Concerns regarding bias in article on achieving universal health coverage in South Africa

To the Editor: I refer to your journal's recent online publication authored by Alex van den Heever, titled 'Achieving universal healthcare access in South Africa: A policy analysis of consensus reform proposals'.[1] While I acknowledge the value of rigorous academic debate and appreciate the journal's role in facilitating open discourse, I would like to respectfully raise several concerns regarding the article's framing, tone and analytical balance. I raise these in the following paragraphs:

The lack of objective assessment and apparent bias against UHC2

Although the article is presented as a comparative policy analysis, from the start it displays a clear preference for UHC1 and portrays UHC2 (as articulated in the National Health Insurance (NHI) reform documents) in an overtly negative light. The analysis and approach applied commonly presumes failure in the implementation of UHC2 without fully exploring risk mitigation strategies or alternative interpretations. This raises questions about the neutrality of the piece, particularly given the author's previously documented involvement in shaping some of the policy foundations of UHC1 – a potential conflict of interest that is not transparently disclosed. The article also disproportionately cites the author's own previous work, which further calls into question the objectivity of the analysis, and the subsequent selection of the preferred option.

Limited assessment of the potential strengths of UHC2

While the article critiques UHC2's centralised funding approach and alleged complexity, it largely overlooks key features of the proposed NHI institutional and organisational reforms. For instance, while funding for healthcare services will be centralised through the NHI Fund, service provision and managerial autonomy are explicitly decentralised to the provider establishment level, with planning and monitoring delegated to district health structures, which include the newly legislated 'contracting units for primary health care'. The policy also proposes a single benefit package – a simplification rather than a complication – and outlines efficiency-enhancing mechanisms such as strategic purchasing, uniform accreditation and provider contracting, and performance-based reimbursement systems – all important aspects for ensuring accountability of providers for health outcomes.

The potential for greater equity, improved procurement efficiency and a streamlined financing system under UHC2 deserves more robust and nuanced engagement than what is currently the simplistic and wafer-thin assessment offered in the article.

Under-emphasis on the political economy context

The article expresses concern over the political motivations behind UHC2, implying an undue desire for central control. However, it largely sidesteps the political and social realities that render UHC1's revival highly improbable – including entrenched inequities and systemic fragmentation that continue to favour wealthier populations at the expense of those who really need healthcare. There is no reference to other key publications that have indicated the inverted nature of who benefits the most from the health system. A more comprehensive analysis would consider the constitutional imperative to redress historical injustices, and the practical limitations of consensus-based reform processes in a deeply unequal society.

Deliberate omission for consideration of the transitional mechanisms

Perhaps most troubling for me is the article's lack of attention to the phased implementation framework outlined in the NHI Act 20 of 2023,[2] specifically section 57. Rather than engage with the transitional steps already legislated, the article implies that UHC2 is 'fatally constrained' – a claim made without acknowledging possibilities for policy adaptation as the implementation process unfolds and matures. This all-or-nothing framing oversimplifies the policy and legislative landscape, and undermines constructive dialogue on pragmatic reform pathways.

Conclusion

To conclude, the article disappointingly lacks the analytical depth, objectivity and policy rigour required of an academic journal contribution. Its strong normative positioning, limited engagement with countervailing evidence and insufficient attention to transitional dynamics make it more akin to an opinion editorial than a scholarly analysis.

These comments are provided in the interest of contributing to a balanced, constructive discourse on how best as a country we can achieve universal health coverage.

M Nkosi
Chief Directorate: Healthcare Benefits and Provider Payment Design, National Department of Health, Pretoria, South Africa
Moremi.Nkosi@health.gov.za

1. Van den Heever A. Achieving universal healthcare access in South Africa: A policy analysis of consensus reform proposals. S Afr Med J 2025;115(7):e3673. https://doi.org/10.7196/SAMJ.2025.v115i7.3673
2. South Africa. National Health Insurance Act No. 20 of 2023.

Response to the letter by the National Department of Health regarding 'Achieving universal healthcare access in South Africa'

To the Editor: I appreciate the opportunity to respond to the letter submitted by the National Department of Health (NDoH) concerning my article, 'Achieving universal healthcare access in South Africa: A policy analysis of consensus reform proposals'. The department raises important concerns, and I welcome the engagement in the spirit of constructive debate. However, it is necessary to correct several mischaracterisations and clarify the basis and intent of the analysis.

On bias and lack of objectivity

The article is explicitly framed as a comparative policy analysis grounded in the organising principle of subsidiarity – a new conceptual entry into the health reform debate in South Africa (SA).

Each universal health coverage (UHC) model – UHC0 (status quo), UHC1 (incremental reform) and UHC2 (National Health Insurance) – is assessed against a set of clearly defined criteria: governance alignment, access equity, financial stewardship, and implementation feasibility. The application of these criteria is transparent and evidence-based, drawing on both public policy documentation and peer-reviewed literature. The concern about 'bias' appears to stem from the conclusion that UHC1 offers a more feasible and constitutionally aligned pathway than UHC2, a position that is at odds with the official position of the current NDoH. This outcome does not reflect bias, but rather the weight of available evidence on institutional capacity, fiscal constraints and

governance risks associated with centralisation. That UHC2 remains largely unimplemented despite political support and legislation further supports this assessment.

Regarding conflict of interest: my past involvement in shaping UHC1-related reforms was public, principled and rooted in efforts to support constitutional health mandates. This contribution is no less legitimate than the department's own institutional commitment to UHC2. Transparency in public policy participation is important, but it should not be misconstrued as undue influence or invalidate evidence-based critique.

On 'excessive' self-reference

The NDoH's charge of 'excessive' self-citation is misplaced. The article's references to the author's own prior work are in fact essential, high-quality sources directly relevant to the analysis. Importantly, in many instances, no other authors have covered the same issues.

These cited works include the author's peer-reviewed studies in reputable journals (for example, a 2016 *Health Policy* analysis of post-apartheid UHC reforms,[1] and a 2024 *Health Economics, Policy and Law* study of health financing outcomes[2]), technical reports and expert reviews (such as the 'NHI Bill expert review' submitted to Parliament), and chapters in authoritative policy compilations on healthcare financing, social security and epidemic preparedness.

Referencing these works is both appropriate and necessary given the subject's complexity and considerable limitations on relevant published works. Many facets of SA's health system performance and reform history have been rigorously documented only through such in-depth research. Far from introducing bias, these self-references strengthen the article's framework by providing original research findings, formal policy documentation and expert interpretation that ground the discussion in evidence.

In academic practice, citing one's earlier relevant work is a legitimate means to build on established findings in a field where knowledge is cumulative – and builds on prior works. Accordingly, the article draws on the author's prior contributions not to promote a personal agenda but to supply a well-founded historical and analytical basis central to understanding SA's health policy evolution, and to credibly compare UHC models. This is precisely the kind of foundation required for an unbiased, informed policy analysis.

On 'underdeveloped' considerations of UHC2's strengths

The article did consider UHC2's potential benefits. These included the aims of greater equity and pooled financing. It, however, contextualised them within the constraints of implementation capacity and institutional coherence.

The claim that UHC2 ensures decentralised service provision is at odds with the model's design: financial control, provider payment decisions and benefit determinations are centrally located within the National Health Insurance (NHI) Fund and the Minister of Health. While 'contracting units for primary health care' are referenced in the NHI Act, they do not function as autonomous district health authorities, and lack constitutional standing or legislative independence. As such, they fall within a rigidly hierarchical structure subject to direct interference by political office-bearers, a clear flaw as evidenced in UHC0. These are relevant design weaknesses that warrant critical examination.

Efficiency mechanisms such as strategic purchasing, provider accreditation and uniform reimbursement systems are not unique to UHC2, and feature prominently in UHC1 proposals and international multi-payer systems. Their effectiveness depends not on centralisation *per se*, but on institutional integrity, regulatory capacity and adaptive governance. These are all areas where SA faces documented challenges.

On political economy considerations and equity

The article does not dispute the existence of deep inequities in SA's health system. Rather, it critiques the assumption that centralisation necessarily addresses them.

Historical evidence shows that institutional weakness and politicised governance, not structural decentralisation, have been key impediments to equity. The comparative success of certain provinces under the existing framework (e.g. Western Cape) highlights the importance of subsidiarity and locally responsive governance.

Furthermore, while UHC1 originated in a different political period, it has not been rendered obsolete. Its recent revival by the Universal Healthcare Access Coalition (UHAC), comprising a substantial portion of the health system, reflects a renewed consensus on incremental and constitutionally grounded reform. Reform feasibility must be evaluated not only by intention in the form of assertions, but by evidence of what has and can be implemented.

On transition planning and the NHI Act

The article does not ignore the transitional provisions in the NHI Act 20 of 2023. Rather, it argues that the implementation assumptions, including rapid fund establishment, tax restructuring and medical scheme dissolution, remain unsubstantiated and legally contested.

Importantly, the UHC2 design is expressly premised on the introduction of a substitutive tax to draw the medical scheme contributions into the system of general taxes, which is technically unachievable when government is at tax capacity, an official position of National Treasury and peer-reviewed research. Phasing cannot correct this important flaw, as it derives from the behavioural dynamics of tax systems – which operate differently to medical scheme contributions. Had the NDOH performed a financial feasibility study (distinct from a mere costing analysis), this would have become evident. The absence of any evidence to contradict this important public finance constraint is noteworthy.

Section 57's transitional provisions, while outlined in legislation (in the form of high-level reform intentions rather than concrete legislative provisions), fail to resolve the core feasibility concerns around institutional readiness, financing gaps and concurrent constitutional competencies.

Raising these limitations is not equivalent to dismissing reform, but is essential to ensuring that it is realistic and sustainable.

Conclusion

Policy debate on UHC in SA must rise above institutional defensiveness and focus on evidence, feasibility and constitutional alignment. The article aims to foster exactly that through informed, comparative analysis grounded in both international principles and local realities. In this regard, all health reform proposals, including UHC2, must be subject to the same level of critical scrutiny.

I look forward to continued engagement on this important national project.

A van den Heever
Chair: Social Security Systems Administration and Management Studies, Wits School of Governance, Johannesburg, South Africa
Alex.VanDenHeever@wits.ac.za

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