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IN THE HIGH COURT OF SOUTH AFRICA
Gauteng Division, Pretoria

CASE NO: **2025-083348**

In the matter between:

HEALTH FUNDERS ASSOCIATION	Plaintiff / Applicant / Appellant
and	
MINISTER OF HEALTH,MINISTER OF FINANCE,NATIONAL TREASURY,PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Defendant / Respondent

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Founding Affidavit

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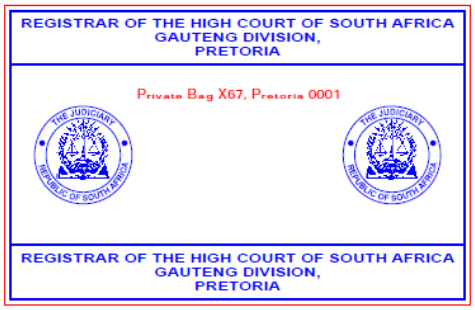

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IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE: _____

In the matter between:

HEALTH FUNDERS ASSOCIATION NPC	Applicant
and	
MINISTER OF HEALTH	First Respondent
MINISTER OF FINANCE	Second Respondent
NATIONAL TREASURY	Third Respondent
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Fourth Respondent

FOUNDING AFFIDAVIT

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I the undersigned,

THONESHAN NAIDOO

INTRODUCTION

state under oath as follows:

1 I am the Chief Executive Officer of the applicant, the Health Funders Association NPC ("*HFA*"), which has its registered address at Country Club Estate Office Park, Building 2, 21 Woodlands Drive, Woodmead, Sandton. A copy of my curriculum vitae is attached to this affidavit marked "*FA1*".

2 I am duly authorised to depose to this affidavit on behalf of the HFA.

3 This application is brought in the interests of the approximately 9.1 million South Africans across the race and class spectrum who are medical scheme beneficiaries, and currently have access to medical scheme coverage of healthcare services in the private sector.[1]

4 The facts to which I depose in this affidavit are true and correct and, save where the context indicates otherwise, are within my personal knowledge and belief. Where I make legal submissions, I do so on the advice of the HFA's legal representatives, whose advice I believe to be correct.

5 The HFA challenges the constitutionality of the National Health Insurance Act 20 of 2023 ("*the NHI Act*").

[1] Genesis Report at overview and key findings p vii/viii/xiv/xix; section 2 (paragraph 21).

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THE PARTIES

6 The HFA is a non-profit organisation with the capacity to sue and be sued in its own name. I attach a copy of its memorandum of incorporation, marked "*FA2*".

7 The HFA was formed in 2015 as an industry body representing medical schemes and administrators, and represents the interest of medical scheme beneficiaries as well as other industry participants. The HFA provides a platform for stakeholders involved in the funding of private healthcare, being medical schemes, administrators and managed healthcare organisations, to support the long-term sustainability and development of the private healthcare funding industry in South Africa. In doing so, it advances the interests of medical scheme beneficiaries. It represents the views of its members on critical issues pertinent to private healthcare funding and with a view to maintaining a viable medical scheme sector.

8 The HFA represents some of South Africa's largest and most prominent medical schemes, which constitute approximately 46% of the total private healthcare funding market. Through its membership , the HFA represents 4.1 million lives and 20 medical schemes.

9 The HFA approaches this Court under section 38 of the Constitution, in its own interest, as an association of medical schemes and related entities, in the interests of its members (and, in turn, their beneficiaries), and in the public interest. The NHI Act will, in its transition period, seriously undermine the viability of medical schemes and, when fully implemented, all but

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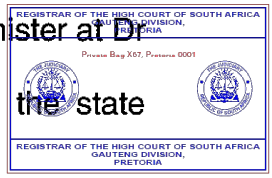
obliterate medical schemes. It will substantially diminish the level of access to healthcare services to which medical scheme beneficiaries currently have access. The HFA's standing in this matter is, therefore, self-evident.

10 The first respondent is the Minister of Health ("*the Minister*"). When the NHI Act comes into force, the Minister will, in terms of section 31 of the NHI Act, be responsible for the governance and stewardship of the national health system and of the National Health Insurance Fund ("*NHI Fund*"), in accordance with the NHI Act. Service will be affected on the Minister at Dr AB Xuma Building, 1112 Voortrekker Road, Pretoria and on the state attorney.



11 The second respondent is the Minister of Finance. In terms of section 4 of the NHI Act, the Minister of Finance is responsible for appropriating funds earmarked for use by the NHI Fund. No specific relief is sought against the Minister of Finance, and he is cited for his interest in the matter, given the HFA's constitutional attack based on the fiscal impossibility of implementing the NHI Act. Service will be effected on the Minister of Finance at 40 Church Street, Old Reserve Bank Building, 2nd Floor, Pretoria and on the state attorney. The Minister of Finance is further required by section 49(2)(a) of the NHI Act to introduce a money Bill earmarked for use by the NHI Fund in Parliament.

12 The third respondent is the National Treasury, which is cited for its interest in the matter, given the HFA's constitutional attack based on the fiscal impossibility of implementing the NHI Act. Service will be effected on

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National Treasury at 40 Church Street, Old Reserve Bank Building, 2nd Floor, Pretoria and on the state attorney.

13 The fourth respondent is the President of the Republic of South Africa, who is cited for his interest in the matter as the head of the national executive. The President is empowered by section 59(1) of the NHI Act to fix the date on which the NHI Act will take effect by issuing a proclamation. Service will be effected on the President at the Union Buildings, Government Avenue, Pretoria and on the state attorney.

OVERVIEW

14 On 15 May 2024, the President signed the NHI Act into law.

15 The NHI Act says that it aims to achieve the progressive realisation of the right of access to quality personal healthcare services and make progress towards achieving universal health coverage. In essence, the NHI Act's stated objective is to achieve universal access to quality healthcare services.

16 The NHI Act seeks to achieve this objective in three key ways.

17 First, it seeks to increase the resources that are available to the large group of people who depend on the public sector, by establishing and maintaining the NHI Fund through a system of mandatory prepayment.

18 Second, it aims to change the way in which healthcare services are acquired. In particular, the NHI Act will make the NHI Fund the sole national purchaser of healthcare services (i.e. a monopsony purchaser, which is a

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single purchaser of goods and services that dominates the market), and the Minister, together with the officials and entities he appoints and over which he exercises oversight, the sole national decision-maker of how health resources are raised and deployed across South Africa, and how the healthcare sector is structured.

19 Third, the NHI Act will all but obliterate medical schemes. In particular, section 33 of the NHI Act provides that "*[o]nce National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund.*"

20 This is a prohibition on what may be called "*supplementary coverage*" – the ability of medical schemes to provide coverage for health services alongside the NHI Fund. Supplementary coverage is neither unusual nor inimical to the achievement of universal health coverage. It is a feature of health systems in numerous countries, including Brazil, China, Costa Rica, Ghana, Indonesia, Mexico, Thailand and Türkiye. The Minister has cited some of these very countries as examples that "*highlight the success of UHC systems*" in an application lodged in this Court which also challenges the NHI Act.[2] But he overlooks the fact that these are not systems in which supplementary coverage is prohibited.

21 The ban on supplementary cover is a drastic change to the South African health sector – an industry that accounts for over 8 percent of South Africa's

[2] *Solidarity v Minister of Health* and others under case number 2024-057449 ("*Solidarity v Minister of Health*"); Minister's answering affidavit at para 82.

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GDP and plays a critical role in our overall well-being, economic productivity, and social development. As appears more fully below, the ban also severely limits the rights of medical scheme beneficiaries to healthcare services.

22 Initially, National Health Insurance ("*NHI*") was not designed to prohibit medical schemes from covering the same benefits provided by the NHI Fund. In fact, the Green Paper on a "*Policy on National Health Insurance*" issued in August 2011 ("*Green Paper*")[3] expressly provided that NHI benefits would "*be of sufficient range and quality that South Africans [would] have a real choice as to whether to continue medical scheme membership or simply draw on their National Health Insurance entitlements*".[4] In other words, government's intention was to make NHI attractive even for those who could afford to contribute to medical schemes, without depriving them of the choice to protect themselves by securing supplementary medical scheme cover. In either instance, medical scheme beneficiaries would be required to contribute to the NHI Fund through taxation, and, therefore, if they elected *also* to contribute to and rely on medical schemes, would only thereby alleviate pressure on the NHI Fund.

23 By 2015, however (i.e. in the 2015 White Paper), the National Department of Health reversed course and sought to enforce the NHI Fund as a monopoly healthcare funding model—one that all but obliterates the role of medical schemes. Access to healthcare services is a fundamental right.

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3 Green Paper. Available: https://static.pmg.org.za/docs/110812nhi_0.pdf.

4 Green Paper on NHI, para 126.

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Section 27(1)(a) of the Constitution enshrines the right of everyone to have access to healthcare services. Access to healthcare services is also inter-related with, and mutually supporting of, the core constitutional values and rights to human dignity and equality, and the constitutional rights to life, freedom and security of the person, and best interests of children. A well-functioning and sustainable health sector is therefore essential to uphold these foundational principles and constitutional rights, and lies at the heart of the Constitution's vision for a society based on human dignity, equality and freedom.

24 The HFA strongly supports government efforts to move towards universal health coverage, and to achieve a greater level of equity and access in the healthcare system. This application is not an attack on the key objective of the NHI Act, namely the achievement of universal access to quality healthcare services in South Africa.

25 Instead, this application is a challenge to the chosen and constitutionally flawed means of achieving this goal expressed in the NHI Act.

26 The unconstitutionality of the NHI Act lies primarily in section 33. Section 33 amounts to an effective ban on obtaining health services outside the NHI. Once the Minister declares the NHI "*fully implemented*" in accordance with this provision, private medical schemes will only be allowed to offer "*complementary cover*" for services not reimbursed by the NHI Fund. Put differently, if the NHI Fund covers a particular service (regardless of the quality or actual availability of that service), medical schemes will be prohibited from funding that service.

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27 The vast majority of people in South Africa cannot afford to self-fund medical expenses as and when they occur. Their only realistic way of covering medical costs is either to access them through the public sector, or to pre-fund them through joining a medical scheme, paying a monthly contribution that is affordable to them, and thereby spreading the risk and cost of adverse medical events across a large pool of members. The prohibition in section 33 is thus akin to an effective ban on private access to most healthcare services as these will be, at least notionally, offered through NHI. It means that patients who would otherwise receive medical scheme coverage for particular services will have no option but to utilise an already overburdened public system to access those services. The ban on medical schemes will accordingly remove an existing layer of protection that millions of people rely on and put access to private healthcare services beyond the means of all except the very wealthiest.

28 This outcome is irrational, unreasonable and unconstitutional. Before launching this application, HFA made numerous submissions to government in order to explain its concerns and propose alternatives. I attach HFA's submissions to the National Assembly and the National Council of Provinces as annexes "*FA3*" and "*FA4*" respectively. As appears more fully below, the HFA also proposes several credible alternatives to the single fund NHI model that will better achieve the objective of universal health coverage, and will be less restrictive and destructive of the existing level of access that medical scheme beneficiaries are provided.

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29 The HFA has instructed Genesis Analytics Proprietary Limited ("*Genesis*"), a firm of independent economists, to consider the financial feasibility and impact of the NHI Act. Genesis has conducted an expert economic analysis that examines the financial and fiscal feasibility of the proposed NHI Fund, and its impact on access to health services for South Africans. The financial and economic modelling has produced a range of scenarios. The Genesis Report is attached marked "*FA5*". The confirmatory affidavits of the primary authors of the Genesis Report – Stephan Malherbe, the Chair of Genesis, Thembalethu Buthelezi, Principal (Competition and Regulatory Economics), and Robert Lipschitz, (Principal Economist), at Genesis – are attached marked "*FA6*" to "*FA8*", together with their respective curricula vitae. In this affidavit, the HFA relies substantially on the expert economic report prepared by Genesis.

30 The HFA contends that the NHI Act is unconstitutional on the following grounds.

31 First, the NHI Act is irrational. The government itself admits that it never undertook a costing and modelling exercise for this major structural overhaul of the healthcare system in related litigation against the Solidarity Trade Union under case number 2024-057449 ("*the Solidarity litigation*"). Legislation was enacted that will fundamentally alter how healthcare is funded and delivered without assessing or investigating the financial and practical feasibility of the NHI Act. The Genesis analysis further confirms that, even assuming generous cost savings and efficiencies, providing anything close to "*comprehensive*" coverage for every person is impossible

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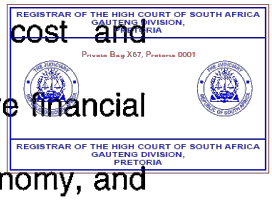
under the NHI. The additional funds required would demand extraordinary tax increases well beyond global norms and what the current tax base can sustain—indeed, such increases would likely reduce overall tax revenue. Far from expanding access, the NHI Act, once implemented, would almost certainly lead to reduced access for millions of people, with the state itself unable to bridge the gap.

31.1 The respondents acted irrationally in failing to conduct the rationally necessary exercise of assessing the cost and feasibility of the NHI Act. That is, despite the massive financial implications for the country's healthcare system, economy, and social security, government has failed to give any meaningful consideration to:



31.1.1 the costs of expanding coverage for healthcare services to the entire population via a single-payer framework as prescribed by the NHI Act;

31.1.2 whether raising taxes to the extent entailed by the NHI Act is economically feasible or sustainable;

31.1.3 the health impact of the NHI Act on millions of South Africans who currently belong to medical schemes;

31.1.4 the extent of healthcare resources, such as hospitals, clinics and healthcare professionals, needed to deliver the required services and the plans to ensure that these are in place; and

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31.1.5 the impact of the NHI Act on the sustainability of existing private healthcare providers.

31.2 In his answering affidavit in *Solidarity v Minister of Health*, which I attach marked "*FA9*", the Deputy Director-General responsible for NHI, Dr Nicholas Crisp, defends this failure by saying that conducting a "*once-off accounting exercise to attach a globular price to NHI*" is not ultimately useful.[5]

31.3 But that is no justification for the failure to perform even the most elementary exercise, such as considering whether the NHI plan as set out in the NHI Act is viable, and the impact it will likely have on the rights of all South Africans.

31.4 The limited examples of costing exercises that Dr Crisp describes in his supporting/confirmatory affidavit either relate to specific, minor components of NHI implementation that do not relate to an overall costing analysis, or they are costing studies that are yet to be undertaken.[6] What is clear, is that government did not undertake any comprehensive costing analysis as to the viability of NHI.

31.5 The Green Paper sets out what it described as preliminary costing estimates for NHI of a comprehensive package of healthcare services. It estimated that resource requirements for

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5 *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at para 35.1.

6 *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at paras 34 to 60.

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the NHI would reach R434 billion in 2020 and R517 billion in 2025 if NHI was implemented gradually over a 14-year period from 2012.[7] As, however, expressly recognised in the Green Paper, further work was required to "*refine cost estimates to take account of detailed proposals being developed*".[8] No such work was conducted. The Green Paper further failed to articulate its critical costing assumptions, and was informed by an analysis of health reforms in Thailand which provided basic insurance coverage for members of the public who had no previous access to public healthcare services. Most significantly, the Green Paper assumed that public resource costs would remain at 2010 prices, and that GDP growth would increase to 4.2% in 2012/13. In reality, the real GDP growth rate in 2012 was about 2.4% and in 2013 was 2.5%. From 2013 to 2023, South Africa's economy performed poorly, with GDP growth averaging only 0.7% per year, compared to 3.3% in the prior decade (2003 to 2013), and declining real per capita income.[9] By the time the NHI Act was passed in 2024, the assumptions in the Green Paper were

[7] Green Paper on NHI, para 122. Since the figures in the Green Paper are expressed in 2010 Rands, they are brought up to current value by applying average annual CPI rates as published by Statistics South Africa from 2010 through 2024. Multiplying the 2010 figures by the cumulative CPI inflation factor (2.0265) provides a realistic representation of their value in 2024 Rands. In other words, an amount of money that was worth R1 in 2010 would now require just over R2 to achieve the same purchasing power. This adjustment does not take account of any excess in medical inflation over CPI or population growth and so is more likely to be understated than overstated.

[8] Green Paper on NHI, para 118.

[9] Genesis Report at section 3.3.4.

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obsolete. I attach a copy of relevant extracts from the Green Paper as "*FA10*".[10]

31.6 As a consequence of this failure, the respondents produced an NHI Act which is wholly unworkable and substantively irrational. The means chosen in the NHI Act—the establishment of a single-payer, single-purchaser national model, and the effective obliteration of private medical schemes for any medical services reimbursable under the NHI—is incapable of achieving the objective of universal coverage of comprehensive healthcare services.

31.7 Genesis has conducted financial and economic modelling that allows for a scenario-based cost and feasibility analysis, which demonstrates that providing access to healthcare services at the same level as that currently available to medical scheme beneficiaries is fiscally impossible under the NHI Act.[11] In its analysis, Genesis generously adopts favourable assumptions for the respondents, including that not all of the cost of NHI will amount to new spending (since some of it will entail a shift within the existing budget); that all contributions paid to medical schemes and tax credits may be utilised to finance NHI; that efficiencies from economies of scale must be integrated into a cost analysis; and that the necessary healthcare resources in

[10] Green Paper. Available: https://static.pmg.org.za/docs/110812nhi_0.pdf.

[11] Genesis Report at Chapters 3 and 4.

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terms of practitioners, facilities and medicines will be available.[12] It has built-in generous assumptions in relation to efficiency gains in its analysis, even though the evidence suggests that the actual efficiency gains will be modest at best, if they exist at all. The modelling conducted by Genesis also assumes that significant efficiencies are achievable through economies of scale and other levers under the leadership of the National Department of Health and the management of the NHI Fund.

31.8 Genesis demonstrates that, even if one assumes that NHI will achieve large efficiencies – for the purposes of its analysis, Genesis assumes substantial efficiencies of *at least 45.5%* of medical scheme expenditures – the cost of providing comprehensive healthcare (at a level of access similar to medical scheme level) would be prohibitive: total healthcare expenditure would approximate R900 billion, equivalent to an increase in total healthcare expenditure of R410 billion and an increase in public healthcare expenditure of R691 billion.[13] This assumption is at the extreme of the spectrum of the savings that could be achieved under the NHI Act.

31.9 If the NHI were to be funded by a payroll tax, that tax would need to be pitched at an extra 25.5% of salaries, on top of existing

[12] Genesis Report at Table 6; sections 3.2.1, 3.2.2.1/2, 3.2.2.3, 3.2.3 and 4.2.1.

[13] Genesis Report at overview and key findings, p viii; sections 4.2.2, 4.2.5, 5.1/2, 5.2.2, 5.4 and 5.5; Annexure C.

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income tax.[14] To fund this, taxation would have to increase from 28% to 38% of GDP.[15] If funded by personal income tax, it would result in an increase in average personal income tax from 21.3% to 45.7% of taxable income, with the highest bracket increasing from 45% to 68.4% and the lowest bracket increasing from 18% to 41.4%.[16]

31.10 Genesis has demonstrated that this is simply impossible.[17] This is not merely a matter of fiscal preferences. The funds required cannot be generated from the South African tax base. Indeed, recent experience suggests that an increase in tax revenue cannot be achieved by simply increasing tax rates. As explained below, the Minister of Finance announced a new top marginal tax rate of 45% in March 2017 (which was an increase from the previous rate of 41%) in an effort to raise an additional R5.5 billion for the fiscus from the 103,000 taxpayers earning more than R1.5 million per year. However, rather than *boosting* the national fiscus, personal income tax receipts from the targeted group of taxpayers *declined* by R6.48 billion. That is because, in response to the tax increase, a significant proportion of these high-income individuals reduced their reported taxable incomes. Some accomplished this by legally rearranging their finances, or

[14] Genesis Report at Table 7; section 4.2.5.

[15] Genesis Report at overview and key findings, p viii.

[16] Genesis Report at Table 7; section 4.2.5.

[17] Genesis Report at overview and key findings, p xviii; Chapters 3 and 4.

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by working less, while others may have turned to tax avoidance or, in some cases, outright evasion.

31.11 Therefore, even on the best case scenario, the NHI is incapable of achieving universal access to comprehensive healthcare services. The entire NHI Act, and section 33 in particular, is, for that reason, and on its own terms, irrational and unconstitutional.

32 Second, the NHI Act results in an unreasonable and unjustifiable infringement of the constitutional right of access to healthcare of existing medical scheme beneficiaries.

32.1 The NHI Act will inevitably result in a drastic reduction in access to fundamental healthcare services for the 9.1 million existing medical scheme beneficiaries.[18] This will occur in circumstances where there is no rational relation between the severe limitations and their purpose, and there are several substantially less restrictive means to achieve the purposes of providing universal health coverage for quality healthcare services. For this reason, the NHI Act is an unreasonable, unjustifiable and unconstitutional infringement of the right of access to healthcare in section 27(1) of the Constitution.

32.2 The Genesis Report models the costing of health services in a manner that permits levels of expenditure (adjusted for efficiencies) to serve as a valid proxy for access to health

[18] Genesis Report at overview and key findings, p viii; section 2.

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services.[19] If less money is available to be spent on healthcare than is required for a particular level of care, then this translates into a commensurate reduction in access and quality of healthcare services.

32.3 Genesis finds that it will be impossible for NHI to provide the same level of access and quality that medical schemes fund for their beneficiaries, and that beneficiaries will inevitably suffer a severe reduction in their access to healthcare under the NHI Act.[20]

32.4 Take just one indicator for example: South Africa would need 97.7 general practitioners (GPs) per 100,000 people to provide the same level of care to which medical scheme beneficiaries currently have access.[21] If private sector general practitioners were combined into one resource pool under NHI, South Africa would have 46 GPs per 100,000 people – less than half the number of doctors required.[22]

32.5 Given the impossibility of providing comprehensive care for all under the NHI Act, Genesis has also modelled a scenario based on shared resources.[23] This model assumes that the only additional financial injection into the health budget would be the

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19 Genesis Report at overview and key findings, p viii; sections 4.2 and 5.1.

20 Genesis Report at overview and key findings, p viii.

21 Genesis Report at section 5.2.1 (paragraph 215).

22 Genesis Report at section 5.2.1 (paragraph 215).

23 Genesis Report at Chapter 5.

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amount currently expended in the private sector. The country would not spend more in total on healthcare, but would distribute what is currently spent more evenly by "*capturing*" the approximately R280 billion in private healthcare expenditure. As I explain later in this affidavit, this model nevertheless requires levels of taxation that are unachievable given the South African tax base. To capture the full R280 billion currently spent in the private sector using personal income taxes, the lowest tax bracket will have to increase from 18% to 27.5% and the highest tax bracket will have to increase from 45% to 54.5%.[24]

32.6 Again, on this model, expenditure serves as a proxy for access to healthcare. Genesis finds that, in the best case scenario where NHI is able to obtain the full private contributions to health expenditure together with a full 45.5% in cost savings, medical scheme beneficiaries will nevertheless experience an average 43% decrease in access to healthcare.[25] This decrease will manifest in rationing of services, medicines and medical products, and long waiting periods for medical procedures.[26]

32.7 Not only will medical scheme beneficiaries suffer a drastic reduction in access to healthcare, they will not be permitted to

[24] Genesis Report at section 5.1 (paragraph 208.1 and Table 12).

[25] Genesis Report at overview and key findings, p viii.

[26] Genesis Report at overview and key findings, p x, xi; section 5.2.1.

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purchase cover from their own pocket in order to make up for the diminished healthcare.

32.8 It is self-evidently a limitation of the right of access to healthcare to suffer a 43% decrease in access. That limitation is severely compounded when people are also prohibited from making appropriate arrangements to secure access to the healthcare they need.

32.9 The government's explanation is that supplementary cover undermines the social solidarity principle of NHI. According to Professor Diane McIntyre, whose expert affidavit in the *Solidarity* proceedings I attach marked "*FA11*", "*supplementary PHI [private health insurance] is that it limits risk and income cross-subsidies in the overall health system*".[27] Genesis demonstrates that the opposite is true: "*the ban on supplementary cover will reduce income cross-subsidisation and redistribution*".[28] It stands to reason that those individuals who would otherwise purchase supplementary cover, will now be forced to use NHI services, thereby utilising scarce NHI resources that would otherwise be used for (or be available to) lower income individuals. This is because for every person that is prevented from buying supplementary cover, they will instead be forced to use the NHI's services. Furthermore, taxpayers who are now

[27] *Solidarity v Minister of Health*; Dr McIntyre's expert affidavit at para 43.

[28] Genesis Report at section 7.3.2.1.1 (paragraph 386).

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contributing to the majority of the costs for public health services through taxation, will become consumers of those services instead of funding their own care through medical schemes. This erodes, rather than enhances, income cross-subsidisation.

32.10 Simply put, section 33 is an impermissible and unjustifiable infringement of the constitutional right of access to healthcare. Most directly affected are the current 9.1 million medical scheme beneficiaries. I am advised that the state bears an obligation not to unreasonably and unjustifiably impair existing access to healthcare services under section 27(1) of the Constitution.

32.11 None of the purposes of section 33 – lower prices through monopsony purchasing, risk equalisation and redistribution, ensuring sound allocation of resources – requires the prohibition of supplementary cover. They can all be achieved through other means, which are less restrictive of the rights of existing scheme beneficiaries. In fact, as the HFA show and explain more fully below, an adjustment to NHI that would allow a multi-fund approach would *improve* access for the whole population to healthcare services relative to the NHI Act.[29]

33 Third, the NHI Act contravenes the state's obligation in section 27(2) of the Constitution to adopt reasonable measures to achieve the progressive realisation of the constitutional right of everyone to access healthcare

[29] Genesis Report at overview and key findings, p xvi/ii.

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services within available resources, and not to adopt retrogressive measures. I am advised that a reasonable measure must be comprehensive and coordinated, and must clearly allocate responsibilities and tasks to the different spheres of government and ensure that the appropriate financial and human resources are available. It must also be one that is financially and practically viable in that it is capable of facilitating the realisation of the right; it must be reasonable in both its conception and implementation; it must be comprehensive and co-ordinated, ensuring the requisite financial and human resources; and it must be balanced and flexible. Implicit in the obligation to adopt reasonable measures is a negative duty of non-retrogression – the state may not take backwards steps that reduce the extent to which the right is currently accessed.

34 The NHI Act fails in all of these respects and is not reasonable in its conception. It does not ensure the requisite financial and human resources and violates the principle of non-retrogression. In addition to the evidence demonstrating its irrationality and the unjustified and unreasonable violation of section 27(1) of the Constitution, as the HFA demonstrates in this affidavit, with substantial supporting evidence, the NHI Act is unreasonable because of the following:

34.1 It is neither comprehensive nor coordinated; it fails to clearly allocate responsibilities and tasks to different spheres of government; and it does not ensure that the appropriate financial and human resources are available;

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34.2 The fiscal infeasibility of the envisaged measures, which cannot be funded by South Africa's already constrained and diminishing taxpayer base, whose access to healthcare services will be severely diminished by the NHI Act, and which place the burden of financing healthcare for the entire population, including medical scheme beneficiaries, on the State;

34.3 The likelihood that the NHI-driven surge in demand for healthcare services, coupled with the shortage of healthcare resources, will raise healthcare prices and compound the NHI Fund's overall costs;[30]

34.4 The likelihood of the NHI, as a fiscally constrained monopsony purchaser, setting prices in a manner that reduces the already inadequate supply of critical health resources, including medicines, doctors and nurses;[31]

34.5 The perverse incentives (such as underservicing) that are likely to arise from alternative reimbursement models under NHI;[32]

34.6 Poor management and quality of services in parts of the public sector;[33]

[30] Genesis Report at section 6.1.

[31] Genesis Report at section 6.2.

[32] Genesis Report at section 6.3.

[33] Genesis Report at section 6.4.

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34.7 Increased medico-legal claims arising from the integration of medical scheme beneficiaries;[34]

34.8 The likely emigration of health professionals;[35]

34.9 The disincentivising of investment in private health facilities such as hospitals and technology, reducing the quality and supply of facilities in the medium to long term;[36] and

34.10 Destabilisation and damage to the system as a result of adverse selection during the transitional period.[37]

35 Fourth, the sweeping and unchecked power conferred on the Minister under the NHI Act is unconstitutional.

35.1 Sections 43 and 44 of the Constitution vest legislative authority in the Parliament. It is Parliament's constitutional role to formulate and pass laws on fundamental policy choices. When Parliament assigns its legislative power to the Executive or an unelected body without appropriate guidance or oversight, it violates the separation of powers.

35.2 Decisions on whether certain healthcare services are covered by the NHI, how they are rationed, and what role private funding can play directly impact millions of South Africans' access to

[34] Genesis Report at section 6.5.

[35] Genesis Report at section 3.2.2 (paragraph 71).

[36] Genesis Report at section 6.8 (paragraph 346).

[37] Genesis Report at section 6.6.

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healthcare. Determining the scope of coverage and financing mechanisms will shift billions of rand in national spending. Such decisions require democratic deliberation and clarity in legislation, given their profound implications, as well as accountability to Parliament. Entrusting these vital issues to executive regulations and committee directives compromises citizens' ability to have meaningful input or recourse through democratic and parliamentary processes.

35.3 The NHI Act grants the Executive the power to create, alter, or remove major constitutional entitlements to healthcare services and fundamentally restructures the relationship between the public and private sectors in a manner that unconstitutionally crosses into plenary legislative territory. The broad powers the NHI Act affords the Executive effectively allows it to define core aspects of NHI without constraints.

35.4 The NHI Act confers on the Minister the authority to determine the scope, nature, and funding of healthcare services; the relationship between public and private providers; accreditation criteria for facilities; and the moment at which point medical schemes may only offer complementary cover. These are core policy decisions at the heart of legislation—effectively deciding who gets which health services, and under what terms, across an entire country, as well as the structure and nature of the South African healthcare sector.

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35.5 The NHI Act provides no appropriate parameters to constrain how the Minister should decide these issues. It grants extensive Ministerial discretion to determine and re-determine essential components of the healthcare system. The Minister's exercise of his powers under the NHI Act are also not subject to any dedicated mechanism for legislative scrutiny or approval. Parliament has essentially abdicated its responsibility to make core policy decisions regarding which treatments or healthcare services are covered, who finances them, and how private providers fit into the system. These are decisions with enormous fiscal implications.

36 The HFA accordingly applies to this Court to declare the NHI Act unconstitutional and invalid in its entirety. In the alternative, it seeks to declare only sections 7(2)(f)(i), 31(2), 33, 39(2)(c)(i), 49(2)(a)(ii) and 55 unconstitutional and invalid.

37 The remainder of this affidavit is structured as follows:

37.1 First, I set out the relevant background by providing an overview of the regulation of the private healthcare system in South Africa, with a particular focus on the existing regulation of medical schemes, and by briefly discussing the outcomes of the Competition Commission's Healthcare Market Inquiry, which made targeted recommendations for the improvement of healthcare regulation in South Africa.

37.2 Second, I describe the scheme of the NHI Act.

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37.3 Third, I deal with the immediate implications of section 33 of the NHI Act for medical scheme beneficiaries.

37.4 Fourth, I address the feasibility and impact of NHI. In this section, relying principally on the Genesis Report, I demonstrate that the implementation of NHI is fiscally impossible and will result in a severe infringement of the right of access to healthcare services.

37.5 Fifth, I set out the grounds on which the HFA asks this Court to declare the NHI Act unconstitutional and invalid, namely that:

37.5.1 the NHI Act is incapable of achieving its intended purpose and is accordingly irrational;

37.5.2 the NHI Act, or at least section 33 of the NHI Act, infringes section 27(1) of the Constitution. In doing so, I set out a comparative review of the way in which universal health coverage is provided in other jurisdictions, to show that there are less restrictive means to achieve the NHI Act's purposes;

37.5.3 in enacting the NHI Act, Parliament has failed to adopt reasonable measures to achieve the progressive realisation of the constitutional right of everyone to access healthcare services within available resources; and

37.5.4 the NHI Act unconstitutionally delegates legislative powers to the Minister.

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37.6 Lastly, I explain that the implementation of the NHI Act risks causing irreparable harm to the healthcare sector, even if, at some stage in the future, government were to abandon NHI and adopt a different path.

THE HEALTHCARE LANDSCAPE

South African medical scheme membership

38 A key feature of the HFA's challenge to the NHI Act is the severe reduction in access to healthcare that will be suffered by existing medical scheme beneficiaries.

39 The protection afforded to medical scheme beneficiaries is secured by the contributions of medical scheme members which are pooled and safeguarded by the scheme in order to fund equitably the healthcare costs of beneficiaries. Medical schemes are non-profit organisations which operate on the basis of social solidarity which is the same basis as proposed for the NHI. All medical scheme members pay funds into a risk pool, or pool of funding from which healthcare services for those members in need of them are purchased. Schemes are therefore similar to mutual trusts where a group of people come together to share risk and obtain relief from the occurrence of those risks when they need it. I am advised that our courts have recognised that medical schemes are essential gateways to realising the right to access healthcare services under section 27(1)(a) of the Constitution.

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40 The principle of social solidarity on which medical schemes operate means that while everyone contributes at the same rate to a particular medical scheme option, the medical scheme will need to purchase more healthcare for members with greater healthcare needs. For example, this can take the form of more healthcare purchasing for older or sicker members than for younger or healthier members, even though both members contribute equally to the fund. In return for the cross-subsidisation of older or sicker members by younger or healthier members, these younger or sicker members can expect to be subsidised by future young and healthy members when they age and / or have greater healthcare needs.

41 The population of medical scheme beneficiaries is racially diverse, largely falls in the middle-and working-class categories, and has important concentrations of working beneficiaries in the public service and unionised sectors. Medical scheme beneficiaries are an economically critical group for the country from a productive and fiscal perspective.

42 As explained in the Genesis Report:

42.1 Two-thirds of medical scheme beneficiaries are black, and more than half are African (51%). 68% of scheme beneficiaries are from historically disadvantaged backgrounds (i.e., African, Coloured or Indian), constituting some 6.1 million people.[38] Only 32% of medical scheme beneficiaries are white.[39]

[38] Genesis Report at section 2 (paragraph 22).

[39] Genesis Report at section 2 (paragraph 22).

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42.2 1.9 million public sector employees belong to medical schemes, almost half of the working medical scheme beneficiary population.[40] Put differently, 46% of the employed portion of medical scheme beneficiaries, or almost two million individuals, are public sector employees spanning central and provincial government staff, local government staff, the SA Police Services, South Africa's teachers and educators, and staff of state-owned enterprises.[41]

42.3 2.7 million unionised workers belong to medical schemes, making up more than two-thirds of working medical scheme beneficiaries.[42]

42.4 44% of medical scheme beneficiaries earn less than R16,000 per month, and 83% earn less than R37,500 per month.[43] Thus, a large proportion of working scheme beneficiaries belong to the middle and working class.

42.5 Medical scheme beneficiaries are a critical source of tax revenues for South Africa. 96% of working medical scheme beneficiaries are registered to pay tax, 81% are above the tax threshold. Moreover, approximately 74% of total Personal Income Tax in South Africa – in other words, R443 billion – is

[40] Genesis Report at section 2 (paragraph 23).

[41] Genesis Report at section 2 (paragraph 23).

[42] Genesis Report at section 2 (paragraph 24).

[43] Genesis Report at section 2 (paragraph 25).

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paid by medical scheme beneficiaries.[44] This group also accounts for a large proportion of VAT generated within South Africa.[45]

42.6 Medical scheme beneficiaries are therefore critical contributors to South Africa's overall tax base on which all public expenditure – including health expenditure – depends. Their continued participation in the tax system is crucial to sustaining the level of public spending needed for South Africa's public expenditure. If they face higher NHI-induced taxes, coupled with worsening access to healthcare services, and either emigrate or otherwise cease to be economically active in South Africa as a result, South Africa risks losing a sizeable chunk of its tax base.[46] Lower tax revenue overall would hurt the government's ability to finance not just NHI, but all public expenditure. Preserving or enhancing the circumstances that keep these medical scheme beneficiaries economically active, employed, and willing to remain in South Africa safeguards tax revenues.

Private healthcare regulation in South Africa

43 The Constitution allocates legislative powers among national, provincial and local governments. Healthcare services is a functional area over which

44 Genesis Report at section 2 (paragraph 26).

45 Genesis Report at section 2 (paragraph 26).

46 Genesis Report at section 4.3 (paragraph 197).

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national and provincial governments share concurrent legislative competence.

44 Government currently fulfils its obligation under section 27(1)(a) of the Constitution to provide access to healthcare services in two broad ways.

45 First, through the public sector, the state directly provides healthcare goods and services. The public health system is funded by general taxation, and – subject to a means test – access to healthcare services at public health establishments is provided subject to the conditions prescribed in terms of section 4(3) of the National Health Act 61 of 2003 ("*NHA*"). In terms of this provision, the State must provide:

45.1 pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;

45.2 all persons, except members of medical aid schemes and their dependents and persons receiving compensation for occupational diseases, with free primary healthcare services

45.3 women with free termination of pregnancy services.

46 The obligation to provide free primary health care services to all persons except members of medical aid schemes and their dependants creates a cross-subsidy that is beneficial to the national fiscus and non-scheme beneficiaries. That is because beneficiaries *contribute* to the financing of public primary healthcare services through taxation, but may not access those public services free of charge. Their taxes are thus used to subsidise

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public primary healthcare services for others, yet their own primary healthcare needs are met through the pooling of their medical scheme contributions. This is to be contrasted with the NHI Act, which, as I explain below, *erodes* this cross-subsidy by effectively requiring everyone, including former medical scheme beneficiaries, to access primary healthcare services through the NHI Fund.

47 Second, government enables the private sector to provide healthcare goods and services. These services are funded by private patients themselves, either through medical schemes or through out-of-pocket payments.

48 Healthcare services in the private sector are provided by practitioners (such as general practitioners and specialists) and facilities (such as hospitals, healthcare centres and clinics).

49 The NHA regulates the provision of healthcare services in South Africa.

49.1 Its purpose is "*[t]o provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard health services…*"

49.2 The NHA establishes the national health system "*which encompasses public and private providers of health services*", and which "*provides in an equitable manner the population of the*

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Republic with the best possible health services that available resources can afford".

49.3 The NHA sets out the rights and duties of users and healthcare personnel, and deals with the respective functions of national and provincial health departments and districts.

49.4 It also establishes "*health establishments*" – e.g. hospitals – which are public or private institutions providing inpatient or outpatient healthcare services, and requires that hospitals must comply with quality requirements and standards of health services prescribed by the Minister.

49.5 Notably, section 58 of the NHI Act, read with Schedule 1, will delete provisions of the NHA which vest substantial powers and functions in the provinces.

50 As things stand, patients who receive private healthcare services may fund them either by paying themselves or by being reimbursed by their medical schemes. Medical schemes reimburse members for the services they receive in accordance with the scheme's rules, registered with the Council for Medical Schemes.

51 Medical schemes are closely regulated, particularly by the Medical Schemes Act 131 of 1998 ("*MSA*").

51.1 The MSA establishes the Council for Medical Schemes ("*CMS*") as the regulatory body for medical schemes. It also provides for the appointment of a Registrar of medical schemes.

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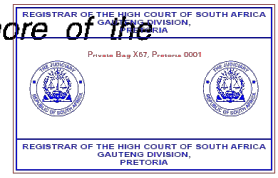
51.2 Medical schemes are not-for-profit trusts that are regulated in terms of the MSA. Individual schemes are managed by independent boards of trustees, chosen by members of the scheme, and operate independently of medical scheme administrators.

51.3 Section 1 of the MSA defines the business of a medical scheme as "*the business of undertaking, in return for a premium or contribution the liability associated with one or more of the following activities*:



(a) providing for the obtaining of any relevant health service;

(b) granting assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; or

(c) rendering a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme."

51.4 As not-for-profit trusts, contributions paid to medical schemes belong to the scheme beneficiaries. From these contributions, medical expenses claimed by beneficiaries are paid out to healthcare providers or refunded to medical scheme members, and all other expenses of the scheme are met. Any surplus, over and above what is paid out, is retained by the scheme to build

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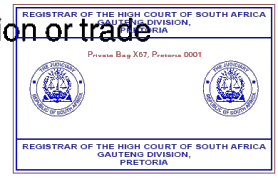
up reserves. Any shortfall must be covered by the scheme's reserves, or by increases to contributions payable by members.

51.5 Two types of medical schemes exist: "*open*" schemes and "*restricted*" schemes. Membership of open schemes is available to any member of the public, provided that they pay the relevant contribution. The MSA defines restricted medical schemes as those that have rules which restrict eligibility for membership with reference to employment, membership of an association or trade union, or in any other prescribed manner.



51.6 A scheme's administration may be performed by the scheme itself (called self-administration) or outsourced to a third-party administrator. Medical schemes most often choose to outsource this function. Unlike medical schemes, third-party medical scheme administrators operate on a for-profit basis. Revenue generated by these administrators takes the form of administration fees charged to schemes for the services provided.

51.7 Medical schemes operate in a highly regulated environment, which is designed to ensure the protection of medical scheme beneficiaries and the sustainability of medical schemes. To achieve this, the MSA and its regulations govern the establishment and operation of medical schemes and related entities.

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51.8 Section 29(n) provides that a scheme cannot vary its contributions on the basis of any factor other than income and the number of dependents. Thus, schemes must be open to all (referred to as "*open enrolment*"). They cannot vary contributions on the basis of individual risk factors, but must set contributions on the basis of global risk (referred to as "*community rating*"). This mechanism disallows medical schemes from limiting benefit options to specific groups of beneficiaries.

51.9 Section 29(o) provides that each benefit option offered by a scheme should provide for certain prescribed minimum benefits ("*PMBs*"). PMBs are a mandatory set of defined benefits that medical schemes must provide cover to all medical scheme beneficiaries. These ensure beneficiaries have access to a certain minimum level of health services, regardless of the benefit option chosen.

52 These provisions are supplemented by the Medical Schemes Regulations:

52.1 Regulation 8 of the General Regulations under the MSA specifies that PMBs must be paid in full without deductibles or co-payments, but permits schemes to specify that treatment for a PMB be sought from a designated service provider. Should the scheme member choose not to make use of a designated service provider, the scheme may impose a deductible or co-payment on that member.

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52.2 Regulation 13 contains provisions regarding the imposition of waiting periods for new beneficiaries and late joiner penalties. These provisions serve the function of protecting schemes against anti-selective behaviour (e.g. when beneficiaries join medical schemes only when they require medical treatment), while still offering protection to beneficiaries who join medical schemes late.

52.3 In terms of Regulation 29, schemes are required to hold a minimum of 25% of their gross annual contributions as a financial reserve.

53 The statutory requirements of operating as a non-profit entity, community rating, preservation of a healthy financial reserve and providing cover for PMBs ensure protection of the health needs of medical scheme beneficiaries on an equitable basis.

54 For example, schemes are required to pay for PMBs in full without requiring that medical scheme members make any co-payments. PMBs include emergencies, in-hospital care, and a large number of chronic and acute conditions. This means that any beneficiary who is hospitalised for any of the over 300 conditions in the PMBs will be covered in full right through the year. Medical scheme beneficiaries therefore have security and comfort in knowing that their catastrophic and chronic conditions are covered by their scheme.

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The Health Market Inquiry

55 In November 2013, the Competition Commission initiated a market inquiry ("*HMI*") into the state of competition in the private healthcare sector under Chapter 4A of the Competition Act 89 of 1998. In September 2019, the HMI issued its Final Findings and Recommendations Report ("*HMI Report*"), the relevant extracts of which I attach marked "*FA12*".[47]

56 The HMI recognised key strengths of the medical scheme industry and, where it found shortcomings, made recommendations aimed at promoting competitiveness in the sector. It recognised that medical schemes are already governed by social solidarity principles such as open enrolment (the principle that schemes must accept all applicants), community rating (the principle that schemes must charge an identical contribution price per plan for all members no matter their age, sex or pre-existing conditions) and prescribed minimum benefit regulations (which had a positive impact in ensuring a minimum level of coverage for members).[48]

57 However, the HMI recognised that incomplete or mismatched regulation can distort competition. Specifically, without the proper risk- and cost-sharing tools in place, medical schemes end up competing for healthier members instead of focusing on better benefits or reduced prices for everyone.[49] Currently, due to the lack of a risk-adjustment mechanism (as well as various other issues, including the absence of mandatory

[47] The HMI Report. Available: https://www.compcom.co.za/wp-content/uploads/2020/01/Final-Findings-and-recommendations-report-Health-Market-Inquiry.pdf.

[48] The HMI Report at Executive Summary (paragraphs 36 and 39); Chapter 9 (paragraph 236).

[49] The HMI Report at Executive Summary (paragraph 36).

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membership, and the lack of a review of PMBs), medical schemes with sicker or older members bear higher costs, which push up contributions. Meanwhile, medical schemes with younger, healthier members can keep contributions lower. This dynamic promotes "*risk selection*" rather than true price or quality competition.

58 The HMI thus highlighted innovative and efficient regulatory reform measures and recommended government intervention to fill gaps in the regulatory framework, and thereby to reduce the cost of medical schemes, including the following:

58.1 The introduction of a risk-adjustment mechanism, where medical schemes with higher-than-average risk profiles receive funds through an appropriate mechanism from those with lower-than-average risk profiles. This will eliminate fragmented risk pools[50] and create an opportunity for income cross subsidisation across the whole population.[51] It could also include a reformulated tax credit regime which further advances the interests of low income members.[52]

58.2 A standardised basic benefit package which covers some catastrophic expenditure as well as some level of out of hospital and primary care.[53]

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[50] The HMI Report at Chapter 5 (paragraph 86).

[51] The HMI Report at Chapter 5 (paragraph 88).

[52] The HMI Report at Chapter 5 (paragraph 94.3).

[53] The HMI Report at Chapter 5 (paragraph 94.1); Chapter 9 (paragraphs 223.1 and 222.3).

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58.3 Additional interventions including, mandatory medical scheme membership for all formally employed South Africans (as affordability levels improve, and once other regulatory reforms are in place),[54] negotiated tariffs between funders and practitioners,[55] provider contracting rules, and revised prescribed minimum benefit structuring.[56]

59 Notably, the HMI did not recommend that medical scheme coverage should be diminished. On the contrary, the HMI recognised that the implementation of its recommendations would require regulatory reforms to ensure that medical scheme cover is more affordable.[57]

60 The HMI also found that competition between multiple medical schemes is beneficial, as it crowds in and encourages investment in higher clinical standards and better patient experiences, compels schemes to negotiate more aggressively with hospitals and doctors thereby keeping costs in check, spurs innovation and new offerings, allows for enhanced consumer choice and promotes accountability. By contrast, Genesis explains in its expert report how, under a single-funder model, the NHI Fund risks concentration of power, slower innovation, and fewer incentives to improve quality or reduce costs.

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54 The HMI Report at Chapter 9 (paragraph 271).

55 The HMI Report at Chapter 9 (paragraph 170.2).

56 The HMI Report at Chapter 5 (paragraph 83).

57 The HMI Report at Chapter 9 (paragraph 16).

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61 The HMI's findings confirm that regulation deficiencies, rather than the mere presence of private medical schemes, drives up healthcare costs. By introducing a risk-adjustment mechanism, standardised plan components, and more effective regulation, medical schemes can become both more affordable and more socially equitable. As explained by Genesis, this is likely to achieve broad, fast, and sustainable health access gains.

62 The HMI also found that the process of strategic purchasing by the public sector need not wait for the NHI. Government could, and should, already, contract with the private sector where it needs capacity.[58]

63 The HMI also called for a Multi-Lateral Tariff Negotiation Forum to jointly set prices for health services. This forum would bring providers and funders together – under regulatory oversight – to negotiate tariffs, with binding dispute resolution mechanisms to break deadlocks. In particular, the HMI recommended establishing a maximum price for prescribed minimum benefit services and a reference price list for non-prescribed minimum benefit services through this multilateral process. Such collective bargaining would be enabled by statutory or exempted processes, ensuring that no single party can dominate the price-setting. This model directly counters the need for a single buyer: it achieves lower prices via negotiated tariffs in a regulated setting, rather than via NHI's top-down contracting mechanism. In short, a negotiation forum maintains multiple purchasers

[58] The HMI Report at Chapter 9 (paragraph 194).

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and providers, supervised by the state, rather than collapsing them into one monopolistic purchaser.

64 To address unbalanced provider market power and fragmentation, the HMI also recommended the creation of a dedicated Supply Side Regulator for Healthcare. This authority would have broad oversight of healthcare providers and facilities. Its core functions would include healthcare facility planning and licensing, value assessments, ongoing monitoring of health services, and pricing regulation. In practice, it would serve as a central regulator of the provider market – for example, by reforming the hospital licensing regime and by guiding or even setting price benchmarks for services. It would achieve cost control with far less restriction on medical schemes than an outright state monopolization of purchasing.

65 The HMI found that outdated rules and norms governing doctors and other practitioners were inflating costs. It noted that the Health Professions Council of South Africa's ("*HPCSA*") ethical rules prevent efficient integrated care and lock in fee-for-service billing. To address this, the HMI recommended sweeping changes to practitioner contracting. First, it urged amendments to HPCSA ethical rules to allow innovative models of care, including multidisciplinary group practices and alternative reimbursement models. This would enable, for example, team-based care and alternative payment arrangements, such as capitation mechanisms in which primary care providers will be paid per patient, not per procedure, that can reduce duplication and cost. Second, the HMI proposed that funders be allowed (and encouraged) to contract with group practices or practitioner networks

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on a value-based basis. Under the HMI's plan, practitioners could enter bilateral contracts with medical schemes for capitation or performance-based payments. Such contracts could be subject to approval by regulators to ensure they include risk-sharing and quality components. This does not require a single state payer and is therefore a less restrictive means to achieve cost containment (through improved practice patterns and billing methods).

66 Private hospital costs were a central focus of the HMI, which found that the hospital licensing regime had failed to control the high levels of concentration in the facilities market or align with health needs. Licenses were being granted in a haphazard manner – often "*evergreen*" (open-ended) and without regard to whether new facilities met population needs or exacerbated cost inflation through over-supply. As a remedy, the HMI issued detailed recommendations to transform hospital licensing into an active cost-control tool. Quality and outcomes reporting would be tied to license renewal, creating accountability for hospitals to deliver value. The HMI also suggested that licensing decisions factor in competition concerns (preventing dominant hospital groups from entrenching their market power).

67 Regrettably, six years later, government has still not implemented the majority of the HMI's core recommendations, which were specifically targeted at reducing cost, enhancing affordability, and improving accessibility in the private sector. Instead of addressing the shortcomings in the existing social-solidarity framework for medical schemes through

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sensible regulation, government has taken the drastic step of effectively abolishing private healthcare funding.

THE SCHEME OF THE NHI ACT

68 I provide a broad overview of the provisions of the NHI Act, and the system of healthcare funding and purchasing that it seeks to establish.

69 As will become evident, the NHI Act is plagued by a lack of detail and specificity. Much of the detail is left to the Minister to determine by Regulations, and for yet-to-be-appointed committees to decide.

70 Chapter 1 of the NHI Act concerns its purpose and application.

70.1 The stated purposes of the NHI Act are important to the HFA's rationality challenge. As the HFA shall explain, it is precisely because the NHI Act is incapable of attaining its stated purposes that there is no rational connection between the purposes of the NHI Act and the legislative scheme it introduces.

70.2 Section 2 describes the purpose of the NHI Act as being to establish and maintain the NHI Fund, financed through "*mandatory prepayment*", that "*aims to achieve sustainable and affordable universal access to quality health care services*" by:

70.2.1 serving as the single purchaser and single payer of healthcare services in order to ensure the equitable and fair distribution and use of healthcare services;

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70.2.2 ensuring the sustainability of funding for healthcare services within the Republic; and

70.2.3 providing for equity and efficiency in funding by pooling of funds and strategic purchasing of healthcare services, medicines, health goods and health related products from accredited and contracted healthcare service providers.

70.3 In terms of section 3, the NHI Act is of broad application, and applies to all health establishments, except those in the military.

71 Chapter 2 of the NHI Act, which is titled "*Access to Healthcare Services*", deals broadly with the users of NHI.

71.1 Section 4 provides that the NHI Fund will purchase services – which are to be determined by a "*Benefits Advisory Committee*" – in consultation with the Minister – on behalf of a wide variety of eligible persons, including citizens, permanent residents and refugees. This provision illustrates that the services to be purchased by the NHI Fund have yet to be determined and will be determined by the NHI Benefits Advisory Committee in due course, with the concurrence of the Minister.

71.2 Persons seeking healthcare services from accredited providers must, in terms of section 4(4) of the NHI Act, be registered as users of the NHI Fund. The registration procedure is set out in section 5, which requires eligible persons to register themselves

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and their children as users at accredited healthcare service providers or establishments, and to provide biometric and other information when registering.

71.3 Section 6 of the NHI Act provides for the rights of users, which include, amongst others, the entitlement to receive necessary quality healthcare services free at the point of care from accredited providers or establishments; not to be refused access to healthcare services on unreasonable grounds; to access healthcare services within a reasonable period; to be treated with a professional standard of care; and to purchase healthcare services that are not covered by the NHI Fund, including through a complementary voluntary medical insurance scheme registered in terms of the MSA.

71.4 Implicit in the right to purchase healthcare services being limited to services that are not covered by the NHI, is the prohibition on medical schemes funding services that *are* covered by the NHI.

71.5 Section 7 of the NHI Act addresses the coverage of healthcare services. In terms of this provision, the NHI Fund must purchase the services which are to be determined by the NHI Benefits Advisory Committee, in consultation with the Minister, for the benefit of users. Again, therefore, precisely which healthcare services the NHI Fund will purchase is to be determined by a committee, with the concurrence of the Minister, in due course.

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71.6 Section 7(2) of the NHI Act provides that users must receive any healthcare services to which they are entitled under the NHI Act from the provider or establishment at which they registered, save that, if users are unable to do so, then "*such portability of health services as may be prescribed must be available to that user*", and if the provider or establishment is unable to provide such services, then they must transfer the user to another appropriate provider or establishment.

71.7 Section 7(2)(d) also obliges users to use the prescribed "*referral pathways*", including by first accessing healthcare services at a primary level, failing which such users are not entitled to healthcare services purchased by the NHI Fund.

71.8 Section 7(2)(f) of the NHI Act seeks to centralise the provision of healthcare services at the hospital level, by, *inter alia*, requiring the Minister to request the Minister of Public Service and Administration to consider and assist in establishing central hospitals as "*national government components*" under the Public Service Act 103 of 1994, and by making the administration, management, budgeting and governance of central hospitals a competence of national government.

71.9 Section 7(4) of the NHI Act describes the circumstances in which treatment must not be funded, namely, where no medical necessity exists for the service in question; where no cost-effective intervention exists for the service (as determined by a

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"*health technology assessment*"); and where the healthcare product or treatment is not included in the "*formulary*" approved by the Minister (which comprises an "*essential medicine list*", an "*essential equipment list*" and a list of approved health-related products used in healthcare service delivery, the contents of which are yet to be determined), except in circumstances where a complementary list has been approved by the Minister.

71.10 Where the NHI Fund refuses to fund a user, it must provide the user with an opportunity to make representations and reasons for the refusal, and the user has a right of appeal to an Appeal Tribunal.

71.11 Section 8 reiterates that users are entitled to receive the healthcare services purchased on their behalf by the NHI Fund from accredited providers or establishments free at the point of care. Section 8(2) stipulates the circumstances in which persons or users must pay for services "*directly or through a voluntary medical insurance scheme*". In essence, a user pays for services when she cannot obtain them at all through the NHI Fund (because she is not entitled to them, or because the Benefits Advisory Committee does not deem them medically necessary or has not included them as a comprehensive healthcare service).

71.12 In the next section of my affidavit, I demonstrate that lower-income medical scheme beneficiaries will be immediately

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vulnerable once the NHI Act is brought into force and the first steps are taken to funnel finances from private health expenditure to the NHI Fund by abolishing the medical scheme tax credit and thereby immediately reducing the disposable income of medical scheme members. This reduction in disposable income will render medical scheme contributions unaffordable for this group of beneficiaries. The result is that they will be required to pay for healthcare services out-of-pocket, or access healthcare services from the public healthcare sector, even before section 33 takes effect. Many young and healthy current medical scheme beneficiaries will also exit private medical schemes due to contribution increases, triggering adverse selection dynamics and a medical scheme death spiral. As additional revenue-raising measures are introduced, a growing number of medical scheme members and their beneficiaries will lose their medical scheme coverage, resulting in increased out-of-pocket healthcare expenses and imposing a greater burden on the public sector. This undermines the very rationale of universal health coverage, as the public sector will be unable to provide the healthcare services required by former medical scheme beneficiaries and its existing users at the current levels they are provided.

72 Chapter 3 of the NHI Act concerns the establishment, functions and powers of the NHI Fund.

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72.1 Section 10 of the NHI Act identifies the functions of the NHI Fund, which include, amongst others, to take all reasonably necessary steps to achieve the objectives of the NHI Fund and the attainment of universal health coverage; to pool allocated resources in order to purchase and procure healthcare services, medicines, health goods and products from accredited service providers and establishments; to purchase healthcare services on behalf of users as advised by the Benefits Advisory Committee; and to enter into contracts with accredited healthcare service providers based on the healthcare needs of users.

72.2 Section 11(1) sets out the NHI Fund's broad powers to, inter alia, employ personnel; improve access to, and the funding, purchasing and procurement of, healthcare services, medicines, health goods and health related products that are of a reasonable quality; identify, develop, promote and facilitate the implementation of best practices in respect of purchase, payment, delivery, design of benefits and referral networks.

72.3 Section 11(2) empowers the NHI Fund to enter into contracts for the supply of healthcare services, goods and products, and obliges it to purchase services of sufficient quality and quantity to meet the needs of users, to ensure that there is no interruption in supply, and to negotiate the lowest possible price for goods and services without compromising the interests of users.

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73 Chapter 4 of the NHI Act provides for the establishment, composition and powers of the Board of the NHI Fund. The Board governs the NHI Fund, and is accountable to the Minister.

74 Chapter 5 of the NHI Act provides for the appointment and responsibility of the Chief Executive Officer of the NHI Fund, who is the administrative head of the Fund and is directly accountable to the Board.

75 Chapter 6 of the NHI Act entitles the Board to establish sub-committees and technical committees.

76 Chapter 7 of the NHI Act provides for the establishment of three specific advisory committees by the Minister, namely:

76.1 The "*Benefits Advisory Committee*" in section 25, whose role it is to determine and review the healthcare service benefits which the NHI Fund must purchase and types of services to be reimbursed at each level of care at primary healthcare facilities and at district, regional and tertiary hospitals; and detailed and cost-effective treatment guidelines;

76.2 The "*Healthcare Benefits Pricing Committee*" in section 26, which consists of experts in actuarial science, medicines, epidemiology, health management, health economics, health financing, labour and rights of patients, and whose role it is to recommend the prices of health service benefits to the NHI Fund.

76.3 The "*Stakeholder Advisory Committee*" in section 27, which is comprised of representatives from the statutory health

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professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers as well as patient advocacy groups.

77 Chapter 8 of the NHI Act deals generally with the operation of the NHI Fund and delineates the respective roles of the Minister, the National Department of Health, and medical schemes.

77.1 Section 31(1)(a) makes the Minister responsible for governance and stewardship of the national health system and the NHI Fund. In terms of section 31(2) of the NHI Act, the Minister is required to clearly delineate in "appropriate legislation" the respective roles and responsibilities of the Fund and the national and provincial Departments.

77.2 Section 32 provides that the National Department of Health is responsible for issuing and promoting guidelines for norms and standards; implementing human resources planning, development, production and management; co-ordinating healthcare services rendered by the Department of Health with the healthcare services rendered by provinces, districts and municipalities; planning the development of public and private hospitals, other health establishments and health agencies; and integrating the annual health plans of the Department of Health and the provincial and district health departments.

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77.3 Section 33 is a particularly important provision in the context of this case. Indeed, it is the central focus of this application, and the primary source of the NHI Act's unconstitutionality.

77.3.1 It provides that once NHI has been "*fully implemented as determined by the Minister through regulations in the* Gazette," medical schemes may only offer complementary cover to services not reimbursable by the NHI Fund.

77.3.2 In other words, section 33 spells the end of medical scheme cover for South Africans, save insofar as they offer complementary cover to services not reimbursable by the NHI Fund. Simply put, therefore, once NHI is determined by the Minister to be fully implemented, medical schemes will be precluded from covering any services which the NHI Fund reimburses.

77.3.3 The prohibition on providing supplementary cover will kick in when NHI is fully implemented, as determined by the Minister in the Gazette. Full implementation is determined, in turn, by section 57 of the NHI Act, which provides for the phased implementation of the NHI Act and sets out the practical steps that must be taken, and the objectives that must be achieved, in Phase 1 and Phase 2.

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77.3.4 I am advised and respectfully submit that the Minister could not lawfully declare NHI to be fully implemented, until the steps and objects identified in section 57 have been achieved.

77.4 Section 35 concerns the purchasing of healthcare services. It requires the NHI Fund to actively and strategically purchase healthcare services on behalf of users in accordance with need. Insofar as reimbursement is concerned, it distinguishes between hospital, primary healthcare and emergency services:

77.4.1 Section 35(2) requires the NHI Fund to reimburse payment directly to accredited and contracted hospitals based on a global budget or "*Diagnosis Related Groups*". The requisite coding systems, costings and data for the development of South African Diagnosis Related Groups for payments are not yet in place.

77.4.2 Section 35(3) requires funds for primary healthcare services to be reimbursed directly to accredited and contracted service providers and establishments at the sub-district level, in accordance with the "*Contracting Unit for Primary Healthcare*" established in section 37.

77.4.3 Section 35(4) requires facility-based and mobile emergency services provided by accredited and

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contracted service providers to be reimbursed on a capped case-based fee basis, with adjustments made for case severity, where necessary. Public ambulance services are to be reimbursed through the undefined "*provincial equitable allocation*".

77.5 Section 36 requires the "*District Health Management Office*", established by section 31A of the NHA as a national government component, to manage, facilitate, support and coordinate the provision of primary healthcare services.

77.6 Section 37 establishes the "*Contracting Unit for Primary Healthcare*". It is comprised of a district hospital, clinics or community health centres and ward-based outreach teams and private providers "*organised in horizontal networks within a specified geographical sub-district area*". The Unit must assist the NHI Fund to, amongst other things, identify healthcare service needs in terms of the demographic and epidemiological profile of a particular sub-district; identify accredited providers at primary care facilities; manage contracts entered into with accredited providers, establishments and suppliers in the relevant sub-district; monitor the disbursement of funds to healthcare service providers, health establishments and suppliers within the sub-district.

77.7 Section 38 requires the Board to establish the "*Health Products Procurement Unit*", which is responsible for facilitating and

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coordinating functions related to public procurement of health related products, such as medicines, devices and equipment.

77.8 Section 39 regulates the accreditation of healthcare service providers and requires such providers to deliver healthcare services at the appropriate level of care to users who are in need and are entitled to benefits purchased by the NHI Fund on their behalf. In terms of section 39(3), the Fund must conclude contracts with certified or qualifying establishments to provide (i) primary healthcare services through "*Contracting Units for Primary Healthcare*"; (ii) emergency medical services; and (iii) hospital services.

77.9 Section 41 concerns payment of healthcare service providers. The mechanisms for the payment of providers are to be determined and applied by the NHI Fund in consultation with the Minister. Accredited primary healthcare providers will be reimbursed in accordance with the "*prescribed capitation strategy*"; specialist and hospital services will be paid for on an "*all inclusive*" basis and based on performance; and emergency services will be reimbursed on a "*capped case-based fee basis*", with adjustments for severity.

78 Chapter 9 of the NHI Act concerns complaints and appeals, including the establishment of an Appeal Tribunal.

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79 Chapter 10 of the NHI Act is titled "*Financial Matters*" and, most significantly, in sections 48 and 49, identifies the revenue sources of the NHI Fund.

79.1 The NHI Fund's chief revenue source is money appropriated annually by Parliament to achieve the objects of the NHI Act. This money must be appropriated from money collected and in accordance with "*social solidarity*" in respect of general tax revenue, reallocation of funding for medical scheme tax credits "*paid to various medical schemes*"; payroll tax; and surcharge on personal income tax.

79.2 This chief revenue source is supplemented by interest or returns on investments; monies paid erroneously to the Fund which cannot be refunded; bequests and donations; and any other money to which the Fund may become legally entitled.

80 Chapter 11 of the NHI Act contains various miscellaneous provisions. Most significant among these are the following:

80.1 Section 55 confers on the Minister wide regulation-making powers, in relation to numerous matters. These range from prescribing payment mechanisms to be employed by the NHI Fund and the budget of the Fund, to prescribing the powers and functions of District Health Management Offices ("*DHMOs*") and Contracting Units for Primary Healthcare Services.

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80.2 Perhaps most significantly, and as set out in more detail below, the Minister is expressly empowered to make regulations concerning matters which appear to be at the heart of the legislative scheme itself, including regulations concerning:

80.2.1 the powers and functions of DHMOs;

80.2.2 the powers and functions of Contracting Units for Primary Healthcare;

80.2.3 the relationship between public and private health establishments, and the optional contracting in of private healthcare service providers;

80.2.4 the relationship between the NHI Fund and medical schemes registered in terms of the MSA and other private health insurance schemes;

80.2.5 all practices and procedures to be followed by a healthcare service provider, health establishment or supplier in relation to the NHI Fund;

80.2.6 the respective roles of the Fund, and national and provincial health departments; and

80.2.7 the scope and nature of prescribed healthcare services and programmes, and the manner in, and extent to which, they must be funded.

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80.3 Section 56 allows the NHI Fund to issue directives in the Gazette, which must be followed in implementing and administering the NHI Act.

80.4 Section 57 is headed "*Transitional arrangements*", and sets out the phased approach for the implementation of the NHI Act.

80.4.1 It provides that the NHI Act must be implemented over two phases, and that NHI must be gradually phased in using a "*progressive and programmatic approach based on financial resource availability*".

80.4.2 Phase 1, which is for a period of four years from 2023 to 2026, requires the taking of various preparatory steps such as implementing health system strengthening initiatives, the development of necessary legislation, the purchasing of personal healthcare services for vulnerable groups, and the development and implementation of administrative and personnel related arrangements to establish the Fund as a Schedule 3A entity.

80.4.3 In Phase 1, the Minister may establish various interim advisory committees.

80.4.4 In terms of section 57(4), Phase 1 must achieve various objectives, including:

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(a) the migration of central hospitals that are funded, governed and managed nationally as semi-autonomous entities;

(b) the structuring of the Contracting Unit for Primary Healthcare at district level in a cooperative management arrangement with the district hospital linked to several primary healthcare facilities;

(c) the establishment of the Fund, including its governance structures;

(d) the development of a Health Patient Registration System;

(e) the process for the accreditation of healthcare service providers;

(f) the purchasing of healthcare service benefits, including personal health services such as primary healthcare services, maternity and child healthcare services including school health services, healthcare services for the aged, people with disabilities and rural communities from contracted public and private providers including general practitioners, audiologists, oral health practitioners, optometrists, speech

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therapists and other designated providers at a primary healthcare level focusing on disease prevention, health promotion, provision of primary healthcare services and addressing critical backlogs;

(g) the purchasing of hospital services and other clinical support services, which must be funded by the NHI Fund; and

(h) the initiation of legislative reforms in order to enable the introduction of NHI.

80.4.5 Phase 2, which must be for a period of three years from 2026 to 2028, must include:

(a) the continuation of health system strengthening initiatives on an ongoing basis;

(b) the mobilisation of additional resources where necessary; and

(c) the selective contracting of healthcare services from private providers.

81 In terms of section 57(5), Phase 2 must achieve the objective of establishing and operationalising the NHI Fund as a purchaser of healthcare services through a system of mandatory prepayment.

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82 These provisions of the NHI Act prescribe how different parts of the new NHI system will operate. There will effectively be one public health insurer for all South Africans. Private healthcare providers will have to contract with the NHI Fund in order to provide services that are funded by NHI. Private medical schemes will be prohibited from offering coverage except in limited cases.

83 Currently, public health facilities are funded by nationally collected tax revenue allocated to provincial governments. Under the NHI, the purchasing entity – the NHI Fund – will be legally and administratively separate from the providers, hospitals and health facilities (albeit that they will all be ultimately accountable to the Minister of Health).

IMMEDIATE IMPLICATIONS FOR MEDICAL SCHEME BENEFICIARIES

84 This challenge to the NHI Act has as its principal focus the irrationality, unreasonableness and unconstitutionality of section 33 of the NHI Act. The Minister and Department officials have attempted to soften the impact of section 33 by suggesting that medical schemes will continue to operate in their current format for another 10-15 years, because that is how long the Minister personally estimates the full implementation of NHI to take. The Minister has said that:

> *"Crucial to this design is also that the restriction of medical schemes to offering complementary cover under section 33 of the NHI Act will only occur once the NHI Act is fully implemented. This means that medical schemes will still be in operation on a basis similar to that currently in*

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operation for several years during the progressive implementation of the NHI Act. I estimate this to be a period of between 10 and 15 years."[59]

85 Dr Nicholas Crisp has also said that:

"The NDOH understanding and view about complementary medical schemes are written into the Bill for a very deliberate reason. The Department does not foresee that there will ever be a termination and a rejection of all medical schemes and all private financing mechanisms because no state is ever able to provide all health care to everyone. There are always exclusions that medical science makes possible, but they are not necessarily in the interests of the broader public or possible within the framework and the budgets available at the time."[60]

86 The Minister and Dr Crisp acknowledge the necessary role of medical schemes for "*complementary*" cover, but as appears more fully below, they gloss over the impact of the transition towards the full implementation of the NHI Act on the affordability and viability of medical schemes – particularly for lower income beneficiaries.

87 In this section, I explain that medical scheme beneficiaries and the public healthcare sector will suffer the negative impact of NHI even before the NHI Act is fully implemented.

88 This will occur in two interrelated ways:

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[59] *Solidarity v Minister of Health*. Minister's answering affidavit at para 257.

[60] Comments by Dr Crisp during South Africa. National Assembly: Health Portfolio Committee. 2022. *National Health Insurance (NHI) Bill: Health Department response to concerns, with Deputy Minister 30 Nov 2022*. Available: https://pmg.org.za/committee-meeting/36195/.

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88.1 The raising of taxes to raise funds for the implementation of the NHI Act will result in medical scheme membership becoming unaffordable for hundreds of thousands, if not millions, of medical scheme members, who will exit their medical schemes. In the most immediate phase, funds will be raised for the implementation of the NHI through the abolition of tax credits, which is effectively a cost increase that medical scheme members will need to bear, since their after-tax income will reduce. That alone will have an adverse impact on many medical scheme beneficiaries—particularly lower- and middle-income earners—who rely on the tax credit to keep monthly contributions at an affordable level. The removal of the tax credit will push between 500,000 to 884,000 beneficiaries into a position where retaining their existing medical scheme cover becomes unaffordable.[61] As additional taxes are raised for incremental implementation, more members will drop off, as modelled by Genesis and set out below;[62] and

88.2 Medical schemes will suffer from adverse selection, as younger, healthier members abandon their scheme coverage leaving older, sicker beneficiaries as members of schemes, and imperilling the sustainability of such schemes.[63] Medical schemes, facing higher per-person costs, will be forced to raise

[61] Genesis Report at section 6.6.3 (paragraph 320).

[62] Genesis Report at section 6.6.1 (paragraph 310).

[63] Genesis Report at section 6.6.

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contributions, which drives out yet more healthy, cost-sensitive beneficiaries. This cycle, referred to as the actuarial death spiral, risks collapsing schemes or making the few remaining, comprehensive plans, prohibitively expensive.[64] Ironically, the very households who lost their medical scheme coverage will still pay the NHI tax, yet will no longer receive the robust coverage they once had. This transition is regressive—it hurts lower-income earners the most, who are amongst the very group the NHI aims to uplift.

89 Before I address each of these aspects, including the impact of the NHI on medical scheme beneficiaries, I point out that as a matter of law, the Minister's statement provides cold comfort – it is no answer to a constitutional challenge, based on an infringement of the right of access to healthcare, to say that the infringement will only manifest sometime later when the Minister decides that the NHI Act has been fully implemented.

90 The Minister's statement is also directly in conflict with the NHI Act, and the time periods it prescribes for the implementation of NHI. As I have already explained, section 57(2) – (5) of the NHI Act stipulate the Phases of implementation, with Phase 1 running for four years (2023-2026) and Phase 2 for three years (2026-2028). Thus, by 2028, the infrastructure, legislative framework, administrative apparatus, and financing model must be in place for the NHI Fund to start functioning as South Africa's principal purchaser of healthcare services for the entire population. At this point,

[64] Genesis Report at section 6.6.4 (paragraphs 329/30).

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pursuant to a declaration by the Minister that NHI has been fully implemented, medical schemes will be effectively prohibited from covering services that the NHI Fund covers.

91 In fact, it is unclear on what basis the Minister says that medical schemes can continue to operate as normal once the NHI Act is brought into operation. Section 58(1) of the NHI Act provides that, subject to section 58 and section 57 dealing with transitional arrangements, the laws mentioned in the second column of the Schedule are repealed or amended to the extent set out in the third column of the Schedule. Section 58(1) does not make reference to section 33 of the NHI Act. In terms of the third column, the MSA is amended so that medical schemes may only undertake liability, in return for a premium or contribution, associated with healthcare services "*not covered by the provisions of the National Health Insurance Act*". Thus, the moment section 58(1) of the NHI Act is brought into force, the MSA will be amended to fundamentally alter the business of a medical scheme.

92 In addition to having no basis in law , the Minister's statement that medical schemes will still be in operation for another 10 to 15 years in their current form is not based on any evidence or considered analysis. It is an unfounded subjective assumption that there will be no impairment to medical schemes and their beneficiaries because medical schemes will be permitted by the Minister to exist in some form for a very long time. As the HFA shows, the Minister's speculation is false.

93 As regards the **first** of the ways in which the public healthcare sector will suffer the negative impact of NHI even before the NHI Act is fully

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implemented, substantial additional funding will be required during the transitional period in order to begin rolling out a comprehensive package of benefits for 50 million people. This is evident from the objectives sought to be achieved in Phase 1, in terms of section 57(4) of the NHI Act.

94 To fund the coverage of health services during Phases 1 and 2 of NHI, the government will inevitably have to raise taxes.[65]

95 The Department of Health has suggested that it will begin raising funds for NHI by removing the medical scheme tax credit, which currently constitutes a critical element of the South African health system. The tax credit – which is a rebate used to reduce the normal tax a person pays – is a means by which government incentivises medical scheme membership. The tax credit provides significant relief to millions of medical scheme beneficiaries—especially lower and middle income beneficiaries. The tax credit currently provides a fixed amount of tax back to each taxpayer dependent only on the number of medical scheme beneficiaries paid for by the taxpayer. For the 2023/2024 tax year, the credit was R364 per month for the main member, R364 per month for the first dependant, and R246 per month for each additional dependant.[66] The effect of the tax credit is to make medical scheme contributions more affordable.

96 In theory, the abolition of the tax credit would, without considering its broader impact, and without at this stage considering the possibility that increased tax rates might result in lower revenue (discussed below) raise

65 Genesis Report at section 6.6.1 (paragraphs 309).

66 Genesis Report at fn 260.

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about R30.4 billion for the fiscus.[67] However, the abolition of tax credits will also have an immediate impact on the ability of the lower income earning beneficiaries of the medical scheme population to continue to afford cover, and hundreds of thousands of current medical aid beneficiaries will for this reason alone be pushed passed their affordability threshold, and be forced to terminate their medical scheme memberships. The financial impact would most keenly be felt by low-income taxpaying medical scheme beneficiaries as the tax credit is a higher proportion of their income.

97 Genesis uses two affordability thresholds – percentage of a household income that can reasonably be devoted to health insurance (or to total healthcare costs) without causing undue financial hardship – of 8% and 16%.[68] Genesis projects that "*the removal of the tax credit would increase the proportion of income spent on medical scheme contributions by up to 4% for low-income taxpaying households and by a lower percentage for higher income households, on average.*"[69] The increase in medical scheme contributions will mean that "*[a]cross the income distribution, the removal of the tax credit will push between **500,000** (16% affordability threshold) and **884,000** (8% affordability threshold) into a position where their existing medical schemes becomes unaffordable.*"[70]

98 This effect will be exacerbated as the further requisite tax increases are implemented to fund the NHI. Genesis has calculated the number of

[67] Genesis Report at section 6.6.2 (paragraph 316.1).

[68] Genesis Report at section 6.6.2 (paragraph 314).

[69] Genesis Report at section 6.6.3 (paragraph 319).

[70] Genesis Report at section 6.6.3 (paragraph 320).

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medical scheme beneficiaries who would drop off medical schemes due to unaffordability depending on whether the tax increase is aimed at raising an additional R100 billion, R200 billion or R280 billion to fund the NHI.

98.1 Even a R100 billion NHI tax hike would push 350,000 additional individuals over a 16% affordability threshold, swelling to 850,000 people if the threshold is set at 8%.[71]

98.2 Should the NHI require R200 billion in additional taxes, an additional 800,000 people would exceed a 16% affordability threshold. That figure jumps to 1.85 million if the threshold is 8%.[72]

98.3 Out of 9.1 million medical scheme beneficiaries spanning all income levels, imposing an NHI tax to raise R280 billion would push an estimated 1.4 million to 3.3 million individuals beyond the affordability threshold, depending on whether the cutoff is set at 8% or 16% of income.[73]

99 These individuals who drop out of medical schemes will then need to fund their healthcare expenses on an out-of-pocket basis, which is highly regressive and unlikely, given that those who can no longer afford medical scheme contributions will struggle to self-fund doctor visits, procedures (especially hospital treatment) and prescriptions. Realistically, most will turn to the public health system. This immediately adds to the already

[71] Genesis Report at fn 261.

[72] Genesis Report at fn 261.

[73] Genesis Report at section 6.6.4 (paragraph 323).

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overburdened system, undermining the intent behind raising additional tax revenue in the first place.

100 For example, the 500,000 to 884,000 medical scheme beneficiaries expected to lose cover if only the medical scheme tax credit disappears will likely seek access to medical services in the public sector.

100.1 Providing 884,000 people with only *basic coverage* in the public sector will cost the state an extra R4.2 billion annually. This is calculated based on a basic benefit package (which is limited only to basic primary care, and excludes all hospitalisation) at a cost of R400 per life per month, in accordance with the CMS Circular 53 of 2022, with inflation adjustments.

100.2 Offering the same number of people a benefits package equivalent to *Prescribed Minimum Benefits* available under the medical schemes of which they are currently beneficiaries would climb closer to R12.1 billion per year. This is calculated based on the CMS' 2023 Industry Report, which estimates that PMBs cost R1,145 per life per month in 2023.

100.3 Providing 884,000 medical scheme beneficiaries with *comprehensive care* would cost the state approximately an extra R13.6bn annually. This is calculated based on Genesis' calculations of an efficiency-adjusted spend per person of R15,342 under their comprehensive care scenario.[74] Charitably

[74] Genesis Report at section 4.2.3 (paragraph 173).

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assuming that these medical scheme beneficiaries will be paying R3.8 billion more tax if the medical scheme tax credit disappears, the net effect is around R9.8 billion more in costs annually.

100.4 These extra costs dilute any "*gain*" from removing the tax credit. While the fiscus raises more tax revenue if the removal of the tax credit is looked at in isolation, it will inevitably end up being required to fund newly uninsured individuals turning to the public health sector.

101 The **second** severe risk to medical schemes and their beneficiaries before the NHI Act is fully implemented arises from adverse selection, a phenomenon whereby younger, healthier members are the first to abandon their medical scheme coverage once it becomes more expensive or they are less able to afford it, given tax increases.[75]

102 Because these younger, healthier individuals typically pay more in contributions than they claim, they effectively cross-subsidise older or sicker beneficiaries who generally incur higher medical costs.[76] This is the principle of social solidarity that underpins the functioning of medical schemes.

103 Once the tax credit is removed or taxes are increased, it is precisely this low-risk group that will be most inclined to withdraw from medical schemes.[77] The remaining pool will then be disproportionately elderly and

[75] Genesis Report at section 6.6.

[76] Genesis Report at section 6.6.4 (paragraph 325).

[77] Genesis Report at section 6.8 (paragraph 350.2).

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higher-risk, the cross-subsidy from younger and healthier lives will be lost, and the average per capita costs will rise significantly.[78] Medical schemes will be forced to increase contributions for those who remain, which will in turn drive out more cost-sensitive—and usually healthier—members.[79]

104 As explained by Genesis, this dynamic quickly escalates into an actuarial "*death spiral*," where each round of contribution hikes prompts further departures, thereby pushing contributions even higher, jeopardising the sustainability of the entire medical scheme sector.[80]

105 Genesis concludes that an increase in taxes during the transition will result in medical scheme coverage becoming unaffordable for many beneficiaries. The removal of the medical scheme tax credit alone is likely to cause between 500,000 to 884,000 beneficiaries to drop their coverage.[81]

106 This will undermine the critical social solidarity function played by medical schemes, which must continually balance affordability, sustainability and the availability of benefits.

106.1 Beneficiaries have short-term affordability needs, within their financial constraints, but medical schemes must be able to sustainably take care of their current and future healthcare

[78] Genesis Report at section 6.8 (paragraph 350.2).

[79] Genesis Report at section 6.8 (paragraph 350.2).

[80] Genesis Report at section 6.6.4 (paragraphs 329/30).

[81] Genesis Report at section 6.8 (paragraph 350.1).

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needs. Medical schemes derive income only from member contributions and investment returns earned on member funds.

106.2 Contributions are priced to match expected claims for the forthcoming year based on healthcare inflation (tariff increases and the impact of supply and demand, including the expected utilisation of healthcare services), the demographic profile of the membership base and the operational expenses of the scheme.

106.3 Medical schemes must hold sufficient reserves in the form of a regulated solvency of not less than 25% of gross annual member contributions. This is to ensure they can weather times of economic difficulty and unexpected claims, provide for variations in utilisation and escalation in the cost of treatment, optimise benefits according to appropriateness, costs, and the health needs of scheme membership, and treat all scheme beneficiaries equitably. These reserves belong to the beneficiaries.

106.4 As the demographic characteristics of beneficiaries differ between medical schemes, each scheme has unique pricing needs and constraints. For example, there are diverse proportions of scheme beneficiaries who suffer from chronic conditions.

106.5 As not-for-profit entities, medical schemes determine their annual contributions based on expected expenses for the upcoming year, (including healthcare claims, non-healthcare

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costs, and to maintain the prescribed 25% solvency ratio), with the objective of achieving a breakeven position or a slight surplus, to cushion the scheme against unexpected expenses such as sudden increased utilisation of healthcare or individual large claims. Medical schemes rely heavily on cross-subsidisation among their members: the majority, typically younger and healthier individuals, claim less than their contributions. The surplus generated from these members is used to cross-subsidise the minority of members, generally older or sicker individuals whose healthcare claims exceed their contributions. A decline in the proportion of young and healthy members reduces the surplus available for cross-subsidisation, thereby necessitating higher contribution increases for the remaining members to maintain financial stability.

107 It follows that the transition to the full implementation of NHI, which relies on complementary cover continuing to be provided by medical schemes, will render medical schemes unable to provide an affordable and sustainable means of cover. This will have disastrous immediate effects. If, for example, medical schemes are unable to fund a particular life-saving drug, then pharmaceutical companies will not import that drug to South Africa. The detailed evidence set out in the Genesis Report also makes it plain that medical scheme beneficiaries, particularly of the lower-income group, will face an immediate impairment of their right to access healthcare services.

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108 It follows that instead of de-risking the implementation of NHI, the transition mechanisms will destroy the sustainability of medical scheme coverage even before the NHI has been fully rolled out.

THE FEASIBILITY AND IMPACT OF NHI

Overview

109 This section describes the **feasibility** of NHI under the NHI Act and its **likely impact** on healthcare access. It summarises the analysis undertaken by Genesis in its report. In doing so, it focuses on two main scenarios:

109.1 In the first instance, a "*comprehensive care for all*" model, where government attempts to raise total healthcare spending so as to provide every person with coverage at a level similar to that accessible to medical scheme members.[82]

109.2 Genesis then models a "*shared model*" scenario where government redistributes current health expenditure—public plus private—equally across the entire population by providing access to healthcare services to all at a level closer to (but above) that currently provided in the public sector.[83]

110 Drawing on the findings in the Genesis Report, this section identifies three key issues regarding the feasibility and impact of NHI.

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[82] Genesis Report at sections 4.2/3.

[83] Genesis Report at Chapter 5.

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111 First, it is fiscally impossible for NHI to deliver comprehensive care for all. Simply put, the money does not exist, and cannot be raised, to provide comprehensive care for all by means of a single-purchaser, single-payer model.

111.1 Even on the most generous assumption that NHI is able to achieve substantial cost savings of 45.5% of current private sector healthcare costs, the provision of comprehensive care for all would be fiscally impossible under the NHI Act.[84]

111.2 According to Genesis's conservative modelling, the provision of comprehensive care for all would require an increase in total healthcare expenditure of R409 billion – effectively increasing total national health expenditure by 77%.[85] This is entirely unrealistic. Raising this through personal income tax would demand massive rate hikes—for instance:

111.2.1 more than doubling the lowest tax bracket for persons at the annual income threshold of R92,000 from 18% to 41.4%;

111.2.2 almost doubling the tax bracket for persons at an annual income of R289,550 from 26% to 49%;

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[84] Genesis Report at overview and key findings, p viii.

[85] Genesis Report at sections 4.2.4 (paragraph 178) and 4.2.5.

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111.2.3 significantly increasing the tax bracket for persons at an annual income of R420,900 from 31% to 54%;

111.2.4 significantly increasing the tax bracket for persons at an annual income of R565,050 from 36% to 59%;

111.2.5 significantly increasing the tax bracket for persons at an annual income of R729,500 from 39% to 62%;

111.2.6 significantly increasing the tax bracket for persons at an annual income of R1,274,600 from 41% to 64%; and

111.2.7 significantly increasing the tax bracket for persons at an annual income of R2 million from 45% to 68%.[86]

111.3 But because South Africa's tax base is extremely narrow, with half of all personal income tax revenue (R345bn) derived from the 491,000 tax payers earning R1m or more per annum (out of a population of more than 63.21 million), and high earners easily adjust their effort or relocate—increasing tax rates by that magnitude would ultimately lead to a decrease in overall revenue.[87] In other words, any attempt to finance a near-doubling of healthcare spend by taxing those already paying the bulk of income tax would reach the point of diminishing tax

[86] Genesis Report at sections 4.2.5 and 4.2.6.1 (Table 8).

[87] Genesis Report at section 3.3.2 (paragraphs 132 to 140).

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returns and would fail to generate the needed funds for the fiscus.

112 Second, given the impossibility of providing comprehensive care for all under the NHI Act, NHI will inevitably result in a drastic curtailment of access to healthcare services for existing medical scheme beneficiaries, despite the fact that they will still have to pay significantly increased taxes. Genesis estimates that, on the shared model, through which current total healthcare expenditure is equally distributed, existing scheme beneficiaries will suffer a 43% decline in effective access.[88] If NHI proves less efficient than anticipated by Genesis's conservative modelling, which is likely, then effective access will drop by significantly more.

112.1 This will directly manifest in the substantial and daily rationing of healthcare services and decreased access in the form of reduced medical staff, medicine availability, hospital beds, theatres, a shortage of equipment, unavailability of procedures and longer waiting times.[89]

112.2 Even in this purely redistributive scenario, government will have to increase taxes significantly in order to capture the over R280 billion that is currently being spent within the private sector. Capturing R280 billion via personal income tax would raise the average tax ratio from 28% to 32% of GDP, with the lowest

[88] Genesis Report at overview and key findings, p ix, section 5.2.

[89] Genesis Report at overview and key findings, p x, xi; section 5.2.1.

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bracket rising from 18% to 27.5%,[90] and the highest tax bracket rising from 45% to 54.5%.[91] These are substantial tax hikes. For millions of taxpayers who are not currently members of medical schemes but who would nevertheless be affected by such increases, their after-tax income would decrease by between 10% and 15%.[92] Further, NHI raises the likelihood of increased out-of-pocket expenditure and places a greater burden of financing healthcare for the entire population on the government.[93]

112.3 The delays that currently plague the public sector would now apply to millions of former medical scheme beneficiaries, escalating queue lengths for surgeries and procedures.[94] Medical scheme members currently managed in the private sector might wait months or years to access necessary healthcare services.[95]

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90 Genesis Report at Table 15.

91 Genesis Report at overview and key findings, p viii; section 5.5 (paragraph 244); section 6.6.1 (paragraph 309).

92 Genesis Report at section 5.3 (paragraph 230).

93 Genesis Report at overview and key findings, p x; section 6.7 (paragraphs 337/9).

94 Genesis Report at overview and key findings, p x/xi.

95 Genesis Report at section 5.2.1.

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112.4 Public procurement in the public healthcare sector already frequently leads to supply bottlenecks.[96] Joining 9.1 million more users to that system will likely exacerbate shortages.[97]

112.5 It follows that under Genesis's "*shared model*," medical scheme beneficiaries will inevitably lose a major share of their current healthcare coverage—and must, at the same time, endure heavier taxes and see less disposable income. The effective reduction in income will have further negative consequences by constraining family resources for other basic needs, such as food and education.

113 Third, NHI – and particularly the establishment of a "*single purchaser*", with monopsony buying power – is likely to result in various further negative impacts, including increased prices, decreased supply and diminished levels of access.

113.1 The respondents have argued that the NHI Fund, as a single purchaser, can cut costs by engaging in bulk-buying. However, the respondents have not realistically quantified the potential scope of this effect. Instead, they have made sweeping and unrealistic assumptions regarding what bulk buying can achieve. They also overlook the fact that the State *already* enjoys substantial purchasing power.

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[96] Genesis Report at section 5.2.1.

[97] Genesis Report at section 5.2.1.

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113.2 However, by bringing millions of new users into the public healthcare system, demand for doctors, hospital beds, and other scarce inputs will escalate sharply. Yet the supply of these resources—particularly skilled medical practitioners—cannot expand as quickly as required, pushing prices upward even as the NHI ostensibly tries to control costs.[98]

113.3 As more people compete for fewer resources under the NHI Act, the result will be longer waiting times, stock-outs of critical medicines, and fewer available healthcare procedures.[99] Overworked staff, insufficient equipment, and chronic underinvestment will lead to lower-quality care across the board—exactly the opposite of NHI's universal coverage goal.

113.4 Paradoxically, if the NHI Fund wields its monopsony muscle to push prices below sustainable levels (for example, by capping doctor fees or hospital reimbursements too low), healthcare providers will respond by exiting the system or reducing services.[100] Doctors emigrate or retire early, there is a reduced variety of medicines available to consumers and private hospitals scale back or stop upgrading facilities—reducing overall capacity right when it is most needed.[101] At the same

[98] Genesis Report at section 6.1.

[99] Genesis Report at section 5.2.1.

[100] Genesis Report at section 3.2.1 (paragraph 67 and 71); section 6.2.4.

[101] Genesis Report at section 6.8 (paragraph 346).

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time, the ability for South African trained doctors to find gainful employment overseas is set to increase.[102]

113.5 NHI proposes capitation (paying a flat rate per patient per month) for GPs and clinics. Although this reduces over-servicing incentives, it fosters underservicing: once a practice hits its cap, extra visits are a net cost.[103] This is because in a capitation model, healthcare practitioners carry the risk if capitation fees are set too low relative to the needs of patients and doctors.[104]

113.6 It is erroneous to treat public and private hospitals as though they are easily substitutable, as NHI does.[105] The reality is that public sector facilities currently offer significantly – and in some cases *dramatically* – lower quality healthcare environments than the private sector.[106] Due to section 33 of the NHI Act, South Africans will be prohibited from making funding arrangements that enable them to manage these differences in access.

113.7 Many public hospitals already fail the minimum Office of Health Standards Compliance standards.[107] Forcibly integrating

[102] Genesis Report at section 3.2.1 (paragraph 69).
[103] Genesis Report at section 6.8 (paragraph 347).
[104] Genesis Report at section 6.8 (paragraph 347).
[105] Genesis Report at section 6.4 (paragraph 302).
[106] Genesis Report at section 6.4 (paragraph 300).
[107] Genesis Report at section 6.4 (paragraph 294).

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millions of additional former medical scheme beneficiaries into these hospitals will likely degrade standards even further.[108]

113.8 As I have already explained, during the transition to full NHI implementation, younger and healthier beneficiaries of medical schemes are likely to drop their cover as tax burdens rise and medical scheme tax credits vanish. Schemes end up with older, sicker members, pushing up contributions again—a "*death spiral*" as set out above. This will destabilize medical schemes well before they are officially prohibited under section 38 of the NHI Act from providing supplementary cover.

114 I now turn to address each of these issues in greater detail.

Comprehensive care for all is fiscally impossible

<u>It will cost more than R900bn</u>

115 The Department of Health has repeatedly claimed that, under the NHI Act, medical scheme beneficiaries would not suffer <u>any</u> reduction in access to and quality of healthcare services. In other words, government's case is that the NHI Act can and will deliver comprehensive care for all, and that NHI will provide a level of care for all that will match (or exceed) the level of care currently available to medical scheme beneficiaries.

[108] Genesis Report at section 6.4 (paragraph 303).

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116 In its report, Genesis has demonstrated that this objective cannot be achieved under the NHI Act. It is fiscally impossible in terms of the mechanisms prescribed by the NHI Act.

117 In order to determine what comprehensive care for all would cost, Genesis started with the actual costs of private provision of those services.[109] Genesis used private sector data from the 2022 CMS Annual Industry Report.[110] Genesis then made two significant downward adjustments to the costs per person (when compared to current outlays of medical schemes):

117.1 first, it adjusted for the demographic profile of the non-medical scheme population, which is significantly younger;[111] and

117.2 second, using a generous estimate of efficiencies, Genesis adjusted the private sector costs downward by an additional 27.7%. These include removing administrative duplication, reducing over-servicing costs, and leveraging monopsony buying power.[112]

118 However, even after these abundant downward adjustments, the cost of providing comprehensive care for all is astronomical.

119 In 2022, average spend per person per year was R28,150 for the medical scheme population.[113] Genesis's analysis shows that assuming

[109] Genesis Report at section 4.3 (paragraph 195).

[110] Genesis Report at fn 139; Annexure C.

[111] Genesis Report at section 4.2.1.

[112] Genesis Report at section 4.2.2.

[113] Genesis Report at section 4.2.3 (paragraph 173).

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government could fully utilise the potential efficiencies of NHI, it would be able to deliver comprehensive care to the whole South African population at an average spend of R15,342 per person, per year.[114] This is almost triple the current average spend of R5,345 per person, per year, on the uninsured population. Put differently, the uninsured segment currently receives 35% of what it requires for comprehensive care (R5,345 divided by R15,342).

120 Because these expenditures are adjusted for efficiency, they serve as a proxy for access. This means that a monetary shortfall of what is required to deliver comprehensive care (adjusted for efficiency) translates into reduced access and/or quality.

121 Assuming, charitably, that there was no upward pressure in healthcare prices (despite a 77% increase in demand for healthcare resources), South African public health expenditure would increase from R250 billion to R941 billion – that is, by 276%.[115] Overall expenditure on healthcare would increase by R409bn.[116] This would require a 76.9% increase in health resources.[117]

It is unaffordable

122 This increased expenditure is simply unaffordable. Overall, total consolidated government expenditure would increase by 32%, pushing

[114] Genesis Report at section 4.2.3 (paragraph 173).

[115] Genesis Report at Table 7.

[116] Genesis Report at section 4.2.4 (paragraph 178).

[117] Genesis Report at Table 7.

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South Africa's expenditure-to-GDP ratio from 32.3% to 42.5%.[118] The implications of this are:

122.1 Total government revenue would increase from 27.8% of GDP to 38.1% of GDP, which is unrealistic for a middle-income country like South Africa.[119]

122.2 If personal income tax were to be used as the source of funds, the average personal income tax rate would more than double from 21% of taxable income to 45.7% of taxable income.[120]

122.3 If only those above the current tax threshold were to pay the tax, the lowest income bracket would increase from a tax of 18% to 41.4%, and the highest income tax bracket would increase from 45% to 68.4%.[121]

122.4 If the funds are sourced from all employed South Africans contributing towards the payroll tax, payrolls would all be taxed an additional 25.5%.[122]

123 As Genesis explains, these adjustments are not possible.[123] The point is not merely that these levels of taxation would have a devastating impact on the South African economy – though they would. The point is that it is not

[118] Genesis Report at section 4.2.5 (paragraph 182).
[119] Genesis Report at section 4.2.5 (paragraph 182.1).
[120] Genesis Report at section 4.2.5 (paragraph 182.2).
[121] Genesis Report at section 4.2.5 (paragraph 182.3).
[122] Genesis Report at section 4.2.5 (paragraph 182.4).
[123] Genesis Report at section 4.2.5 (paragraph 183).

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possible for the South African government to raise money at this scale. It cannot do so through increasing taxes,[124] and it cannot do so through increasing government debt.[125]

124 Insofar as taxation is concerned:

124.1 The primary sources of tax in South Africa are personal income tax, value-added tax and corporate income tax.[126] Personal income tax comprised 40% of total tax revenue in FY2023, VAT 26% and corporate income tax 16%.[127] The balance comes from other tax revenue sources such as customs duties and fuel levies.[128]

124.2 Over the last 30 years, total South African tax revenue has increased from 20.5% of GDP in 1994 to 25.1% in 2023.[129] As explained by Genesis, the ability for South Africa to increase taxes further is limited by a) the tax elasticity of revenue generation, b) a declining tax base and c) the negative impact of increased taxes on economic growth.[130]

[124] Genesis Report at section 3.3.2 (paragraph 140).

[125] Genesis Report at section 3.4 (paragraph 151.2); section 4.2.5 (paragraph 183).

[126] Genesis Report at section 3.3.2 (paragraph 130).

[127] Genesis Report at section 3.3.2 (paragraph 130).

[128] Genesis Report at section 3.3.2 (paragraph 130).

[129] Genesis Report at section 3.3.2 (paragraph 131).

[130] Genesis Report at section 3.3.2/4 (paragraph 132/47).

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124.3 Higher taxes do not always guarantee higher revenue.[131] Faced with higher taxes, capital and labour can reduce economic output, or migrate to locations which are more rewarding, after tax.[132]

124.4 In response to a tax hike, taxpayers can also increase tax avoidance and tax evasion. Moreover, when faced with lower disposable income, taxpayers are likely to reduce consumption.[133] Responses such as these *shrink* the tax base and have severe consequences for the economy.[134] If that shrinkage exceeds the increase in tax, a higher tax rate results in a *reduction* of government tax revenue.[135]

124.5 Genesis presents evidence which shows that South Africa, which has a remarkably narrow tax base, has likely already passed the top of its Laffer curve – the point at which further tax increases would begin to *decrease* government revenue.[136] Almost half of all personal income tax revenue (R345 billion) comes from the 491,000 people earning R1m or more per annum.[137] These 491,000 people represent 6.6% of those inside

[131] Genesis Report at section 3.3.2 (paragraph 132).
[132] Genesis Report at section 3.3.2 (paragraph 132).
[133] Genesis Report at section 3.3.2 (paragraph 132).
[134] Genesis Report at section 3.3.2 (paragraph 132).
[135] Genesis Report at section 3.3.2 (paragraph 132).
[136] Genesis Report at section 3.3.2 (paragraph 134).
[137] Genesis Report at section 3.3.2 (paragraph 138).

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the personal income tax net (or 1.2% of South African adults).[138] Raising rates drastically among this small, mobile group leads to reduced taxable income—through emigration, reduced work effort, or avoidance.

124.6 It is thus a flawed assumption that increasing tax rates (or levying additional taxes) will increase tax revenue. An increase in tax rates is in fact likely to lead to a reduction in revenue. South Africa does not have the unused tax capacity for tax increases far smaller than that required to fund NHI.

124.7 Therefore, if government were to increase taxes as proposed, it would lead to a *decline* in tax revenue and would be economically and socially devastating for the country, sparking emigration and a winnowing of the tax base, and degrading South African's long run economic growth.

124.8 This is illustrated by the introduction by the Minister of Finance, in March 2017, of a new income tax band in an effort to increase progressivity and raise additional revenue from personal income tax.[139] Amongst other changes, the top marginal tax rate was raised from 41% to 45%, with the expectation that this would generate additional revenue of R5.5 billion from the 103,000 tax payers earning more than R1.5 million per annum.[140] Tax

[138] Genesis Report at section 3.3.2 (paragraph 138).

[139] Genesis Report at section 3.3.2 (paragraph 134).

[140] Genesis Report at section 3.3.2 (paragraph 134).

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revenue, however, *declined* by R6.48 billion, as taxpayers subject to the tax increase drastically reduced their taxable income reporting in response to the reform.[141] The reduction in revenue was caused by both reduced work effort and a strong likelihood of increased tax avoidance and even tax evasion.[142]

124.9 Treasury is well aware of the limited capacity to raise revenue by way of tax increases. In his March 2025 Budget Speech, the relevant extract of which I attach marked "*FA13*",[143] the Minister of Finance justified the decision to increase VAT by 0.5% this year and by 0.5% next year on the basis that Treasury is *unable* to raise corporate or income tax rates. As he explained:

> *"Honourable Members, we thoroughly examined alternatives to raising the VAT rate. We weighed up the policy trade-offs involved, including increases to corporate and personal income taxes.*
>
> *Increasing corporate or personal income tax rates would generate less revenue, while potentially harming investment, job creation and economic growth.*
>
> *Corporate tax collections have declined over the last few years, an indication of falling profits and a trading environment worsened by the logistics constraints and rising electricity costs.*

[141] Genesis Report at section 3.3.2 (paragraph 134.2).

[142] Genesis Report at section 3.3.2 (paragraph 134.3).

[143] March 2025 Budget Speech. Available: https://www.treasury.gov.za/documents/National%20Budget/2025Mar/speech/speech.pdf.

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Furthermore, South Africa's corporate income tax collections are already higher than most of our peer countries.

On the other hand, an increase to the personal income tax rate would reduce taxpayers' incentives to work and save.

Our top personal income tax rate and our personal income tax collections as a percentage of GDP are far higher than those of most developing countries. Increasing it is therefore not feasible.

Taking on additional debt to meet the spending pressures was also not feasible. The amount is simply too large. The cost of borrowing would be unaffordable. Our sub-investment credit rating would also make this level of borrowing costlier and put us at risk of even further downgrades.

Madam Speaker, VAT is a tax that affects everyone. By opting for a marginal increase to VAT, its distributional effect and impact were cautiously considered.

The increase is also the most effective way to avoid further spending cuts and to enable us [to] extend the social wage."

124.10 Similar reasoning was applied in the March 2025 Budget Review, the relevant extract of which I attach marked "*FA14*",[144] and which indicates the likely revenue impact of an increase to income and corporate tax rates:

[144] March 2025 Budget Review. Available: https://www.treasury.gov.za/documents/National%20Budget/2025Mar/review/FullBR.pdf.

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"Increasing taxes on consumption through a higher VAT rate will have the least detrimental effect on economic growth and employment over the medium term, relative to increases in personal or corporate income tax rates.

Raising personal income tax rates is likely to be inefficient as taxpayers make adjustments to reduce their tax liabilities. Higher personal income tax rates would also reduce the incentive to work and save, with potentially larger negative impacts on the economy. Over the past decade, several measures have been implemented to raise personal income taxes. While these have increased the tax burden on individuals, the tax rate increases generated less revenue than expected. South Africa's personal income tax collection measured as a contribution to GDP, and the top tax rate, are far higher than those of most developing countries (Figure 4.3). For these reasons, the personal income tax rates have not been increased, although additional revenue is generated by not adjusting the tax brackets and rebates for inflation.

Increases in the corporate tax rate are likely to impede competitiveness while generating less revenue than VAT. Corporate taxes make a higher contribution as a percentage of GDP in South Africa than the Organisation for Economic Co-operation and Development and African averages (Figure 4.4). Of 123 reporting countries, South Africa ranks 13th for corporate tax as a share of GDP. These collections are also more volatile as they depend heavily on commodity price cycles and economic growth. Corporate income tax revenues are expected to increase over time due to the introduction of the Global Minimum Tax Act (2024), which will raise revenue and reduce the incentive for large firms to shift profits."

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124.11 Genesis demonstrates that the tax increases required to deliver comprehensive care through the NHI would in fact generate *negative* revenue.[145] Given the adverse impact on the level of economic activity, generating the required revenue to fund comprehensive care for all under the NHI Act is, quite simply, hopelessly impossible.

124.12 Health is also not the only societal imperative for increased spending. Even if tax revenue were somehow to increase, it is improbable that all, or even most, of the additional revenue would be allocated to healthcare, given the competing priorities facing the country. Other priorities include social protection, education, housing and public safety. Apart from debt service costs (discussed below), the biggest growth area of the budget has been social protection, a necessity in a country with South Africa's social disparities.[146] Between 2010/11 and 2022/23, expenditure on social grants increased from 15.7% to 16.6% of the budget.[147]

125 Genesis explains that NHI also cannot be funded through debt.

125.1 South Africa's debt burden is high, and rising. In 2024, government debt reached approximately R5.5 trillion, or 74% of

[145] Genesis Report at section 3.3.2 (paragraph 137).

[146] Genesis Report at section 3.3.2 (paragraph 145).

[147] Genesis Report at section 3.3.2 (paragraph 145).

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GDP, up from 26% of GDP in 2008.[148] Each year, South Africa's government expenditure has been a few percentage points higher than revenue, resulting in persistent budget deficit of between 2.4% and 5% of GDP.[149]

125.2 With increased debt, comes increased debt service costs.[150] Debt payments have risen from 2.8% of GDP in 2014, to 5.1% of GDP in 2024.[151] In the 2026/27 financial year, a projected 21% of all tax revenue will be spent on interest payments, up from 11% in 2012/13.[152]

125.3 Funding NHI through additional debt would substantially accelerate the increase in the debt burden.[153] Absent tax increases (which is not a feasible means by which to raise revenue, for the reasons discussed above), funding an expansion of NHI through debt would accelerate the process of South African indebtedness. If current health expenditure were to increase by one percentage point of GDP, funded by debt, the debt to GDP ratio of the country would rise commensurately *every year.*[154]

[148] Genesis Report at section 3.3.2 (paragraph 142).
[149] Genesis Report at section 3.3.2 (paragraph 142).
[150] Genesis Report at section 3.3.2 (paragraph 142).
[151] Genesis Report at section 3.3.2 (paragraph 142).
[152] Genesis Report at section 3.3.2 (paragraph 142).
[153] Genesis Report at section 3.3.2 (paragraph 143).
[154] Genesis Report at section 3.3.2 (paragraph 143).

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125.4 National Treasury has detailed plans to reduce the nation's debt and ensure South Africa progresses on a sustainable growth path. Treasury has stated in its 2024 Budget Review: Macroeconomic Policy,[155] the relevant extract of which I attach marked "*FA15*",[156] that:

> *"a large structural deficit has emerged between governments' spending commitments and its revenues. What this means in practice, is that while the medium-term of objective of debt stabilisation has remained intact throughout the period, the achievement of that objective has been repeatedly deferred. As a result of this pattern, the composition of spending has moved away from capital expenditure, and the debt to GDP ratio has increased to a level that was never proposed as government policy, and is, if anything, antithetical to stated policy goals."*

126 It will also be functionally impossible for the NHI Act to provide a level of healthcare that will match (or exceed) the level of healthcare currently available to medical scheme beneficiaries. Genesis shows that the number of specialists would need to increase by 204%, GPs by 113%, nurses by 86%, and hospital beds by up to 86%.[157]

127 The upshot is that comprehensive care for all is fiscally impossible under the mechanism prescribed by the NHI Act. The funds required to fund comprehensive care for all – including for those who can currently rely on

[155] See also Genesis Report at section 3.3.3 (paragraph 144).

[156] 2024 Budget Review: Macroeconomic Policy. Available: https://www.treasury.gov.za/documents/national%20budget/2024/Macroeconomic%20Policy%20Review.pdf.

[157] Genesis Report at section 4.3 (paragraph 198).

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their medical schemes – cannot be generated from the South African tax base or from debt. For that reason, it is impossible for the NHI to match the access and quality available to medical scheme members. A necessary implication is that, under NHI, medical scheme beneficiaries will inevitably suffer a significant reduction in their access to healthcare. By contrast, and as appears more fully below, there are several alternatives to NHI that *are* capable of achieving comprehensive care for all South Africans, precisely because they allow medical schemes to provide supplementary cover.

128 The Department of Health has, publicly and in affidavits filed in this Court in the Solidarity litigation, denied that there would be any reduction in the access to and quality of healthcare previously afforded to medical scheme beneficiaries. It maintains, in other words, that NHI will deliver comprehensive healthcare for all.

128.1 The Minister states plainly that:

> "The aim of NHI is to pay for *"comprehensive health care services"*, which is defined in section 1 of the NHI Act as *"health care services that are managed so as to ensure a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services across the different levels and sites of care within the health system in accordance with the needs of users."*[158]

[158] *Solidarity v Minister of Health,* Minister's answering affidavit para 186.1.

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128.2 Professor Diane McIntyre says in her expert affidavit in the Solidarity litigation that:

"*Medical scheme members are very unlikely to be deprived of the services and providers they currently use. The NHI will purchase comprehensive services from both public and private providers. The reality is that, as medical scheme members and private providers are heavily concentrated in urban areas, particularly the largest metropolitan areas, medical scheme members will in all likelihood continue to use the same providers as at present under the NHL.*

There certainly will be differences in how people access services, particularly that they will be required to first seek care from a primary care provider and follow the referral route, except in an emergency. This used to be the norm in medical schemes, but due to medical savings accounts having to be used for "day-to-day" benefits such as GP visits, which generally are exhausted very quickly with members then having to pay out-of-pocket for these services, whereas specialist care is covered from the scheme's "risk pool" and therefore the scheme will pay for these services, the incentive has been created to go directly to a specialist. This is highly inefficient and has contributed to expenditure increases in the medical scheme sector and has also disempowered and reduced the scope of practice of general practitioners and other primary care providers. For example, there is no justification for going to a gynaecologist for a pap smear when this could equally well be undertaken by a GP or a primary care nurse. This is not inferior care, it is appropriate care. It is the approach adopted by all health systems concerned with efficient use of resources. It will require a mind-set change

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among medical scheme members, but it cannot be regarded as care that is of "lower benefit"."[159]

128.3 The Minister further asserts that:

"*As Prof McIntyre states in...her affidavit, while NHI changes how people access health care, NHI will neither deprive medical scheme members of their access to necessary health care services, nor will it necessarily mean that these individuals will pay more through taxation for the same services.*"[160]

129 I have demonstrated above that this is simply incorrect. Government cannot maintain the level of access to healthcare provided to existing medical scheme beneficiaries, because it simply cannot afford to do so.

130 The Minister also overlooks the fact that that any revenue derived from the taxation of medical scheme beneficiaries would not merely be shifted to replace their medical scheme contributions. It would, instead, go towards funding healthcare services for the whole population, which is more than 6.5 times larger than the medical scheme population. It would also go towards funding other fiscal imperatives, such as social grants and education.

[159] *Solidarity v Minister of Health*; Dr McIntyre's expert affidavit at paras 75/6.

[160] *Solidarity v Minister of Health*; Minister's answering affidavit at para 609.

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The shared model will curtail access to healthcare

Medical scheme beneficiaries will suffer decline in access

131 Because comprehensive care for all under the NHI Act is fiscally impossible, NHI will necessarily entail a level of access to healthcare services that falls below comprehensive care. This means that medical scheme beneficiaries will inevitably suffer a reduction in their access to healthcare.

132 I emphasise that the decline in effective access for medical scheme beneficiaries is a direct consequence of section 33 of the NHI Act. That is, it is the effective abolition of medical scheme cover – save insofar as it provides complementary cover – that results in previous medical scheme beneficiaries being entirely beholden to the system of NHI.

133 The Department of Health has claimed that, under NHI, total health expenditure as a percentage of GDP will remain unchanged. On this basis, in order to determine the *extent* to which existing access will be curtailed, Genesis has calculated an efficiency-adjusted expenditure per medical scheme member, based on current expenditure.[161] Again, Genesis has employed generous assumptions regarding the savings that NHI might achieve, including savings that may be achieved from eliminating the over-servicing of medical scheme beneficiaries.[162]

[161] Genesis Report at section 5.1 (paragraph 206).

[162] Genesis Report at section 5.1 (paragraph 206).

134 In this scenario:

134.1 Genesis assumes that government will seek to provide equal care for all by redistributing existing healthcare expenditure, and by providing access to healthcare services to all, at a level closer to (but above) that currently provided in the public sector (the "shared" model).

134.2 The country does not spend more on healthcare – it merely redistributes existing resources more evenly. Government will attempt to raise taxes only to "capture" what is currently being spent in private medical care (i.e., medical scheme contributions, out-of-pocket expenses, short-term medical insurance and removing the tax rebate). Armed with existing public sector funds, plus the new taxes, the idea is that the NHI Fund would then purchase healthcare services on behalf of all South Africans.

135 Genesis explains that, even though, on this model, the country as a whole does not increase overall healthcare expenditure, the 53% of expenditure that went through the private sector would now need to be channelled through government.[163] This would increase the health budget by 113%.[164] Total government expenditure would increase from 32.3% of GDP to 42.5%

[163] Genesis Report at section 5.1 (paragraph 205).

[164] Genesis Report at Table 12.

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of GDP,[165] and total government revenue would increase from 27.8% to 32% of GDP.[166]

136 As explained above, if personal income tax (on those above the tax threshold) is used to fund the comprehensive care model, the tax on the lowest tax bracket would increase from 18% to 41,4%, and the tax on the highest tax bracket would increase from 45% to 68.4%. Importantly, this tax increase would apply to all taxpayers and would not be limited to those who are currently paying for medical scheme contributions.[167]

137 However, even if personal income tax is only used to fund the shared model, average personal income tax will increase from 21.3% to 31.2% of taxable income, with the highest bracket increasing from 45% to 54.5%.[168]

138 These are highly significant tax increases, and they would likely result in substantial economic pressure, in the form of lower tax revenues and potentially emigration.[169] Given what I have said above about the limited capacity to raise taxes, even though average incomes (after-tax and after healthcare expenditure) would initially remain broadly unchanged, the feasibility of raising this money by way of taxation is highly doubtful.

139 More importantly for present purposes, even if it is feasible to implement the shared model, it will result in medical scheme beneficiaries suffering a

[165] Genesis Report at section 5.1 (paragraph 208).

[166] Genesis Report at section 5.1 (paragraph 208).

[167] Genesis Report at section 5.1 (paragraph 208).

[168] Genesis Report at section 5.5 (paragraph 244).

[169] Genesis Report at section 5.5 (paragraph 244). See also section 4.3 (paragraph 197).

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substantial reduction in efficiency-adjusted per capita spend, and hence in effective access.

139.1 Even assuming that there is currently a high degree of over-servicing, and that this will all be eliminated under NHI, medical scheme beneficiaries will suffer a 43% decrease in effective access.[170]

139.2 Assuming that NHI fails to secure all anticipated efficiencies (but still secures demographic profile savings of 12.8%), medical scheme beneficiaries will experience a 65% decrease in effective access.[171]

140 As a result, a crucial part of the country's economic and human capital base, covering both the public and the private sectors, is likely to experience a significant decrease in access to healthcare services. The 9 million plus South Africans who will be adversely affected account for 74% of the country's personal income tax (PIT) revenue, and a large portion of the country's value-added tax (VAT) revenue.[172]

Medical scheme beneficiaries will suffer rationing, delays and stock-outs

141 This will have real, practical impacts on the lives of current medical scheme beneficiaries.

[170] Genesis Report at section 5.2 (paragraph 210).

[171] Genesis Report at section 5.2 (paragraph 210).

[172] Genesis Report at section 5.5 (paragraph 241).

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142 It is evident from the analysis conducted by Genesis that the demand for healthcare services from medical scheme beneficiaries – and likely from the whole population – will far exceed supply, even once any efficiencies have been realised.[173] The shortage of skilled personnel (GPs, specialists, nurses) remains acute; doubling or tripling utilisation will push waiting times sky-high and erode per-patient care.

143 The inevitable result is, therefore, rationing.

144 Rationing can take explicit or implicit forms. Implicit rationing is not clearly visible but manifests in the unavailability of timely medical appointments with practitioners, beds and operating theatres; reduction in the availability of range of pharmaceuticals or stock-outs; extended delays in procedures; the effective (if implicit) refusal to perform certain procedures; and tight treatment protocols that are driven by fiscal constraints rather than medical considerations.[174]

145 To take just one example, currently, the private sector has roughly 140 GPs per 100,000 people.[175] The public sector has only 32 GPs per 100,000 people. If South Africa's GPs are combined into one resource pool under NHI, South Africa would have 46 GPs per 100,000 people.[176] If the number of GPs does not increase, South Africans will still face poor access levels

[173] Genesis Report at overview and key findings at x.

[174] Genesis Report at overview and key findings at x.

[175] Genesis Report at section 5.21 (paragraph 215).

[176] Genesis Report at section 5.21 (paragraph 215).

under the NHI – and the medical scheme population will suffer a 53% decline in access to GPs specifically.[177]

146 Similar shortfalls exist for hospitals, specialist doctors, nurses, beds, pharmacists, dentists, and other allied health professionals. Even with efficiency gains, there would be large percentage increases needed to match current private-sector standards. The same is true of access to medicines and treatments. Stock-outs of medicines, and long waiting times for essential procedures, are an inevitability for existing medical scheme beneficiaries if existing resources are combined into a single resource pool under NHI.

147 As demonstrated by Genesis, the resources available to NHI will fall far short of that required for healthcare access at the level currently provided by medical schemes even after correcting for over-servicing and other efficiencies as intended in NHI. To the extent that ex-medical scheme beneficiaries will continue to contribute the same amount as they do now (albeit in the form of a tax), that population will be significantly worse off, as they will receive a lot less in return than they do now.

148 Important as that is, a more severe harm will be inflicted on this group – they will be prohibited by section 33 of the NHI Act from purchasing cover to maintain appropriate access using their own money. South Africans will be prohibited by the NHI Act from purchasing private cover for the conditions that endanger their lives.

[177] Genesis Report at section 5.21 (paragraph 215).

149 Supplementary cover through a medical scheme for the full range of health services allows individuals who can afford to do so, to manage the risk of rationing. This is what section 33 of the NHI Act will prohibit. Section 33 will significantly limit the access to healthcare for South Africa's current and future medical scheme beneficiaries. Simply put, it will prohibit them from making proper arrangements for the healthcare they need.

150 Under the NHI Act, if a healthcare service is theoretically covered by NHI but practically unavailable—perhaps because the patient has not followed the stipulated referral pathway, or there are delays, or the procedure simply isn't offered at the facilities accessible to the patient—then the patient is effectively stranded. Section 33 compounds the problem: medical schemes will be barred from covering services that NHI "*covers*", even if NHI fails to deliver them in a timely or effective way, or at all. In practice, patients will not receive access to the healthcare services—even though, on paper, they are entitled to them under the NHI. Medical schemes will not be able to supplement or rescue a beneficiary if the NHI treatment pathway fails—because they cannot fund any healthcare service notionally covered by the NHI, even if NHI is not, in real terms, providing that service.

Other negative impacts and risks

151 The scenarios presented by Genesis are best-case because they assume the flawless execution of the NHI and no serious setbacks. In reality, as explained by Genesis, the following major risk areas will likely cause outcomes worse than those set out in the Genesis Report. These

interlocking risks point to diminished access and poorer outcomes than the conservative scenarios forecast by Genesis.

Price increases

152 The NHI is intended to exert monopsony (single-buyer) power to reduce prices.

153 However, expanding coverage to include both public and private sector users will likely increase demand for scarce healthcare resources (e.g. doctors, facilities), putting upward pressure on prices.[178]

154 As demand rises (by millions of new users being brought into the public healthcare system), the prices of these resources will rise, further increasing the cost of NHI from the levels estimated by Genesis.[179] In addition, South Africa would need to train, recruit or retain more healthcare professionals, and expand or upgrade facilities—requiring higher payments or salaries to incentivise professionals and investors.

Reduced supply

155 Section 33 of the NHI Act provides that once NHI is fully implemented, medical schemes will be precluded from providing cover for services that are reimbursable by the NHI Fund.

156 It appears that the rationale for this provision is to enable the NHI Fund to become a "*single purchaser*", with monopsony buying power, and therefore

[178] Genesis Report at section 4.2.4 (paragraph 180); and section 6.1 (paragraphs 250 to 255).

[179] Genesis Report at overview and key findings at ix.

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the ability to force down prices charged by healthcare facilities, practitioners and other providers of healthcare goods and services, thereby lowering overall healthcare costs.

157 However, Genesis has shown that section 33 is incapable of producing these efficiencies, and is in fact likely to *reduce* consumer welfare and introduce significant risk into the system.

158 In this regard, moving towards a monopsony is, as a matter of economic theory, associated with a decrease in supply.[180] This is likely to impact various aspects of the market for healthcare services, such as pharmaceuticals, human resources and healthcare facilities.

159 Thus, while monopsony power can reduce prices, it risks undercutting healthcare service providers' financial viability if prices are pushed below market-sustainable levels. Doctors, nurses, hospitals and pharmaceutical and medical device suppliers can respond by exiting the market, emigrating or reducing available products and/or services. This is no doubt why the drafters of the NHI Act felt it necessary to create an exemption from the application of the Competition Act in section 3(5).

160 Indeed, profit margins in South Africa's private healthcare are not high.[181] Any aggressive price-cutting would discourage new investment and curtail

[180] Genesis Report at section 6.2.

[181] Genesis Report at section 3.2.2.2.2 (paragraph 94).

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improvements. Severe price pressure would also worsen medicine stock-outs or shrink the variety of drugs available to South African patients.[182]

Under-provision of primary care

161 The NHI envisions capitation (a fixed payment per enrolled patient per month) for primary care, rather than the payment of a fee-for-service. This will create strong incentives for *under*servicing, because healthcare service providers do not receive additional payment for additional treatments.[183] In a capitation model, when doctors provide suboptimal care, this does not reduce revenues in the short term, thus providing a system-wide incentive to underservice patients.[184]

162 Risk-adjusted capitation requires complex data analysis and continuous monitoring.[185] Mistakes in setting capitated rates or insufficient oversight can lead to financial losses, pushing providers to skimp on care, or to leave the system altogether.[186]

163 The NHI also creates financial risk for the owners and practitioners of the new multi-disciplinary practices that would be established. Under NHI, if utilisation increases, for example because of a bad flu season, the clinic will have to bear the additional costs and make a loss.[187] Public-sector clinics

[182] Genesis Report at overview and key findings at ix.

[183] Genesis Report at section 6.3.1.

[184] Genesis Report at section 6.8 (paragraph 347).

[185] Genesis Report at section 6.3.2.

[186] Genesis Report at section 6.3.2.

[187] Genesis Report at section 6.3.3 (paragraph 285).

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would also face new financial risks if their allocated funds failed to cover unexpected fluctuations or spikes in demand.

Lower quality provision

164 The quality gap between public and private facilities in South Africa is stark.

165 The NHI Act requires that facilities must be certified by the Office of Health Standards Compliance.

166 However, only 33% of public facilities currently meet basic compliance standards.[188] By contrast, private hospitals often achieve 95% plus scores on internationally recognised accreditation measures.[189]

167 This means that even maintaining existing capacity would require substantial investment.

168 In the NHI system, public and private hospitals are treated as if they are close substitutes, yet in practice they differ profoundly in quality, maintenance and governance. The impact could worsen if private hospitals face fee pressures or under-investment. The majority of services would also still need to be delivered through public facilities.

[188] Genesis Report at section 6.3.4 (paragraph 294).

[189] Genesis Report at section 6.4 (paragraph 299).

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Adverse selection during transition

169 I have already explained in some detail that, during the transition phase, the NHI will begin to cover many services while also raising taxes significantly to fund them.

170 Higher taxes, combined with removal of medical-scheme tax credits, will make private cover less affordable, especially for healthy (younger) medical scheme beneficiaries, who are likely to drop out of medical schemes first.[190]

171 Current medical scheme membership data in South Africa shows a stark contrast between young adults and older individuals. In South Africa, 1 in 4 people have medical scheme cover over the age of 65 but only 1 in 10 people in the 20-29 age group have medical scheme cover.[191] The lack of younger and healthier lives entering the risk pool which, by law, operates on the basis of community rating and guaranteed access, means that the cost of cover is escalating which causes immediate risk to medical schemes and their members in terms of the ability to offer affordable cover.

172 In other words, pooling the healthy with the sick is essential – it keeps contributions affordable by spreading costs broadly. When that balance is upset by the departure of younger and healthier lives in anticipation of the NHI, the economics of medical schemes falters. Simply put, without enough young members contributing, medical schemes will not be able to maintain

[190] Genesis Report at section 6.8 (paragraph 350.2).

[191] These figures are calculated by comparing the population of medical schemes published in the 2022 CMS Annual report and the total South African population published by Statistics South Africa.

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the required cross-subsidies under community rating, and the cost per member will inevitably rise.

173 This "*adverse selection*" causes scheme contributions to rise, leading to further member exits and actuarial death spirals for medical schemes (fewer, older, and sicker beneficiaries remain, driving costs up). Genesis provides the real-world example of Health Squared Medical Scheme, which had a poor demographic profile, and suffered an actuarial death spiral consisting of selective withdrawals and downgrades, leading to financial losses, high contribution increases and further selective withdrawals and downgrades.[192]

174 Therefore, even before section 33's prohibition on parallel private cover becomes operative, the viability of medical schemes could be severely undermined.

FIRST GROUND: THE NHI ACT IS IRRATIONAL

Government failed to consider and assess cost and feasibility

175 The irrationality of the NHI Act is both procedural and substantive.

176 In the first instance, government acted irrationally in failing to perform even the most basic analysis of the costs that NHI would involve, and whether it would be feasible or affordable.

177 In particular, the Department of Health did not interrogate whether the NHI Fund could actually purchase the promised benefits with the resources that

[192] Genesis Report at section 6.6 (paragraph 330).

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would likely be available; did not attempt to assess or consider the viability of the efficiencies on which the NHI's design so heavily depends; and did not quantify or model the likely financial impact of the NHI Act.

178 In other words, government made no genuine attempt to determine whether the NHI Act is something that the country can afford. That is highly irregular, particularly when one has regard to the NHI Act's enormous fiscal implications.

179 As stated in the World Health Organisation ("*WHO*") brief on which the government relies in the Solidarity litigation, cost studies are valuable if they raise "*core policy issues*" and "*if they reveal information on the underlying cost structure of service delivery and enable the modelling of different scenarios using various assumptions about prices, the impact of incentives, changes in service delivery configuration and the levels of service use*". I attach a copy of the relevant WHO brief as "*FA16*".

180 Similarly, the Cabinet-approved Socio-Economic Impact Assessment System ("*SEIAS*")[193] on cost-benefit analysis, the relevant extract of which I attach marked as "*FA17*", states that government should "*analyse risks and costs associated with the development of policies, legislation and regulations and propose ways to mitigate them.*" SEIAS specifically asks drafters to evaluate the full costs of a policy, to avoid underestimating the risks involved or over- or underestimating the benefits.

193 SEIAS. Available: https://www.presidency.gov.za/sites/default/files/2022-05/SEIAS%20Application%20Manual%20April%202020.pdf.

181 In other words, government's own guidelines required a thorough costing and risk analysis as part of the policy-development process for the NHI Act. But government never undertook such an exercise.

182 In an affidavit filed in the Solidarity litigation, the Deputy Director-General: National Health Insurance at the National Department of Health, Dr Nicholas Crisp, describes the initial costing steps that were undertaken which he claims "*[are] appropriate to the stage at which the NHI process is.*"[194]

183 However, the partial or incremental costing exercise to which Dr Crisp refers is manifestly inadequate, and could never rationally substitute for the full-fledged cost-benefit analysis that government needed to conduct to assess whether the NHI Act is fiscally and practically feasible.

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION,
PRETORIA

184 Each of Dr Crisp's examples addresses only small components of NHI—for instance, limited infrastructure upgrades or the preliminary administrative costs for Phase 1 of the Department of Health's own structure. These expenses, while real, account for a tiny fraction of the overall system-wide costs the NHI will inflict.

185 I address each of the shortcomings in Dr Crisp's approach below:

185.1 **Unspecified costing for upgrading public sector infrastructure.** Dr Crisp mentions that there are some "*costings for [the] incremental upgrading of service delivery infrastructure*

[194] *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at para 39.

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in the public sector."[195] This offers no sense of how the massive gaps in hospital capacity, equipment, and staffing in the public healthcare sector, for millions of additional users, will be bridged by the NHI Act and the costs associated with the deep, long-term investments that NHI would demand.

185.2 **Administration costs in preliminary stages**. Dr Crisp describes "*phase 1 costing*" in which the National Department of Health attempted to cost changes in the "*NDoH's organisational structure*" and the "*administration and governance of the [NHI] Fund*".[196] In other words, the costing exercise focused on purely administrative and bureaucratic aspects of NHI. This analysis says nothing about the far larger costs of delivering actual healthcare services—doctors, hospitals, drugs and technology—once the NHI is in full effect. The budget for running the Department of Health itself currently accounts for around 1% of total healthcare spend.[197] The administrative costs of the NHI Fund will account for less than 10% of healthcare costs.[198] It should be noted that the total costs budgeted for the NHI Fund administration within this exercise are around R400m in 2022/3, which accounts for 0.1% of current healthcare expenditure.[199] In other words, the costing exercise only covers a tiny fraction of

[195] *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at para 37.2.

[196] *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at paras 40 to 50.

[197] Genesis Report at section 10.1 (paragraph 547.2).

[198] Genesis Report at section 10.1 (paragraph 547.2).

[199] Genesis Report at section 10.1 (paragraph 547.2).

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what the administration of NHI will cost once NHI has been implemented. In any event, the NHI administration costs are substantially underestimated. As set out in the Genesis Report, it will likely cost R65 billion a year to administer the NHI in respect of the comprehensive care model or R37 billion for the shared services model. These costs have still been estimated in favour of the respondents by assuming that NHI can be administered at 6.9% of total costs, as compared to current admin costs in the order of 10%. The HMI assessment concluded that there are no excessive super profits being made in the administration of medical scheme business and there are inevitable costs and complexities associated with running and managing a health fund that need to be adequately provided for, let alone a fund of the scale of the NHI Fund.

185.3 ***Preliminary work on some primary care costs labelled as 'not reliable or accurate'.*** Dr Crisp says that "*a lot of costing work has been done*" on primary healthcare costing, as this is a priority of Phase 1 in the implementation of NHI.[200] The purpose of this costing, which has not yet been conducted, will eventually be to determine provider payment rates. Dr Crisp refers to three costing exercises which are mentioned: a) the development of a capitation framework which specifies the components that need to be costed, b) deriving costing information from proof-of-

[200] *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at paras 51 to 54.

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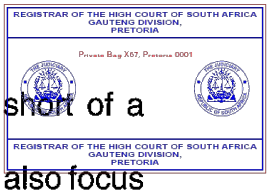
concept CUPs and c) an "*average expenditure per visit analysis at primary care level in the public sector to inform capitation pricing and contract development.*" Dr Crisp himself concedes that the results "*are not reliable or accurate estimates of what cost per visit will ultimately be to the NHI Fund as the costing process is ongoing, the data remains incomplete, and the process is currently focussed only on public sector costing as a first step*".



185.4 These initial steps toward capitation costing fall far short of a rational assessment of nationwide service costs. They also focus largely on public-sector baselines, entirely neglecting private-sector data and failing to account for the costs that will be charged by private providers. This is likely to drastically understate true nationwide costs and means that the initial cost assessments are divorced from reality. Private sector data is also available at a level of detail that is simply not available in the public sector and so lends itself to the necessary analysis which can be adjusted to account for variables like differences in modes of delivery, remuneration models and economies of scale, as the Genesis Report has demonstrated.

185.5 ***Working committees in process of designing evaluation methods***. Dr Crisp says that the Technical Working Committee has been established to work on benefits costing. They are in the process of "*designing methods to evaluate technologies that*

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the NHI Fund may adopt in its benefits package". The committee has done international research to "*gather information on how other entities are performing these kind of cost assessments*".[201] Once again, this only serves to demonstrate that no such information has been gathered yet, and no modelling on resource requirements has yet been undertaken.

185.6 ***Discussions by an Interdepartmental Committee***. Dr Crisp says that there is an Interdepartmental Committee (consisting of numerous governmental departments) that has established various workstreams where there are "*discussions and technical work on shifting current health funding resources*".[202] Again, the establishment of a committee to discuss resource allocation *after* the NHI Act was passed cannot substitute for the necessary consideration that government was required to give to the affordability of the NHI Act.

185.7 **Preliminary explorations on modelling**. Lastly, Dr Crisp says that the National Department of Health is "*[exploring] modelling work in relation to NHI implementation between 2024 and 2033. This work is very much in its early stages and I am therefore unable to provide more useful information on the process*".[203] Once more, Dr Crisp effectively acknowledges that the Department of Health has only recently begun "*[exploring]*

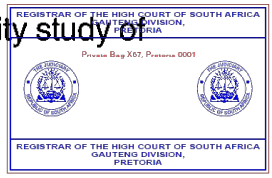
[201] *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at paras 55-57.

[202] *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at para 58.

[203] *Solidarity v Minister of Health*; Dr Crisp's supporting/confirmatory affidavit at para 59.

modelling work", implying that no evidence-based projections were undertaken before the NHI Act was introduced to Parliament and enacted.

186 The piecemeal and simplistic exercise undertaken by the Department of Health does not come close to providing a rational cost-benefit and feasibility analysis. On the contrary, what Dr Crisp makes clear repeatedly is that the Department of Health has still not undertaken an exercise that could be described as a costing, cost-benefit analysis, or feasibility study of NHI.



187 This was publicly confirmed in a recent statement by the Minister of Finance, who confirmed that he was unsure whether the Minister had costed the NHI as a state-run single-payer healthcare plan. The Minister of Finance stated:

> "*What I do know, which we have requested, is for them to help us develop a programme for rolling out NHI so that we can begin to interact with the numbers. At the moment, it is difficult to interact with the numbers.*"

188 He indicated that National Treasury requires more information about exactly how the NHI system will work before it can determine what it will cost. This is further evidence that no costing has been done. I attach a copy of a press report about the Minister of Finance's statements as "*FA18*".

189 Although the Department of Health has sought in the Solidarity litigation to rely on WHO advice to justify its failure to cost NHI, this reliance is unwarranted. As explained by Genesis, the WHO counsels the modelling

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of different scenarios, an accounting of possible efficiencies, and an avoidance of a narrow focus on estimating a single number. All these steps are possible and demonstrated in Genesis's report. In failing to estimate the cost of NHI, the Department of Health has irrationally overlooked the key trade-offs and implications of NHI.

190 I also emphasise that before the NHI Bill was introduced into the National Assembly, on 9 November 2018, the Acting Director-General of the Treasury raised concerns with the Advisor to the Presidency on NHI regarding the constitutionality of the draft NHI Bill. The Acting Director-General complained that the Bill was substantively amended without any consultation with the Treasury or Minister of Finance, and the previous amendments effected to satisfy the Treasury's concerns around the intergovernmental financing system were unilaterally removed.

191 The Acting Director-General for Treasury listed major problems with the NHI Bill in the memorandum, a copy of which is attached as "*FA19*". These included the inadequacy of detail on financial implications including the cost of NHI itself and the NHI Fund.

192 The irrational failure by the Department of Health to perform the basic analysis of estimating the cost of NHI obscured the reality that (i) the NHI Act is fiscally unworkable; and (ii) the NHI Act will markedly reduce access to healthcare of 9.1 million people, namely medical scheme beneficiaries

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The NHI Act is substantively irrational

193 Government's irrational failure to consider the fiscal implications of the NHI Act resulted in a statute that is incapable of achieving its purposes and is therefore substantively irrational.

194 I am advised that rationality concerns the relationship between means and ends. It is a standard that applies to the exercise of all public power, including the passing of legislation, and is an incident of the rule of law, contained in section 1(c) of the Constitution.

195 Specifically, rationality concerns the relationship between the exercise of a power and the purpose for which the power was granted. In the context of legislation, the rationality enquiry turns on the relationship between the purpose of a statute or a particular provision, and the terms of the statute or provision. If the terms of the legislation are incapable of giving effect to its purposes, then they are irrational.

196 As I have explained in setting out the scheme of the NHI Act, broken down to its constituent elements, section 2 of the NHI Act describes the Act's purpose as being to establish and maintain the NHI Fund through mandatory prepayment, that aims to achieve:

196.1 sustainable universal access to quality healthcare services;

196.2 affordable universal access to quality healthcare services;

196.3 the equitable and fair distribution and use of healthcare services;

196.4 the sustainability of funding for healthcare services; and

196.5 equity and efficiency in funding.

197 The NHI Act cannot achieve its purposes. The Genesis Report amply demonstrates that it is not possible for the NHI to deliver comprehensive healthcare services to all South Africans, even if the NHI were to achieve substantial cost savings and efficiencies.

198 That is because comprehensive care for all is not fiscally feasible under the NHI Act and its prescribed mechanisms. Comprehensive care for all cannot be achieved without the resources of the private healthcare sector, and particularly the supplementary cover provided by private medical schemes, which the NHI Act will obliterate. Even if total current healthcare expenditure across both public and private sectors is appropriated under the NHI Act, this will entail significant tax increases, which, given South Africa's already constrained and diminishing tax base, is not a viable means by which to raise revenue. Furthermore, NHI both raises the likelihood of increased out-of-pocket expenditure, which will negatively affect South African households (with a disproportionately harsh effect on the lowest income individuals and households), and it places the burden of financing healthcare for the entire population on the State. This is not capable of achieving the purpose of the NHI Act with respect to entitlement to healthcare services, financial protection and sustainability in financing.

199 For this reason alone, the NHI Act as a whole is incapable of achieving its stated purposes, is irrational, and is unconstitutional and invalid.

200 In addition, the purposes of the NHI Act must also be understood with reference to the time period within which the Act requires them to be

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achieved. In this regard, section 57, which is headed "*Transitional Arrangements*", stipulates the two phases over which the Act must be implemented.

201 For present purposes, the relevance of section 57 is that it implies that the NHI Act's purpose is, by the end of 2026, to provide (amongst other things) for the purchasing of healthcare service benefits, including:

201.1 personal health services such as primary healthcare services, maternity and child healthcare services including school health services, healthcare services for the aged, people with disabilities and rural communities from contracted public and private providers including general practitioners, audiologists, oral health practitioners, optometrists, speech therapists and other designated providers at a primary healthcare level focusing on disease prevention, health promotion, provision of primary healthcare services and addressing critical backlogs;

201.2 the purchasing of hospital services and other clinical support services, which must be:

201.2.1 funded by the NHI Fund;

201.2.2 an expansion of the personal health services purchased; and

201.2.3 from higher levels of care from public hospitals (central, tertiary, regional and district hospitals) including emergency medical services and pathology

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services provided by National Health Laboratory Services.

202 By the end of 2028, the NHI Fund must be established and operationalised as a purchaser of healthcare services through a system of mandatory prepayment.

203 In addition to what is stated above regarding the general fiscal impossibility of implementing NHI, it is certainly not possible for the NHI Act to meet its objectives over the course of the two phases stipulated in section 57.

203.1 There are a substantial number of steps that the NHI Act specifies must be completed before 2026, and before 2028. This includes a wide array of changes to existing legislation, a significant number of administrative and operational steps that must be implemented, and the actual purchasing of healthcare services by the NHI Fund. Given the sheer number of steps that must be taken within such a tight time frame, it is not practically possible for the Department of Health to adhere to the deadlines set by the NHI Act.

203.2 Moreover, Genesis shows that the envisaged NHI transition will have a destabilising impact on medical schemes and their beneficiaries, well before full implementation. An increasing tax burden on households through the removal of the tax credit and tax increases will result in individuals dropping off medical schemes, thereby increasing contributions for remaining beneficiaries. Through this self-reinforcing cycle of anti-

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selection, the viability and sustainability of medical schemes may be compromised, despite the need expressed in the NHI Act to rely on medical schemes throughout the transition.

204 Section 33 of the NHI Act also does not result in increased cross-subsidisation. On the contrary, by prohibiting private medical schemes from offering supplementary coverage, it reduces the overall degree of cross-subsidisation. This is because cross-subsidisation stems primarily from everyone's mandatory contributions to the NHI. If supplementary coverage were permitted, those who choose it would continue paying into the NHI but draw far fewer benefits from it, thereby freeing up resources for NHI Fund users. Far from undermining social solidarity, allowing supplementary coverage would strengthen cross-subsidisation by ensuring that higher-income individuals bolster the NHI without imposing an added service burden on it.

205 Finally, establishing the NHI Fund as a monopsony purchaser, a key purpose of the NHI Act, is the further stated reason for section 33's prohibition of supplementary coverage. But that makes no sense at all. Supplementary coverage would be prohibited only once NHI is fully implemented, according to section 33. If the NHI Fund is able to fully implement NHI before it becomes a monopsony purchaser then the stated rationale for banning supplementary medical scheme cover falls away.

206 It follows that the NHI Act as a whole, and section 33 in particular, is incapable of achieving its stated purposes, is irrational, and is unconstitutional and invalid.

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SECOND GROUND: SECTION 33 INFRINGES THE RIGHT TO HEALTHCARE

Introduction

207 Section 27 of the Constitution provides, in relevant part, as follows:

> *"(1) Everyone has the right to have access to—*
>
> *(a) healthcare services, including reproductive healthcare;*
>
> *…*
>
> *(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*
>
> *(3) No one may be refused emergency medical treatment."*

208 In addition to its obligations under section 27, the state also bears an overarching obligation under section 7(2) of the Constitution to "*respect, protect, promote and fulfil the rights in the Bill of Rights*".

209 I am advised that the constitutional right of access to healthcare, and the correlative obligation it imposes on the state, have both a negative and positive dimension:

209.1 The first dimension is the positive right of access to healthcare services. This positive right imposes a negative obligation on the state not to prevent, impair or interfere with existing access to healthcare. Any such prevention, impairment or interference limits the right and is unconstitutional unless justified in terms of section 36.

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209.2 The second is the positive obligation imposed upon the state to promote access to healthcare in subsection (2). This is an obligation to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to healthcare services.

210 I am advised further that where the negative aspect of the right of access to healthcare is limited, the next question is whether that limitation is justified under section 36 of the Constitution, having regard to:

210.1 the nature of the right;

210.2 the importance of the purpose of the limitation;

210.3 the nature and extent of the limitation;

210.4 the relation between the limitation and its purpose; and

210.5 less restrictive means to achieve the purpose.

Limitation of the right

211 Genesis makes it clear that, even on the conservative modelling of NHI implementation as envisaged by the NHI Act, the consequence will be a dramatic reduction in access to healthcare services for existing medical scheme beneficiaries. Beyond paying taxes, the public will in fact be prohibited from taking steps to contribute to the funding of health services, either for themselves or their dependants, including by sustainably pooling funds to collectively mitigate their health risks. Other than the wealthiest individuals (who can afford to pay out-of-pocket), the public will have no

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option but to experience rationing of those services by the government, whether in the shape of long delays, poor quality or refusal of certain services. The wealthiest individuals will still be able to pay out of pocket for treatment, and it is unlikely that alternative healthcare providers will be available as the Minister has implied in his answering affidavit in the Solidarity litigation that contracted providers to the NHI will not be permitted to treat users outside of the NHI for services included under the NHI.[204] Instead, they will only be able to provide healthcare services under the NHI's referral pathways. In any event, it will be extremely challenging for alternative healthcare providers to sustainably operate, given the limited number of individuals who will be able to afford their services out of pocket.

212 This is a consequence that flows directly from section 33 of the NHI Act, which prohibits supplementary cover for health services by medical schemes. If medical scheme beneficiaries had the option to utilise medical scheme cover, even for services available under NHI, any negative impact on the right of access to healthcare would be significantly mitigated.

213 As a result of section 33, existing medical scheme beneficiaries will experience a 43% to 65% decline in healthcare access – both in terms of the speed of access and the quality of that access.

214 Rationing is the unavoidable consequence of a system where demand for healthcare services far outweighs available resources. Genesis's analysis shows that once millions of former medical scheme beneficiaries join NHI,

[204] *Solidarity v Minister of Health,* Minister's answering affidavit paras 437, 349.7 and 349.8.

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the financial and capacity pressures on the public sector will intensify, causing a universal shortfall in the timely delivery of care. Even if NHI implements significant cost-saving efficiencies, the influx of new patients (ex-medical scheme beneficiaries plus the long-served public sector patients) will outstrip the number of practitioners, hospital beds, and clinics. This will result in too many people chasing too few resources.

215 Patients will inevitably confront stringent and drastic rationing (e.g., extensive waiting times for operations) and a significantly lower quality of service. It bears emphasising that the increase in financing of the public health sector does not translate into a commensurate increase in the health resources required to provide health services. The availability of doctors and nurses in particular, who are already in short supply, will not change.

216 Many of these forms of rationing are already present in the public health system. Genesis provides the example of up to 3000 cancer patients in Gauteng who did not receive required radiation therapy,[205] and of a particular patient who suffered a recurrence of cancer when she did not receive radiation therapy 3 months after surgery, as recommended, but only received it 16 months later.[206]

217 As the Gauteng oncology crisis shows, delayed treatment can be devastating. Delaying critical interventions—chemotherapy, for instance—can turn treatable conditions into life-threatening recurrences. Longer

[205] Genesis Report at section 5.2.1 (paragraph 229.1).

[206] Genesis Report at section 5.2.1 (paragraph 229.3).

queues, more complications, and less timely care will also increase the ultimate cost to the system, leading to deeper inefficiencies down the line.

218 Under NHI's constrained finances, these waiting times and implicit refusals will only become more common. When medical scheme beneficiaries lose their medical scheme coverage and are forced to rely on a public health system already grappling with widespread demand and rationing, they will experience the outright refusal of certain procedures or endless waitlists.

219 It is therefore beyond question that the negative aspect of existing beneficiaries' right of access to healthcare is limited: through legislative intervention, the state is preventing, impairing and/or interfering with existing access to healthcare.

Limitations analysis

220 Having regard to the factors identified in section 36 of the Constitution, and especially the availability of less restrictive means to achieve the realistically attainable purposes of the NHI Act, section 33 of the NHI Act constitutes an unjustifiable limitation of the right of access to healthcare services.

Nature of the right

221 I am advised and submit that the right of access of everyone to healthcare services under section 27 of the Constitution includes the right of access to the necessary inputs for good healthcare, including timely access to general practitioners, specialists, nursing staff, hospital beds, theatres, medical devices and pharmaceuticals.

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222 South Africa has ratified the International Covenant on Economic, Social and Cultural Rights. In terms of Article 12,[207] the relevant extract of which I attach marked "*FA20*", state parties recognise "*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*". General Comment 14, a copy of which is attached as "*FA21*", confirms that the right to health contains four interrelated and essential elements: availability, accessibility, acceptability, and quality. South Africa is therefore required to ensure that health services are available (i.e. that there are sufficient facilities, goods, services and programs); that health services are accessible to everyone without discrimination, including by providing physical and economic access to care; that services are acceptable, in the sense of being provided ethically and in a culturally appropriate manner; and that services are provided at scientifically and medically appropriate levels of care.

223 As set out by the National Department of Health in the Patients' Rights Charter, a copy of which is attached as "*FA22*", the rights of everyone to access healthcare services includes without limitation:

223.1 receiving timely emergency care;

223.2 treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;

[207] International Covenant on Economic, Social and Cultural Rights. Available: https://treaties.un.org/doc/Treaties/1976/01/19760103%2009-57%20PM/Ch_IV_03.pdf.

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223.3 provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV or AIDS patients;

223.4 counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;

223.5 palliative care that is affordable and effective in cases of incurable or terminal illness;

223.6 a positive disposition displayed by healthcare providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and

223.7 health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

Extent of the limitation

224 The limitation of the right of access to healthcare is extensive and severe:

224.1 there will be a substantial and dramatic reduction in access to healthcare services for millions of existing medical scheme beneficiaries;

224.2 existing medical scheme beneficiaries will experience a 43% to 65% decline in healthcare access – both in terms of the speed of access and the quality of that access; and

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224.3 existing medical scheme beneficiaries will be prohibited from obtaining medical scheme cover in respect of any services that are reimbursable by the NHI Fund.

225 By forcing South Africans to use only the NHI system, the negative impact on medical scheme beneficiaries will be dramatic: they will face a 43% to 65% decline in healthcare access (depending on the extent to which NHI secures efficiencies). This may take the form of:

225.1 outright denial of procedures which do not pass the NHI's cost-benefit criteria;

225.2 rationing of medicines, with NHI funded facilities facing stockouts and offering a substantially reduced variety of medicines;

225.3 increased waiting times for crucial hospital procedures;

225.4 inability to have any say in doctors and specialists under the prescribed referral pathways; and

225.5 potentially being forced to use facilities that are sub-standard.

Importance of the purpose

226 I address the purpose of the limitation, and the relation between the limitation and its purpose, at two levels.

227 First, given that it is the effective abolition of private medical schemes in section 33 of the NHI Act that is substantially responsible for the curtailment of access to healthcare by current beneficiaries, I consider the importance

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of the narrow purposes of section 33 in particular, and the extent to which section 33 is necessary for the achievement of those purposes.

228 Thereafter, I consider the importance of the purposes of the NHI Act as a whole, and the extent to which the prohibition in section 33 is necessary for the achievement of those broader purposes.

229 As regards section 33 of the NHI Act:

229.1 The apparent purposes of section 33 of the NHI Act are as follows:

229.1.1 First, the monopsony buying power which the provision affords to government, will enable it to drive down the price of healthcare services;

229.1.2 Second, a single risk pool which covers all South Africans will maximise cross-subsidisation from rich to poor and from healthy to sick; and

229.1.3 Third, it would eliminate the competition for healthcare resources from the private sector, allowing government to ensure the equitable and fair distribution and use of healthcare services.

229.2 I deny that there is a sufficient relation between section 33 and these objectives. In other words, I deny that, in order to reduce the costs of the provision of healthcare services, or to create a single risk pool, or to ensure the equitable and fair distribution

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and use of healthcare services, it is necessary or even beneficial to effectively abolish medical schemes.

229.3 Genesis has demonstrated that there is limited scope to use monopsony power to lower prices without causing a reduction in supply.

229.3.1 From an economic point of view, there is little basis to argue that the accumulation of monopoly buying power could be used to reduce prices without sparking a reduction in supply. This is especially true for the remuneration of medical practitioners and other medical staff and payments for pharmaceutical supply, which account for the bulk of private sector medical costs.

229.3.2 Some evidence suggests prices could be mildly reduced through improving efficiencies in hospital (which account for 35% of private sector costs), but the total savings are small (around 3.4%) and there is significant risk that even attempting to secure this 3.4% would reduce investment in health facilities.[208]

229.3.3 Moreover, government already controls nearly 50% of healthcare expenditure. Even without section 33, it therefore already has significant buying power. The

[208] Genesis Report at section 3.2.2.2 (paragraph 94); section 7.3.1.1 (paragraph 370).

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majority of the 6.9% in cost savings can likely be secured even without section 33.

229.3.4 There is accordingly little if any benefit in eliminating competition for the acquisition of healthcare services.

229.4 The ostensible benefits of having a single pool of covered lives (as opposed to numerous medical schemes) are (i) reduced variability and (ii) cross-subsidisation.

229.4.1 But these benefits find little application in the case of NHI.

229.4.2 Once a fund covers a sufficiently large number of lives, there will be very little change in the variability of per capita spend.

229.4.3 And again, if the NHI did not effectively abolish medical schemes, the public sector would in any event continue to cover the 50 million lives it already does. There is accordingly very little benefit in abolishing medical schemes and increasing the NHI risk pool with the 9.1 million existing scheme beneficiaries.

229.4.4 This is compounded by the fact that medical scheme lives are on average older, and therefore have a *higher* cost per capita, which they bring into the

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funding pool and, in so doing, undermine the benefits of reduced variability and cross subsidisation.

229.4.5 Nor does section 33 result in increased cross-subsidisation. In fact, the prohibition in section 33 will lead to a *reduction* in cross-subsidisation, because the cross-subsidisation benefit comes from the mandatory prepayments that will be imposed on all South Africans. If supplementary coverage were allowed, the result would be *increased* cross subsidisation, as those using private cover (i) would not burden the NHI with their healthcare requirements, (ii) but would still make the same mandatory contributions.

229.4.6 On the contrary, section 33 *reduces* income cross subsidisation as it means higher income individuals – who would otherwise be funded by medical schemes to which they are contributing – will be forced to use NHI resources for their healthcare needs, as opposed to allowing all NHI resources to be used for lower income population segments.[209]

229.4.7 Banning supplementary cover will also increase the average risk profile of the NHI pool by increasing the

[209] Genesis Report at section 7.3.2.1.

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share of higher-risk individuals who rely solely on the NHI, raising the pool's average risk and cost.[210] At each income level, the relatively less healthy individuals who expect to face greater healthcare needs would have been more inclined to opt for supplementary coverage because they stand to gain more from the benefits, while healthier individuals are less inclined to do so.[211] If less healthy individuals are prevented from obtaining supplementary coverage, their higher risk needs to be covered by NHI, thereby elevating the overall risk profile of the pool.[212]

229.5 Section 33 of the NHI Act is also not necessary to ensure an equitable distribution of existing healthcare resources or to eliminate negative externalities from the private sector.

229.5.1 Government has various means by which to redistribute. Even before section 33 is implemented, government intends to increase taxes to capture and redistribute existing spend in the private sector, amounting to R280 billion in 2022 terms. It does not require section 33 to do this.

[210] Genesis Report at section 7.3.2.1 (paragraph 389.1).

[211] Genesis Report at section 7.3.2.1 (paragraph 389.1).

[212] Genesis Report at section 7.3.2.1 (paragraph 389.1).

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229.5.2 In fact, section 33 stands in the way of redistribution taking place through a transfer of members/patients from medical schemes to the NHI Fund. In other words, it prevents those who can afford to do so from contributing to, but not burdening, the NHI Fund.

229.5.3 The private sector also does not impose a negative externality on the public sector. There is no evidence that the private sector "*hoards*" resources relative to its spend. Instead, the current distribution of healthcare professionals is a consequence of resource inequality.[213] To the extent that NHI can address that inequality, it can do so *without* section 33 of the NHI Act. That is, as government seeks to capture nearly the entirety of current healthcare spend within South Africa, it can direct healthcare resources as desired. There is simply no need for an outright ban on private healthcare insurance in order for the fundamental redistributive purpose of NHI to be fulfilled.

230 As regards the purposes of the NHI Act as a whole:

230.1 The purpose of the NHI Act is to achieve:

[213] Genesis Report at section 7.4 (paragraph 435.3).

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230.1.1 sustainable universal access to quality healthcare services;

230.1.2 affordable universal access to quality healthcare services;

230.1.3 the equitable and fair distribution and use of healthcare services;

230.1.4 the sustainability of funding for healthcare services; and

230.1.5 equity and efficiency in funding.

230.2 There can be no question that these purposes are important. They are objectives to which the HFA is committed.

230.3 However, the HFA does not accept that there is any relation between the limitations imposed by section 33 of the NHI Act – the decline in access to healthcare services, and the prohibition on medical schemes providing supplementary cover – and these purposes of the NHI Act.

230.4 On the contrary, as I have already shown, the NHI Act, as currently drafted, is not capable of achieving these stated purposes.

230.5 In addition, as I explain below, these purposes can better be achieved by means that are less restrictive of the rights of existing scheme beneficiaries.

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Less restrictive means

231 As regards the availability of less restrictive means to achieve the purposes of NHI in general, I refer again to the Genesis Report, and its detailed assessment of alternative routes to universal health coverage, which are substantially less restrictive of the rights of existing medical scheme beneficiaries.

232 At the outset, I emphasise that prohibition on supplementary cover by medical schemes was not a component of the NHI as initially proposed. According to the initial conception, South Africans could continue to rely on their medical schemes to purchase private medical care. According to the 2011 Green Paper,[214] a relevant extract of which is attached as "*FA23*":

> *"The intention is that the National Health Insurance benefits, to which all South Africans will be entitled, will be of sufficient range and quality that South Africans have a* ***real choice*** *as to whether to continue medical scheme membership or simply draw on their National Health Insurance entitlements." (emphasis added)*

233 However, in the 2015 White Paper, a relevant extract of which is attached as "*FA24*",[215] the National Department of Health changed tack. It said that, once the NHI was fully implemented, medical schemes would only provide complementary cover.

234 Genesis has undertaken a comparative analysis of healthcare systems in a number of other countries, which illustrates that models have generally

[214] Green Paper. Available: https://static.pmg.org.za/docs/110812nhi_0.pdf.

[215] White Paper. Available: https://www.gov.za/sites/default/files/gcis_document/201512/39506gon1230.pdf.

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been adopted that have achieved or enhanced universal health coverage without the abolition of private healthcare funding.[216] In fact, countries achieving progress towards universal health coverage generally incorporate a central role for extensive supplementary private health insurance.[217] This includes countries referenced by the National Department of Health, and others, which have made substantial progress to realising universal health coverage, as measured by the World Health Organisation's Universal Health Coverage Service Coverage Index.

235 The vast majority of countries with excellent universal health coverage levels, or good progress to that end, across all income categories, allow for supplementary private insurance covering the full spectrum of health services.[218] This, of course, is the very activity that section 33 of the NHI Act seeks to prohibit.

236 It makes good sense to allow supplementary coverage of this kind. It reduces the fiscal and operational pressure on the national system. And it allows people to mitigate the inevitable rationing of health services, and introduces competition and consumer choice.

237 In most high-income countries that have made significant strides towards universal health coverage (such as Britain, Finland, Sweden, South Korea and Japan), supplementary cover is permitted.[219] These countries often

[216] Genesis Report at section 8.4 (paragraph 510).

[217] Genesis Report at section 8.4 (paragraph 510).

[218] Genesis Report at overview and key findings p xvi.

[219] Genesis Report at section 8.2.2 (paragraphs 451 and 457).

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have a multi-tiered health system, with publicly funded care at a competent level. In Germany, Chile and the Netherlands, private health insurance plays an even larger role.[220] The evidence from these countries is that it is entirely feasible to establish a system of NHI, and to achieve universal health coverage, *without* having to ban private insurance, or limit it to only complementary insurance.

238 The same is true for upper-middle-income countries like South Africa. Indeed, in 13 out of the 14 upper-middle-, middle- and low-income countries canvassed by Genesis, including China, Brazil, Indonesia, Mexico, Thailand and Türkiye, private insurers are permitted to insure for the full spectrum of health services.[221] Contributions to the central scheme remain mandatory. The only exception is Cuba, which has no private health insurance.[222]

239 Brazil, Thailand, China, and Mexico have multi-purchaser models, in that i) the public insurance system operates with funds pooled and administered at a decentralised level; and ii) private insurance is primarily supplementary, allowing patients to choose from a wide range of private schemes and options.[223]

240 Even in countries where the public insurance takes the form of a large, centralised, single purchaser – such as Indonesia, Ukraine and Moldova –

[220] Genesis Report at section 8.2.2 (paragraphs 452).

[221] Genesis Report at Table 20.

[222] Genesis Report at Table 20.

[223] Genesis Report at section 8.2.3 (paragraphs 461).

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private insurers provide supplementary cover, allowing coverage of the full spectrum of health services.[224]

241 In sum, therefore, Genesis's findings demonstrate that countries can, and generally do, successfully maintain NHI systems and progress towards universal health coverage, whilst still allowing a choice for supplementary insurance covering the full spectrum of services.

242 In comparative terms, therefore, the prohibition in section 33 of the NHI Act is drastic and restrictive. It is certainly not necessary for the achievement of universal health coverage.

243 In addition to the comparative analysis, Genesis has identified various alternatives, which have been proposed by stakeholders in South Africa, and which are aimed at achieving the core objectives of NHI – increasing access to universal health coverage; ensuring more equitable allocation of resources; and improving efficiencies – but without the restriction on the continued existence of medical schemes.

244 These alternatives include:

244.1 A "*hybrid NHI*" as proposed by the High Level Panel on the Assessment of Key Legislation and the Acceleration of Fundamental Change, appointed by the Speakers' Forum of South Africa and chaired by former President Kgalema

[224] Genesis Report at section 8.2.3 (paragraphs 462).

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Motlanthe, which envisions a multi-fund system (and multi-payers),[225] in which:

244.1.1 current medical schemes remain, with mandatory participation for all the formally employed;

244.1.2 public sector employees are covered by public sector medical schemes; and

244.1.3 the NHI Fund is created to cater to the poor and unemployed.[226]

244.2 The comprehensive universal health coverage proposal by the South African Private Practitioner's Forum, which envisions a multi-fund model including both medical schemes and a government fund, in which:

244.2.1 all employees are required to make mandatory contributions;

244.2.2 alternative models, such as risk equalisation and alternative reimbursement models, can reduce contributions without compromising quality of care, are used to create an improved risk pool among medical schemes to reduce contributions and improve competition;

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[225] Genesis Report at section 8.3.2.1 (paragraphs 485.1).

[226] Report of the High Level Panel on the Assessment of Key Legislation and the Acceleration of Fundamental Change, pages 189/93.

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244.2.3 the proposed savings from reduced contributions are then channelled into an NHI fund, in terms of which the wealthy subsidise the poor, and which would be used to cover the poor and vulnerable.[227]

244.3 The *"Rejigged NHI"* proposed by Percept/Inclusive Society Institute, which envisions a multi-fund system that includes both private insurers and a government fund, with risk pooling and sharing, implemented through a central risk equalization fund.[228]

244.4 The proposal by the Hospital Association of South Africa of a multi-fund system, in which health insurance is mandatory for all formally employed workers, and where participation in medical schemes is compulsory (including coverage for dependents).[229]

245 Each of these models presents a less restrictive alternative to NHI. I emphasise that there is convergence across these models with respect to a multi fund approach incorporating measures similar to the HMI recommendations, with some variation on the role of the NHI Fund.

246 In addition, Genesis analyses a further model proposed by the HFA, which is called NHI+.[230] This approach combines the NHI with a supplementary role for private funds. This essentially preserves the entire NHI apparatus, goals and impacts. It ensures that all the objectives of efficiency, lower

[227] Genesis Report at section 8.3.2. (paragraphs 485.2).

[228] Genesis Report at section 8.3.2. (paragraphs 485.3).

[229] Genesis Report at section 8.3.2. (paragraphs 485.4).

[230] Genesis Report at section 8.3.3.

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costs, equity and social solidarity are retained. But it preserves choice for medical scheme beneficiaries through access to supplementary private health cover.

247 The outline of the NHI+ approach is as follows:

247.1 All taxpayers would pay a contribution to the NHI Fund, whether through mandatory contributions (income related), via general taxes or a combination.

247.2 There would also be an option to opt in to medical scheme membership and pay additional voluntary contributions.

247.3 Medical schemes would be obliged to provide the NHI benefit package (at a minimum), plus any additional coverage to their beneficiaries. The NHI Fund would provide financial support to medical schemes for providing the benefit package on a capitated basis, but at a modest discount compared to the average it pays for the rest of the population.

247.4 A single virtual risk pool would be established in order to minimise anti-selection and other consequences associated with fragmented risk pools, as referenced in an expert affidavit filed by the Minister in the Solidarity litigation by health economist Mr Joseph Kutzin.

247.5 Through cooperative arrangements with medical schemes or regulation, the NHI Fund could achieve the same impact on pricing as envisaged in the current version. The benefit package

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could be increased incrementally, as affordability allows, and as capacity for delivery of benefits increases.

248 Genesis finds that NHI+ would better advance South Africa's progress to the goal of universal healthcare than the NHI Act.[231] This is for two reasons.

249 First, the NHI+ approach would free up more resources for uninsured South Africans compared to the current NHI.

249.1 Medical scheme beneficiaries tend to be older and sicker than the population as a whole, and tend to use health services more intensively.[232]

249.2 Medical schemes would therefore remove relatively high-cost individuals from the NHI's responsibility.[233]

249.3 At the same time, the NHI's capitated contribution to the medical schemes would be less than the average cost to the NHI, allowing for effective redistribution to those who are not medical scheme members.[234]

250 Second, the NHI+ approach would be more conducive to the innovations required to secure the efficiencies necessary to make the system work.[235]

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[231] Genesis Report at section 8.3.3.2 (paragraph 509).

[232] Genesis Report at section 8.3.3.2 (paragraph 509.1).

[233] Genesis Report at section 8.3.3.2 (paragraph 509.1).

[234] Genesis Report at section 8.3.3.2 (paragraph 509.1).

[235] Genesis Report at section 8.3.3.2 (paragraph 509.2).

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250.1 The NHI+ approach allows the authorities to achieve the optimal blend of cooperation and competition.[236]

250.2 Gains from cooperation, including accumulating buyer power and appropriate allocation of resources, can be ensured through regulation of the integrated system.[237]

250.3 At the same time, a degree of managed competition to incentivise the private funds to deliver more value to beneficiaries would be accommodated.[238] This would also attract investment into the health sector which in turn creates contracting capacity for government.

251 NHI+ shows that it is possible to pursue the goal of sustainable and affordable universal access to quality healthcare services without having to prohibit access to private health funding. Contributions to the NHI Fund would be mandatory for everyone. But those that wish to supplement their coverage would be allowed to do so in respect of all health services.

252 Genesis concludes that by incorporating medical schemes together with the NHI Fund, NHI+ would better achieve the objective of expanding access to healthcare for all South Africans than the existing NHI Act, but without the massive harm inflicted by the NHI Act in its present form.[239]

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[236] Genesis Report at section 8.3.3.2 (paragraph 509.2).

[237] Genesis Report at section 8.3.3.2 (paragraph 509.2).

[238] Genesis Report at section 8.3.3.2 (paragraph 509.2).

[239] Genesis Report at section 8.4 (paragraph 512.2).

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253 By utilising the existing administrative capacity and analytical capabilities of medical schemes and their administrators, NHI+ would materially reduce the considerable execution risk associated with the current version of NHI.[240] NHI+ also allows for managed competition between schemes, which is a more fertile environment for the innovation required to lower costs of care.[241] NHI+ also incorporates the multiple efficiency-enhancing reforms proposed by the HMI for the medical scheme sector.[242]

254 To be clear, HFA does not suggest that government has a constitutional obligation to adopt an NHI+ model. HFA accepts that government is entitled to choose from a range of constitutionally permissible and reasonable measures to achieve the objective of equitable access to quality healthcare services. However, when government adopts a measure that results in a severe limitation of the right of access to healthcare services, then the availability of less restrictive means to achieve that purpose becomes a cardinal consideration in the limitations analysis. The NHI+ model, as with the comparative examples cited above, demonstrates the availability of less restrictive means.

255 Genesis has also demonstrated that less restrictive means exist to achieve the narrower purposes of section 33, without requiring the banning of supplementary medical scheme cover.

256 In this regard:

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[240] Genesis Report at section 8.4 (paragraph 512.4).

[241] Genesis Report at section 8.4 (paragraph 512.5).

[242] Genesis Report at section 8.4 (paragraph 512.6).

256.1 Monopsony power, and, where feasible, lower prices, can readily be achieved through regulation, without requiring a section 33 type prohibition.[243]

256.2 Cross-subsidisation is already a feature of the current system and is part of the existing regulatory framework. And nothing prevents mandatory contribution living alongside supplementary health coverage by medical schemes.[244] All that is needed is to ensure a mechanism exists whereby those who elect to join medical schemes (providing supplementary cover) also contribute to the NHI Fund.

256.3 Indeed, once section 33 is removed, and a multi-fund model is adopted, the additional redistributive mechanism of virtual pooling between medical schemes and the NHI Fund becomes available.[245] This is to the substantial benefit of beneficiaries of the NHI.

257 Genesis has further demonstrated that equity in access to healthcare services is better achieved by allowing medical schemes to look after high-cost lives while ensuring their sustainability in a conducive regulatory environment, thereby providing greater resources to lower income users of the NHI Fund.[246]

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[243] Genesis Report at overview and key findings p xiii; section 7.3.1.3.

[244] Genesis Report at overview and key findings p xiv; section 7.4 (paragraph 435.2).

[245] Genesis Report at section 8.3.1 (paragraph 479).

[246] Genesis Report at section 7.4 (paragraph 439).

258 As set out above, the HMI also recommended a suite of evidence-based interventions to tackle high healthcare costs without resorting to an NHI-style single purchaser model. The NHI Bill was published before the HMI panel published its report. The panel therefore published the HMI recommendations fully aware of the NHI Bill. These recommendations, grounded in extensive data analysis of cost drivers in the private sector, debunk the NHI Act's central assumption that only a monopsony can reduce healthcare prices. The HMI's key findings and proposals include detailed and specific recommendations for collective tariff negotiations, a supply-side regulator, and reforms to provider contracting and hospital licensing, which constitute less restrictive and effective alternatives to the NHI Act.

258.1 The HMI implicitly rejected the notion that a single-payer is the sole or indispensable route to cost reduction. It identified other major drivers of cost inflation with a far greater impact than provider tariffs – notably excessive utilisation of services. This directly debunks the claim that monopsony purchasing is uniquely capable of cutting costs. Cost containment can – and should – be achieved through targeted regulatory measures that do not eliminate medical schemes.

258.2 The HMI found that South Africa's private healthcare sector suffers from market failures and regulatory gaps that enable high costs. Key findings included concentrated hospital groups with too much pricing power, a lack of transparency on quality or outcomes, and an incomplete regulatory framework in the

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medical scheme market. Crucially, the HMI concluded there had been "*inadequate stewardship*" of the private sector by the state – meaning government had not actively regulated prices, competition, medical schemes or quality in a way that protects consumers.

258.3 The HMI essentially found that better regulation – not necessarily single-payer control – is needed. It identified specific areas where intervention could unlock competition and lower costs: for example, standardizing benefit packages to stop risk-rated competition, monitoring health outcomes to enable value-based purchasing, and breaking the cycle of ever-rising utilisation (through payment reform, clinical protocols, the establishment of a supply-side Regulator for Health, multilateral negotiated tariff determination and the gradual introduction of mandatory membership to address anti-selection).

259 Importantly, the HMI envisioned its reforms as a comprehensive package of measures working in concert. This package represents a robust regulation and negotiated price-setting that enhance equity and affordability without abolishing the multi-payer system. These constitute alternative, less drastic means to achieve the same aims as NHI.

260 Given that the limitation placed by section 33 is a severe one, and all of the narrow purposes of section 33, and all of the broad purposes of the NHI Act in general, can be readily achieved by other, far less restrictive means, I am

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advised and respectfully submit that section 33 of the NHI Act is an unjustifiable limitation of the right of access to healthcare services.

THIRD GROUND: THE NHI ACT IS NOT A REASONABLE MEASURE

261 Section 27(2) imposes a positive obligation on the state, to devise a comprehensive and workable plan to meet its obligations.

262 This positive obligation has three elements:

262.1 It is an obligation to take reasonable legislative and other measures;

262.2 The measures must achieve the progressive realisation of the right; and

262.3 The obligation is subject to the state's available resources.

263 I am advised that the overarching inquiry with regard to the positive duties of the state is whether the legislative and other measures taken to realise the rights are reasonable. There are various factors that a court will consider in reviewing the reasonableness of a government measure seeking to realise socio-economic rights. Most significantly:

263.1 The measure or programme must be comprehensive and coordinated, and must clearly allocate responsibilities and tasks to the different spheres of government and ensure that the appropriate financial and human resources are available.

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263.2 The measure or programme must be capable of facilitating the realisation of the right.

263.3 The measure or programme must be reasonable both in its conception and its implementation.

263.4 The measure or programme must be balanced and flexible, make appropriate provision for short-, medium- and long-term needs, and cannot exclude a significant segment of society.

264 According to its Preamble, the NHI Act is, on its own terms, a measure aimed at the progressive realisation of the right of access to quality personal healthcare services.

265 However, it falls short of every one of the factors set out above.

266 It is not comprehensive and coordinated; it does not clearly allocate responsibilities and tasks to different spheres of government; and it does not ensure that the appropriate financial and human resources are available.

267 Far from being comprehensive and coordinated, the NHI Act leaves substantial detail – regarding, for example, which healthcare services will be available under the NHI Act and how they will be financed – to the Minister and the NHI Benefits Advisory Committee to determine.

268 Far from clearly allocating responsibilities and tasks to different spheres of government, the NHI Act allocates considerable power to the national sphere of government, by centralising national control over healthcare

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resources, purchasing, and service standards. It shifts control over healthcare policy, financing, and administration to the national sphere, thereby substantially diminishing provincial authority over the provision of healthcare services, despite this being a matter of concurrent competence under the Constitution.

269 For the reasons set out earlier in this affidavit, it is not capable of facilitating the realisation of the right. On the contrary, as I have explained, it is fiscally impossible for the NHI Act to achieve its purposes or to realise the right of access to healthcare.

270 For similar reasons, it is not reasonable in its conception. It is fiscally unworkable. At best, it will severely curtail medical scheme beneficiaries' existing access to healthcare services. It also gives rise to numerous other negative impacts and risks, including price increases, reduced supply, under-provision of primary care, and diminution in the quality of healthcare provision.

271 It does not make appropriate provision for short, medium and long-term needs. On the contrary, the phased approach contemplated in section 57 of the NHI Act is entirely unrealistic. It is not possible, by 2026, for the NHI Act to provide for the purchasing of the array of healthcare service benefits that the NHI Act contemplates. It is similarly not possible for the NHI Fund to be fully established and operationalised as a purchaser of healthcare services through a system of mandatory prepayment by 2028. It will also have an immediate destabilising effect on medical schemes, threatening the ability of beneficiaries to take care of their short term healthcare needs.

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272 The NHI Act is also, in various respects, internally unworkable and deficient, which further demonstrates its unreasonableness as a measure to realise the right of access to healthcare services. Merely by way of example:

272.1 Section 11(1)(i)(vii) confers the power on the NHI Fund, in consultation with the Minister, to identify, develop, promote and facilitate the implementation of best practices in respect of the design of the healthcare service benefits to be purchased by the NHI Fund. However, the determination of healthcare service benefits is a power granted to the *Benefits Advisory Committee* in terms of section 25(5) of the NHI Act. The NHI Act thus provides overlapping and conflicting functions to different bodies, without any guidance as to how their respective functions ought to be coordinated.

272.2 Section 31(2) provides that "*[t]he Minister must clearly delineate in appropriate legislation the respective roles and responsibilities of the Fund and the national and provincial Departments, taking into consideration the Constitution, this Act and the National Health Act, in order to prevent duplication of services and the wasting of resources and to ensure the equitable provision and financing of health services*".

272.3 This provision is not a model of clarity. But on any reading of it, it is fundamentally flawed. On its face it is an impermissible delegation of plenary power since the Minister cannot pass legislation. If, by 'appropriate legislation', the section means

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subordinate legislation such as regulations (even though it does not use the language of 'prescribe'), then the provision is still unquestionably an impermissible delegation of law making power. It permits the Minister to effect vital changes to the roles of the national and provincial health departments, requiring only that the Minister 'takes into consideration' the Constitution and the NHA.

272.4 If, on the other hand, the provision is intended to refer to the Minister introducing appropriate legislation in Parliament, then it points to a fundamental deficiency in the NHI Act. In effect, it means that the NHI Act has left it to *future* legislation – which may or may not ultimately be passed by Parliament – to determine the interrelationship between the NHI Fund, the National Department of Health and the Provincial Departments, in order to prevent duplication and wastage and to ensure equitable provision and financing. By implication, the NHI Act anticipates that there will be duplication, wastage and inequitable provision and financing until and unless the further legislation is passed. It is clear that the NHI Act will have a significant impact on the roles of the national and provincial departments given the extensive mandate of the NHI Fund. Yet the nature of the changes, and their constitutional, structural and financial implications, are left unaddressed.

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272.5 Section 49(2)(a)(ii) provides that the money appropriated annually by Parliament to achieve the purposes of the NHI Act must be appropriated from money collected and in accordance with social solidarity in respect of "*reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance*". This provision – a key pillar of how NHI will notionally be funded – rests on a factually incorrect premise. That is because tax credits are **not** paid to medical schemes. Instead, tax credits take the form of *rebates* in terms of which SARS provides a fixed amount of tax back to each taxpayer, dependent on the number of medical scheme beneficiaries paid for by the taxpayer. In other words, a key provision, which concerns the manner in which NHI will be financed and where the funds will come from, is based on a material error of fact.

FOURTH GROUND: UNCONSTITUTIONAL DELEGATION

Principles of delegation

273 The constitutional limits of the delegation of legislative powers are informed by the separation of powers principle embedded in the Constitution.

274 Sections 43 and 44 of the Constitution vest national legislative authority in Parliament, which comprises the National Assembly and National Council of Provinces. Parliament is tasked with making laws. This accords with the foundational constitutional principles of multi-party, representative and participatory democracy.

275 Section 44(5) provides expressly that Parliament is bound by the Constitution when exercising its legislative authority and must act in accordance with, and within the limits of, the Constitution. This means that Parliament must comply with the Constitution when it enacts legislation to delegate or confer its legislative power.

276 There is no absolute prohibition on Parliament delegating authority to other bodies. Indeed, in modern government, it is often a practical necessity that functions assigned by the Constitution and legislation need to be performed by administrative officials or executive organs of state.

277 The question, therefore, is not *whether* Parliament may delegate law-making authority to the executive. The question instead concerns the *limits* imposed by the Constitution on such delegation.

278 I am advised and submit that it is contrary to the separation of powers and unconstitutional for the legislature to delegate "*plenary*" legislative powers. The question, ultimately, is not merely whether the power is plenary or regulatory in nature – though the delegation of plenary power is more likely to be constitutionally impermissible than if it is merely regulatory. The question, instead, is what the separation of powers demands in the specific context.

279 I am advised that the following factors should be considered to determine the constitutionality of a delegation by Parliament of its powers:

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279.1 the nature and ambit of the purported parliamentary delegation, and particularly whether the delegated function or power in issue belongs essentially to the legislature;

279.2 the subject matter to which the parliamentary delegation relates;

279.3 the degree of the parliamentary delegation and the extent to which Parliament provides adequate guidance as to how that discretion must be exercised so that the delegation is sufficiently constrained. The delegation must not be so broad, unfettered, untrammelled or vague that the authority to whom the power is delegated makes law rather than acting within the framework of the law made by Parliament;

279.4 the control and supervision retained or exercisable by Parliament over the delegate;

279.5 the circumstances prevailing when the delegation is made;

279.6 when the delegation is expected to be exercised;

279.7 the identity of the delegate; and

279.8 practical necessities generally, and whether the situation "*cries out for swift Executive intervention*".

280 It follows that the assessment of the constitutionality of a delegation by Parliament of its law-making authority is a fact and circumstance-specific determination.

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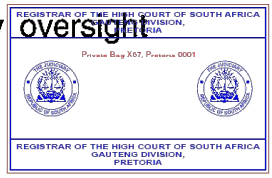
281 Under the NHI Act, Parliament has delegated significant legislative authority to the Minister. I am advised that the nature of the delegation to the Minister extends to fundamental policy questions that directly impact constitutional rights and the overall structure of the national healthcare system.

282 What is more, Parliament has done so without providing the Minister with any guidance or limitations as to the manner in which he ought to exercise his wide powers, and without providing for any parliamentary oversight mechanisms.



The delegation to the Minister is unconstitutional

283 Section 55 of the NHI Act provides for the Minister's regulation-making powers. It casts these powers in wide and untrammeled terms, empowering the Minister to prescribe regulations on a range of matters that will fundamentally shape NHI and the health system as a whole. This would also negatively affect the amount of public funding available for other purposes, such as government's constitutional obligations to provide education, housing, water and social security.

284 Indeed, certain of the matters in respect of which the Minister is granted the power to make regulations are cast in such broad terms that they, when read with other provisions of the NHI Act, constitute an unconstitutional delegation of law-making power.

285 I note that this concern was pertinently raised prior to the NHI Act being passed, by the National Planning Commission ("*NPC*") – a government

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agency, which reports directly to the President, and which is responsible for coordinating joint priority projects amongst different ministries, and the custodian of South Africa's National Development Plan: Vision 2030.

286 In its submission on the NHI Bill, which I attach marked "*FA25*", the NPC cautioned that a "*vexing matter*" was the "*excessive and vast powers given to the Minister of Health*". While the NPC expressed its full confidence in the incumbent, it emphasized that *"laws should be crafted to withstand the worst inclinations of any public official*".

287 The NPC raised specific concerns regarding the concentration of control over both the public and private sectors, making both "*subject to a single source of failure*", as well as in respect of the appointment of all health sector regulatory bodies. It specifically recommended the direct involvement of Parliament (and the President) in the appointment of the governing body.

288 Unfortunately, the drafters of the NHI Act did not take heed of the NPC's recommendation.

289 In this respect, and numerous others, the NHI Act constitutes an unconstitutional delegation of law-making power to the Minister, in a manner that is unfettered and unguided by the empowering legislation.

290 First, various provisions vest in the Minister the power to determine which healthcare services and programmes will be funded.

290.1 Under section 55(1)(w) of the NHI Act, the Minister is empowered to make regulations concerning the scope and

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nature of prescribed healthcare services and programmes and the manner in, and extent to which, they must be funded.

290.2 The NHI Act thus delegates the Minister significant authority to define which healthcare services will be available under the NHI and how they will be financed. This is, in essence, a Ministerial power to determine the content of NHI. In the absence of regulations concerning the scope and nature of prescribed services and the extent to which they must be funded, it is impossible to say precisely what NHI is or will be.

290.3 The Minister may also make regulations under section 55(1)(v) of the NHI Act concerning all practices and procedures to be followed by a healthcare service provider, health establishment or supplier in relation to the NHI Fund. This too affords the Minister broad and significant authority. It essentially enables the Minister to dictate the conduct of healthcare providers and their interactions with the NHI Fund, which is central to the operation of the national healthcare system. The NHI Act does not structure or guide the Minister's discretion and there is no clear or binding framework within the NHI Act delineating how the Minister should exercise this power.

290.4 These provisions must be read together with sections 4(1) and 7(1) of the NHI Act, which empower the Minister to concur in the purchase of healthcare services by the NHI Fund. Section 4(1) provides that:

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> "*The Fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee, on behalf of-*
> *(a) South African citizens;*
> *(b) permanent residents;*
> *(c) refugees;*
> *(d) inmates as provided for in section 12 of the Correctional Services Act, 1998 (Act 111 of 1998); and*
> *(e) certain categories or individual foreigners determined by the Minister of Home Affairs, after consultation with the Minister and the Minister of Finance, by notice in the Gazette.*"

290.5 Section 7(1) of the NHI Act further provides that the NHI Fund, in consultation with the Minister, must purchase healthcare services, determined by the Benefits Advisory Committee, for the benefit of users.

290.6 It is well-established that the phrase "*in consultation with*" means that there must be concurrence between the functionaries, and that the power may only be exercised by one functionary with the concurrence of the other. The concurrence of the Minister is thus required for the NHI Fund to purchase healthcare services under section 4(1) of the NHI Act.

291 Second, the NHI Act vests in the Minister the power to determine the relationship between public and private healthcare establishments, providers and suppliers, and the future role that private entities will play.

291.1 The Minister is empowered by section 55(1)(a) of the NHI Act to make regulations regarding the legal relationship between the

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NHI Fund and the various categories of health establishments, healthcare service providers or suppliers.

291.2 Section 55(1)(m) of the NHI Act also empowers the Minister to make regulations concerning the relationship between public and private health establishments, and the optional contracting in of private healthcare service providers.

291.3 Taken together, these provisions effectively enable the Minister to determine the future role and status of private health establishments and their relationship with the NHI Fund.

292 Third, in terms of section 7(2)(f)(i) of the NHI Act, the Minister is further obliged to request the Minister of Public Service and Administration to "*consider and assist in the establishment of central hospitals as national government components*".

292.1 Central hospitals are defined in section 1 of the NHI Act to mean public hospitals "*designated as such by the Minister*" as a national resource to provide healthcare services to all residents, irrespective of the province in which they are located, and that must serve as a centre of excellence for conducting research and training of health workers.

292.2 Where central hospitals are not established as national government components, the Minister is further required by section 7(2)(f)(ii) to "*establish or designate central hospitals as organs of state in an appropriate form*".

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292.3 The Minister's power to establish or designate central hospitals affects the allocation of responsibilities between national and provincial spheres of government. Yet the Minister would not be required to comply with the burdensome constitutional procedure for Bills whose provisions, in substantial measure, fall within a functional area of concurrent national and provincial legislative competences before establishing or designating central hospitals.

292.4 Decisions about creating or restructuring central hospitals on such a large scale are core legislative functions. They involve setting policies that have widespread implications for how healthcare services are delivered nationally and how authority is allocated between the spheres of government. Given the importance and constitutional sensitivity of the subject matter of the delegation, it is constitutionally inappropriate for such significant powers to be delegated to the Minister without any oversight by the National Assembly or NCOP.

292.5 The NHI Act also does not provide detailed criteria or guidelines on how the Minister should exercise the power to establish or designate central hospitals, and the broad delegation afforded to the Minister allows him to make substantial decisions that would effectively alter the legal and operational framework of the healthcare system, which is akin to law-making.

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293 Fourth, the NHI Act grants the Minister powers regarding the accreditation of healthcare service providers.

293.1 The Minister has the power under section 39(2)(c)(i) of the NHI Act to specify the minimum required range of personal healthcare services for the accreditation of healthcare service providers.

293.2 Section 55(1)(h) further empowers the Minister to make regulations concerning the accreditation and conditional accreditation of healthcare service providers, health establishments or suppliers.

293.3 Setting these standards impacts the rights and obligations of healthcare providers and affects public access to healthcare services. Establishing accreditation criteria is a fundamental policy decision that shapes the healthcare landscape. The delegation accordingly involves essential legislative functions that belong to Parliament.

293.4 There are no specific standards or principles outlined in the NHI Act that constrain how the Minister should determine the criteria. The absence of any parameters also leads to uncertainty and unpredictability, affecting the ability of healthcare service providers to understand and comply with the requirements.

294 Fifth, the NHI Act delegates the power to the Minister to determine the role of medical schemes in the national health system.

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294.1 The Minister is empowered by section 55(1)(n) of the NHI Act to make regulations regarding the relationship between the NHI Fund, medical schemes registered in terms of the MSA and other private health insurance schemes.

294.2 Regulating the relationship between the NHI Fund and medical schemes involves significant policy decisions that will also alter the landscape of the national healthcare system. It affects the rights and obligations of private insurers, healthcare providers, and medical scheme beneficiaries. This delegation pertains to an essential legislative function that only Parliament should exercise.

294.3 The NHI Act also does not establish clear criteria, principles, or parameters to guide the Minister's exercise of his power to regulate the relationship between the NHI Fund and medical schemes. The absence of detailed instructions means the Minister has substantial discretion to regulate these relationships as he sees fit, effectively allowing the Minister to perform a legislative function. There is also no requirement for the Minister to obtain parliamentary approval for the regulations, report back to Parliament, or for the regulations to be subject to legislative scrutiny before they come into effect.

294.4 Under section 33 of the NHI Act, the Minister is empowered to determine when "*National Health Insurance has been fully implemented*", at which time medical schemes may "*only offer*

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complementary cover to services not reimbursable by the Fund". This grants the Minister authority to decide the moment when medical schemes are restricted to offering only complementary coverage.

295 Lastly, section 31 of the NHI Act renders it an unconstitutional delegation of law-making power to the Minister.

295.1 Section 31(1)(a) of the NHI Act provides that the Minister is responsible for the "*governance and stewardship of the national health system*" and the NHI Fund.

295.2 In terms of section 31(2) of the NHI Act, the Minister is required to:

> "*clearly delineate in appropriate legislation the respective roles and responsibilities of the Fund and the national and provincial Departments, taking into consideration the Constitution, this Act and the National Health Act, in order to prevent duplication of services and the wasting of resources and to ensure the equitable provision and financing of health services.*"

296 Section 31(2) requires the Minister to delineate certain issues in "*appropriate legislation*". It is, of course, not for the Minister to make legislation at all; he can, at most, introduce a Bill into Parliament in which he delineates the matters identified in section 31(2).

297 The provision means that the Minister is required to make regulations in which he delineates the matters identified in section 31(2). Given that the

provision requires the Minister to address the issues contained in section 31(2) in Regulations, then it unconstitutionally delegates the Minister core legislative functions to allocate responsibilities between national and provincial spheres of government without taking special account of the interests of provinces through the prescribed constitutional process.

IRREPARABLE HARM TO THE HEALTHCARE SECTOR

The nature of the harm

298 The HFA brings this application because the risk that the health sector will suffer irreparable damage from a failed NHI Act is too grave and will ultimately harm the population as a whole. Our members and medical scheme beneficiaries who stand to lose their access to healthcare services cannot afford a "*wait and see*" approach to the implementation of the NHI Act.

299 In other words, it should not be assumed that there is no harm in allowing the NHI Act to be implemented, as an experiment, on the basis that government can always change tack at some point in the future if the experiment does not work. The harm that even the partial implementation of the NHI Act will cause will be severe and irreversible. It is therefore imperative that the NHI Act is stopped in its tracks.

300 As detailed by Genesis and set out above, the NHI Act is fiscally impossible and will result in the virtual obliteration of medical schemes, the reduction in the supply of critical health inputs, such as medicines and healthcare workers, significant price surges, the under-provision of healthcare care

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services, failures in facilities management, rising medico-legal claims, and more expensive out-of-pocket and complementary cover costs.

301 In addition, the HFA has pointed out in its submission to Parliament, a copy of which is attached as FA3, that due to policy uncertainty, particularly in respect of section 33 of the NHI Act, healthcare investment will be dissuaded and healthcare practitioners will be driven out:

> "*there have been material consequences from an investment perspective. For example, Discovery Group – owner of one of South Africa's largest medical scheme administrators – and all three corporate hospital groups, namely Life Healthcare, Netcare and Mediclinic, experienced significant declines in their share price following the publication of the 2019 version of the NHI Bill.*
>
> *Clause 33 of the Bill curtails the ability of schemes to cover healthcare services. This deters foreign (and local) investment in such entities, which has implications not only for the private healthcare sector, but for the broader economy as a whole. Limiting the role of medical schemes in healthcare provision has significant implications for healthcare practitioners and creates an incentive for them to consider leaving South Africa. It will become increasingly difficult to attract foreign direct investment in the absence of the guarantee that companies can provide access to high-quality healthcare for their employees. This has a very real impact on the country's economic trajectory and is a concern that must be taken seriously."*[247]

302 In this Chapter I highlight three categories of irreparable harm that will be inflicted by the NHI Act that are so severe that they cannot be reversed when the NHI Act fails. Each factor, on its own, let alone cumulatively, will

[247] HFA's submissions to the National Assembly, para 88-89.

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mean that the damage caused will be so detrimental to the health sector that it cannot simply be walked back. These are: the closure of medical schemes, the flight of healthcare professionals and the significant increase in the price of healthcare services that will render access to healthcare not covered by the NHI Fund unattainable.

Shrinking and closure of medical schemes

303 The risk of irreparable harm to medical scheme beneficiaries even during the transition period is set out in the above section entitled "*Immediate Implications for Medical Scheme Beneficiaries*".

304 Contrary to the protestations of the Minister, the promulgation of the NHI Act will have an immediate impact on medical schemes and their members. In summary:

304.1 Even the least of the Department's proposed tax measures to fund NHI – removing the medical scheme tax credit – will impair medical scheme beneficiaries and rapidly erode the affordability of medical schemes, particularly for lower income members. Between **500,000** and **884,000** members will be pushed into a position where their existing medical schemes become unaffordable.[248] I remind the Court that the tax credit is an incentive for people to join medical schemes so as to lessen the burden on the public health sector. The removal of the tax credit results in an increase in personal income tax payable by medical

[248] Genesis Report at section 6.6.3 (paragraph 320).

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scheme members. It is not revenue that is available to the South African Revenue Service to redirect towards a different function, such as the NHI Fund itself.

304.2 The number of affected members and their dependents rises much higher as further tax measures are imposed. The plan to "*capture*" the R280 billion that is spent on private healthcare through taxation, will mean that medical scheme membership will become unaffordable for between 1.4 million and 3.3 million members.[249]

304.3 These individuals who drop off cover will then either need to fund their healthcare expenses on an out-of-pocket basis (which is highly regressive) or they will use the public sector – thus increasing the burden on the public sector. Providing the equivalent of existing prescribed minimum benefit cover to these individuals, assuming only the tax credit is removed and no further taxes are imposed, would cost the state between R5.5 billion (for 500,000 lives) and R9.6 billion (for 884,000 lives) annually.[250]

304.4 As younger and healthier members drop off, scheme costs for remaining members will spike, causing further drop offs. The contributions of the remaining members will increase

[249] Genesis Report at section 6.6.4 (paragraph 323).

[250] The CMS Industry Report (2023), the relevant extract of which is attached as "*FA26*", estimates that PMBs cost R1,145 per month in 2023. Available: https://www.medicalschemes.co.za/the-cms-2023-industry-report-is-here/.

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significantly sparking an actuarial death spiral whereby contribution increases lead to more drop-offs, which in turn lead to more contribution increases.

305 Medical schemes will be forced to close down, leaving former beneficiaries with no feasible route to the healthcare services they once had access to.

306 The risk of harm to the former beneficiaries is thus irreparable as there will be no prospect of rejoining the medical scheme in order to benefit from the cover and access to health services they once had. It will only be the very wealthy who will be in a position to afford out-of-pocket payments to obtain healthcare outside of NHI. The rest will have no choice but to forego access to timely services, or to services (including medicines) that are not available through the NHI Fund.

Loss of vital human resources

307 The second irreparable harm manifests in the reduction in the number of healthcare service professionals required to provide healthcare services. South Africa already suffers from low health professional ratios. This is acknowledged by the government, whose own analysis confirms the need for additional healthcare workers to be trained:

> *"Compared to other middle-income countries, South Africa has a shortage of medical doctors and specialists. To improve the country's doctor-to-patient ratio, government has increased the number of doctors trained at domestic medical schools through a combination of bursary*

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schemes that target students from underprivileged areas, and has increased the general intake at medical schools."[251]

308 As Genesis points out, in one analysis by the Department, they "*identified the additional health workers that would be required for the health worker densities of the six lowest ranked provinces to be improved to the level of the province with the third highest health worker density. To meet this goal by 2025, a total of 96,586 additional public health workers would be needed. This is a modest goal – raising the poorest performing provinces to the province in third position – but it still constitutes a 34% increase on total current South African health workers.*"[252]

309 This is in the context where doctors are highly mobile, with many emigrating to OECD countries. According to the World Bank, over the last two decades, South Africa has already experienced **net losses** of physicians to OECD countries.[253] A related study found that for every 100 physicians that graduated from South African medical schools, at least **30** had moved to OECD countries.[254] A further analysis cited by Genesis shows that **21.6%** of South Africa trained physicians (11 224) were already actively registered to practice in Australia, Canada· New Zealand, the US, or the UK.[255]

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[251] South African government. 2024. *Health.* Available: https://government.co.za/health.

[252] Genesis Report at section 3.2.2.1 (paragraph 66.1).

[253] Ivins, C. et. al. 2022. The future of medical work in Southern Africa: case study of the future of medical work and the impact of the COVID-19 pandemic on medical work in South Africa. World Bank Discussion Paper. Washington: World Bank Publications.

[254] Tankwanchi, A. 2019. International migration of health labour: monitoring the two-way flow of physicians in South Africa. BMJ Health Journal. 4:e001566. Available: https://doi.org/10.1136/bmjgh-2019-001566.

[255] Genesis Report at section 3.2.2.1 (paragraph 67.3).

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310 The risk of health professionals exiting the health sector is material. In August 2024 the South African Private Practitioners Forum conducted a survey ("*the SAPPF Survey*") of its members to assess the response of health practitioners to the anticipated NHI. The SAPPF Survey is annexed to the SAPPF application challenging the NHI Act under case number 2024-111209. It shows that, of the more than one thousand participants in the SAPPF Survey, 305 indicated that they would "*definitely*" emigrate from South Africa, 275 indicated that they would "*definitely*" close their practice, and 175 indicated that they would "*definitely*" pursue a different career.[256] If forced to accept significantly reduced rates or wait for uncertain reimbursements, more professionals will emigrate or retire early, inducing a serious healthcare workforce crisis.

311 The model of a monopsony purchaser established in the NHI Act is intended to lower costs. But leveraging the monopsony buying power against health professionals will "*highly likely result [in] a reduction in supply and the increased emigration of healthcare workers. It would also hamper the ability to increase supply through attracting overseas doctors to work locally.*"[257]

312 The exit of health professionals will occur at the same time as the demand for healthcare resources (doctors, nurses, health facilities) increases under the NHI Act. Currently the NHI Act assumes that the significant increase in healthcare expenditure will be capable of absorption. This is a false

[256] SAPPF Founding affidavit, page 126 para 315.

[257] Genesis Report, para 71.

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assumption – healthcare resources, particularly human resources are in short supply. The increase in expenditure will require a commensurate increase in healthcare professionals (amongst other resources). On the comprehensive care model, healthcare resources would have to increase by 77%.

313 Once healthcare professionals migrate out of the healthcare system (whether by emigration or change of career) the impact will be irreversible.

Catastrophic expenditure

314 The third irreparable damage arises from the NHI's impact on the cost of healthcare services. Genesis explains that NHI is more likely to face *increasing* prices as demand for healthcare resources grows. The demand will grow in circumstances of constrained supply of health services. This constraint is evident in at least four respects:

314.1 The first is the existing shortage of health professionals referred to above.

314.2 The second is the emigration of doctors and nurses from the system.

314.3 The third is a result of section 39 of the NHI Act, which requires that health service providers and health establishments are accredited by the NHI Fund to provide services. Those who are not certified with the Office of Health Standards Compliance will not be permitted to render services to the NHI Fund. While the importance of enforcing quality of services is not in dispute, the

inevitable impact will be to reduce the supply of health services. Although section 39(12) of the NHI Act permits conditional accreditation to a provider or health establishment, such accreditation would be temporary and subject to meeting the required criteria within a particular time frame in order to protect the public from poor quality health services. I note, though, that the section is conspicuously silent on this.

314.4 Fourth, with section 33 in place, if NHI rations cover (or provides poor quality service), users will have to pay out-of-pocket. The Genesis Report shows that higher out-of-pocket expenditure is experienced in many countries cited by the Department of Health in the Solidarity litigation.[258]

315 The surge in demand and the constrained supply will mean that the price of health services will escalate.

316 The price escalation may not have an impact on those who seek services covered by the NHI Fund. But the NHI Act envisages that individuals will pay for services not covered by the NHI Fund through out-of-pocket expenditure or complementary cover. The Minister states explicitly in his answering affidavit in the Solidarity case that "*if the Fund refuses to pay for a treatment on the basis that it is not medically necessary or part of the benefits covered by the Fund, the user may still access that treatment if*

[258] Genesis Report (paragraphs 337 and 338).

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their health care provider considers it more optimal. The user will however have to pay for it out of pocket or through complementary insurance".[259]

317 Complementary medical scheme cover will be prohibitively expensive other than for a small sliver of the population for the reasons I have already explained above in the section titled "*Immediate Implications for Medical Scheme Beneficiaries*". This means that most individuals would have to pay out-of-pocket for services that are not covered by the NHI Fund.

318 The cost of accessing services under NHI is prohibitive because:

318.1 the increased demand will result in an increase in prices of health services, and

318.2 the increased taxation will mean a significantly reduced after-tax income for tax payers. For the "*millions of taxpayers who currently do not belong to medical schemes, their after tax-incomes will decline by between 10% and 15%.*"[260]

319 Under the NHI Act, taxpayers, particularly those who are not currently medical scheme members, will be left with less money in their pocket after tax and will have to pay more for healthcare services. The impact of the NHI Act will be to fundamentally alter the pricing of health services for the worse, and expose millions of people to the risk of catastrophic expenditure, in direct conflict with the raison d'être of the NHI Act. Currently, South Africa has one of the lowest out-of-pocket payment levels for healthcare services

[259] Para 355.8.

[260] Genesis Report at section 9.2 (paragraph 531).

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in the world, and ranks 182nd out of 193 countries for which a value was recorded by the World Health Organisation.[261] Out-of-pocket payments in the private sector are generally used to purchase discretionary care, while expensive in-hospital and emergency care is covered in full by medical schemes, as required by prescribed minimum benefit regulations, which ensure that medical schemes absorb these costs. The NHI Act will reverse this.

320 The damage to the health system as a result of the three outcomes above, individually or cumulatively, will be ruinous. There will be no easy return to the status quo in the event that the NHI Act fails.

321 This will be the result at the system level. At an individual level, these systemic failures will translate into irreparable harm in the form of serious health complications, untreated conditions, the inability to access timely healthcare intervention, a failure to halt the progression of a disease in time, disability and death. Rationing of care is inevitable in the already overburdened public health system. The extent of rationing will expand as resources decrease and prices increase.

322 Rationing can be explicit – for example, the type of services that will be included in the package of services determined by the NHI Fund based on what is cost-effective. Rationing can also be implicit. According to the Genesis Report,

[261] Genesis Report at section 6.7 (paragraph 337).

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> "*Implicit rationing is not clearly visible but manifests in the unavailability of timely medical appointments with practitioners, beds and operating theatres; reduction in the availability of range of pharmaceuticals or stock-outs; extended delays in procedures; the effective (if implicit) refusal to do certain procedures; and tight treatment protocols that are driven by fiscal constraints rather than medical considerations . . .*
>
> *The lived experience of rationing can be devastating. A case currently before the High Court provides an example.*[262] *In this matter, up to 3 000 cancer patients in Gauteng did not receive radiation therapy. It is claimed that Charlotte Maxeke Johannesburg Academic Hospital already had an 18-month delay in radiation treatment, and that this has still not been addressed. A patient called Lydia Staats suffered a recurrence of cancer in her breast and lymph nodes due to the lack of the required radiation follow-up after repeated surgery to remove cancerous growths. She eventually received radiation 16 months after surgery instead of after the recommended 3 months. This case is an example of extended rationing, followed by further delays even though money was eventually voted to address the backlog. This was first a failure of resources, then a failure of contracting and management.* "[263]

323 Under the NHI, without supplementary coverage from medical schemes, millions of current beneficiaries would experience similar wait times or outright denials.

324 The consequences for individuals can be dire. Yet section 33 of the NHI Act prohibits individuals from managing the effects of rationing through the supplementary cover of medical schemes. It denies individuals the right to

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[262] Banda, M. 2024. Urgent legal battle: Activists demand action for 3,000 Gauteng cancer patients awaiting treatment. Daily Maverick. Available: https://www.dailymaverick.co.za/article/2024-11-26-urgent-legal-battle-activists-demand-action-for-3000-gauteng-cancer-patients-awaiting-treatment/?utm_source=Sailthru&utm_medium=email&utm_campaign=first_thing.

[263] Genesis Report at overview and key findings p x-xi.

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make their own arrangements, without burdening the state, to obtain the healthcare they need. For those who suffer serious health setbacks or death, the consequences will be irreversible.

CONCLUSION

325 For these reasons set out in this affidavit, I pray for an order in terms of the notice of motion.

THONESHAN NAIDOO

I hereby certify that the deponent knows and understands the contents of this affidavit and that it is to the best of the deponent's knowledge both true and correct. This affidavit was signed and sworn to before me at **Sandton** on this the **3rd** day of **June 2025**, and that the Regulations contained in Government Notice R.1258 of 21 July 1972, as amended by R1648 of 19 August 1977, and as further amended by R1428 of 11 July 1989, having been complied with.

COMMISSIONER OF OATHS

Full names:

Address:

Designation:

Capacity: