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Health sector reforms in South Africa: Evaluating financing models for universal health coverage in the post-apartheid era

S M Cleary,[1,2] MA (Economics), PhD; **M Haji**,[2] MPH (Health Economics), **G C Solanki**,[2,3] BChD, DrPH

[1] *Head of Department and Director, School of Public Health, Faculty of Health Sciences, University of Cape Town, South Africa*
[2] *Division of Health Economics, School of Public Health, Faculty of Health Sciences, University of Cape Town, South Africa*
[3] *Principal Consultant, NMG Consultants and Actuaries, Cape Town, South Africa*

***Corresponding author**: S M Cleary (susan.cleary@uct.ac.za)*

From the Gluckman Commission's call for a universal, equitable health system, through the racial exclusion of apartheid, to the reform agenda of the post-apartheid period, South Africa's journey toward expanding universal health coverage (UHC) has been marked by historical inequities and bold reform visions. With current health sector reform initiatives challenged by polarising debates and legal contestation, this paper aims to compare and contrast reform options to encourage engagement and debate that advances UHC. An adapted UHC analytical framework is applied to four alternative health financing models that have either been implemented or considered in the post-apartheid period: the current public sector (National Health Service (NHS) model), the current private sector (voluntary health insurance), and two key alternatives, namely National Health Insurance (NHI) and Social Health Insurance (SHI). This analysis suggests that, while NHI offers the most comprehensive vision for UHC, its success depends on overcoming significant governance and fiscal constraints. SHI offers a more incremental and financially sustainable pathway by expanding formal sector coverage and enabling regulated risk pooling. However, a key finding is that no financing model, however well designed, will succeed without addressing underlying governance failures in the public health system. Drawing on lessons from the post-apartheid period, this paper argues for a phased hybrid approach that advances financing reforms alongside investment in governance capacity as the most feasible pathway to enable progress toward UHC.

Keywords: universal health coverage (UHC), National Health Insurance (NHI), National Health Service (NHS), Social Health Insurance (SHI), health sector reforms, South Africa, health financing, governance

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South Africa (SA) has committed to the goal of progressively realising universal health coverage (UHC), as defined by the World Health Organization (WHO).[1-3] While definitions of UHC differ, the overall vision is: (*i*) that individuals and communities can use quality health and related services when needed; and (*ii*) that there is financial protection when accessing these services. Given the nature of these goals, UHC can be understood as a continuum, in which the health system continues to expand the scope and quality of services in such a way that the health equity goal of equal access for equal need is met.

While the vision of UHC is widely accepted, health system arrangements for progressing toward UHC differ. The body of literature on comparative health system typologies[4] provides a framework for classifying health systems and assessing the extent to which alternative financing models may enable progress toward UHC, given contextual and economic realities. The current SA health system is characterised as a plural or mixed health system, with a combination of public and private financing and delivery models.[5,6] The public sector is based on a National Health Service (NHS) model with public financing and delivery.[1,7] The private sector is characterised by private provision and a mixture of funding through voluntary private health insurance (commonly known as 'medical schemes', which may include medical savings accounts as a component) and a direct market (i.e. out-of-pocket payment) model.[6,8,9] Since democracy, health sector reform discussions have also included consideration of Social Health Insurance (SHI) and National Health Insurance (NHI). Mixed or plural health systems have become the norm globally.[10] In SA, however, private sector weaknesses include poor value for money that drives disproportionately high spending,[6,11] while public sector weaknesses centre on inefficient governance and poor quality of care.[12,13] These concerns foreground the need for ongoing health sector reform.

This paper presents a brief overview of the historical trajectory of health sector reform in SA, identifying four key health system models: public sector NHS, voluntary private health insurance, NHI and SHI – all of which have been implemented or proposed at various times. These models are mapped and critically assessed using an adapted UHC framework to examine financing arrangements and alignment with UHC objectives and goals. This analysis aims to evaluate the strengths, limitations and operational implications of each model to identify the most feasible and equitable reform pathway for accelerating progress toward UHC.

History of universal health coverage

SA's vision for equity in healthcare dates back to the 1940s, when the Gluckman Commission proposed a centrally controlled NHS, funded through a national health tax and delivering free care at the point of use. This aligned with the thinking outlined in the Beveridge Report, which enabled the establishment of an NHS in Britain.[7,14] However,

this proposal was abandoned as apartheid-era policies institutionalised a fragmented, racially segregated health system, including a public sector organised under multiple health departments for different racial groups and geographical regions.[15] Toward the end of apartheid, health sector reforms included deregulation of medical schemes, relaxation of licensing requirements to allow the development of private hospitals, and rapid increases in public sector user fees.

Since democracy in 1994, considerable progress has been made in dismantling these apartheid-era structures,[16] framed by the vision articulated in the 1997 White Paper for the Transformation of the Health System. The racially based public sector was consolidated under a single National Department of Health and nine provincial departments, and user fees were removed, first for pregnant women and children under six, and then for all primary care services. While user fees for hospitals were maintained, they were reduced and means-tested. In this way, elements of the Gluckman vision of an NHS were achieved in the public sector, although this did not realise the full vision of a universalist system. In the private sector, reforms to medical schemes were implemented through the passage of the Medical Schemes Act of 1999, which reversed much of the deregulation implemented in the late 1980s.[8]

While a hybrid health system was maintained – combining an NHS-style model in the public sector and voluntary health insurance in the private sector – the system nevertheless produced notable gains toward the goals of UHC. Fig. 1 illustrates out-of-pocket expenditure as a percentage of total health expenditure, where lower values indicate that a smaller percentage of healthcare costs are incurred at the point of use, indicating stronger financial protection. As shown, SA performs well on this metric compared with other African and upper-middle-income countries, with performance improving over time. Fig. 2 illustrates the UHC service coverage index, compiled by the WHO. This is a composite measure based on tracer indicators across four categories: reproductive, maternal, newborn and child health; infectious diseases; non-communicable diseases; and service capacity and access. The index ranges from 0 to 100, with higher scores indicating broader service coverage. As can be seen, SA has made progress over time on this metric, albeit less marked than that of other upper-middle-income countries.

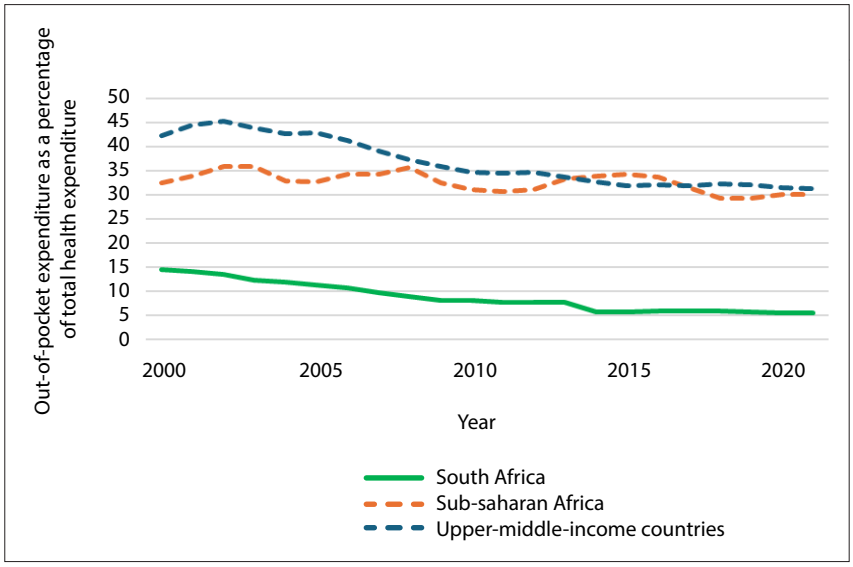


Fig. 1. Out-of-pocket expenditure as a percentage of total health expenditure.[31]

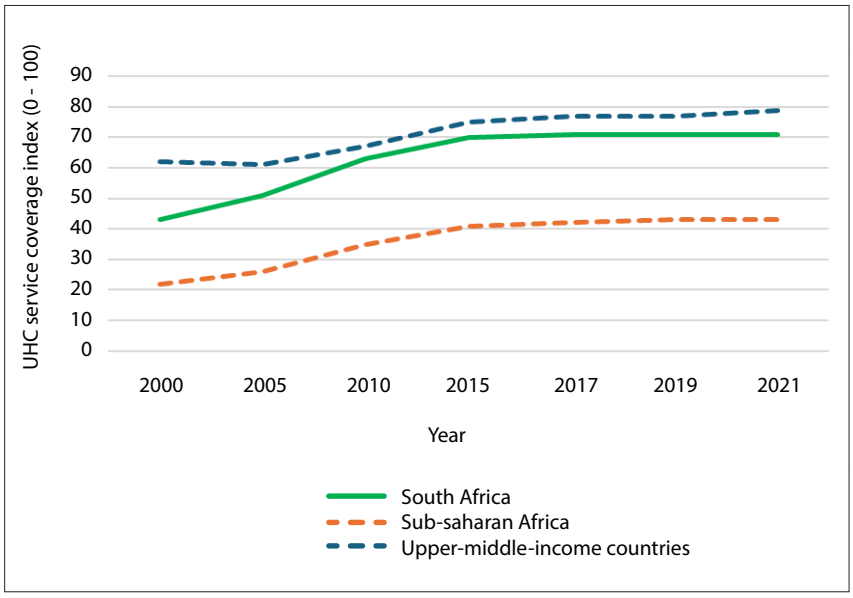


Fig. 2. Universal health coverage service coverage index.[32] (UHC = universal health coverage).

This progress toward UHC goals has been accompanied by real per capita increases in government spending on the public sector since democracy.[17] Prior to COVID-19-related health budget fluctuations, SA nominally met key health financing benchmarks, such as the Abuja target of dedicating 15% of total government expenditure to the health sector and the WHO's recommendation of government expenditure on health of 4.5% of gross domestic product.[18,19] However, since the end of the COVID-19 pandemic, the public sector has experienced real decreases in health budgets, a situation exacerbated by the withdrawal of funding from the President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID), amid ongoing economic uncertainty.[20]

During this post-democracy period, consideration was also given to further health sector reform that would enable convergence between the public and private sectors. While the history is complex and coloured by political contestation,[15] broadly speaking, these alternatives converged into either SHI or NHI models. For example, the 2002 report of the Committee of Inquiry into Comprehensive Social Security for SA (the Taylor Committee) considered various options for health sector reform, but ultimately recommended a progressive form of SHI to overcome some of the challenges of voluntary health insurance and private sector cost escalation, arguing

that universalist options of either an NHS or NHI were unaffordable.[21] This stance was subsequently supported by a 2005 Ministerial Task Team.[22] The proposed SHI model entailed an expansion of medical scheme cover (in part via the allowance for low-cost benefit options), as well as the implementation of a risk equalisation mechanism to allow for cross-subsidisation between pools. Further aspects of such an approach also formed part of the detailed recommendations in the final report of the Competition Commission 2019 Health Market Inquiry.[6]

However, at its annual policy congress in 2007, the African National Congress voted in favour of a universalist NHI model, in contrast to the previous SHI reform agenda. While contested, this was nevertheless followed by the 2011 NHI Green Paper, the 2015 NHI White Paper, the 2018 NHI Draft Bill, and ultimately the signing of the NHI Act in May 2024.[5,10,23,24]

Evaluating health sector reform models against a universal health coverage assessment framework

As shown in Fig. 3, we adapted a UHC framework from Kutzin[25] to evaluate the strengths and limitations of the four models: the current public sector model (NHS), the current private sector model (voluntary health insurance), and two alternatives proposed since democracy, namely NHI and SHI.

On the left-hand side, the framework draws attention to four financing arrangements:

- The sources of, and approaches to, revenue collection (with prepayment and mandatory approaches being strongest).
- The nature of pooling (with larger pools enabling better cross-subsidisation between younger and healthier, and older and sicker, populations).
- Whether the system can purchase from public and/or private providers, and how providers are paid (with historical budgets and user fees tending to produce worse outcomes than strategic purchasing and newer provider payment mechanisms such as capitation and diagnosis-related groups).
- The extent to which the health benefit package (i.e. the package of services and interventions) is clearly defined and used to guide or mandate service delivery.

These financing arrangements are conceptualised as contributing toward two intermediate UHC goals: equity in resource distribution and efficiency, specifically:

- Equity as financial progressivity (cross-subsidisation between wealthier and poorer populations).
- Equity as risk equalisation (cross-subsidisation between healthier and sicker populations).
- Technical efficiency (the ability of the health system to convert available resources into the maximum possible services or outputs).
- Allocative efficiency (the cost-effectiveness of the services and interventions included in the health benefit package).

Together, these contribute to the two final UHC goals: (*i*) ensuring access to quality services when needed; and (*ii*) financial protection against the costs of care. Using this framework, we mapped SA's current public and private sectors (Table 1) and evaluated the potential for NHI and SHI reforms to advance UHC.[5,6,13,26,27] This comparative assessment helps identify which models – and which combinations of financing arrangements – offer the greatest potential to accelerate progress given contextual realities.

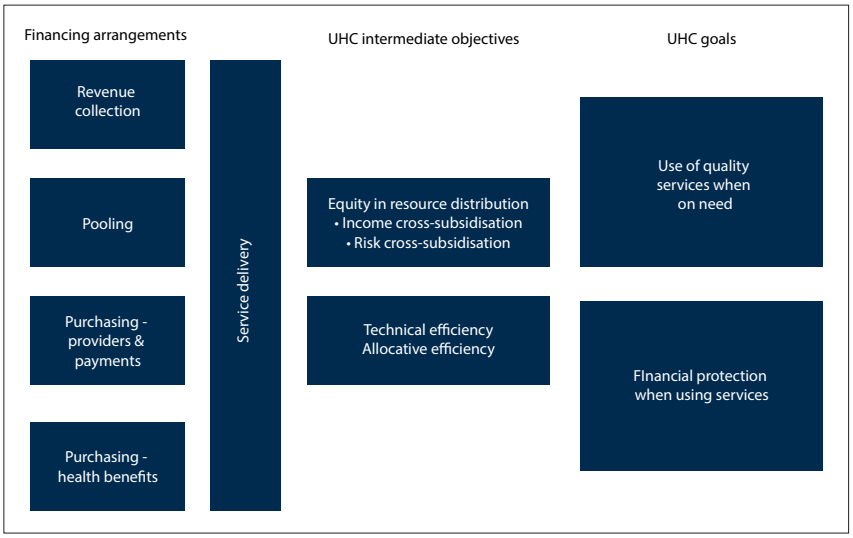


Fig. 3. Conceptual framework of financing arrangements and UHC objectives and goals.[25] (UHC = universal health coverage).

Current health systems

The current public sector NHS model serves approximately 85% of the population and is primarily financed through general tax revenue, which is allocated from national to provincial treasuries via a combination of equitable share formulae and conditional grants. Primary care services are free at the point of use, while hospital services carry means-tested fees, although collection remains uneven. Providers are salaried employees and facility budgeting is largely historical. Benefits are implicitly linked to national standard treatment guidelines and essential medicines lists. The system embodies a high degree of income and risk cross-subsidisation owing to its progressive financing and pooling arrangements. However, in practice, a combination of governance and capacity challenges results in uneven quality of care and service coverage across regions and facilities, undermining the system's promise of equal access to necessary care.

By contrast, the private sector covers approximately 15% of the population and is primarily financed through voluntary private health insurance contributions, supplemented by out-of-pocket payments, including co-payments and user fees. Risk pooling is limited in a highly fragmented system, comprising 71 medical schemes and over 300 registered benefit plans.[9] Providers are often independent practitioners, reimbursed via fee-for-service payment models. Prescribed minimum benefits (PMBs) are the base requirement for all benefit options, providing more explicit definitions than in the public sector. PMBs cover a defined set of 270 diagnostic and treatment pairs, including emergency care, certain chronic conditions and hospital admissions, ensuring that medical schemes cover the costs of these conditions regardless of the benefit option chosen by the member.[8] Coverage of other services depends on the selected benefit option. While private insurance offers financial protection for those who can afford it, the absence of meaningful income and risk cross-subsidisation renders the system regressive and inequitable. Based on the findings of the Competition

Table 1. Comparison of SA financing arrangements against UHC objectives and goals

	Public sector (NHS model)	Private sector	SHI	NHI
Population coverage	±85%	±15%	±20%, depends on design	Up to 100%
Annual expenditure	ZAR243 billion in 2019/20 (4.7% GDP).[26]	ZAR249 billion in 2019/20 (4.9% GDP).[26]	Unclear; depends on design.	Unclear; depends on design.
Financing arrangements				
Revenue collection	Mandatory via general taxes and means-tested user fees at hospitals.	Voluntary via private health insurance contributions, medical savings accounts, co-payments and user fees.	Mandatory via community-rated insurance contributions, co-payments and user fees; depends on design.	Mandatory via general taxes and possibly new payroll tax; no user fees.
Pooling	One public sector pool.	Multiple pools equal to number of medical schemes; compounded by choice of benefit options.	Multiple pools equal to number of medical schemes, but use of risk equalisation is common.	One health sector pool.
Purchasing – providers and payment mechanisms	Users can select from public providers; payment to providers via historical budget model.	Users can select from public (in theory) or private providers; payment to providers largely via fee-for-service model.	Users can select from public or private providers; payment to providers can be through various models; depends on design.	Users can select from public or private providers; payment to providers using capitation and diagnosis-related group models.
Purchasing – clarity on the health benefit package	Implicitly linked to standard treatment guidelines and national EMLs; uneven implementation.	Explicitly defined in PMBs and chronic disease lists; implicit for other services and/or linked to specific benefit option chosen by member.	Can be explicitly defined.	Health benefit package to be explicitly defined in regulation.
UHC intermediate objectives				
Equity – income cross-subsidisation	Good income cross-subsidisation via progressive tax system.	No population level income cross-subsidisation; regressive. Potential income cross-subsidisation within medical schemes; dependent on design.	Limited to those who are enrolled in the SHI; therefore, limited population-level equity. For those enrolled, can be progressive; dependent on design.	Good income cross-subsidisation via progressive tax system.
Equity – risk cross-subsidisation	Good risk cross-subsidisation used in national to provincial funding transfers; no risk cross-subsidisation implemented at lower levels.	Risk cross-subsidisation within medical schemes, but no cross-subsidisation between insured and non-insured populations.	Potential for good risk cross-subsidisation.	Potential for good risk cross-subsidisation for primary care; unclear for hospitals.
Allocative efficiency	Some consideration of cost-effectiveness in standard treatment guidelines and national EMLs; a bit *ad hoc*.	Unclear – some medical schemes might consider cost-effectiveness in benefit choices.	Considerations of cost-effectiveness could be applied; depends on design.	Considerations of cost-effectiveness to be more systematically applied.
Technical efficiency	Mixed; weaknesses include supply chain failures, staff shortages, poor management and infrastructure decay.[5,13,27]	Poor; fee-for-service incentives and fragmentation drive high costs.[6]	Potential for improvement through regulated purchasing and scale economies.	Potential for improvement via single-payer administration and strategic purchasing.
UHC goals				
Use of quality services when in need	Yes, in theory, but in practice highly variable.	Yes, but depends on chosen insurance option.	Yes, in theory, but in practice will depend on design and implementation challenges.	Yes, in theory, but in practice will depend on design and implementation challenges.
Financial protection when using services	Good financial protection due to zero user fees for primary care and low means-tested user fees at hospitals.	Good financial protection linked to insurance mechanism (although co-payments common).	Good financial protection linked to insurance mechanism (co-payments dependent on design).	Excellent financial protection due to zero user fees on all services.

SA = South Africa; UHC = universal health coverage; NHS = National Health Service; NHI = National Health Insurance; SHI = Social Health Insurance; GDP = gross domestic product; PMBs = prescribed minimum benefits; EMLs = essential medicines lists.

Commission's Health Market Inquiry,[9] the private sector also suffers from multiple market failures, including structural, behavioural and regulatory constraints that undermine competition and restrict access.

Transitioning to National Health Insurance

While still tax-financed, the NHI proposes a consolidation of all funding into a single national fund, as opposed to nine provincial pools, and the elimination of user fees entirely.[28] Over time, the tax allocation to health would need to increase to accommodate up to 100% of the population, given the proposal to limit private health insurance coverage once the system is 'fully implemented'. Both public and private providers meeting accreditation standards would be able to contract with the NHI and would be remunerated through mechanisms such as risk-adjusted capitation for primary care and diagnosis-related groups for hospitals. If implemented effectively, NHI has the potential to advance population-wide coverage, promote equitable financing through progressive risk pooling and enhance financial protection. It also enables the integration of private provider capacity into a universalist system. However, these benefits hinge on overcoming significant challenges related to governance, technical inefficiency and fiscal capacity.[10,16,23] Without adequate expansion of the funding envelope, NHI could lead to real per capita decreases in spending, resulting in an unintended outcome: apparent progress toward UHC goals alongside a reduction in health benefits and potentially in health outcomes.

Transitioning to Social Health Insurance

The SHI model is characterised by mandatory, income-linked insurance contributions (typically payroll-based), community rating and potential user fees. Unlike the current fragmented private insurance market, SHI has the potential for risk pooling (possibly through risk equalisation mechanisms), income cross-subsidisation and standardised benefit packages and provider payments. Implementing SHI would require systems for contribution collection, enrolment and claims management. Public and private providers would contract with SHI funds and deliver care based on clearly defined entitlements. Private funders would be regulated to ensure community rating and standardised coverage. This represents a shift from voluntary, fragmented coverage to mandatory, regulated insurance for certain categories of the employed population.

Overall assessment and recommendations

The passing of the NHI Act signals a commitment to a particular UHC pathway, yet high levels of contestation and legal challenges indicate poor stakeholder buy-in.[23] Many of these legal challenges relate to the intended reductions in private health insurance. By contrast, key innovations proposed under NHI – such as explicit health benefits, removal of hospital user fees, provider payment reforms and accreditation for quality, and private sector contracting – are already possible within the current public sector under the National Health Act.[29] A key difference between NHI and an NHS model lies in the introduction of a purchaser–provider split, where the NHI fund acts as purchaser and provincial departments of health and private sector entities act as providers. This would enable the fund to terminate contracts with providers or facilities and, where alternative facilities exist within a particular jurisdiction, potentially improve quality of care.

However, certain important strengths of an NHS model are weakened under NHI. Although the provision of health services would remain the mandate of provincial governments, the funding of services would no longer be the responsibility of provincial treasuries. This may disrupt the potential for provincial governments to implement 'whole-of-government' or 'whole-of-society' approaches to improve social determinants, such as community-oriented primary care. It may also complicate the management of the health ecosystem and the sharing of resources between facilities. Examples include specialist support to peripheral facilities via telemedicine and redeployment of oxygen to hospitals with high burdens during the COVID-19 pandemic. The verticalisation proposed by NHI could generate significant fragmentation within such an ecosystem.

An underlying theme of this analysis is that, however well designed, none of the financing models will succeed without addressing the underlying governance failures that contribute to technical inefficiency in the health system. The NHI's centralised fund will concentrate significant resources within a single public entity. If implemented within the current governance environment, it risks amplifying rather than resolving existing weaknesses.[23] Conversely, SHI's more incremental approach may allow for parallel governance strengthening, but it would not automatically resolve the public sector challenges affecting the majority of the population.[10] This suggests that health sector reform must proceed on two parallel tracks: financing reforms (whether NHI, SHI or hybrid) must be accompanied by sustained investment in governance capacity, including financial management, human resource systems, supply chain integrity and accountability mechanisms.[30] Without this dual approach, progress toward UHC will remain uneven, regardless of legislative reform or the selected financing model.

SHI, meanwhile, provides a pragmatic and financially sustainable entry point for addressing the challenges of the current private sector by introducing mandatory formal sector coverage and risk pooling within a regulated environment. This has the potential to advance UHC goals for this segment of the population and may pave the way toward a future universalist system. Whether this system is based on NHI or an NHS model, absorbing the entire population – including those currently dependent on private health insurance – would require a substantially larger government health budget.

Conclusion

The NHI reform includes multiple innovations that could accelerate progress toward UHC, yet many of these are already feasible within the current public sector system and should be implemented. In parallel, SHI-related reforms should be pursued to strengthen the private sector. Ultimately, SA's health reform trajectory should prioritise pro-poor, cost-effective and politically feasible steps toward a more equitable health system that maximises health outcomes and financial protection, rather than strict ideological adherence.

Data availability statement. Available from the corresponding author on reasonable request.

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