



## INCLUSIVE SOCIETY INSTITUTE

### Op-ed

#### **UNIVERSAL HEALTH COVERAGE IS NOT THE QUESTION. DESIGN IS.**

*By Daryl Swanepoel*

There is a tendency in public policy debates to collapse complex questions into binary choices. In South Africa's current discourse on National Health Insurance (NHI), this tendency is particularly pronounced. One is either for universal healthcare or against it. One either supports the NHI Act or opposes it. The space in between, where the real work of policy design lives, is often neglected. But universal healthcare is not, and has never been, the real question.

In South Africa, the principle is already settled. It is embedded in the Constitution. It is reflected in our public health system, which already provides free or low-cost access to a large share of the population. And it is supported by a broad moral consensus that access to healthcare should not be determined by income alone.

The real question is not whether we pursue universal coverage. It is how. And more precisely: how we design a system that can sustain it.

This is where the debate becomes more difficult, and more uncomfortable. Because design is not ideological. It is institutional. It requires trade-offs, constraints, sequencing and discipline. It forces us to confront not only what we want to achieve, but what we can realistically sustain over time.

It is for this reason that comparative reflection becomes useful, not as a search for templates, but as a way of sharpening our own thinking. China offers one such point of reflection.

Now, let us be clear. China is not South Africa. Its political system, administrative structure and governance model differ profoundly from our own. Any suggestion that its system can be transplanted would be both naïve and inappropriate. But that is not the purpose of comparison.

The value lies elsewhere, in understanding how another large, complex and unequal society approached the same foundational challenge: how to extend healthcare coverage at scale, without collapsing under its own weight.

Over the past three decades, China has expanded health insurance coverage to 95% of its population. That achievement alone is noteworthy. But what is perhaps more instructive is how it did so.

Not through a single, centralised fund. Not through an open-ended entitlement. Not through the elimination of private provision. Instead, China built a layered system.

At its core are two primary social insurance schemes, one for formally employed workers, funded through payroll contributions, and another for residents outside formal employment, supported by a combination of individual premiums and state subsidies. Around this core sits a network of supplementary municipal insurance products, as well as a growing private insurance market that covers additional services, advanced treatments and higher levels of care.

In other words, universal coverage was not pursued through institutional singularity. It was achieved through structured plurality.

This matters. Because one of the central features of South Africa's NHI proposal is the concentration of healthcare purchasing power within a single national fund. Proponents argue that this enables equity and efficiency, but critics warn of systemic risk, of placing too much weight on a single institutional pillar in a context where governance capacity is uneven and fiscal space is constrained.

The Chinese model does not resolve this debate. But it does demonstrate that there are alternative ways of organising risk. Ways that distribute, rather than concentrate. Ways that allow different financing streams to coexist, rather than collapse into one.

A second insight relates to the role of private insurance.

In South Africa, the NHI framework envisages a future in which private medical schemes are limited to covering services not provided by the state. This signals a move toward exclusivity. China took a different path.

Private insurance was not dismantled. It was incorporated, positioned as a complementary layer that absorbs costs not covered by the public system, particularly in relation to high-cost or specialised care. Patients navigate between public and private financing streams, with overlap, rather than separation defining the relationship between the two.

The point here is not neutral. The comparative evidence suggests quite clearly that universal coverage does not require the exclusion of private medical schemes. On the contrary, it is strengthened by their presence. Systems that permit supplementary and parallel private financing introduce flexibility, absorb excess demand and create additional layers of risk protection. The real task is therefore not to eliminate private cover, but to define its role with precision, so that it complements, rather than competes destructively with, the public system. In this sense, clarity is not about drawing lines of exclusion, but about structuring coexistence in a way that enhances both sustainability and resilience.

Perhaps the most important lesson, however, lies in the question of discipline. Universal healthcare systems do not fail because they are too ambitious. They fail because they are insufficiently structured.

In China, three forms of discipline are embedded in the system.

First, contribution discipline. Even individuals outside formal employment contribute something, however modest, toward their coverage. This reinforces the principle that healthcare financing is a shared societal responsibility.

Second, benefit discipline. Coverage is not open-ended. Reimbursement is limited to defined lists of treatments and medicines. Choices exist, but they are structured within fiscal boundaries.

Third, cost discipline. Mechanisms such as Diagnosis-Related Group (DRG) payments and bulk pharmaceutical procurement are not peripheral features; they are central to the system's sustainability. They shape provider behaviour, contain costs and align incentives across the system .

Together, these elements reflect a simple, but often overlooked truth: solidarity requires structure. Without it, universal coverage becomes a promise that cannot be kept.

This brings us back to South Africa.

The NHI debate is currently unfolding in parallel with legal challenges before the Constitutional Court. Questions are being raised about governance, financing feasibility and the concentration of institutional authority. These are not technical objections. They are foundational. Because once a system of this scale is implemented, it is not easily reversed. This is why sequencing matters.

China's reforms did not proceed on an open-ended "as finances permit" basis. Each phase of expansion was accompanied by defined contribution rates, reimbursement rules and cost-control mechanisms. Financing was not an afterthought. It was the architecture upon which expansion rested.

In South Africa, by contrast, financing clarity remains incomplete. The absence of a detailed, costed financing framework introduces uncertainty, not only for policymakers, but for providers, investors and citizens alike. And uncertainty, in systems of this magnitude, is not a neutral condition. It is a risk.

None of this suggests that South Africa should abandon its pursuit of universal healthcare. On the contrary, the aspiration remains both legitimate and necessary. But aspiration alone is not enough.

Universal coverage is not achieved through legislation. It is achieved through design. Through institutions that can withstand pressure, through financing models that align with economic reality, through governance structures that inspire confidence across political cycles, and perhaps most importantly, through a willingness to engage honestly with complexity, to resist the temptation of binary debates, and to recognise that the success of such a system lies not in what it promises, but in how it is built.

In the end, the question is not whether we want universal healthcare. It is whether we are prepared to design it properly.

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