



**African Health  
Policy Alliance**



# **IMPLEMENTING UNIVERSAL HEALTH COVERAGE IN SOUTH AFRICA**

## **NATIONAL HEALTH INSURANCE FRAMEWORK ANALYSIS**

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# 1. Introduction

## 1.1 Context and Objective

Universal Health Coverage (UHC) has become a global policy priority, embodied in the Sustainable Development Goals (SDG 3.8) (*United Nations, 2025*) with an aim for all countries to achieve UHC by 2030. UHC means ensuring that everyone can access the health services they need without suffering financial hardship. In South Africa, the pursuit of UHC is rooted in the Constitution's mandate (Section 27) that "everyone has the right to have access to health care services", obliging the state to take reasonable measures towards that goal (*South African Department of Justice and Constitutional Development, 2021*). However, South Africa's current health system is sharply divided. Approximately 84% of the population relies on an overstretched public health sector, while about 16% (mainly those with higher incomes) use a well-resourced private health sector (*South African Department of Science, Technology and Innovation, 2023*). This two-tier system is characterized by deep inequalities in access and quality: the public sector faces chronic underfunding, human resource and capacity gaps, whereas the private sector, though world-class, serves a small minority (*Parliament of the Republic of South Africa, 2024*). The inequity has tangible effects – poorer South Africans often live farther from facilities and experience unmet health needs, contributing to worse health outcomes.

To address these disparities and fulfil the constitutional right to health, South Africa has embarked on implementing UHC through a National Health Insurance (NHI) framework. After more than a decade of planning, debate and publication of a green paper and white paper for public comment, the **National Health Insurance Bill** was passed and adopted by National Parliament. This Bill was assented to by President Cyril Ramaphosa in May 2024 as the **National Health Insurance Act 20 of 2023** to establish a single national health insurance system (*South African Government, 2023*). The NHI is envisioned as a **centralised funding mechanism** that will pool public revenues and strategically purchase health services for the entire population, effectively moving South Africa towards a universal single-payer model. By consolidating funding and access, the NHI seeks to **reduce fragmentation, improve equity, and ensure quality health services for all citizens and residents** regardless of socio-economic status (*Parliament of the Republic of South Africa, 2023*). President Cyril Ramaphosa has described the NHI as an "important instrument to tackle poverty" by eliminating the financial barriers to health care and correcting historical inequities (*BBC, 2024*).

**Objective of this Report:** This analytical report examines how South Africa can implement UHC through the NHI framework. It provides an overview of the NHI policy approach, analyzes the challenges and opportunities in its implementation, and discusses strategies to ensure success. Specifically, the report will (1) describe the NHI policy approach as a means to achieve comprehensive and financially sustainable health coverage; (2) assess key governance mechanisms for improving health system performance, transparency, and accountability; (3) analyse the implementation of UHC via NHI, including the provisions of the National Health Insurance Act 20 of 2023 (NHI Act), anticipated challenges (economic, political, and institutional), and stakeholder roles in this transformation; and (4) demonstrate how data from authoritative sources (World Health Organization, World Bank, International Monetary Fund, and the South African Ministry of Health) can be used to inform policy, including quantitative evaluations of financing models and health outcomes.

The aim is to provide policymakers and academics with a **detailed, evidence-based roadmap** for making UHC a reality in South Africa through NHI, highlighting both the potential gains and the critical issues that must be addressed. This report maintains an analytical and impartial tone, suitable for informing policy decisions and scholarly discourse on health system reform.

## 2. Policy Approach

**2.1 NHI Framework and Centralised Funding:** South Africa's National Health Insurance (NHI) represents a fundamental shift to a **single-payer, centrally funded health system** designed to achieve universal coverage (*South African Government, 2023*). The NHI Act establishes a National Health Insurance Fund (NHIF) as the core institution, a public entity that will pool funds and serve as the **single purchaser and single payer** of health care services for the population. Instead of the current multi-payer arrangement (with multiple government budgets and private insurance schemes), the NHI Fund will consolidate various funding sources into one coherent, national pool (*South African Government, 2023*). The goal is to use this single pool to **strategically purchase** health services on behalf of all eligible individuals, thereby spreading risk and ensuring equitable resource distribution. In essence, all South Africans (and legal residents, including specific groups like permanent residents, refugees and prisoners) will contribute to and receive benefits from this Fund (*South African Government, 2023*). Healthcare services will then be **free at the point of use** when an NHI member needs care, they can go to an NHI-contracted provider without paying upfront, as costs are covered by the Fund. This eliminates user fees and co-payments that could deter the poor from seeking care (*South African Government News Agency, 2023*). By design, the NHI aims for **comprehensive coverage**, meaning it will eventually cover a wide package of services across preventive, primary, and specialised care, ensuring financial protection and access for all.

**2.2 Financial Sustainability Mechanisms:** A central promise of the NHI approach is to achieve universal coverage in a phased and **financially sustainable way** (*South African Government, 2023*). The NHI framework plans to fund the expanded coverage through **mandatory prepayment** (primarily tax-based) rather than voluntary premiums. According to the NHI Act, the Fund will be financed by Parliament via new taxes, including a surcharge on personal income tax and a payroll tax for employers and employees, alongside reallocating existing government health expenditures into the Fund. This means that the current provincial health budgets (which constitute the bulk of government health spending) and the taxpayer-funded medical scheme subsidies will be redirected into the NHI pool. In fact, about 90% of health budget administration currently handled by provinces will shift to the NHI Fund along with the equivalent resources. By unifying revenue collection and pooling, the NHI aims to **spread financial risk** across the entire population and leverage the large pool to negotiate better prices (*Parliamentary Monitoring Group, 2021*). The Fund will employ **strategic purchasing**, for example, it will set standard reimbursement rates for services and medicines nationwide and negotiate bulk prices for drugs and supplies (*South African Government, 2023*). A Health Care Benefits Pricing Committee and a Health Products Procurement Unit are being established within the NHI's governance structure to determine fair prices and manage supply chains. These mechanisms are intended to contain costs and improve efficiency, ensuring that the system is financially viable in the long run. The Deputy director-general for NHI, Nicholas Crisp, has argued that South Africa already spends around 8.5% of GDP on health and that these funds **could be allocated more efficiently** under a single payer to get better value and outcomes (*Parliament of the Republic of South Africa, 2023*). By eliminating duplication (such as parallel public and private financing for the same services) and focusing on cost-effective primary care, the NHI expects to use resources more rationally than the fragmented status quo.

**2.3 Improving Health Governance, Transparency and Accountability:** The NHI policy explicitly incorporates governance reforms to strengthen accountability in the health system. The NHI Fund will be governed by a Board and oversight structures defined in the Act, and it will operate under public finance management rules to ensure proper use of funds (*South African Government, 2023*). The Act creates multiple bodies to promote inclusive and evidence-based decision-making: for instance, a Benefits Advisory Committee (BAC) will determine the health service benefits to be covered, and a Stakeholder Advisory Committee is expected to give inputs from civil society and experts. By formalising such committees, the NHI aims to increase **transparency** in how benefits are decided and resources allocated. The government has also emphasized **public accountability** measures through

regular reporting to Parliament on NHI operations and audits by the Auditor-General to deter corruption or mismanagement in this large Fund (*South African Government, 2023*). Notably, critics have voiced concern about corruption risks, given South Africa's challenges with governance; thus, ensuring transparency is paramount (*Solanki, G. et al., 2022; Juta Medical Brief, 2022*). In response, officials indicate that anti-corruption frameworks will be integrated, including digital health information systems to track spending and outcomes, and strict provider accreditation standards (see below) to prevent fraud. Furthermore, the consolidation of funding is expected to simplify governance: instead of nine provincial departments managing funds independently, the single Fund can enforce uniform accountability standards and **public oversight** over how money is spent. This centralisation, while controversial to some, could reduce variability in management capacity and allow stronger central monitoring of performance and finances. In summary, the NHI's governance approach couples **centralised oversight** (to enforce standards and curb inequities) with structured stakeholder input and transparency requirements, aiming for a health system that the public can trust and hold accountable.

**2.4 Efficiency through Targeted Resource Allocation:** A key rationale for NHI is to improve the **efficiency of health spending** by directing resources to where they are most needed. Under the current system, resources are skewed where a disproportionate share of doctors and health spending serves the insured minority, while the majority face shortages (*News 24, 2023*). The NHI Fund as a single buyer can more deliberately allocate funds based on population health needs and equity considerations, rather than historical budgets or ability to pay. For example, the Fund can contract more providers in underserved rural or township areas and invest in clinics where gaps are greatest. The Act envisions **Contracting Units for Primary Health Care** at district level that will contract both public clinics and private GPs to deliver primary care in each area (*South African Government, 2023*). By doing so, NHI directs spending toward strengthening frontline services and preventive care, which can yield better health outcomes per rand spent. The referral system mandated by NHI (patients must start at primary care and get referrals to specialists when required) is intended to reduce unnecessary high-cost specialist visits and hospitalisations, again improving efficiency. Additionally, pooling procurement of medicines and equipment nationally can harness economies of scale. The NHI's Procurement Unit will seek the lowest possible prices for drugs and health products. This bulk purchasing power can dramatically lower unit costs (as seen in other countries' single-payer systems), allowing scarce funds to treat more patients (*Republic of South Africa Department of Health, 2025*). Lastly, by **reducing administrative duplication**, NHI should cut overhead costs. Presently, dozens of medical schemes and multiple government funding streams each have their own administration; under NHI, a unified claims and payment system will handle transactions, yielding administrative savings. In summary, the policy approach uses **targeted allocation** – prioritising primary care and underserved areas and **monopsony purchasing power** to enhance efficiency, so that South Africa's health spending translates to maximum coverage and health gain.

### 3. Thematic Focus: Implementation of UHC through NHI

#### 3.1 National Health Insurance Act 20 of 2023 – Key Provisions

The National Health Insurance Act 20 of 2023 provides the legal foundation for UHC implementation in South Africa. Its **long title** makes the intention clear - to achieve universal access to quality health services in accordance with the Constitution, by establishing an NHI Fund with the powers to purchase health care services and to create mechanisms for equitable, effective, and efficient use of resources. The Act establishes the NHI Fund as a juristic entity and details its governance structures, functions, and powers. Critically, the Act positions the NHI Fund as the “**single purchaser and single payer**” of health services nationwide. This means once NHI is fully implemented, the Fund will pay for **comprehensive personal health services** for all eligible users, whether those services are provided in public or private facilities. The covered benefits will range across preventive, promotive, curative, rehabilitative, and palliative services at all levels of care, as defined by a comprehensive benefits package (to be determined by the Benefits Advisory Committee) (*Moonstone, 2025*). Notably, the law **prohibits duplication** of coverage: “*Once the NHI Fund covers a benefit, medical schemes may not cover the same benefit*”. In other words, private health insurers (medical schemes) will eventually be restricted to offering only complementary services not provided by NHI. This clause (Section 33 of the Act) has been among the most contested, as it effectively reshapes the role of private insurance in the health system.

The Act also outlines **implementation phases** and transitional arrangements. It is understood that the NHI will be rolled out in stages over several years (government has suggested full functionality by around 2026–2028). Initially, certain priority services or vulnerable groups may be covered, and existing structures will co-exist with NHI. The Act’s transitional provisions (which President Ramaphosa indicated would be activated immediately upon signing) call for setting up the various committees (e.g. Benefits Advisory Committee, Pricing Committee, Stakeholder Advisory Committee) and aligning other laws with NHI. A notable early change is an amendment to the Medical Schemes Act to remove maternity benefits from medical schemes immediately, signalling that maternity care will be one of the first benefits taken up by NHI (*BusinessTech, 2024*). The Act also mandates that within a specified period; all healthcare providers must obtain **accreditation** with the NHI Fund to be eligible to deliver services to NHI patients. Accreditation criteria include quality standards (such as adherence to clinical protocols, use of essential medicine formulary, and participation in the national health information system) and accessibility requirements. To facilitate this, the Office of Health Standards Compliance (OHSC) will certify health facilities on core quality measures; providers will need OHSC certification (or conditional accreditation during transition) in order to contract with NHI (*South African Government News Agency, 2023*). Through these provisions, the NHI Act ties the goal of UHC to concrete levers: legally entrenching the right to health care, eliminating parallel financing streams, and enforcing quality standards nation-wide.

#### 3.2 Implementation Challenges: Economic Constraints

Implementing UHC via NHI in South Africa faces **significant economic challenges**. Chief among them is the question of **financial feasibility and fiscal space**. While the NHI promises to extend comprehensive services to the entire population, the cost of doing so is substantial. Estimates of the NHI’s price tag vary, but all suggest a large increase in health spending will be required (*Daily Investor, 2024; Moonstone, 2023*). For instance, an official policy document estimate projected the NHI could cost around **R256 billion (in 2010 prices) by 2025/26; equivalent to roughly R594 billion in today’s prices** (*Government Gazette, 2015*). This figure is more than double the current public health budget of R296 billion for 2025/2026. Private sector analyses are even more pessimistic: Discovery Health, the country’s largest private insurer, estimated the NHI’s full benefit package could cost on the order of R859 billion per year, which would imply a shortfall of over R600 billion given current government funding (*The Citizen, 2023*).

Such an expansion of health financing by hundreds of billions of rand poses a huge **fiscal challenge**, especially in a context of modest economic growth and heavy existing budget pressures. This has resulted in the unprecedented deadlock on the passing of the new budget for 2025/2026 by political parties at a sitting of Parliament. This led to a delay in the adoption of the national budget and exposed rifts on the budget priorities between the parties of the coalition government. Central to this impasse were 2 matters - the proposed increase in VAT at 2% base points and the differences on what had to be done to address the inefficiencies in spending and poor economic growth. This impasse led to the national budget having to be revised but this second revised budget (phased increase in VAT at 0,5% basepoints on 1 May 2025 and another 0,5% basepoints on 1 April 2026) was also rejected by the lawmakers. A third national budget was developed and presented at National Parliament. In this budget the minister of finance stated “the decision to do away with the VAT increase, without a viable alternative source of revenue, significantly reduced our ability to fund additional government programmes and projects to the extent we had deemed necessary”.

The May 2025 budget proposed an inflation-linked increase to the general fuel levy, which is the only new tax proposal announced for the 2025/26 fiscal year since the tax revenue projections had been revised down by R61.9 billion over the 3 years to compensate for the reversal of the VAT increase and a much weaker economic outlook. The health sector budget allocation is R845 billion over the medium term. It is worth while noting that the budget will be increased by R20.8 billion over three years to employ 800 post-community service doctors, procure essential goods and services and reduce accruals. This is in contrast to the additional R28.9 billion to the health budget, as proposed in the 12 March 2025 Budget allocations. The intention was to keep about 9 300 healthcare workers in our hospitals and clinics and to employ additional 800 post-community service doctors, as well as to ensure that our pharmacies do not run out of medicines. Essentially it means that the additional funding for healthcare workers and allied health professionals; and for medicines procurement had been removed from the earlier budget proposal (*2025 Budget Speech*).

These budget changes will have a direct impact on the service delivery as envisioned in the NHI Act.

Much emphasis was made of additional funding for NHI programmes with the allocations of R1.4 billion for the NHI grant over the MTEF during the 2024 budget speech of the Minister of Finance. This allocation for the NHI was made as a demonstration of the government's commitment to this policy. It was noted that there is a range of system-strengthening activities, that are key enablers of an improved public health care system, that must be undertaken. Such activities mentioned included: Building a national health information system and digital patient records; Upgrading health facilities and improving quality of care to ensure that they meet the minimum criteria to be certified and accredited for contracting under NHI; Strengthening facility and district management in preparation for contracting; Granting semi-autonomous status for central (and potentially other) hospitals; and Developing reference prices and provider payment methods for hospitals. Many of these activities were said to be already underway but require further development before the NHI can be rolled out at scale (*Budget Speech 2024*).

South Africa's debt-to-GDP is around 75–76% (*African Union, 2025*) (76,1% in September 2024 according to CEICC Data and is projected to stabilise at 76, 2% of GDP in the fiscal year 2025/26), and the government's ability to raise taxes is constrained by an already small tax base (only a few million individual taxpayers in a population of 60+ million). The International Monetary Fund has cautioned that any new large expenditure like NHI must be matched by new revenue sources or spending cuts elsewhere to avoid unsustainable deficits (*IMF, 2024*). In practical terms, to finance NHI, government would likely need to **increase taxes significantly**. The NHI Act anticipates new taxes (income tax surcharge and payroll tax), and one projection by Discovery suggests that personal income taxes might have to rise by as much as 82% to generate the necessary funds (*The Citizen, 2024*). Such tax hikes could have macroeconomic implications, potentially dampening growth or driving away skilled workers, and thus represent a political challenge as well.

Another economic constraint is the **risk of cost overruns and inefficiency** during implementation. If not well controlled, the expanded demand for services under NHI could strain resources. For example, providing free healthcare might lead to over-utilization or unnecessary care (a known risk called moral hazard), which needs to be managed through referral controls and clinical guidelines. Additionally, the public health sector will need upgrades and investments (in infrastructure, staffing, and equipment) to absorb the increased patient load, which requires upfront capital outlays. There is concern that without dramatic improvements in efficiency, simply injecting money cannot be sufficient as funds might be absorbed by administrative costs or corrupt procurement if governance is weak. Government will need robust public financial management to ensure that new funds translate to actual service delivery improvements. Economic experts also point out the **opportunity cost**: committing a very large share of national resources to health means less fiscal room for other priorities (education, housing, etc.), so NHI must demonstrate value for money. In summary, the financing of NHI is a delicate balancing act that demands raising substantial new revenues in a sluggish economy and ensuring those funds are efficiently and transparently spent. Careful phasing of benefits, cost containment strategies (like price negotiations and gatekeeping referrals), and perhaps a **realistic benefit package** (starting with primary and essential services) will be necessary to align aspirations with economic reality. Failure to heed these constraints could jeopardise the sustainability of UHC implementation.

### 3.3 Implementation Challenges: Political and Institutional Dynamics

Beyond economics, the NHI initiative faces **political and institutional challenges** that will influence its trajectory. Politically, the NHI has generated sharp debates among stakeholders. While there is broad agreement on the principle of UHC, the **NHI model has met resistance from opposition parties and segments of the healthcare industry** (*Mail & Guardian, 2024*). The main opposition party, the Democratic Alliance (DA), voted against the NHI Bill and has vehemently criticised it; a DA official even called the Act the “death warrant” of South African healthcare. The DA and others argue that the NHI could become a huge, unwieldy bureaucracy prone to corruption, and they fear it will undermine the existing private healthcare system without necessarily fixing public sector problems (*Juta Medical Brief, 2023*). Following the 2024 general election, South Africa entered a new political landscape: the ruling African National Congress (ANC) lost its outright parliamentary majority for the first time. As a result, the ANC now governs in cooperation with other parties (potentially including the DA) in a Government of National Unity (*Mtkima, O., 2024*). This has introduced **political uncertainty** for NHI, even though the Act became law, its implementation could be slowed or altered by a government that includes NHI sceptics. Indeed, DA leaders in the post-election coalition have signalled that NHI remains a “sticking point” and discussions are ongoing on its future. This dynamic underscores that sustained political will is not guaranteed; changes in administration or priorities could affect NHI roll-out.

The private healthcare sector, including insurance companies and private hospitals, also presents significant opposition. Major private insurers (like Discovery Health) have raised concerns about the NHI’s impact on their business and on healthcare quality (*Mail & Guardian, 2024*). They criticise the exclusion of private duplication cover as “globally unprecedented” and warn that skilled healthcare professionals might emigrate or exit the sector if the NHI severely limits private practice. Business associations (Business Unity South Africa, etc.) have commissioned analyses highlighting the potential **tax burden and economic impact** of NHI, arguing the funding model is unworkable without harming the economy (*Business Unity South Africa, 2023*). These groups are expected to continuously **mount legal challenges** against the NHI. In fact, even before NHI is fully in force, there have been related legal battles for example, a July 2024 High Court ruling struck down certain provisions of the existing National Health Act (on “certificate of need” requirements) as unconstitutional central planning, a decision interpreted by some as a warning shot that aspects of NHI could face constitutional hurdles (*Southern African Legal Information Institute, 2024*). The Western Cape provincial government (governed by the DA) has hinted it may argue that the NHI’s centralisation violates the Constitution’s assignment of health functions to provinces (*South African Government, 2025*). Thus, **judicial review**

is likely, and if courts find parts of the NHI Act irrational or unconstitutional, implementation could be delayed or require amendments.

In one of the legal challenges, the Board of Healthcare Funders (BHF) and the South African Private Practitioners Forum (SAPPF), received a ruling in their favour by the High Court earlier in May 2025 which confirmed that it (the court) had jurisdiction to hear the matter on the question of the process and legality of the President signing the NHI Bill in May 2024. These groups questioned the rationality of the President to sign the Bill into law. The judge ordered the President to submit documents explaining the reasoning behind his decision to enact the NHI Act in 2024. Ramaphosa has now notified the court of his intention to approach the Constitutional Court directly by 27 May 2025, confirming that the High Court proceedings would be withdrawn should the Constitutional Court agree to hear the case.

The Health Funders Association (HFA), with the latest legal challenge, states that the NHI Act in its current form is fiscally impossible and operationally unworkable, threatening the stability of the economy and health system (*HFA Media Release June 2025*).

Institutionally, a major challenge is **integrating NHI with existing health system structures**. The South African health system is complex, with responsibilities shared across national, provincial, and local governments, and a large private sector. Transitioning to NHI means that many of these structures must adapt. For instance, provincial health departments currently employ tens of thousands of health workers and manage hospitals. Under NHI, the funding for these will come directly from the NHI Fund rather than provincial treasuries (*Republic of South Africa Department of Health, 2025*). This raises questions: Will provinces still have autonomy in health service delivery, or will they essentially act as agents of the NHI Fund? How will provincial staff (both administrative and clinical) be transitioned or reassigned? The Act indicates that **provincial health administration will shrink**, with the NHI Fund taking over most financing functions. Managing this realignment requires careful change management and clarity to avoid disruptions in services. The creation of **District Health Management Offices** (DHMOs) under the NHI is another institutional change as these DHMOs will coordinate primary care at district level and work with the Contracting Units for PHC. Effective implementation means **devolving certain operational tasks** (like contracting local doctors, monitoring clinics) to these district units, which must be staffed and capacitated anew. There is a risk of confusion or duplication if roles between national (NHI Fund), provincial, and district entities are not well delineated during the transition.

Human resources for health present a further implementation issue. South Africa already struggles with maldistribution of health workers (many doctors prefer urban private practice) (*Mumbauer, A. et al., 2021*). The NHI promises patients they can choose public or private providers under the Fund, but to make this meaningful, the supply of services must expand in underserved areas. The NHI will need to contract private GPs and even private hospitals in areas where public facilities are lacking capacity. Will private providers participate? Many will if the terms are favourable, but some specialists or high-end hospitals worry about price controls and may opt out. The Act does allow providers to continue private practice outside NHI, but patients using those providers would have to pay out-of-pocket fully. Over time, if NHI succeeds in attracting most of the population, private providers will have strong incentive to join. Still, setting up the **contracting framework** and payment systems to pay thousands of providers on time is a massive administrative task. Health professionals' support is crucial if doctors and nurses perceive NHI as a threat to their income or autonomy, they may resist or even leave (e.g., increase brain drain to other countries). Thus, implementation must involve continuous engagement with healthcare professionals, addressing their concerns (for example, about reimbursement rates or working conditions in the public sector).

Despite these challenges, it is worth noting that **public support for the principle of NHI remains relatively high**, especially among users of the public sector. Surveys found nearly 80% of public sector users supported the idea of NHI, compared to about 49% support among private medical scheme members (*Booyesen, F. et al., 2018*). Civil society organizations and health advocacy groups largely favour UHC goals, though they too demand transparency and accountability in NHI implementation (*Peoples Dispatch, 2022*). Government has signalled willingness to consult stakeholders continually as the then Health Minister Joe Phaahla stated that further **consultations with stakeholders** will happen as detailed policies and implementation plans are fleshed out (*South African Government, 2023*). This inclusive approach will be important to navigate the political landscape. In summary, implementing NHI is not just a technical exercise but a **deeply political process**, requiring balancing of interests, legal navigation, and institutional restructuring. Success will depend on maintaining broad-based commitment to the UHC vision while pragmatically addressing stakeholders' concerns and fostering cooperation between the public and private sectors during the transition.

### 3.4 Ensuring Service Quality and Accessibility under NHI

Achieving UHC is not only about financing; it crucially depends on the **quality and accessibility** of health services delivered. The NHI implementation strategy therefore places heavy emphasis on governance measures and standards to ensure that expanded coverage translates into actual health system improvements. One cornerstone is the **provider accreditation system** introduced by the NHI Act (*South African Government, 2023*). All healthcare providers whether public clinics, private general practitioners, or hospitals must meet certain criteria to be accredited by the NHI Fund. These criteria include having the appropriate range of services and health professionals, adhering to agreed clinical protocols and treatment guidelines, using medicines from the approved formulary, and complying with referral pathways and national pricing regulations. Providers also must contribute data to the national health information system, enabling monitoring of performance. The Office of Health Standards Compliance (an independent regulator) will certify facilities for basic quality of care (covering aspects like cleanliness, safety, patient rights, etc.), which is a prerequisite for NHI accreditation (*South African Government News Agency, 2023*). By linking payment to accreditation, the NHI creates **incentives for facilities to improve quality**; those not meeting standards risk losing access to NHI funding (and thus patients). Over the past few years, South Africa has piloted quality improvement initiatives (such as the "Ideal Clinic" program) to raise standards in public clinics in anticipation of NHI; these efforts must be intensified so that public sector facilities can achieve certification and deliver better service to the influx of NHI patients (*Republic of South Africa Department of Health, 2013*).

Ensuring accessibility means **expanding the availability of services across all regions and communities**. The NHI's design addresses this through both public sector strengthening and private sector inclusion. On the public side, government is investing in revitalising clinics and hospitals, improving medicine supply chains, and hiring additional healthcare workers (e.g., community health workers and nurses) to boost capacity. The equitable resource allocation mechanism of NHI should direct more funds to historically under-served rural provinces and districts, allowing them to staff clinics, stock medicines, and maintain facilities at a higher standard. On the private side, NHI will **contract private providers to supplement public services**, especially in areas where specialists or certain services are scarce. For instance, a private hospital in a town with no large public hospital could be contracted to provide inpatient and emergency care to NHI patients, ensuring those residents have local access rather than needing to travel far. By purchasing services from both sectors, NHI intends to **create a unified health system** with more balanced distribution of providers. This integration, however, must be carefully managed to maintain quality: the Fund will set clear performance indicators in contracts (such as waiting times, clinical outcomes for certain conditions, patient satisfaction) that providers must meet. Regular evaluations and a feedback system will be needed to track whether NHI is improving service delivery. Early monitoring could focus on metrics like

clinic waiting times, availability of essential medicines, and utilisation rates of primary care versus hospital care to ensure that accessibility is improving in practice.

The governance strategy for quality also involves **strengthening accountability loops**. Community representation and civil society oversight can play a role in highlighting service delivery problems. The NHI Bill's emphasis on transparency can empower the public to know what services they are entitled to and to voice complaints if standards are not met. The introduction of a complaints management system and an Ombud for NHI (building on the existing Health Ombud's office) could give patients a channel to report issues, thereby prompting corrective action. Moreover, **inter-sectoral governance** will be important: factors outside the health system (like water, sanitation, transportation) affect health service accessibility. UHC implementation under NHI will benefit from coordination with other sectors and levels of government for example, ensuring that clinics have reliable water/electricity and that there is transport infrastructure for patients to reach facilities. The policy framework recognises these broader determinants and calls for integrated development initiatives in parallel with NHI (for instance, the Presidential Health Compact in 2019 brought various sectors together to support health system improvements) (*The Presidency, 2024*).

In essence to ensure UHC is meaningful, South Africa's NHI rollout is coupling **financing reform** with **rigorous quality assurance and accessibility measures**. Service quality will be guarded through accreditation standards, compliance monitoring, and active purchasing (where the Fund can drop poorly performing providers or assist them to improve), while accessibility will be improved by resource reallocation to needier areas and harnessing the full capacity of both public and private providers for the public good. If these strategies are effectively implemented, NHI has the potential to greatly enhance the consistency and reach of healthcare services so that a clinic in a rural village offers a similar standard of care as one in a big city, and all citizens can get timely, appropriate care when needed.

### 3.5 Stakeholder Roles: Government and Civil Society

Implementing a reform as far-reaching as the NHI requires the active involvement of many stakeholders. **Government actors** at various levels have distinct but coordinated roles (*South African Government, 2023*). The National Department of Health (NDoH) is leading the policy and will oversee the NHI Fund. Within NDoH, a dedicated NHI office (led by the NHI deputy director-general) is tasked with setting up the Fund's structures, developing detailed regulations and policies (such as the benefits package and reimbursement models), and steering the overall UHC transition. The National Treasury also plays a critical role as it must design and legislate the new financing measures (the money Bills for new taxes) and ensure the NHI Fund is integrated into the fiscal framework sustainably. Treasury's buy-in is essential to secure funding flows and manage the macro-fiscal implications. Meanwhile, **provincial governments** will remain responsible for health service delivery during the transition, but they will need to align their operations with NHI directives. Provincial health departments will have to coordinate with the NHI Fund for contracting of facilities they manage (e.g., provincial hospitals). As NHI phases in, provinces must possibly reconfigure their budgets and staff: for example, if most financing comes via NHI contracts, provinces might reduce their health administrations and focus on compliance and oversight at facility level. Local governments, which currently run some clinics in metros, also will need to adjust and ensure those clinics meet NHI standards and contracts.

**Civil society and community stakeholders** are invaluable for the success of UHC. In South Africa, civil society (including patient advocacy groups, health NGOs, and community health committees) has historically been very active in health issues, for instance, driving the response to HIV/AIDS. With NHI, civil society can contribute by monitoring implementation on the ground, voicing patient concerns, and holding authorities accountable to the UHC promises. The Act's provision for a Stakeholder Advisory Committee suggests an official channel for civil society input into NHI governance. This committee is

expected to include representatives of patients, health workers, and experts to advise the NHI Fund on matters of public interest and ensure transparency. Outside formal structures, NGOs can help educate the public about NHI informing people how to register, what their rights are under NHI, and how to navigate the system. This public awareness is crucial, especially in early phases when confusion might be high. Community health workers and local leaders also have a role in linking communities to the health system; as NHI rolls out, they might assist in registering people or facilitating referrals, thus enhancing accessibility at the community level.

The **health workforce** itself is a key stakeholder grouping. Doctors, nurses, and other professionals through their associations and unions have influence. Their acceptance of NHI will depend on how well the implementation addresses their practical needs such as prompt payment for services, manageable workload increases, and inclusion in decision-making about clinical guidelines and benefit design. Engaging these professionals in planning (for instance, through the medical and nursing associations) can help smooth implementation and improve the design of clinical aspects of UHC. For example, family physicians have advocated for strengthening the district health system and clarifying governance as NHI comes in; incorporating such frontline perspectives can guide effective reforms (like devolving certain decisions to districts) (*Mash, R. et al., 2025*).

Finally, the **private sector** is both a stakeholder to regulate and a partner to engage. Private healthcare providers (hospitals, clinics, manufacturers, pharmacies) will contribute significantly if they contract into NHI. Government must negotiate terms that bring these providers on board setting fair tariffs and assuring timely reimbursement. Some private sector actors, such as groups of general practitioners or networks of private clinics, are already preparing to work with NHI to expand services to more people (*Reach Alliance, 2023; Moosa, S. et al., 2016*). On the other hand, private medical schemes and administrators, whose role will diminish, are stakeholders who might innovate by offering complementary insurance or repurposing their businesses (some may become third-party administrators managing claims for the NHI Fund, leveraging their experience). The transition requires managing potential conflict: for example, medical schemes may lobby for a continued role or extended timeline before their benefits are curtailed. Government's approach, as indicated by Health Minister Aaron Motsoaledi, is to emphasize the voices of the uninsured majority and the moral imperative of equity, while being open to input "the door would not be closed" to further consultations (*South African Government, 2016*). In practice, this means ongoing dialogue in forums like the National Health Council, Parliamentary committees, and public consultations on regulations, will shape how these stakeholders' roles evolve.

Ultimately, implementing UHC via NHI is a **collective effort**. Government must lead with clear direction and coordination across its branches, but it must also foster collaboration with civil society, the private sector, and health workers. Each has a role in ensuring the system delivers for the people: government provides stewardship and resources, providers deliver quality care, and civil society/community offers oversight and feedback. If these stakeholders work in concert, the ambitious goals of NHI have a far better chance of being realized in practice.

### 3.6 Integration with Existing Healthcare Structures

Integrating the NHI with South Africa's existing healthcare structures is a delicate process, as it essentially re-engineers the health system's financing while trying to avoid disruption of services. A major integration challenge is merging the **public and private delivery systems** into one cohesive UHC system. Under NHI, **public hospitals and clinics** will remain the backbone of service delivery, but they will operate under new financing arrangements (getting paid per service or per patient through NHI contracts, instead of pre-paid budgets). This requires these facilities to adjust their management for example, improving billing systems to claim from the NHI Fund and meeting the Fund's performance criteria. Government is likely to grant public facilities some management autonomy to be competitive with private providers under NHI contracts. Public facilities may also see

changes in patient flows: currently, they serve those who cannot afford private care, but under NHI they could receive patients from all income groups (*South African Department of Science, Technology and Innovation, 2023*). This could be positive for integration, but it means public facilities must elevate their service quality to meet the expectations of all South Africans. Improvements in waiting times, cleanliness, and staff attitude in public facilities will be vital to integrate the patient experience; otherwise, higher-income patients may avoid using NHI services, undermining the system's universality.

For the **private sector**, integration means converting from an out-of-pocket or privately insured model to an NHI-contracted model for the majority of patients (*South African Government, 2023*). Private GPs and specialists will need to sign contracts with the NHI Fund, agreeing to provide services at regulated rates (determined by the Health Care Benefits Pricing Committee). They will also be expected to follow the NHI rules such as not charging balance-billing or extra fees to NHI patients and adhering to referral protocols (no direct specialist visits without referral, for instance). Some might worry about loss of income, but if NHI enrolls virtually the entire population, private providers would stand to gain many more patients (albeit at lower margin per patient). International experience suggests many private providers do join national health systems when the patient pool is large enough. In South Africa's case, a likely strategy is **phased integration**: initially, NHI might contract private GPs for primary care in underserved areas (leveraging their capacity where public clinics are few), and contract selected private hospitals for procedures that public hospitals have long waiting lists for (like certain surgeries). This incremental approach was hinted in NHI pilot projects earlier and in statements by officials that primary and emergency care will be prioritised. Over time, as the NHI Fund and its contracting mechanisms mature, more private providers will be brought in. By full implementation, the aim is that **any NHI member can visit any NHI-accredited provider (public or private) and receive care with the Fund paying for this care**. This is the ideal of integration: the distinction between "public patient" and "private patient" would disappear.

Another structural integration is with **existing insurance schemes and programmes**. South Africa currently has various public sector funding streams (e.g., the Compensation Fund for workplace injuries, the Road Accident Fund (*Road Accident Fund, 2025*) for auto injuries, etc.) and disease-specific programmes (like the large donor-funded HIV/AIDS program through PEPFAR (*HIV.gov, 2025*)). The NHI will have to interface with these. The Act suggests that the NHI Fund might eventually consolidate some of these or at least coordinate benefits. For example, if someone is injured at work, the Compensation Fund might still pay for certain services, but ideally through a unified claims process with NHI Fund so that providers don't have to bill multiple entities. Such harmonisation can reduce administrative burden and ensure patients have seamless coverage. As for donor-funded vertical programmes, government will need to integrate their services into NHI benefits (e.g., HIV treatment is likely to be covered by NHI as an essential service). Donor funds could then be channelled into the NHI Fund or aligned with it to avoid parallel systems. This requires negotiations with donors and careful transition planning, but it ultimately strengthens the sustainability of UHC by bringing all health financing under one framework.

Lastly, integrating information systems is crucial. A unified health financing system works best with a **unified health information system**. The NHI plans include developing an electronic patient record system and a beneficiary registry (hence the NHI Card each person will get). Integration means linking existing databases (e.g., those of medical schemes, hospital records, the Department of Home Affairs for identification) into a single NHI information platform. This will help prevent duplication (for instance, a person shouldn't be covered twice under different schemes) and improve continuity of care (patient histories accessible across providers). South Africa has begun projects like the Health Patient Registration System (HPRS) (*Health Patient Registration System, 2025*) to register patients at public clinics; these will need scaling up and merging with any private sector data for NHI. A national Unique Patient Identifier is being introduced for NHI users, which will be a backbone for integrated data.

Overcoming legacy fragmentation in IT systems is challenging but necessary for monitoring utilisation, costs, and outcomes under NHI.

In summary, integration strategies for NHI revolve around **gradual phasing and alignment**: phasing in services and populations, aligning provincial and private providers into the new system, and unifying the underlying administrative and information infrastructure. By carefully managing the transition for example, by issuing detailed regulations on how medical schemes must adapt (the Act stipulates they will be given notice of which services they can no longer cover as NHI expands) government aims to minimise shocks. Stakeholder communication is part of integration: clear messaging that, for instance, *“if you like your doctor, you can keep your doctor”* under NHI (as the government has promised), goes a long way to assuage public concerns. Ultimately, integration is successful when all components of the health system operate under the common goal of UHC, with the NHI Fund serving as the connective tissue that links financing to service delivery across the board.

## 4. Data Utilisation: Sources and Analysis

Evidence-based policymaking is vital for the successful implementation of UHC. This report utilises data from authoritative sources including the World Health Organization (WHO), World Bank, International Monetary Fund (IMF), and South Africa's Ministry of Health to inform the analysis of NHI. By combining **quantitative data** on health financing and outcomes with **qualitative insights** into governance and policy design, we can create a comprehensive picture of the challenges and opportunities in implementing NHI.

### 4.1 Data Sources and Relevance:

- WHO Data:** The WHO provides key health indicators and has been closely involved in UHC monitoring. From WHO's data, we note South Africa's population was about 63.2 million in 2023, with a life expectancy at birth around 62–65 years (which dipped during the COVID-19 pandemic) (*WHO, 2025*). These outcomes are modest for an upper-middle-income country, reflecting the burden of HIV/AIDS and inequality in access. WHO's global UHC service coverage index for South Africa is approximately 71 (out of 100) as of 2021 (*African Union, 2025*), indicating moderate coverage of essential health services. This index, however, hides large internal disparities. WHO data also show that current health expenditures reached about **8.3% of GDP** in 2025, a relatively high share, yet health outcomes lag behind peers. This suggests inefficiencies and inequities in spending, reinforcing the rationale for reform.
- World Bank Data:** The World Bank's databases were used to extract health financing figures and comparative benchmarks. For instance, South Africa's **health expenditure per capita** was about **\$584 in 2021** (in current USD), considerably higher than the regional average, yet not yielding commensurate health status improvements (*World Bank Open Data, 2025*). Out-of-pocket spending is remarkably low in South Africa at **around 6–7% of total health expenditure** because the public sector (funded by taxes) and medical schemes cover most formal spending. Indeed, government and insurance contributions are high, which aligns with UHC goals of financial protection (WHO recommends <20% out-of-pocket share) (*WHO, 2016*). World Bank indicators on service coverage and financial protection help gauge where South Africa stands currently and set targets for NHI (for example, to maintain low out-of-pocket burdens while raising service coverage index closer to 80–90 like higher-income countries). The World Bank also offers analyses on fiscal space for health; these, combined with IMF insights, inform how much additional funding could be mobilised for NHI without jeopardizing fiscal sustainability.
- IMF Data and Analysis:** The IMF's Article IV reports and fiscal assessments provide an external view on South Africa's economy and budget (*IMF, 2024*). IMF analysis has underscored the limited room in the budget advising that new permanent expenditures (such as the NHI or new social grants) be matched by new revenue. We use IMF projections of economic growth and revenue to estimate how much revenue a payroll or income tax surcharge for NHI might yield and whether that keeps pace with rising health demand. The IMF's debt sustainability outlook (*IMF, 2025*) also frames how much government can borrow for health system upgrades in the interim. Additionally, IMF technical assistance on health financing (globally) often suggests efficiency reforms: e.g., better procurement, cutting waste which aligns with NHI's strategies. By citing IMF remarks (such as needing to crowd-in additional resources for NHI and concerns about value for money), the report highlights areas where financial governance must be tight (transparency, competitive tendering in procurement to avoid corruption, etc.).
- Ministry of Health / Government Reports:** Data and information from South Africa's own health authorities ground the analysis in local context. The National Department of Health has published NHI policy documents, an official **White Paper (2017)** and periodic **NHI progress reports**, which include costing scenarios and pilot results (*University of Cape Town, 2017*). For example, the Ministry's figures on current public health spending (~R250 billion) and

human resource gaps feed into understanding what expansion is needed. The “**National Health Insurance: All You Need to Know**” (South African Government News Agency, 2023). FAQ from the government provides insight into policy intent such as stating that 84% of the population uses public health services vs 16% private and claiming that pooling funds into one fund will improve quality and outcomes by leveraging the strengths of both sectors. These assertions are evaluated against data: for instance, does evidence show that consolidating funding leads to quality gains? We examine local pilot experiences (NHI pilot districts from 2012–2017) (Parliamentary Monitoring Group, 2019) which reported mixed results some improvement in clinic infrastructure, but also persistent management weaknesses (these qualitative findings help identify what governance fixes are needed). The Ministry’s “**Saving Mothers**” report with maternal mortality data, or its health outcome statistics (like an infant mortality rate of ~24 per 1,000 in 2021) give a baseline to measure future UHC improvements (Republic of South Africa Department of Health, 2023). Parliamentary Budget Office or Treasury documents on NHI funding options also supply quantitative models (e.g., projecting that a 1% increase in VAT or a payroll levy of a few percentage points could raise tens of billions of rand for NHI such figures help illustrate financing choices).

Using these sources, the report employs **qualitative analysis** to examine governance frameworks (e.g., comparing NHI’s governance structure to international best practices for health financing agencies) and **quantitative evaluation** to assess funding models. For example, a quantitative analysis might look at **how reallocating the provincial health budget into NHI and adding a payroll tax would impact total health spending as % of GDP**, and whether that aligns with global benchmarks. The data show that South Africa already spends significant resources on health, but with inequitable outcomes. A scenario analysis could demonstrate that if the same total (8–9% of GDP) is pooled and used to cover the whole population, the distribution of benefits would be far more equitable benefiting especially the lower-income 84% currently reliant on a thinly stretched public sector. On the other hand, data from private sector utilisation indicates that there are far more specialists and high-tech services per capita for the insured group than for the rest. NHI aims to redistribute some of that capacity. Our analysis uses data on doctor-to-population ratios and hospital bed distribution to estimate the scale of integration needed (e.g., private sector has ~1.5 doctors per 1,000 people vs public sector 0.3 per 1,000; NHI would effectively create a combined doctor pool of ~0.8 per 1,000 distributed more evenly).

**4.2 Data Presentation – Funding Mechanisms and Outcomes:** To clarify complex information, the report includes simple charts and tables. Below is a table of key health and financing indicators that provides baseline figures for South Africa in context:

Indicator (Year)	South Africa
Population (2023)	63.2 million
Life expectancy at birth (2021)	~62.3 years
Maternal mortality ratio (2019)	118 per 100,000 live births
Health expenditure per capita (2021)	US\$ 584
Health expenditure (% of GDP, 2021)	8.3%
Government health spending (% of total, 2021)	~60% (African Union, 2025)
Private health insurance spending (% of total, 2021)	~32% (African Union, 2025)
Out-of-pocket spending (% of total, 2022)	6.7%
UHC Service Coverage Index (2021)	71/100 (African Union, 2025)

This snapshot shows that South Africa has a relatively high investment in health for its income level (over 8% of GDP) and strong financial risk protection (very low out-of-pocket costs due to tax funding and medical schemes). Yet, health outcomes like life expectancy and maternal mortality are still lagging, underscoring inefficiencies and inequalities. The **financing breakdown**, roughly 60% public, 40% private (mostly insurance), <7% out-of-pocket illustrates the current multi-payer structure (*African Union, 2025*). The NHI reform will change this breakdown by replacing private scheme spending with public pooling. Ideally, post-NHI, government (NHI Fund) would account for an even larger share of total health spending, perhaps 80–90%, with private insurance only supplementary.

*Sources of Health Expenditure in South Africa (2021)*. Government financing (tax-funded) accounts for about 60% of health spending, private voluntary insurance 32%, out-of-pocket payments only 6%, and donor funding ~1% (*African Union, 2025*). Under NHI, the government share will rise as it subsumes much of the private insurance role, aiming for a single pooled fund. Low out-of-pocket spending is a strength to preserve, as it indicates strong financial protection NHI will maintain this by ensuring services are free at point of use (*South African Government News Agency, 2023*).

In analysing funding mechanisms, data is used to compare options. For example, using World Bank and IMF data on GDP and income distribution, one can simulate how different tax instruments for NHI impact households. A payroll tax would primarily affect formal sector workers data shows only about 14 million South Africans are formally employed suggesting the burden would concentrate on a subset of the population unless other broad taxes (like VAT) are used. By quantifying such impacts (e.g., “a 2% payroll tax on formal employment could raise approximately R30 billion per annum”), policymakers can weigh equity considerations (payroll taxes are progressive among the employed but exclude the informal sector, whereas a VAT increase spreads cost but can hit the poor unless mitigated). This report cites data-driven studies (from the local Treasury or think tanks) to discuss these trade-offs. One study projected that rolling out NHI would need an **additional R33 billion per year by 2025/26** beyond existing allocations equivalent to roughly a 15% increase in the health budget (*BusinessTech, 2019*). Such figures provide a concrete sense of scale for the financing challenge.

Qualitative data on governance such as evaluations of pilot projects or case studies from other countries are also utilized. For instance, the report references Ghana’s National Health Insurance or Canada’s single-payer provincial systems as comparators (*Harvard Public Health, 2023*). Data from those cases (like Ghana’s improvement in service utilization after NHIS, or Canada’s cost containment track record) serve as evidence to predict potential outcomes and pitfalls for South Africa. We also use data from **household surveys** (like the General Household Survey (*Stats SA, 2025*)) which indicate how many people forego care due to cost (financial barrier was relatively low in SA, ~15% reported not seeking care due to cost in some studies, thanks to free public services). This helps measure one aspect of UHC financial access, which NHI should maintain or improve. On the other hand, survey data on waiting times and perceived quality highlight current system weaknesses that NHI must address (e.g., long waits in public clinics, which could initially worsen if demand surges without supply improvement). Tracking these indicators year by year will be essential to evaluate UHC progress.

In conclusion, **data utilisation** in this report underpins each argument: global benchmarks rationalise the pursuit of UHC; national statistics reveal baseline gaps and inform targets; financial models guide the discussion on sustainability; and performance indicators will monitor implementation success.

**We emphasise that ongoing data analysis will be crucial during NHI roll-out as a learning health system approach, where policies are adjusted based on what the data shows. The combination of qualitative and quantitative evidence presented provides a nuanced understanding that should assist policymakers in making informed decisions as South Africa navigates the complex journey to universal health coverage through the National Health Insurance.**

This report is intended to provide a ready resource for decision-makers and scholars, synthesising the available evidence and policy insights as of now (2025). South Africa stands at a crossroads with the NHI. **The data and analysis herein aim to illuminate the path forward towards a healthier future for all.**

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