risk adjustment mechanism.

In effect, the HMI report provided an opportunity to revert to a phased implementation of health systems reform, building on the strengths of both the public and the private sectors and improving the regulatory

framework through which a multi-fund system could allocate resources equitably, promote competition, control costs and prices and counter abuse of market power.

Five years after publication of the HMI report, no measures had been implemented in response to its recommendations. However, in February 2025, the ministers of health and of trade, industry and competition announced that an agreement had been reached between the national Department of Health and the Competition Commission for an "interim block exemption" for negotiated multi-stakeholder tariff determinations in the health sector, together with several other planned reforms. The minister of health also called for public comment on the Low-Cost Benefit Option Report prepared by the Council for Medical Schemes in 2023. Although details of these initiatives are not yet clear, this may signal the beginning of a reconsideration of the plausible contours of the NHI reform path.

Challenges to the unitary NHI proposal

The sweeping reforms and financing requirements of NHI have been challenged on numerous fronts.

- The Davis Tax Committee concluded that the funding requirements of NHI would require substantial increases in personal income tax or VAT or a large new social security tax.
- The High-Level Panel review of SA legislation chaired by former president Kgalema Motlanthe proposed a three-tier model that would include private sector medical schemes, government employees' medical schemes and an NHI scheme for those outside these arrangements.
- Parliament's portfolio committee on health received over 64,000 written submissions. Three key areas of concern emerged during the presentations to parliament: the NHI funding model, the governance of the scheme, and potential infringements of constitutional and human rights.

Supporters of the bill saw the single-purchaser model as a means to address the inequities and inefficiencies in SA's two-tier health system. Critics argued that the additional funds required for NHI would entail unrealistic and unaffordable tax increases. Business Unity South Africa's central concern with the bill was its limitation on the role of medical schemes and the effect this would have on the private healthcare sector and the economy.

In December 2024 the Universal Healthcare Access Coalition representing several national organisations of healthcare professionals published a review arguing that "there is no feasible scenario in which a single tax-financed fund can provide all the coverage for the entire population of South Africa." It proposed greater decentralisation in the public healthcare system, implementation of risk equalisation and social insurance mechanisms, a mandatory standardised benefit package and a multilateral tariff negotiation system.

Public-private partnerships: enthusiasm cools

Public-private partnerships, in their various forms, shed light on some of the opportunities and challenges ahead if bridges are to be built across South Africa's divided health system.

SA introduced a national framework for PPPs in the early 2000s, formalised in regulation 16 of the Public Finance Management Act (PFMA). By 2018, eight large health sector PPPs had been concluded by provincial health departments that sought to widen access to quality services for state patients by leveraging private sector capital, experience and managerial capacity.

The largest PPP to date is the 2001 R4.5 billion Inkosi Albert Luthuli Hospital project, in which the KwaZulu Natal provincial health department entered into an initial 15-year agreement with the Impilo Consortium for

the provision of non-clinical services at a newly built 850-bed referral hospital in Durban. Provision and maintenance of equipment, well-kept facilities and a paperless administrative system were amongst the key elements of this agreement. A subsequent review found that it had provided value for money, though savings could have been achieved with more flexibility in the equipment refreshment cycle.

Other provincial PPPs include the Limpopo health department's renal dialysis project which reduced the extent to which patients were forced to travel to over-burdened hospitals in Gauteng, and the Universitas-Pelonomi scheme entered into by the Free State health department which had an unexpected benefit in reducing abuse of remunerative work outside the public sector (RWOPS) arrangements.

A subsequent Treasury proposal for an Enhanced Amenities Hospital Strategy (EAS) to facilitate service-level agreements between the Eastern Cape health department and medical schemes, the Road Accident Fund and the Compensation Fund did not proceed beyond conceptual design. Currently, the Western Cape Health Department is planning a R5 billion project to redevelop Tygerberg Hospital in Cape Town through a PPP construction and facilities maintenance concession.

Experience with hospital PPPs is illustrative of the complex contracting challenges that will be faced in implementing an NHI system that takes advantage of established private hospital and health service capacity. Time-consuming negotiation processes are required, disputes or difficulties can arise, and suitable expertise on both sides is needed. It should be stressed, though, that PPPs do not solve the budget shortfall problem. If a building or equipment is financed initially by a concession-partner to be repaid over twenty years through a PPP "unitary charge", then this is effectively a form of government borrowing. The benefit of a PPP is not access to finance, it is the operational efficiency and project management capabilities that come with "turnkey" structured concession contracts. It is also potentially the revenue gain and resource benefits associated with shared technology and clinical expertise.

There are also lessons in less structured partnership arrangements, some of which have a long history. During apartheid years, contracts to provide 'sanatoria' for black and coloured TB and psychiatric patients involved extensive neglect and sometimes forced incarceration. Revelations of these abuses led to improved oversight and tighter contract conditions, but the state continues to rely on private providers for mental health, frail care and drug rehabilitation services in several provinces. In 2016, the termination of its contract with Life Esidemeni resulted in the Gauteng Province transferring over 1,300 mental health patients to unlicensed and unqualified NGOs, leading to at least 144 deaths. The Health Ombud's investigation report concluded that the abuses resulted from the nature of the new contracts, an over-hasty and careless procurement process, incompetent service-providers and poor government oversight.

Managerial and contracting weaknesses have held back progress in some collaborative health partnerships, while there have been successes in others. The health department has well-established agreements in place with retail pharmacy chains to provide childhood immunisation and well-baby services to state patients, for example, and for distribution of chronic medication. The state has benefited from philanthropic contributions from the private sector via the Public Health Enhancement Fund, established by the health department and 22 private companies in 2012 to tackle the shortage of healthcare professionals, train hospital CEOs, and invest in research. The government worked closely with the private sector to respond to the Covid-19 crisis, collaborating with pharmacies, medical scheme administrators and private hospitals to roll out vaccines to both medical scheme members and state patients.

However, the prevailing environment for collaborative partnerships is institutionally complex, and progress has at times been held back by poor planning, drawn-out processes and incomplete negotiations.

Pragmatic step-wise reform: notes on the way forward

Our analysis suggests there will be substantial practical and institutional difficulties in the transition from present arrangements to a unitary integrated health system. It seems sensible, therefore, to explore options for less ambitious reforms that would offer patients a better deal in the short to medium term, building on existing public sector capabilities and the established health insurance system. Some considerations that might assist in pursuing a pragmatic reform path are summarised below.

Redistribution and risk-pooling

Redistribution between rich and poor is the responsibility of the fiscal system as a whole, not solely of the health insurance regulatory framework. Seen in this perspective, there is a welfare-theoretic problem with the idea of *categorical equality* as a goal in the health financing system despite the clear appeal of the equity principle. In a society as unequal as South Africa's, greater equity in health outcomes might well warrant higher spending allocations to employment, income security, housing or municipal services. There is some limit to the degree to which equality in health expenditure should be pursued rather than other redistributive priorities.

There is considerable complexity to this kind of welfare analysis. In broad terms, the approach envisaged in the 1997 White Paper and the Taylor Committee Report involved a Rawlsian presumption – that the goal should be the maximum affordable basic basket of health care to be assured for everyone, which would rise as economic growth and resources allow.

South Africa's public health services generate low levels of revenue from patient fees or other charges, and alongside education and social assistance grants rely mainly on a tax base that is strongly redistributive. A phased-in payroll or social security tax might be a feasible way of raising additional redistributive revenue, but social security reform proposals for a statutory retirement funding plan, together with improved income security for the unemployed also present compelling claims on this tax base.

If, as seems likely, the national tax base will be unable to accommodate a larger redistributive public health spending envelope over the foreseeable future, then the reform strategy should turn to mechanisms that would expand medical scheme membership and relieve the service delivery burden on public health services.

Information asymmetries, behaviour and choice

The Health Market Inquiry (HMI) addressed in some detail the question of the optimal design structure of a competitive insurance market, in the light of information challenges and limitations on rationality of choice. It proposed a "standardised basic benefit option," in part to facilitate comparison between schemes. Alongside this, it recommended procedures for supply-side regulation and negotiation of tariffs or reimbursement arrangements, further limiting the scope for price differentiation within the prescribed basic package.

The HMI report provides a useful conceptual paradigm for reform along these lines and announcements by the minister of health in early 2025 indicate that at least some elements of this analysis have been accepted. It is an obvious advantage of this approach that it could build on both experience with the existing prescribed minimum benefits and on options for low-cost medical scheme coverage, though reservations about the balance between costs and benefits will need to be addressed.

Pooling of health funds

The archetypal response to adverse selection in social insurance is mandatory participation. This would bring more young and healthy lives into the medical scheme system, reduce the average cost of contributions, and lead to a reduced burden on public health facilities.

The NHI proposal envisages that South Africa's medical tax credits should be phased out, but this is unlikely to be feasible. They not only provide significant relief to lower middle-income households and the elderly, but also provide an important cost-sharing vehicle for households with high levels of out-of-pocket expenditure related to disability or serious disease. A better approach would be to build on the existing tax dispensation to give effect to the Taylor Committee's intended broadening of coverage, risk equalisation between medical scheme pools and income cross-subsidisation. The South African Revenue Service's institutional interface with payroll providers and medical schemes provides an efficient available vehicle for distributing funds to nominated medical schemes.

These are measures that would lead to greater participation in medical schemes, particularly if accompanied by well-regulated, affordable basic benefit options. In the longer term, a broad-based payroll tax to subsidise medical scheme contributions and supplement funding for the uninsured would further deepen the redistributive tax-benefit structure of these arrangements.

Third-party payer effects: containing demand and over-servicing

Though the available mechanisms vary, both public and private sector insurers, and both unitary and multi-fund systems, are obliged to adopt measures to control costs and utilisation because "third party payer" systems inevitably lead to upward pressure on demand.

The HMI proposed establishing an Outcomes Measurement and Reporting Organisation (OMRO), an independent statutory body with stronger powers than the existing Office of Health Standards Compliance, that would create a systematic process for reporting health outcomes. It could assist public and private sector partnerships, as all parties would have a better idea of what they were paying for.

More complete information and data analysis are also the key to implementing alternative reimbursement mechanisms such as capitation-based pay or diagnosis-related groups and case-mix-based funding of hospitals and specialist services.

This is not just about the state, provincial departments or a national health fund purchasing from private providers, it is also about how medical schemes incorporate public health facilities into their benefit options and how the Road Accident Fund and the compensation funds contract with and reimburse public and private hospitals. An important focus area, for example, might be the facility requirements, staffing standards and clinical protocols that are required for an accredited emergency care facility – and then how these costs should be recovered from the various funds that have shared and overlapping responsibilities to emergency care patients.

For partnerships to improve utilisation of both public and private sector facilities, considerable effort has to go into negotiation of contract terms, with sufficient attention to the principles of affordability, certainty, value-for-money and appropriate risk-assignment.

Competition and concentration in supplier markets

The HMI proposed several remedies to address problems of concentration and pricing power in the hospital and specialist services markets. Progress also needs to be made in levelling the institutional playing field between the public and private hospital and specialist service sectors if the benefits of competition are to be fully realised. This has implications for the governance and tax regimes, which differ markedly. The existing regulatory barriers to the employment of health professionals in the private hospital sector should be abolished – arguably the paramount reform required to reduce costs and limit the incentives that lie behind over-servicing.

The private hospital sector has substantial capacity to contribute to meeting shortfalls in training healthcare professionals, overseen by university-based medical schools.

Progress towards autonomous management of public hospitals would assist in narrowing the institutional gap between the integrated public and separated private health financing systems.

Networks, gate-keeping and referrals

Consideration should be given to dismantling the existing referral and gate-keeping barriers between public and private sector service-providers, accompanied by negotiated tariffs and cost-recovery arrangements.

This also applies to intermediate inputs and facilities management where no obvious clinical considerations apply. The National Health Laboratory Service (NHLS) functions as a monopoly supplier in the public sector, while public hospital administration and infrastructure maintenance make little use of private sector management capacity. Opening up to competition would, in time, bring lower costs to both sectors.

The regulated PPP framework provides a principled platform through which to test collaborative contractual arrangements, both for private sector service delivery on behalf of the state and for private sector utilisation or management of state facilities and resources. There is also scope to improve the care provided in the private sector, which is characterised by high costs and over-servicing.

Our informants have advocated implementing referral systems between the private and public sector. If the more cost-effective and efficient option is for public sector patients to be referred to private service providers or for provincial departments to make use of private sector dispensary capabilities, for example, this should also be accommodated. The path forward requires proceeding in steps through targeted collaborative ventures that can be monitored, improved and extended as the lessons of integrated health system development are learnt.

Conclusion: priorities for further research

South Africa has excellent university-based medical schools and research capacity. But there are many gaps in the available research and analysis required for health system planning and improved coordination between the public and private health sectors.

Public-private partnerships, health services procurement and contract management, and comparative studies across public and private health services and insurance systems are not sufficiently under the research spotlight. Critical research areas include the following.

- *Cost-effectiveness analysis:* analysis of the costs and efficacy of health interventions and therapies, both in the public and private sectors

- *Technology assessment:* largely focused on essential medicines at present, South Africa's health technology assessment programme needs to be extended to cover diagnostic and therapeutic applications more fully and their applications in both public and private services.

- *Human resource needs, remuneration, earnings and conditions of service:* long-term human resource planning and approaches to training, internship, career progression and remuneration in both the public and private sectors.

- *Case mix analysis and planning:* well-structured administrative data and systematic case mix analysis can contribute to improved health planning and resource allocation, and comparative review of institutional performance.

- *Social policy and health outcomes:* prioritisation in social and development policy requires a multi-disciplinary approach to understanding health outcomes.

- *Governance, financing and management systems:* governance systems founded on integrity, transparency and accountability are the foundations of progress towards improved services.

Our analysis suggests that the comprehensive integration of South Africa's public health system and contributory insurance arrangements envisaged in the current NHI framework is impractical and out of touch with existing public and private sector institutional capabilities. A series of pragmatic reforms that both strengthen public services and expand the contributory system while standardising and regulating a package of health care affordable across both sectors, is a more feasible reform strategy. But we emphasise too that the present inequalities are indefensible and the reform imperative is urgent. Progress will depend on establishing a trusted forum for constructive engagement between the health authorities and health sector stakeholders.

1. Introduction

South Africa's peaceful transition to democracy in 1994 placed a highly fragmented, racially divided health system in the hands of the new ANC-led government. The socio-economic landscape forged by apartheid shaped the risks people faced and the services they could access.

Life expectancy at birth diverged sharply along racial lines, ranging from 76 for white women to just 65 for coloured women.[3] Black African women were seven times more likely to die during childbirth or in the immediate aftermath than their white counterparts.[4]

The ANC quickly moved to transform the health administrations of 10 homelands and four provinces into a single national department and nine provincial departments. It sought to create a unitary system built on the principle that access to healthcare is a human right, while recognising the interim constitution's assignment of health services to the new provincial authorities.[5] It embarked on an intensive process of systems review and reform, guided by the Constitution and later by the 1997 White Paper for the Transformation of the Health Sector[6] as it sought to overcome the bias in resource allocation towards historically white areas. The initial reforms focused on improving access to primary health care within the public system, while strengthening the regulation of medical insurance to improve protection from catastrophic health expenses in the private sector.

Following the recommendations of the 1995 Committee of Inquiry into a National Health Insurance System, the Department of Health in January 1996 issued an official policy document titled *Restructuring the National Health System for Universal Primary Health Care*. It set out details of a district-based primary healthcare delivery system and proposed a mandatory defined hospital benefit package to be offered through a regulated competitive health insurance market.

The subsequent 1997 White Paper, similarly, prioritised primary care:

> *"South Africa has well developed, high technology hospitals in the main cities, but underdeveloped basic health services, especially in the former rural homelands. As a consequence, essential health care is deficient for the poorer two thirds of the population. To rectify this situation, national health policy affords first priority to the development of the district health system, which comprises integrated PHC (primary healthcare) and district hospital services."*

Additional funding for the health system was to be sought through retention of hospital fee revenue and through social health insurance, requiring:

> *"…all formally employed people to be insured for the costs of treatment of themselves and their dependents in public hospitals. Contributions will be shared between employers and employees, and will be related to income and family size."*

The White Paper envisaged increased contracting out of services, particularly in urban areas where this would introduce greater competition in the provision of services. It also emphasised the need to ensure that medical

[3] Health Systems Trust, 1998.
[4] Ibid.
[5] Schedule 6 of the Constitution of the Republic of South Africa Act, 1993, listed health services as a provincial legislative competence. In schedule 4 of the 1996 Constitution, health services were listed as a concurrent national and provincial legislative competence.
[6] Department of Health, 1997.

schemes should not exclude individuals based on their health risk, and to improve the regulatory framework governing private health services. The underlying strategy was to expand social health insurance and broaden access to public and private hospital services, alongside improved basic health services funded through the fiscus.

Over the next few years there was considerable progress in implementing this reform strategy – a public clinic building programme was implemented, charges for public primary healthcare services were phased out, public health spending increased in real terms, the regulatory framework for medical schemes was tightened and minimum benefits were prescribed, controls on medicine pricing were introduced and several health sector public-private partnerships were signed.

But after 2007, there was a decisive shift in policy and several key elements of the 1997 White Paper policy framework were abandoned. Signalled first in the 2011 National Health Insurance (NHI) Green Paper, elaborated in the 2015 and 2017 NHI White Papers and culminating in the 2024 NHI Act, the new approach envisages a consolidated national health fund under state control rather than a competitive insurance market. The NHI Act implies that prescribed minimum benefits in the medical schemes environment will be replaced by a prohibition on insurance cover for benefits covered by the national insurance plan.

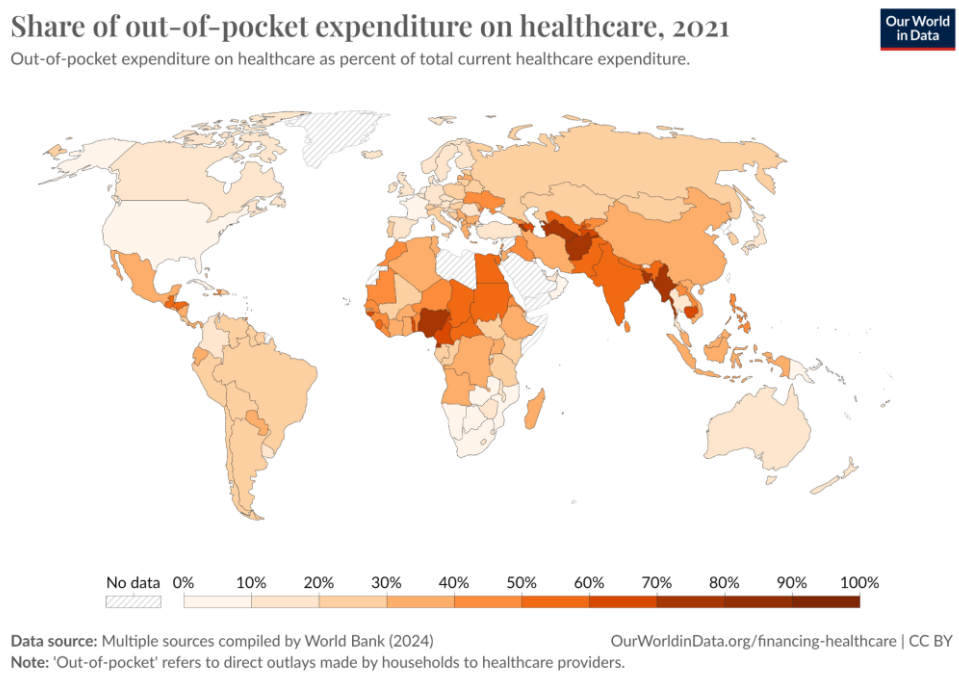
This paper argues that a comprehensive unitary national fund is an unrealistic aspiration, in part because it fails to build on the existing institutional strengths and capabilities of South Africa's public and private health sectors. The ANC government's adoption of this policy goal has had the effect of undermining and delaying practical reforms that would otherwise have contributed to more rapid progress towards equitable health coverage. The NHI plan also represents an ill-considered rejection of the role of competition in the health sector, despite the extensive guidance provided by the Competition Commission's Health Market Inquiry on how both the insurance and provider markets might be better regulated. Options for a return to a pragmatic reform strategy over the decade ahead are discussed in our concluding section.

2. The landscape today – persistence of a dual health system

Thirty years after the advent of democracy, South Africa still has a health system riven by inequalities, with patients' access to care substantially determined by their socio-economic status and where they live. The country is classed as an upper middle-income country with well-developed infrastructure but remains one of the most unequal societies in the world, with a Gini coefficient of 0.67.[7] Unemployment is extremely high, at over 32 per cent, and more than half the population lives below the poverty line. The proportion of the population covered by medical scheme membership has declined from 16.5% in 2000 to 14.9% in 2022,[8] while dependence on public clinic and hospital services has increased. However, a recent survey found that a quarter of the population (25.4%) turn first to the private sector for primary healthcare,[9] which implies that there is some overlap between reliance on the public and private health sectors. Many people pay out of pocket for some private healthcare services and rely on the state for hospital care.

A World Bank review finds out-of-pocket spending is low in comparison with other countries (Figure 1). Though health spending is unequally distributed, the combined outcome of largely free or means-tested public health services and health insurance coverage amongst higher income groups is that few South Africans face catastrophic health expenses.

Figure 1[10]

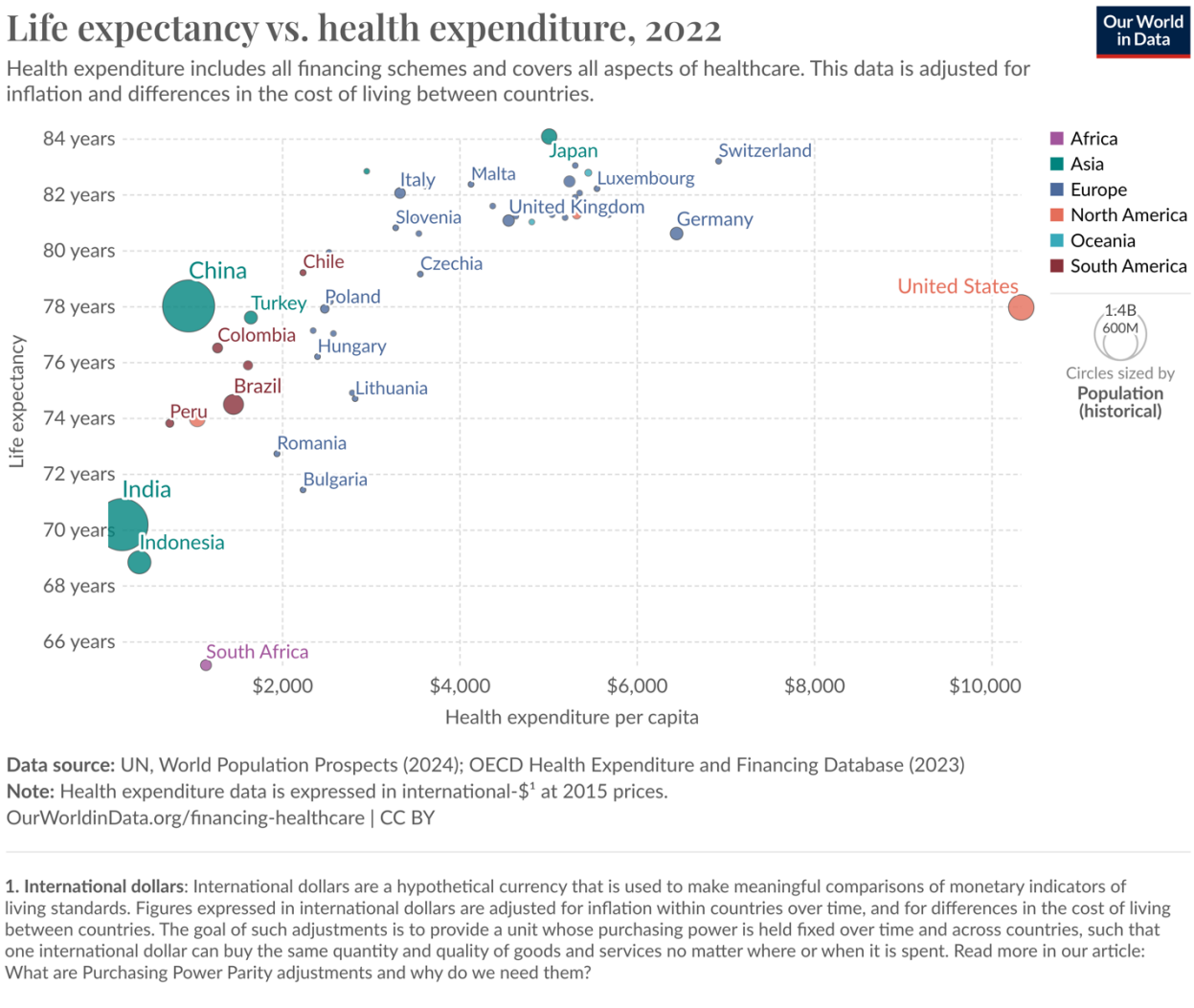


[7] Valodia, I, 2023.
[8] Council for Medical Schemes, 2023.
[9] Statistics SA, 2023.
[10] Our World in Data, 2024a.

However international comparative studies find that South Africa achieves poor health outcomes relative to its economic development (Figure 2) despite the adoption of policies broadly consistent with the advice of the World Health Organisation.[11]

There are several broad explanations for this paradox. South Africa faces a unique quadruple burden of disease that places particularly high demand on the public health system. The systemic governance and managerial weakness that characterize much of the public sector leave provincial health departments unable to respond adequately to patients' needs. The resource imbalances between the public and private health sectors are clearly also relevant, as a minority of the population is served by a disproportionate share of SA's limited healthcare professionals working in the private sector.

Figure 2[12]



SA has extraordinarily high levels of HIV and tuberculosis, rates of non-communicable disease that are more than double the average of developing countries, high rates of violence and injury (including a homicide rate five times the global average), and maternal and newborn mortality rates that are considerably higher than

[11] Notably, the priority given to primary health care, reflected in the 1978 Declaration of Alma-Ata of the International Conference of Primary Health Care.

[12] Our World in Data, 2024b.

the average for similar countries.[13] The structure of this disease burden is part of the reason for the emphasis given to primary healthcare in the 1995 Committee of Inquiry and the 1997 White Paper. There is still much to be done to strengthen the basic capabilities of the public health system, and yet progress in this domain appears to have stalled.

Over the past decade, total public health expenditure has increased in real terms by an average of 2.3% a year, while medical scheme expenditure has grown at a similar rate (2.4% per annum in real terms). Out-of-pocket expenditure as a share of total health expenditure has remained steady, at 7.3%, according to Treasury estimates (Table 1).

Table 1: Expenditure on health services in South Africa, 2011/12–2022/23

	2011/12	2022/23	% of Total	% increase pa	% increase pa (real)
	R billion				
National Dept of Health	1.8	5.7	1.0%	11.2%	5.7%
Defence & Prisons	3.9	6.8	1.2%	5.2%	0.0%
Provincial Health Departments	111.5	251.1	43.0%	7.7%	2.3%
Road Accident & Compensation funds	4.2	7.7	1.3%	5.8%	0.6%
Municipalities	2.4	5.7	1.0%	8.2%	2.8%
Total: Public sector	**123.8**	**277.0**	**47.5%**	**7.6%**	**2.3%**
Medical schemes expenditure	107.4	244.6	41.9%	7.8%	2.4%
Out-of-pocket household spending	19.1	42.6	7.3%	7.5%	2.2%
Medical insurance	3.1	5.5	0.9%	5.3%	0.1%
Employer-provided services	1.5	2.6	0.5%	5.3%	0.1%
Total: Private sector	**131.1**	**295.4**	**50.6%**	**7.7%**	**2.3%**
Donors/Non-govt organisations	**5.3**	**11.1**	**1.9%**	**6.9%**	**1.6%**
Total	**260.2**	**583.5**	**100.0%**	**7.6%**	**2.3%**

Source: National Treasury.

In recent years, public sector health budgets have come under increasing pressure as provincial health departments have struggled to pay salaries from their compensation budgets while meeting the growing demand for services. Many state patients are attended to in crowded and dilapidated public health facilities and face long waiting times for specialised services such as oncology or surgical procedures, compromising their prognosis and increasing treatment costs. Provincial health departments have, in many instances, managed their budget shortfalls by cutting spending on infrastructure and maintenance, reducing agency staff, and increasing their accrued liabilities.[14]

The budget challenges facing provincial health departments have been exacerbated by wide-spread corruption and financial mismanagement. Provincial health departments have repeatedly received qualified

[13] Abdool Karim, S, 2024. Before the coronavirus pandemic struck, SA's institutional maternal mortality rate stood at 98.8 per 100,000 live births in 2019 (Saving Mothers Report 2020-2022), markedly higher than Peru (72) and Brazil (61). Our World in Data: maternal mortality by country. Available at: https://ourworldindata.org/grapher/maternal-mortality. Accessed 28.10.24.
[14] Sachs et al., 2023.

audits from the Auditor-General, and most have regressed in their audit outcomes.[15] The Western Cape is an outlier in that it has had clean audits for over a decade, though it also faces resource constraints and management challenges.

A series of investigations by the Office of the Health Ombud have exposed systemic governance weaknesses in a variety of public health institutions that have led to catastrophic crises in patient care. The most high profile of these was the probe into the deaths of more than 144 state mental health patients, who were transferred by the Gauteng health department to ill-equipped and unlicensed non-governmental organisations despite repeated warnings from health professionals and civil society organisations.[16]

Patients who rely on the private healthcare sector continue to face a scenario in which their medical scheme contributions and out-of-pocket expenses are increasing faster than consumer price inflation. The incomplete regulation of medicine prices sold in the private sector has over time enabled companies to exploit loopholes in the rules. After the introduction of the single exit price regulations for medicines sold in the private sector, which controlled prices and annual increases, the health department abandoned efforts to benchmark the launch price of new products entering the market. It also jettisoned plans to expand the regulations to stamp out perverse sales incentives employed by the pharmaceutical industry.[17]

Medical scheme membership remains largely a function of formal employment and income. SA's weak economic growth and high joblessness have consequently seen the number of beneficiaries stagnate at around the 9-million mark for more than a decade.

By contrast the market for health insurance products for primary healthcare care is growing, reflecting demand from employers of low-income workers for basic products that deliver services in the private sector. Expansion is however constrained by the lack of a regulatory framework to migrate existing products into a standard low-cost benefit option and open the market to new entrants.[18]

Several of our informants identified the ANC's 2007 elective conference in Polokwane as a watershed moment that abruptly tipped SA's health policy trajectory onto an ambitious new path that more than 15 years later has yet to bear fruit. It torpedoed work already underway to develop a social health insurance system based on mandatory medical scheme enrolment for people in formal employment, blocked the implementation of a risk equalisation fund, slowed the development and approval of low-cost medical scheme options, and had a chilling effect on further reforms to the private healthcare sector. The political climate became increasingly hostile towards the private sector, and the appetite for public-private partnerships, which was evident in the early 2000s, dwindled. Opportunities to learn from these initiatives were lost, while corruption and weak managerial capacity hindered provincial health departments' efforts to meet the growing demand for services. The absence of effective mechanisms for negotiating tariffs or managed care arrangements between medical schemes and dominant service providers contributed to rising costs relative to consumer price inflation, while slow economic growth and high unemployment meant that medical scheme membership remained unaffordable for most of the population.

In the context of South Africa's extreme inequalities and disparate access to health services, there is clearly an appeal in the idea of a unitary health system capable of centrally rationing resources to meet health care needs. But it is difficult to describe a credible transition path from South Africa's multi-fund insurance system

[15] Ibid.
[16] Makgoba, M, 2024.
[17] Kahn, T, 2014.
[18] Kahn, T, 2024a.

to a single purchasing authority, or from nine provincial health authorities to a nationally controlled system. The more common approach internationally has been to expand existing insurance coverage while tightening the regulatory framework and targeting fiscal resources to ensure that an equitable healthcare package is available to all.[19] In the presence of multiple funding pools and established decentralised health services, it has to be asked how reforms might be sequenced to chart a plausible path towards more equitable service delivery. Health economics tools can assist in clarifying the rationale for identified reforms and highlighting key design considerations.

Although the NHI proposals have now been passed into law, their implementation has emerged as a major point of contention within SA's new government of national unity, formed from 10 political parties after the ANC lost its majority in the 2024 general election. By February 2025, four separate legal challenges had been launched against the NHI Act, and more were in the pipeline.[20] Is there perhaps a more pragmatic reform path which would draw more effectively on the strengths and capacities of both the public and private healthcare systems, while improving insurance coverage and reducing inequality in healthcare resource allocation?

[19] See Toth, F, 2021.

[20] Legal challenges to the NHI Act had been launched by trade union Solidarity, the Board of Healthcare Funders, the SA Private Practitioners Forum and the Hospital Association of SA. The South African Medical Association, the Health Funders Association and Business Unity SA had indicated they were still considering their options.

3. Analytical perspective

Analysis of health systems typically begins with a distinction between the "Bismarckian" and "Beveridge" frameworks – health insurance with its origins in occupational or regional sickness funds, leading to a regulated multi-fund system, as in Germany, or unitary and integrated systems exemplified by the UK's National Health Service. From this perspective, SA's adoption of an NHI plan after 2007 rather than the reform path envisaged in the 1997 White Paper can be read as a switch from the social insurance paradigm to a unitary framework as the envisaged end-goal.

But a broader reading of recent literature on comparative health systems reveals a more complex picture. Federico Toth distinguishes between seven alternative health financing systems found in contemporary OECD countries[21] and, importantly, points out that at least three and often four or more financing systems co-exist in *all* the 27 OECD countries for which he finds sufficient available data. Modern health financing systems are all *hybrid* systems, with varying forms of interaction between their component parts and subsystems.[22] Many countries feature both a national or near-universal financing plan alongside market-based arrangements, voluntary health insurance or targeted health services for specific communities or groups – the elderly, for example, the armed forces, refugees or the unemployed. Even in countries in which the dominant financing system is a unitary national fund, accompanying voluntary insurance and out-of-pocket payments account for at least 14% of total health expenditure, and contribute 26% on average in all 27 countries.[23]

Toth also makes the important institutional distinction between "integrated" and "separated" health financing systems – arrangements in which funders also provide health services and employ service providers and arrangements in which funding or insurance is institutionally separated from the provision of healthcare services. The NHS in the UK and Canada's Medicare system are both "universalist" models, but insurance and provision are predominantly integrated in the UK and separated in Canada. Alongside insurer-provider integration or separation, health systems are also integrated or separated along several other dimensions: primary and secondary care, the presence or absence of gatekeeping mechanisms, the freedom of patients in choosing their providers, and whether general practitioners operate individually or in group practices.[24] These arrangements typically have long historic antecedents, in part because both internal management and employment systems and the alternative purchasing, procurement and reimbursement arrangements are complex and require long evolutionary developments of system capabilities.

Whereas the UK NHS is largely an integrated system, South Africa's NHI plan aims at least to some degree to accommodate the purchaser-provider separation that is characteristic of either unitary or multi-fund insurance arrangements and is the dominant organising principle of SA's medical schemes. But the provincial health departments are essentially integrated systems. How a transition path might be constructed that brings together these very different institutional frameworks is far from clear.

[21] Toth, F, 2023. Toth distinguishes the direct market system (dental services, psychological services or rehabilitative therapy not covered by standard insurance plans, for example), voluntary health insurance (as in the USA or South Africa), social health insurance (typically tied to employment), targeted programmes (Medicare and Medicaid in the USA), mandatory residence insurance (Switzerland for example), the universalist model (Medicare in Canada or the UK NHS), and pre-funding through individual medical savings accounts (in use in China, Singapore, South Africa and the USA, commonly in combination with other forms of insurance).

[22] Ibid, chapter 2.

[23] Ibid, calculated from Table 3.1; unweighted average for 27 OECD countries of which 15 have universalist single funds.

[24] Ibid, chapter 4.

The choice of a reform strategy is in part about institutional dynamics – about how the regulatory framework, government arrangements and the structure of incentives that they generate affect supply and demand, the quality of services and relative prices. Institutions matter when they work well – shaping standards of care, for example, or ensuring the availability and efficient use of resources – and when they work badly, leading to corruption or over-servicing. Institutional reform is about finding and reinforcing arrangements that enhance productivity and correcting arrangements that do not. But institutions cannot be restructured overnight – a strategy for reform has to address questions about how existing institutions adapt over time to changes in regulation or financing arrangements.

Health economics offers some useful tools for thinking about these questions. Broadly speaking, it provides the underlying logic and rationale for the organisation, regulation and financing of health services. It also provides an analytic perspective on the role of competition, individual choice and service provider independence, even in systems characterised by centralised coordination and financing. There is no single welfare-maximising organisational structure: there are many ways in which different countries have made progress in broadening the quality and availability of healthcare, with varying combinations of public and private insurance.

In our evaluation of South Africa's shift in health policy, we draw on six broad themes in health economics:

- ***Distributional and risk-pooling issues:*** It is widely accepted and clearly articulated in the UN's 2019 political declaration on universal health coverage[25] that access to needed healthcare should not be constrained by income or wealth. This is often taken to mean that care should be free at the point of delivery. More fundamentally, it implies some form of community-wide risk-pooling,[26] together with redistributive transfers or subsidies using tax measures and tariff structures.

- ***Information asymmetries and behavioural concerns:*** Since US economist Kenneth Arrow's seminal 1963 paper, the role of "non-market" arrangements in the organisation of health services has been understood to be at least in part a response to medical information problems such as "uncertainty in the incidence of disease and in the efficacy of treatment."[27] The implications range from rigorous professional training and ethical standards to the control of pharmaceutical products and prescribing, maintenance of records and the structure of social insurance plans.

- ***Health financing arrangements:*** Pooled health funding systems generate the archetypal moral hazard and adverse selection problems of pre-financing and insurance markets.[28] Arrow showed that health insurance systematically affects the behaviour of the parties to the contract. Insured individuals consume more healthcare and might take more risks than they otherwise would. The old and sick purchase more insurance than the young and healthy.

- ***Third-party payer effects:*** Related to the above, when health costs are neither a charge to the consumer nor an expense to the service provider, the usual mechanisms through which demand and supply lead to efficient outcomes are ineffective. Demand increases and over-servicing or excessive expenditure arise.

[25] United Nations, 2019.
[26] Mathauer, I, Saksena, P and Kutzin, J, 2019.
[27] Arrow KJ, 1963.
[28] For an evaluation of the impact of moral hazard and adverse selection on health insurance choices, see Powell, D and Goldman, D, 2021.

- ***Market concentration:*** Health markets are characterised by varying degrees of local or regional monopoly power, particularly in the private hospital and specialist sectors.[29]
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- ***Gate-keeping and referral:*** Health systems have network features. Unfettered access to specialist and tertiary care has the potential to drive increases in healthcare expenditure. Referral protocols, usually with a GP as the steward, are used to manage access and limit costs.[30]

The concluding sections of this paper return to these themes as considerations in assessing the health reform strategy envisaged in the NHI Act, and possible alternatives.

[29] Evidence of substantial market concentration in the South African private health sector was found by the Market Inquiry conducted by the Competition Commission of South Africa. See Nkonki L, Bhengu, N, Ramokgopa, M and Fonn, S, 2019.
[30] For a review of the impact of GP gatekeeping, see Sripa, P, Hayhoe, B, Garg, P, Majeed, A and Greenfield, G, 2019.

4. National health insurance – its policy evolution

The ANC's pre-1994 Reconstruction and Development Programme listed "a new national health system, based on the primary health care approach" as one of the critical "basic needs" to be addressed by the new government. In keeping with the RDP's intent, one of President Nelson Mandela's first acts after assuming office in 1994 was to introduce free healthcare for pregnant women and children under the age of six. The government embarked on a massive clinic-build programme as it sought to change a highly centralised, curative and hospi-centric public health system into one with a greater emphasis on decentralised management of preventive and primary healthcare. User fees for primary care were largely abolished, as public clinic services were provided free of charge. Means-tested and differentiated tariffs were retained for public hospital services.

A summary of key policies, programmes and health sector reforms since 1994 is set out in table 2. Although the ANC's health system reform proposals were shaped in the context of South Africa's democratic transition, the historic record shows that tensions between universalist plans and narrower health sector interests can be traced back at least to the 1920s. A South African health system plan in the 1940s was largely framed along the lines of reforms underway in the UK that paved the way for its National Health Service. However these plans were abandoned after the National Party rose to power in 1948, fueling the growth of private health insurance. In the decade preceding the 1994 democratic transition, a phase of medical scheme deregulation further weakened the social insurance features of SA's health financing system.[31]

Table 2: Key policies, programmes and legislation implemented between 1994 and 2024 [32] [33]

Year	Intervention
1994	Free healthcare for pregnant women and children under six
1995	Committee of inquiry into a National Health Insurance System
1996	Policy document: Restructuring the national health system for universal primary health care
1996	Primary healthcare standard treatment guidelines and essential drugs list
1996	Choice on Termination of Pregnancy Act
1997	White Paper for the Transformation of the Health System in SA
1997	Medicines and Related Substances Control Amendment Act
1998	Medical Schemes Amendment Act
1998	Compulsory internship and community service introduced
1999	Tobacco Products Control Amendment Act
2000	Regulations for PPP's issued in terms of the Public Finance Management Act
2001	National Health Laboratory Service established
2002	Medicines and Related Substances Control Amendment Act

[31] Whyle and Olivier, 2023.
[32] Academy of Science of South Africa (ASSAf), 2024.
[33] Health Systems Trust, various editions.

Year	Intervention
2002	Committee of Inquiry into a Comprehensive System of Social Security for South Africa
2003	Competition Commission bans collective bargaining between medical schemes and healthcare providers
2004	National Health Act
2004	Regulations relating to a transparent pricing system for medicines and scheduled substances (Single Exit Price)
2006	Low Income Medical Scheme report
2007	ANC Polokwane elective conference resolution on NHI
2008	Rejection of National Health Amendment Bill and Medical Schemes Amendment Bill
2011	NHI Green Paper
2013	Office of Health Standards Compliance established
2015	Draft NHI White Paper
2017	Regulations to demarcate medical schemes from health insurance products
2017	Final NHI White Paper
2017	Davis Tax Committee Report on financing NHI
2017	Motlanthe High Level Panel report
2018	Draft NHI Bill released for comment
2018	South African Health Products Regulatory Authority established
2019	Health Market Inquiry Report
2019	NHI bill submitted to parliament
2024	NHI Act signed into law

In 1995 Health Minister Nkosazana Dlamini-Zuma appointed a Committee of Inquiry into National Health Insurance (NHI). It proposed universal access to a basic primary health care package provided in the public sector but notably preserved the choice of individuals to use private providers and to insure themselves for doing so.[34]

Following the recommendations of the 1997 Social Health Insurance (SHI) working group, the government implemented far-reaching reforms to the medical scheme market, which had been deregulated in the late 1980s and early 1990s.[35] The Medical Schemes Act of 1999 introduced community rating, open enrolment, and Prescribed Minimum Benefits (PMBs) – a basket of hospital-based services, later supplemented by a list

[34] Committee of Inquiry into a National Health Insurance System, 1995.
[35] African Development Bank and Wits School of Governance, 2017.

of chronic conditions, that all schemes were obliged to cover in full, regardless of the option chosen by the member.

This reform programme drew strongly on key principles in health economics, including the need to lean against selection bias or "risk-rating" by health insurers and to correct for information failures by standardising benefits. Health financing arrangements in the public sector recognised the system's reliance on central referral hospitals associated with academic training capacity and the need to ensure that affordability should not function as an access barrier.

Building on these reforms, the 2002 report of the Committee of Inquiry into Comprehensive Social Security for SA (the Taylor Committee) set out a four-phase process for achieving universal contributory health cover "based on multiple funds and a public sector contributory environment."[36] Key elements of these recommendations included:

- Consolidation of medical scheme reforms to remove any residual risk-selection and to increase coverage
- Risk-equalisation between medical schemes
- Conversion of the medical schemes tax subsidy into an explicit income and risk-adjusted subsidy
- Mandatory medical scheme membership for higher income groups, accompanied by the development of a subsidised contributory scheme for non-medical scheme members
- Introduction of a Central Equity Fund to make allocations to both public sector health providers and medical schemes based on a risk-adjusted equity formula.

A notable feature of the Taylor Committee's approach was its explicit recognition of South Africa's unequal income distribution and of the need to structure redistributive health financing arrangements accordingly while retaining the institutional advantages of a competitive multi-fund system.[37] Investment in enhanced amenities would enable public hospitals, over time, to increase revenue through contracts with medical schemes.

The health department established a task team to implement these recommendations, which included establishing a risk equalisation fund to level the playing field between more than 80 schemes and thereby promote competition on efficiency grounds rather than on the number of young and healthy lives they could attract. In the early 2000s, the Treasury supported several privately financed investments in improved public hospital facilities, discussed further below. With effect from 2013, the Treasury amended the tax treatment of medical scheme contributions and medical expenses to shift the tax benefit from higher-income to lower-income beneficiaries.[38]

While extensive preparatory work was undertaken, mandatory enrolment and a risk equalisation mechanism were never implemented. The ANC in 2007 resolved instead to pursue a unitary-fund National Health Insurance (NHI) model, called for the creation of a state-owned pharmaceutical company, and urged caution on public-private partnerships.[39]

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[36] Committee of Inquiry into a Comprehensive System of Social Security for South Africa, 2002. Chapter 8.

[37] For an elaboration of the analysis underlying the Taylor Committee's recommendations, see Van den Heever, AM, 2012.

[38] The key reform was the replacement of medical expense deductions from taxable income with credits against tax liability, effectively eliminating the disproportionate benefit to higher-income taxpayers resulting from the progressive structure of personal income tax.

[39] ANC 52nd National General Council Resolution 67 on health. Available at: https://www.anc1912.org.za/resolutions-2/. Accessed 2.10.24. The ANC has never clearly articulated the rationale for this policy shift, fuelling speculation that it was due to pressure from unions loyal to the newly ascendant Jacob Zuma who were disenchanted with the market-friendly policies pursued by Thabo Mbeki, or driven by the views of a few influential advisors within the party (Interviews with Informants).

There has been little change to the ANC's NHI policy in the almost 15 years that have elapsed since health minister Aaron Motsoaledi released the NHI Green Paper in August 2011.

Public discussion of the NHI proposals focused particularly on the Green Paper's indicative cost estimates, which suggested that the public health budget would need to increase from R110 billion in 2010/11 to R256 billion in 2025/26 (in 2010 prices) – an increase of 130% in real terms. The parliamentary portfolio committee on finance asked the National Treasury to submit an analysis of the fiscal implications of NHI, which led to considerable work being undertaken by the Treasury's public finance team on the health system and financing reform options.[40] However, the Treasury and the Department of Health failed to reach agreement on publication of this analysis, and it had little impact on the Department's views.

The Treasury's work on health systems reform is instructive in its delineation of the institutional capabilities that make up a health financing system:

- Mobilisation of revenue (tax, social and private insurance, user fees) and determination of collection agencies
- Pooling of funds, including the regulation of independent funds and needs-based resource allocation or risk adjustment mechanisms
- Purchasing arrangements, benefit packages, payment mechanisms, contractual arrangements and quality management
- Provision of health services – clinics, general practice services, public and privately managed hospitals, and associated accreditation standards and quality assurance arrangements.

New arrangements for these systemic functions have to be accompanied by appropriate legal and institutional reforms, and adaptive learning processes through which they are introduced, tested and rolled out more widely.

The reforms initiated in the 1990s and envisaged in the 1997 White Paper comprised the first steps in a longer-term strategy for building a health system that would *combine* public and private financing flows, administrative capacity and service delivery platforms. Enhancement of public services and broader participation in medical schemes would contribute, over time, to greater equity in health service quality, access and availability. But the ANC's NHI proposals envisaged a different reform path.[41]

The initial NHI White Paper was published in 2015, followed by a second version in 2017 that contained no material changes despite extensive public input. The draft NHI Bill considered by a NEDLAC task team in 2019 was broadly supported by the labour and community constituencies while a range of objections were raised by business which were subsequently elaborated in representations to Parliament. Parliament passed the NHI Bill without making any significant amendments, despite concerns about the fiscal implications and extensive commentary and objections from health industry stakeholders, healthcare professionals, civil society organisations, and individuals. President Cyril Ramaphosa signed the NHI Act in May 2024, confirming the ANC's unwillingness to contemplate changes to the single-fund model.

One notable feature is that the ANC's position on medical schemes has hardened over time: the NHI Green paper left space for voluntary medical scheme membership to continue but this shifted in the final 2017 White Paper which prescribed a diminished role for schemes.[42] The NHI Act explicitly restricts medical

[40] Public Finance Division, National Treasury, 2016.
[41] For an analysis of the shift in health insurance policy, see van den Heever, 2016.
[42] Department of Health, 2017.

schemes to offering cover only for “complementary” services not provided under NHI. The shift from a multi-payer system to a single fund is not just a significant change in policy in its rejection of the envisaged role of the established regulated medical schemes, but in the absence of a credible transition strategy is also a much more complex and riskier undertaking.

Amongst the questions that arise are the following:

- Taking into account the dominance of specialist and hospital services in medical scheme coverage, what does the consolidated NHI framework imply for the primary health care priority articulated in earlier policy statements?
- How will the NHI demarcate the services it covers that medical schemes will be prohibited from reimbursing? What will be the institutional and behavioural consequences of this demarcation?
- How will the regulation of medical schemes change, given their diminished role?
- How will publicly funded services (hospitals, clinics, and laboratory and other services) be financed on terms equivalent to the reimbursement of private service provider costs?
- If competition between funds and service providers is abolished, how will quality and efficiency be incentivised?

The Department of Health has until recently been silent on the report of the Competition Commission’s Health Market Inquiry. But its findings and recommendations can assist in thinking through these and related questions that will need to be addressed in the transition to a new health insurance architecture.

5. The Health Market Inquiry

The ANC's decision to pursue NHI aborted work on broadening medical scheme coverage and torpedoed planned amendments to the Medical Schemes Act. As a result the regulatory framework for medical schemes is incomplete, with no mechanism to pool risk between schemes, counter adverse selection or negotiate tariffs collectively. This contributes not just to higher costs but also to a continuing cost spiral and reduced affordability of coverage.

The political impetus for NHI and growing antipathy from the health department towards the private sector inhibited further reforms to the private healthcare market. The health department failed to counter the Competition Commission's 2003 ban on collective bargaining between medical schemes and providers by maintaining a reference price list against which medical schemes could benchmark provider charges[43] or ensure the Council for Medical Schemes regularly review the prescribed minimum benefits (PMBs) and develop a framework for low-cost benefit options. The Medical Schemes Act requires the PMBs to be reviewed every two years, but no amendments have been made for over 20 years.

Table 3: HMI key findings

Features that restrict competition: 1. Highly concentrated facilities and funder markets 2. Disempowered and uninformed consumers 3. Absence of "value-based purchasing" 4. Inadequate regulation and failures of accountability 5. Lack of price transparency
Facilities: 1. Three hospital groups account for 80% of market, with few new entrants 2. A lack of quality assurance 3. Independent hospitals (mainly National Hospital network) have limited ability to attract specialists despite some relief from competition rules
Practitioners: 1. The prohibition on collective tariff negotiation creates a price vacuum 2. Excessive utilisation is a driver of healthcare costs
Funders: 1. PMB provisions on catastrophic cover result in exclusion of primary care 2. Absence of mandatory cover leads to anti-selection (adverse selection) 3. Barriers to entry in the administrator market

Source: HMI final report.

In 2014, the Competition Commission initiated a Health Market Inquiry (HMI) to probe the private healthcare sector's structure and operations and identify potential barriers to competition that might raise costs or hinder patients' access to care. Its final report, released in September 2019, provided the government with

[43] Barber, S. et al, 2018.

a detailed and systematic assessment of the private healthcare sector.[44] It concluded that the cost of healthcare was high and rising, and that there was significant over-utilisation. Its recommendations were made with a view to giving consumers a better deal and strengthening the private health sector in order for it to contract with the state under NHI (Tables 3 and 4).

Table 4: HMI key recommendations

1. Introduce a supply side regulator for health (SSRH) responsible for facility planning and licensing, economic value assessments of health technology and interventions, monitoring and pricing of health services
2. Implement an Outcomes Measurement and Reporting Organisation (Omro)
3. Transition from fee-for-service to alternative reimbursement mechanisms
4. Separate the academic and business functions of healthcare practitioner associations, with guidelines to prevent anti-competitive behaviour
5. Revise the Health Professions Council of SA ethical rules to allow multidisciplinary practices and alternative care models
6. Introduce a single, comprehensive, standardised benefit option to allow comparisons between schemes and encourage lower prices
7. Implement a risk adjustment mechanism linked to the base benefit to stop schemes competing for young and healthy members
8. Strengthen separation between funders and administrators
9. Devise an "opt-in system" for brokers

Source: HMI final report.

The HMI pointedly stated that many of the problems it had identified were attributable to the health department's abdication of its stewardship role and a failure to see that the private and public healthcare sectors were inextricably linked.[45] In effect, the HMI report provided an opportunity to revert to a phased implementation of health systems reform, building on the strengths of both the public and the private sectors and improving the regulatory framework through which a multi-fund system could allocate resources equitably, promote competition, control costs and prices and counter abuse of market power.

The national health department has maintained an intent focus on its NHI proposals that appears to have crowded out consideration of other potential reforms. Five years after publication of the HMI report, no measures had been implemented in response to its recommendations. No discernible efforts to reduce the cost of private healthcare or widen access to medical scheme membership have been taken for the past two decades.[46]

However, in February 2025, the ministers of health and of trade, industry and competition announced that an agreement had been reached between the national Department of Health and the Competition Commission for an "interim block exemption" for tariff determination in the health sector, in order to accommodate a structured multi-stakeholder price determination framework.[47] Accompanying this, the minister of health announced plans to centralise healthcare planning and licensing, consolidate health information systems, introduce alternative reimbursement mechanisms as alternatives to fee-for-service

[44] Competition Commission of South Africa, 2019.

[45] Stakeholder interview.

[46] The last amendment to the PMB's was in 2003, when the definition was extended to include a comprehensive list of chronic diseases.

[47] Draft regulations for a three-year block exemption were published in February 2025.

tariffs, upgrade health technology assessment initiatives, discuss the proposed standardised benefit package and the amendment of rules overseen by the Health Professions Council of SA to allow for multidisciplinary group practices.[48]

The minister of health also called for public comment on the Low-Cost Benefit Option Report prepared by the Council for Medical Schemes in 2023. In doing so, the Minister indicated that he had reservations about the desirability of this reform, characterising it as a "low-cost low-benefit" proposal rather than a low-cost comprehensive benefit proposal. The Minister stated further that "it would be most appropriate to implement the Health Market Inquiry recommendations relating to the establishment of a basic benefit package through an amendment to the Medical Schemes Act combined with a Multilateral Price Negotiation Forum which is more likely to lead to the development of a comprehensive benefit package at an affordable premium for low-income households." [49]

Although details of these initiatives are not yet clear, they perhaps signal the beginning of a reconsideration of the plausible contours of the NHI reform path. However, the initial response of national organisations representative of healthcare professionals to the "interim block exemption" proposal was decidedly lukewarm. It appears to have been formulated in haste without either stakeholder consultation or sufficient attention to the required statutory foundations and the broader recommendations of the HMI.[50] Progress over the period ahead will require deeper and more constructive engagement between the health authorities and representatives of the private sector and healthcare providers.

[48] Departments of Health and of Trade, Industry and Competition joint press statement February 24, 2025.
[49] Department of Health, 2025.
[50] Universal Access Healthcare Coalition, 2025.

6. Challenges to the unitary NHI proposal

The sweeping reforms and financing requirements of NHI have been challenged on numerous fronts, including the Davis Tax Committee, the High-Level Panel review of SA legislation chaired by former president Kgalema Motlanthe, and various stakeholders who made submissions to parliament when the legislation was under consideration. Towards the end of 2024, an alternative approach to universal healthcare access was published by a coalition of national organisations representing a substantial proportion of healthcare professionals in the South African health system.

The Davis Tax Committee concluded that the funding requirements of NHI outlined in the White Paper were unlikely to be sustainable without more rapid economic growth and warned that the scale of the projected revenue shortfall would require substantial increases in personal income tax or VAT or a large new social security tax.[51]

The High-Level Panel proposed a three-tier model for universal health coverage that included private sector medical schemes, government employees' medical schemes and a new NHI scheme as an alternative to the single purchaser model proposed under NHI.[52]

Parliament's portfolio committee on health received over 64,000 written submissions and heard 117 oral submissions from business, labour, civil society organisations and individuals during the public participation process on the NHI Bill. Three key areas of concern emerged during the presentations to parliament: the NHI funding model, the governance of the scheme and its vulnerability to corruption, and potential infringements of constitutional and human rights.

Supporters of the bill saw the single-purchaser model as a means to address the inequities and inefficiencies in SA's two-tier health system and took it as a given that all the funds currently directed to private healthcare services, including medical scheme member contributions, employer subsidies and tax credits, could be redirected into the NHI Fund.

Critics such as Business Unity SA (Busa), an umbrella body for organised business, challenged this assumption, arguing that raising the additional funds required for NHI would entail unrealistic and unaffordable tax increases. It commissioned research that concluded that raising the extra R200bn the health department said was required for NHI would require raising personal income tax by 31%, increasing VAT from 15% to 21.5%, collecting a payroll tax of R1565 per month from everyone in formal employment, or a combination of these measures.[53]

Busa's central concern with the bill was its limitation on the role of medical schemes and the effect this would have on the private healthcare sector and the economy. It was also concerned that the uncertainty created by Section 33 of the Act, which says medical schemes will be limited to providing only 'complementary cover' for services not offered by the NHI, would deter investors.

SA's biggest medical scheme administrator Discovery Health articulated a widely held view in the medical scheme industry that a single-purchaser model would reduce consumer choice, curb competition and efficiency, and lead to implicit rationing. It was one of the few stakeholders that presented an alternative to

[51] Davis Tax Committee, 2017.
[52] High Level Panel, 2017.
[53] Business Unity South Africa, 2023.

NHI, advocating a blended funding model with a role for public and private insurers and public and private providers within a collaborative, phased implementation programme.[54]

The majority of stakeholders who made oral submissions to parliament raised concerns about inadequate safeguards against corruption and the extent to which powers are vested in the health minister. Many stakeholders wanted the NHI Fund to be accountable to parliament rather than the minister.[55]

A number of constitutional concerns were raised by stakeholders, including the NHI's infringement on the role of the provinces, the reduction in access to healthcare currently available to medical scheme beneficiaries and the exclusion of care for refugees and migrants. While the state law advisor told parliament that the bill passed constitutional muster, parliament's legal advisors raised similar concerns to those of stakeholders and warned that it would be vulnerable to legal challenge on these grounds.[56]

The December 2024 proposals of the Universal Healthcare Access Coalition[57] represent the most systematic challenge to the NHI framework to date. The Coalition argues that "there is no feasible scenario in which a single tax-financed fund can provide all the coverage for the entire population of South Africa" and that an institutional design is required "that must rely on both tax funding and the contributory system." Key proposals include greater decentralisation in the public healthcare system, including independent governance structures for provincial health services, health districts and hospitals, implementation of risk equalisation and social insurance mechanisms, a mandatory standardised benefit package and a multilateral tariff negotiation system. Drawing strongly on the findings and recommendations of the HMI, the Coalition argues that its reform framework would lead "over time to de-segmentation of the public and private systems without undermining the revenue-generating potential of the contributory system."[58]

[54] Discovery Health, 2022.
[55] Solanki, G. et al, 2022.
[56] Kahn, T, 2023.
[57] Universal Healthcare Access Coalition, 2024, 2025.
[58] Ibid., p. xxi.

7. Public-Private Partnerships: enthusiasm cools

Greater convergence between South Africa's public health services and the contributory health insurance system will require considerable adaptation and learning in institutional management, service provision, procurement and contract management. South Africa's experience with public-private partnerships and with collaboration between the public and private sectors sheds light on both the opportunities and challenges of building bridges across its deeply divided health system.

Regulation 16 PPPs

In the late 1990s and early 2000s provincial health departments entered into several formal public-private partnerships (PPPs) that sought to widen access to quality services for state patients by leveraging private sector capital, experience and managerial capacity. Political support from the national health department subsequently waned and activity slowed. Netcare's controversial and highly publicised PPP with the Lesotho government to build and operate the Queen Mamohato Memorial Hospital in Maseru had a chilling effect, increasing the Department of Health's wariness of entering into complex and potentially costly contracts with the private sector.

The agreements that underpin public-private partnerships, their close-out reports and subsequent evaluations are largely confidential and there is no central government repository for these records. This represents a lost opportunity for provincial health departments and the private sector, who could have learnt from prior projects to replicate successes and iteratively improve future projects.

SA introduced a national framework for PPPs in the early 2000s, formalised in regulation 16 of the Public Finance Management Act (PFMA) and backed by a unit within the National Treasury to support project development and oversee the official approval process. By 2018, eight large health sector PPPs had been concluded,[59] summarised in Table 5.

The largest PPP to date is the 2001 R4.5 billion Inkosi Albert Luthuli Hospital project, in which the KwaZulu Natal provincial health department entered into an initial 15-year agreement[60] with the Impilo Consortium for the provision of non-clinical services at a newly built 850-bed referral hospital in Durban. It was regarded by the Treasury as a 'pathfinder' project as it was the first to operate fully under the regulation 16 provisions of the PFMA.[61]

The Impilo Consortium provided and maintained medical equipment and infrastructure together with a digital patient record system. As the consortium was responsible for both providing and maintaining state-of-the-art medical equipment there were few asset-related delays, and adopting a paperless system meant records were not misplaced or lost. Patients felt cared for, as they were attended to timeously in clean and well-kept facilities, and working conditions for clinical staff improved. In contrast to other public hospitals in the province that frequently failed patients due to frequent equipment failures and industrial action, the Inkosi Albert Luthuli Hospital, which serves as a referral site for patients as far afield as Eastern Cape, had virtually no downtime.[62] A World Bank review[63] concluded it had provided value for money, though its

[59] National Treasury, 2018.
[60] It was later extended for a further three years.
[61] Wits Business School, 2007. Several prison-building and national toll road concessions, structured as PPPs, were initiated prior to regulation 16 coming into effect.
[62] Interviews with informants.
[63] World Bank, 2020.

financing arrangements had not adequately hedged against foreign exchange risk, which can be significant as medical equipment is largely imported. The five-year refreshment cycles for medical equipment were costly, and the project could have saved money by opting for a more flexible approach to replacing infrastructure.[64] The hospital saw fewer in-patients than anticipated due to staff shortages arising from budget constraints, and more outpatients than expected.

Table 5: Health public-private partnerships

Province	Project	Type	Value (R m)	Initial Project Period
Eastern Cape	Port Alfred and Settlers Hospital	Co-location*	169	2007-2034
Eastern Cape	Humansdorp District hospital	Clinical and facilities management	49	2003-2023
Free State	Universitas and Pelonomi Hospital	Co-location and clinical care management	81	2002-2019
KwaZulu-Natal	Inkosi Albert Luthuli Hospital	Asset financing & maintenance and	4,500	2001-2017
Limpopo	Phalaborwa Hospital	Concession	90	2005-2020
Limpopo	Polokwane Hospital Renal Unit	Provision of specialised renal care	88	2006-2016
Western Cape	WC Rehabilitation Centre and Lentegeur	Facilities management	334	2006-2018
National	Biovac	Vaccine supply and manufacturing	75	2003-2007

*co-location: public sector facility provides services such as radiology, theatre and critical care beds to private patients
Source: National Treasury

The relatively modest Limpopo health department's PPP for the Polokwane Hospital Renal Unit is also regarded as largely successful.[65] It established a 24-hour renal dialysis unit at the public hospital that enabled the province to increase the number of renal dialysis machines from four to 25. Previously many patients had been forced to travel to over-burdened hospitals in Gauteng.

PPPs sometimes yield unanticipated benefits: the Universitas-Pelonomi scheme entered into by the Free State health department and a consortium led by private hospital group Netcare unexpectedly reduced abuse of the policy that allows state-employed doctors to conduct a limited amount of remunerative work outside the public sector (RWOPS). This co-location project aimed to refurbish ageing infrastructure and use excess capacity at Universitas hospital, and fulfil the private sector's need for additional capacity. Doctors employed by the Free State health department attended to private sector patients in the same building in which they treated state patients, an arrangement that improved managerial oversight, reduced abuse of the RWOPS

[64] Interviews with informants.
[65] African Development Bank and Wits School of Governance, 2017.

system, and increased the amount of time clinicians were available to state patients.[66] The shared services model saw the private partner assume responsibility for the supply and maintenance of equipment, ensuring limited down time.

Lack of political support blocked a subsequent Treasury proposal to establish a quasi-PPP that sought to leverage funds from medical schemes to improve public hospitals. The Enhanced Amenities Hospital Strategy (EAS) was positioned as a potential NHI Pilot project for the Eastern Cape, in line with the NHI Green Paper on NHI. It envisaged a special purpose vehicle (SPV) co-owned by the government and private sector that would enter into service-level agreements with the public platform and set up contracts with medical schemes, the Road Accident Fund, the Compensation Fund and private patients. It was positioned to benefit both the public and private sector. Public hospitals and the provincial health department would derive additional revenue to bolster their budget allocations while their facilities were improved, and medical schemes would save money as the fees charged by the public platform would be lower than private hospitals.

The 2003 Biovac Institute partnership covering vaccine research, development and manufacturing has not fully met its planned expansion of domestic value-added in the supply of vaccines, though it has arguably improved South Africa's ability to respond to vaccine shortages. A 2018 review concluded that despite the project's contribution to both health and industrial policy, "it appears not to have convinced the NDoH (National Department of Health) of the value of such initiatives."[67]

Despite the national health department's antipathy towards the private sector, there is still interest among private providers and some provinces for PPPs. The Western Cape Health Department, for example, is planning a R5 billion project to redevelop Tygerberg Hospital in Cape Town through the construction of a new 893-bed academic hospital on the current site. The private partner, which has yet to be selected, will design, build and maintain the facility and provide soft services such as cleaning and security. A linked regional hospital at a site in Belhar will be funded through the provincial infrastructure budget. A private partner is expected to be appointed in 2025 with construction to begin in 2026.

Experience with hospital PPPs is in some respects illustrative of the complex contracting challenges that will be faced in implementing an NHI system that takes advantage of established private hospital and health service capacity. Even contracts for non-clinical facilities require detailed specifications and time-consuming negotiations. Disputes or difficulties in contract management can arise, and suitable expertise on both sides if healthy client-service provider relations are to be maintained. Greater progress over the past decade in developing the capabilities needed to develop and manage these initiatives would have assisted in building the capacity needed to implement NHI purchasing responsibilities.

It is important to stress, however, that PPPs do not solve the budget shortfall problem. If a R5 billion building project is financed initially by a concession-partner (or the Public Investment Corporation), to be repaid over twenty years through a PPP "unitary charge", then this is effectively a form of government borrowing at a debt cost that will be some premium over the government bond rate. The benefit of a PPP is not access to finance, it is the operational efficiency and project management capabilities that come with "turnkey" structured concession contracts. It is also potentially the revenue gain and resource benefits associated with shared technology and clinical expertise.

[66] Informant interviews.
[67] Walwyn and Nkolele, 2018.

Public-private collaboration in other forms

In addition to the large-scale PPPs described above, the government has entered into a variety of other initiatives with the private sector, the longest of which is its more than 50-year relationship with private hospital group Life Healthcare. Through its subsidiary Life Nkanyisa, mental health, frail care and drug rehabilitation services are provided to state patients in five provinces.[68]

The history of these arrangements has its darker side, which may partially explain the ANC's wariness of outsourcing care to the private sector. Life Healthcare's roots go back to the accounting firm Smith Mitchell,[69] which in 1948 contracted with the apartheid government to run 'sanatoria' for black and coloured TB patients. The Urban Areas Act prohibited Smith Mitchell from accommodating these patients in areas reserved for whites, so it instead used hostels and compounds in abandoned mines, many of them in the so-called homelands.

In 1962 it was contracted to operate psychiatric facilities in which an estimated 10,000 black Africans were held involuntarily in squalid and overcrowded conditions. Investigations by the media and the World Health Organisation[70] in the 1970s exposed extensive neglect, abuse and forced labour. The WHO investigation concluded that Smith Mitchell had colluded with the apartheid government in social control, citing instances in which people who had no need of psychiatric intervention were arrested for minor infractions and detained indefinitely in its facilities.

Following these revelations, contractual arrangements were tightened and standards of care improved. By the 2000s, Life Healthcare was providing care of chronic mental health state patients in several provinces through its subsidiary Life Esidimeni. The termination of this contract in 2016 by the Gauteng Province and the transfer of over 1,300 mental health patients to unlicensed and unqualified NGOs, leading to at least 144 deaths, became known as the "Esidemeni scandal". The Health Ombud's investigation report concluded that outsourcing per se was not the problem – the abuses resulted from the nature of the new contracts, an over-hasty and careless procurement process, incompetent service-providers and poor government oversight.[71] Esidemeni subsequently changed its name to Life Nkanyisa, which is still the largest public-private healthcare partnership in South Africa, operating in five provinces.

In the democratic era, the government has had limited success with outsourcing arrangements, such as purchasing oncology radiation services, due to managerial weaknesses in many provincial health departments and a lack of data on public sector costs against which to benchmark private sector bids.[72]

The health department has well-established agreements in place with retail pharmacy chains to provide childhood immunisation and well-baby services to state patients, in which it provides government stock and pays the private provider an administration fee. It also uses private sector pharmacies and non-governmental organisations such as churches as collection points for stable state patients on chronic medication under its Central Chronic Medicines Dispensing and Distribution (CCMDD) programme. More than 3.1 million patients are currently using the scheme, picking up their monthly supplies at over 3,500 public sector and nearly 2,900

[68] Life Healthcare company website. Available at: https://www.lifehealthcare.co.za/about-us/life-nkanyisa/. Accessed 4.10.24.

[69] Smith Mitchell & co. was a partnership of chartered accountants that evolved into Lifecare Special Health Services, the hospital division of African Oxygen (Afrox). In 1999 it acquired Presmed and reverse listed on the JSE. It delisted in 2005 and changed its name to Life Healthcare, and listed again on the main board in 2010.

[70] World Health Organisation, 1977.

[71] Office of the Health Ombud, 2017.

[72] Informant interview.

private sector sites.[73] These kinds of public-private initiatives are managed at the provincial level, and run on shorter-term contracts than the PPPs overseen by the National Treasury.

The state has benefited from philanthropic contributions from the private sector via the Public Health Enhancement Fund, established by the health department and 22 private companies in 2012 to tackle the shortage of healthcare professionals, train hospital CEOs, and invest in research. Private hospitals, pharmaceutical manufacturers and medical scheme administrators donated an initial R40m to kick-start the fund, which has raised over R200m to support more than 100 post-graduate doctors.[74] [75] A variety of innovative projects have used non-governmental organisations to tap into individual and corporate funding to bolster the resources of public health facilities and improve clinical care.[76] Start-up costs for NGOs are relatively low, they can bypass state bureaucracy to quickly hire personnel or purchase equipment, and can forge links with other organisations. However, while NGOs may have a profound impact in the communities in which they operate, they do not fundamentally alter the architecture of SA's health system.

The government worked closely with the private sector to respond to the Covid-19 crisis, drawing up service-level agreements between provincial health departments and private hospitals to transfer hospital patients should the need arise, and collaborating with pharmacies, medical scheme administrators and private hospitals to roll out vaccines to both medical scheme members and state patients. The Covid-19 vaccine partnership enabled people to obtain shots that were free at the point of delivery, regardless of their insurance status and whether they attended a public or private site. But the health department's arrangements with community pharmacies saw protracted disagreement about reimbursement, highlighting record-keeping challenges and the inflexibility of the public finance management act.[77]

Although these and other arrangements arguably illustrate the potential for enhancing services, reducing costs or sharing resources through contractual partnerships with private sector service providers, they are limited in scope and only marginally alter the general divide between the public and private health sectors. Funding set aside by the Treasury in recent years for "piloting" GP contracts and other contractual NHI partnerships or alternative reimbursement arrangements has either gone unspent or has yielded few results.[78] [79] Notwithstanding the Covid-19 collaboration and other recent initiatives, the prevailing environment for collaborative partnerships is institutionally complex, and progress appears to be held back by poor planning, drawn-out processes and incomplete negotiations.

[73] Department of Health, 2024.

[74] Silaule, Y, 2020.

[75] Department of Health press statement 1 May 2019.

[76] In KwaZulu Natal, for example, the Jabulani Rural Healthcare Foundation eased some of the pressure on doctors and nurses at the Zithulele District Hospital by taking on tasks such as ordering stationery and packing medicines, hiring translators and pharmacy assistants, and procuring specialized wheelchairs with donated funds. It partnered with other NGO's operating in the region, such as the Mercy Ships which offer primary eye care and the Donald Woods Foundation, which helped extend the hospital's ARV programme.

[77] Kahn, T, 2024b.

[78] Genesis consultants, Centre for Health Policy, PWC, 2019.

[79] In 2018 the National Department of Health invited proposals from the private sector for appointment of "clinical care service providers" to support implementation of NHI priority programmes (mental health services, high risk pregnancy management, cataract surgical services, radiation oncology services and school health services. Bids were initially awarded to two leading health administration companies, but were subsequently withdrawn.

8. Pragmatic step-wise reform: notes on the way forward

Given the ideological differences between the parties in the government of national unity, agreeing on a common policy direction will be challenging, while the grand vision of the NHI Act may be stalled in the courts for years to come. Our analysis suggests, furthermore, that there will be substantial practical and institutional difficulties in the transition from present arrangements to a unitary integrated health system. It seems sensible, therefore, to explore options for less ambitious reforms that would offer patients a better deal in the short to medium term, building on existing public sector capabilities and the established health insurance system. We set out some ideas on a pragmatic reform path below, including several interventions proposed in discussions with our informants.

Redistribution and risk-pooling

A central idea behind the unitary NHI project is that all South Africans, rich or poor, should have access to the same package of health benefits. Health insurance is in part about pooling the risks associated with disease or injury, but the regulation of medical schemes goes well beyond this, for example in the requirement that age cannot be a factor in determining membership contribution rates. Medical expenses rise steeply with age, and so this results in substantial age-related cross-subsidisation. To some extent this encourages delayed joining, which is a consideration behind the mandatory participation proposal in the policy proposals of the late 1990s. It is also the primary reason why a risk-equalisation mechanism is needed.

Redistribution across income groups is much harder to achieve than redistribution related to healthcare needs in a multi-fund environment. South Africa's medical schemes are characterised by substantial price differentiation associated with increasing "richness" or comprehensiveness of benefits, which effectively negates or offsets income-related cross-subsidisation, even when membership fees are differentiated by salary level (as in some closed or occupational schemes).

But redistribution between rich and poor is the responsibility of the fiscal system as a whole, not solely of the health insurance regulatory framework. It is, in economist Richard Musgrave's well-known typology, one of the great "branches" of public finance.[80] Seen in this perspective, there is a welfare-theoretic problem with the idea of *categorical equality* as a goal in the health financing system despite the clear appeal of the equity principle. There are many categories of inequality that must be addressed through redistributive tax and spending programmes. In a society as unequal as South Africa's, greater equity in health outcomes might well warrant allocating higher spending allocations to employment, income security, housing or municipal services. There is some limit to the degree to which equality in health expenditure should be pursued rather than other redistributive priorities.

There is considerable complexity to this kind of welfare analysis. In broad terms, the approach envisaged in the 1997 White Paper and the Taylor Committee Report involved a Rawlsian presumption – that the goal should be the maximum affordable basic basket of health care to be assured for everyone, which would rise as economic growth and resources allow.[81] The post-2007 NHI framework envisages a much more demanding equity criterion.

The welfare-theoretic considerations are challenging, but so is the empirical evidence. Even in more equal societies than South Africa and in much wealthier contexts, consolidated health systems founded on strict

[80] Musgrave, R, 1989.
[81] Rawls, J, 1971.

equity principles do not achieve fully equitable health expenditure outcomes relative to health needs.[82] This is partly because utilisation of health services is to some extent associated with socio-economic differentiation. But it is also because resource constraints lead to rationing in various forms, and it is hard to counter the impact of privilege and status on rationing or queuing outcomes.

South Africa's public health services generate low levels of revenue from patient fees or other charges, and alongside education and social assistance grants rely mainly on a tax base that is strongly redistributive. A phased-in payroll or social security tax might be a feasible way of raising additional redistributive revenue, but social security reform proposals for a statutory retirement funding plan, together with improved income security for the unemployed also present compelling claims on this tax base.[83]

If, as seems likely, the national tax base will be unable to accommodate a larger redistributive public health spending envelope over the foreseeable future, then the reform strategy should turn to mechanisms that would expand medical scheme membership and relieve the service delivery burden on public health services.

Information asymmetries, behaviour and choice

It is widely accepted that market-based health systems fall short of socially optimal outcomes in part because of information gaps between consumers and suppliers and the resulting risks of over-selling and inefficient or ineffective product ranges. A unitary health system solves this problem through central planning and standardisation of services, with some loss of provider independence and consumer choice. But centralised coordination and remuneration systems bring their own behavioural problems – capitation-based remuneration of GPs leads to over-referrals, for example – and so in recent decades we have seen various strategies to bring "internal markets" or managed forms of competition in advanced country health systems.

The Health Market Inquiry addressed in some detail the question of the optimal design structure of a competitive insurance market. It drew attention, in particular, to the problem of choice in the presence of "too many" medical scheme product alternatives.[84] It proposed a "standardised basic benefit option," in part to facilitate comparison between schemes. Alongside this, it recommended procedures for supply-side regulation and negotiation of tariffs or reimbursement arrangements, further limiting the scope for price differentiation within the prescribed basic package. This is broadly consistent with the approach to managing competition in multi-fund systems elsewhere and, in principle, combines central coordination and cost control with competition and choice in ways that reduce uncertainty and risk while allowing for system adaptation over time as understanding of the regulatory framework evolves.

The HMI report provides a useful conceptual paradigm for reform along these lines and announcements by the minister of health in early 2025 indicate that at least some elements of this analysis have been accepted. Considerable work will need to be done on both institutional arrangements and the scope and costs of a basic benefit package. It is an obvious advantage of this approach that it could build on both experience with the existing prescribed minimum benefits and on preparatory analytical work on low-cost medical scheme options, though it is somewhat disconcerting that the minister appears to have rejected the low-cost benefit option proposals already.[85]

[82] See for example, le Grand, J, 1982.

[83] Comprehensive social security reform proposals including a payroll tax were set out in a green paper tabled by the Minister of Social Development in August 2021, subsequently withdrawn for further consideration.

[84] There were over 80 medical schemes with almost 300 different benefit options at that stage.

[85] Department of Health, 2025.

Pooling of health funds

The archetypal response to adverse selection in social insurance is mandatory participation. This is implicit in the unitary national fund idea, and it was also recommended in the 1997 White Paper for the medical schemes environment for higher income groups, elaborated in the Taylor Committee report which included proposals on subsidisation of lower-income contributors and risk adjustment across schemes. Mandatory participation by higher income groups and large employers in standardised contributory plans is also recommended in the recent *Universal Healthcare Access* report.[86]

The Hospital Association of SA (HASA) has recently argued for mandatory medical scheme membership for people in formal employment, with the backing of Business Unity SA (BUSA).[87] The HASA analysis suggests that this could triple the size of the medical scheme market from 9.2 million to 27.5 million beneficiaries and reduce the number of people dependent on the state from 53.8 million people to 35.5 million people. Mandatory enrolment would bring more young and healthy lives into the medical scheme system and could, it is claimed, reduce the cost of contributions by up to 30%. These estimates perhaps overstate the likely impact of mandatory participation, which would have to be accompanied by subsidisation arrangements. But the key point remains valid: reducing the demand for overburdened public health facilities would free up more resources for the remaining state patients.

Tax incentives provide an alternative approach to encouraging participation. The NHI proposal envisages that South Africa's medical tax credits should be phased out, but this is unlikely to be feasible. They not only provide significant relief to lower middle-income households and the elderly, they also provide an important cost-sharing vehicle for households with high levels of out-of-pocket expenditure related to disability or serious disease.

A better approach would be to build on the existing tax dispensation to give effect to the Taylor Committee's intended broadening of coverage, risk equalisation between medical scheme pools and income cross-subsidisation. The South African Revenue Service is the most efficient available national vehicle for collecting funds. Its institutional interface with payroll providers and medical schemes can also distribute funds to nominated medical schemes.

Options for reform include the following:

- The medical scheme contribution tax credit currently takes the form of a flat-rate reduction in tax liability (equivalent to a subsidy per beneficiary[88]) in the hands of a tax-paying medical scheme member. It could, without any effect on either the net income of the taxpayer or gross contribution to the medical scheme, be converted into a subsidy paid to the insurer.
- Employer-paid contributions to medical schemes are taxable. However, employer-paid contributions on behalf of *retired* individuals are still treated as "no-value" fringe benefits. This is anomalous and inequitable and should be phased out.
- Risk-equalisation between health insurers can largely be implemented through age-related subsidies. The tax treatment of medical expenses already distinguishes between taxpayers below or over the age of 65 – a higher medical scheme tax credit for those over the age of 65 would be straightforward to

[86] Universal Access Healthcare Coalition, 2024.
[87] Friedland, R, 2024.
[88] For the 2023/24 and 2024/25 years, the medical scheme contribution tax credit is R364 a month for the first two beneficiaries and R246 a month for additional beneficiaries.

implement; it could over time be refined to include higher age categories or disability and chronic illness criteria.

- A greater degree of income-related cross-subsidisation and broader medical scheme participation could be achieved by extending medical tax credits to taxpayers below the tax threshold and perhaps by phasing out the subsidy for high-income individuals. This would have to be accompanied by anti-avoidance measures associated with selection within households of contributing members.

These are measures that could be implemented without substantial change to the existing tax structure or distribution of medical scheme risk pools. They would lead to greater participation in medical schemes, particularly if accompanied by well-regulated, affordable basic benefit options. In the longer term, a transition to a broad-based payroll tax to finance medical scheme contribution subsidies and to supplement funding for the uninsured or for a default insurance plan could be considered, which would further deepen the redistributive tax-benefit structure of these arrangements.

Third-party payer effects: containing demand and over-servicing

Though the available mechanisms vary, both public and private sector insurers, and both unitary and multi-fund systems, are obliged to adopt measures to control costs and utilisation because "third party payer" systems inevitably lead to upward pressure on demand.

In principle, a consolidated NHI that "purchases" services from both public and private providers needs to do so on the basis of comparable and reliable information on both costs and quality of care. But there is no readily available public information source for patients, healthcare professionals or funders to gauge the quality of services provided by either public or private healthcare institutions. As emphasised by the HMI, patients and medical schemes alike are buying blind, and there is limited scope to assess whether they are getting value for money. The Office of Health Standards Compliance (OHSC) conducts assessments of healthcare facilities, but it provides only high-level reports on its website, the facilities it inspects do not publish its detailed findings, and hospitals and clinics that fail its assessments continue to operate.

The HMI proposed establishing an Outcomes Measurement and Reporting Organisation (OMRO), an independent statutory body with stronger powers than the OHSC, that would create a systematic process for reporting health outcomes. Health facilities would be obliged to routinely submit data to the OMRO and report to the public. If such a body were established it could improve the quality of care in both the public and private sector and facilitate assessments of value for money.[89] It would assist public and private sector partnerships, as all parties would have a better idea of what they were paying for.

An OMRO-type organization would facilitate strategic purchasing, as it would provide both public and private sector funders with the data required to assist in rationing resources appropriately, improving quality of care and limiting over-servicing. More complete information and data analysis are also the keys to implementing alternative reimbursement mechanisms such as capitation-based pay or diagnosis-related group and case-mix-based funding of hospitals and specialist services.

There is considerable complexity in this, exacerbated by both the lack of data and the many differences between institutional arrangements in the public and private sectors. However, our informants have suggested various ways in which public-private partnerships might enable better use of existing capacity targeted at specific needs or support services. Private hospitals operate at sub-optimal occupancy rates due

[89] Stakeholder interviews.

to low demand, while public hospitals have spare capacity due to managerial weaknesses combined with personnel and equipment shortages that result in facilities such as theatres, radiology and oncology treatment services frequently standing idle despite high demand. The result is long delays and worse health outcomes for state patients.[90]

This is not just about the state, provincial departments or a national health fund purchasing from private providers, it is also about how medical schemes incorporate public health facilities into their benefit options and reimburse them appropriately. It is about how social insurance funds such as the Road Accident Fund and the compensation funds contract with and reimburse public and private hospitals. An important focus area, for example, might be the facility requirements, staffing standards and clinical protocols that are required for an accredited emergency care facility – and then how these costs should be recovered from the various funds that have shared and overlapping responsibilities to emergency care patients.

There is scope for partnerships that would mobilise either public or private sector physical facilities, specialist capacity, equipment, management expertise, logistics or information systems to be more efficiently utilised – as was done in South Africa's Covid-19 vaccination programme – provided partnership terms and purchasing contracts are constructed and negotiated with sufficient attention to the principles of affordability, certainty, value-for-money and appropriate risk-assignment.

Competition and concentration in supplier markets

Hospitals and specialist service providers often enjoy a degree of monopoly pricing power, reinforced in South Africa's circumstances by comparatively high levels of concentration in the private hospital market. The HMI explored these issues in some detail and proposed a series of remedies that would build on but go well beyond the licensing, accreditation and "certificate of need" paradigm envisaged in current policy.

Provincial health departments issue licences for private hospitals but do not link renewals to reporting requirements that could improve management of the health sector. The HMI identified this as a missed opportunity and recommended that continued licensing be conditional on annual reporting, including quality indicators, bed types and occupancy rates, and the identity and hours worked by healthcare professionals – including state employees, to limit the scope for moonlighting or working more hours than permitted under the official Remunerative Work Outside the Public Service (RWOPS) system.

Progress also needs to be made in levelling the institutional playing field between the public and private hospital and specialist service sectors if the benefits of competition are to be fully realised. This has implications for the governance and tax regimes, which differ markedly. The existing regulatory barriers to the employment of health professionals in the private hospital sector should be abolished – arguably the paramount reform required to reduce costs and limit the incentives behind over-servicing in the private health sector.

The public sector has limited capacity to provide a training platform for doctors, registrars and other health professionals, but although private hospitals have indicated they are willing and able to assist, they are prohibited from training doctors and constrained by the SA Nursing Council in the number of nurses they can educate. The public sector currently struggles to absorb all newly qualified doctors due to budget constraints, and many new graduates do not have the financial resources to establish their own independent practices.

[90] Stakeholder interviews.

A solution to both problems would be to give the private hospital sector a greater role in training healthcare professionals, overseen by university-based medical schools.[91]

Scrapping the Health Professions Council of SA (HPCSA) rules prohibiting the employment of doctors by private hospitals would provide medical graduates with greater employment options and help strike a better balance between remuneration in the public and private sector as doctors in private practice would no longer be carrying steep overhead and insurance costs. Progress towards autonomous management of public hospitals would assist in narrowing the institutional gap between the integrated public and separated private health financing systems.

Networks, gate-keeping and referrals

Perhaps the single most important reform needed, at this stage of South Africa's transition to a more integrated and equitable health system, is a dismantling of the referral and gate-keeping barriers between public and private sector service-providers, accompanied by negotiated tariffs and cost-recovery arrangements.

There is a pervasive assumption in the present arrangements that insured patients should not be referred to ("dumped on") the public sector and that uninsured patients must be seen in public facilities only. There are no statutory or ethical grounds for this – the public system as "insurer of last resort" is paid for by the insured and the uninsured alike; costs are recovered from patients in public hospitals, subject to means tests; and provincial departments can procure services from private sector service providers subject to value-for-money considerations.

This separation extends to intermediate inputs and facilities management where no obvious clinical considerations apply. The National Health Laboratory Service (NHLS) functions as a monopoly supplier in the public sector, while public hospital administration and infrastructure maintenance make little use of private sector management capacity. There are public interest considerations behind these arrangements. The NHLS is a notable research centre that runs teaching programmes and is central to the country's response to HIV and TB care, for example. But these are not good reasons to exclude private laboratories as suppliers to the public sector, or to limit the NHLS to its public sector role. Opening up to competition would, in time, bring lower costs to both sectors. There would have to be competitive procurement in a consolidated NHI system. A far more complex task would be instituting fair and equitable financing or contracting terms between public and private hospitals and specialist providers.

The regulated PPP framework provides a principled platform through which to test and improve collaborative contractual arrangements, both for private sector service delivery on behalf of the state and for private sector utilisation or management of state facilities and resources. To date, PPPs have largely focused on improving the quality of services delivered by the public health sector. But there is also scope to improve the care provided in the private sector, which is characterised by high costs and over-servicing. For example, the South African private sector has one of the world's highest caesarean section rates (over 75%), raising questions about the appropriateness of care[92] provided to low-risk pregnant women. Researchers have proposed a model in which birth centres servicing women from both the public and private sector are established in private hospitals with teams of practitioners that make greater use of midwives for low-risk births and apply

[91] Stakeholder interviews.
[92] Solanki, G et al, 2024.

public sector guidelines for medical intervention.[93] Indemnity risks in this model would be borne by the private hospital, reducing the incentives to practise defensive medicine.

Our informants have advocated implementing referral systems between the private and public sector, for example allowing private sector GPs to refer patients to the state for diagnostic tests such as X-rays or specialist services. If the more cost-effective and efficient option is for public sector patients to be referred to private service providers or for provincial departments to make use of private sector dispensary capabilities, for example, this should also be accommodated. In either a fully developed unitary health insurance system or a regulated multi-fund framework, the long-term aim would surely be a level playing field between public and private sector service providers. As the case management, purchasing and contract management arrangements are not straightforward, tax and governance reforms would be needed, and so the path forward requires proceeding in steps through targeted collaborative ventures that can be monitored, improved and extended as the lessons of integrated health system development are learnt.

[93] Ibid.

9. Conclusion: priorities for further research

South Africa has excellent university-based medical schools, a well-resourced Medical Research Council and wide-ranging collaborative research engagements with international research partners. Actuarial and economic research capacity is also well-established. The annual *SA Health Review* published by the Health Systems Trust is an invaluable resource, exemplifying what can be achieved through collaborative and cumulative research. But for the purposes of health system planning and improved coordination between the public and private health sectors, there are many gaps in the available research and analysis.

This is in part a consequence of insufficient attention to the administrative information systems in both the public and private health sectors which are the essential sources of reliable data on health needs, services provided, costs and therapeutic efficacy. The National Health Research Strategy for 2021-2024 is impressively wide-ranging in scope – it lists 130 "key focus areas" including several "health system" themes.[94] But its identified "information and intelligence" focus areas do not include health economics components, comparative cost information or any efficiency-related research topics. Public-private partnerships, health services procurement and contract management, and comparative studies across public and private health services and insurance systems are not under the research spotlight. It seems clear that progress towards convergence between the public and private health sectors will require substantial improvements in health information systems, covering both sectors and targeted research efforts focused on the economics and institutional dynamics of health system change.

Critical research areas include the following.

- ***Cost-effectiveness analysis.*** To make progress in health service planning, benefit design and alternative reimbursement arrangements, detailed information about the costs and efficacy of health interventions and therapies is needed, both in the public and private sectors.

- ***Technology assessment.*** Largely focused on essential medicines at present, South Africa's health technology assessment programme needs to be extended to cover diagnostic and therapeutic applications more fully, their applications in both public and private services, and appropriate protocols to ensure the best value for money.

- ***Human resource needs, remuneration, earnings and conditions of service.*** Sustainability and broadening of health services require long-term human resource planning and sound approaches to training, internship, career progression and remuneration structuring. Convergence between the public and private sectors must rest, in part, on progress towards alignment in terms of employment, contract management and remuneration.

- ***Case mix analysis and planning.*** Hospitals and health centres differ in their case mix loads and associated health outcomes. Well-structured administrative data and systematic case mix analysis can contribute to improved health planning and resource allocation, and comparative review of institutional performance.

- ***Social policy and health outcomes.*** Prioritisation in social and development policy requires a multi-disciplinary approach to understanding health outcomes, recognising the balances and trade-offs that have to be found between infrastructure investment, income security, social development and health promotion, primary care, welfare services and hospital-based services.

[94] Department of Health, 2021.

- ***Governance, financing and management systems***. Both in the relationships between insurers, administrators and service providers in the private sector and between political office-bearers, regulatory bodies and public health administrations, governance systems founded on integrity, transparency and accountability are the foundations of progress towards improved services. A better understanding of these institutional arrangements and their evolution is a vital element in health systems reform.

At its broadest level, our analysis suggests that the comprehensive integration of South Africa's public health system and contributory insurance arrangements envisaged in the current NHI framework is impractical and out of touch with existing public and private sector institutional capabilities. A series of pragmatic reforms that both strengthen public services and expand the contributory system while standardising and regulating a package of health care affordable across both sectors, is a more feasible reform strategy. But we emphasise too that the present inequalities are indefensible: the reform imperative is urgent, and the work to be done is complex and challenging. Progress will depend on establishment of a trusted forum dedicated to constructive engagement between the health authorities, the private sector, healthcare funders and providers, supported by expert advisory teams.

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