ECIPA HEALTHCARE · 2026

Universal Healthcare access: Convergence, *not disruption.*

Path forward for primary care.

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EWN EYEWITNESS NEWS

Godongwana wants legal challenges to NHI to be settled out of court

Cape Town

Lindsay Dentlinger
14 January 2026 | 9:25

> A truce is only a pause in hostilities.

A MOMENT OF OPPORTUNITY

Finance Minister Godongwana's call for parties challenging the NHI Act to step out of the courtroom and craft a joint approach has shifted the conversation.

But genuine universal coverage needs more than a ceasefire: it needs a clear, technically sound roadmap.

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THE NHI DEBATE IS ASKING *THE WRONG QUESTION.*

Centralising funding alone won't solve our health system challenges – *it will only replicate them on a larger scale.*

The NHI as currently designed addresses ***pooling –*** but not technical aspects of ***purchasing***.

But the real question isn't ***who*** holds the money.....

It's ***how*** care is purchased, organised, and incentivised.

Get these right and the system can function.
Neglect them and we repeat past failures – only bigger.

DIAGNOSIS

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Two systems. Both failing — in different ways.

~9 million members in private cover. **~60 million people** in total. The 9 million sit in the politically influential middle and upper / middle class – they will not relinquish access without a credible alternative.

PUBLIC SECTOR · 80+% OF THE POPULATION

Centralised, but unaccountable

Centralised, poorly managed

Unresponsive to patient needs

Weak accountability

Large budget but no measurement system

PRIVATE SECTOR · ~9 MILLION MEMBERS

Costly, fragmented, extractive

Extraordinary cost per member

Profit extraction over value creation

Hospital-centric, fragmented, destructive competition

Underfunded, weak primary care

Competes for scarce skills from the public sector

Around **70% of specialists** work in the private sector.

Premiums could be roughly **40% lower** if the private sector were properly managed.

Neither system functions well. They fail in different but reinforcing ways.

Council for Medical Schemes, Annual Report 2024; Competition Commission, Findings of the Health Market Inquiry, 2019.

THE STRUCTURAL CAUSE

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SA never built an effective healthcare value purchasing framework.

The deeper failure is upstream — in how we pay providers and organise healthcare delivery.

PUBLIC SECTOR

Provinces are funder, purchaser *and* provider — all at once.

No separation. No accountability tension.
No mechanism to ensure value.

Guaranteed salaries regardless of productivity and quality care – there is **no feedback loop**

PRIVATE SECTOR

Scheme administrators earn most of their income as a percentage of premiums.

Higher costs perversely *increase* their revenue.
Little incentive to commission integrated, low cost, high value care.

Fee-for-service rewards **volume, not outcomes.**
It fragments care, encourages unnecessary procedures, and prioritises short-term outputs over long-term health.

*"…Health care provision in South Africa lacks consistent comparable **measures of quality and health outcomes** and, by extension, the ability to **purchase strategically, to purchase on the basis of value.** This is true for both the **public and private sector**…"*

– Academy of Science of South Africa, Achieving Good Governance and Management in the SA Health System (2024), ch. 4 (*Blecher, Kaye, Atim, Cashin, Daven*).

THE INTERNATIONAL PRINCIPLE

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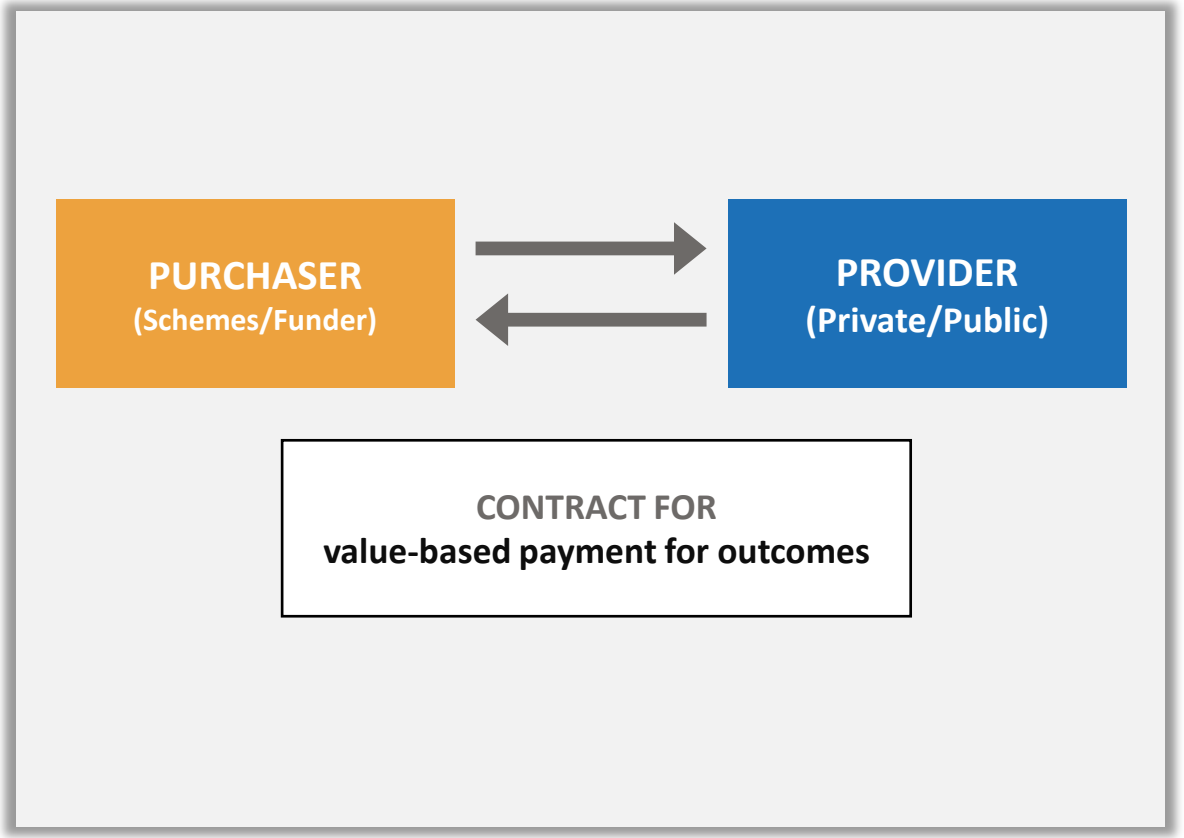
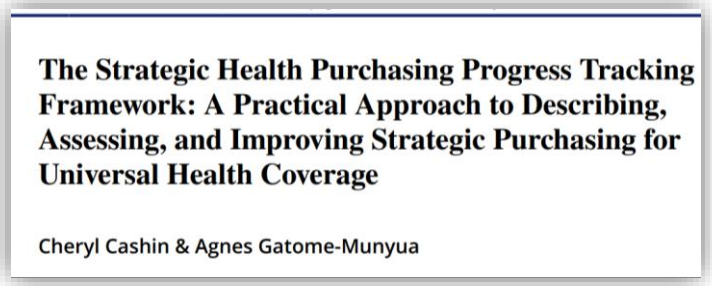
Separate the buyer of care from the deliverer of care.

> *The whole idea of an National Health Insurance system is that you split those functions.*
>
> *There is a purchaser, who holds the money and holds the contract – and a supply side that provides the services. That's a tension you want.*

> *Operates identically whether the funder is a single public payer or multiple private schemes*
>
> **Needs commitment to Health Informatics:**
> Coded encounter data (ICD, Tariff code)
> Case-mix groups - DRGs, EPG
> Structured clinical assessments




The Strategic Health Purchasing Progress Tracking Framework: A Practical Approach to Describing, Assessing, and Improving Strategic Purchasing for Universal Health Coverage

Cheryl Cashin & Agnes Gatome-Munyua

A PREDICTABLE QUESTION

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Who should be the purchaser?

Government management mostly poor track record – political and structural concerns with its ethos and ability.
However, experienced purchasers already exist in this market: **the major medical scheme administrators.**
The question is how they have used that purchaser role?? **Mostly by restricting benefits and hiking premiums**

PASSIVE

Medical Scheme Administrators

Admin services and manage by benefit design.

Focus: to attract healthy lives and enable individual self management – don't manage populations or systems

PASSIVE

Managed care organisations

Administrators turned managed care into a revenue line

MCOs undermine clinical decisions, are largely ineffective - and deeply resented by patients and

PASSIVE

Schemes

Typically controlled by their administrators

ACTIVE

GEMS
The credible candidate - commitment to VBC contracts

- Administrators perversely own provider business via the MCO license for which the scheme they administer pays – instead of commissioning supply-side structures that create value
- Negotiating tariffs once year with hospital and pathology groups does not build the structures the system needs.

COUNCIL for MEDICAL SCHEMES

The Council for Medical Schemes has not intervened to enforce the Schemes purchase role.

They have had the opportunity to commission a better functioning system. ***They have not taken it.***

CONVERGENCE — NOT DISRUPTION

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A path that works *with* South Africa's reality, not against it.

Sudden replacement of one system with another is unrealistic. The credible route to universal coverage is gradual convergence.

> ***Healthcare is a mirror of society. It can't exist independent of everything else happening in the country.***

- **Narrowing income and wealth inequality (a critical precondition).**
- **Organic, iterative reform** that improves both systems where they currently operate.
- **Increasing overlap**, shared services, and aligned incentives.
- **Trust built through tangible improvements** – not promises.
- **Lead with Primary care**

A TANGIBLE VISION

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Any functioning health system needs three things. South Africa has none of them at scale.

A single fund without these three things will not produce better health outcomes.

REQUIREMENT 1

Population Need Measurement

Accurate information on population health is the basis for every other decision.

REQUIREMENT 2

Value-based payment

Paying providers for outcomes, not volume – the incentive that aligns care with health.

REQUIREMENT 3

Organised delivery

Integrated local care systems able to act on the measurement and earn the value payment reward.

A UNIFIED SYSTEM (CONVERGENCE)

The state governs the market – it neither runs the supply side nor abandons it.

- Regionally organised – local models vary depending on context.
- Competent purchasers contracting both public and private providers on measured value.
- Populations enroll with integrated local care systems; the systems that produce value prosper, those management teams that fail lose their contracts.
- Public and private converge through designed competition on value.

This does not start with legislation. It starts with building a clear policy and vision.

The NHI Act describes a destination. ***The work shown here is the route, and we have already started.***

CONVERGENCE IN OPERATION

The Value Care Team

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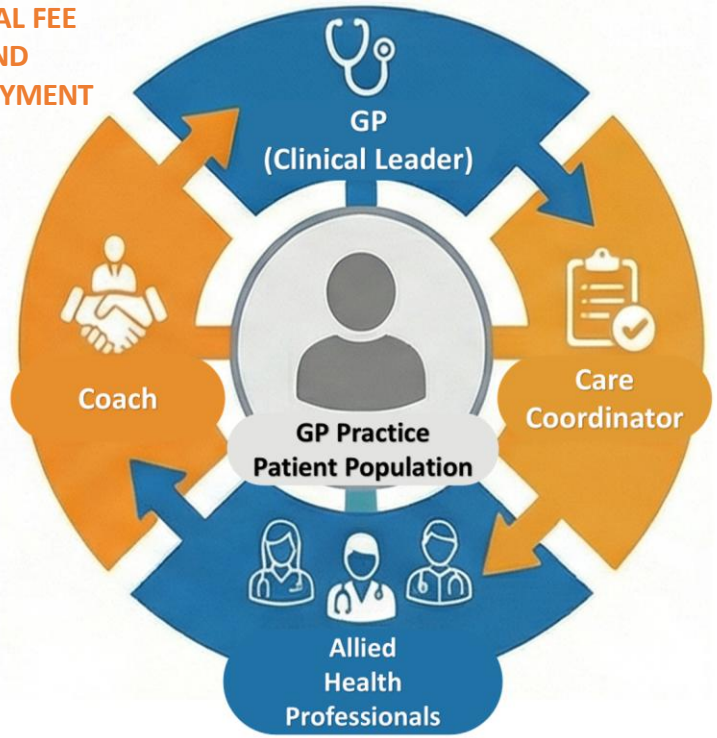
A working example, today – The Value Care Team

PPO Serve: a decade of practice in South African private primary care.

135,000+	230+	5	15	55+	10+
LIVES	GP PRACTICES	PROVINCES	HUBS	CARE COORDINATORS	COACHES

GLOBAL FEE AND VBC PAYMENT



LESSONS FROM A DECADE OF IMPLEMENTATION

Horizontal integration first. GPs with care coordinators, allied health, and local services. Trust within hubs is the foundation for broader coordination.

Sustained coaching, not just training. Practice Transformation Coaches are the central change agents. Behaviour embedded over decades cannot be changed by workshops and incentives alone.

Technology enables but doesn't drive transformation. It supports the shared-purpose structures that drive change.

PPO Serve is a Healthcare Services Management Organisation (HSMO) – not an insurer, not a managed-care organisation. **No downside financial risk transferred to clinicians.**

POPULATION HEALTH, ORGANISED – HOW THE MODEL WORKS

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▲ FEWER PATIENTS

Complex	**COMPLEX** Care coordination · MDTs
Chronic	**CHRONIC** Chronic disease management
At Risk	**AT RISK** Targeted programmes
Healthy	**HEALTHY** Prevention & screening

▼ MORE PATIENTS

TRACK WHAT MATTERS

- Screenings done
- Chronic patients monitored
- Hospital admissions avoided
- Bed-days avoided
- Complex patients orientated

RISK-ADJUSTED
Monthly global fee, paid upfront

+

EARNED ON OUTCOMES
Value-linked fee

Scheme members in a local area. Identify the active patients.

Stratify every patient into four risk tiers. The sicker the patient, the more the team does.

The sickest patients get the most attention – proactively, before a crisis.

Measure what matters – outcomes, not visits.

Risk profile sets the fee. Outcomes earn the value-linked fee. No fee-for-service bills.

1. **Population** → 2. **Planning** → 3. **Action** → 4. **Measure** → 5. **Value**

Every patient accounted for. Effort matched to need. ***Paid for keeping people well.***

WHO CAPTURES THE SAVINGS FROM WASTE REDUCTION ?

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In US healthcare, **35–50% of all spending is waste**. James & Poulsen split waste into three levels – and only **population-based payment** lets the care delivery group capture savings at *all three*.

TYPE OF WASTE		PAYMENT METHODS: FEE FOR SERVICE	PER CASE	POPULATION-BASED PAYMENT
Service level Inefficient production of individual care units, such as drugs, tests, nursing support.	5%	Payer	Provider	Provider
Patient Case level Use of unnecessary or suboptimal services in treating a case.	50%	Payer	Provider	Provider
Population level Unnecessary or avoidable patient cases.	45%	Payer	Payer	Provider

Payer captures the savings **Provider** captures the savings

ECONOMICS & SOCIETY
The Case for Capitation
by Brent C. James, MD and Gregory P. Poulsen
From the July–August 2016 Issue

Under Fee-for-Service, *doing the right thing is financially punishing.*
Under Population-based payment, *it's financially rewarded.*

THE INTERMOUNTAIN NEONATAL EXAMPLE

An intervention for borderline preemies cut intubation rates from **78% to 18%**. Hospital costs fell by **$544,000/year**. Under Fee-for-Service, insurance payments dropped by **$873,000** (a **$329,000 loss** per hospital). Scaled across Intermountain: a **$5 million annual loss** for doing the right thing for children.

HOW A GP GETS PAID FOR KEEPING PEOPLE HEALTHY

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Needed: a secure base, plus a ladder you climb by being good at your job.

Fee-for-service pays you for volume. **This pays you for value** and ***your most complex patients become worth proportionately more, not less.***

COMPONENT 1 · THE SECURE BASE

PROFESSIONAL GLOBAL FEE

A predictable monthly fee for your whole enrolled population – paid upfront.

Risk-adjusted, so a practice carrying sicker patients is paid more.

It does not depend on how many people walk through the door.

The base is yours. The team is around you. The income is stable, regardless of daily volume.

+

COMPONENT 2 · CLIMB ON OUTCOMES ↑

Level 5	TOP PERFORMANCE
Level 4	STRONG
Level 3	SOLID
Level 2	BUILDING
Level 1	STARTING

The value-based fee is sized at **25 to 33 percent of total potential payment:** **big enough to be worth real effort, never big enough that one bad quarter sinks the practice.**

Predictable income. A team around you. ***Paid to keep your patients healthy and optimise their care – not just to see them more often.***

PRIMARY CARE IS CENTRAL – NOT PERIPHERAL

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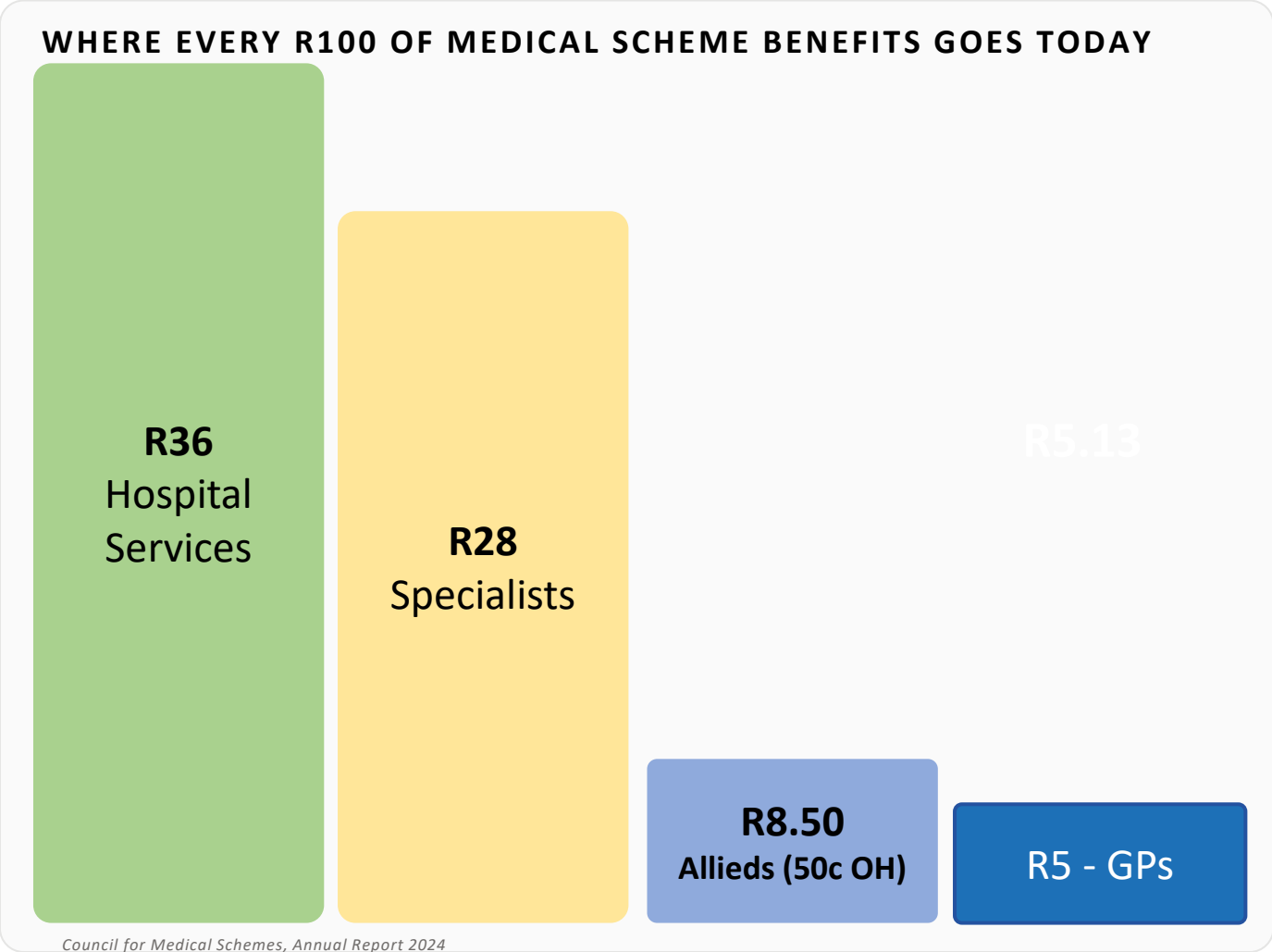
> *There are roughly **10,000 GPs** in the South African private sector.*
>
> *That capacity is the supply side of any credible reform.*



A rebalance can make a difference:

A 5% shift from hospital and specialist spending toward general practice would double current GP funding — per R100.

R5 → R10

This is funded by stopping unnecessary admissions and bed days:

Earlier, better-coordinated outpatient care.

Under population-based payment: the savings flow back to providers and members rather than to intermediaries.

SPEND MORE ON PRIMARY HEALTHCARE
SAVE MUCH MORE ON HOSPITAL CARE

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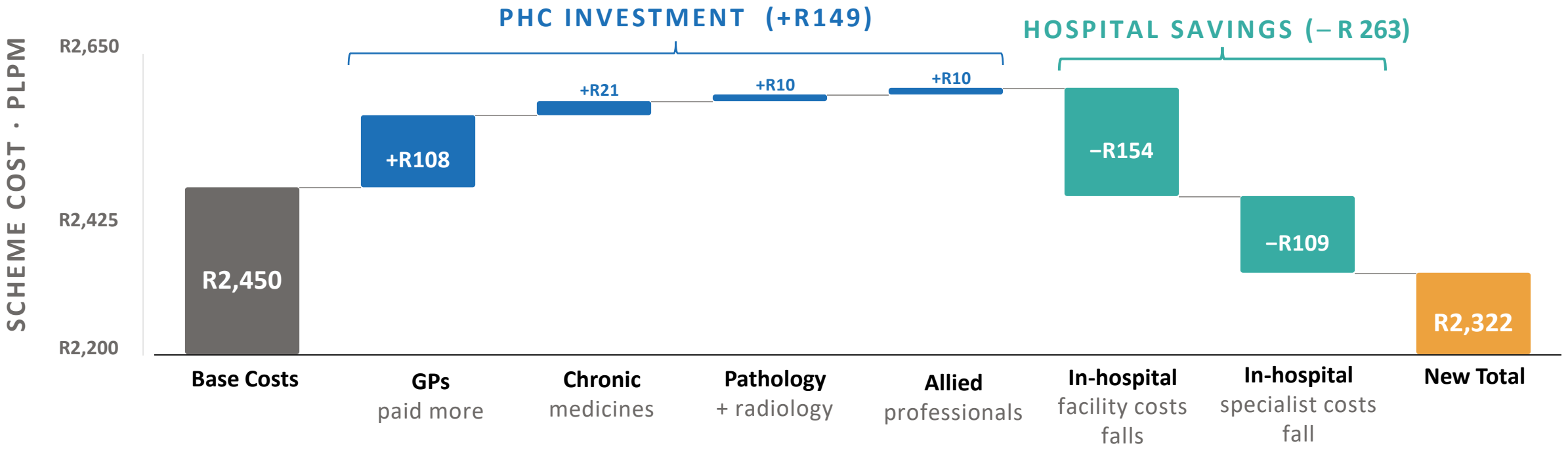
TVCT effect on Scheme costs in 2025: Scheme cost per member, per month – from R2,450 to R2,322.

The practice is paid more; the scheme still spends less.



Investing in the GP practice and the primary healthcare team produces a far larger fall in hospital and specialist costs.

Better primary healthcare more than pays for itself.

REAL RESULTS, REAL PRACTICES

This is not a theory. ***It is already happening.***

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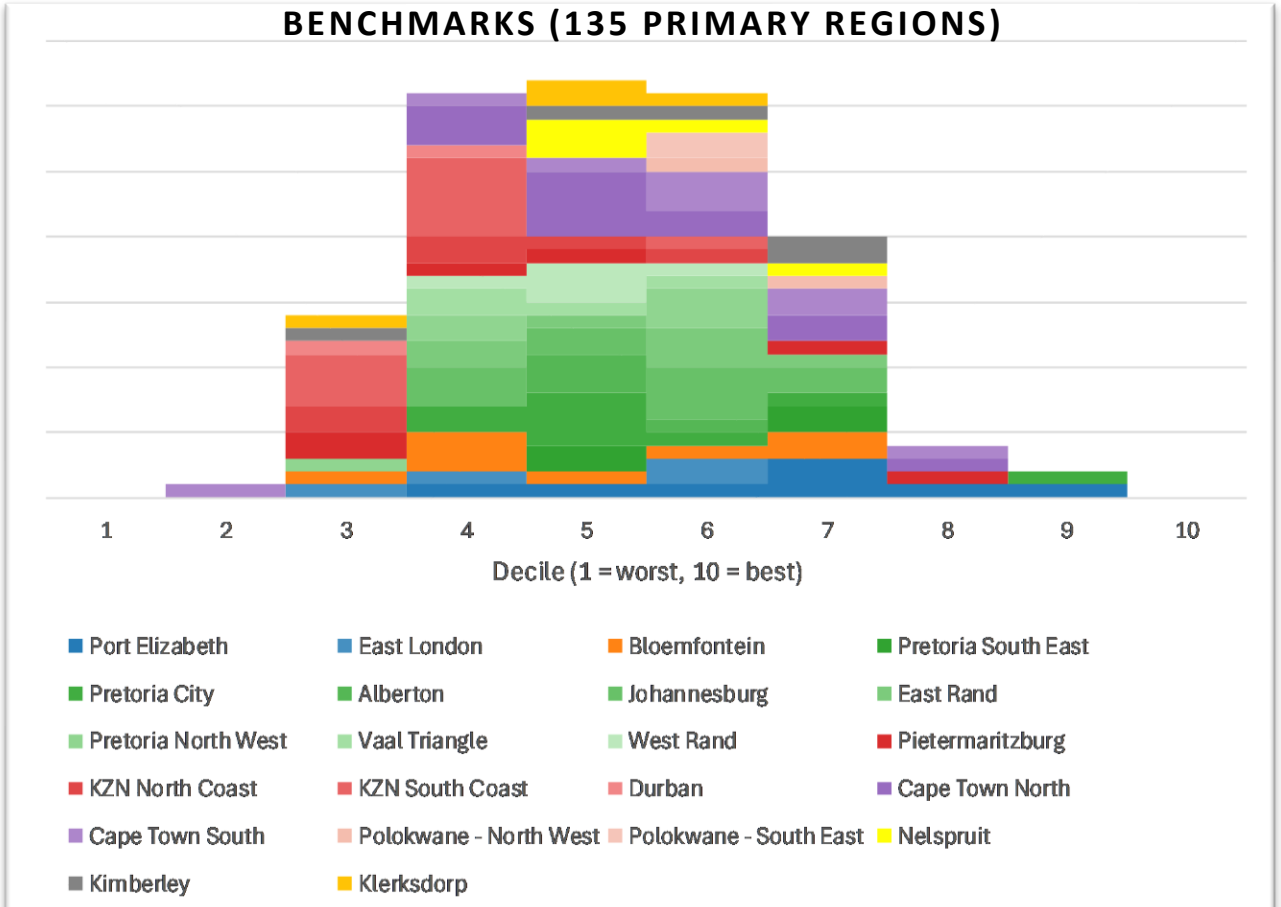
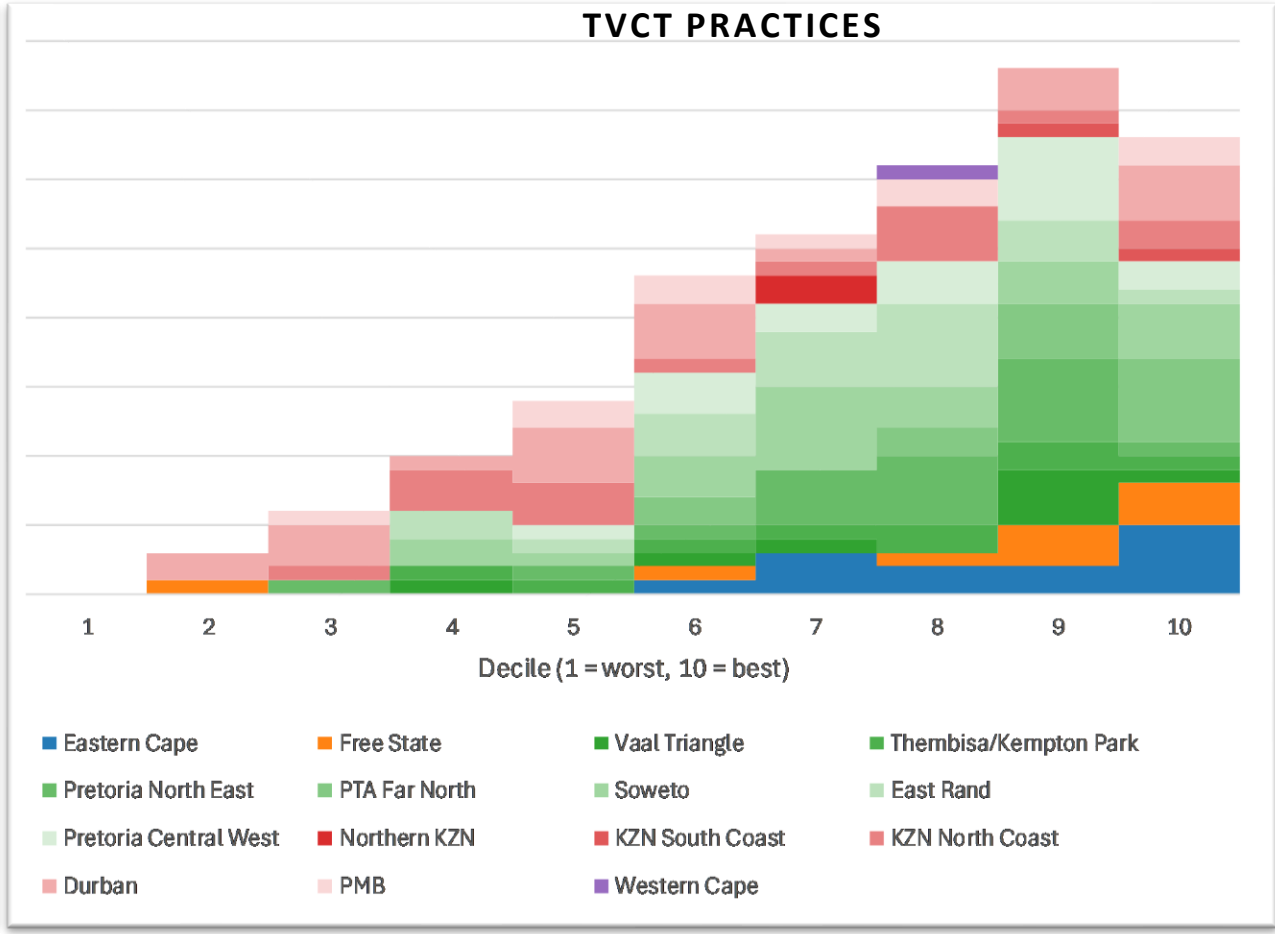
BENCHMARKS (135 PRIMARY REGIONS)



TVCT PRACTICES



HOSPITAL ADMISSIONS (WITH REGIONAL ADJUSTMENT) – Q4 2024 to Q3 2025

TVCT against the national benchmark average (Chronic and Non-Chronic)

REAL RESULTS, REAL PRACTICES

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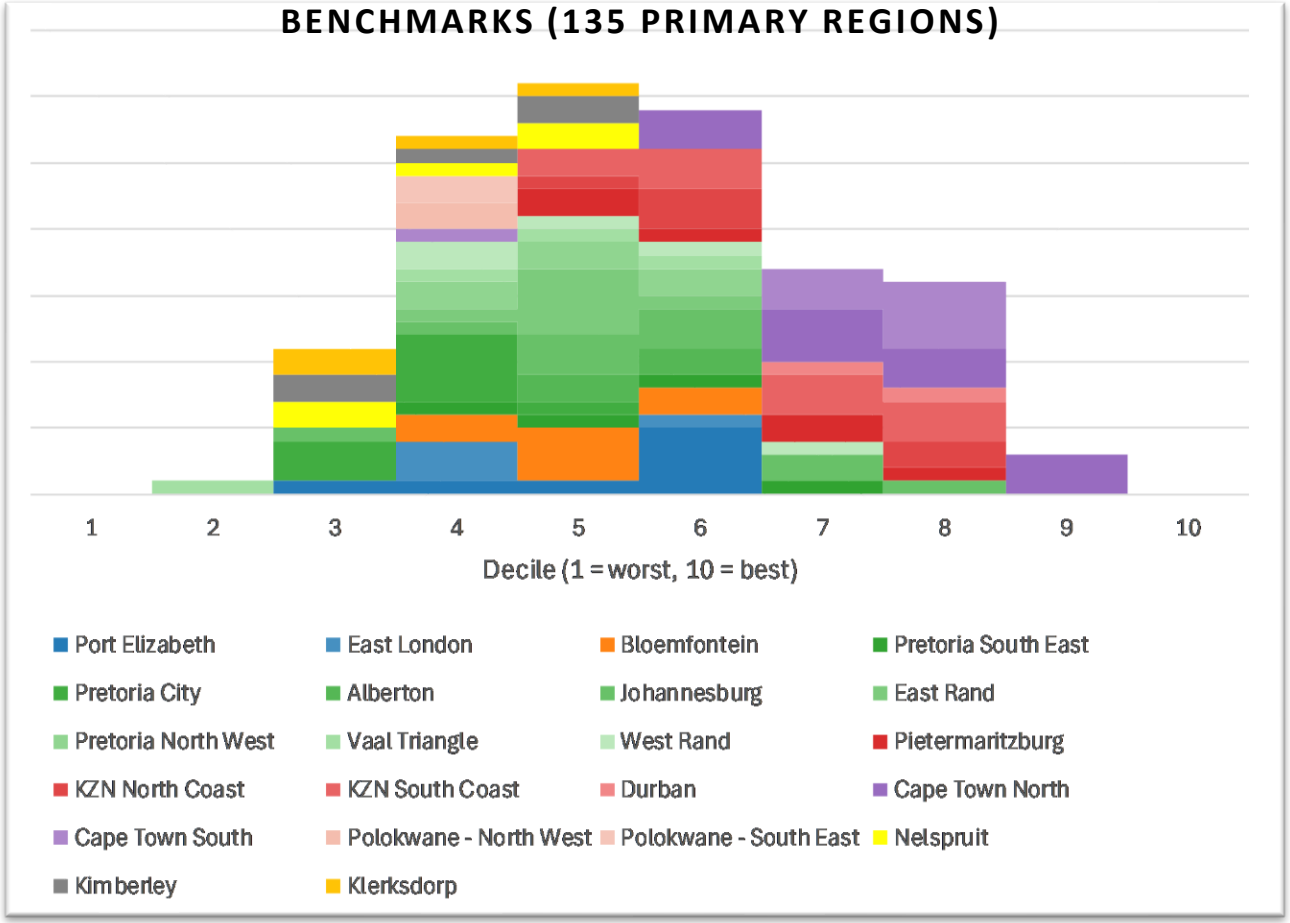

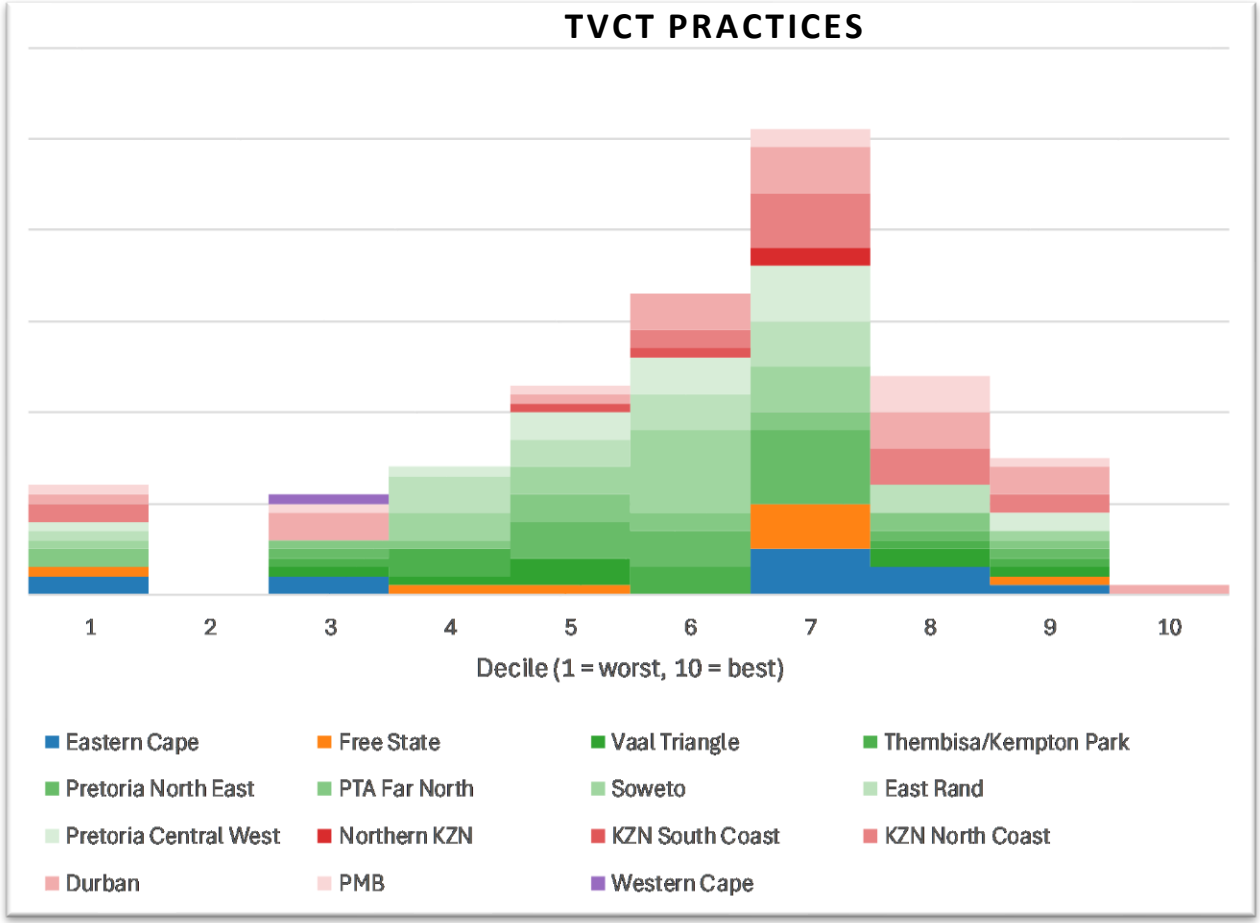

COMPLIANCE (CHRONIC LIVES) – Q4 2024 to Q3 2025

TVCT against the national benchmark average

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THE CONVERGENCE PATH:

The settlement is a rare opportunity. But it only matters if it addresses root causes:

- **Real purchaser–provider separation** – Schemes that don't purchase to restructure lose their accreditation
- **Primary care prioritised** over hospital dependence
- **Trust built** through tangible improvements – takes time

Do we cling to entrenched interests and outdated approaches
– *or take the practical, evidence-driven path forward?*

Dr Brian Ruff
Founder, PPO Serve
Clinical R&D