

National Health Insurance



**SAAFP 27th National Family Practitioners Congress
5th – 6th September 2025
Midrand Conference Centre, Gauteng**



**“LEARNING AND PRACTICING FAMILY MEDICINE AND
PRIMARY HEALTH CARE IN AN ERA OF GLOBAL CHANGE”**

www.health.gov.za/nhi/



Saturday 06 September 2025



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Part 1: Why reform?

Part 2: What is NHI all about and what is in the Act?

Part 3: What are we doing in NDOH?

Part 4: What does the Act say about financing?

Part 5: How do we transition to NHI?



- President Ramaphosa assented to the National Health Insurance Act (NHI), 2023, on **15 May 2024**. This marked the culmination of a lengthy legislative process that commenced in 2019 with the tabling of the Bill in Parliament.
- After delays due to the Covid-19 pandemic, the National Assembly passed the amended bill in June 2023, after which the National Council of Provinces (NCOP) took over the process. Some 60 community consultations were held in all nine provinces. The NCOP adopted the bill by a majority of eight provinces to one in December 2023.
- Now that we have reached this critical milestone, we are able gradually to phase in the NHI using a progressive and programmatic approach based on financial resource availability, as required in the Act. The NHI must be implemented in two phases, phase 1 from 2023 to 2026 and phase 2 from 2026 to 2028.



PART 1:

Why reform?

What are we aiming to 'fix'?

**Why massive systemic health sector reform
is needed**



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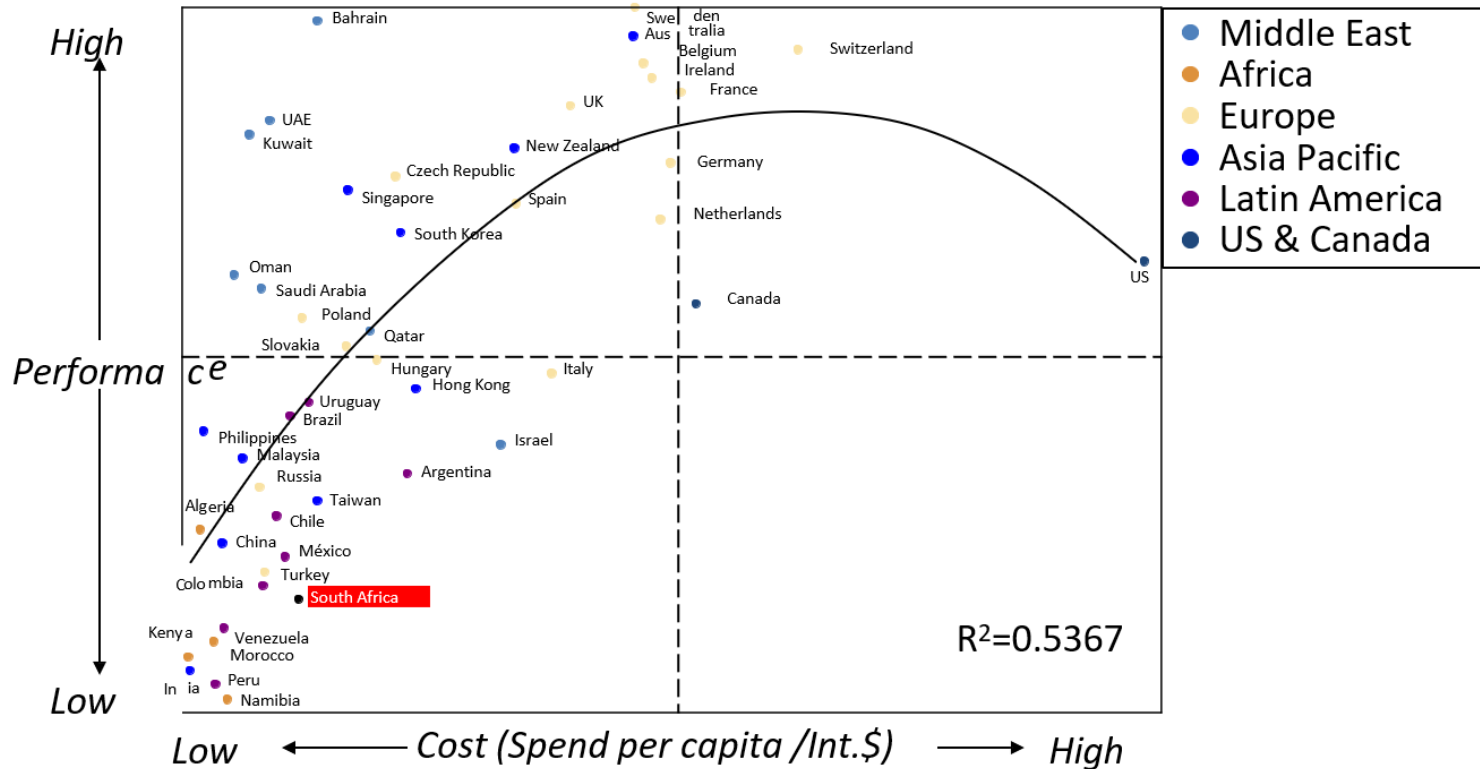


OVERALL, SOUTH AFRICA GETTING POOR PERFORMANCE RELATIVE TO COST

Countries sitting above the trend line are producing relatively better performance for the cost per capita inputs that they are investing



Performance vs. Cost Comparison, 2008



Note: Trend line is a polynomial
Source: Discovery Health Pool Stream Database, Monitor Analysis

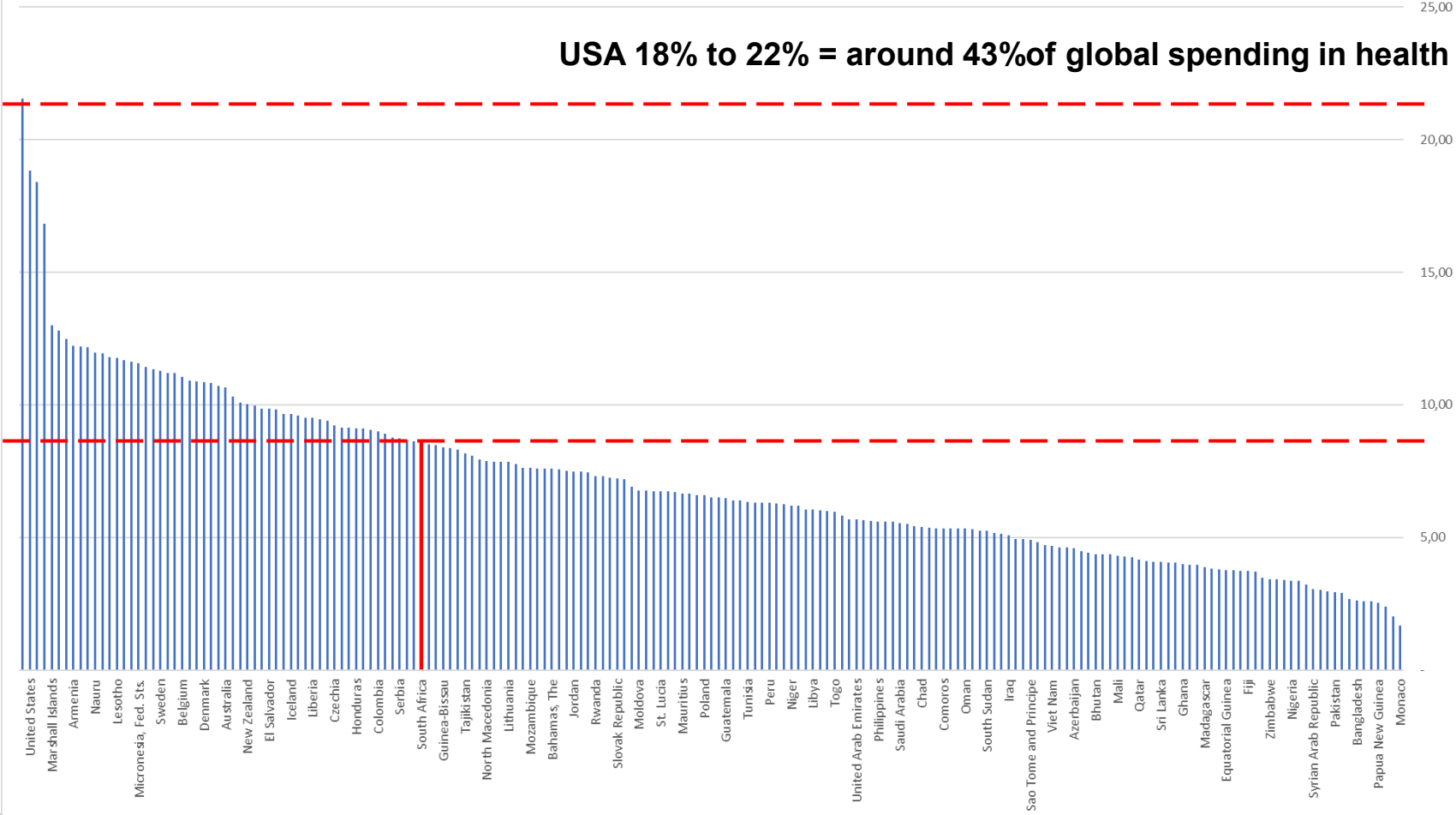
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World Bank Report %GDP on Health

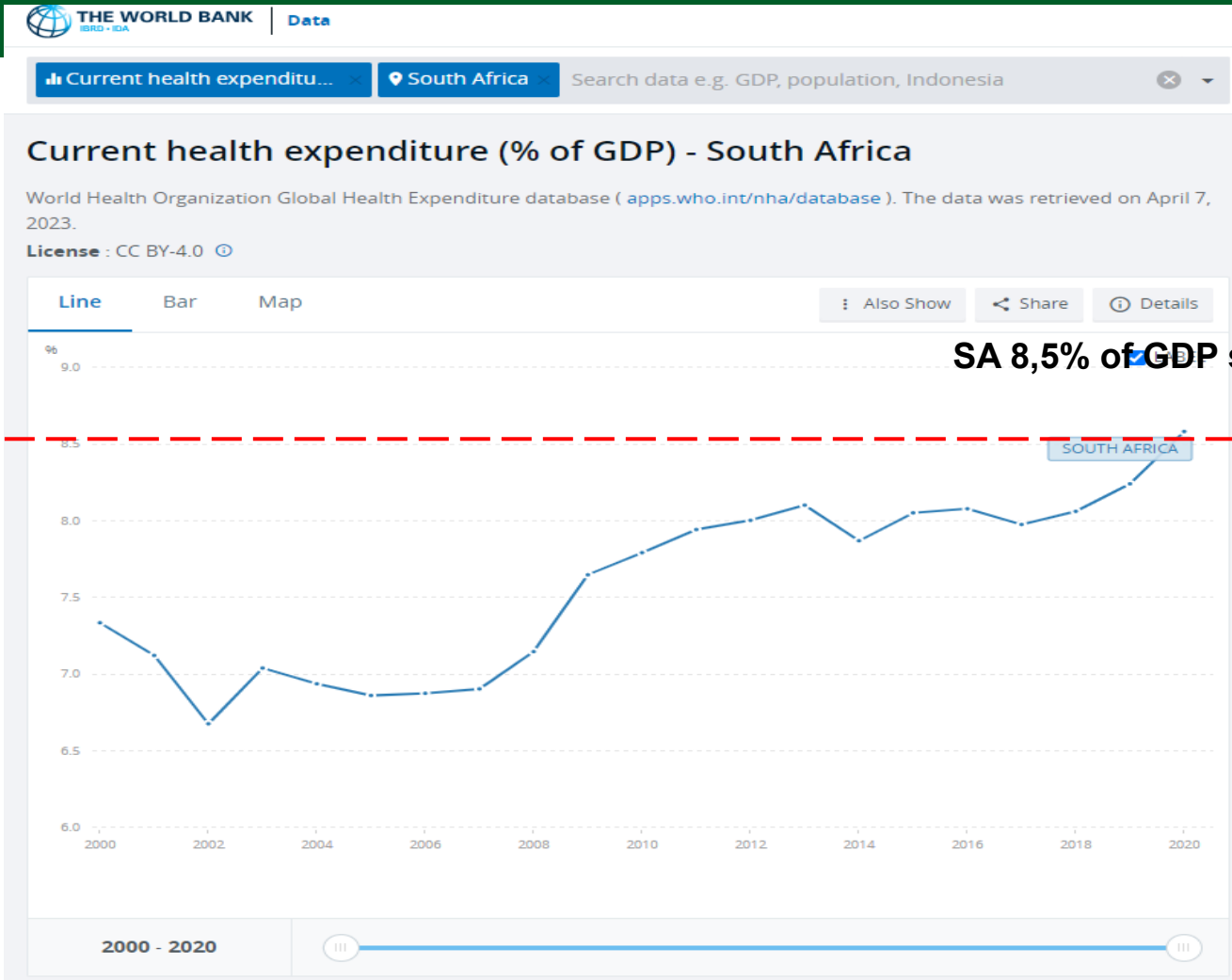


%GDP on Health (Most Recent Value)

USA 18% to 22% = around 43% of global spending in health



World Bank Report RSA %GDP on Health



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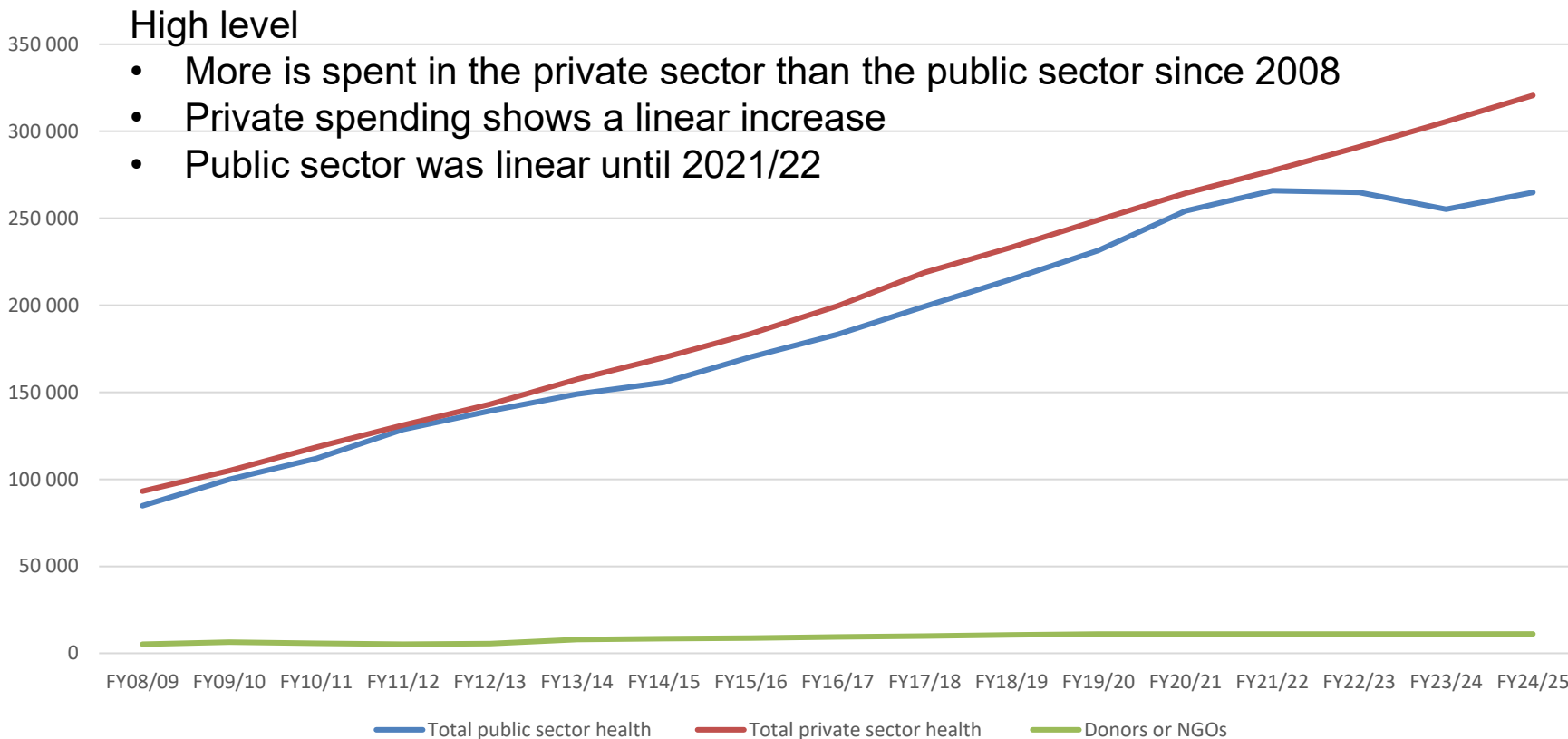
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Inequitable health sector funding trends over the past 15 years



TOTAL HEALTH SPENDING SOUTH AFRICA (RAND) (FY08/09 TO FY24/25)

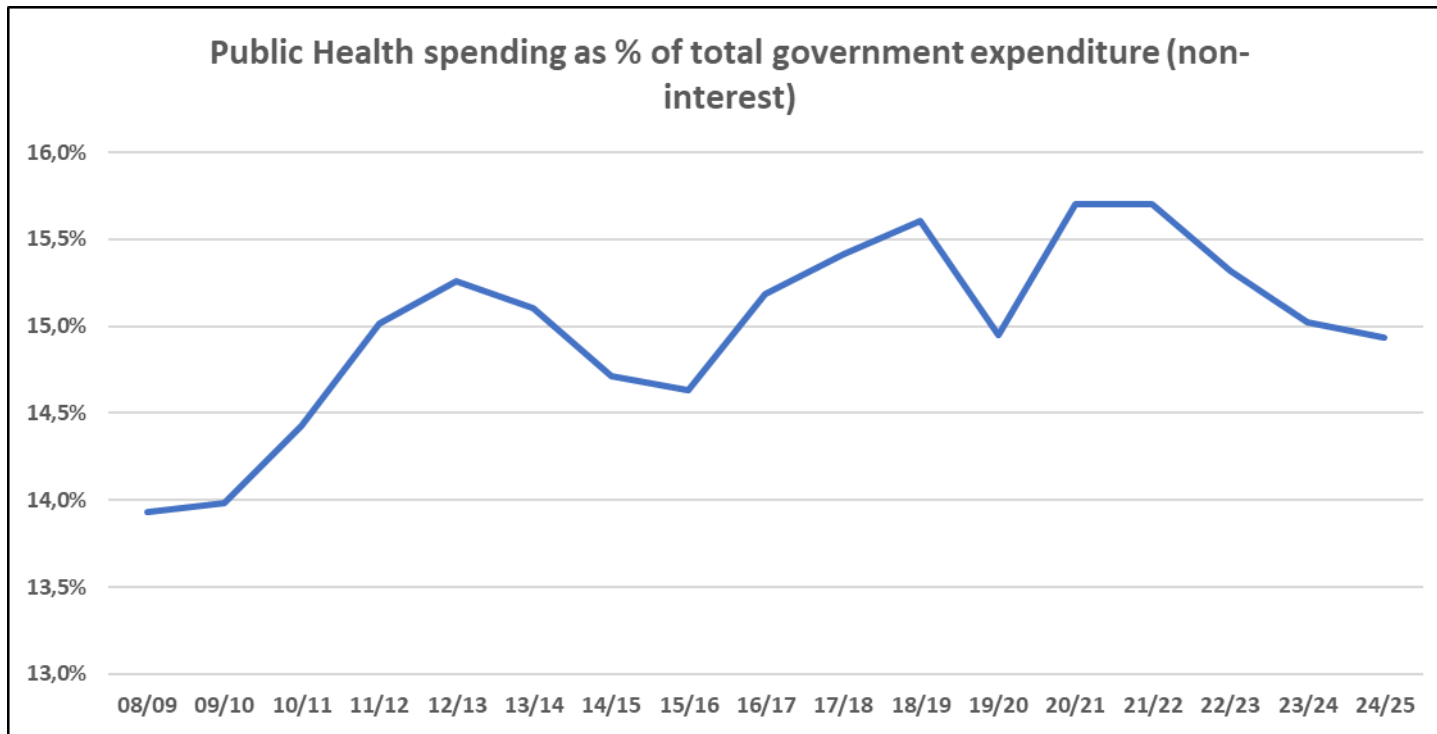


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Government spend on health



High level

- Spending by government on health has increased as a % of allocations from the fiscus (from 14% to 15,5% and **now at around 15%**)



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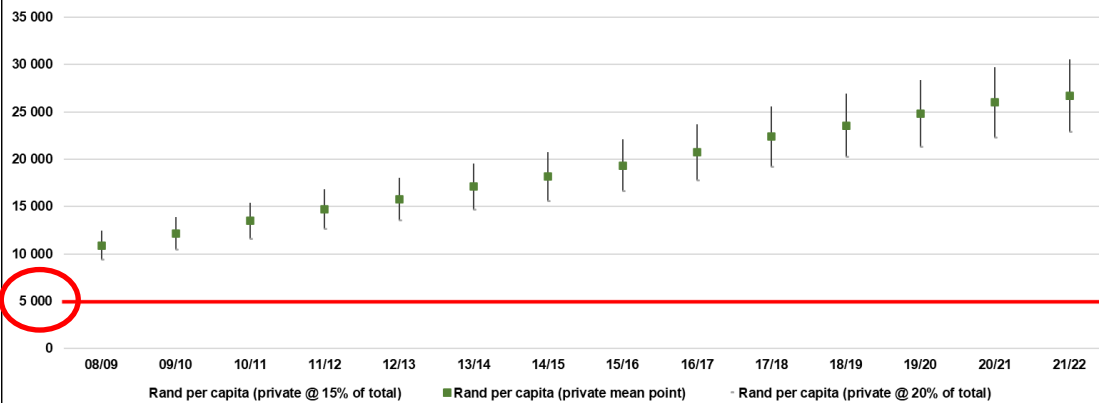
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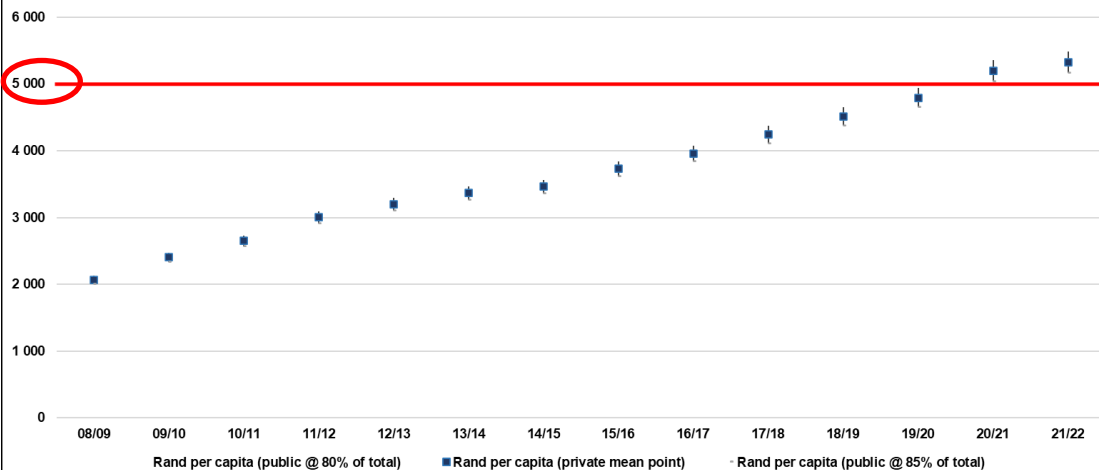
Per capita spending on Health 2008/09 to 2021/22



ESTIMATED PRIVATE PER CAPITA HEALTH SPEND (2008/09 to 2021/22)



ESTIMATED PUBLIC PER CAPITA HEALTH SPEND (2008/09 to 2021/22)



Rand per capita spend on health

- public @ 80% and private at 20% of total
- mean point Rand per capita
- public @ 85% and private at 15% of total

2021/22 FY

- **Private spend per person is 5,0 times that of public**
- Range 4,4 to 5,6 times depending on proportion of the population regularly using private providers

Per capita spending on Health 2021/22

Rand per capita (private @ 15% of total)	R30 515
Rand per capita (private mean point)	R26 700
Rand per capita (private @ 20% of total)	R22 886
Rand per capita (public @ 80% of total)	R5 483
Rand per capita (private mean point)	R5 322
Rand per capita (public @ 85% of total)	R5 161



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Administrative cost of maintaining medical schemes

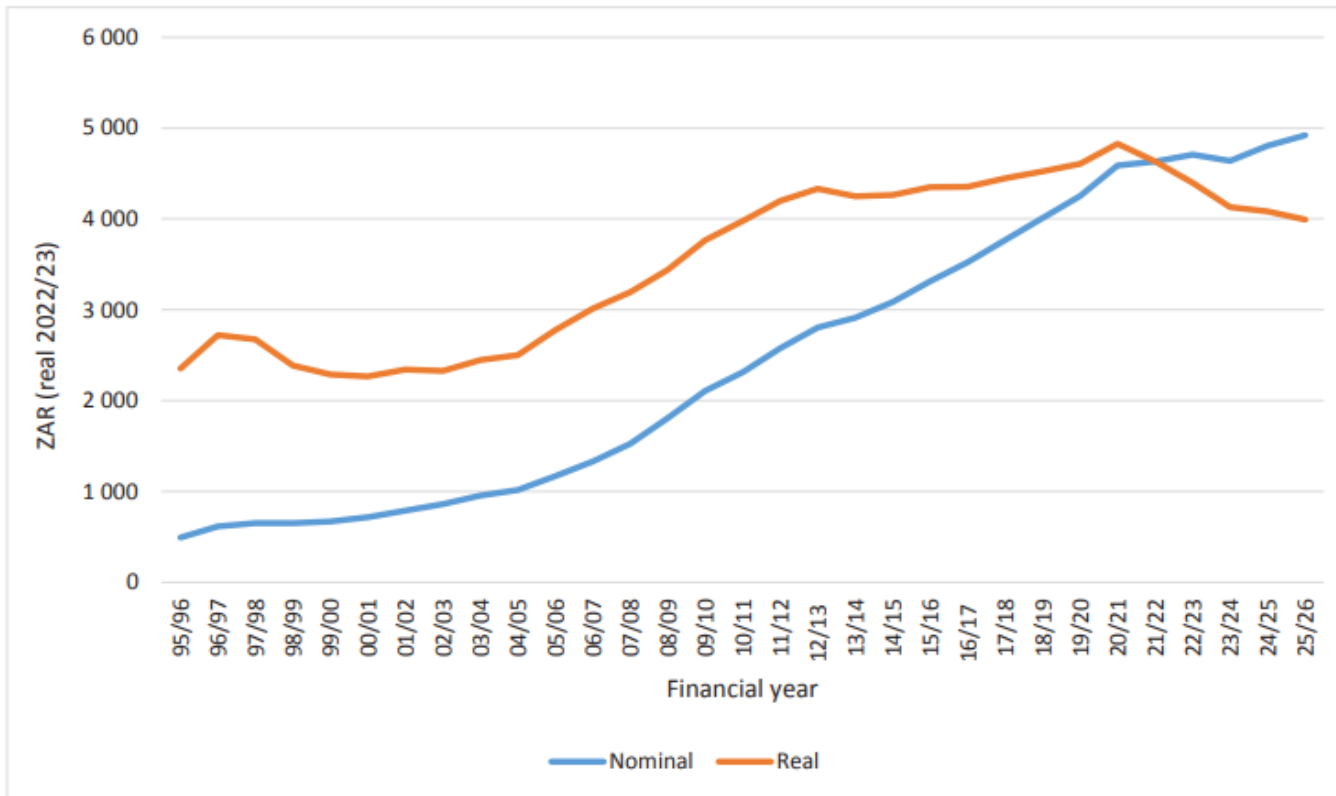


- At the start of 2024 there will be 71 schemes offering 311 'options'
- Schemes had 833 trustees in 2022, at a cost of over R104m
- Principal Officers cost almost **R140m** (several paid over R6m per annum)
- **Gross administration cost of schemes was almost R21bn (9% of R230bn)**
- Despite this cost the reported fraud, waste and abuse in 2023 was R28bn in one year (around 6 times the AGSA reported unauthorised expenditure in the public sector)
- The problem is massive perverse incentives with such complex pathways that are easy to defraud

Declining allocation to public health services



Figure 1: Provincial health expenditure per capita, 1995/96–2025/26



Real public health expenditure (allocations from fiscus) per capita are decreasing since 2019/20

Source: Authors' calculations based on published provincial budgets

Summary of what we need to fix



- There is plenty of money being spent on health care in the country
 - >8,5% of GDP
 - R543 246bn public and private spend (2021/22)
 - Including donors R554 341bn (2021/22)
- Duplication is costly
 - Public 10 DoHs, SAMHS, others, plus 71 medical schemes (311 options)
 - Increases administration, creates perverse incentives, increased fraud, poor coordination of care
- Inequity of access to resources
 - Concentration in private sector
 - Intra-provincial and inter-provincial public inequity of resource allocation
 - Massive quality disharmony
- Poor systems for coordinated data management
 - Difficult to change direction, strategic planning and strategic purchasing



PART 2:

What is NHI all about?

What the NHI aims to achieve
What the Act provides for by way of a statutory mandate

Equity vs equality

If fairness is the goal, equality and equity are two processes through which we can achieve it

- **Equality** simply means everyone is treated the same exact way, regardless of need or any other individual difference
- **Equity** means everyone is provided with what they need to succeed

What is National Health Insurance (NHI)?



- NHI aims to achieve Universal Health Coverage (UHC) for all who live in South Africa
 - “Every person gets the quality health care that they need, when they need, where they need and without incurring financial hardship”
- NHI (National Health Insurance) is a **health financing system** that is designed to pool funds to provide access to quality affordable personal health services for all South Africans, based on their health needs, irrespective of their socio-economic status
- Note:
 - The NHI Bill (Act) goes beyond enabling financing and enhances/amends the National Health Act – but **does not repeal it**
 - The NHI Bill (Act) enhances/amends other health Acts, including the Medical Schemes Act – but does not repeal them

How will NHI work?



- NHI will pool all health resources into **one NHI Fund**
(Publicly funded means collection through the tax system)
- NHI Fund will **purchase services (benefits)** on behalf of the whole nation from both the public and private health sectors
- The NHI Fund **contracts directly with service providers**
- The public (Users) must register with clinics and doctor/family practitioners to obtain services, and must start their care at this primary health care (PHC) level

- **It is not possible to address one part of the existing health dichotomy without addressing the other**, they are mutually dependent
- The whole system needs a ‘face-lift’ (revamp)
- There is a need for both systemic change and local changes

Big picture – Purchaser/Provider split

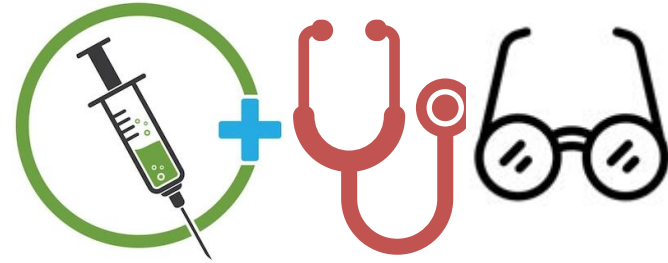


Purchaser of health care

NHI Fund Office

- Public Entity
- Administrative purchasing units

(Private Medical Aids -
complementary)



Providers of health care

Public
Private
PHC/Hospitals
Accreditation



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When will NHI be implemented?



- As soon as the Bill is assented to by the President sections can be proclaimed law (different dates)
- It will be **implemented in two phases**
- Phase 1: 2023 to 2026
- Phase 2: commences 2026/27 and should be well on its way by 2028/29 Financial Year



Many years of concentrated and consistent work



Broken up into manageable phases and parts each of shorter duration



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PART 3:

What are we doing in NDOH?

Preparation for implementation



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NHI BRANCH



1. Governance and administrative capability

- The **Branch** is created in NDOH to do the preparatory work for the NHI Fund but is not administering the NHI
- The Branch is developing draft policies, procedures and processes for the Board to review and adopt once it is appointed
- This was challenged in court and the court ruled that it is a correct approach
- Immediate first step now that there is a signed Act is to **appoint a Board** and for them to recruit a CEO and staff (as provided for in the Transitional Arrangements in the Act)
- **Regulations** to empower the appointment of the Board and other governance structures are drafted and awaiting finalisation of the translations

Other policy issues being addressed



2. Classification of health establishments

- Current classification is regulated in terms of section 35 of the National Health Act in Gazette R185 “Categories of Hospitals” March 2012
- The challenge is that this covers only public hospitals
- Wider than classification of hospitals
- All health establishments, of which hospitals are a subset
- Every health establishment may be accredited to provide services that the NHI Fund will pay for
- Capabilities for accepting and managing referrals and a range of other administrative, quality and outcome measure which are part of the contracting requirements



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Other policy issues being addressed

3. Master Health Facility List

- Every establishment gets an **identity** linked its location and describing its service capabilities
- Managing and maintaining the classification should be expanded to include the identity management of all health establishments

4. Public Health Infrastructure

- NDOH monitors all public sector infrastructure spending, and the establishments built, refurbished and maintained
- NDOH also manages a portfolio of projects that are managed through indirect grants
- Budget is far to small to make a meaningful impact (R11bn annually) and it is managed in each of the 10 departments making each part even smaller
- Regulated process (by Treasury) is extremely long and cumbersome, pushing up the cost of execution
- There are current discussions with Minister of Finance on acceleration funding



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Other policy issues being addressed



5. Health Records

- NHI Fund must pay each provider ‘directly’
- Public service, the Fund must contract with the ‘sections’ in the province
- Need data and the systems to manage that data
 - **Interoperability** - Fund will prescribe the information and how it is provided (will be automated but must ‘talk to many different digital systems’) NHI Fund will prescribe the interoperability parameters, the normative standards and the processes, including codes
 - **Health Patient Registration System (HPRS)** – provides the single identity of a user (patient) so every establishment and individual provider must use the HPRS which is key to opening a patient’s clinical electronic file and to making notes, adding codes and receiving results of investigations



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Other policy issues being addressed



5. Health Records - cont

- **Hospital Management System (HMS2)** - Public and private hospitals (establishments) are using different hospital information systems (HIS) to manage their records and finances but many have no electronic systems. HMS2 which has been developed in E Cape and is owned by government is an option for rapid roll-out
- **Electronic Patient Record (e-Impilo) (EMR)** – being rolled out in PHC establishments (clinics, health centres and private general practitioner rooms at this stage). It is state-owned system, developed by the NDoH and is fully compliant with standards

Without a ‘transversal public digital health system’ the health system will continue to struggle, to waste money and fail to achieve optimal patient care

Concerted focus on connectivity



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Other policy issues being addressed



6. Referrals

- Referrals in and out of hospitals when the provider is not capable of providing the necessary treatment or care
- Of relevance to public hospitals because patients will be referred to private providers if necessary and appropriate
- Relevant to private providers for the same reason
- Will change utilisation and the need for infrastructure in some areas

7. Private Hospital Licenses

- Challenges with licensing of establishments
- Statutory mandate for licensing any other establishment has been judged unconstitutional and needs to be challenged in Constitutional Court
- This creates a legal lacuna being managed through a Standing Committee
- Pharmacies are licensed under the Pharmacy Act and are issued by NDOH DG



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Other policy issues being addressed



8. Central Hospitals

- 10 public hospitals are classified as 'central hospitals'
- NHI Act provides for these hospitals to be funded, governed and managed nationally as semi-autonomous entities
- must be established or designated as organs of state in an appropriate form (semi-autonomous)
- ten staff establishments will be moved to the national sphere and the CEOs will report to the Director General
- organisational structures must be revised (Clinical Departments and Clinical Units)



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Other policy issues being addressed



9. Cost Centres and Functional Business Units (FBUs)

- Cost centres allow disaggregated management of large budgets
- FBUs allow clinical managers to enjoy dedicated admin support
- Complex and different functions need more disaggregation of budgets and financial management, logistics and SCM, etc.
- Cost centres of hospitals must reflect the organisational structure and establishment
- Several public hospitals have already implemented
- The ‘template’ is now available for others
- Benefits of this organisation of budgets has been positive



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Other policy issues being addressed



10. Payment Methods

- Fund must actively and strategically purchase health care services on behalf of users in accordance with need
- This means the services do not wait for patients to seek care but allocates resources knowing that the need for care already exists
- PHC will be paid for through **capitation** to geographical contracting units for PHC (CUPs)
 - Capitation is where the budget is allocated per healthcare user in a geographical area and is paid to the providers irrespective of whether particular users visit or not
- Fund must reimburse payment directly to accredited and contracted central, provincial, regional, specialised and district hospitals based on a global budget or Diagnosis Related Groups
 - DRG is a 'case-mix complexity system' implemented to categorise patients with **similar clinical diagnoses** in order to better control hospital costs and determine payor reimbursement rates



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OTHER BRANCHES - issues



11. Institutions that must be the foundation for a fully functional Fund

- Minister may establish the following interim committees to advise him or her on the implementation of the National Health Insurance:
 - ✓ National Tertiary Health Services Committee
 - ✓ National Governing Body on Training and Development
 - ✓ Ministerial Advisory Committee on Health Care Benefits for National Health Insurance
 - ✓ Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance

Other policy issues being addressed



12. District Health Management Offices

- NDOH must establish District Health Management Offices (DHMOs) for each district
 - must facilitate and coordinate the provision of primary health care services at district level in compliance with national policy guidelines and relevant law
 - Detailed functions in amendment to National Health Act, 2003 (new section 31A)
 - Must plan, manage and report on all healthcare providers (including the non-personal services of municipalities) in the whole health system of the district (public and private)



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Other policy issues being addressed



13. Contracting Units for Primary Health Care (CUPs)

- The NHI Fund must pay for PHC through capitation payments to providers in specified geographical areas
- Providers will work in 'horizontal networks' that include a district hospital, clinics or community health centres and ward-based outreach teams and private providers – the present approach envisages:
 - +/- 150 000 population, addition of wards within a district
 - Multi-disciplinary teams (MDTs)
 - 'Users' (people) in the community enroll with the MDT
 - Budget is allocated based on enrolment (number of users to be served)
 - Allocation weighted by health 'risk factors' (eg age, sex)
- Progress is that there is one proof-of-concept site in each province
 - Collecting detailed data (population/users, providers, spending, etc)
 - Installing systems and testing them (incl EMR /e-Impilo and biometrics)
 - Will then rollout to all CUPs in the same district, then other districts



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PART 4:

What does the Act say about financing?

Shifting funds

Budgeting and funding for the roll-out of the NHI

UN Declaration on **Universal Health Coverage** – December 2012



United Nations

A/67/L.36



General Assembly

Distr.: Limited
6 December 2012

Original: English

Sixty-seventh session
Agenda item 123
Global health and foreign policy

Andorra, Australia, Belgium, Bosnia and Herzegovina, Brazil, Bulgaria, Burkina Faso, Croatia, Cyprus, Czech Republic, Denmark, Egypt, Estonia, Finland, France, Gabon, Germany, Greece, Hungary, Iceland, Indonesia, Ireland, Israel, Italy, Japan, Jordan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Mexico, Monaco, Mongolia, Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Korea, Romania, Senegal, Seychelles, Slovakia, Slovenia, **South Africa**, Spain, Sweden, Switzerland, Thailand, the former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland and United States of America: draft resolution

6. *Recognizes* that, although countries have realized important achievements, all countries have scope for further improvements in their health financing policies to enhance and sustain more efficient, equitable, inclusive and high-quality health systems for their populations, and that health financing systems in many countries need to be further developed in order to provide access to necessary services while **providing protection against financial risk**;



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Role of health financing



Dr Tedros Adhanom Ghebreyesus, the current DG of the WHO, in addressing the critical role of health financing in realising the goals Universal Health Coverage (UHC) has on several occasions made the following remarks:

1. *"Sustainable health financing is crucial for achieving Universal Health Coverage. It ensures that health systems can provide quality services to everyone, everywhere, without financial hardship."*
2. *"Investing in health financing is investing in the future of a nation. It is essential to prioritize health spending and ensure equitable distribution to cover all populations."*
3. *"Strong health systems require strong financing. We need to mobilize additional resources and ensure that funds are used efficiently to expand coverage and improve service quality."*
4. *"Countries must adopt innovative financing mechanisms and increase domestic investments in health to make Universal Health Coverage a reality for all."*



Section 49 of the NHI Act, 2023

Chief source of income

- 49. (1) The Fund is entitled to money appropriated annually by Parliament in order to achieve the purpose of the Act.
- (2) The money referred to in subsection (1) must be— 20
 - (a) appropriated from money collected and in accordance with social solidarity in respect of—
 - (i) general tax revenue, including the shifting of funds from national government departments and agencies and the provincial equitable share and conditional grants into the Fund; 25
 - (ii) reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance;
 - (iii) payroll tax (employer and employee); and
 - (iv) surcharge on personal income tax, introduced through a money Bill by the Minister of Finance and earmarked for use by the Fund, subject to section 57; and 30
 - (b) calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act.
- (3) Once appropriated, the revenue allocated to the Fund must be paid through a Budget Vote to the Fund as determined by agreement between the Fund and the Minister and subject to the provisions of the Constitution and the Public Finance Management Act. 35



Section 57 of the NHI Act, 2023

Transitional arrangements

57. (1) (a) Despite anything to the contrary in this Act, this Act must be implemented over two phases. 30

(b) National Health Insurance must be gradually phased in using a progressive and programmatic approach based on financial resource availability.

(2) The two phases contemplated in subsection (1)(a) are as follows:

(a) Phase 1, for a period of four years from 2023 to 2026 which must— 35

(i) continue with the implementation of health system strengthening initiatives, including alignment of human resources with that which may be required by users of the Fund;

(ii) include the development of National Health Insurance legislation and amendments to other legislation; 40

(iii) include the undertaking of initiatives which are aimed at establishing institutions that must be the foundation for a fully functional Fund; and

(iv) include the purchasing of personal health care services for vulnerable groups such as children, women, people with disabilities and the elderly; and 45

(v) prepare for the establishment of the Fund as a Schedule 3A entity contemplated in section 9, including developing and implementing administrative and personnel related arrangements.

Subsection 7(4) of the NHI Act, 2023



- (4) Treatment **must not be funded if** a health care service provider demonstrates that—
- (a) no medical necessity exists for the health care service in question;
 - (b) no cost-effective intervention exists for the health care service as determined by a health technology assessment; or
 - (c) the health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the Minister.

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Can we 'afford' NHI? What will it cost?



Common questions:

- Can we 'afford' NHI?
- What will it cost?

Both are the wrong questions, need to ask:

- What is fair value that we should be spending on health care?
- How do we get maximum impact from what we spend?
- How much cost can we remove through efficiencies and redirect to more care?
 - Everything changes all the time so asking how long a piece of string is may be very unhelpful – rather 'how much can we bind with the string that we have'
 - Evidence is that efficiencies from private sector are at least 50% of the current spend and at least 10% from the current public sector spend

“More money for health and more health for our money”



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PART 5:

How do we transition to NHI?

Capacity to manage

Transitional provisions



Section 57 of the NHI Act provides for 2 phases

- 1. 2023 to 2026** – essentially to **establish the governance and administration**
 - A. Proclaim the parts of the Act that allow for a Board and other governance structures (S12 to S30)
 - B. Establish enough administrative capacity to manage essential NHI Fund functions (transitional funding)
 - C. Public sector strengthening
 - D. Private sector regulation
 - E. Funding shifts and costing
- 2. 2026 to 2028** – continue strengthening provision and start to purchase benefits

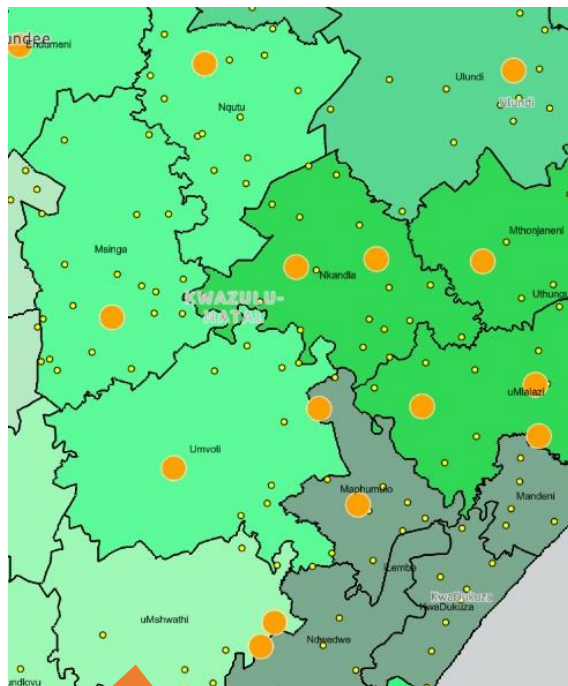


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CUP is principally a demarcated geographical area



Guidance will be developed on how to define CUP boundaries

What a CUP IS...

- CUP is level at which we think about geographical provision of primary health care services for a local population: whether there are sufficient/appropriate services within a geographical area; and whether services are fairly distributed between different geographical areas.
- CUP is a subdivision of a district and for now CUPs will follow subdistrict boundaries.
- Under NHI, budgets for primary health care will be allocated at CUP level. However, this budgeting process will be administrative; all funding will remain at the national level and be paid directly to health care providers by the central NHI Fund.

What a CUP IS NOT...

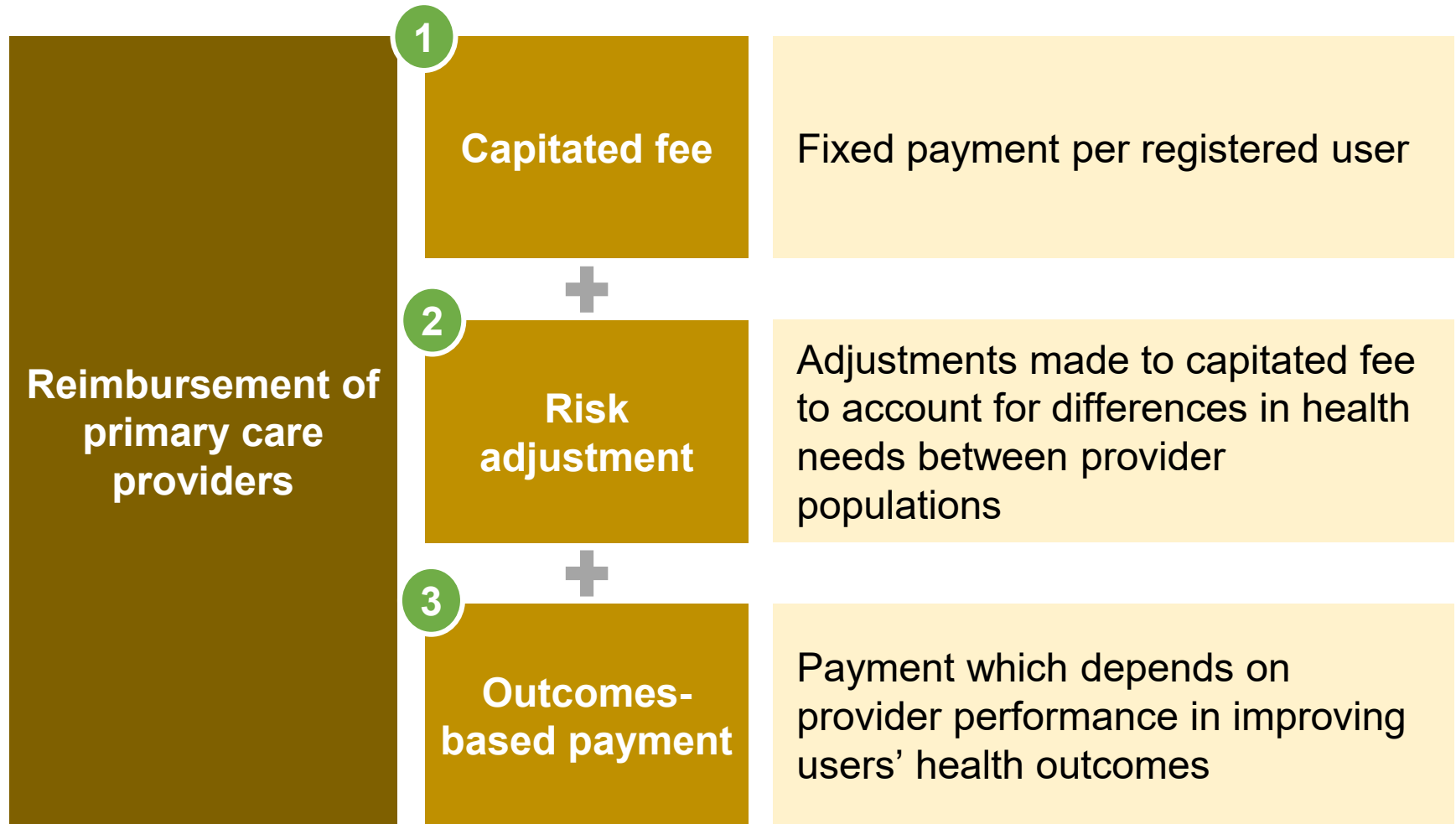
- A CUP is NOT the providers operating in the CUP area. A CUP is also NOT an institution with staff or physical premises.
- However, the NHI Fund may or may not choose to locate staff or suboffices of the Fund at the District or CUP level to facilitate the performance of the Fund's purchasing functions.



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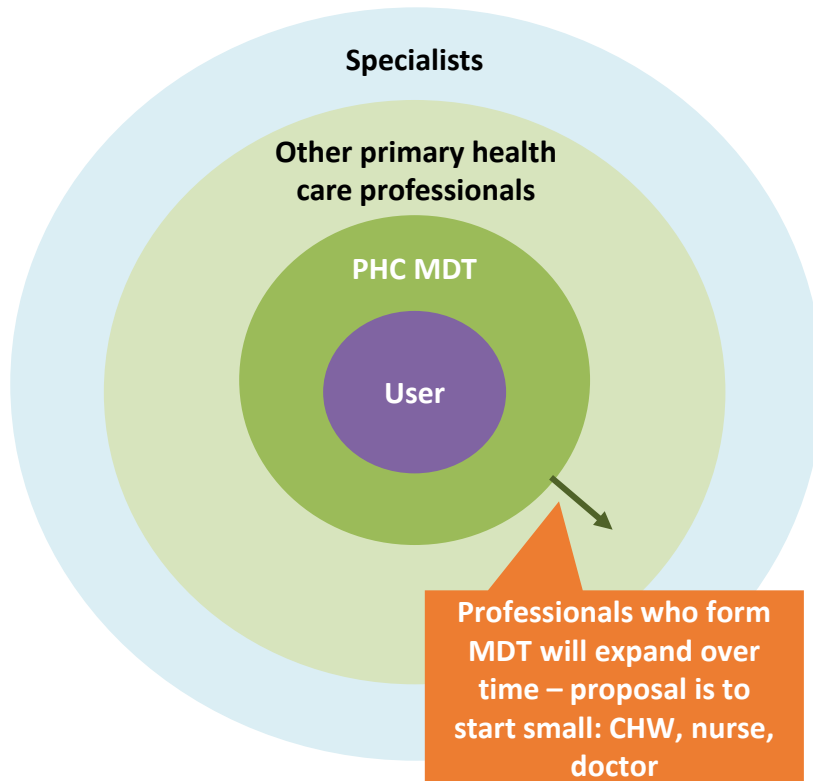
Proposed payment structure



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NHI Bill envisages primary healthcare being provided by multi-disciplinary teams



What is a multi-disciplinary team (MDT)?

- MDT is a group of healthcare professionals with different skills and expertise working together to provide joined-up, patient-centred care
- Members of the team can work together in the same building or work together from different locations as a virtual team

PHC MDT could include...

- WBOT professionals
- Nurse
- Pharmacist
- Clinical associate
- Doctor
- Oral health
- School health teams
- Allied Health Professionals
- ...

MDT reimbursed through team payment, not separate payments to individual professionals



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Developing an outcomes-based capitation contract for PHC



Work in 2023/24 and in 2024/25 focused on 1, 2, 3, 4, 5 and 6: developing service delivery model, scope of contract and payment mechanism design

Work the NDOH NHI Branch is now busy with

1	Service delivery model	Multi-disciplinary teams
		Access and integration
2	Scope of contract	Service benefits
		Medicines and health products
		Users
		Duration
3	Design of payment mechanism	Core components
		Split fee structure
		Other fee adjustments
		Outcomes-based payment
4	User registration	Rules governing user enrolment
5	Provider procurement and accreditation	Provider procurement
		Provider accreditation
6	Setting the capitated fee	Calculating the capitated fee
		Risk-adjustment methodology
		Negotiation with providers
7	Data requirements	Data collection and reporting

Conclusion



- NHI Fund does not yet exist, and will not until there is a mandating law (NHI Act)
- Once the law is in place it can be expected that phase 1 (creating the governance and administrative capabilities) will take three years
- Limited paying of services may be possible to test PHC capitation but only if the conditional grant is amended
- During this time costing of the first MTEF period can be done and then annually depending on which sources of funds are shifted and when
- There will be administrative costs in setting up the agency
- Both public and private sectors must be subjected to greater scrutiny to curtail costs, waste, fraud and abuse and to improve quality
- Private sector regulation must be implemented
- Public sector infrastructure investment must be planned and approved nationally to avoid further waste and inequity

THANK YOU



NGIYATHOKOZA!

ro livhuwa!

dankie!

ke a leboga!

ENKOSI!

inkomu!

thank you!

udo livhuwa!

ke a leboga!

ngiyabonga!

siyabonqa!



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