NHI - where are we now?

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National Health Insurance (NHI): Where Are We Now?

AGENDA

NHI Reform Overview

- The challenge of reforming healthcare financing in South Africa
- What the NHI Act aims to achieve

The NHI Litigation Challenges

- Who are the litigants?
- What is the current status?
- What are the main arguments?

ASSA Inputs

- ASSA contributions to informing health reform
- Actuarial modelling and realistic sequencing to ensure equitable, affordable, and sustainable system transformation

NHI Reform Overview

Background to the NHI Act

Lengthy policy process

The NHI Act followed over a decade of policy papers, debates, and legislative drafts before becoming law in 2024.

Centralised National Fund

The Act establishes a single national fund as the main purchaser of a defined healthcare service package.

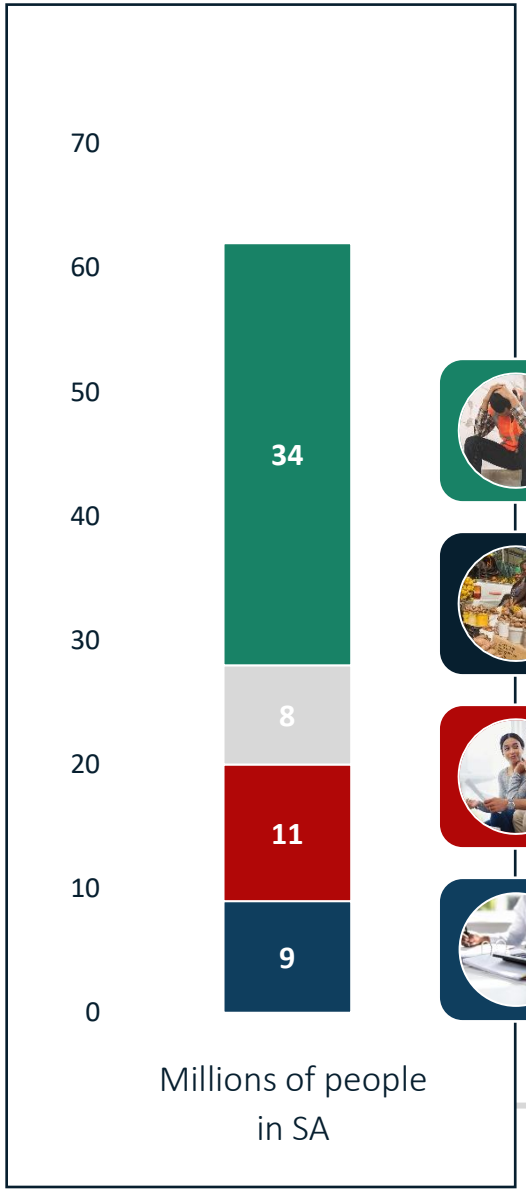
Healthcare System Restructuring

The NHI represents a fundamental shift in South Africa's public–private healthcare system structure.

Implementation Uncertainty

Despite being law, the Act is not yet operational, causing uncertainty in planning and stakeholder concerns.

Health coverage in South Africa



- The healthcare access landscape is more complex than the 2-tier label suggests
- Low catastrophic out of pocket payments but limited access to care
- A large number of people are paying out of pocket for some healthcare and receiving no tax support for this

Unemployed lives who depend on the public sector

Informal sector with less ability to pay out of pocket for and more reliance on the public sector

Taxpayers not on medical schemes paying out of pocket for primary care and using the public sector for secondary/tertiary

Medical scheme membership mostly accessing private care

Around 25m are accessing the private sector for healthcare

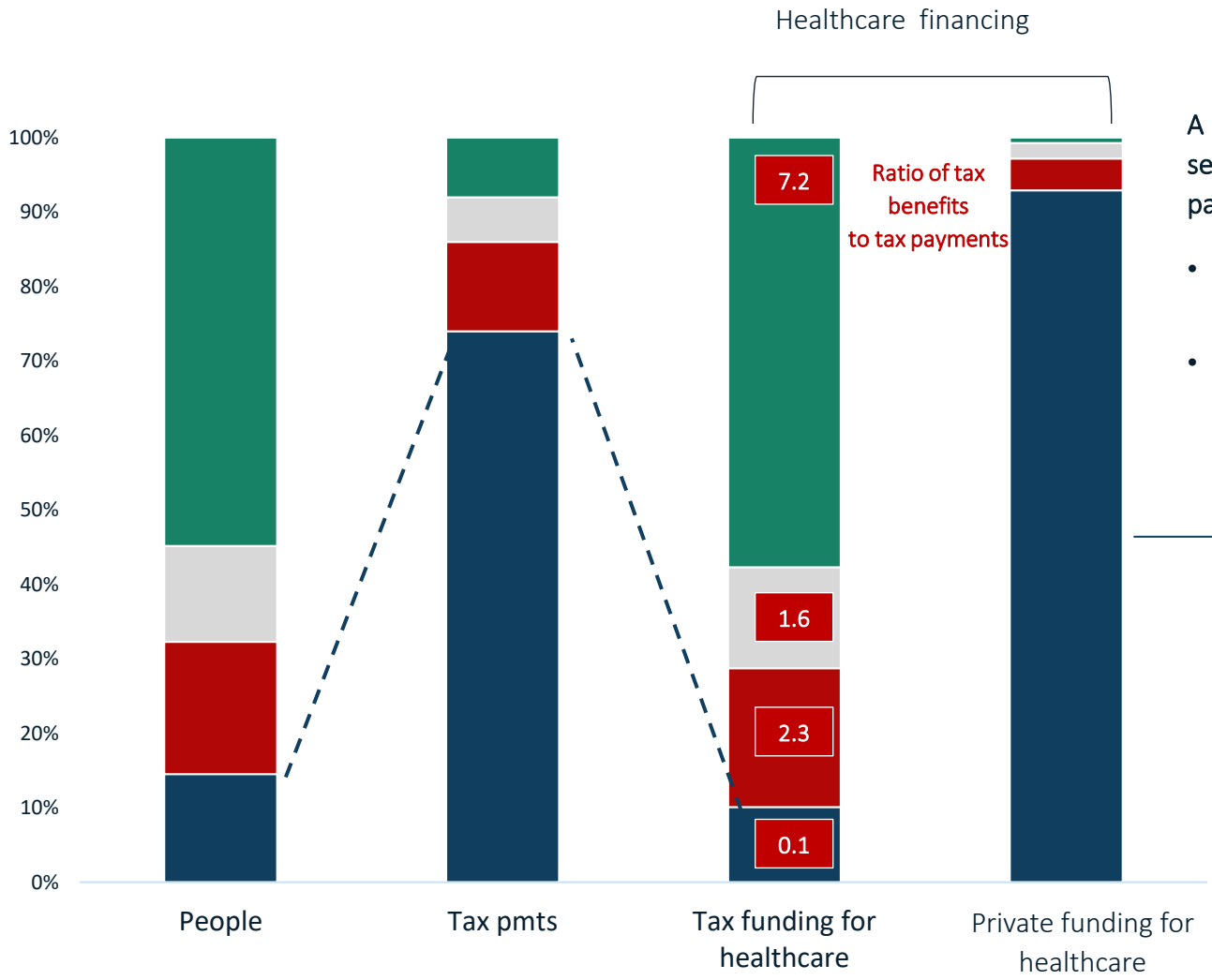
The progressivity of healthcare funding adds to the complexity of reform


Unemployed


Informal sector


Taxpayers not on medical schemes


Medical scheme members



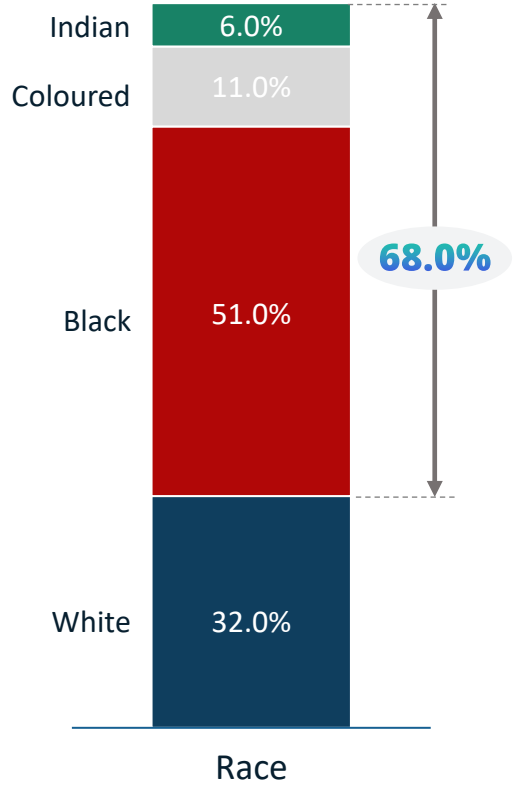
A progressive funding mechanism is highly sensitive to changes in the number of tax payers

- **14%** of people are contributing **74%** of the tax funding.
- Only medical scheme members pay more in tax than they receive in tax funded health benefits (ratio is only 10%)

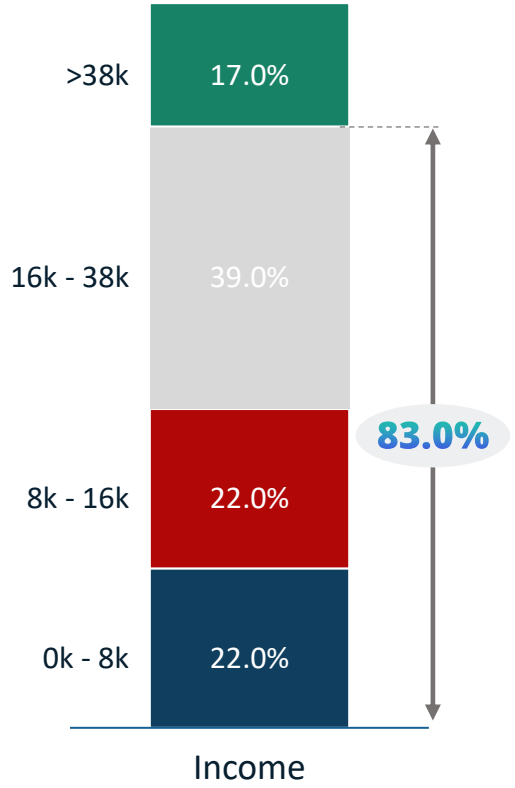
Capturing own funding as additional tax means a drop in cover of more than 50% for those paying the bulk of taxes

SA medical scheme demographics

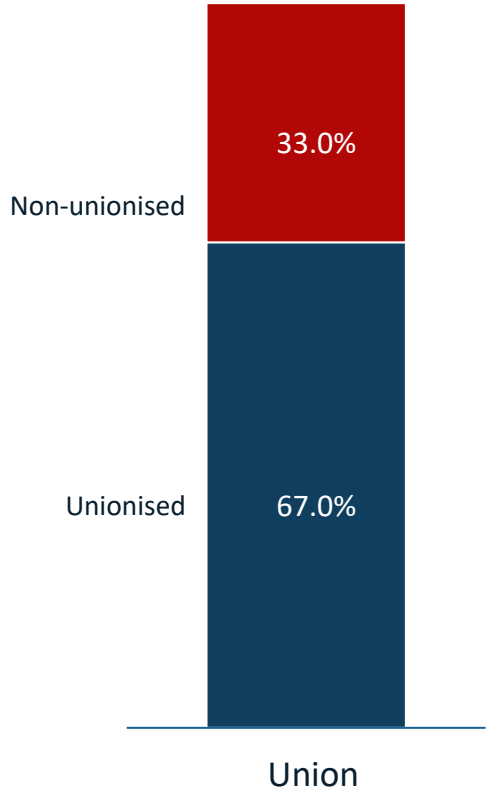
68%
African, Coloured or Indian



83%
earn < R37.5k per month



2/3
members of a union



Tax contributions

Non-Medical Scheme
R156bn
26%

Medical Scheme Members
R443bn
74%

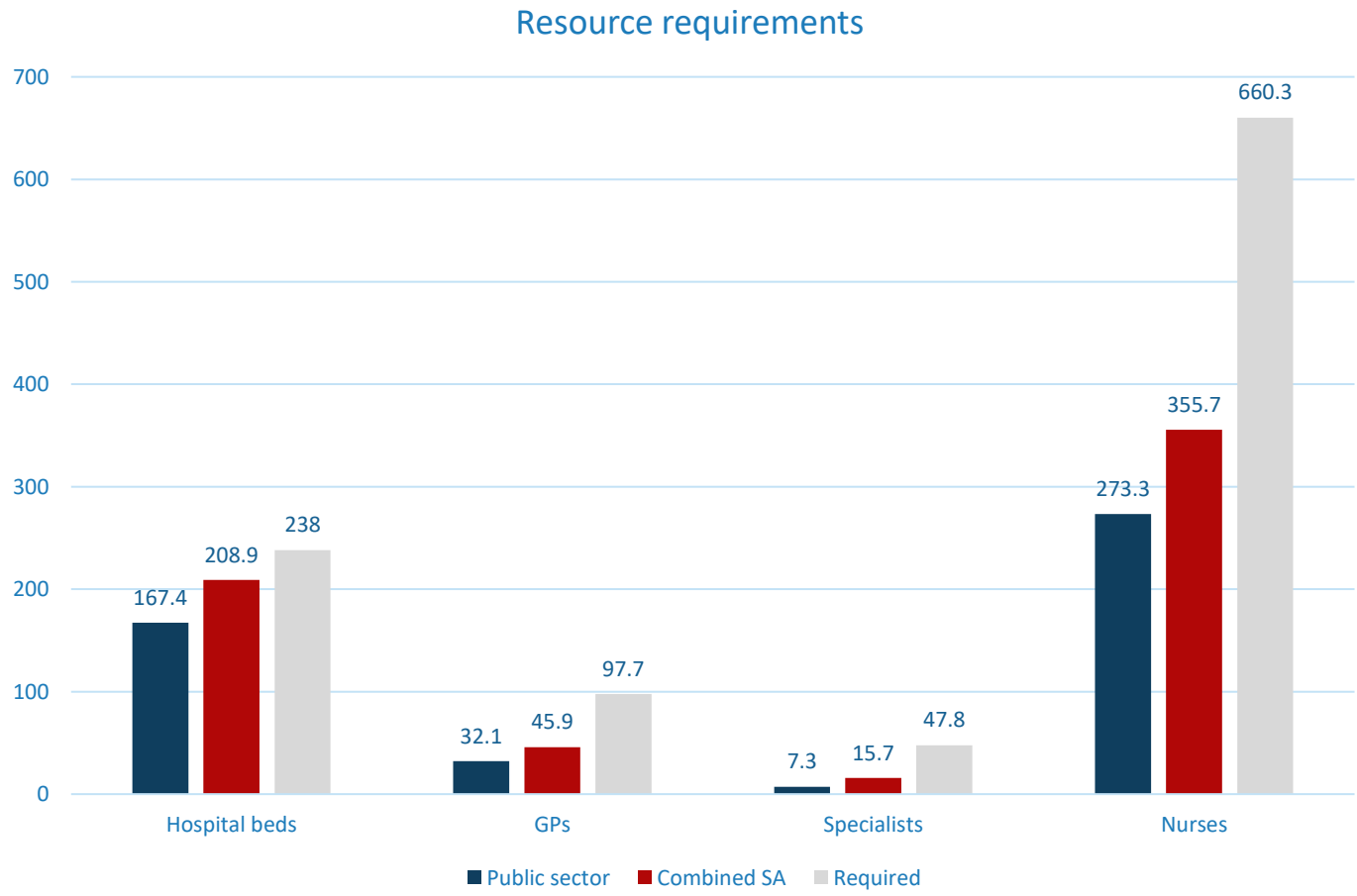
Note: Numbers are rounded off for ease of reading. Refer to Genesis Report for exact numbers.
*Source: GHS; This was calculated based on the 2023 General Household Survey ("GHS") which likely under reports the proportion of higher-income earners

HEALTH FUNDERS ASSOCIATION

G:ENESIS UNLOCKING VALUE

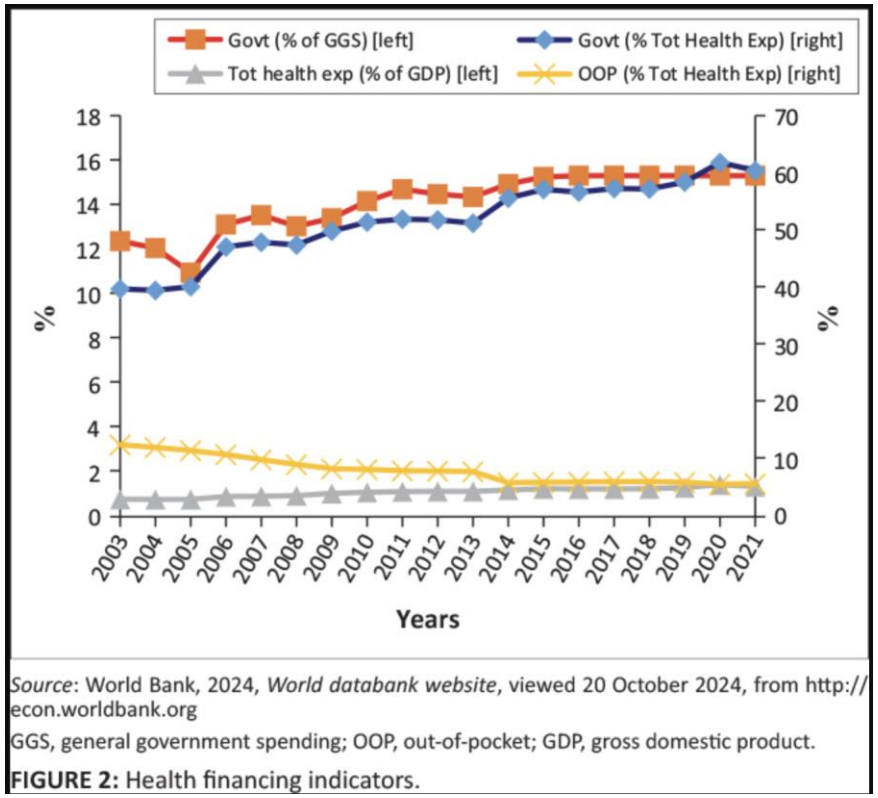
Health resource requirements for essential coverage

- Even combining public and private sector healthcare personnel does not address the resource challenges
- SA has an ageing healthcare professional population and constrained training pipeline
- Context of global shortages in healthcare resources is important



Source: Genesis Analytics

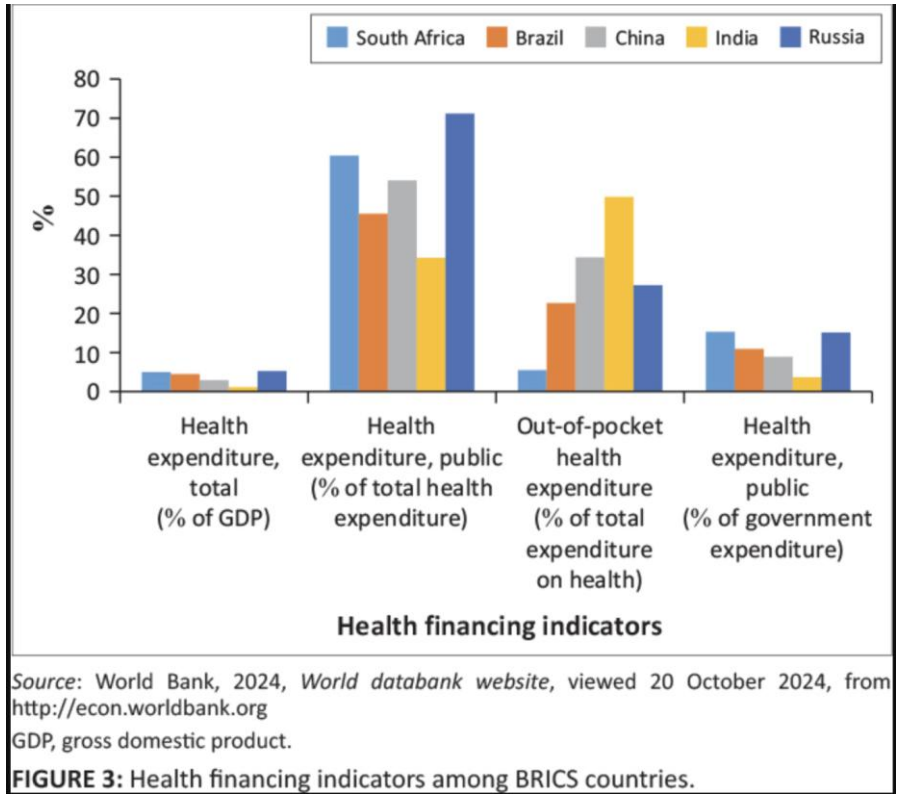
Health funding in South Africa



Source: World Bank, 2024, *World databank website*, viewed 20 October 2024, from http://econ.worldbank.org

GGS, general government spending; OOP, out-of-pocket; GDP, gross domestic product.

FIGURE 2: Health financing indicators.



Source: World Bank, 2024, *World databank website*, viewed 20 October 2024, from http://econ.worldbank.org

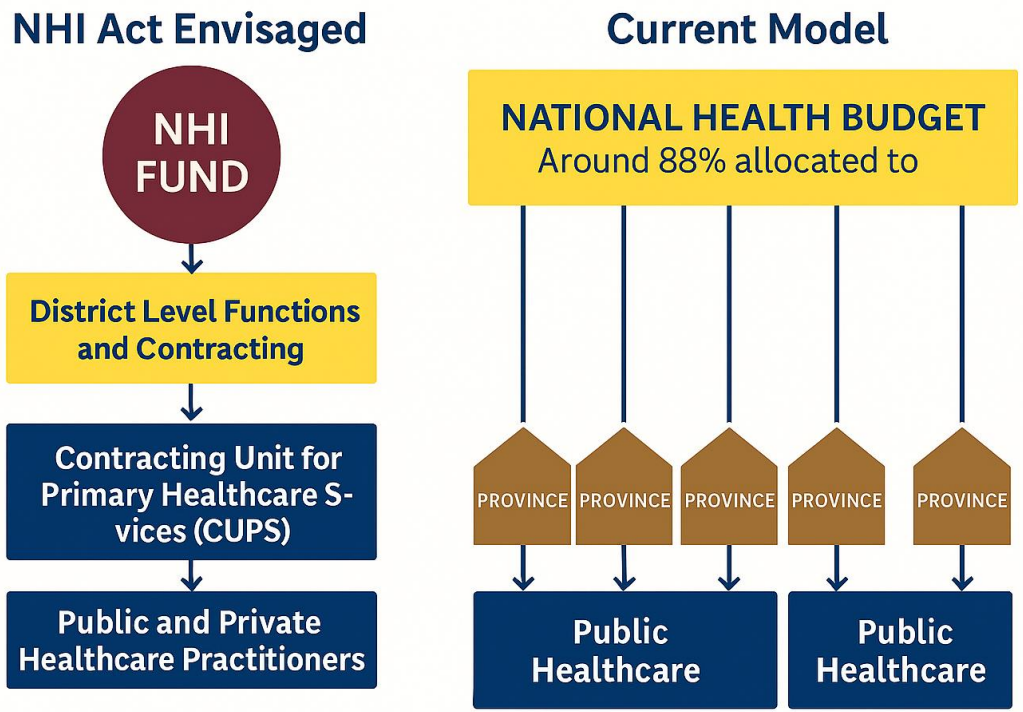
GDP, gross domestic product.

FIGURE 3: Health financing indicators among BRICS countries.

- Health budgets have not kept pace with population growth rates
- Costs for medicines and other consumables have remained above CPI
- Rising trends of population growth and life expectancy will require considerable increases in health care funding in the next decade.
- Reforms in the health sector and mobilisation of additional resources are essential for tackling disparities and access but it is also crucial to improve the efficiencies in the utilisation of these resources.

Mkhize, N.I., 2026, 'Critical assessment of health financing indicators and expenditure in South Africa', *Health SA Gesondheid* 31(0), a3142. https://doi.org/10.4102/hsag.v31i0.3142

The NHI Act envisages a centralised single fund vs current provincial financing model



Centralised NHI Fund Model

NHI Act proposes a single national fund pooling resources to promote equity and universal health access.

District-Level Contracting

Contracting Units for Primary Health Care are proposed to operate at district level, integrating public and private providers.

Current Provincial Financing

The current model allocates funds provincially, with provinces acting as both funders and providers, creating fragmentation.

Limitations of Current System

Fragmented financing limits portability, strategic purchasing, and reduces efficiency and equity.

But localised delivery models can be more responsive to population needs.

Global comparisons suggest an important role for private cover particularly in resource constrained settings

HIGH INCOME

Country	Private Insurance Role
UK	Supplementary
Finland	
Norway	
South Korea	
Sweden	
Japan	
Estonia	
Hungary	
Taiwan	
Denmark	
Spain	
Slovenia	
Portugal	
Netherlands	Mandatory
Switzerland	
Germany	Substitutive
Chile	
Canada	Complementary - services
France	Complementary - user fees

UPPER MIDDLE-INCOME

Country	Private Insurance Role
Mexico	Supplementary
Thailand	
Turkey	
Brazil	
Costa Rica	
Indonesia	
China	
Ukraine*	
Moldova	
South Africa	Proposed Complementary / No private insurance
Cuba	No private insurance

LOWER TO MIDDLE-INCOME

Country	Private Insurance Role
Nigeria	Supplementary
Kenya	
Mali	
Vietnam	
Philippines	
Ghana	

Definition:

- Supplementary: Mandatory contributions to public scheme. Private insurance is allowed, including for services covered by the public scheme.
- Mandatory: A system where all citizens are required to sign up to private insurance
- Substitutive: Individuals can voluntarily opt out of public scheme in favour of a private scheme.
- Complementary: Mandatory participation in public scheme. Citizens are only allowed to purchase private insurance to provide cover for services not included in the public scheme

Source: Genesis Analytics using health system reviews and various other online sources, as well as WHO
Notes: Only Cuba, and some provinces in Canada limit private insurance role; France allows private insurance for co-payments

NHI Act basis for a single fund model

Prohibiting medical scheme cover will:

- Enable the NHI Fund to drive down cost of care through monopsony purchasing
- Maximise income and risk cross subsidization
- Reduce the cost of administration

The purchaser / provider split will -

- Increase accountability from providers (public and private)
- Increase competition between providers
- Enable access to private sector resources

Strategic purchasing and alternative reimbursement mechanisms

- To promote more efficient care

Optimised referral protocols

- To ensure patients receive care at lowest acuity level that is clinically justifiable

Key Uncertainties in the NHI Act

Unclear Benefit Package

The exact composition of the NHI benefit package remains undefined, causing uncertainty among stakeholders.

Funding Model Ambiguity

Long-term funding sources and financial management frameworks lack clarity, creating planning challenges.

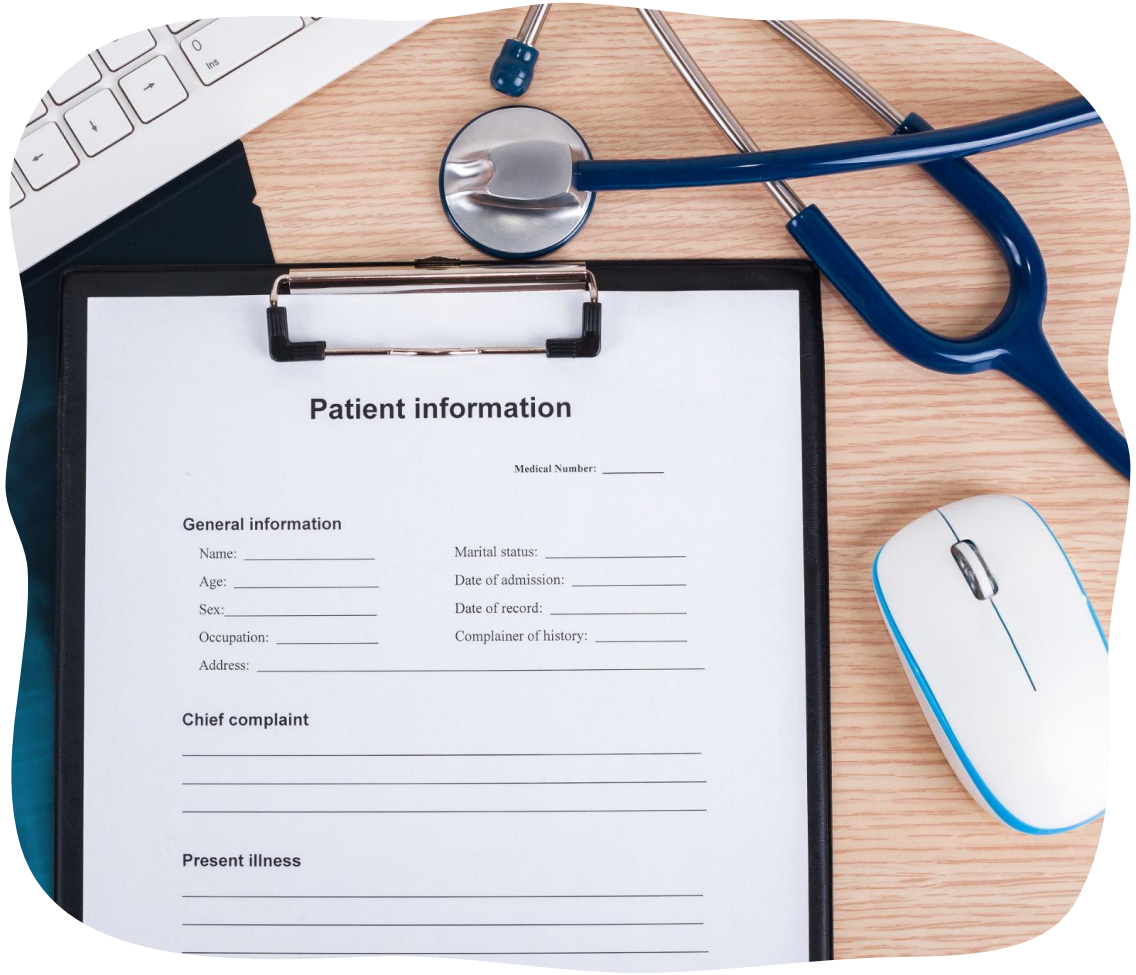
Contracting and Reimbursement

Undefined contracting arrangements and reimbursement models complicate provider engagement and system design.

Trust and Communication Risks

Discrepancies between public messaging and fiscal reality risk undermining trust among health sector stakeholders.

Early Implementation Signals from Government



Focus on Primary Healthcare

Initial NHI benefits will prioritize primary healthcare with pharmacists playing a key role in service delivery.

Hybrid Payment Models

Primary care funded by risk-adjusted capitation, with some services reimbursed fee-for-service, indicating hybrid payment approach.

Pharmaceutical Pricing Changes

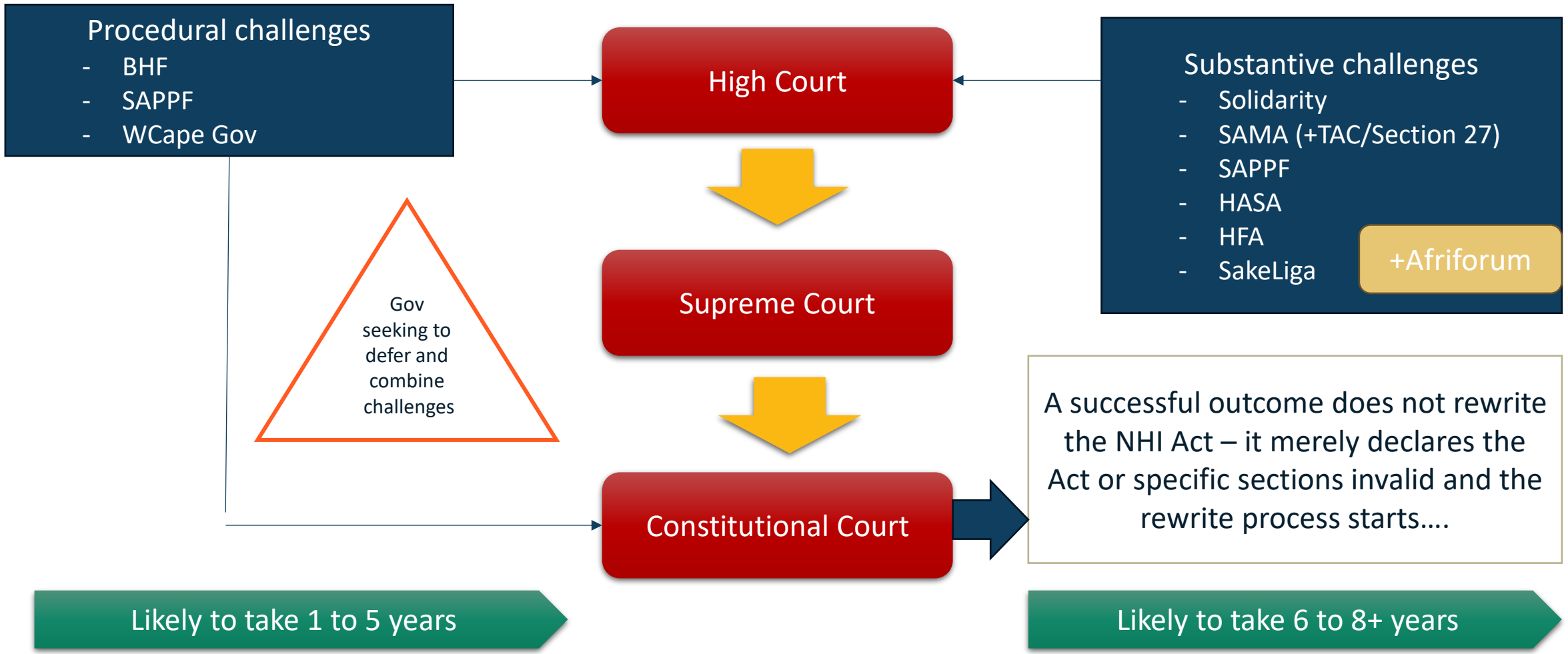
Pharmaceutical prices may be set directly by NHI Fund, diverging from existing Single Exit Price regulations.

Importance of Piloting and Monitoring

Early implementation signals highlight need for piloting, data readiness, and careful monitoring before national rollout.

The NHI Litigation Challenges

Multiple legal challenges



Minister says that full implementation will take 10 to 15 years (DDG says maybe 35)
NHI Act says must be implemented by 2028

Current status

Engagement process to find a workable model

	Procedural A (Parliament)	Procedural B (President)	Substantive
Litigants	W Cape Gov BHF	BHF SAPPF	HFA HASA SAMA SAPPF Solidarity Sakeliga
Current status	Directions issued regarding sequencing of cases ConCourt 5-7 May	Postponed indefinitely (Will follow Procedural A)	**24 Feb 2026** : Consolidation and deferral case consent order pauses proclamation and implementation of the Act until procedural challenge A ruled upon

Key legal arguments

Procedural challenges

- The Constitutional Court prioritized challenges to Parliament's public participation before addressing the President's signing of the NHI Act.
- Parliamentary process needed to consider all inputs
- Provincial input in light of change in function
- Sufficient information required for effective public participation
- If the public participation is found unconstitutional, the Act could be invalidated or require parliamentary reconsideration, causing delays.
- President's requirement to confirm that there are no constitutional flaws

Substantive challenges

- Multiple constitutional flaws relating to a reasonable approach to expand access to care within available resources and
- Limitations of rights are only permitted if there is no reasonable alternative mechanism
- Remedies sought range from outright declaration to various proposed amendments

The Constitution of SA

Section 27

(1) Everyone has the right to have access to—
(a) **health care services**, including reproductive health care;

(b) **sufficient food and water**; and

(c) **social security**, including, if they are unable to support themselves and their dependants, appropriate social assistance.

(2) The state must take reasonable legislative and other measures, **within its available resources**, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.

Section 36

(1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including—

(a) the nature of the right;

(b) the importance of the purpose of the limitation;

(c) the nature and extent of the limitation;

(d) the relation between the limitation and its purpose; and

(e) less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

Legal arguments

Parties	Status
Trade Unions	
Solidarity	• Action launched in May 2024 • NDoH response filed 27 November 2024
Funders	
BHF	• BHF review application heard in March 2025 (positive jurisdictional ruling 6 May 2025) • President granted leave to appeal • Substantive action may follow
HFA	• Substantive action launched 4 June 2025
Healthcare professionals	
SAPPF	• Action launched on 1 October 2024 and part of successful jurisdictional argument in High Court (ruling 6 May 2025)
SAMA	• Action launched 1 April 2025
Hospitals	
HASA	• HASA action launched Feb 2025 • Papers not in public domain

Remedies sought:

Some seeking to declare the NHI Act invalid for being inconsistent with constitution (procedure, rationality, reasonableness)

Others focusing on specific sections:

- Section 3: Remove exclusion of the Competition Act
- Section 4: Amend limitations for asylum seekers
- Section 7: Amend to remove reliance on referral pathways
- Sections 11 & 26: Amend to ensure that the contracting provisions are sustainable for healthcare providers
- Section 31: Amend to reduce concentration of power
- **Section 33: Amend to allow medical schemes to collaborate with the public sector**
- Section 49: Remove this section – requires a Money Bill
- Section 57: Amend to provide clear milestones for phased implementation in terms of access to care
- Section 58: Remove this section and subject changes to

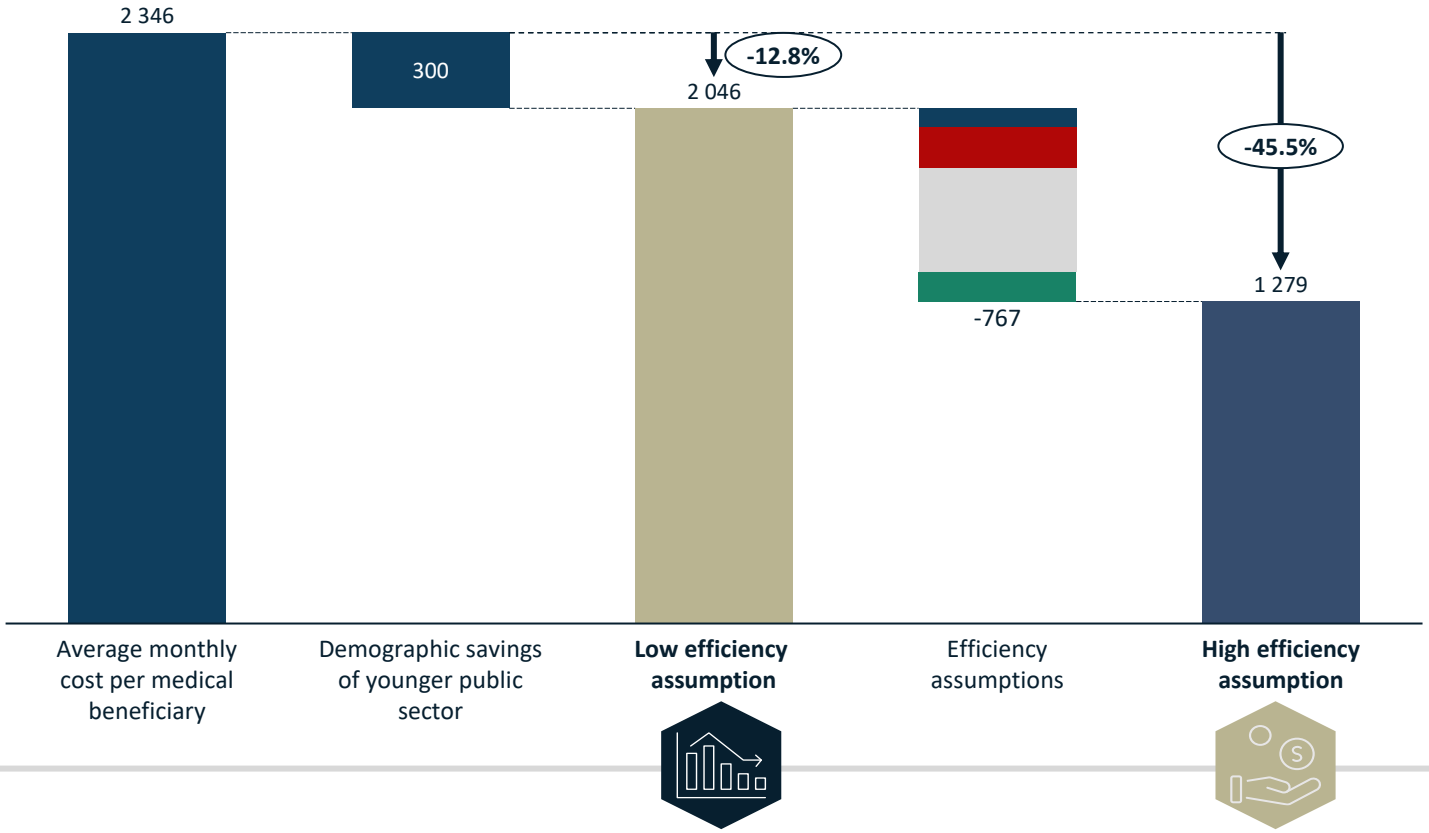
BUSA seeking engagement with the Presidency on a parallel, multi-stakeholder process to amend NHI Act to make it workable

Efficiency assumptions for financial modelling

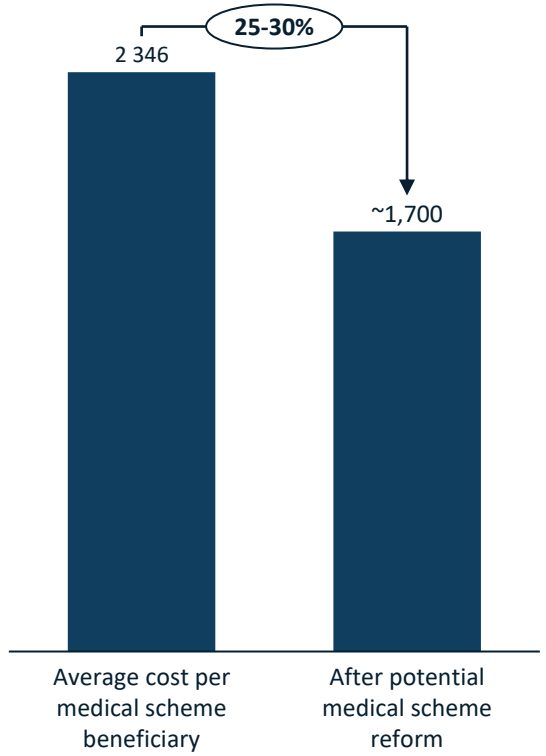
Rands per Person Per Month

EFFICIENCY ASSUMPTIONS

45.5% is a very ambitious savings assumption; Less savings means higher NHI cost



COMPARATOR: POTENTIAL IMPACT OF MEDICAL SCHEME REFORM BASED ON HMI RECOMMENDATIONS*



Note: Numbers are rounded off for ease of reading. Refer to Genesis Report for exact numbers.
At the time of the analysis 2022 data was the latest available data from CMS. Calculation has been based on medical scheme costs since this is where the data is available.

* Source: Insight Actuaries comparative analysis

Summary of modelled scenarios

		SHARED RESOURCES	COMPREHENSIVE CARE
HIGH EFFICIENCY SAVINGS (45,5%)	Increase in personal tax	+47% (x 1.5)	+115% (x 2.2)
	Benefit level relative to comprehensive care	-43%	~
	Health expenditure as % of total Govt. expenditure p.a.*	22%	33%
LOW EFFICIENCY SAVINGS (13%)	Increase in personal tax	+47% (x 1.5)	+208% (x 3.1)
	Benefit level relative to comprehensive care	-65%	~
	Health expenditure as % of total Govt. expenditure p.a.*	22%	44%

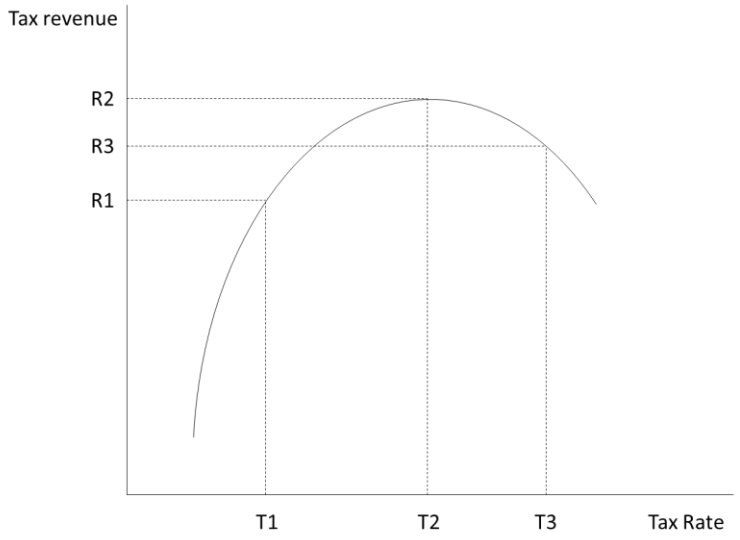
ADDITIONAL POTENTIAL ADVERSE SCENARIO BASED ON HFA MODELLING

Prohibition of medical schemes with tax increases below threshold of 25% could result in ***lower healthcare access for both public sector healthcare consumers and medical scheme members*** (based on different demographic risk and consumption patterns)

Note: Numbers are rounded off for ease of reading. Refer to Genesis Report for exact numbers.
*Assumes that 100% of increase in tax revenue is allocated to health; Target: The Abuja Declaration target is 15% of Gov expenditure on health. Impact is that other social priorities and SDOH (healthcare access and quality, education access and quality, social and community context, economic stability, and neighbourhood and built environment) are ignored.

Feasibility of raising taxes

Laffer curve: higher taxes do not guarantee higher revenue



- Recent experience demonstrates that tax increases struggle to increase revenue
- Tax increases constrain economic growth

Limited capacity for tax increases

- Recent PIT experience (and other taxes) – revenue yield below expectations
- Narrow tax base
- Adverse impact of tax increases on long-term growth

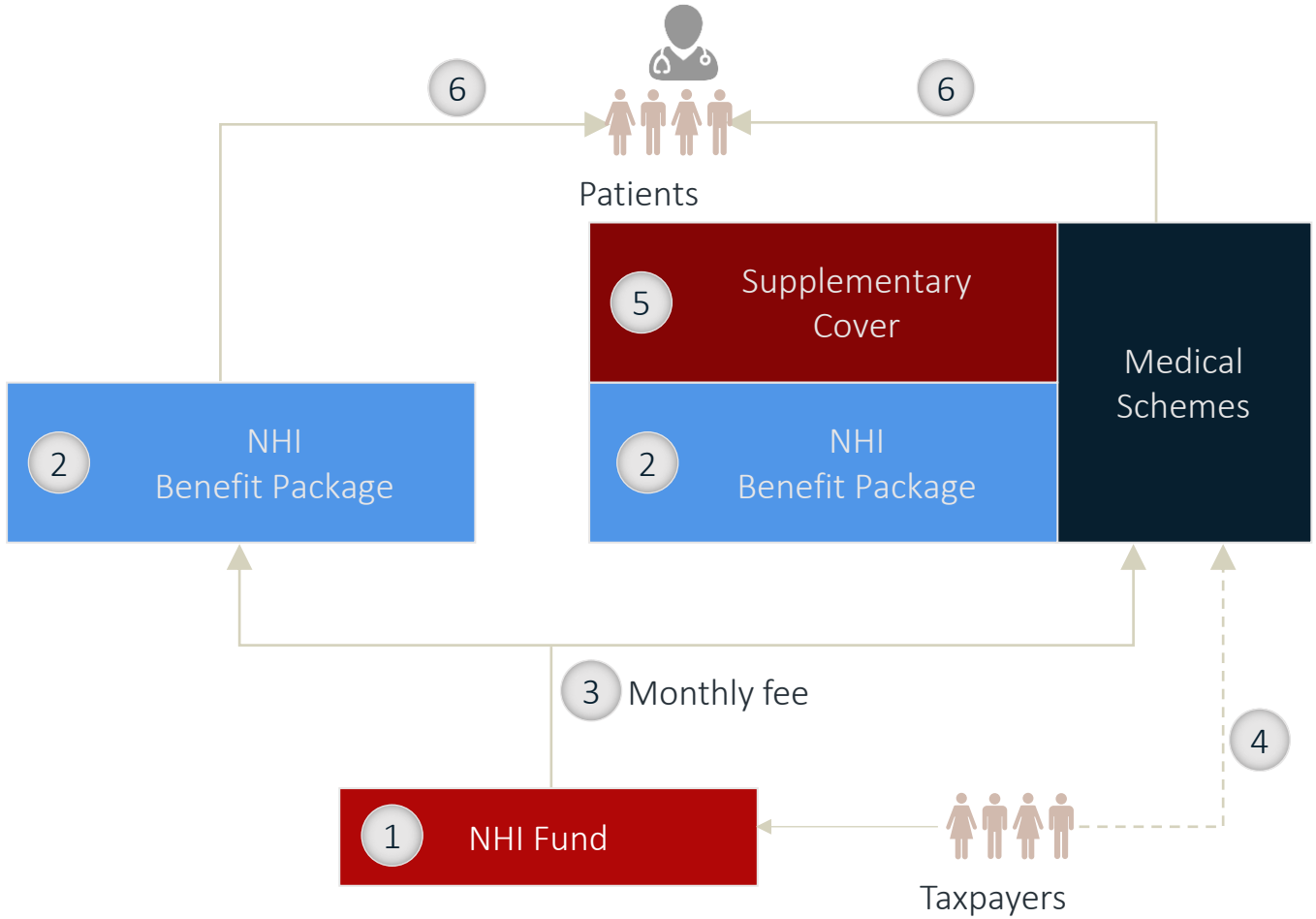
Gov debt burden is high and rising

- Health is not the only (or even the top) societal imperative for increased spending

Economic growth not adequate to sustain comprehensive NHI model

- Requires 37% real growth in GDP (45 years at 10 yr ave growth rate)

Example of Hybrid multi-fund model



1. Tax based contributions to NHI Fund
2. Common NHI benefit package covers benefits at public and private providers
3. NHI monthly fee paid to medical schemes is at less than cost of NHI package (social cross-subsidy), with the difference paid from medical schemes
4. Voluntary contributions by members opting in to medical scheme cover
5. Medical scheme members have access to NHI benefit package and supplementary cover
6. Providers (Public & Private) are contracted and paid from NHI Fund and / or Medical Schemes. Under a common contracting framework for the NHI package

Why a single fund does not necessarily achieve equity

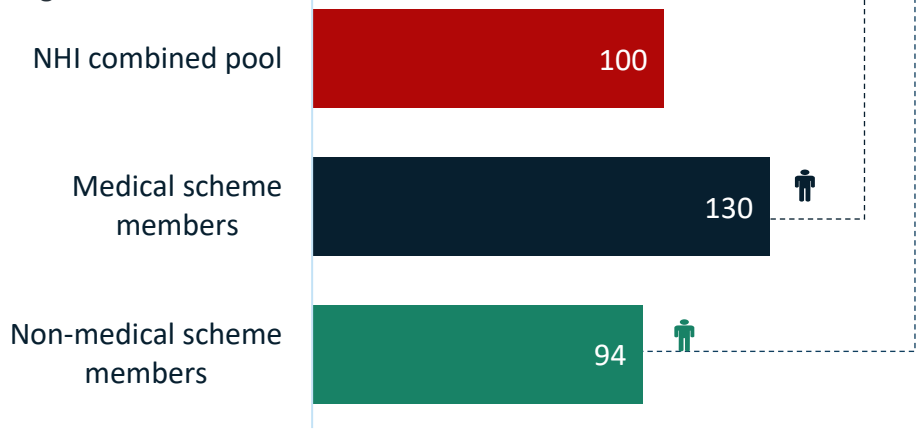
Single fund

NHI Fund

Medical scheme members:

- Worse demographics (older population)
- Higher healthcare utilisation (all else equal)
- Use disproportionate share of funds, leaving less for non-medical scheme members

NHI Fund – average cost per person for a common benefit package



Multi-fund model

Medical Schemes

- NHI monthly fee paid to medical schemes, which is discounted to R80 for example
- Difference between the R80 and R130 is covered by voluntary contributions to supplementary cover

~~R100~~
R80

Non-medical scheme

- Non-medical scheme members benefit by receiving a R104 allocation which is higher than the previous R94 allocation, for same amount of public funding in total

~~R94~~
R104

Improved NHI Fund – average cost per person for a common benefit package

- Saving results in 10% higher allocation for the vulnerable in particular those with income less than R30k per month
- The effect increases as affordability of supplementary cover / economic growth increases medical scheme population

Note: Numbers are illustrative and simplified to explain the concept. Separating the risk pools with social solidarity cross subsidy is more equitable than a single risk pool.

Health System Strengthening Despite the Pause

Ongoing Infrastructure Investments

Investments in hospital infrastructure and digital health systems continue independently of the NHI Act pause.

Priority Health Projects

Focus on HIV prevention, HPV vaccination, child stunting, and alcohol abuse reduction remain key health initiatives.

Policy and System Resilience

Health system improvements can progress toward universal health coverage beyond financing reforms.

Training and employment opportunities are critical for building the health workforce

Collaborative approach can unlock opportunities e.g. progressing primary care cover

ASSA Role

ASSA's Position on NHI and Universal Health Coverage

Support for Universal Health Coverage

ASSA endorses universal healthcare access without financial hardship as a vital social objective.

Complexity of Healthcare Reform

Healthcare reform requires long-term planning, robust data, and sequenced policy changes to be effective.

Sustainability and Evidence-Based Approach

ASSA emphasizes sustainable funding, protecting capacity, and avoiding abrupt policy shifts to maintain service delivery.

Risks of Unrealistic Timelines

Unrealistic timelines and uncosted promises can undermine access and financial protection in healthcare reforms.

Model development

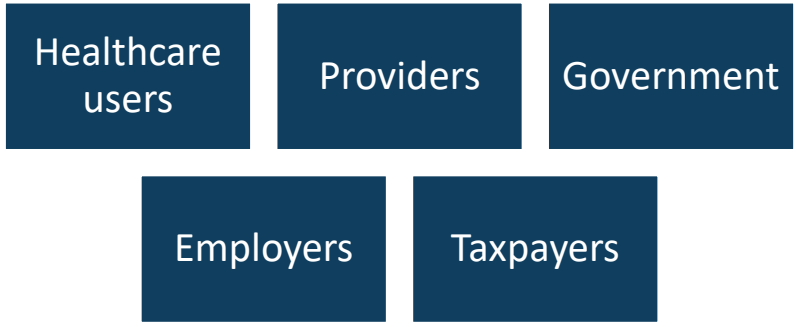
- The ASSA NHI model was first developed in 2010 to provide constructive input to the policy development process
- The model considers demographics, benefit costs and resource requirements
- Data collection process to facilitate costing – lack of public sector data is a key challenge
- Population calibration and sensitivity analysis

Human resources for health (HRH)

- Assessment of healthcare workforce
- Blending public and private sector data sources

Policy risk assessment (ERM project)

- Policy implementation/ alignment
- Fiscal feasibility
- Out of pocket expenses (transition)
- Benefit definitions and access
- Resource constraints
- Operational and systems access



Stakeholder Perspectives and Key Takeaways

Support with Fiscal Caution

Business groups and ASSA support Universal Health Coverage but warn against fiscal unsustainability and disruptions in access.

Public-Private Collaboration

Stakeholders advocate for pragmatic multi-payer or hybrid models leveraging both public and private healthcare capacities.

Evidence-Based Policy Making

ASSA brings modelling and risk expertise to provide robust input on costs, risks, and trade-offs for policy guidance.

Role of Actuaries

Actuaries play a key role in ensuring reforms improve access and equity without compromising sustainability or quality.