Response to the letter responding to the article 'Achieving universal healthcare access in South Africa'

To the Editor: I appreciate the engagement with my recent article on universal health coverage (UHC) in South Africa (SA).[1]

The letter raises relevant issues regarding the National Health Insurance (NHI) Act No. 20 of 2023, particularly around subsidiarity, equity and the roles of contracting units for primary healthcare (CUPs) and district health management offices (DHMOs). These interventions warrant careful consideration.

Subsidiarity and decentralisation

The letter suggests that the NHI Act advances subsidiarity through CUPs and DHMOs. However, while these entities are created in statute, their authority is tied to the central NHI Fund and hierarchical decision-making within the National Department of Health. Accreditation, contracting and accountability processes remain centralised. This reproduces, rather than resolves, the governance weaknesses associated with excessive centralisation already found in the provinces. Subsidiarity requires that local structures have genuine decision-making powers, not that they act merely as administrative agents of the centre – whether national or provincial.

Importantly, CUPs and DHMOs lack credible accountability frameworks. The legislation is silent on this. Presumably because it assumes, worryingly, that existing accountability frameworks are sufficient. Effective upward accountability requires independent supervision, free of conflicts of interest with political parties, trade unions or other stakeholders. Downward accountability requires the direct embedding of communities in governance processes. As designed, CUPs and DHMOs perpetuate the conflicted accountability arrangements currently entrenched in provincial health services. This may serve the interests of patronage networks, but it fails communities. Provincial health departments fail, not because they are not centralised enough, the presumption of UHC2, but that they are not decentralised enough, the presumption of UHC1.

Equity and national pooling

The critique is correct that differences in health expenditure and access remain structural. National pooling is one mechanism to address this problem on a progressive basis. There is no instant solution. But such pooling requires a blending of structurally capped tax-funded and contributory coverage through medical schemes. The UHC1 framework envisages a blended system of national pooling – which maximises the pooling opportunities, while preserving decentralised governance and institutional diversity. This would lead to more efficient service delivery in both the public and private systems together with social de-segmentation over time. The lesson from international experience is not that pooling requires a single-payer monopoly, but that risk-sharing must be combined with governance models that foster accountability and adaptability.

Historical continuity

It is argued that the NHI Act (UNC2) represents the 'legislative maturation' of the 1994 National Health Plan and the 1997 White Paper. In reality, both emphasised decentralisation, district authorities and hospital autonomy – core features later diluted or effectively abandoned, with significant consequences. The NHI Act structurally departs from the UHC1 trajectory by concentrating authority in a national purchaser, raising significant constitutional, fiscal and institutional concerns.

Feasibility and fiscal constraints

The achievement of equity requires feasible and sustainable systems of pooling and delivery. The NHI Act's reliance on a single payer funded solely by general taxation is inconsistent with SA's fiscal realities, where tax capacity is already reached. Without viable financing and governance frameworks, the risk is that UHC2 (the NHI model) converges in practice on UHC0 (the fragmented status quo), thereby perpetuating inequities. In effect, UHC2 is not a real option: it is fiscally unimplementable, and its envisaged centralisation is likely to exacerbate inefficiencies. Even if a single national 'pool' were feasible, the centralisation of 'purchasing' would embed structural inefficiencies, harming equity and coverage objectives.

Conclusion

The commitment to equity is shared. Differences exist on institutional design and feasibility. I maintain that UHC1, with its emphasis on subsidiarity, decentralisation and structured and feasible risk pooling, remains the most viable route to deepen UHC in SA. The challenge is not whether equity should be pursued. It must. But the question is how to do so within the bounds of constitutional, fiscal and institutional realities.

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1. Van den Heever A. Achieving universal healthcare access in South Africa: A policy analysis of consensus reform proposals. S Afr Med J 2025;115(6):45-53. https://doi.org/10.7196/SAMJ.2025.v115i7.3673

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