

The seven hidden dangers of NHI implementation

The National Health Insurance (NHI) Act has been presented to South Africans as a bold step toward Universal Health Coverage (UHC). While the goal of equitable access to quality healthcare is both noble and necessary, the underlying economic and operational assumptions of the NHI model are deeply problematic. The system will require personal income tax increases to more than double the current average rate and an estimated additional 286,000 healthcare professionals will need to be trained or recruited to provide the services. Beyond the fiscal and logistical impracticalities, the NHI presents additional risks that have received too little public scrutiny.

The Genesis Analytics report, commissioned by the Health Funders Association (HFA) to assess the feasibility and impact of the NHI Act, highlights seven major downside risks that could destabilise South Africa's health system, weaken public finances, and ultimately reduce access to care. These risks particularly affect the very people the NHI seeks to support.

1. Escalating prices from increased demand

The promise of universal access will, at first, raise demand for healthcare services. Without a proportional increase in capacity, this will push up the prices of critical inputs such as healthcare workers, hospital beds, diagnostic tools, and medicines. Rather than reducing costs, the NHI could increase overall expenditure and become financially unsustainable. Local and International experience shows that healthcare inflation consistently outpaces general consumer inflation due to rising utilisation. This means South Africa's healthcare expenditure will rise each year, forcing either a greater share of the national budget to be allocated to health or, alternatively, rationing of care to control costs.

2. Shrinking supply due to dictated prices

The NHI Fund is designed as a single purchaser of healthcare services (also referred to as a monopsony buyer) with a view to being able to dictate prices to counter the above effect. While the theoretical increase in bargaining power for monopsony buyers is real, the evidence shows that the practical application of this power often leads to significant trade-offs. Later on in the implementation phase, when the government tries to keep costs down by

setting low prices in response to initial demand-driven price/rationing pressure, providers may exit the system. For example, international pharmaceutical companies that generate just one percent of their global revenues from South Africa may choose to withdraw – either completely or to further reduce the range of products on offer. This could lead to reduced access to medicines, emigration of doctors, and declining investment in healthcare infrastructure. All of which, will impact the quality and accessibility of healthcare services.

3. Reduced access to care due to payment mechanisms

The NHI plans to use capitation-based payment models, in which providers are paid per patient (regardless of how many times the patient needs care) rather than per service. While capitation can be useful, implementation can only be done successfully if adequate data is collected and analysed. This supports the development of incentives for providers to deliver high quality care. On the other hand, capitation payments that are not supported by robust analytics create an incentive to minimise service delivery. A risk adjustment mechanism, where funds or insurers with a higher proportion of high-risk (i.e., older or sicker) members receive compensation from those with a lower-risk membership base, requires detailed analytics and, without robust data systems and quality monitoring, health care providers may not be appropriately reimbursed resulting in reduced access or delayed treatments so that health care providers remain financially viable.

4. Facility management challenges in the public sector

The NHI Act assumes that public and private health facilities can be used interchangeably. However, long-standing issues in public hospital management remain unresolved. One in three public facilities audited by the Office of Health Standards Compliance did not meet minimum compliance standards. Problems include equipment failures, poor procurement practices, chronic understaffing, and weak accountability. Integrating private providers into this system without reform could worsen outcomes for all patients.

5. Rising medico-legal costs

As medical scheme beneficiaries are absorbed into an overstretched public system, dissatisfaction and clinical errors are likely to increase. This may

drive up medico-legal claims against the state. Public information shows that more than R100 billion in such claims have already been made against provincial health departments in recent years. Under the NHI Act, this figure is likely to grow. These liabilities could divert more funds away from service delivery toward legal settlements and indemnity cover.

6. Rising costs of medical scheme cover during the lengthy transition

Up to 83 percent of medical scheme members earn less than R37,500 per month. Removing tax credits and restricting medical schemes will impose a financial burden on these lower-middle income earners. Analysis shows that as many as 884,000 potentially healthier, surplus-generating members could exit medical schemes early. This would increase contributions for those remaining, potentially triggering an actuarial death spiral of rising costs and declining membership before the NHI becomes operational. The Minister of Health has indicated that this transition period is expected to take at ten to 15 years meaning that this resulting transition shock could leave millions without reliable healthcare coverage for an extended period. Since those most affected by the transition risk are from the employed population, there will be broader economic impacts if they do not have reliable access to healthcare.

7. Out-of-pocket costs for middle-class households

Section 33 of the NHI Act prohibits medical schemes from covering services included in the NHI package once the legislation has been fully implemented. The NHI Act explicitly states that if patients face denial of care or long delays, they will need to pay out of pocket. South Africa's UHC index, as measured by the World Health Organisation, is currently 71, above the global average of 68, and out-of-pocket expenditure is only 6.7 percent of current health spending, ranking twelfth lowest globally. The NHI's limitations on private cover could result in increased household costs and a declining UHC index.

A high-risk path to health reform

South Africa urgently needs a more inclusive and equitable health system. However, in its current form, the NHI Act risks collapsing the private sector, overburdening public care, and reducing access for many. These negative effects are already being felt due to the loss of confidence in the sector, even

before considering the effects of completely unfeasible tax increases. Alternative, less risky paths to universal health coverage exist, such as the Health Funders Association's proposed hybrid multi-fund model. This model strengthens primary care, supports informed choice through medical schemes, and encourages public-private collaboration. And most importantly, there are immediate opportunities for reforms that will expand access to healthcare and encourage investment in the health sector and which would improve access for the whole population to healthcare services relative to the NHI, without having to implement tax increases.

Good intentions are not enough. South Africa must ensure that health policy is financially sound, operationally feasible, and genuinely focused on expanding access for all.