# Developing a strategy for National Health Insurance


## Group 4

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## Abbreviations

CBHI – Community Based Health Insurance

DHMO – District Health Management Office

DRG – Diagnosis Related Group

HTA – Health Technology Assessment

M&E – Monitoring and Evaluation

NHI – National Health Insurance

NHIS – National Health Insurance Scheme

OHSC – Office of Health Standards Compliance

PFMA – Public Finance Management Act

PHC – Primary Health Care

SCI – Service Coverage Index

SDG – Sustainable Development Goal

SHI – Service Health Insurance

UCS – Universal Coverage Scheme

UHC – Universal Health Coverage

WHO – World Health Organization

## Executive summary

South Africa has a health system that is divided into two distinct sectors. The public sector provides healthcare to the majority of the population through funding from general tax revenue, while the private sector is supported by voluntary medical scheme contributions and serves a much smaller portion of the population. Although the country invests a comparatively high percentage of its national income in health, South Africa continues to experience unequal health outcomes that are shaped by persistent socio-economic inequalities, provincial variation in service delivery capacity, and differences in the availability of skilled health professionals. These disparities are reflected in access to services, quality of care, and financial protection across different communities.

South Africa remains committed to achieving universal health coverage, which refers to the ability of all individuals to obtain essential healthcare services without experiencing financial hardship. In response to the challenges of fragmented financing and unequal access, the South African government has proposed the implementation of national health insurance. The national health insurance is intended to restructure health financing to create a more equitable and efficient system that promotes equal access to quality healthcare for all residents.

The national health insurance will use a mixed funding model that combines existing government budgets with new revenue sources to ensure fairness and sustainability. Financial management under the national health insurance will be centralised, with all funds pooled nationally and used to purchase services based on health needs rather than income or location. The benefit package will cover promotive, preventive, curative, rehabilitative, and palliative services, with all South African citizens, permanent residents, refugees, and certain foreign nationals entitled to access. The system proposes eliminating user fees at point of care to protect beneficiaries from financial hardship.

Strategic purchasing will transform health financing from passive budget allocation to active resource deployment based on population needs, provider performance, and health system objectives. Provider payment mechanisms will include capitation for primary care, diagnosis-related group payments for hospitals, and performance-based financing for priority programmes such as maternal and child health, HIV and tuberculosis management, and chronic disease control.

Governance structures will include a national health insurance fund governed by a board appointed through a public nomination process and accountable to the Minister of Health. The fund will operate under public finance legislation, with oversight mechanisms including independent audits and public reporting. Institutional arrangements will shift financing and administration to the national level, while provinces and districts will focus on service provision and local oversight. District health management offices will

coordinate primary healthcare services and ensure accessible care through contracted networks of providers.

Monitoring and evaluation will be critical to track progress toward universal health coverage. The framework will include indicators for service coverage, financial protection, quality of care, and health outcomes. Data sources will include routine health information systems, administrative records, household surveys, and reports from oversight bodies. Targets will be aligned with national health plans and global health goals. The framework will also include financial sustainability components that track revenue flows, expenditure patterns, and cost drivers. Capacity building will be essential to support implementation, including training in strategic purchasing, health economics, and data analytics.

## Introduction

South Africa has a health system that is divided into two distinct sectors. The public sector provides healthcare to the majority of the population through funding from general tax revenue, while the private sector is supported by voluntary medical scheme contributions and serves a much smaller portion of the population. Although the country invests a comparatively high percentage of its national income in health, South Africa continues to experience unequal health outcomes that are shaped by persistent socio economic inequalities, provincial variation in service delivery capacity, and differences in the availability of skilled health professionals.[1] These disparities are reflected in access to services, quality of care, and financial protection across different communities.

South Africa remains committed to achieving Universal Health Coverage, which refers to the ability of all individuals to obtain essential healthcare services without experiencing financial hardship. The World Health Organisation emphasises that movement toward Universal Health Coverage requires improvements in revenue collection, pooling of resources, and strategic purchasing of health services.[2] In South Africa, these functions of the health financing system remain fragmented, leading to uneven resource allocation and unequal access to care across the population. The result is a system where access to quality healthcare is often determined by income rather than by health need. In response to these challenges, the South African government has proposed the implementation of National Health Insurance. The National Health Insurance is intended to restructure health financing to create a more equitable and efficient system that promotes equal access to quality healthcare for all residents.

This paper uses the World Health Organisation Health Financing Country Diagnostic framework to analyse the South African health financing system, identifying its strengths, weaknesses, and the underlying causes of limited progress toward Universal Health Coverage. It then outlines the core elements of the National Health Insurance and explains how these address the challenges identified. Based on this foundation, the paper develops a health finance strategy for the National Health Insurance, including considerations for funding, the roles of public and private sectors, equity and access implications, financial sustainability, governance arrangements, and monitoring and evaluation. The strategy is supported by evidence from national policy documents, international guidance, and relevant literature.

# SITUATIONAL ANALYSIS OF THE SOUTH AFRICAN HEALTH SYSTEM

## Overview of the Health Financing Landscape

The current health financing system in South Africa reflects deep disparities in access and resource allocation. The private sector receives a large proportion of national health expenditure but serves only a small group of the population who are able to afford medical scheme membership. Meanwhile, the public sector is responsible for providing services to the majority of people, including those who are most socially and economically vulnerable. Budget constraints, high patient volumes, and infrastructure challenges in the public sector continue to limit service quality in many areas.[1] These structural imbalances highlight the need for a unified and equitable pooling mechanism that supports redistribution based on health needs rather than income.

## Strengths, weaknesses and systemic challenges of the current Health System

Despite these challenges, the South African health system has several strengths that create a foundation for reform. The recognition of health as a constitutional right provides strong policy support for expanding access. South Africa has also demonstrated the ability to implement large national health programs such as those for HIV and tuberculosis, childhood immunisation, and chronic disease management. These successes illustrate the capacity of the health system to plan, coordinate, and deliver services at scale when provided with appropriate support and resources. The physical infrastructure for health service delivery also reaches many parts of the country, including rural districts, even though the quality of facilities varies.

However, the system continues to face serious weaknesses that limit progress toward equitable health access. One of the central challenges is the separation of public and private financing arrangements, which prevents funds from being pooled across the entire population and restricts the sharing of financial risks. Resource allocation remains uneven, with insured and urban populations often receiving more comprehensive services compared to uninsured and rural communities. Many households still pay directly for healthcare at the time of use, which can delay treatment and contribute to financial strain. Budgeting processes in the public sector are often based on historical spending patterns rather than current population needs or performance, which reduces accountability and efficiency.[3] This combination of factors contributes to continued inequality and prevents the system from delivering care based on need.

### Problem Diagnosis

Applying the World Health Organisation diagnostic approach, the main causes of underperformance in the system relate to fragmented pooling of funds, inefficient allocation of resources, and purchasing arrangements that do not encourage improvements in quality or value. The private sector continues to operate largely through fee for service payment mechanisms, while the public sector is limited by incremental budgeting processes. These issues reinforce patterns of inequality, as they link access to healthcare more closely with the ability to pay rather than with the level of health need.

### Introducing the NHI

The National Health Insurance is designed to address these structural weaknesses by establishing a single national fund that will pool resources and purchase services on behalf of the entire population. The central aim of the National Health Insurance is to ensure that everyone in South Africa is able to access quality healthcare without having to pay at the point of use. The model emphasises mandatory prepayment and the sharing of financial risk across all households, regardless of income level or employment status. It also proposes to contract both public and private providers under standards that promote efficiency, accountability, and quality of care.[4] Through this reform, the National Health Insurance seeks to create a healthcare system where equitable access is determined by health needs rather than financial means.

## NHI FUNDAMENTALS, BENEFITS AND OBJECTIVES

### Objectives of the National Health Insurance Bill (2019)

The National Health Insurance (NHI) is based on two key principles: universality and social solidarity. Universality means that everyone in South Africa should have equal access to quality health care, while social solidarity ensures that the rich support the poor and the healthy support the sick through shared funding.[5] The main goal of the NHI is to achieve universal health coverage by creating a single national fund that purchases health services for all citizens. This will reduce out-of-pocket payments and make essential health care more affordable and accessible.

**The Fund aims to**

1. Protect people from financial risk

2. Ensure fair distribution of funding
3. Promote equal access to health services
4. Improve efficiency and quality of care and
5. Strengthen good governance and accountability.

## Revenue Sources and Financial Management for the NHI

The National Health Insurance (NHI) will use a mixed funding model that combines existing government budgets with new revenue sources to ensure fairness and sustainability. Most of the funding will come from general taxes such as personal income tax, value-added tax (VAT), and possibly health-related taxes on alcohol and tobacco, making the system progressive as higher earners contribute more. In the future, the government may introduce special earmarked taxes, such as a small income tax surcharge or payroll tax, once the economy is stronger. Employed individuals might also make mandatory prepayment contributions to the NHI Fund, replacing private medical aid payments to create a fair, single national pool of resources. Some existing government health grants, such as the National Tertiary Services Grant and the HIV/AIDS and TB Grant, will be reallocated to the NHI Fund to reduce duplication and improve efficiency.

Financial management under the NHI will be centralised, with all funds pooled nationally and used to purchase services based on health needs rather than income or location. The Fund will operate under the Public Finance Management Act (PFMA) to ensure transparency, with oversight by the Minister of Health and regular audits to prevent misuse. Accredited health facilities will be funded based on quality standards verified by independent bodies like the Office of Health Standards Compliance. Providers will be paid through modern systems such as capitation for primary care, Diagnosis-Related Group (DRG) payments for hospitals, and performance-based payments to reward good-quality care. To control costs, the NHI will use referral systems, promote disease prevention, implement digital tracking systems, and eliminate duplication.

Recognising South Africa's economic constraints, the NHI will be implemented gradually to ensure fiscal realism and sustainability. This phased approach will prioritise reallocation of existing budgets, improved efficiency, and expansion of coverage starting with primary health care before new taxes are introduced. The model is expected to provide equitable access to essential services, protect people from high out-of-pocket costs, reduce waste, and improve service quality. Ultimately, the NHI aims to build a fair, efficient, and sustainable health system that promotes universal health coverage and strengthens national development through better health outcomes.

## NHI Benefit Package Design

### Service Coverage and Population Entitlement

The NHI benefit package covers a lot of components of health, promotive, preventive, curative, rehabilitative, and palliative services, with all South African citizens, permanent residents, refugees, and certain foreign nationals entitled to access.[6][7] Primary health care (PHC) serves as the entry point, with guarded referral pathways to specialist and hospital services similar to Thailand and Rwanda's models.[8][9] Rwanda's Essential Health Package, implemented through Community-Based Health Insurance (CBHI), covers cesarean sections, pediatric care, and malaria treatment with minimal copayments of up to US$0.30, while PHC operates under capitation payments, enabling coverage to scale from 7% in 2000 to 74% by 2013.[10][11]

### Cost-Sharing Arrangements and Financial Protection

The NHI currently proposes eliminating user fees at point of care to protect beneficiaries from financial hardships.[12] Thailand's Universal Coverage Scheme (UCS), serving 48 million beneficiaries, initially implemented a nominal 30-baht or US$1 copayment but eventually eliminated it, to enhance access to services demonstrating that well-designed purchasing mechanisms can manage utilisation without financial barriers.[8][13] Ghana's National Health Insurance Scheme (NHIS) covers 95% of disease conditions with no copayment, though irregular government funding, provider payment delays, and inadequate capitation rates in remote areas have weakened sustainability.[14][15] These lessons emphasise the necessity of pairing comprehensive benefit packages with adequate and predictable financing through general taxation, payroll contributions, and appropriate health levies.[16]

### Priority-Setting and Health Technology Assessment

Ensuring a transparent, evidence-based priority-setting is fundamental for a sustainable benefit package design. South Africa has initiated Health Technology Assessment (HTA) institutionalisation to guide decisions based on cost-effectiveness, disease burden, and equity considerations.[17] WHO's Priority Benefits Package approach emphasises linking HTA to resource allocation, ensuring high-priority interventions receive equivalent funding.[18][19] Kenya's NHIF expanded its benefit package in 2015 but faced implementation gaps such as delayed communication, unequal geographic distribution of accredited providers, and inconsistent benefit delivery, all highlighting the importance of embedding HTA within coherent governance structures.[20]

### Strategic Purchasing and Provider Payment Mechanisms

Strategic purchasing transforms health financing from passive budget allocation to active resource deployment based on population needs, provider performance, and health system objectives.[21] This is particularly important for the NHI, which must coordinate purchasing across fragmented public and private sectors while aligning financial incentives with efficiency, quality, equity, and financial protection goals.[20]

## Provider Payment Mechanisms  Options and Incentive Structures

Provider payment mechanisms are the primary levers shaping provider behavior. Evidence from LMICs demonstrates the utility of blended payment models combining multiple mechanisms to balance competing objectives and to mitigate unintended consequences.[22][23]

Table 1 summarises key mechanisms, incentive structures, and LMIC examples

| Payment Mechanism | Description | Incentive Structure | LMIC Examples |
|---|---|---|---|
| **Capitation** | Fixed payment per beneficiary per period | Efficiency, prevention and risk of under provision | Rwanda, Ghana, Indonesia [22][32] |
| **DRGs** | Case-based hospital payments per occurrence of care | Standardization, efficiency; risk of upcoding | Thailand, Ghana, Kenya [8][14][20] |
| **Performance-Based Financing** | Payment linked to measurable results | Quality, accountability; risk of gaming | Rwanda, DRC, Cameroon [11] |
| **Blended Models** | Combination of multiple mechanisms | Balanced incentives; adaptive to context | Indonesia, Philippines, Bangladesh [25] |
| **Fee for Service** | Payment per service delivered | Volume, responsiveness, risk of over servicing | Nigeria |

Capitation provides fixed payments per enrolled beneficiary for defined service packages, creating strong efficiency and prevention incentives.[24] Rwanda's CBHI demonstrated administrative feasibility, promoting teamwork and flexibility.[10] Indonesia's Jaminan Kesehatan Nasional (JKN) utilises capitation for PHC covering 144 services for over 200 million beneficiaries, piloting performance-based capitation to incentivise appropriate referrals and chronic disease management.[25][26] Ghana's transition to capitation revealed challenges  irregular payment flows, inadequate rates in remote areas, insufficient IT systems, and provider resistance.[27] For South Africa, this emphasises the necessity of robust payment infrastructure, geographic variation in rate-setting, provider training, and stakeholder engagement.

Diagnosis-Related Groups (DRGs) classify hospital admissions by clinical condition and complexity, enabling case-based payment that standardises reimbursement while accounting for case-mix variation.[28] Ghana implemented Ghana DRG (G-DRG) in 2008, and South Africa has DRG experience since 2000.[29] Thailand's UCS combines DRG-based payments for inpatient care with global budget ceilings, such that DRG-weighted point values vary based on total provider activity, thereby controlling overall costs whilst allowing service delivery flexibility.[8] DRGs require robust clinical coding systems and mechanisms to prevent upcoding. For South Africa, phased implementation beginning with tertiary hospitals combined with prospective global budgets is a representation of a pragmatic approach.

Performance-Based Financing (PBF) links payments to the achievement of measurable service delivery and quality indicators, creating incentives for improved outcomes and accountability.[30] DRC's large-scale PBF program launched in 2016 shows improvements in structural quality by 4%, technical quality of 5%, and service coverage of 3% compared to unconditional financing.[31] Rwanda and Cameroon implemented PBF linked to vaccination rates, institutional delivery, and disease management outcomes.[32] Although, sustainability depends on institutionalising performance monitoring systems and avoiding narrow incentives that distort priorities.[33] For South Africa, selective PBF application to priority areas such as, maternal and child health, HIV/TB management, chronic disease control can enhance its accountability.

These Blended Payment Models combine multiple mechanisms tailored to provider type, service setting, and health system objectives, balancing efficiency, quality, and equity incentives.[34][35] The Philippines' PhilHealth employs blended payments, including capitation for PHC with case-based payments for hospital services and performance incentives for quality improvement serving as a model for comprehensive UHC in fragmented systems.[25][36]

### Strategic Purchasing Framework and Institutional Architecture

Strategic purchasing extends beyond the payment design to encompass benefit specification, provider selection and authorisation, contracting, and performance monitoring.[37][38] The effectiveness of strategic purchasing depends on governance clarity, institutional capacity, and integration of multiple purchasing functions.[39] Thailand's UCS success reflects multi-stakeholder coordination  HTA conducted by semi-autonomous research agencies informs benefit package updates, provider authorisation is managed by a dedicated Healthcare Accreditation Institute, quality improvement is overseen by Ministry of Public Health departments, and civil society engages through annual public hearings and health assemblies.[8] This enabled Thailand to negotiate favorable pharmaceutical prices saving approximately 12.5 billion baht from 2008-2011 and manage a per capita system for 48 million beneficiaries.[40]

For South Africa, establishing related structures requires clarity on roles of the NHI Fund, National Department of Health, provincial health departments, and contracted providers. Provider contracting should specify service delivery standards, quality metrics, and referral protocols. Kenya's NHIF demonstrates that selective contracting based on quality criteria can strengthen purchasing leverage, though weak implementation and monitoring undermine intended incentives.[41] Vietnam's Social Health Insurance (SHI) covers 71% of the population but faces challenges with mandatory contracting of all state facilities regardless of quality, limiting purchaser leverage.[42][43]

## Financial Sustainability and Revenue Mobilisation

Long-term sustainability requires coherent financing arrangements aligned with purchasing functions. Most LMICs pursuing UHC employ mixed revenue models. Rwanda finances CBHI through progressive premiums, government subsidies for the poor, and risk pooling at district and national levels.[10] Thailand funds the UCS through general tax revenue channeled to the National Health Security Office based on per-capita capitation rates, enabling predictable annual budgets.[8] Indonesia's JKN relies on payroll contributions, government subsidies for vulnerable populations, and general budget support, serving over 200 million beneficiaries.[26]

South Africa's fiscal context differs from lower-middle-income comparators due to higher per-capita GDP and existing tax capacity, yet the NHI must address fragmentation across public and private insurance. Some revenue options include expanded general tax funding which is most progressive and protective of the poor, appropriate health levies providing stipulated funding, and payroll contributions with attention to informal worker inclusion.[44] Financial sustainability also requires cost containment strategies establishing transparent, evidence-based payment rates, negotiating pharmaceutical prices through pooled purchasing power as Thailand has done, and deploying gatekeeping systems to manage utilisation of higher-level care.[40] Bangladesh's Health Care Financing Strategy for 2012-2032 targets halving out-of-pocket payments from 64% to 32% through social health protection combining increased government budget allocation, results-based financing, and facility incentive retention, providing a roadmap for progressive financial protection realisation.[45][46]

## Recommendations for South Africa's NHI Implementation

Based on some comparative evidence from countries like Ghana, Rwanda, Kenya, Thailand, Vietnam, Bangladesh, Indonesia and the Philippines

1. South Africa should try to prioritise a continuous evidence-based benefit model design linked to Health Technology Assessment and epidemiological data, with regular stakeholder engagement and transparent communication of claims to build public understanding and trust.
2. Ensuring there are some blended provider payment models tailored to the service type; capitation with performance incentives for primary health care, DRG-based (Diagnosis Related Group- based) payments within the proposed global budgets for hospital services and selective performance-based financing for priority programs such as maternal and child health, HIV/TB, and chronic disease management.[14][15]
3. Establishing an institutional structure for the strategic purchasing that coordinates benefit specification, provider contracting, accreditation and performance monitoring across national and provincial levels, with clear representation of roles for the NHI Fund, the National Department of Health, and provincial health departments. Also, listening to incoming decisions around NHI implementation would strongly benefit from actively including academic institutions (universities, colleges) and engaging people currently in learning spaces and those entering the workforce. This ensures that emerging health professionals, health systems researchers, and future policy-makers are equipped with understanding of strategic purchasing principles, payment mechanisms, and benefit package design from early in their careers. Such integration can build long-term institutional capacity, foster innovation, and ensure continuity of expertise as the NHI matures, lessons observed in Thailand's deliberate investment in training health economists and HTA specialists, and Indonesia's engagement of academic institutions in JKN monitoring and evaluation.[8][25]
4. Ensuring we have a diverse revenue mobilisation leveraging South Africa's fiscal capacity through expanded general taxation, reserved health levies and progressive payroll contributions, whilst protecting the poor through targeted subsidies and eliminating user fees at the point of care.
5. SA would need to prioritise investing in information systems, provider training, and routine performance monitoring to enable adaptive purchasing arrangements as implementation experience accumulates, including robust claims processing, clinical coding systems for DRGs, and data analytics for population health needs assessment.
6. There can be a step-by-step implementation with pilot testing in selected provinces or districts to evaluate payment mechanisms, refine benefit packages, and build institutional capacity before national scale-up, learning from Thailand's deliberate piloting approach and Indonesia's iterative refinement of capitation models.

## The Role of Public and Private Sectors, and the Impact of NHI on Equity and Access

The successful implementation of South Africa's NHI relies on a well-defined and cooperative partnership between the public and private healthcare systems, alongside a firm commitment to health equity. The current system, however, is deeply divided and works against this objective. The public sector serves approximately 84% of the population but suffers from a lack of funding and staff. In contrast, the private sector, which serves only 16% of the population, consumes over half of the nation's total healthcare expenditure.[47] The NHI Act, therefore, aims to create a single-payer fund. This fund would purchase healthcare services for everyone based on their medical needs, not their ability to pay.[48] This section analyses the projected impact of NHI on health equity and access to services for different population groups. It defines the specific roles and responsibilities of the public and private sectors within the new framework and evaluates the strategies designed to ensure strong financial risk protection for the whole population.

### The Impact of NHI on Health Equity and Access to Health Services

Achieving health equity is a core goal of the NHI, driven by the need to address clearly documented inequalities. The current South African health system is defined by severe disparities, often described as a primary barrier to improving national health outcomes.[49] The NHI Act aims to overcome this division by creating a single, unified system where access to quality healthcare is based on need, not ability to pay.[48] A key mechanism for this is to redistribute resources from the healthier and more affluent to the sicker and less wealthy, thereby directly addressing the fragmented financing that reinforces these inequities.[47]

Monitoring the progress towards equitable UHC requires robust data at the local level. A 2021 study showed that for South Africa, it is feasible to construct a UHC Service Coverage Index (SCI) mainly from routine data sources, which allows for detailed analysis at a district level.[50] The district-level data revealed significant equity challenges a clear socio-economic gradient was evident, with poorer performance consistently observed in the most economically deprived districts.[50] This evidence proves that healthcare coverage is not equitable and that resource allocation and system strengthening must be deliberately targeted to address these geographic and economic disparities. Although the study found improvements in certain areas like maternal and child health, it highlighted that such detailed monitoring is crucial for the NHI to ensure that "no one is left behind" becomes a practical achievement, not just a policy aspiration.[50]

The strategic design of the NHI must be explicitly tailored to address South Africa's unique quadruple burden of disease, which disproportionately impacts vulnerable populations. This need supports the proposed blended provider payment mechanisms discussed in the previous section. For instance, linking a portion of payments for priority programmes like maternal and child health and HIV/TB can create targeted incentives to improve the quality and quantity of services in these key areas.[14][15] By allocating resources based on population health needs, rather than historical budgets, the NHI can make the health system better at tackling the diseases that are central to the country’s health inequities.

A critical measure of the NHI's success in promoting equity will be its ability to bridge the geographical access gap. The unequal distribution of healthcare resources, especially between urban and rural areas is a critical challenge.[49] To ensure equitable healthcare distribution, the NHI must function as an active, strategic purchaser, not just a bill-payer, to change where and how care is provided. This directly compensates primary care providers for lower patient density and higher operating costs, making rural practice financially sustainable. These financial measures need to be coupled with direct government investment in rural infrastructure to create a functional service platform. In addition, expanding mobile and telehealth services will be essential to overcome geographical barriers, connecting remote clinics to specialists and reduce the need to undertake expensive and prohibitive patient travel, a trend already showing promise within the South African context.[51]

## The Role of Public and Private Sectors in NHI Implementation

To ensure succession of the NHI, the roles of the public and private sectors must be clearly defined and regulated. The planned system moves from a fragmented system to an integrated one, governed by the state but will utilise the resources and capacity of both sectors.

The public sector is tasked with a multifaceted role including stewardship, service provision, and financial management. This involves providing overarching leadership, governance, and regulation for the entire health system through the National Department of Health, provincial health departments, and the NHI Fund.[52] This stewardship function involves critical tasks such as setting national health policy, defining the comprehensive benefits package, and managing the system's strategic purchasing activities. The reason for concentrating purchasing power to a single public fund is that it can then negotiate effectively with healthcare providers. This helps control rising costs and ensures the same quality standards are applied everywhere, which passive budgeting and fragmented private funders have failed to do.[53] A central challenge, however, will be improving the public sector's own institutional capacity to perform this complex stewardship role effectively and without corruption.

The role of the private sector within the NHI framework is heavily debated. Although a proposed compromise has suggested that higher-income individuals would be required to have private medical insurance alongside the NHI, the current NHI Act outlines a more transformative path. Under this framework, private healthcare providers like hospitals, general practitioners, and specialists will be integrated into the system by contracting with the NHI Fund to deliver services to beneficiaries, provided they meet strict quality standards and agree to predetermined payment rates.[54] This integration is seen as crucial for increasing the system's overall capacity and expanding patient choice.

Furthermore, the most significant political and legal battle is the plan to limit the function of private medical schemes. The NHI Bill seeks to restrict them to covering services not offered by the NHI, a measure its

supporters argue as essential to prevent a separate, two-tier system that would weaken the principle of shared responsibility by allowing the wealthy to opt-out.[55] Thus, they warn that if the wealthy can opt out, political and financial support for the public NHI system could collapse. However, this restriction is strongly opposed by political entities like the Democratic Alliance, arguing this is an unfair restriction on individual rights, ensuring this will remain a focal point of debate “50 Reasons why the NHI will never work,” (n.d.). Despite this shift in financing, the private sector will remain important in driving innovation and securing the supply of medicines, technologies, and equipment. Trends like increasing local manufacturing and public-private partnerships are expected to strengthen the system’s self-sufficiency and reduce reliance on imports.

### Strategies for Financial Risk Protection

A main goal of the NHI is to protect households from financial hardship due to illness. This protection is achieved through a defined system's benefit package and funding model. This directly eliminates out-of-pocket payments at the point of use and thereby directly addresses the primary cause of large, unaffordable medical bills.[56] By eliminating upfront costs for a defined set of services, the NHI breaks the connection between falling ill and facing financial ruin.

This protection is strengthened by a funding model that is based on ability to pay. The progressive revenue collection strategy that utilises sources such as general taxation and income-based contributions.[48] This means that those with higher incomes contribute more to the pool. This approach ensures that the financial burden of funding healthcare is distributed across the population based on economic capacity, rather than being concentrated on individuals at the moment of sickness.[48] This pre-payment and pooling model is proven to be both efficient and equitable than relying on out-of-pocket payments at the time of illness.

Lastly, the system's integrity and stability are protected by strong regulatory and oversight. The NHI is designed with transparent processes for paying claims, auditing providers, and robust anti-corruption measures. These measures are crucial to prevent the diversion of resources and ensure that funds are utilised efficiently for its intended purpose, protecting the population from health costs. If funds are lost to waste or corruption, the system's ability to provide services and financial protection is weakened, disproportionately harming the poor who are most reliant on the public system. Therefore, transparency and accountability are not secondary concerns but essential requirements for achieving the NHI's goals of equity and financial risk protection.[57]

## Governance and Institutional Arrangements for NHI in South Africa

### Governance Structures

The National Health Insurance (NHI) Fund in South Africa will be established as a single, national purchaser of health services, and its governance framework is designed to ensure accountability and transparency. The NHI Act of 2024 creates an NHI Fund governed by a Board of no more than 11 members, appointed through a public nomination process and ultimately accountable to the Minister of Health.[58] The Board serves as the fund's accounting authority in line with public finance legislation, advising the Minister on key policies and overseeing the Fund's strategic direction and financial management.[59] A Chief Executive Officer (CEO) will head the Fund's executive operations, reporting to the Board, and is responsible for day-to-day financial administration and implementation of the Fund's mandate. The governance design emphasises clear accountability lines. The Board and CEO are accountable to the Minister and, via the Minister, to Parliament and the public. To promote integrity and public trust, Board members are required to act without conflicts of interest and the Fund's performance and finances will be subject to independent audit by the Auditor-General and regular reporting. In previous policy proposals, an NHI Commission or similar oversight body was envisaged to monitor the NHI Fund's performance and protect the public interest.[6]

In practice, this oversight function is now largely built into the Board and reporting requirements. Strong governance mechanisms including regular performance reviews, public annual reports, and stakeholder engagement are considered vital to ensure that the NHI Fund operates effectively and avoids mismanagement, given the large public revenues it will control.[60] International evidence supports this emphasis on governance. Countries that have successfully moved toward universal health coverage (UHC), such as Thailand and Ghana, have instituted robust governance structures for their national insurance funds, combining government oversight with expert input and public transparency.[57] These lessons inform South Africa's NHI design, underlining the need for fiduciary expertise and public participation in governance.[57]

### Institutional Arrangements (National–Provincial–Local)

Implementing the NHI will require redefinition of roles across all levels of government. National level institutions will take primary responsibility for policy, funding allocation, and purchasing of services. The NHI Fund at national level will pool public revenues and undertake strategic purchasing of health services on behalf of the entire population.[59] The National Department of Health will set standards, benefits policy (through bodies like the Benefits Advisory Committee), and regulate quality via entities such as the Office of Health Standards Compliance. The provincial level, which currently carries a large share of health service delivery responsibility, will see a significant shift in its role. Under NHI, the financing and much of the administration for health services will be centralised estimates indicate that about *"90% of healthcare administration by provinces"* and the associated budgets will be reallocated to the NHI Fund.[61] This means provincial health departments will no longer manage the bulk of funds or contracting for health

services, instead, they are expected to transition into a more limited role focused on service provision and local oversight.

Public hospitals and clinics, which are mostly provincially run, will be funded by NHI contracts rather than block provincial budgets. Provinces will need to ensure their facilities meet accreditation standards and deliver services according to NHI agreements, effectively acting as providers within the national system. They will also likely continue to handle certain administrative functions such as human resource management for health workers as public servants and coordinate health programs at the regional level, but under the policy and funding guidance of the NHI Fund.[58] The change will require careful management of the transition including potentially reallocating provincial staff and functions into the NHI's administrative structures to avoid disrupting service delivery.[62] At the district and local level, the NHI reforms envisaged strengthened local health management to support primary health care (PHC). The policy calls for establishing District Health Management Offices (DHMOs) to plan and coordinate health services in each district.[6]

These DHMOs would be responsible for managing public clinics and health centres, and for coordinating networks of providers including private GPs or clinics contracted into the NHI to ensure accessible services. Importantly, the district health system will become the locus for service delivery under NHI, with contracting units for primary care possibly organised at that level.[6] Local governance structures such as Hospital Boards and Clinic Committees are set to be strengthened to give communities a voice and to improve accountability for service quality at facility level. Moreover, municipal governments will continue to play their part in public health functions like environmental health and water/sanitation and support health promotion, in alignment with NHI goals. Overall, the institutional arrangement under NHI is one of centralised financing and standard-setting, combined with decentralised service delivery. National structures will ensure uniform standards and equitable resource distribution, while provincial and district authorities implement services on the ground.

This multi-level collaboration must be underpinned by clear roles and communication channels. For example, provinces and districts will need formal agreements with the NHI Fund regarding performance targets and reporting. The success of NHI will depend on effective intergovernmental coordination mechanisms so that national, provincial, and local entities work in concert rather than at cross purposes.[60] The NHI shifts South Africa's health system from a fragmented, provincially-funded model towards a unified national system, a change that requires new governance and institutional arrangements to ensure every level of the state contributes appropriately to the common goal of UHC.

South Africa's NHI will rely on a strong governance framework and intergovernmental arrangements to manage the Fund and deliver services, while a robust M&E framework will track progress toward universal

health coverage. Together, these elements are designed to ensure that the NHI achieves its objectives of equitable, efficient health service provision for all. By learning from both domestic experiences and international models of health insurance, the NHI's governance and M&E systems can be structured to promote accountability, continuous learning, and ultimately, better health outcomes for the population.

## Monitoring and Evaluation Framework

A comprehensive Monitoring and Evaluation (M&E) framework is critical for the NHI's success, as it will track progress towards universal health coverage and allow for adjustments to be made over time. The M&E framework for NHI should include specific indicators, data sources, and targets aligned to UHC goals, ensuring that reforms remain on course and benefit the population equitably. Key dimensions to monitor include service coverage, financial protection, quality of care, and health outcomes.[12] International standards such as the *WHO/World Bank UHC index* emphasise tracing the coverage of essential health services e.g. immunisation, maternal health, treatment for major diseases and the proportion of households facing catastrophic health expenditures. In the South African context, relevant coverage indicators may encompass the percentage of the population accessing primary healthcare within a reasonable time frame, the availability of medicines and specialists as per the NHI benefits, and utilisation rates of different levels of care.

Quality indicators will also be vital for instance, facility compliance with national quality standards as assessed by the Office of Health Standards Compliance, patient satisfaction levels, and health outcomes like maternal and infant mortality rates or disease survival rates that reflect the effectiveness of services. To capture UHC's equity dimension, the M&E framework should disaggregate indicators by province, district, income level, and other demographics to ensure that improvements are reaching traditionally underserved groups.[12]

## Data sources and systems

Implementing this framework will draw on multiple data sources. Routine health information systems such as the District Health Information System will supply data on service delivery volumes, health workforce, and facility performance. Administrative data from the NHI Fund for example, claims and payment records can be analysed for coverage trends e.g. number of patients treated for certain conditions, or referral patterns and financial protection e.g. out-of-pocket payments remaining. Household surveys, like the General Household Survey or Demographic and Health Survey, will be important to measure population health status, service utilisation and any persisting financial burdens on patients. Surveys can provide baseline and follow-up measures on UHC indicators such as the share of people who skipped care due to cost. The M&E framework will also incorporate data from oversight bodies, for instance, reports by the Auditor-General and annual NHI Fund reports will contain financial performance and maybe some health

status information. A key element is ensuring data quality and integration. South Africa will need to invest in strengthening information systems to accurately capture and report NHI performance data in a timely manner.[12] This includes linking databases across public and private sectors and improving the completeness of health statistics.

### Indicators and targets

The M&E plan should set clear targets linked to UHC goals. For example, South Africa might aim to raise its UHC service coverage index, a composite of essential services to a specific value by a certain year, or to ensure that 100% of districts have a functional clinic providing a defined package of PHC services. Targets could include reducing the percentage of households experiencing catastrophic health expenditures to near zero reflecting improved financial protection under NHI. Other possible targets are more operational, such as reducing patient waiting times at clinics or achieving a certain accreditation rate of health facilities under NHI quality standards by a deadline. Each target should correspond to an indicator that is regularly measured. For instance, if a target is to improve chronic disease care, an indicator may be the percentage of diabetic patients achieving controlled blood sugar, measured via clinic registers or surveys. All targets should be aligned with the Sustainable Development Goals (SDG) UHC objective (SDG 3.8), and with national health plans like the Department of Health's strategic plans. By linking NHI performance to these broader UHC targets, the M&E framework ensures that the NHI does not only increase coverage nominally, but also leads to real health gains and equity improvements.

### Feedback and improvement

An effective M&E framework is not just about data collection, but about using data for continuous improvement. The NHI governance structures must establish processes to review M&E findings at regular intervals e.g. quarterly and annually. This involves comparing indicators against the set targets and benchmarks. For example, if data show that certain provinces or districts are lagging in service coverage, the NHI Fund and Department of Health can investigate causes such as resource gaps or management issues and implement corrective actions. The M&E system will also monitor the implementation process itself. Early phases of NHI are being introduced in stages, so tracking readiness and rollout for instance, number of facilities contracted, amount of funds disbursed, etc. is essential. Research suggests that monitoring and evaluation of NHI implementation must be an ongoing process to proactively identify challenges and ensure timely resolutions.[60] In practice, this means creating a feedback loop where data on issues like provider payment delays, patient complaints, or drug stock-outs are quickly reported and addressed. Regular health system reviews and possibly annual UHC progress reports should be institutionalised. These would synthesise the indicator data and qualitative evaluations to give an overall assessment of NHI's impact on UHC goals. Transparency is also important publishing M&E results allows stakeholders including civil society and academia to hold the system accountable and contribute ideas.

## MONITORING, EVALUATION, AND SYNTHESIS

Monitoring and evaluation are an important part of ensuring that the health care outcomes which are intended to be achieved by a policy are indeed realised. This is done by making sure that the policy is implemented effectively and evaluated against the stated objectives.[63] Without a robust monitoring and evaluation (M&E) framework, even the most well-intentioned health reforms risk falling short of their goals. In the context of South Africa's National Health Insurance (NHI), M&E is not merely a technical exercise, it is a strategic imperative that ensures accountability, transparency, and continuous improvement. A step-by-step implementation approach is essential. This includes pilot testing in selected provinces and healthcare districts, as demonstrated in Thailand's health reform journey. Thailand's phased implementation allowed for real-time learning, adjustment, and capacity building before scaling up to a national level. Similarly, Indonesia refined its universal health coverage strategy by embedding monitoring mechanisms and investing in capacity development prior to national rollout. These international examples underscore the importance of adaptive learning and iterative implementation, especially in complex health systems.

The purpose of the monitoring and evaluation plan is to be used as a tool to identify gaps which pose a threat to achieving the objectives of NHI.[64] These gaps may arise in any of the six health system building blocks service delivery, health workforce, information systems, access to essential medicines, financing, and leadership/governance. A comprehensive M&E framework must therefore be designed to assess performance across all these domains. This ensures that no component of the system is overlooked and that interdependencies between them are well understood and managed.

When Dubai implemented new healthcare services, it relied heavily on the monitoring and evaluation strategy it had in place. This strategy was instrumental in assessing the healthcare needs of the population, setting priorities, and addressing the gaps identified in service delivery and infrastructure.[65] Dubai's experience illustrates how M&E can be used not only to track progress but also to inform strategic planning and resource allocation. Importantly, the monitoring and evaluation strategy in place goes beyond just ensuring that there is overall healthcare coverage, it also ensures that the healthcare provided is of good quality, equitable, and responsive to the needs of the population.

In the South African context, where disparities in access and quality of care persist, the M&E framework must be designed with an equity lens. This means disaggregating data by geography, income, gender, and other relevant factors to identify who is being left behind. It also means involving communities and frontline

health workers in the design and implementation of M&E activities, ensuring that the system is not only top-down but also responsive to grassroots realities.

According to Tabish (2024), understanding and monitoring the finances in healthcare is crucial.[66] It includes budgeting, financial reserves, and financial management, which in turn lead to informed decision-making regarding resource allocation, efficiency, and sustainability. Financial monitoring is not just about tracking expenditures, it is about ensuring value for money, identifying inefficiencies, and preventing misuse of funds. In a context like South Africa's, where the public healthcare system is already under-resourced, this becomes even more critical. The financial sustainability of NHI relies on the ability to monitor and manage resources effectively, anticipate future costs, and implement cost-containment measures without compromising quality.

The M&E framework will therefore include a financial sustainability component that tracks revenue flows, expenditure patterns, and cost drivers. It will also monitor the implementation of fraud prevention strategies and assess the efficiency of procurement and supply chain systems. This financial lens will be integrated with service delivery and health outcomes data to provide a holistic view of system performance. The framework will involve tracking the goals at every phase of the implementation. This includes both process indicators e.g., number of facilities upgraded, number of staff trained and outcome indicators e.g., reduction in maternal mortality, increase in patient satisfaction. The tracking of these indicators will be achieved by monitoring the number of people who access healthcare services, assessing patient and health worker satisfaction, and evaluating the use of finances. These indicators will be aligned with the broader objectives of NHI and will be reviewed regularly to ensure relevance and responsiveness.

Data collection will be a cornerstone of the M&E strategy. This will involve multiple methods, including patient and healthcare worker surveys, tracking patient records using the national health information system, and conducting regular resource and financial audits. The integration of digital health technologies will be essential in this regard. Electronic health records, mobile data collection tools, and real-time dashboards can enhance data accuracy, timeliness, and accessibility. However, this will require significant investment in IT infrastructure, data governance frameworks, and digital literacy among health workers. Capacity building is another critical pillar of the M&E strategy. Identifying key capacity gaps, such as limited skills in strategic purchasing, health economics, and data analytics. Once these gaps are identified, a targeted capacity-building plan must be developed. This could include training programs, mentorship initiatives, and partnerships with academic institutions. Building a cadre of skilled professionals who can design, implement, and interpret M&E activities is essential for the long-term success of NHI.

## Conclusion

South Africa's health care system is heavily unequal. It is mainly divided into the government funded public healthcare system and the private health system which only caters to a minority of the population. Implementing the NHI aims to restructure the health system and ensure equitable and efficient health care access for the population. The national health insurance will use a mixed funding model, centralised financial management, and strategic purchasing to ensure that services are purchased based on health needs rather than income or location. Governance structures will include a national fund governed by a board accountable to the Minister of Health, with oversight through audits and public reporting. The roles of public and private sectors must be clearly defined, with private providers integrated into the system under strict quality standards. Financial risk protection will be achieved through progressive revenue collection and elimination of out-of-pocket payments. Monitoring and evaluation will track service coverage, financial protection, quality, and health outcomes. Data sources will include routine health information systems, household surveys, and financial audits. By implementing the NHI South Africa can build a responsive, transparent, and equitable health system that delivers real progress toward universal health coverage

## References


1. National Treasury (2023) Budget Review 2023. Pretoria National Treasury.

2. World Health Organisation (2020) Developing a National Health Financing Strategy A Reference Guide. Geneva World Health Organisation.

3. WHO (2017a). Aligning public financial management and health financing a process guide for identifying issues and fostering dialogue. [online] www.who.int. Available at https //www.who.int/publications/i/item/9789241513074

4. National Department of Health (2023) National Health Insurance Bill. Pretoria Government of South Africa.

5. Fusheini A, Eyles J. Achieving universal health coverage in South Africa through a district health system approach: conflicting ideologies of health care provision. BMC Health Serv Res. 2016;16(1):558. doi:10.1186/s12913-016-1797-4.

6. Department of Health (2015). White Paper on National Health Insurance for South Africa | Department of Health Knowledge Hub. [online] knowledgehub.health.gov.sa. Available at https //www.gov.sa/sites/default/files/gcis_document/201512/39506gon1230.pdf.

7. Republic of South Africa (2019). NATIONAL HEALTH INSURANCE BILL. [online] Available at: https //www.gov.sa/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf.

8. Tangcharoensathien, V., Witthayapipopsakul, W., Panichkriangkrai, W., Patcharanarumol, W. and Mills, A. (2018). Health systems development in Thailand A solid platform for successful implementation of universal health coverage. The Lancet, [online] 391(10126), pp.1205–1223. Available at https //pubmed.ncbi.nlm.nih.gov/29397200/.

9. Sekabaraga, C., Diop, F. and Soucat, A. (2011). Can innovative health financing policies increase access to MDG-related services? Evidence from Rwanda. Health Policy and Planning, [online] 26(Suppl. 2), pp.ii52–ii62. Available at https //pubmed.ncbi.nlm.nih.gov/22027920/.

10. Partners in Health (2016). The Development of Community-Based Health Insurance in Rwanda Experiences and Lessons. [online] Available at https //msh.org/wp-content/uploads/2016/04/the_development_of_cbhi_in_rwanda_experiences_and_lessons_-_technical_brief.pdf.

11. Lu, C., Chin, B., Lewandowski, J.L., Basinga, P., Hirschhorn, L.R., Hill, K., Murray, M. and Binagwaho, A. (2012). Towards Universal Health Coverage An Evaluation of Rwanda Mutuelles in Its First Eight Years. PLoS ONE, [online] 7(6), p.e39282. Available at https //pubmed.ncbi.nlm.nih.gov/22723985/.

12. Ataguba, J.E., Day, C. & McIntyre, D. (2014). *Monitoring and evaluating progress towards Universal Health Coverage in South Africa*. PLoS Medicine, 11(9): e1001686.

13. Barber, S.L., Lorensoni, L. and Ong, P. (2019). Institutions for Health Care Price Setting and regulation a Comparative Review of Eight Settings. The International Journal of Health Planning and Management, [online] 35(2), pp.639–648. Available at https //pmc.ncbi.nlm.nih.gov/articles/PMC7161922/.

14. SPARC (Strategic Purchasing Africa Resource Center) (2021). Strategic Health Purchasing in Ghana POLICY BRIEF MAY 2021 STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA GHANA Strategic Health Purchasing in Ghana Health Financing Schemes in Ghana. [online] Available at https //sparc.africa/wp-content/uploads/2021/05/SPARC_Policy_Brief_GHANA_L3a.pdf

15. Amporfu, E., Agyei-Baffour, P., Edusei, A., Novignon, J. and Arthur, E. (2022). Strategic health purchasing progress mapping A spotlight on Ghana's National Health Insurance Scheme. Health Systems & Reform, [online] 8(2). Available at https //pubmed.ncbi.nlm.nih.gov/35695801/.

16. McIntyre, D., Garshong, B., Gemini Mtei, Filip Meheus and Goudge, J. (2008). Beyond fragmentation and towards universal coverage insights from Ghana, South Africa and the United Republic of Tansania. Bulletin of the World Health Organisation, [online] 86(11), pp.871–876. Available at https //www.researchgate.net/publication/317452761_Beyond_fragmentation_and_towards_universal_coverage_insights_from_Ghana_South_Africa_and_the_United_Republic_of_Tansania.

17. Norheim, O.F. and Watkins, D.A. (2023). The Role of HTA for Essential Health Benefit Package Design in Low or Middle-Income Countries. Health Systems and Reform, [online] 9(3), p.2273051. Available at https //pubmed.ncbi.nlm.nih.gov/37948391/#~text=In%20summary%2C%20HTA%20can%20play.

18. World Health Organization (WHO). (2021). Priority benefits packages: operational manual. Geneva: World Health Organization. Available at: https://www.who.int/teams/health-financing-and-economics/economic-analysis/health-technology-assessment-and-benefit-package-design/resource-guide-for-the-use-of-hta-and-hbp-design-processes/what-are-the-overall-principles-of-hbp-design/principles-of-health-benefit-packages

19. Glassman, A., Giedion, U. and Smith, P.C. (2017). What's In, What's Out Designing Benefits for Universal Health Coverage. [online] Research Gate. Available at https //www.researchgate.net/publication/321320007_What.

20. Hajji O., El Abbadi, El Houcine Akhnif (2025). Systematic Review of Financing Functions for Universal Health Coverage in Low- and Middle-Income Countries Reforms, Challenges, and Lessons Learned. Public health reviews, [online] 46. Available at https //pmc.ncbi.nlm.nih.gov/articles/PMC125014 /

21. Cashin, C., Chi, Y-Ling., Borowits, M. and Thomson, S. (2014). Paying for Performance in Health Care Implications for Health System Performance and Accountability. [online] ResearchGate.

Available at https //www.researchgate.net/publication/275637944_Paying_for_Performance_in_Health_Care_Implications_for_Health_System_Performance_and_Accountability.

22. AHPSR (2025). CALL FOR Proposals Paying Providers for Primary Care – Designing and Implementing Blended Provider Payment Models. School Science and Mathematics, [online] 110(6), pp.328–328. Available at https //ahpsr.who.int/docs/librariesprovider11/calls-for-proposals/year/2025/alliance-rfp-paying-proviers-primary-care.pdf?sfvrsn=b631eea9_4.

23. Mathauer, I., Vinyals Torres, L., Kutzin, J., Jakab, M. and Hanson, K. (2020). Pooling financial resources for universal health coverage: options for reform. *Bulletin of the World Health Organization*, [online] 98(2), pp.132–139. Available at: https://pubmed.ncbi.nlm.nih.gov/32015584/.

24. Busse, R., Geissler, A., Aaviksoo, A., Cots, F., Hakkinen, U., Kobel, C., Mateus, C., Or, s., O'Reilly, J., Serden, L., Street, A., Tan, S.S. and Quentin, W. (2013). Diagnosis related groups in Europe moving towards transparency, efficiency, and quality in hospitals? BMJ, [online] 346(jun07 3), pp.f3197–f3197. Available at https //pubmed.ncbi.nlm.nih.gov/23747967/.

25. ThinkWell (2021). The Philippine UHC Law Series Brief 4 - Immediate Eligibility for Health Benefit Packages. [online] Available at https //thinkwell.global/wp-content/uploads/2021/03/PH-UHC-Law-Series_-Immediate-Eligibility_Brief-4_final.pdf.

26. Pisani, E., Olivier Kok, M. and Nugroho, K. (2016). Indonesia's road to universal health coverage a political journey. Health Policy and Planning, [online] 32(2), p.csw120. Available at https //pubmed.ncbi.nlm.nih.gov/28207049/.

27. Siita, R., Cox, T., Hanson, K., & Goudge, J. (2019). Ghana's Experience with Changing Provider Payment to Improve Performance. London: London School of Hygiene & Tropical Medicine

28. Mathauer, I. and Wittenbecher, F. (2013). Hospital Payment Systems Based on diagnosis-related groups Experiences in low- and middle-income Countries. Bulletin of the World Health Organisation, [online] 91(10), pp.746–756A. Available at https //pubmed.ncbi.nlm.nih.gov/24115798/.

29. Percept Health Consulting. (2023). Diagnosis-Related Groups (DRGs): Utility and Feasibility for South Africa's Public Health Sector. Johannesburg: Percept.

30. Eichler, R., Agarwal, K., Askew, I., Iriarte, E., Morgan, L. and Watson, J. (2013). Performance-based Incentives to Improve Health Status of Mothers and Newborns What Does the Evidence Show? Journal of Health, Population, and Nutrition, [online] 31(4 Suppl 2), p.S36. Available at https //pmc.ncbi.nlm.nih.gov/articles/PMC4021698/.

31. World Bank. (2022). Performance-Based Financing in the Health Sector of the Democratic Republic of Congo: Impact Evaluation Report. Washington DC: World Bank.

32. Ndayishimiye, C., Sowada, C. and Dubas-Jakóbcsyk, K. (2025). Health care provider payment reforms in African states of the Commonwealth—a scoping review. Frontiers in Public Health, [online] 13. Available at https //pubmed.ncbi.nlm.nih.gov/40606072/.

33. Renmans, D., Holvoet, N., Orach, C.G., & Criel, B. (2016). Opening the 'black box' of performance-based financing in low- and lower middle-income countries: a review of the literature. Health Policy and Planning, 31(9), 1297-1309.

34. OECD (2023). Innovative Providers' Payment Models for Promoting value-based Health Systems. [online] OECD. Available at https //www.oecd.org/en/publications/innovative-providers-payment-models-for-promoting-value-based-health-systems_627fe490-en.html

35. Porter, M. and Kaplan, R. (2016). How to Pay for Health Care. [online] Harvard Business Review. Available at https //hbr.org/2016/07/how-to-pay-for-health-care

36. Co, P.A., Vîlcu, I., Gusman, D.D. and Banson, E. (2024). Staying the Course Reflections on the Progress and Challenges of the UHC Law in the Philippines. Health Systems & Reform, [online] 10(3). Available at https //pubmed.ncbi.nlm.nih.gov/39531615/.

37. World Health Organization (WHO). (2018). Strategic Health Purchasing: A Guide for Purchasers and Policymakers. Geneva: World Health Organization.

38. Hafner, T. and Shiffman, J. (2013). The Emergence of Global Attention to Health Systems Strengthening. Health Policy and Planning, [online] 28(1), pp.41–50. Available at https //pubmed.ncbi.nlm.nih.gov/22407017/

39. Savedoff, W.D., de Ferranti, D., Smith, A.L. and Fan, V. (2012). Political and Economic Aspects of the Transition to Universal Health Coverage. The Lancet, [online] 380(9845), pp.924–932. Available at https //pubmed.ncbi.nlm.nih.gov/22959389/.

40. WHO (2016). MEDICINES IN HEALTH CARE DELIVERY THAILAND Situational Analysis 23 November -4 December 2015 Report prepared using the WHO/SEARO workbook tool for undertaking a situational analysis of medicines in health care delivery in low and middle income countries. [online] Available at https //cdn.who.int/media/docs/default-source/searo/hsd/edm/csa-thailand-situational-assessment-2015.pdf?sfvrsn=5b7590c4_2

41. Mbau, R., Kabia, E., Honda, A., Hanson, K. and Barasa, E. (2020). Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. International Journal for Equity in Health, [online] 19(1). Available at https //pubmed.ncbi.nlm.nih.gov/32013955/.

42. ResYST Consortium (2016). STRATEGIC PURCHASING FOR UNIVERSAL HEALTH COVERAGE A CRITICAL ASSESSMENT SOCIAL HEALTH INSURANCE FUND, VIETNAM. [online] Available at https //resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/Vietnam%20purchasing%20brief.pdf.

43. Le, Q.N., Blissard, L., Si, L., Giang, L.T. and Neil, A.L. (2020). The Evolution of Social Health Insurance in Vietnam and Its Role Towards Achieving Universal Health Coverage. Health Policy OPEN, [online] 1, p.100011. Available at https //pubmed.ncbi.nlm.nih.gov/37383313/.

44. National Treasury (2024). National Treasury. [online] www.treasury.gov.sa. Available at https //www.treasury.gov.sa/documents/National%20Budget/2024/review/FullBR.pdf.

45. Government of Bangladesh (2013). Implementation Plan for the Bangladesh Health Care Financing Strategy 'Health Protection for All'. [online] Available at https //p4h.world/app/uploads/2023/02/2013_06_16_Bangladesh_HCFS_Implementation_Plan_16Jun13_0.x80726.pdf.

46. Ahmed, S., Hoque, M.E., Sarker, A.R., Sultana, M., Islam, s., Gasi, R. and Khan, J.A.M. (2016). Willingness-to-Pay for Community-Based Health Insurance among Informal Workers in Urban Bangladesh. PLOS ONE, [online] 11(2), p.e0148211. Available at https //pubmed.ncbi.nlm.nih.gov/26828935/.

47. Whyle, E.B. and Olivier, J. (2023) 'A socio-political history of South Africa's National Health Insurance', International Journal for Equity in Health, 22, 247. doi 10.1186/s12939-023-02058-3.

48. National Department of Health (n.d.) NHI – Home [online] Available at https //www.health.gov.sa/nhi/

49. Gordon, T., Booysen, F. and Mbonigaba, J. (2020) 'Socio-economic inequalities in the multiple dimensions of access to healthcare The case of South Africa', BMC Public Health, 20, 289. doi 10.1186/s12889-020-8368-7.

50. Day, C., Gray, A., Cois, A., Ndlovu, N., Massyn, N. and Boerma, T. (2021) 'Is South Africa closing the health gaps between districts? Monitoring progress towards universal health service coverage with routine facility data', BMC Health Services Research, 21, 194. doi 10.1186/s12913-021-06171-3.

51. Agbeyangi, A.O. and Lukose, J.M. (2025) 'Telemedicine adoption and prospects in Sub-Saharan Africa A systematic review with a focus on South Africa, Kenya, and Nigeria', Healthcare, 13, 762. doi 10.3390/healthcare13070762.

52. Health | South African Government (n.d.) [online] Available at https //www.gov.sa/about-sa/health

53. Greer, S., Klasa, K. and van Ginneken, E. (2020) 'Power and purchasing Why strategic purchasing fails', The Milbank Quarterly. doi 10.1111/1468-0009.12471.

54. National Department of Health (n.d.) NHI – FAQ [online] Available at https //www.health.gov.sa/nhi-faq/.

55. Rammila, D. (2023) 'Evaluating the potential impact of National Health Insurance on medical scheme members' rights to have access to health-care services in South Africa', Law, Democracy and Development, 27, pp. 360–391. doi 10.17159/2077-4907/2023/ldd.v27.14.

56. Okoroh, J., Essoun, S., Seddoh, A., Harris, H., Weissman, J.S., Dsane-Selby, L. and Riviello, R. (2018) 'Evaluating the impact of the National Health Insurance Scheme of Ghana on out-of-pocket

expenditures A systematic review', BMC Health Services Research, 18, 426. doi 10.1186/s12913-018-3249-9

57. Christmals, C.D. and Aidam, K. (2020) 'Implementation of the National Health Insurance Scheme (NHIS) in Ghana Lessons for South Africa and low- and middle-income countries', Risk Management and Healthcare Policy, 13, pp. 1879–1904. doi 10.2147/RMHP.S245615.

58. Republic of South Africa. (2024). *National Health Insurance Act 20 of 2024*. Government Printer, Pretoria.

59. Department of Health, South Africa. (2017). *National Health Insurance for South Africa: Towards Universal Health Coverage*. Policy document (Government Gazette No. 40955).

60. Mudzweda, A.D., Simbeni, T.V. & Mogale, N.M. (2025). *State of readiness: National Health Insurance implementation in hospitals, Gauteng province*. Curationis, 48(1): a2689.

61. Bowmans. (2024). *Critical changes under the NHI Act – legal perspective*. (Bowmans Law Firm analysis, cited in BusinessTech, 2 June 2024).

62. Results for Development (R4D). Translating health financing for South Africa's NHI reforms [Internet]. Washington (DC): R4D; 2015 . Available from: https://r4d.org/projects/translating-health-financing-south-africas-nhi-reforms/

63. O'Neill, K., Viswanathan, K., Celades, E. and Boerma, T. (2016) 'Accept terms and conditions on JSTOR', JSTOR [online] Available at https //www.jstor.org/stable/pdf/resrep56871.12.pdf?addFooter=false

64. Danforth, K., Ahmad, A.M., Blanchet, K., Khalid, M., Means, A.R., Memirie, S.T., Alwan, A. and Watkins, D. (2023) 'Monitoring and evaluating the implementation of essential packages of health services', BMJ Global Health, 8(Suppl 1), p. e010726. doi 10.1136/bmjgh-2022-010726.

65. Monsef, N., Suliman, E., Ashkar, E. and Hussain, H.Y. (2023). Healthcare services gap analysis: a supply capture and demand forecast modelling, Dubai 2018–2030. *BMC Health Services Research*, 23(1). doi:https://doi.org/10.1186/s12913-023-09401-y.

66. Tabish, S.A. (2024) 'Healthcare finance', in [Book Title], pp. 99–120. doi 10.1007/978-981-97-3879-3_5.

67. Alwan, A., Yamey, G. and Soucat, A. (2023). Essential packages of health services in low-income and lower-middle-income countries what have we learnt? BMJ Global Health, [online] 8(Suppl 1), p.e010724. Available at https //pmc.ncbi.nlm.nih.gov/articles/PMC9853117/.

68. Democratic Alliance (n.d.) '50 reasons why the NHI will never work', Democratic Alliance [online]. Available at https //www.da.org.sa/2023/05/50-reasons-why-the-nhi-will-never-work

69. Department of Health (2023). NATIONAL HEALTH INSURANCE (NHI) UNDERSTANDING THE Frequently asked questions. [online] Available at https //www.health.gov.sa/wp-content/uploads/2023/10/NHI-Frequently-asked-questions-ALL.pdf.

70. Kantor, G., Strydom, S., Mannie, C. and Wishnia, J. (2023). Percept Actuaries and Consultants Contributing writers Diagnostic-related groupers Utility and feasibility for South Africa's public health sector. [online] Available at https //percept.co.sa/wp-content/uploads/2023/02/Part_one_DRGs-1.pdf.

71. Mohan, C. (2024). Counterpoint, Provider Payment Reforms in Indonesia Lessons and Future Directions - ThinkWell. [online] ThinkWell. Available at https //thinkwell.global/counterpoint-provider-payment-reforms-in-indonesia-lessons-and-future-directions/

72. Parliament of the Republic of South Africa (2025) National Health Insurance (NHI Bill) [online] Available at https //www.parliament.gov.sa/project-event-details/54

73. Parmaksis, K., Pisani, E., Bal, R. and Kok, M.O. (2022). A systematic review of pooled procurement of medicines and vaccines identifying elements of success. Globalisation and Health, [online] 18(1). Available at https //pmc.ncbi.nlm.nih.gov/articles/PMC9188018/.

74. World Health Organisation (2017b) Health Financing Country Diagnostic A Foundation for National Strategy Development. Geneva World Health Organisation.