



SAPPF

SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM



The Wanderers Club

The NHI Act and Real Health Reform



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CEO: SA Strachan, **Chairman:** PJ Matley (Surgicom)

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P Cole (NPG), J Talma (OMG), M Vaithilingum (PMG), I Westmore (PsychMg), R Tuft (RSSA), K Jehle (SAUA)





SAPPF 2026

From legal, advocacy and coding reform to education, collaboration, leadership development, practice management and challenging inappropriate legislation

To ensure that the voice of private practice is heard; clearly, consistently, and courageously. As challenges intensify, unity becomes our greatest strength.

SAPPF looks forward to working with its members, partners, and stakeholders - standing firm, shaping policy, and securing a sustainable future for private healthcare in South Africa.



Membership update

<i>Emergency Medicine</i>	12
<i>ENT Manco</i>	182
<i>FCPSA</i>	325
<i>General Surgeons - Surgicom</i>	371
<i>Gynaecology (SASOG)</i>	654
<i>Izandla Consulting Physiotherapists</i>	53
<i>National Pathology Group - Ampath</i>	141
<i>National Pathology Group - Lancet</i>	119
<i>National Pathology Group - Pathcare</i>	125
<i>Ophthalmology - OMG</i>	309
<i>Paediatricians - PMG</i>	562
<i>Plastic Surgeons - APRASSA</i>	142
<i>Psychiatry - PsychMG</i>	422
<i>Radiological Society RSSA</i>	489
<i>SACRO (Radiation Oncology)</i>	62
<i>Urology - SAUA</i>	129
<i>Individual Members</i>	16
<i>IsoLeso Optometrists</i>	913

Total 5026



Healthcare Professionals (HCPs) are committed to delivering quality healthcare to all individuals.



Achieving equity in access and delivery of services is becoming more challenging.



Public Sector

- Crumbling infrastructure
- No health reform
- Lack of financing
- Poor leadership
- Fraud Waste and Abuse



Private Sector

- Poor governance
- Under-regulation
- Escalating costs
- Stagnant medical aid membership
- Aging MA membership



Impact on HCPs

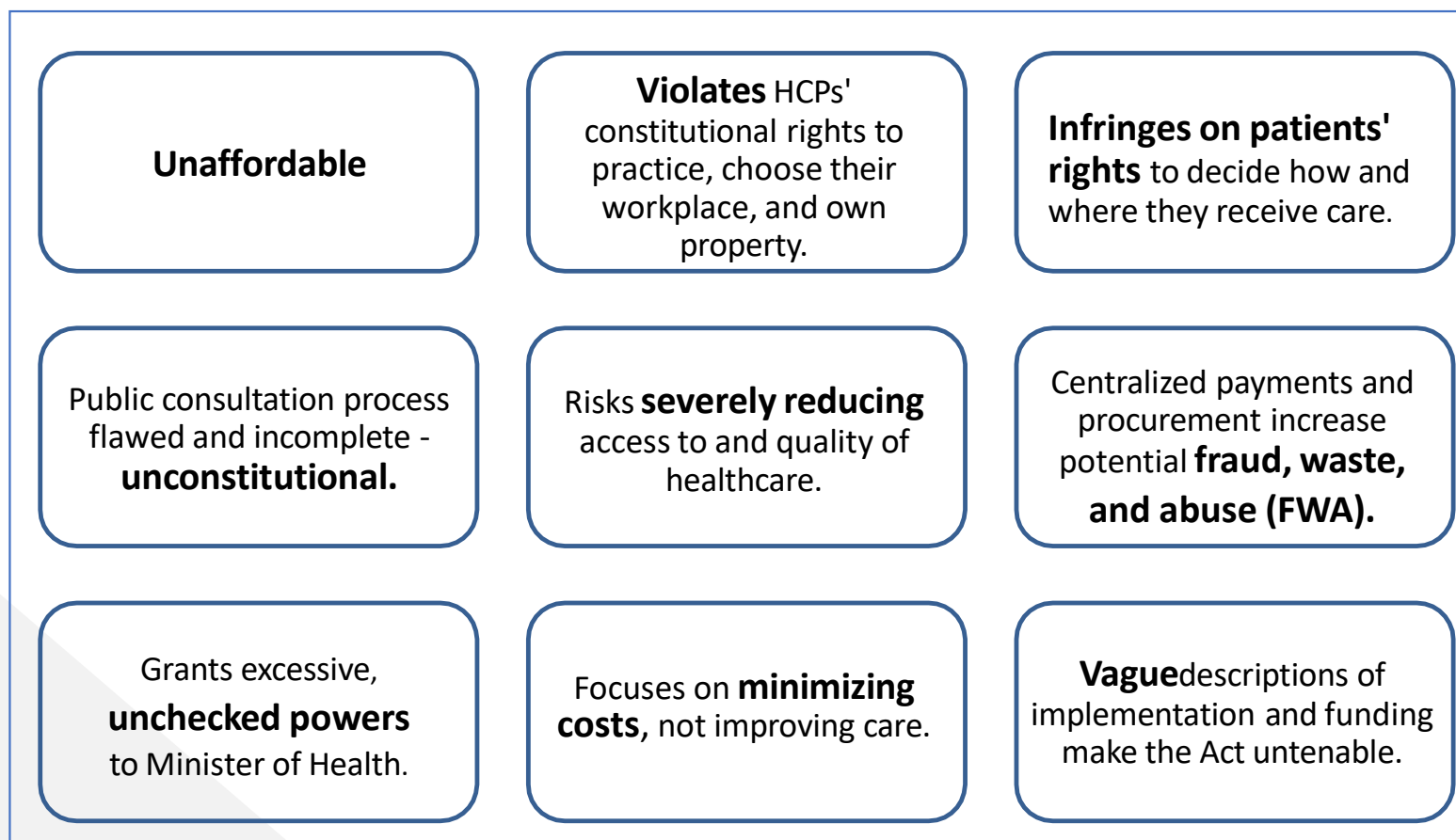
- Overworked
- Mental trauma
- Declining workforce
- Unemployment
- Reduction in training posts
- Rising medicolegal claims



The Problem: Healthcare is facing a crisis



The NHI Challenge. Why the NHI Act is Problematic.





The SAPPF Actions



- **Fund the NHI legal challenge**
- **DTIC block exemption for Tariff determination**
- **Regulations for NHI**
- **Coding governance**



Educate HCPs and the public on NHI and alternatives



Collaborate

- **SAMA**
- **UHAC**
- **Consensus building Health Reform Project**



Advocate for change in the private sector

- **UHAC Proposal**
- **HMI**
- **SACHI coding**



Current Legal Challenges

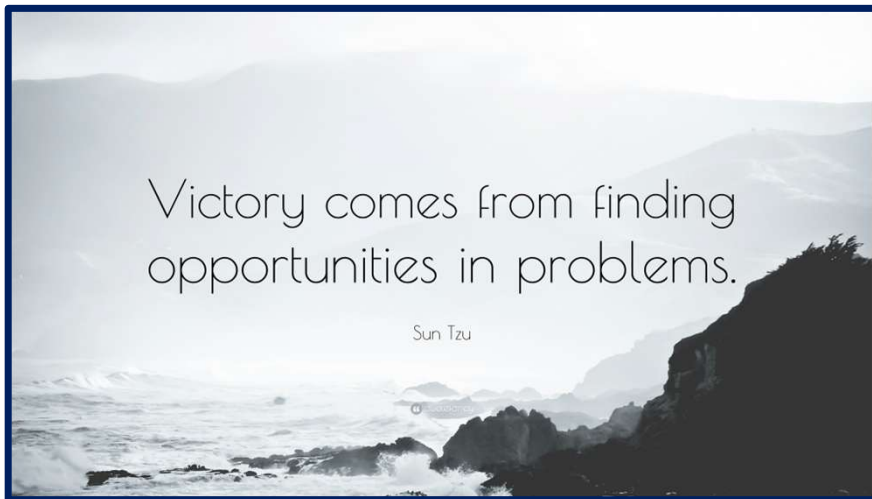
Organisation	Date	Grounds
Solidarity	May 2024	Broad, Unconstitutional and invalid
BHF	May 2024	Review the President's decision, Request the record, High Court and CC, Process, Unconstitutional
SAPPF	October 2024	Review the President's decision, Request the record, Unconstitutional
HASA	February 2025	Unconstitutional, Invalid. Section 33
SAMA	April 2025	Unimplementable, Unconstitutional
HFA	June 2025	Unconstitutional, Invalid, Section 33
SAKELIGA	September 2025	Unconstitutional
Western Cape	September 2025	Procedural
Afriforum	February 2026	Constitutional

Unconstitutional:

Vague, irrational, unjustifiable, Centralisation of powers,
Unchecked power to the Minister, Inconsistent with
Section 27 of Constitution



Be part of the Solution



Solidarity and Equity
Access

- Participate in Improving the Public health sector
- Public private partnerships -Training
- Implement Health market inquiry recommendations
- Embrace value-based healthcare
 - Outcomes monitoring and reporting
 - Develop a group practice culture
 - Create possibilities for Multidisciplinary teamwork
 - Independent Practice Units (IPU)
 - Improve the coding schema
 - Drive adoption of electronic health record keeping
 - Drive integration of EHR systems
 - Embrace AI in Healthcare
- Develop employment contracts
- Develop Service level agreements
- Unified voice for collaboration and participation

Universal Healthcare Access Coalition (UHAC)

South African Medical Association

Progressive Health Forum

South African Private Practitioners Forum

Radiological Society of South Africa

Association of Palliative Care Centres

Association of Plastic Reconstructive and Aesthetic Surgeons of South Africa

Board of Healthcare Funders

Chiropractic Association of South Africa

Clinical Psychology Forum

CPC/Qualicare

Emergency Medicine Society of South Africa

ENT Society of South Africa

Faculty of Consulting Physicians of South Africa

Institute for Occupational Therapists in Private Practice

Iso Leso Optics

Izandla consulting Physiotherapists

National Pathology Group

Ophthalmological Society of South Africa

Paediatrician Management Group

Podiatry Association of South Africa

Psychiatry Management Group

Society of Hearing Aid Acousticians of South Africa

Society of Medical Laboratory Technology of South Africa

Society of Radiographers of South Africa

South African Association of Audiologists

South African Dental Association

South African Gastroenterology Society

South African Orthopaedic Association

South African Society of Anaesthesiologists

South African Society of Obstetricians and Gynaecologists

South African Society of Physiotherapy

South African Urological Association

Surgicom

The South African-Speech-Language-Hearing Association



34 Signatories





The UHAC Framework



UHC 2 = NHI

UHC 1 = UHAC

Overall UHAC reform framework

The health system is failing in both its public and private components. The report argues that the current NHI route is not feasible, does not fit the existing system, and leaves longstanding governance, service delivery, and financing weaknesses unresolved. The result is persistent polarisation between public and private care, with no coherent framework for combining tax funding and contributory cover.

A pragmatic reform framework that separates pooling from purchasing, strengthens free public services through autonomous districts and hospitals, and improves the contributory system through risk equalisation, social reinsurance, and better regulation. The aim is to stabilise existing institutions while progressively de-segmenting the system over time.



Three-pronged Strategy

1) Separation of 'pooling' from 'purchasing'

- **Equitable resource allocation outcomes** rely on fair pooling systems which are most logically situated and executed at a national level
 - Public system
 - Medical scheme system
- **Purchasing is decentralised and carried out by**
 - provincial governments,
 - district health authorities and
 - medical schemes

2) Optimise the performance of free public services

- **Strengthen governance and ensure quality healthcare for households unable to afford their own coverage** with three important features
 - hospital and district authority autonomy
 - close localised supervision
 - removal of interference from the executive of government in appointments, procurement and operational decisions

3) Optimise the performance of the (paid for) contributory system

- **Establish a sustainable contributory health insurance framework** for income-earning households
 - Contributory systems supplement the maximum levels of coverage attainable financed from general taxes alone
 - This system needs to be properly regulated to address known market failures to and to maximise coverage

- Institutional Governance for Health System Integrity
- District Health Authorities, subsidiarity and accountable primary health care for universal health access
- Towards an Autonomous Public Hospital System for South Africa
- Social Health Insurance Integration of Medical Schemes into Universal Health Coverage
- Breaking the Patronage-Procurement Cycle: Rebuilding South Africa's Public Procurement System
- Strategic Health Workforce Planning for Universal Health Access in South Africa
- The 7th is just about ready for publication: Voluntary Solidarity Framework in the private health system

www.uhac.co.za



UHAC Framework



Corporate governance

Public health institutions are weakened by political interference in appointments, weak oversight structures, limited public accountability, and corruption. The current model relies too heavily on centralised executive control, while the NHI model risks intensifying over-centralisation without adequate safeguards.

Independent corporate governance across public health entities, with professional boards insulated from executive interference, an Independent Appointments Authority, fit-and-proper criteria for senior posts, and stronger upward and downward accountability mechanisms.



District health system

Primary care remains trapped in a fragmented and centralised structure. District services lack true autonomy, coherent financing, and accountability to communities, while provincial control limits responsiveness and innovation. The NHI alternative would centralise contracting even further.

Autonomous District Health Authorities, grounded in subsidiarity, with governing boards, broad operational authority, formula-based funding, and the capacity to contract with both public and private providers to improve local accountability and service delivery.

Autonomous public hospitals

Public hospitals are constrained by provincial bureaucracies, weak local accountability, poor maintenance, procurement failures, and blurred responsibility for performance. Under the status quo, they do not function as accountable institutions with meaningful operational authority.

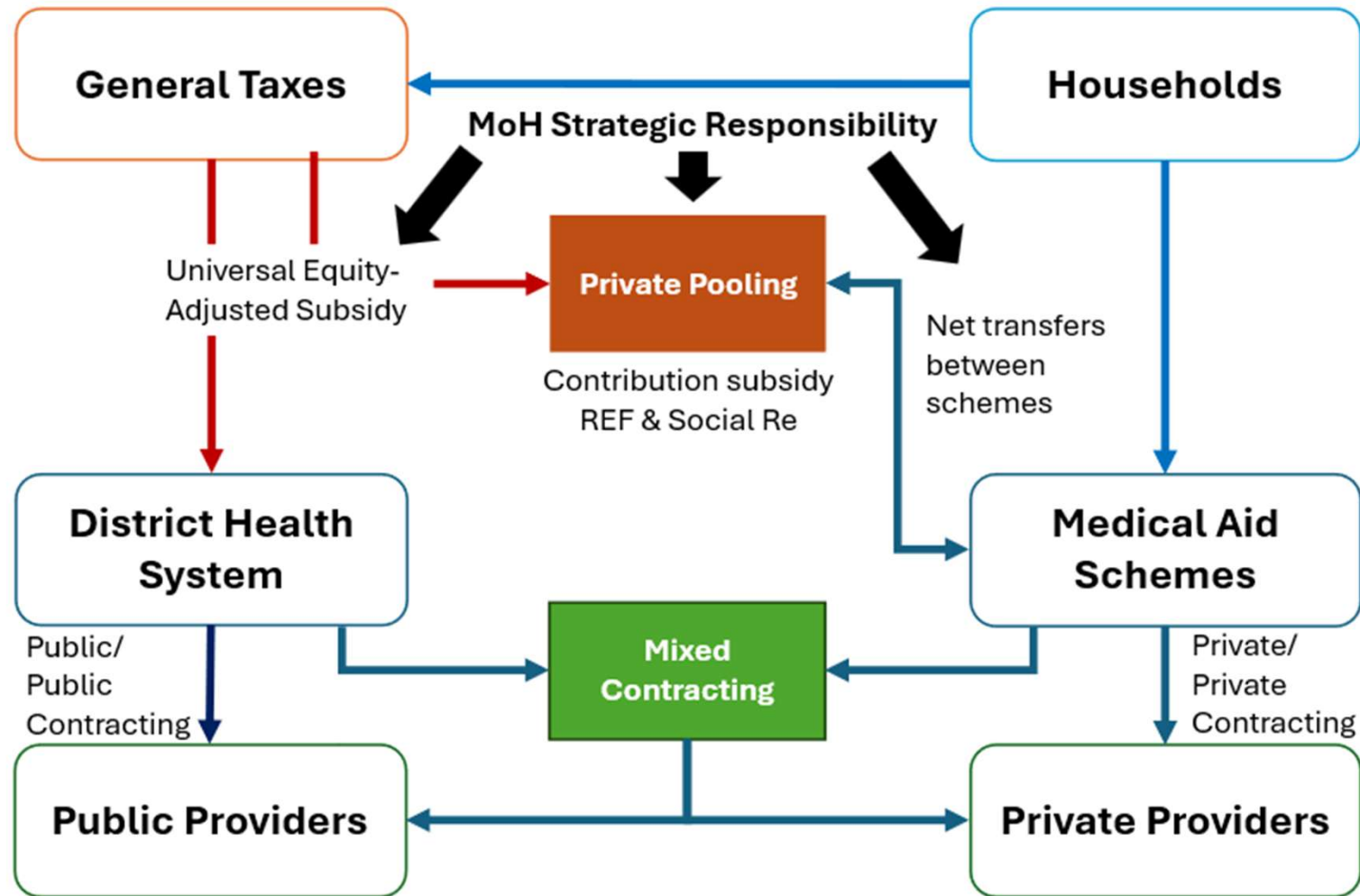
Reconstitute public hospitals as autonomous provincial entities with independent supervisory boards, their own bank accounts, authority over staffing, procurement, and infrastructure, and the power to contract directly with provinces and medical schemes while retaining revenue.



Social health insurance

Risk pooling is fragmented, costs escalate through weak price formation and fee-for-service incentives, and accountability is weakened where hierarchy substitutes for contracts. Incremental fixes within the present system cannot resolve these structural failures.

A decentralised social health insurance framework built around unified essential benefits, independent benefits governance, a Risk Equalisation Fund, a Social Reinsurance Fund, contribution subsidies, mandatory participation for higher-income groups, regulated tariffs, and decentralised purchasing through contracts.





Procurement reform

Procurement failure is treated as a structural governance problem rather than merely a compliance problem. Political influence over senior appointments makes procurement vulnerable to manipulation, patronage, and weak consequence management, preventing the system from self-correcting.

A three-pillar reform: insulate operational appointments from political leverage, create a single integrated digital procurement platform with transparency by default, and introduce concurrent accountability through rapid consequence mechanisms and real-time oversight.

Inter-relationship between the policy areas

The failures are systemic and mutually reinforcing. Weak governance affects service delivery, poor procurement undermines all public provision, fragmented insurance weakens equity and cost control, and the absence of accountable delivery institutions prevents effective integration across the system.

The policy areas fit together as a UHC1 architecture: governance reform provides the institutional backbone, DHAs organise primary care, autonomous hospitals organise hospital care, SHI provides the pooling and purchasing framework, and procurement reform protects the conversion of resources into services.



Health Workforce Strategy



National stewardship: NDoH • DHET • National Treasury • DPSA • provinces • HEIs • professional councils • private and non-state platforms



Funding reform: from historic block grants to allocations that fund the plan



Annual decision cycle: data → model → budget → train → appoint → evaluate

Core financing principle
Funding follows function, student load, supervision and output

Public-interest guardrail
Accreditation, standard contracts, patient safety and public reporting



High road / Low road



Winning

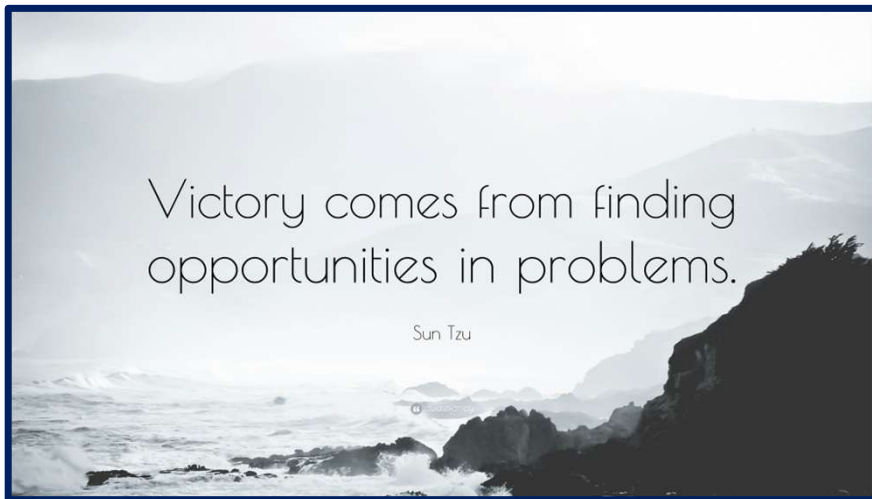
- NDoH redirect plans and engage appropriately
- Sustainable solutions to equitable access to healthcare
- Private sector retained and regulated
- PPP = improved delivery



Losing

- Deterioration in healthcare delivery
- Eventual collapse of health system
- Financial burden on tax payers
- Emigration of the tax base

Be part of the Solution



Solidarity and Equity

A Health Reform Policy that enables sustainable, scalable, affordable and equitable access to healthcare services for all in South Africa.

- Participate in Improving the Public health sector
- Public private partnerships -Training
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