

Achieving universal healthcare access in South Africa: A policy analysis of consensus reform proposals

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Background. South Africa's ongoing efforts to realise universal health coverage (UHC) have produced three discernible policy trajectories: UHC0, the *de facto* configuration of public and private health systems; UHC1, the incremental reform framework initiated post 1994 and recently revisited by the Universal Healthcare Access Coalition; and UHC2, the centralised National Health Insurance approach formalised in a 2017 White Paper.

Objective. To offer a comparative analysis between the three alternative policy trajectories, to determine which offers the most productive pathway to deepen UHC.

Methods. This analysis uses the organising principle of subsidiarity, which argues that decision-making authority should be handled at the most local level possible, with higher levels stepping in only when needed. A qualitative comparative policy analysis methodology is applied to assess the institutional design, financial sustainability, governance integrity, implementation feasibility and equity outcomes of these approaches.

Results. Drawing from primary policy documents, the study finds that UHC1 provides the most feasible and constitutionally aligned pathway for realising UHC. UHC2, by way of contrast, is least likely to be implemented, with design features that deviate substantially from the principle of subsidiarity. UHC0, the status quo option, also incorporates severe deviations from the principle of subsidiarity and is likely to perpetuate systemic inequity and poor outcomes. Importantly, continued attempts to implement UHC2 effectively converge on UHC0, with the result that UHC0 is likely to continue indefinitely unless revised toward UHC1.

Conclusion. Of the three options, UHC1, as envisaged in the 1990s, remains the most viable approach to deepen UHC, with UHC2 unlikely to achieve any key UHC goals owing to design weaknesses that deviate from the principle of subsidiarity and financial constraints. Attempts to implement UHC2, thereby obstructing the implementation of key aspects of UHC1, defaults the health system to the residual UHC0 approach – which lacks any strategic vision for deepening UHC.

Keywords: universal health coverage, social health insurance, medical schemes, equity, subsidiarity, National Health Insurance, risk equalisation, social reinsurance

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Since 1994, multiple strategic directions have been proposed to reform the South African (SA) health system toward achieving universal health coverage (UHC). These have coalesced into three discernible policy trajectories (Table 1):

- Universal health coverage 1 (UHC1), initially framed in the 1997 Health White Paper,^[1] represents an incremental reform model aligned with constitutional mandates and broadly consistent with social health insurance principles. While partially implemented between 1997 and 2008, its rollout was never completed.
- Universal health coverage 2 (UHC2), conceptualised in 2007^[2] and formalised in the 2017 NHI White Paper^[3] and 2023 legislation,^[4] presents a centralised model underpinned by a single-payer framework. Despite political endorsement and legislative enactment, it remains largely unimplemented due to fiscal, institutional and legal constraints.
- Universal health coverage 0 (UHC0), the current system, is an unplanned amalgam of legacy public-private structures, the partial implementation of UHC1, and constitutional reforms. It is characterised by dual financing and delivery arrangements, systemic inequities and policy inertia.

Despite strong political backing for UHC2 from the governing African National Congress (ANC), which had also advanced the earlier UHC1 proposals, serious concerns have emerged regarding

its viability. These include budgetary infeasibility, unresolved constitutional issues and institutional limitations.^[5] In response, revised iterations of UHC1, most recently outlined by the Universal Healthcare Access Coalition (UHAC),^[6] a broad alliance of healthcare associations in SA, have re-entered the policy discourse as more pragmatic alternatives.

Nevertheless, in the absence of coherent implementation plans for either UHC1 or UHC2, SA remains effectively locked in the default UHC0 configuration.

This article examines these three UHC policy trajectories – UHC0, UHC1 and UHC2 – through a comparative policy analysis. It evaluates their respective institutional designs, financial and administrative feasibility, alignment with constitutional and ethical imperatives, and overall potential to advance equitable and sustainable UHC in SA.

Definition of universal health coverage

As described by the World Health Organization (WHO), the 'goal of universal health coverage (UHC) is to ensure that all people receive the health services they need without facing financial hardship.'^[7]

Financial hardship refers to both the direct and indirect costs of accessing health services, and is described as 'financial risk protection'.

Table 1. High-level summary of the key features of UHC0, UHC1 and UHC2

Category	UHC0 (status quo)	UHC1 (incremental reform model)	UHC2 (NHI model)
Public sector	Service delivery provincialised, with hospitals and health districts governed through a centralised hierarchy.	Service delivery provincialised but structured into autonomous public hospitals and health districts. Minimum essential benefits determined for the country (public and private sector) through an independent authority.	Health financing and service provision ultimately transferred to the national level of government. Provision of services structured into the hierarchy of national government. Ministerial committee determines essential care.
Private sector	Private coverage enabled through regulated medical schemes. However, risk pooling is fragmented due to partial regulation, causing inefficient competition with resulting cost increases and incentives to discriminate against less healthy individuals.	Augments existing regulatory interventions through the introduction of national pooling mechanisms (risk equalisation and social re-insurance); transparent mandatory minimum benefits; multilateral price negotiations; and mandatory membership for higher-income groups.	Phased removal of medical schemes for essential services. Services procured from private providers through central fund.
Financial framework	Dual financing (general taxation and private insurance); low out-of-pocket spending but inequitable resource allocation.	Mixed funding system, with income cross-subsidies organised through the tax system; regulated risk pooling in the private system; with a focus on constantly improving equity in resource allocation.	Single-payer system funded by general taxation, with national pooling concentrated exclusively in the NHI Fund.
Governance framework	Highly centralised decision-making at both a national and provincial level, with power concentrated in the hands of political appointees (members of the executive of government). These appointees have direct and indirect control over the running of all aspects of the public health system and regulators of the private health system.	Decentralised governance with district and provincial accountability; autonomous hospital boards; and participatory (community) oversight. Strict demarcation is established between the functions of the government executive and autonomous public entities (regulators, hospitals, health districts).	Highly centralised governance via national NHI Fund; provinces and local structures reduced to service providers where this continues. Deepening this centralisation, the Minister of Health has direct and indirect control over all aspects of the health system. Indirect control is exerted through the ability to appoint the leadership of the entire health system.

UHC = universal health coverage; NHI = National Health Insurance.

Consistent with the broad WHO understanding, SA's Constitution establishes the right of everyone to access healthcare services (section 27 of the Bill of Rights), thereby obligating the state to take reasonable measures to ensure universal access to healthcare.^[8] This implies that the healthcare system must be both available as a service, and accessible financially.

Problem statement

Given the prospect of indefinite retention of UHC0, due to the potentially fatal constraints facing the implementation of UHC2, it is necessary to examine the feasible strategic options required to move away from UHC0. In this regard, an updated version of UHC1 has been put forward as an alternative to UHC2.^[6] It is, however, necessary to determine which of these alternatives presents the most productive approach to deepening UHC in SA.

Background

SA's post-apartheid commitment to deepening UHC has resulted in three distinct policy trajectories: the default configuration of UHC0; the initially adopted but only partially implemented UHC1 reform path; and the more recent UHC2 model. Each trajectory reflects a different set of arrangements about how to structure financing, delivery and governance to ensure universal access to care.

UHC1, articulated in the 1997 Health White Paper, was designed as an incremental reform approach built upon SA's existing health system architecture. It proposed a unified national health system (or NHS) underpinned by district health authorities, decentralised hospital governance, a reorientation toward primary healthcare (PHC) and the integration of the private financing system through regulated

medical schemes and risk equalisation. Between 1997 and 2003, several reforms consistent with UHC1 were initiated, including the rationalisation of the fragmented apartheid-era health departments, statutory recognition of a weak version of hospital boards and the re-regulation of the medical scheme industry via the Medical Schemes Act 131 of 1998.^[9] Additional technical proposals, such as the Taylor Committee's recommendations on public hospital autonomy and risk equalisation, further consolidated the UHC1 vision.^[10-13]

However, by the mid-2000s, this reform trajectory had stalled. Key structural elements, particularly those involving decentralised governance, hospital autonomy and risk equalisation, were either diluted or abandoned. The National Health Act 61 of 2003 reversed the commitment to decentralisation, favouring politically appointed governance structures that entrenched concentrated control in the hands of political appointees. Participatory mechanisms and community oversight envisioned under UHC1 were never realised.

Furthermore, the 2008 Medical Schemes Amendment Bill, intended to establish risk equalisation (a system of national pooling for medical schemes through inter-scheme transfers) and extend coverage, was allowed to lapse.^[14]

Crucially, this withdrawal was underpinned by the assumption, expressed in the ANC's 2009 National Health Insurance (NHI) report, that medical schemes would be eliminated within 5 years following the introduction of NHI legislation.^[15] This report argued for the implementation of a single public pooling mechanism, replacing existing scheme-based coverage of any relevance. This expectation directly halted further reform efforts under UHC1, including the legislative advancement of long-planned regulatory and financial architecture for private health financing.

The ANC therefore began advancing a new reform proposal, UHC2, encapsulated in its 2007 conference resolutions^[2] and eventually formalised in the 2017 NHI White Paper.^[3] UHC2 envisages a centralised single-payer model funded through general taxation and mandatory contributions, effectively replacing medical schemes and consolidating purchasing power in a state-controlled fund. The proposed reforms departed from the incremental, institutionally focused strategies of UHC1 toward a state-centric model.

Despite legislative enactment in 2023,^[4] UHC2 remains unimplemented. Critical concerns have emerged regarding its fiscal viability, its unresolved constitutional challenges and the state's institutional readiness to assume such an expansive role.^[5,16] The model originally presumed the rapid dissolution of medical schemes and the seamless creation of a new central fund, assumptions that have not materialised. The apparent lack of implementation capacity, combined with legal ambiguities, has effectively stalled progress.

In the absence of either completed UHC1 or implemented UHC2 reforms, the SA health system has defaulted to UHC0, an unplanned and unstable configuration marked by regulatory gaps, public-private bifurcation and governance deficits. While UHC0 achieves a broad level of financial risk protection, reflected in low out-of-pocket expenditure relative to total health expenditure,^[17] its sustainability is undermined by systemic inefficiencies.

The resulting policy vacuum has prompted renewed calls for a return to the UHC1 framework. UHAC, comprising key health sector stakeholders, has proposed an updated UHC1 model as a feasible and constitutionally aligned pathway. This proposal reinstates many of the abandoned features of the original UHC1 trajectory, including regulated risk pooling for medical schemes (mandatory participation, risk equalisation, mandated minimum benefits, open enrolment, community rating) and decentralised governance in the public system.

The evolution of SA's UHC policy reveals a shift away from an institutionally integrated reform strategy (UHC1) toward a highly centralised (politically and administratively) but largely theoretical model (UHC2). The abandonment of UHC1 was not based on any demonstrated failure of UHC1, but arguably on the political attractiveness of concentrated political control.

With UHC2 now effectively stalled and UHC0 entrenching systemic inequity, there is an urgent need to re-evaluate the policy direction.

This article critically examines the three trajectories to identify a coherent and sustainable path toward equitable UHC. Central to the analysis is the introduction of the organising principle of 'subsidiarity' as basis for a well-organised health system.

Methodology

This study employs a qualitative comparative policy analysis to evaluate three models of UHC in SA – UHC0, UHC1 and UHC2 – using the principle of subsidiarity as the core organising framework.

Emphasis is placed on whether centralisation or decentralisation of authority and function enhances the system's ability to deliver on UHC commitments in the SA context.

To ensure coherence and focus, the analysis is structured around four integrated policy dimensions:

- First, governance and institutional alignment: assessing the degree to which each model aligns with constitutional mandates, allocates authority appropriately across governance levels and upholds institutional integrity, accountability and subsidiarity.
- Second, service delivery and access equity: evaluating how each model structures health services to ensure equitable geographical

and socioeconomic access, comprehensive care and functional public-private integration. Given SA's persistent disparities and dual health system, this dimension captures whether structural reforms can bridge or entrench inequalities.

- Third, financial stewardship and risk protection: analysing the sustainability, equity and effectiveness of each model's financing arrangements, including pooling, cross-subsidisation and financial risk protection. This dimension responds to SA's constrained fiscal environment and high reliance on private financing.
- Fourth: implementation capability and system adaptability: examining historical performance, institutional readiness, administrative feasibility and the capacity to support decentralised innovation, community participation and policy resilience.

This framework allows for a nuanced assessment of whether deviations from subsidiarity are justified by functional necessity or whether they compromise the system's capacity to realise equitable and sustainable UHC outcomes.

Understanding the principle of subsidiarity

Subsidiarity is the idea that decisions and functions should be addressed at the most local level capable of doing so, with higher-level or more centrally placed authorities stepping in only when necessary.

Consistent with this, the concept of subsidiarity has both vertical and horizontal dimensions.^[18]

- First, vertical subsidiarity argues for the allocation of public responsibilities to the lowest effective tier of government (e.g. local or provincial) before higher levels intervene.
- Second, horizontal subsidiarity means that if non-state (private) or community actors (civil society, private sector) are better suited to perform certain tasks, the state should enable and not supplant them.

The two dimensions therefore apply to both the organisation of the state and to the demarcation between the state and private actors for the same justifications, which include both ethical and efficiency grounds.

The ethical rationale reflects the values that individuals and communities are the 'only ultimate bearers of value'^[18] such that ethical governance requires that everyone affected by a decision be permitted the opportunity to participate meaningfully in the making of those decisions. This includes shaping their own social and political environments. People and communities entrusted with tasks they can perform are argued to be more likely to act responsibly and ethically. Subsidiarity guards against problematic concentrations of power and discrimination against less powerful actors.^[18-20]

Subsidiarity is also justified on efficiency grounds. The European Union, for example, incorporates subsidiarity to ensure that decisions are taken in close proximity to those affected.^[21] The rationale includes: the better use of local knowledge; improved responsiveness; faster decision-making; greater innovation and policy experimentation; improved accountability; and more efficient allocation of resources.^[18,22,23]

The efficiency grounds of subsidiarity were also laid out in schedule 4 of SA's interim Constitution to act as a guide for the framing of the final Constitution – the 'level at which decisions can be taken most effectively in respect of the quality and rendering of services, shall be the level responsible and accountable for the quality and the rendering of the services, and such level shall accordingly be empowered by the Constitution to do so' (24. Schedule 4, XXI(1)).

Whereas the principle of subsidiarity does not rule out centralisation, it suggests that this should only occur where local or non-state decision-making involve problems that cannot be resolved in any other way. Where such instances exist, however, the principle implies that any intervention should be restricted to the relevant problem.

Before performing the analysis, the three UHC approaches are briefly compared.

Comparative summary of the three health policy options

UHC0 represents SA's current default health system configuration, an unplanned hybrid of legacy apartheid-era structures, partially implemented post-1994 reforms and fragmented governance. It is characterised by a dual public-private system with significant disparities in funding, access and quality.

UHC1 refers to the incremental reform model outlined in SA's 1997 Health White Paper and associated policy instruments. It proposed building a unified, equitable health system by strengthening public infrastructure, decentralising governance through district health authorities, integrating the private sector via regulated medical schemes and introducing risk equalisation. The proposals have been updated by various official policy processes, with the most recent being the Health Market Inquiry^[25] and the UHAC proposals.^[6]

UHC2 is the centralised NHI model championed by the ANC since 2007, and formalised in the 2017 White Paper and 2023 legislation. It envisions a single-payer system funded by general taxes, with a national fund acting as the sole purchaser of health services. UHC2 aims to replace existing medical schemes and consolidate public and private financing under state control.

Evaluation

Applying the principle of subsidiarity as a guiding framework, the three UHC configurations (UHC0, UHC1 and UHC2) are compared across four dimensions: governance and institutional alignment; service delivery and access equity; financial stewardship and risk protection; and implementation capability and adaptability. The analysis assumes that any unnecessary centralisation of authority, that is, a deviation from subsidiarity's allocation of functions to the lowest competent level, will undermine both ethical governance and system performance efficiency.

Governance and institutional alignment

Under UHC0, governance is marked by highly centralised control and fragmented accountability, reflecting deviations from the principle of subsidiarity in the public sector.^[26,27] Political appointments and top-down management have displaced local decision-making in provincial health departments, undermining community oversight and accountability.^[27,28] This has led to systemic underperformance and pervasive mismanagement in eight of the nine provinces, as evidenced by chronically high levels of irregular expenditure (Fig. 1). The Western Cape Province, which has maintained comparatively stronger institutional controls, exhibits far lower irregular spending and much better maternal health outcomes than the other provinces (Fig. 2). Given that health budgets are allocated fairly equally across provinces,^[38] these disparities point to governance failures resulting from the violation of subsidiarity principles.

Similarly, the private health financing system under UHC0 lacks accountability: regulatory deficits create perverse incentives that drive up costs and leave many without adequate coverage.^[25,39]

UHC1, by design, realigns the system with subsidiarity. In the public sector it devolves authority to district health authorities

and autonomous hospital boards, fostering local accountability in place of UHC0's politicised central control.^[1,10,11] In parallel, UHC1 respects the horizontal subsidiarity principle by empowering non-state actors. It retains a role for regulated private financing, introducing structural changes, such as a risk equalisation mechanism, to fix market failures without sacrificing the benefits of competition and choice.^[12,13,41]

By contrast, UHC2 recentralises health system authority into a single national purchaser (the NHI Fund), largely sidelining provincial autonomy.^[3,4] The private sector's role is reduced to that of a contracted service provider, with the role of medical schemes removed. While centralisation under UHC2 aims to enforce uniform standards, it effectively compounds the vertical and horizontal subsidiarity weaknesses of UHC0 by concentrating power at the national level, raising concerns that accountability and responsiveness would further diminish under this model.

Service delivery and access equity

UHC0 maintains a two-tier system with stark disparities: public services are poorly managed, while private care, though of high quality, remains accessible only to a small affluent minority.^[25] With virtually no co-ordination or resource-sharing between the public and private sectors, location and income largely determine health outcomes under the status quo. The resulting health outcomes widen spatial disparities, particularly between poorly and better-managed public health systems. Inequity in outcome within the public system, while a resource allocation concern, as noted from Figs 1 and 2, is also driven principally by governance considerations.

UHC1 seeks to improve equity by strengthening public sector primary healthcare and integrating private providers into a unified system. District health authorities would be empowered and supported by dedicated funding to expand clinic-level services, while regulated medical schemes with risk equalisation and income cross-subsidies would make private care more accessible to low- and middle-income populations.^[6,10,13,39] In this way, UHC1 harnesses all available healthcare resources to extend coverage and reduce disparities.

UHC2 likewise promises universal access, but it relies on a single national purchaser (the NHI Fund) to achieve uniform coverage. In principle, pooling all funds in one mechanism could direct more resources to underserved areas, but the plan provides little detail on how to expand and maintain healthcare capacity at local level and compensate for the significant deviation from the principle of subsidiarity – both vertical and horizontal.^[42] Replacing the multi-payer system with a single scheme is a complex transition; if private sector provision contracts faster than the public sector can expand, interim gaps in care could be expected to arise. Without strong measures to invest in rural facilities and to retain healthcare personnel, UHC2's centralised model is unlikely to deliver equity in practice, as suggested by failures of the NHI pilot projects.^[43]

Financial stewardship and risk protection

UHC0 splits health financing between a tax-funded public system and a voluntary private insurance system, with virtually no explicit cross-subsidisation between them. However, the families on medical schemes provide the tax funding for the public system, while being excluded from its coverage without payment.^[10,13] In combination, both systems yield very low out-of-pocket payments, which is indicative of successful financial risk protection.^[17] However, the quality of this coverage is in question, with the public sector demonstrating poor health outcomes relative to the allocated funding (Figs 1 and 2),^[42,44,45] and the private system subject to increased costs due to inefficient competition.^[25,39,46]

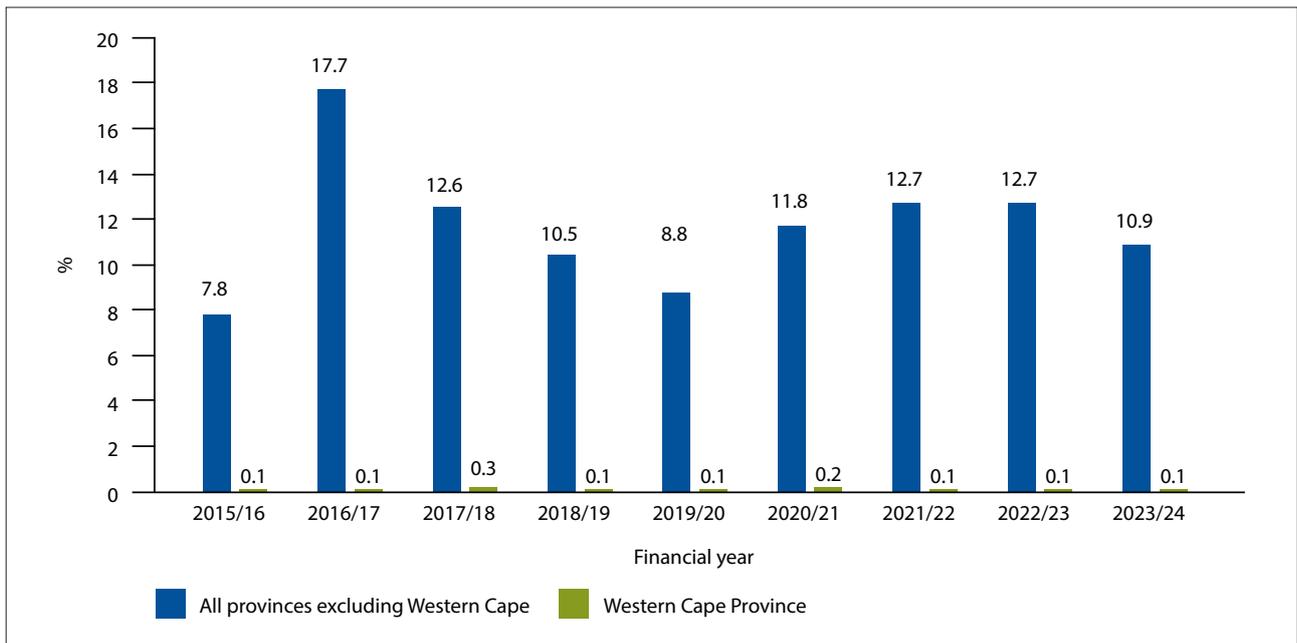


Fig. 1. Irregular expenditure: Western Cape Department of Health compared with all provinces outside of the Western Cape – expressed as a percentage of non-personnel expenditure (2016/17 to 2023/24).^[29-37]

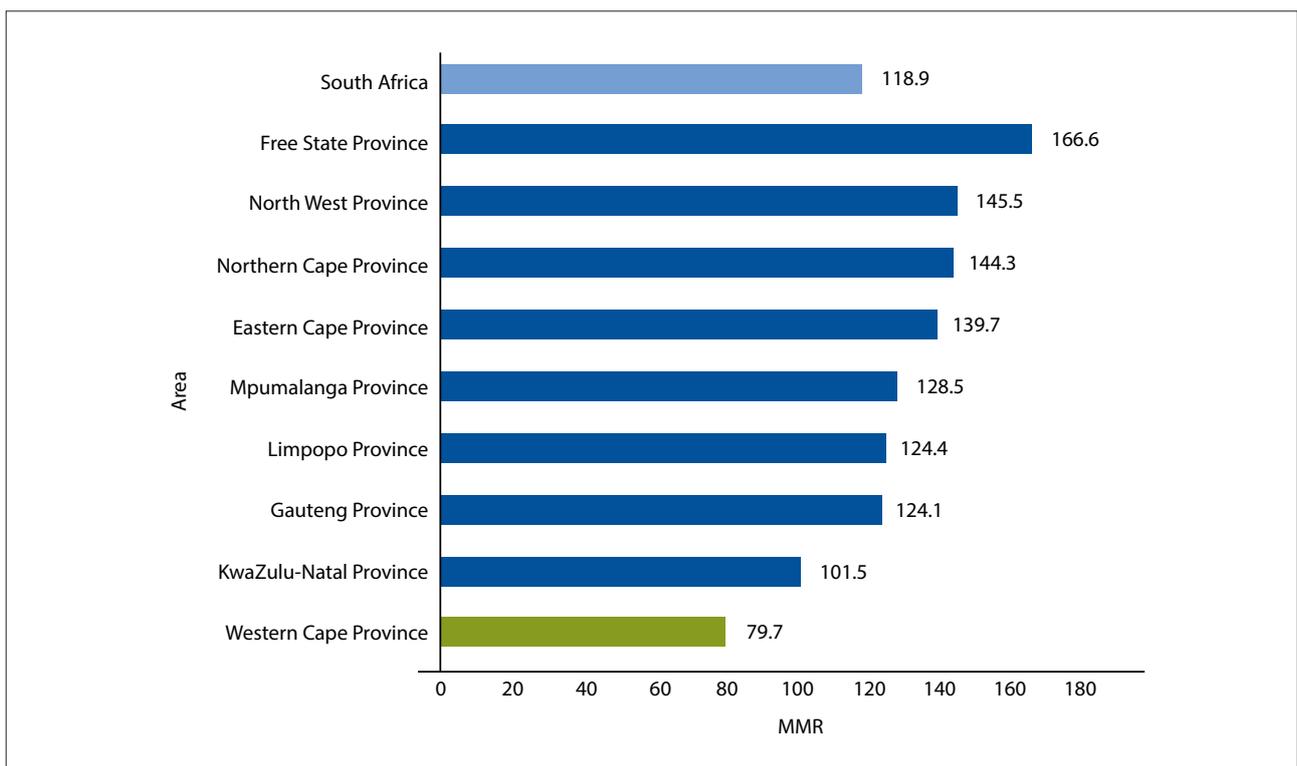


Fig. 2. Institutional maternal mortality ratios (MMRs) by province – 5-year average to 2023.^[40]

UHC1 adopts a co-ordinated multi-payer financing model to enhance equity and sustainability. It retains general tax financing for a broad base of services, with improved oversight and strategic purchasing, while reforming private health financing through mandatory benefits and a Risk Equalisation Fund to spread costs between healthy and sick, as well as between rich and poor.^[10,13] By aligning public and private funding, UHC1 would achieve financial risk protection across the population while preserving user choice and efficiency in line with subsidiarity. It improves on UHC0 while avoiding the fiscal pitfalls of UHC2.

UHC2 proposes to consolidate all health financing into a single national pool under the NHI Fund. In theory, this single-payer approach enhances solidarity by pooling risk across the entire population, but it also concentrates financial control at one point – deviating from the principles of subsidiarity. Given SA’s governance track record, such centralisation carries risks of inefficiency or misuse of funds if oversight is weak.^[28] Furthermore, eliminating most medical schemes removes the private safety nets that currently help cushion the public system, reducing the resilience of the

overall health system by eliminating coverage for approximately 9 million people without the ability to match their coverage or raise additional funding.^[47] UHC2's promise of comprehensive financial risk protection therefore depends on achieving an exceptionally high standard of centralised stewardship, which requires that it overcome the significant governance and efficiency disadvantages of centralisation. A fatal constraint with UHC2 is that the approach is premised on the implementation of a new tax to substitute for historical medical scheme contributions. The opportunities for additional taxes are, however, unlikely to materialise, as SA is assessed to be at tax capacity, where any new tax is more likely to reduce tax revenues rather than increase them.^[16,48-50]

Implementation capability and adaptability

UHC0's implementation record is characterised by institutional inertia and poor co-ordination arising from the over-centralised decision-making in both the public and private systems, resulting from poorly structured institutional frameworks. The public sector's ability to execute improvements varies widely, with some provinces able to manage their health services effectively while others face chronic governance shortfalls, while private sector decisions are driven heavily by poorly incentivised market forces rather than value for money. There are therefore few mechanisms for system-wide learning and adaptation through more localised self-organisation under UHC0, allowing performance gaps to persist indefinitely.

UHC1 is comparatively more feasible to implement, as it builds on existing structures through reforms focused on adjustments to the strategic frameworks that enable heightened self-organisation. Rather than attempting an unprecedented overhaul, UHC1 can roll out changes in phases via strategic projects, such as empowering a few district health authorities or hospital boards at a time, allowing lessons learned to inform broader expansion. This evolutionary, bottom-up method aligns with subsidiarity and mitigates the risk of disruption, by improving the system stepwise.

UHC2, by comparison, presents the most formidable implementation challenges due to its sweeping, centralised overhaul of the system. Instead of enabling self-organisation, it places the entire burden of solving complex health system problems on centralised decision-makers in a strict, politically controlled, hierarchy. It requires an aggressive merging of provincial services and private insurance arrangements into a single NHI framework, far exceeding what SA's institutions have previously managed. Importantly, it seeks to circumvent the constitutional authority of provincial governments to finance and manage healthcare services, as 'health services' are a concurrent function of national and provincial government (8, schedule 4 part A), in the absence of an amendment to the Constitution.^[42] It also limits the right of income earners to obtain essential coverage from medical schemes, in the absence of reasoned analysis.^[42] In both instances, legal challenges have now been initiated.^[5]

Without a carefully phased transition and substantial capacity-building, there is a high risk that the NHI rollout could overwhelm administrative systems; failures at the centre would have nationwide consequences. Because the UHC2 institutional framework leaves little room for local autonomy or pilot testing, it lacks the adaptability needed to troubleshoot issues during implementation, casting doubt on its practical attainability. Importantly, by design it leaves in place many of the governance weaknesses, such as political appointments into leadership structures, that have harmed the capacity of provincial health systems to perform.^[28] Implementation of UHC2 is furthermore fatally constrained by the requirement that it be financed entirely from general taxes, while SA is at tax capacity indefinitely into the future. As both the institutional model and

the financing framework have a very low probability of successful implementation, effectively UHC2 converges on UHC0 – leaving the health system largely in its current form. Given this, the poor outcomes resulting from UHC0 effectively become those of UHC2.

Conclusion

Viewed through a subsidiarity lens, UHC1 emerges as the most balanced and constitutionally aligned reform path. It integrates decentralised authority with national oversight, supports pluralistic financing, promotes equity in service access and builds on existing institutions to enable adaptive implementation. It focuses on the establishment of a framework that enables productive self-organisation in both the public and private health systems. UHC2, while argued to be committed to equity, risks undermining the institutional diversity and local autonomy needed for sustainable reform – if it were to be implemented, which is unlikely. UHC0, meanwhile, perpetuates fragmentation and inequity and lacks the structural features necessary for achieving universal, equitable and financially protected healthcare. However, UHC2 converges on UHC0 due to low feasibility and the hold that its pursuit has placed on any other strategic health reforms for SA. The poor performance outcomes of UHC0 are therefore those of UHC2 – although not by design. In the absence of a commitment to UHC1, SA will find itself indefinitely trapped in UHC0.

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