Strengthening universal health coverage through the NHI: A response to recent critique

To the Editor: Van den Heever's recent *SAMJ* article[1] on universal health coverage suggests that the National Health Insurance (NHI) model risks centralisation and may undermine subsidiarity. While this concern deserves reflection, it appears to understate how the NHI Act No. 20 of 2023 embeds stronger local accountability while addressing the persistent inequities that continue to define South African (SA) healthcare. I write here in my personal capacity, though I am a member of the NHI implementation team at the National Department of Health.

The Act represents the culmination of a policy arc stretching back three decades. The ANC's National Health Plan of 1994 proposed a 'single comprehensive, equitable and integrated National Health System' to unify the fragmented apartheid-era system.[2] The 1997 White Paper on the transformation of health services then emphasised district-based care, decentralisation and pooling of both public and private resources.[3] The NHI Act can be read not as an abrupt departure but as a legislative maturation of these foundational principles.

A single national fund may seem heavy-handed in a diverse federation, yet the status quo is demonstrably unjust. In the early 1990s, half of all health spending accrued to just 20% of the population, covered by medical schemes. Today, inequities persist. The District Health Barometer 2022/23 shows that per capita non-hospital primary care expenditure in the highest-funded district (Sedibeng) is ZAR1 036, v. the lowest-funded district (Sarah Baartman) at ZAR504.[4] Such disparities entrench privilege and reproduce apartheid geographies of health. Fragmented provincial pools and multiple medical schemes shield well-off groups while limiting solidarity. If equity is the goal, risk pooling at national scale is not simply desirable – it is unavoidable.

On subsidiarity, the Act goes further than acknowledged by van den Heever. It creates contracting units for primary healthcare (CUPs) that tie clinics and private providers to a district hospital anchor as a planning tool, ensuring that care is organised at a very local level. It also mandates direct transfers to accredited hospitals and primary care providers, bypassing excessive bureaucracy, and establishes district health management offices (DHMOs) as statutory bodies with an accounting officer who in law is substantially accountable to district health councils (compared with the current situation, where s(he) is an appointee of the provinces). In practice, this architecture situates decision-making as close as possible to communities while using the national fund to equalise resources.[5]

SA is not alone in this direction. It follows on the internationally accepted direction of financing, including pooling and strategic purchasing, which puts people first.[6] The NHI's design is not only historically grounded but internationally validated.

Implementation will be difficult. The district health system will require substantial technical support, and district governance must mature quickly. The transition will face resistance from vested interests defending the privileges of fragmented pooling. Yet the alternative – accepting a two-tiered system that locks in inequality – is far worse. The Constitution obliges us to pursue equity; the NHI Act is the clearest legislative attempt to meet that mandate since 1994. The challenge is not whether to implement, but how to do so effectively.

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