THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

Case No 2024-057449

In the matter between:

SOLIDARITY TRADE UNION	Applicant
and	
THE MINISTER OF HEALTH	First Respondent
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Second Respondent
DIRECTOR-GENERAL, NATIONAL DEPARTMENT OF HEALTH	Third Respondent
MINISTER OF FINANCE	Fourth Respondent
NATIONAL TREASURY	Fifth Respondent

FIRST AND THIRD RESPONDENTS'
ANSWERING AFFIDAVIT

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I, the undersigned,

PAKISHE AARON MOTSOALEDI

state under oath as follows:

1 I am the first respondent, a medical doctor and the Minister of Health. I was appointed to this position on 3 July 2024, after previously serving as the Minister of Home Affairs from 30 May to 19 June 2024. I was also the Minister of Health from 26 May 2014 until 25 May 2019. The Ministry's offices are situated at Dr AB Xuma Building, 1112 Voortrekker Road, Pretoria.

2 During the period from 26 May 2014 and 19 June 2019, I played an instrumental role in the formulation, introduction, and development of what became the National Health Insurance Act, 20 of 2023 ("**the NHI Act**"). This period was marked by significant milestones in the making of the legislative and policy framework that was aimed at establishing a more equitable health care system in South Africa.

3 As such, I have extensive experience in the introduction and progression of National Health Insurance ("**NHI**"), and a comprehensive understanding of the objectives, policy considerations and challenges that are associated with the NHI Act. My involvement has been both historical and continues in the present. I am thus well placed and able to provide relevant insights into the NHI Act, and on its content and workings.

4 The facts in this affidavit are true and correct and fall within my personal knowledge unless otherwise indicated. Where I make legal submissions, I do so on the advice of my legal representatives, which advice I accept. Where I

rely on evidence that may be considered hearsay, I either provide a confirmatory affidavit or ask that it be admitted in terms of section 3(1)(c) of the Law of Evidence Amendment Act 45 of 1988. Where I express opinions, I do so either on the basis of my own qualifications and experience or on the basis of the evidence of the expert witnesses whose affidavits are filed together with this one.

5 I attach marked "**PAM1**" a list of abbreviations and acronyms that I use in this affidavit, and which are also referred to in the expert affidavits.

6 I depose to this affidavit in my capacity as the Minister of Health ("**the Minister**"), and on behalf of the third respondent, the Director General National Department of Health ("**the DG**").

7 I have read the application that has been filed by Solidarity Trade Union ("**Solidarity**"). The DG and I oppose Solidarity's application and answer to it as set out in this affidavit.

I INTRODUCTION

8 At its core, the purpose of the NHI Act is to protect human life, health, and dignity, and to address the egregious inequity that defines the South African health care system.

9 Access to health care shapes every aspect of our lives. It determines whether we live or die, whether we suffer pain and disability, or thrive, work, learn, play, and participate in society. It determines whether and, if so, how we have families. It influences every aspect of our sensory experience as human beings and is foundational to the enjoyment of all our constitutional rights.

10 The NHI Act is a transformative piece of legislation which is aimed at achieving Universal Health Coverage ("**UHC**") by integrating the funding of South Africa's fragmented public and private health care systems. The current two-tier system, comprised of a distinct and separately funded public and private health care system, was shaped by apartheid-era policies. This two-tier system is unsustainable in a constitutional democracy that upholds the right to equality under section 9, the right to human dignity under section 10, the right to life under section 11 and the right of access to health care under section 27(1)(a) of the Constitution. The NHI Act aims to rectify the disparities that exist in the distribution of health care resources and services.

11 Our Constitution recognises the right of everyone to have access to health care services in section 27(1) of the Constitution. It is a fundamental human right, the enjoyment of which should be based on a person's *need* for health care, not their socio-economic status, employment status, or race.

12 What must remain central to all questions regarding our health care system is that we are dealing with human beings and the vulnerability of human life. In the current health care system, financial gain has been and continues to be emphasised ahead of the health needs of the South African population, and this is happening at an alarming rate and on a grand scale.

13 The prevailing levels of inequity in the health care system between private and public health care are much worse than they were during the apartheid era.

14 The State is constitutionally obliged to change this. Our Constitution demands a health care system that is equitable and transformed, and which puts human life and dignity at its centre. This is what the NHI Act is designed to achieve, and what it will achieve.

15 Solidarity has brought a constitutional challenge against the entire NHI Act. Solidarity in essence asks this Court to undermine the constitutionally protected powers and duties of the Legislature and the Executive to take reasonable legislative and other measures to progressively realise the right of everyone to have access to health care services, including reproductive health care in section 27(1) of the Constitution, as demanded by section 27(2) thereof. I will refer to it as "the right to health care".

16 Solidarity's review is not properly made out. It impermissibly seeks by way of relief the declaration of the entire statute as unconstitutional, without in any way seeking to link each and every provision of the NHI Act to a constitutional review ground. In the alternative it asks, tautologically, that this Court "declare such sections of the NHI as are found to be unconstitutional to be unconstitutional and invalid". This leaves me and the third respondent prejudiced and at sea

as to what the case is that we must meet. This Court will be similarly prejudiced in adjudicating the matter.

17 Solidarity's grounds of review are based solely on abstract challenges and speculative arguments that border on fearmongering. It provides no real evidence, expert or otherwise, to substantiate its sensationalised claims of how the NHI Act will impact access to health care. Where it does cite academic articles, the sources relied upon are outdated and no attempt has been made to confirm the contents of these sources with the academic in question. This renders them inadmissible hearsay and I will apply at the hearing of the matter for their striking-out. Moreover, Solidarity fails to qualify them as experts insofar as it fails to put up evidence of their purported qualifications, experience and expertise. On this basis too they are inadmissible and stand to be struck out.

18 South Africa's international law commitments affirm that health care is a fundamental right. The NHI Act is a step toward fulfilling these obligations by creating a more equitable health care system that is accessible to all, and is based on need rather than socio-economic status.

19 I demonstrate in this affidavit that NHI is an urgent necessity. It is not a measure that has been recklessly and thoughtlessly enacted. To the contrary, the NHI Act is in line with global best practice. It carefully aligns with progressive legal interpretations of socio-economic rights and aims to promote substantive equality by ensuring that health care services are distributed based on need, not wealth. Contrary to Solidarity's claims, the NHI Act is a rational and reasonable legislative intervention aimed at progressively realising the right of access to health care for all in South Africa.

20 The NHI Act is the product of almost two decades of work, research, consultation, and policy development. Over 64,000 comments were received during the legislative process, and hearings were conducted across all nine provinces to ensure that the voices and concerns of people from all walks of life were heard. This inclusive process reflects the NHI Act's intent to serve the public good. It is based on the best available evidence and international best practice, in order to progressively achieve the State's constitutional obligations and to transform the inequity that defines health financing in South Africa.

21 Unlike Solidarity, I do not make these claims in the ether. I provide expert evidence and statistical information to support them.

22 Viewed objectively, there is no merit in any aspect of Solidarity's application. I ask this Court to dismiss it.

23 I draw attention, at the outset, to the following affidavits filed together with mine, which are of overall importance and are referred to in several parts of my affidavit to follow:

23.1 an expert affidavit by **PROFESSOR DIANE MCINTYRE**.

23.2 an expert affidavit by **Dr JOSEPH KUTZIN**.

23.3 an expert affidavit by **DR DEBORAH BUDLENDER**.

24 I point out further that I refer in this affidavit to data and statistical information that is drawn from various sources. At each instance, I indicate the source of the data, but I do not attach the source data to this affidavit so as to avoid prolixity. I will, however, make the source data available to the Court if required.

II POINTS *IN LIMINE*

25 In this Part of the affidavit, I address the following four points *in limine* which I contend on their own or collectively are dispositive of Solidarity's application:

25.1 First, Solidarity's application is premature and not ripe for adjudication. It should be dismissed on this basis alone.

25.2 Second, Solidarity's application constitutes an abstract challenge, that is not supported by facts. It should be dismissed on this basis alone.

25.3 Third, Solidarity's main relief is fundamentally flawed insofar as Solidarity seeks the setting aside of the NHI Act in its entirety without pleading any case in its founding affidavit for such all-encompassing relief. The alternative relief in prayer 2 of its notice of motion ("declaring such sections of the NHI as are found to be unconstitutional to be unconstitutional and invalid") is tautologous, nonsensical and lacks the necessary specificity. Given that the balance of the relief in prayers 4 to 6 of the notice of motion is contingent upon the relief in prayer 1 or 2, the entire application should be dismissed on this basis alone.

25.4 Fourth, Solidarity has failed to plead the averments necessary for the grant of a final interdict. Prayer 4 of its notice of motion should therefore be dismissed on this ground alone.

Solidarity's application is premature

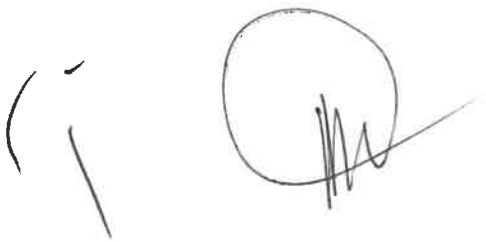
26 Solidarity seeks relief, *inter alia*, declaring that the NHI Act is unconstitutional and invalid before the legislation has been brought into force by the President in terms of section 59 and before it has been fully implemented pursuant to sections 33, 55, 56 and 57 of the NHI Act.

27 Section 59(1) of the NHI Act specifies that the NHI Act will come into effect on a date determined by the President, as announced in the Government Gazette. Section 59(2) allows the President to fix different dates in respect of the coming into operation of different provisions of the NHI Act. No determination has as yet been made by the President in terms of either section 59(1) or (2).

28 Section 57 of the NHI Act outlines the transitional arrangements for implementing NHI in two phases.

28.1 Phase 1 (2023–2026) focuses on health system strengthening, legislative development, and preparations for establishing the National Health Insurance Fund ("**the NHI Fund**"), with priority given to vulnerable groups. It also includes setting up governance structures, accrediting service providers, and initiating legislative reforms.

28.2 Phase 2 (2026–2028) involves continuing health system improvements, mobilising additional resources, and contracting private health care providers. Advisory and interim committees will also assist me with key decisions during both phases, and the Fund will gradually assume its role as the primary purchaser of health care services.



29 Even the date of 2028 does not represent the final date for full implementation because section 33 requires me or my successor as Minister of Health to determine by way of regulations in the Gazette when the NHI has been fully implemented.

30 The NHI Act provides in sections 55 and 56 for the making of regulations and the issuing of directives. This is subject to the requirements for procedural fairness, including the notice and comment procedure in section 55(2) of the NHI Act (insofar as regulations are concerned) and the provisions of sections 3 and 4 of the Promotion of Administrative Justice Act 3 of 2000 ("**PAJA**"). These regulations and directives are yet to be promulgated and issued. They will supplement the provisions of the NHI Act, within the four corners of the statutory framework that it establishes, and assist in operationalising the overall scheme of the legislation.

31 The NHI Act envisages the passing of further Acts of Parliament before it is fully implemented, including the passing annually of money bills to provide for the appropriation of funds to the NHI Fund. I refer in this regard to sections 3(4) and 49(2)(a) for example. Again, the impact of the NHI Act can only be assessed properly once this legislation has been implemented.

32 The NHI Act thus provides for a progressive rollout of its reforms. Any constitutional challenges could only be properly and fairly considered once the legislation has been fully brought into force and implemented and the full effects of the legislation are evident.

33 The phased implementation of the NHI, as outlined above accordingly demonstrates that the concerns raised by Solidarity are speculative and hypothetical at this stage.

34 For this reason, our Courts have long recognised the need to defer to the elected branches of government in the absence of a clear violation of constitutional rights coupled with immediate harm. Solidarity's application invites this Court to intervene in a process that is not yet ripe for judicial scrutiny.

35 In this regard the courts have emphasised the importance of allowing the legislative and executive branches to fully enact and implement their policy decisions and legislation passed consequent upon them, before the judiciary intervenes. In this context, premature declarations of unconstitutionality would infringe upon the proper functioning of both the executive and the legislature and violate the principle of separation of powers.

36 Moreover, a consequence of the premature challenge is that there is at this stage no evidence of harm, whether imminent or otherwise.

37 For the reasons set out above, I submit that Solidarity's challenge is premature and should be dismissed with costs on this basis alone

Solidarity brings an abstract challenge

38 Solidarity's challenge is abstract in that (despite challenging the constitutionality of the NHI Act in its entirety) it raises no facts to demonstrate any particular difficulty with particular sections, subsections or paragraphs of the NHI Act.

39 This raises several concerns:

39.1 First, I am advised that our courts will generally treat abstract challenges with disfavour because they ask the court to peer into the future, stretching the limits of judicial competence, and short-circuiting the democratic process.

39.2 Our courts therefore impose a heavy burden on a litigant who brings an abstract or "*facial*" challenge to prove that the law is unconstitutional merely on its face. Such a litigant must prove that there are no circumstances in which the NHI Act would be valid, or that it lacks a "*plainly legitimate sweep*".

39.3 Second, I am advised further that Solidarity must overcome the presumption against unconstitutionality. Where it is possible to do so, legislation must be construed consistently with the Constitution. If there exists any interpretation of the NHI Act that is constitutionally sound, that interpretation must be favoured over a speculative possibility that the NHI Act could be interpreted or applied unconstitutionally.

39.4 Third, I am advised that a court will not presume that the State will apply the law in an unconstitutional or unlawful manner.

40 Solidarity's application is an abstract challenge that ought to be dismissed, in that:

40.1 Solidarity's repeated references to the NHI Act's *"laudable aims"* indicates that it accepts the legitimacy of the NHI Act's purpose and scope.

40.2 Solidarity has failed to show that there is no constitutionally sound interpretation of the NHI Act.

40.3 Solidarity's claims regarding the alleged unconstitutional impacts of the NHI Act are unsupported by any objectively verifiable evidence.

40.4 Solidarity relies to a significant extent on the supposition (without evidence) that the State will use the NHI Act for corrupt and illegitimate purposes. This is insufficient, inconsistent with what the courts have laid down as to the basis upon which a constitutional challenge is considered and is, in any event, denied.

41 Solidarity has therefore failed to discharge its heavy burden in having mounted an abstract challenge. The application should be dismissed.

Solidarity's relief lacks the necessary specificity

42 The main relief sought by Solidarity in prayer 1 of the notice of motion is to declare the NHI Act unconstitutional and invalid in its entirety. Such a declaration of invalidity in respect of an entire Act is appropriate where there is a flaw in the procedure adopted by Parliament in passing a Bill (although it falls outside the jurisdiction of the High Court in terms of section 167(4)(e) of the

Constitution). Yet Solidarity expressly disavows any such challenge, saying in paragraph 216 of the founding affidavit that *"for present purposes, Solidarity does not seek relief on the basis of what it says has been a flawed Parliamentary process, or on the basis of the asserted failures of the President to fulfil his constitutional obligations*". I deny that there were any such flaws or failure to fulfil constitutional obligations.

43 From this it is clear that the challenge to the NHI Act is a substantive and not a procedural one. To sustain a substantive challenge to the NHI Act, Solidarity was called upon in its founding affidavit to plead and prove a case based on averments of fact and law, identifying the precise cause of action upon which each and every provision of the statute was impugned. Solidarity fails entirely to do this. Instead, it assumes that each of its grounds of challenge will apply automatically across every one of the provisions of the NHI Act.

44 I am advised that this is not a sufficient basis upon which to bring a substantive constitutional challenge.

45 One would have expected in these circumstances that at least the alternative relief provided the requisite specificity. It does not. The alternative relief that is sought by Solidarity in prayer 2 of the notice of motion seeks to declare "*such section/s of the NHI [Act] as are found to be unconstitutional to be unconstitutional and invalid*". This prayer is tautologous, nonsensical and does not give any indication of the specific sections which the Court is invited to enquire into and declare unconstitutional and invalid.

46 Solidarity's alternative relief presents several problems:

46.1 The relief is, as just stated, tautologous and nonsensical and calls upon this Court to do Solidarity's work by asking the Court to select and identify sections of the NHI Act the Court considers to be unconstitutional. That is not the function of a Court.

46.2 The alternative relief is vague and fails to clearly specify the exact remedy sought. Courts are less likely to grant relief when it is unclear what action is required from them, particularly when the alternative options are not defined in terms of what the relief entails or how the relief sought addresses the alleged constitutional violations.

46.3 Vague relief creates uncertainty for the parties involved, including the present respondents, as to how to answer to the application and how to comply with a court order, should one be granted. This leads to difficulties in practical implementation or enforcement of the relief granted, creating legal uncertainty and potential inefficiency in rectifying the alleged constitutional issues.

46.4 Courts are hesitant to issue orders that are ambiguous or open to broad interpretation. They should only be approached for relief that is clear, precise, and enforceable. If the main and/or alternative relief is vague, the court must refuse to grant it.

46.5 Solidarity must seek relief that directly addresses the problem it complains of and offer a solution that a court can practically enforce. The vague main and alternative relief undermines the principle of providing an effective remedy for the alleged constitutional violation.

47 The notice of motion must clearly specify without any ambiguity the orders which are sought. It is undesirable and unorthodox for this Court to have to identify the impugned sections that are contemplated in the notice of motion on behalf of Solidarity.

48 As a result the notice of motion and founding affidavit, taken together, do not comply with the standard and requirements of rule 6(1) of the Uniform Rules, which requires "*a notice of motion supported by an affidavit as to the facts upon which the applicant relies for relief*". If this Court allows Solidarity to seek unspecified relief of the kind that it does, it would undermine the respondents' rights under the *audi alteram partem* principle, as they are forced to defend the constitutionality of every provision of the NHI Act without Solidarity having made out a case in relation to each provision of the NHI Act it seeks to challenge.

No pleaded requirements for a final interdict

49 Solidarity asks this Court to grant just and equitable relief pending the Constitutional Court's confirmation proceedings, including but not limited to interdicting the President from bringing any section of the NHI Act into effect by promulgation as contemplated in section 59.

50 I am advised that the granting of a temporary interdict pending the outcome of further proceedings is a remedy within the discretion of a court, exercised upon a consideration of all the facts. It is provided for in section 172(2)(b) of the Constitution.

51 Solidarity ought to have made out its case in its founding affidavit with sufficient particularity to enable the opposing party to respond thereto. Solidarity has made no such case in this application.

52 I am also advised that for an applicant to be successful in an application for a temporary interdict, they must establish the following:

52.1 A *prima facie* right on the part of the applicant.

52.2 A well-grounded apprehension of irreparable harm if the temporary interdict is not granted.

52.3 A balance of convenience in favour of the granting of the interim relief.

52.4 The absence of any other satisfactory remedy available to the applicant.

53 Solidarity has in its founding affidavit made no averments whatsoever pertaining to the four pre-requisites of a temporary interdict. There is no reference in the founding affidavit to an interdict.

54 Solidarity has thus failed to establish the four essential prerequisites for a temporary interdict. First, they have not demonstrated a prima facie right which has been infringed. Second, no irreparable harm has been identified, nor is it reasonably apprehended, where the NHI Act will only be implemented in phases in the future and over a number of years. Third, the balance of convenience favours me and the DG, not Solidarity, because there are already substantial numbers of patients benefitting from the steps that are being taken in anticipation of the implementation of the NHI Act and they will be seriously

prejudiced by the cessation. This includes patients benefitting from the pilot projects. Further , Solidarity has failed to make out any case that it has no other satisfactory remedies available to it. In light of this, their request for a temporary interdict is legally unfounded and should be dismissed.

55 In this regard, I submit that prayer 4 of the notice of motion should be dismissed with costs.

III SOLIDARITY'S APPLICATION INVITES A BREACH OF THE SEPARATION OF POWERS

56 In this Part of the affidavit, the extent to which Solidarity's application invites an unconstitutional breach of the separation of powers principle is addressed.

57 The decision to introduce NHI is primarily informed by government policy. Policy formulation constitutes executive action.

58 The Constitution establishes a clear separation of powers between the legislature, executive, and judiciary, with each branch having distinct roles and responsibilities. This structure is integral to the functioning of South Africa's democracy, with checks and balances designed to prevent overreach by any single branch.

59 The legislature's role is to take the policies developed by the executive and translate them into law. This process is underpinned by section 43 of the Constitution, which grants the legislative authority to Parliament (national level as set out in section 44 of the Constitution), provincial legislatures (provincial

level as set out in section 104 of the Constitution), and municipal councils (local level as set out in section 156 of the Constitution). The national legislative process is set out in sections 73 to 82 of the Constitution.

60 The Constitutional Court has made it clear that judicial review should not unduly interfere with the legislative process.

61 The NHI Act is a product of extensive policy-making and democratic deliberation. Declaring the NHI Act unconstitutional before it has even commenced would not only amount, with respect, to judicial overreach but would also pre-emptively undermine the policy choices of the executive branch of government and the legislative choice of those elected by the populus to represent them. In this case, Solidarity invites the courts to trespass into areas of polycentric decision-making that are the preserve of the executive and legislature. This is so in the main because Solidarity's constitutional challenge is overwhelmingly founded on whether or not the legislation represents a wise policy choice.

62 I respectfully suggest that the courts should be slow to accept an invitation from Solidarity to rule lock, stock and barrel on the constitutionality of the entire NHI Act before it comes into operation. Premature intervention would disrupt the delicate balance between the three branches of government and violate the separation of powers that is central to the functioning of South Africa's constitutional democracy.

63 Parliament, in particular, is tasked with scrutinising and debating proposed legislation to ensure that it serves the public interest. This process allows for public participation and thorough deliberation, both of which are essential for

creating legitimate laws that reflect the values of a democratic society. Here the level of public participation and deliberation during the Parliamentary process was extensive, to say the least.

64 Like the executive, the legislature engages in value-based decision-making. This is a process of weighing various competing interests, which are often polycentric in nature, affecting multiple stakeholders across society in complex and interrelated ways.

65 As this Court will be well-aware, unlike the executive and the legislature, the judiciary's role is not to develop policy or to evaluate the value judgements that inform legislation. Instead, the judiciary functions as a constitutional referee, ensuring that the executive and legislature act within the confines of the Constitution.

66 The judiciary's authority is rooted in section 165 of the Constitution, which grants the courts the power to uphold the law and the Constitution, with a particular emphasis on ensuring that the rights enshrined in the Bill of Rights are protected. The judiciary is tasked with reviewing the constitutionality of laws and executive actions, but it does so within the framework of the Constitution. It does not, with respect, have the constitutional mandate to second-guess the policy choices made by the executive or the legislature, provided those choices are lawful and constitutional.

67 In light of the above, I emphasize that the nature of Solidarity's challenge to the NHI Act raises quintessentially polycentric issues that require balancing numerous societal interests, including economic sustainability, health care equity, and resource distribution. The polycentric issues include technical

considerations of optimal models for health care delivery, optimal financing mechanisms to fund the delivery of health care, and the organisation of health care services, including how both the public and private health care sectors should be integrated into the delivery of health care. All of this falls squarely within the expertise of the executive.

68 Whilst not advanced as a point *in limine*, Solidarity's attempt to draw this Court into a breach of the separation of powers is a powerful consideration for the Court to take into account in dismissing its constitutional challenge as fundamentally flawed.

IV NHI IS NECESSARY AND BASED ON INTERNATIONAL BEST PRACTICE

69 In this section:

69.1 I explain why NHI is necessary to fulfil the right to health and to achieve UHC, in line with South Africa's domestic and international obligations.

69.2 I explain the key features of the NHI Act.

69.3 I demonstrate how these features have been designed to meet our unique context, and are based on the best available evidence and international best practices.

70 I provide only a brief overview of these issues. A more detailed explanation of the concept of UHC, its reflection in the NHI Act, and key concepts relating to the NHI Act's design is provided in the expert affidavits.

Universal health coverage

The concept of UHC

71 The NHI Act establishes a health financing system that is designed to enable access to quality, personal health services for all based on their health needs, irrespective of their socio-economic status.

72 The NHI Act is designed to progressively realise UHC. This is evident from the design of the NHI Act and is expressly stated in:

72.1 the long title of the NHI Act which is *"to achieve universal access to quality health care services"*;

72.2 the Preamble which notes the objective to *"make progress towards achieving"* UHC and that the strategic purchasing mechanisms under the NHI Act are based on *"universality and social solidarity"*;

72.3 the purpose of the NHI Act in section 2, which *inter alia*, includes the achievement of *"affordable universal access to quality health care services"*; and

72.4 the functions of the Fund in section 10(1)(a) which include taking all reasonable steps to attain UHC.

73 It is important to understand the concept of UHC, particularly because Solidarity (and Professor Alex van den Heever, whose work is cited by Solidarity) appear to misunderstand and misapply it.

74 The World Health Organisation ("**WHO**") defines UHC as follows:

> *"Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care."*

75 The three goals of UHC are to advance access to health services on the basis of need (not employment or socio-economic status), to provide access to quality (effective) health services, and to provide universal financial protection to health care users.

76 It is a principle of UHC that, whatever their socio-economic status and whoever they may rely on to provide health care, users should not be confronted with catastrophically large out-of-pocket payments in order to secure treatment for any particular condition.

77 These goals may be achieved by ensuring financial resources in the health system are used efficiently and allocated equitably, and ensuring transparency and accountability in health financing.

78 This, in turn, requires the health financing system to perform revenue collection, to pool financial resources to spread risk across the population, and to engage in strategic health care purchasing.[1]

Equity is at the core of UHC

79 Equity and the right to equality and freedom from discrimination is central to UHC. This is critically missing in Solidarity's conceptualisation of UHC. Section

[1] See also in this regard Prof McIntyre's expert affidavit at paragraphs 7 to 13 and Dr Kutzin's expert affidavit at paragraphs17 to 21..

27(2) of the Constitution mandates the progressive realisation of access to health care through the adoption of reasonable legislative and other measures. The NHI Act, embodying the principles of equity and universal access, fulfils this mandate by ensuring that health financing aligns with both the Constitution and international human rights obligations.

80 The NHI Act not only addresses the right of access to health care but also rectifies the historical injustices in health access, in line with sections 9 and 10 of the Constitution.

81 As Dr Kutzin explains in paragraph 22 of his affidavit, equity in the distribution of health resources and services is an intermediate objective of UHC. This must be assessed at the level of the entire population, not merely within one particular health financing scheme.

82 Comparative international models, such as Thailand's Universal Health Coverage Scheme and Brazil's SUS, or Sistema Único de Saúde, highlight the success of UHC systems that centralize funding and prioritize primary health care. These systems ensure equitable access and reduce out-of-pocket costs, which are principles that are mirrored in the NHI Act's approach to addressing South Africa's unique health care inequities.

South Africa has not realised UHC

83 Contrary to Solidarity's claims, South Africa does not presently enjoy UHC.

84 Solidarity claims incorrectly that the existing *"public and private health systems developed in tandem, and taken together, enable universal access to health*

care" and public health care is *"universally free ... at point of service for the entire population"* (founding affidavit para 4).

85 The current health financing system produces serious deficiencies in access to quality, needed care on an equitable basis across the population.[2] It prevents effective income and risk cross-subsidisation, and it does not provide sufficient financial protection to all health care users. NHI is designed to address these UHC deficits.

86 Despite significant investments, the current health system in South Africa fails to equitably distribute resources across socio-economic groups. Only a fraction of the population can access high-quality, comprehensive health care services, largely confined to the privately insured segment, leaving the majority of the population under-resourced and underserved. This fragmented system hinders effective risk pooling and creates inefficiencies that limit the health system's capacity to achieve UHC, as mandated by both domestic law and South Africa's international obligations.

International and regional frameworks

87 South Africa has international, regional and domestic legal obligations to realise progressively the rights to health, and equality. It has particular obligations to make progress towards UHC. NHI is designed to fulfil these obligations.

88 The right to health was first expressed as a fundamental human right in 1948 in the Universal Declaration of Human Rights ("**UDHR**").

[2] See also in this regard Prof McIntyre's expert affidavit at paragraphs 31 to 48 and Dr Kutzin's expert affidavit at paragraphs 26 to 27.

89 Article 25 of the UDHR provides for the right in a very broad sense that includes food, clothing, housing, medical care and necessary social services. In this articulation of the right, we see the interconnectedness of various rights and needs. Article 25 also provides for State assistance in the event of "*unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond [their] control.*"

90 The preamble to the Constitution of the WHO (1948) states that:

> *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."*

91 South Africa ratified the International Covenant of Economic, Social and Cultural Rights ("**ICESCR**") on 18 January 2015. The ICESCR's right to health emphasises equal access to health care and minimum guarantees of health care for sickness. It states that -

> *"Each state party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."*

92 General Comment 3 of the UN Committee on Economic Social and Cultural Rights refers to progressive realisation and stipulates that –

> *"... it thus imposes an obligation to move as expeditiously and effectively as possible towards that goal. Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources."*

93 The UN Committee on Economic Social and Cultural Rights has defined the normative content of the right to health care as equal access, based on the principle of non-discrimination, to health care facilities, goods and services. These should be available in sufficient quantity; must be physically and economically accessible to everyone; must be ethically and culturally acceptable; and must be of a medically appropriate quality.

94 The UN Committee on Economic, Social and Cultural Rights has explained that:

94.1 the State's duty to protect the right to health includes the duties to *"ensure equal access to health care and health-related services provided by third parties"* and to *"ensure that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services"*; and

94.2 the obligation to fulfil the right to health requires the State to ensure that whether the health insurance system is public, private or mixed, it should be *"affordable for all"* (United Nations General Comment No 14 on the Right to Health care. The Right to the Highest Attainable Standard of Health (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) paras 35 – 36).

95 The Declaration of Alma-Ata on primary health care was adopted by the WHO and the United Nations Children's Emergency Fund ("**UNICEF**") in 1978, which set out *inter alia* minimum core obligations imposed on states by the right to health care, which were expanded on by the Committee on Economic Social and Cultural Rights.

96 The 2018 Declaration of Astana affirmed States' commitments to the right to health without discrimination. It recognised that strengthening primary health care is the most inclusive, effective and efficient approach to enhancing peoples' health and a cornerstone of UHC. States further committed to addressing –

> *"the inefficiencies and inequities that expose people to financial hardship resulting from their use of health services by ensuring better allocation of resources for health, adequate financing of primary health care and appropriate reimbursement systems in order to improve access and achieve better health outcomes."*

97 Furthermore, Goal 3 of the UN Sustainable Development Goals (2015) aims to "*ensure healthy lives and promote well-being for all at all ages*". Target 3.8 specifically aims to

> *"achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."*

98 In 2012, South Africa, as part of the UN General Assembly, G.A. Res UN Doc. A/67/L.36 endorsed a resolution on global health and foreign policy. That resolution provided that the UN General Assembly—

> *"Recognizes the responsibility of Governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services;*
>
> *Acknowledges that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population; and*

Calls upon Member States to ensure that health financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoid catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed".

99 States' commitments to realising UHC continue to be recognised in the UN General Assembly and World Health Assembly resolutions. These include General Assembly, G.A. Res. 74/2, UN Doc. A/RES/74/2 (2019), where the UN General Assembly *"strongly recommit[ed] to achieving universal health coverage by 2030"*. These States would also *"p]ursue efficient health financing policies … to respond to unmet needs and to eliminate financial barriers to access to quality, safe, effective, affordable and essential health services, medicines, vaccines, diagnostics and health technologies, reduce out-of-pocket expenditures leading to financial hardship and ensure financial risk protection for all throughout the life course, especially for the poor and those who are vulnerable or in vulnerable situations, through better allocation and use of resources, with adequate financing for primary health care"*. The commitment to *"expand pooling of resources allocated to health, maximize efficiency and ensure equitable allocation of health spending"* is also included.

100 The duty to advance UHC, as embodied in the NHI Act, has also been recognised as part of South Africa's human rights obligations under international human rights law. By way of example:

100.1 The former UN Special Rapporteur on the right to health has said that *"[u]niversal health coverage is crucial to ensuring equity in implementing the right to health"*. The Special Rapporteur described

UHC as the "*practical expression*" of the right to health and a core obligation under children's right to health. He said that UHC which is consistent with the right to health "*requires a financing system that is equitable and pays special attention to the poor and others unable to pay for health-care services*". (D. Puras, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/71/304 (2016)).

100.2 The UN Committee on Economic, Social and Cultural Rights has interpreted "*coverage*" in UHC to mean that "*all persons are covered by the social security system, especially individuals belonging to the most disadvantaged and marginalized groups without discrimination*" and has noted that non-contributory schemes (i.e. mandatory prepayment systems) are necessary to ensure *"universal coverage*" (Committee on Economic, Social and Cultural Rights, General Comment No. 19, The Right to Social Security, UN Doc. E/C.12/GC/19 (2008)).

100.3 The former UN Special Rapporteur on the right to health has drawn attention to the infringement of the right to health in states where there exists a dual system of public and private care where the latter offers superior health care to those who can pay for it (Human Rights Council, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health on His Visit to Algeria, UN Doc. A/HRC/35/21/Add.1 (2017)).

101 Of particular importance, the widely-commended National Development Plan ("**NDP**") Vision 2030 envisages a phased approach to NHI. By 2030 there should have been a significant shift in equity, efficiency, effectiveness and quality of health care provision and that universal coverage should be available. Chapter 10 of the NDP provides that:

101.1 "Everyone must have access to an equal standard of care, regardless of their income".

101.2 "A common fund should enable equitable access to health care, regardless of what people can afford to pay or how frequently they need to make use of health services". (emphasis added)

102 The NHI is designed to achieve precisely what the NDP envisages in this regard. Chapter 10 aligns closely with what is set out in the NHI Act in numerous other respects.

103 In addition, the NHI Act will contribute directly to achieving the NDP government outcome that calls for "*a long and healthy life for all South Africans*" (Outcome 2). Output 4 of this outcome requires "*Strengthening Health System Effectiveness*". One of the ways of doing so is to improve the financing of health care as conceived by the NHI Act, in order to attain UHC. The strengthening of health system effectiveness is already under way in key respects in anticipation of the coming into force of the NHI Act.

104 Furthermore, the Presidential Health Compact, which is an agreement with all the sectors to improve the quality of the health system shows the determination of government to ensure equal quality access to health care for all.

105 Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women provides that "*State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning*".

106 The African Charter on Human and Peoples' Rights (1981) includes the "*right to enjoy the best attainable state of physical and mental health*" in Article 16.

107 Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ("*the Maputo Protocol*") provides that "*States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted*." It mandates States to provide adequate, affordable, and accessible health services. Reproductive health care is expressly included in the definition of "health care service" in section 1 of the NHI Act.

108 Article 14 of the African Charter on the Rights and Welfare of the Child provides that *"[e]very child shall have the right to enjoy the best attainable state of physical, mental and spiritual health"*. State parties are mandated to take measures to reduce infant and child mortality and ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care. The health of children is a focused concern of the NHI Act. Already in Phase 1, described earlier, section 57(2)(a)(iv) requires that *"Phase 1, for a period of four years from 2023 to 2026 ... must ... include the purchasing of personal health care services for*

vulnerable groups such as children, women, people with disabilities and the elderly".

109 The enactment of the NHI Act in South Africa aligns well with both international and regional obligations by:

109.1 Ensuring the right to health care for all in South Africa, in line with the UDHR, ICESCR, and various other international conventions.

109.2 Promoting equitable access to health services, addressing discrimination, and focusing on vulnerable populations.

109.3 Contributing to the achievement of the Sustainable Development Goals, particularly Goal 3 on health and well-being.

109.4 Complying with regional commitments to health rights and services as outlined in the African Charter, Maputo Protocol, the Lusaka Agenda[3] and South African Development Community's Protocol on Health.[4]

110 South Africa's taking of measures to align its national health policies with these international and regional frameworks, particularly by way of the passing of the NHI Act, underscores its commitment to achieving UHC and ensuring the health and well-being of all.

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[3] The Lusaka Agenda, published in December 2023, concluded that to improve global health, countries should work together to: strengthen primary health care; achieve equity of health outcomes; create resilient and equitable health systems for all Africans; streamline efforts and resources; work towards a common set of metrics to demonstrate outcomes and impact; coordinate approaches to products, research, and development; support domestically-financed health systems; create a long-term vision of nationally-funded healthcare systems; work towards universal health coverage (UHC); and create a path towards UHC that leaves no one behind.

[4] The Southern African Development Community's (SADC) Protocol on Health promotes cooperation among member states on health issues to control communicable and non-communicable diseases. The protocol was approved in 1999 and went into effect in 2004.

111 The NHI Act includes within its aims the fulfilment of these duties.

The necessity for reform

112 In this subsection, I describe how private and public health care is financed in South Africa and I explain why systemic reform is required to achieve UHC.

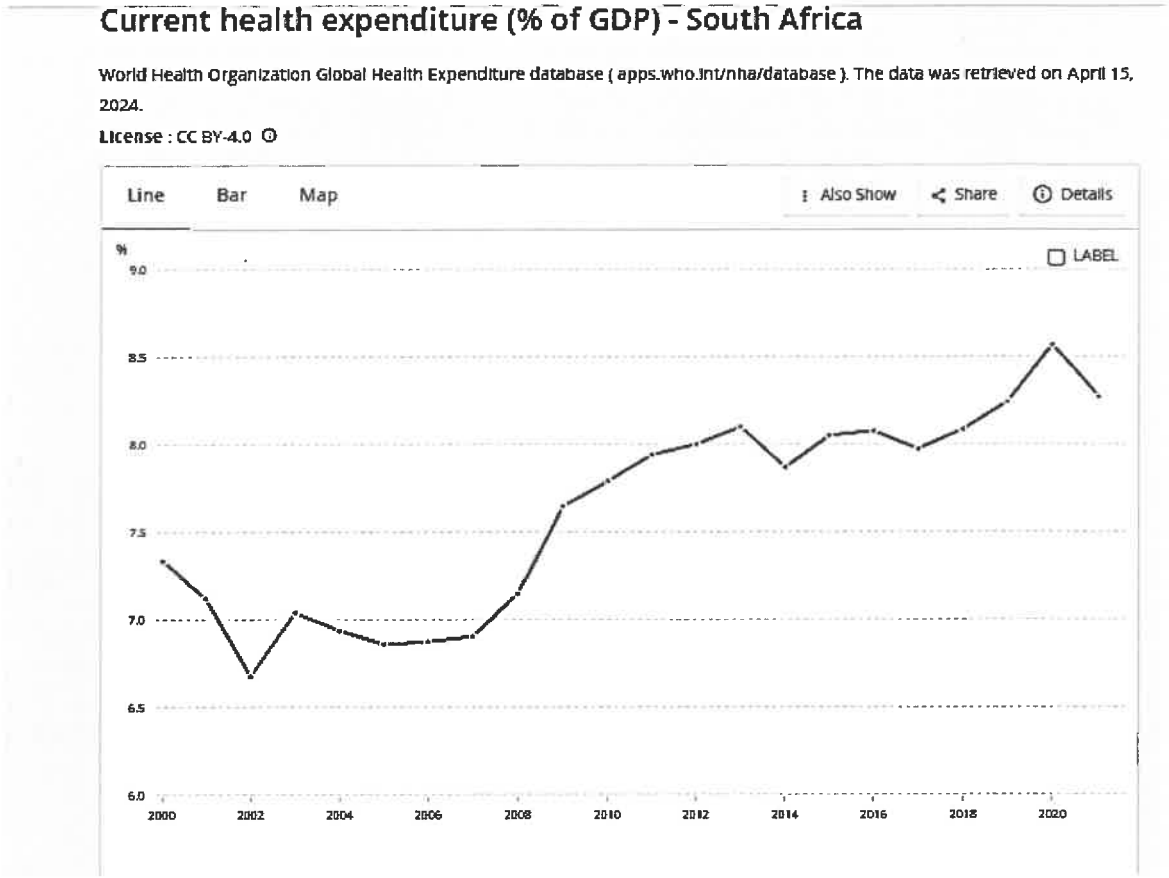
Health care spending in South Africa

113 In this subsection, I explain that the total proportion of gross domestic product ("**GDP**") spent on health care in South Africa is sufficient. It is the inequity and inefficiency of that expenditure that must be reformed in order to achieve UHC.

114 The WHO recommends that countries spend at least 5% of their GDP on health care.

115 World Bank data indicates that in 2021, South Africa spent about 8.5% of its GDP on health.

116 The graph below represents South Africa's health expenditure as a percentage of GDP. It shows the increase in expenditure over time, with a slight decrease in the last four years on account of fiscal consolidation. It is extracted from the World Bank website on 19 October 2024. Despite the recent drop, it remains well above 8% of GDP.



GRAPH 1: Current health expenditure (% of GDP) – South Africa (Source: World Health Organization Global Health Expenditure database (apps.who.int/nha/database). The data was retrieved on April 15, 2024).

117 Despite the fact that South Africa spends far more than what is recommended by the WHO on health care, health outcomes in South Africa remain inadequate. While the causes of this are complex and manifold, a significant causal factor is the inequality in health care expenditure.

118 The percentage share of health spending funded through private health insurance in South Africa was about 43%. This served only 15%-16% of the population.[5]

[5] See also in this regard the affidavit of Dr Kutzin at para 30 and footnote 11.

119 National Treasury data projects that in 2024, 51% of health care expenditure will be in the private sector, and 49% in the public sector. This means that the majority of 84%-85% of the population receives less than half of all health care expenditure nationally, despite the fact that they are the poorer part of the population and have the greatest burden of disease. And their share of the health spend is decreasing as the preceding statistics show.

120 The current dual structure of South Africa's health care system thus entrenches inequity. This situation is contrary to the values of equality, dignity, fairness and justice that underlie South Africa's constitutional framework, and, in particular, the values underlying section 27 of the Constitution. To address these problems, the NHI Act aims to dismantle this structural inequality by pooling financial resources and pooling risk, to ensure that universal health coverage in its true and correct sense can be achieved across the population.

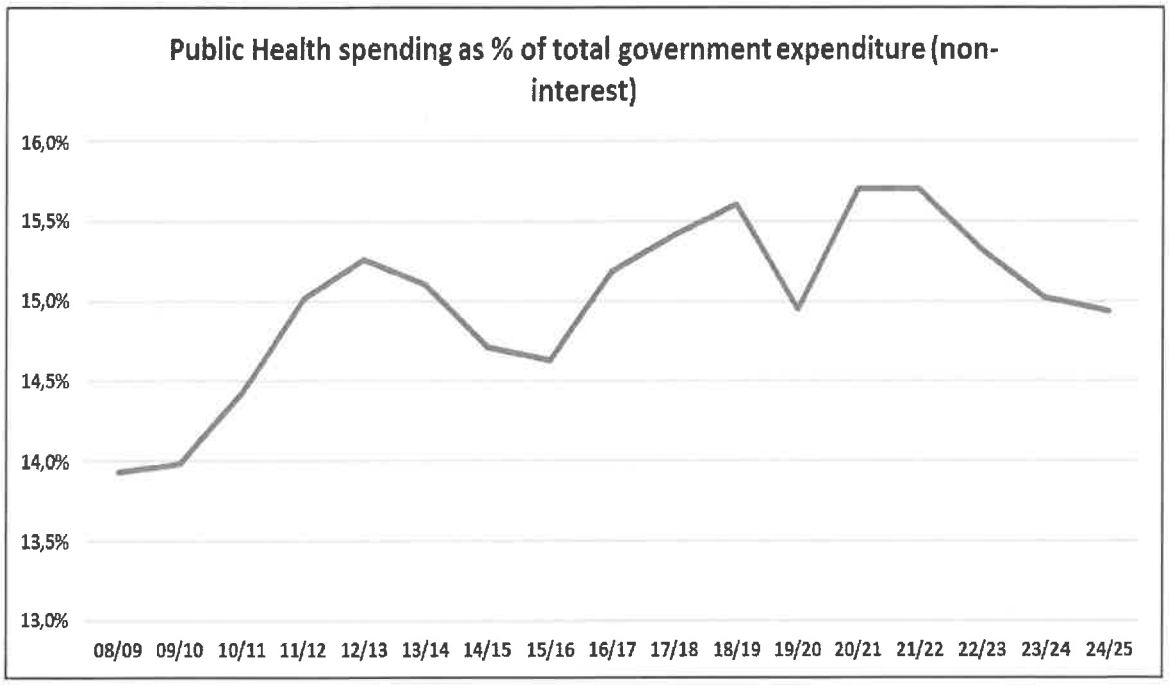
121 As Dr Kutzin explains in paragraph 28 of his affidavit, South Africa is an extreme global outlier in this regard. It is the country with the world's highest share of health spending through voluntary health insurance ("**VHI**") for a small part of the population.

122 It is not only private funds that sustain VHI, but government funds both directly and indirectly subsidise VHI. In 2020, about a quarter of VHI spending was from either direct subsidies to the purchase of VHI (such as the purchasing of medical scheme membership for government employees) or indirect subsidies (i.e. through tax credits for medical scheme members).[6]

[6] See also the affidavit of Dr Kutzin in this regard at paras 29 to 32.

123 Currently, the State contributes about R49 billion to private medical schemes through medical scheme coverage of state employees (excluding PARMED), and about R30.4 billion for tax credits for medical scheme members. This system is unfair to most taxpayers, because they are not employees of the State, yet they pay tax through PIT, VAT, fuel levy, etc., and their tax money contributes to financing the medical scheme fees of a small portion of the population employed by the state. Where the affected taxpayers are not themselves members of a medical scheme, they are forced by financial circumstances to use the public health care sector with fewer resources.

124 Spending on public health care by government has on average increased as a percentage of total government expenditure (excluding interest payments) since 2008/9 and is currently at about 15%. This is reflected in the graph below. The graph is based on Health Consolidated Expenditure Data from National Treasury.



GRAPH 3: Public health spending as % of total government expenditure (non-interest) (Source: Own, with Health Consolidated Expenditure Data from National Treasury).

125 Government spending on public health care accords with the 2000 Abuja Declaration, in which African Union States set a target of allocating at least 15% of their national budgets to health care. The South African government's proportionate contribution of national expenditure to health is therefore in line with its international commitments.

126 In short, this data shows that it is not the total amount of money spent on health care that is the problem. The problem is the inequitable distribution of the money. Dr Kutzin confirms this in paragraph 50.2 of his affidavit where he states that to achieve UHC, South Africa does not necessarily require more funding, as "*progress can be made with more efficient and equitable use of funding*".

127 To illustrate the problem of inequality more starkly, based on Health Consolidated Expenditure Data from National Treasury:

127.1 In 2021/22 per capita spending on health care was on average about five times more in the private sector than in the public sector.

127.2 This means that on average, R5,322 is spent per annum on health care per person in the public sector, and R26,700 is spent per person in the private sector.

127.3 The expenditure on health care per capita is on average five times more for people who access private health care than in the public sector.

128 This inequality in health care expenditure is not benign. It impacts the entire health system. As an illustration:

128.1 The obvious implication is that there are substantial disparities in how different socio-economic groups are able to access health care. Put crudely, richer people (who generally have fewer health care needs) are able to access more health care services than poorer people.

128.2 There is therefore a glaring, disproportionate concentration of medical specialists and health professionals in the private sector, relative to the population size covered.

128.3 The unrestrained cost of health care in the private sector increases income expectations for health professionals overall. This in turn creates constant upward pressure on overall health expenditure, as the public sector must compete with salary expectations to retain human resources.

128.4 This is drawing health care resources away from the bulk of the population.

128.5 Importantly, this inequality fragments the distribution of risk across the health system in a way that is difficult and costly to regulate and/or equalise.

128.6 The reduction of risk fragmentation is an important measure in achieving progress towards UHC.

129 UHC cannot effectively be achieved without effective risk pooling. This requires both income cross-subsidies and risk cross-subsidies.[7] To explain this in simple terms:

129.1 People in poor health have higher needs for health care and require more funds for these services. If every individual bore their own financial risk alone in a health care system, the people who most need care would never get it because they would be too sick to be productive so as to afford it.

129.2 Pooling risks allows the higher costs of less healthy people to be offset by the relatively lower costs of healthier people.

129.3 The more fragmented risk pools are in a health care system, the less likely it is that people who most need health care will be able to afford it. To ensure access to health care and equity in access, it is important

[7] See also in this regard the affidavit of Prof McIntyre at paragraph 44 of her affidavit and Dr Kutzin at paragraph 27 of his affidavit.

to reduce fragmentation by spreading that risk across a wider pool of the population.

129.4 The inequality in health expenditure in South Africa obstructs effective risk and resource pooling.

The trajectory of the private health care sector

130 In this subsection, I explain certain features and shortcomings of the current private health care sector which has informed the reform towards the achievement of UHC in South Africa.

131 The private health care sector currently operates predominantly on a "*fee-for-service*" payment system. This means that health care providers are paid for each individual service provided, with fees typically being fixed by the provider for each service or group of services.

132 Fee-for-service systems have a tendency to incentivise supplier-induced demand, which results in over-servicing of patients, and wasteful and inefficient spending relative to patient outcomes. These systems have the additional risk of compromising the quality of patient care where unnecessary or harmful care is provided in cases of over-provision of treatment.[8]

133 I refer in the following and in later portions of this affidavit to the Competition Commission's 2019 Health Market Inquiry: Findings and Recommendations Report ("**the HMI Report**"). In order not to overburden the Court, I attach only

[8] See also in this regard the affidavit of Prof McIntyre at paragraphs 67 to 70.

the relevant portions of the Report to this affidavit, which I mark as Annexure "**PAM2**".

134 The HMI Report found the following in relation to the private health care market:

134.1 The costs of health care and medical scheme cover in the private sector are high and are rising.

134.2 There is "*significant*" overutilisation of health care services without correlative improvements in health outcomes. This is driven by the perverse incentives created by fee-for-service payments and medical scheme benefit designs which encourage unnecessary admission of patients to hospital.

134.3 A feature of the private health care sector is that practitioners tend to admit patients to hospital more frequently, keep them in hospital longer, use higher levels of care, and perform more expensive and unnecessary tests, than can be explained by the patient's prognosis and treatment.

134.4 Hospitalisation rates have increased significantly in the private sector. The high rate of increase is "*worrying*". Admission rates to intensive care units are also significantly higher than in the USA and several European countries. This has startling cost implications.

134.5 The promotion of hospital-centric care has been to the detriment of primary health care, which in turn is raising costs of medical scheme coverage for members.

134.6 Consumers of medical scheme products are disempowered and uninformed.

134.7 There is an absence of value-based purchasing.

134.8 Private hospitals are able to distort and prevent competition, *inter alia* by binding medical specialists to their hospitals with lucrative inducement programs.

134.9 Health care providers are unaccountable and subject to little regulation.

134.10 Private health care facilities operate without any scrutiny on the quality of their services and clinical outcomes and it is therefore impossible for patients, funders and practitioners to exercise choice based on value (quality and price).

135 There is an urgent need for the cost of health care in the private sector to be contained to protect users from high prices. The escalating costs are attributable to private hospitals, specialists (doctors) and medicines, which claim the largest proportion of medical benefits paid by medical schemes. This is exacerbated by the failure of the medical industry to agree on the applicable tariffs, thus causing health professionals to charge differing rates to the detriment of patients.

136 Despite the massively inequitable expenditure on health care in the private sector, much of those costs do not go to the actual provision of health care but to the administration of medical schemes.

137 According to data supplied by the Council for Medical Schemes ("**CMS**") on Registered Schemes in 2024:

137.1 There were 73 medical schemes in 2023 (there are now 71).

137.2 In 2022, medical schemes had a total 833 trustees, at a cost of over R104 million per annum.

137.3 Principal Officers of the schemes cost almost R140 million, with several each being paid over R6 million per annum.

138 The CMS released its 2022 Industry Report in December 2023. I attach a copy of the relevant extracts of that Report, which I mark as Annexure "**PAM3**". It shows the following:

138.1 Non-health care expenditure (including commercial reinsurance, marketing costs, administrative costs, broker costs and impaired receivables) was increasing, and was R18.88 billion at the end of 2022. Administrative expenditure accounts for 84.18% of these non-health care expenditure costs.

138.2 Non-health care expenditure has been increasing steadily since 2018.

138.3 In total, schemes offer 311 different "*options*". Open schemes have up to 24 "*options*", and even closed schemes may have up to 10 options. "*Open*" schemes are medical schemes that are open for membership to the general public, such as Discovery Health Medical Scheme. "*Restricted*" schemes are closed to a defined group of persons, such as the Government Employees Medical Scheme.

139 What the CMS data and report demonstrates is the immense administrative burden and expense of medical schemes. The vast array of largely incomparable offerings amongst schemes creates administrative complexity, cost and perverse incentives for fraud.

140 The CMS Report further shows that:

140.1 In 2022, about 9 million people were beneficiaries of medical schemes in South Africa. Medical scheme membership is declining, especially as a proportion of the total population.

140.2 In 2022, 43% of members in open schemes had hospital plans and 23% had partial cover plans. Only 22% had comprehensive plans. In restricted schemes, 50% had comprehensive cover, with 3% having hospital plans and 45% having partial cover plans. There is also a decline in the enrolment of members in comprehensive plans.

140.3 With the exception of the COVID-19 period, the trend is that medical scheme contributions are increasing at rates that exceed the consumer price index.

141 Annexure "AB44" to the founding affidavit is a Circular from the CMS on its 2022 Industry Report. It states on page 6 at para 1.4. that out-of-pocket payments ("**OOPPs**") increased from R27,2 billion in 2015 to R39.7 billion in 2022. The CMS says that the total OOPPs is likely understated as members do not always report OOPPs. Considering that the CMS reported 9,04 million scheme beneficiaries in 2022, this translates to each beneficiary spending on average about R4,391 in OOPPs in 2022.

142 As alluded to, it has been the trend over years that the cost of medical scheme membership has increased at rates that exceed inflation. In some cases, these increases have been at a rate double that of inflation.

143 There is no indication that this rate of increase is likely to slow down in the future if the factors that are driving these costs up are not changed. This is a significant concern. Left as is, it is inevitable that medical scheme membership will simply become less and less affordable and the portion of the population who is able to afford medical scheme membership will continue to decline.

144 As Prof McIntyre explains in paragraph 68 of her affidavit, the increasing cost of medical scheme contributions is largely because of supplier-induced demand due to fee-for-service reimbursement mechanisms and the power imbalance in annual price/fee increases between medical schemes and the oligopoly of three large private hospital groups and the specialists working in these hospitals.

145 CMS data shows, moreover, that over time, the average age of medical scheme members is increasing, as is the ratio of members who are pensioners. This drives up costs in many ways, including that schemes have fewer young, healthy members to subsidise the higher costs of care for older less healthy members.

146 CMS has seen a decline in the number of registered medical schemes over the years, even before NHI was introduced. In 2000, there were 144 registered medical schemes. By 2021, this number had decreased to 73 due to the amalgamations among smaller, less sustainable schemes. The number of medical schemes is likely to decrease further because the population of medical scheme members are ageing, with few young people joining. Furthermore, the

medical schemes and health expenditure has increased on average by 6.9% versus CPI inflation of 5.5% between 2005 and 2021. This is the reason why the number of medical schemes is likely to decline.

147 Furthermore, medical schemes are experiencing expenditure increases far exceeding inflation because they serve a small and relatively stagnant population share. These small risk pools cannot absorb increases in tariffs charged by health care providers that are not matched by health service outputs and outcomes. A lack of pricing regulation does not facilitate determining fair tariffs that will reduce pressure on member premiums.

148 The trajectory of the private health care system is unsustainable. The private health care financing that Solidarity seeks to preserve is tending towards diminishing access to care at an increasingly unaffordable cost for a declining portion of the population who can afford it. As borne out by the HMI Report, this massive expense does not translate into improved health outcomes.

149 The implication of this is that a growing proportion of the population is having to rely on the public health care sector. For those members who have only non-comprehensive coverage such as hospital plans, health care is either avoided, paid for out of pocket, or accessed in the public sector.

150 These deficiencies in the private health care sector are not insulated in their impact. They have externalities, negatively impacting the efficiency, equity and accountability of the health care system as a whole.

The inequalities of the South Africa's two-tier health care system

151 Prior to 1994, South Africa had a health care system that was fragmented on racial and ethnic lines. There were 14 health departments spread amongst the former Bantustans. In 1994, a new, single de-racialised public health system was born with national, provincial and local government services. Significant improvements have been made since 1994 in service coverage and service delivery, as well as in health outcomes. There have been challenges, however, to address inequalities in the health care system. There is a need to introduce health care financing reforms.

152 Today, the public health care system is funded by general taxation and public social insurance schemes. About 84% of the population relies on public health care and are largely without medical insurance (i.e. financial protection from a medical scheme or an insurance product).

153 Solidarity makes a factually incorrect claim that public health care is "*universally free at point of service for the entire population*" (founding affidavit para 4). The statement is untrue for the following reasons:

153.1 In the public sector, primary health care is free to the user at the point of care. The cost of services in public hospitals is (with limited exceptions) means-tested according to household income. While the poorest households are entitled to free health care, persons who receive a modest income pay subsidised rates, and those earning in the upper threshold are required to pay in full. Services and supplies are therefore not free to everyone.

153.2 As Prof McIntyre points out at paragraph 24 of her affidavit, the financial burden of health care must also take into account the significant burden of transportation costs for people who have to access public health care, along with things like accommodation costs where a mother accompanies a child who is hospitalised and hidden costs where patients have to take unpaid time off.

154 The inequity in access to health care between the public and private sectors cannot be addressed by dealing with the two (private and public) sectors as separate. The problems in the private sector have "*externalities*", as Prof McIntyre explains in paragraphs 32 to 34 of her affidavit, or "*harmful spillover effects*", as Dr Kutzin says at paragraph 31 of his affidavit.

155 As I explain above, the consequence of this is that the economics of private health care in South Africa raises the cost of health care in the system as a whole, and concentrates human resources (and particularly specialist care) in the private sector, away from the majority of the population and greatest health need.

156 Because of the rising and unsustainable cost of private health care, the proportion of the population that is reliant on the public health care system is growing, with fewer financial resources to sustain it, and with a growing exodus of specialists to the private sector.

157 It must be acknowledged that there remains significant racial inequity in the South African private health care sector. Only 9.8% of Black Africans are beneficiaries of a medical scheme. As Dr Budlender explains at paragraph 63 of her affidavit, *"the vast majority of Black Africans simply cannot afford the cost*

of belonging to a medical aid and are not employed in a job where the employer contributes to help cover the cost". In comparison, 71.7% of white people in South Africa are beneficiaries of a medical scheme.

158 Rural populations are also typically under-resourced and underserved by both the public and private health care sectors.

159 The inequity in the two-tier health care system is inconsistent with the founding values of human dignity, the achievement of equality and the advancement of human rights and freedoms contained in section 1(a) of the Constitution. The executive, the legislature and, for that matter, the judiciary cannot stand idly by in the face of this glaring and continuing unfair discrimination. As Dr Budlender says in paragraph 60 of her affidavit, the two-tier system of health financing in South Africa "*is neither reasonable nor sustainable*". The State is obliged to address this in terms of, amongst others, section 27(2) of the Constitution.

The State is obliged address these problems

160 The State has legal, moral and ethical duties to address the challenges that I have highlighted above. While I am advised that this will be addressed more fully in legal argument, I point out some of the obligations that necessitate the State's response to these problems through the NHI Act.

161 Equalising access to health care services is a constitutional imperative. The theme of reducing the discrepancies in life chances runs right through the Constitution, commencing with the forceful opening words of the Preamble and the reminder of the past.

162 Transformative constitutionalism emphasises attaining socio-economic justice and has been described as having a "*pro-poor*" (or "*anti-poverty*") orientation that focuses on addressing inequalities.

163 As the Preamble of the Constitution proclaims, the aim is to assist in creating a better life for all by establishing a "*society based on democratic values, social justice and fundamental human rights*", and by improving "the quality of life of all citizens".

164 While recognising that all human rights are universal, indivisible and interdependent, socio-economic rights are particularly important in the South African context of widespread poverty and inequity. Socio-economic rights are relevant for vulnerable and disadvantaged groups who are most affected by poverty and have limited access to resources, opportunities and services.

165 Section 27(2) of the Constitution requires the State to "*take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation*" of the right of "*everyone*" to have access to health care services, including reproductive health care. The State must also realise children's right to basic health care services under section 28(1)(c) of the Constitution.

166 Section 9 of the Constitution, as read with section 7(2) thereof, requires the State to respect, protect, promote and fulfil the right to equality, including to take legislative and other measures to advance people who have been disadvantaged by unfair discrimination.

167 The NHI Act is the fulfilment of these obligations, in response to the problems I have highlighted above.

NHI is designed to realise UHC

168 The particular features of the health funding system in the NHI Act have been developed in order to deal with South Africa's unique and specific context.

169 As I have explained, the key feature of the South African context, which differentiates it from many other countries, is the severe inequity in health access and expenditure. UHC cannot be achieved in this context without adopting proactive, redistributive financing measures.

170 In this subsection, I provide a summary of the features of the NHI Act.

170.1 I demonstrate that the NHI Act is designed to meet South Africa's domestic and international human rights obligations and its commitment to UHC.

170.2 I demonstrate further that the mechanisms in the NHI Act which are designed to achieve these purposes are reasonable and rationally connected to their purposes.

171 The WHO has articulated that there are three broad principles guiding health financing reforms to accelerate progress towards universal health coverage. The first is to move towards a predominant reliance on compulsory (i.e. public) funding sources. The second is to reduce fragmentation in pooling to enhance the redistribution capacity of these prepaid funds. The third is to move towards

strategic purchasing, which seeks to align funding and incentives with promised health services.

172 All three of these principles are embodied in the NHI Act and are indispensable to its achievement of UHC.

NHI is only part of the bigger picture

173 Solidarity's application proceeds from the misguided premise that NHI is being pursued as a panacea to all challenges in South Africa's health care system, and that it is being pursued in the absence of other important interventions. This is wholly incorrect.

174 The National Department of Health ("**NdoH**") recognises the WHO's six building blocks of a health care system, namely:

174.1 leadership and governance;

174.2 access to essential medicines and other commodities;

174.3 health workforce;

174.4 health systems financing;

174.5 health information systems; and

174.6 health service delivery.

175 The NHI Act is predominantly focused on reforming the health system's financing.

176 The implementation of the NHI Act is an important part, but only one component, of the NdoH's current ten-point plan. The other components of this plan include:

176.1 the provision of strategic leadership and creation of a social compact for better health outcomes;

176.2 improving quality of services;

176.3 overhauling and improving management of the health care system;

176.4 improving human resource management;

176.5 revitalisation of physical infrastructure;

176.6 accelerated implementation of the HIV and AIDS Plan and reduction of mortality due to tuberculosis and other communicable diseases;

176.7 mass mobilisation for better health of the population;

176.8 review of the drug policy; and

176.9 strengthening research and development.

177 As alluded to above and as I explain below, in line with section 57 of the NHI Act the NHI will be implemented in phases. Its implementation will necessarily be complemented by efforts to reduce the relative cost of private medical care and improvements in human capacity and systems in the public health sector.

Systemic financing reform for a unified health system

178 NHI is a substantial policy shift that will, over time, necessitate a very substantial reorganisation of health care financing, both in the public and private sectors. Solidarity however seeks to stoke fear about the extent of the reform that is being initiated through NHI, in part by giving the impression that it will occur overnight. This is not so.

179 The premise of Solidarity's application is that the State should tinker with the public health care system rather than reform the public and private health financing system in its totality. This approach by Solidarity has significant limitations and would not achieve UHC.

180 As I have demonstrated above, widescale reform is necessary. This is confirmed by Dr Kutzin in paragraph 43 of his affidavit where he says that "*it would seem that significant changes are indeed warranted*."

Mandatory pre-payment

181 As Dr Kutzin says at paragraph 33 of his affidavit, health financing systems that are geared towards UHC should place predominant reliance on public or compulsory funding sources. This is a key feature of the NHI Act.

182 Section 2 of the NHI Act articulates that the purpose of the NHI Act is to establish and maintain the Fund which is to be "*funded through mandatory prepayment*".

182.1 Mandatory prepayment is defined in the NHI Act as "*compulsory payment for health services before they are needed in accordance with*

income levels". This is to say that all persons contribute to a common pool of health care finance according to their means but that health care is free at the point of care.

182.2 This is in contrast to other modes of payment such as voluntary prepayment (where people pay for care before getting sick, for example, through medical aids) and OOPP.

182.3 International best practice indicates that mandatory pre-payment financing is critical for UHC. This is recognised in the UN General Assembly resolutions and WHO guidance cited above.

182.4 While prepayment will be mandatory and incremental according to income (i.e. through progressive taxation or payroll tax), no registered user will be required to make any payments at the point of care. OOPP's will be eliminated in respect of primary health services.

182.5 This is affirmed in sections 6(a) and 8(1) of the NHI Act which entitle users to necessary quality health care services free at the point of care from accredited health care service providers or health establishments.

183 The chief sources of income for health financing under the NHI Act are specified in sections 48 and 49 thereof. I deal with this further in the section below on Solidarity's grounds of review as they relate to funding.

Universal access

184 There are certain attributes of health care benefits and conditions of access that enable UHC. These include the existence of a set of priority health service

benefits within a unified framework that is implemented for the entire population. Benefit design should protect access to services for vulnerable groups.[9]

185 I address three features of the NHI Act below in turn to show how these elements are included in the NHI Act.

186 First, health service benefits are to be defined within a uniform framework.

186.1 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*".

186.2 Section 4 of the NHI Act determines the population coverage of persons who may register to be "*users*" of NHI-funded health care. This includes all South African citizens, permanent residents, refugees, inmates under the Correctional Services Act 111 of 1998 and certain categories of individual foreigners, regardless of the person's income status.

186.3 Under section 6(a) of the NHI Act, all users are entitled to "*necessary quality health care services*".

186.4 As described in section 7(2) of the NHI Act, users will generally receive the health care services that they are entitled to from the provider or establishment where they are registered.

[9] See also in this regard the affidavit of Dr Kutzin at paragraph 33.4.

186.5 Sections 7(2)(b) and (c) and 7(3) of the NHI Act provide for portability of health care services. If the user is unable to access the health care service provider or establishment with whom they registered with in terms of section 5 of the NHI Act, a user must be transferred to an appropriate alternative provider or establishment.

186.6 Section 7(4) of the NHI Act precludes the Fund from paying for health care services and supplies that are not medically necessary, where there is no cost-effective intervention, or where the product or treatment is not provided for in the formulary or the complementary list approved by me or my successor.

186.7 The nature of health care services that will be funded by NHI will be determined and reviewed by the Benefits Advisory Committee ("**BAC**") in consultation with me or my successor and the Fund's Board (sections 15(3)(b) and 25 of the NHI Act).

186.8 Section 57 of the NHI Act provides for phased implementation of the NHI Act.

186.8.1 In Phase 1, section 57(2)(iv) of the NHI Act prioritises the purchasing of personal health care services for vulnerable groups first such as children, women, people with disabilities and the elderly. The health care service benefits that will be purchased include personal health services such as primary health care services, maternity and child health care services including school health services, health care 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 health care level focusing on disease prevention, health promotion, provision of primary health care services and addressing critical backlogs (section 57(4)(f) of the NHI Act).

186.8.2 As the implementation progresses, the Fund will expand the purchase of personal health services through hospital services and other clinical support services (section 57(4)(g)(ii) of the NHI Act).

186.8.3 Moreover, the Fund will at all times be required to operate within the budget available to it. The health service benefits that will be funded through NHI will therefore necessarily be defined in line with the available budget.

187 Second, these services will be available to all users without charge.

187.1 In terms of section 8(1) of the NHI Act, the health services covered by NHI will be provided free at the point of care.

187.2 This advances the financial protection and equity goals of UHC. Access is based on the person's need and not their socio-economic status meaning that the needs of the most vulnerable are accommodated.

187.3 Moreover users would have paid the mandatory prepayment already and the focus at point of care will shift away from payment and towards the users' needs and treatment requirement.

188 Third, there are particular mechanisms in the NHI Act to ensure universal access across the country (i.e. geographic equity) and according to population need.

188.1 Section 2(a) of the NHI Act states that the purposes of the NHI Act are to be achieved by the Fund serving as a single payer of health care services to ensure "*the equitable and fair distribution and use of health care services*" (emphasis added).

188.2 As I expand on further below, the Fund, as a single payer, will actively and strategically purchase health care services, goods and products. The strategic purchasing methods and mixed provider payment systems will enable the Fund to purchase goods and services where they are needed, and will incentivise health care providers and facilities to be responsive to population needs on a more equitable basis.

Pooled revenue

189 As Dr Kutzin explains in paragraphs 25.3.1 to 25.3.2 of his affidavit, pooled revenue is one of the WHO's desirable attributes of UHC reform. This requires that the pooling structure spans the health system and enhances the potential to redistribute prepaid funds. Health system and financing functions should be integrated and coordinated across schemes and programmes.

190 As Dr Kutzin says further at paragraphs 26 to 27, from a structural perspective, a single pool arrangement has the potential to maximise the capacity of the health financing system to redistribute funds to where the needs are. Pooling

of health funds reduces fragmentation in the system. This enhances system-wide equity and efficiency.

191 UHC is dependent on achieving cross-subsidies within the whole health financing system. This occurs when funds are pooled to enable a net transfer of financial resources for health care between groups with different socio-economic and different health risk profiles.[10]

192 This is provided for in the NHI Act through the pooling of revenue. In this regard:

192.1 Section 2(c) describes one of the purposes of the NHI Act to be to "*provide for equity and efficiency in funding by pooling of funds and strategic purchasing of health care services, medicines, health goods and health related products from accredited and contracted health care service providers*".

192.2 The Fund is established in section 9 as an autonomous public entity for this purpose.

192.3 Section 10(1)(b) states that to achieve the purposes of the NHI Act, the Fund must:

> *"pool the allocated resources in order to actively purchase and procure health care services, medicines, health goods and health related products from health care service providers, health establishments and suppliers that are certified and accredited in accordance with the provisions of this Act, the National Health Act and the Public Finance Management Act".*

[10] See also the affidavit of Prof McIntyre in paragraphs 14 to 16.

Single-payer system

193 The single-payer system is established under section 2 of the NHI Act.

194 The term "*single-payer*" describes the funding mechanism and not the type of health care provider.

195 NHI will be implemented through the creation of a single fund that is publicly financed and publicly administered.

196 The Fund, a single payer, contracts for health care services from providers (section 10(1)(d) of the NHI Act) and purchases health care services from those providers on users' behalf (section 10(1)(c) of the NHI Act).

197 From a structural perspective, a single purchaser arrangement has the potential to provide a coherent set of financial incentives to providers while ensuring budgetary control and maintaining public accountability. Dr Kutzin describes many countries as having such arrangements and that, from a health financing perspective, it is considered best practice.

198 Prof McIntyre further says at paragraph and 79.5 of her affidavit, that international experience demonstrates very low administration costs where a single institution purchases health care services for the entire population, leaving more of the health budget to be spent on health care. A monopsony purchaser will also hold considerable power to manage provider payment rates and ensure that they are kept at a reasonable, efficient and cost-effective level.

199 Single purchaser systems have several benefits to achieving the objects of NHI. These include the following:

199.1 Single purchaser systems enable cross-subsidisation within the health financing system. This is critical for the achievement of UHC's goals. Cross-subsidisation under NHI includes income and risk cross-subsidisation.

199.2 Risk cross-subsidies are maximised in a single pool of funds.

199.3 Single payer systems enable greater administrative and revenue collection efficiencies. International evidence indicates that single public purchasers have administrative costs of well below 5% of total expenditure with administrative costs being considerably higher for medical schemes. In short, less money is spent on administering a single fund, and more money can be spent on health care.

199.4 Single purchaser systems harmonise signals from multiple funding flows and constrain health care providers to respond to undesirable incentives. In short, they allow coherence in managing the positive and negative incentives that any particular funding model implies.

199.5 International experience shows that single, large monopsony purchasers are able to better manage provider payment rates.

200 The underlying impetus of Solidarity's application is that it takes issue with NHI's redistributive ambitions. The State does not hide from this. NHI is necessarily redistributive in nature. Cross-subsidisation (and therefore redistribution) in health care financing is central to the achievement of equity and universalism in UHC. But redistribution does not operate alone. The NHI Act is designed to improve efficiencies and lower the cost of care.

201 Solidarity annexes a review of the NHI Bill (not the final Act) by Professor van den Heever as Annexure "*AB21.1*" to its founding affidavit. Prof van den Heever argues that risk pooling must be separated from purchasing. He further attempts to criticise single-payer systems by reference to the HMI report which he claims "*recognised that equity concerns resulting from fragmented risk pools can be resolved without consolidating purchasing systems into monopolies. It therefore recommends that pooling be addressed through a centralised scheme, through a combination of risk adjustment and social reinsurance.*"

202 Prof van den Heever's claims are misleading. I refer to the extracts of the HMI report that I annex to this affidavit.

202.1 The HMI Report was issued in 2019, before the NHI Act was passed.

202.2 The Report states that its recommendations are made in light of the pending implementation of NHI, and the need of the private sector to continue to operate in the interim.

202.3 Those recommendations aim to provide a better environment within which NHI can function once implemented as "*the state becomes the purchaser of services*". Its vision for a single risk pool was so that it would be "*ready for integration with the NHI Fund in due course*".

203 The HMI Report does not criticise NHI's single-payer system. Its recommendations are also not made as an alternative to NHI. To the contrary, the recommendations were made on an interim basis, with the single-payer system of NHI as the ultimate endpoint in mind.

204 Prof McIntyre explains in paragraph 73 of her affidavit that a single purchaser is critical to achieving efficiency gains by reducing administrative expenditure in the health care system. In addition, strategic purchasing is evidenced to be compromised when there are multiple purchasers in the health care system.

Strategic purchasing

205 The purchasing of health care services and supplies can be either passive or strategic. The NHI Act seeks to implement strategic purchasing, which means active, evidence-based engagement with revenue raising, revenue pooling, and health purchasing. Strategic purchasing is critical to ensuring efficiency, equity, financial protection and quality to achieve UHC.

206 Section 35(1) of the NHI Act requires that the Fund "actively and strategically purchase health care services on behalf of users in accordance with need".

207 The health care services that the Fund will purchase are determined by the BAC in terms of sections 7(1), 10(1)(c) and 25(5)(a) and (c) of the NHI Act.

208 The Health Care Benefits Pricing Committee ("**HCBPC**") makes recommendations for the pricing of health service benefits to the Fund (section 26(3) of the NHI Act).

209 Members of the BAC and the HCBPC are appointed by me or my successor and must include persons with expertise in the areas of expertise laid down in the NHI Act (sections 25(1) and (2) and 26(1) and (2) of the NHI Act).

210 Accredited health care service providers and establishments are required to adhere to the national pricing regimen for the services that they deliver (section 39(2)(c)(vi) of the NHI Act).

211 A Health Products Procurement Unit ("**HPPU**") will be established within the Fund to set the parameters for the public procurement of health-related products such as medicines, medical devices and equipment (section 38(1) and (2) of the NHI Act).

212 The formulary is comprised of lists of essential medicines, equipment and health-related products (section 38(4) of the NHI Act).

213 Accredited health care service providers and establishments will be required to procure according to the formulary, with suppliers listed in the formulary delivering directly to those providers and establishments (sections 38(6) and 39(2)(c)(iii) of the NHI Act). This is to ensure that appropriate evidence-based products are used and because large volumes make it possible to negotiate better prices.

214 The HPPU will support the BAC in developing and maintaining the formulary, which will be approved by me or my successor in consultation with the National Health Council and the Fund (section 38(4) of the NHI Act).

215 The formulary will be reviewed at least annually by the HPPU for my approval or that of my successor taking into account changes in disease burden, product availability, price changes and disease management (section 38(5) of the NHI Act).

216 The Fund must under section 11(2)(e) of the NHI Act negotiate the lowest price for goods and services without compromising the interests of users, violating the NHI Act, or any other applicable law.

217 At paragraph 25.4 of his affidavit, Dr Kutzin highlights the following features of health systems' financing that the WHO considers as essential to progress towards UHC:

217.1 Resource allocation to health care providers should be based on population health need, provider performance or both.

217.2 Purchasing arrangements should be tailored in support of service delivery objectives.

217.3 Purchasing arrangements should incorporate mechanisms to ensure budgetary control.

218 Again, the NHI Act embodies all of these best-practice features.

Mixed provider payment system

219 One of the main ways in which strategic purchasing is engaged is through how health care providers are paid.

220 Most countries have mixed provider payment systems. Each payment method creates its own set of incentives that influence health care providers' behaviours whether through resource shifting, service shifting or cost shifting.

221 The NHI Act envisages a mixed provider payment system. The NHI Act's design (including the regulatory flexibility to adjust aspects of these payment

mechanisms over time) seeks to manage and balance those incentives appropriately and to constrain providers from responding to undesirable incentives from any particular payment system. It further seeks to ensure that health care providers will enjoy a predictable funding flow that is sufficient to cover the costs of providing the services.

222 Different payment mechanisms are provided for different kinds of health care services under the NHI Act.[11]

222.1 Accredited and contracted hospitals are to be paid by the Fund on the basis of a global budget or Diagnosis Related Groups ("**DRGs**" or case-based funding) (section 35(2) of the NHI Act).

222.2 A global budget is where providers receive a fixed amount of funds for a certain period to cover aggregate expenditures. The budget is typically flexible and not tied to line items.

222.3 DRGs are where hospitals are paid a fixed amount per admission for a treatment package depending on patient and clinical characteristics. This payment method is meant to incentivise efficiency and discourage supplier-induced demand and over-servicing.

222.4 Specialist and hospital services must be all-inclusive and based on the performance of the health care service provider, establishment or supplier (section 41(3)(b) of the NHI Act).

[11] See also the affidavit of Prof McIntyre at paragraph 79.3.

222.5 For emergency medical services, a distinction is made between facility-based, private mobile services, and public ambulance services.

222.5.1 Facility-based emergency medical services and private mobile emergency services are to be reimbursed on a capped case-based fee basis with adjustments made for severity where necessary (section 35(4)(a) and (b) and section 41(3)(c) of the NHI Act).

222.5.2 Public ambulance services are to be reimbursed through the provincial equitable share (section 35(4)(c) of the NHI Act).

222.6 Accredited and contracted primary health care providers and health establishments are to be reimbursed according to a capitation strategy (section 41(3)(a) of the NHI Act).

222.7 Capitation is where providers are paid a fixed amount for a specific period of time, per head of the population. The amount is risk-adjusted for the make-up of the enrolled beneficiaries (age and sex, plus burden of disease or epidemiological profile).

222.8 Capitation systems promote financial protection by pooling risk. It incentivises efficiency as well as the provision of preventative and health-promoting care as it is cost effective for primary health care providers and establishments to keep their patients healthy rather than treat them when they are ill.

223 Under section 10(1)(f) of the NHI Act, the Fund must establish mechanisms and issue directives for the regular, appropriate and timeous payment of health care

service providers, establishments and suppliers. It must determine the payment rates annually in terms of section 10(1)(g) of the NHI Act.

224 There are several mechanisms in the NHI Act to constrain perverse incentives from the various provider payment methods applied. These include the bottom-up accountability mechanisms or complaints systems as well as the enforcement of performance requirements that are explicit in contracts between the Fund and health care providers. I address these issues further below.

225 What is envisaged under the NHI Act is a transformation of the pricing system that will ensure the sustainability of both the public and private sectors, as both will be funded by the Fund (for the private sector that opts to be accredited and contracted). This change in price regulation is not an arbitrary step; it is meant to stabilise the health system and ensure services are provided and funded. If nothing is done, the system will crash because people cannot afford to pay for services.

Primary health care model

226 The NHI Act accords with the focus on primary health care that is embodied in the normative framework for UHC. This will assist in reducing the cost of health care, and improving people's overall health with a shift to preventative rather than curative care and hospital-centric care.

227 A focus on preventative and health promotive services at the primary health care level has been shown internationally (particularly in middle-income countries) to support affordability and sustainability of UHC.[12]

[12] See also the affidavit of Prof McIntyre at paragraph 92.

228 This is facilitated in the NHI Act in the following ways, namely:

228.1 Under section 7(2)(d) of the NHI Act, adherence to the referral pathways is required. This means that, except in an emergency, the user must first access health care services at the primary health care level and cannot go directly to a specialist health care provider outside of the recognised referral pathways.

228.2 While this will ensure that people who need specialist care can access it equitably, it will also ensure that interventions that do not require specialist services are performed at the primary health care level in the most cost-effective and efficient way. An example is that users will not need to see a specialist gynaecologist for a routine pap smear. This can be performed by a GP or primary care nurse as effectively but at a significantly reduced cost.

228.3 Health care service providers and establishments must adhere to the referral pathways in order to be accredited under the NHI Act (section 39(2)(c)(iv) of the NHI Act).

The health information platform

229 In order for strategic purchasing to yield greater efficiency and equity, NHI requires a health information system that allows for data to be collected and used to inform purchasing decisions.

230 The framework for this is established in the NHI Act, as follows:

230.1 Section 34 requires that the Fund contributes to the development and maintenance of the national health information system as contemplated in section 74 of the National Health Act 61 of 2003 ("**NHA**").

230.2 The Fund must further establish an information platform in terms of section 40(1).

230.3 Under section 5, the framework is established for the registration of NHI users. Unlike in private health care settings where people register or fill out a form with each individual GP or specialist, a user will only have to register once with the NHI. All of this data will go into the health information system.

230.4 The NHI Act protects the confidentiality of users' information and prevents unsanctioned third-party disclosure, as per section 40(4).

230.5 Section 39 further deals with the accreditation of health care service providers and establishments. All of this data will also go into the health information system.

230.6 Health care service providers and establishments are required to submit information to the national health information system in order to be accredited by the Fund (section 39(2)(c)(v)) and must submit information to the Fund as may be prescribed, taking into account the provisions of the Protection of Personal Information Act 4 of 2013 ("**POPIA**") (section 40(2)).

231 The NHI Act embeds the strategic use of information systems into the Fund's decision-making and processes. This serves several functions, including,

231.1 In terms of section 40 of the NHI Act, the Fund is required to use its information platform to enable it to make informed decisions on population health needs, financing, purchasing, patient registration, service provider contracting and reimbursement, utilisation patterns, performance management, setting the parameters for the procurement of health goods, and fraud and risk management.

231.2 In section 10(1)(i) of the NHI Act, the Fund is obliged to collate utilisation data and to implement information management systems to assist in monitoring the quality and standard of health care services and supplies that it purchases. Health care providers and establishments in turn are required under section 39(2)(c)(v) to submit information to the national health information system to enable performance monitoring and evaluation.

231.3 Under section 10(1)(j) of the NHI Act, the Fund must develop and maintain a service and performance profile of health care service providers, establishments and suppliers.

231.4 Under section 10(1)(l) of the NHI Act, the Fund is required to monitor health care service providers', establishments' and suppliers' registration, license and accreditation statuses.

231.5 In terms of section 10(1)(q) of the NHI Act, the Fund must maintain a national database on the demographic and epidemiological profile of the population.

231.6 Section 11(1)(i) and (j) of the NHI Act empowers the Fund to identify develop, promote and facilitate the implementation of best practices and to undertake or sponsor health research.

231.7 The unified health information system further enables patients to enjoy the seamless portability of their health care services and continuity of care wherever they may be in the Republic (section 39(2)(c)(v) of the NHI Act). This is something that no person enjoys in today's health care system, whether they access health care in public or private facilities.

232 A seamless portability of health information through a single patient record will improve continuity of care between health care providers, will improve efficiency, and will reduce wasteful and unnecessary testing, investigations and care. It will ultimately make life easier for health care users who will no longer have to keep copies of medical records or remember all aspects of their medical histories from birth. There will no longer be a risk of lost records or challenges with users who access care in different provinces. Every person will enjoy mobile health records that are digitised and secure.

233 Dr Kutzin explains in paragraph 25.1.1 of his affidavit, that the active use of international evidence, systems-wide data and evaluations to inform the implementation of health policy and policy adjustments is one of the WHO's desirable attributes of health financing for UHC. Based on his international experience, Dr Kutzin, at paragraph 33.3 of this affidavit, considers it important that mechanisms for paying providers increasingly incorporate data on their performance and the health needs of the populations they serve, while managing overall expenditure growth by operating within a budget.

234 The NDoH has made considerable progress already to build the architecture on which all information systems will be managed to allow for users' health records to be stored and made accessible everywhere, and for the Fund to collect and analyse data to inform decision-making under the NHI Act.

235 To operate effectively, the health information system will need to capture information about health care users, facilities, providers, services, and costs.

236 The system to capture information about health care users has already been developed through the Health Patient Registration System ("**HPRS**"). This system currently includes about 66 million records of about 35 million users across 3,219 public health facilities. Testing is underway for the use of biometric user identity verification.

237 The system to capture information about facilities has been developed through the Master Health Facility List ("**MHFL**"). The MHFL covers some 51,131 establishments in both the public and private sectors, including hospitals and community-based health service points.

238 The conceptual design of the system to capture information about health care providers, the Provider Registry ("**PR**") has been completed. Its development and rollout will be completed in the next financial year.

239 The development of the system to capture health service information is underway for Clinical Diagnostic Procedural and Medicine Coding. The National Health Council has approved the transition to the coding system.[13]

[13] See Regulation No. 314 in GG No. 37583 dated 23 April 2014.

240 Finally, benefit pricing will be linked to payment methods described above. The health information platform will draw from pricing tables and link to, for example, the DRG codes or capitation contracts to make payments.

Responsiveness and accountability

241 The Fund is subject to several transparency and accountability measures, which include the following:

241.1 First, the Fund is a statutory body, the powers and functions of which are limited to, and governed by, the NHI Act. Amongst many other things, this includes the requirement under section 11(2)(c) of the NHI Act that it conducts its business in a manner that is consistent with the best interests of users.

241.2 Second, section 6(l) of the NHI Act further acknowledges the reviewability of the Fund's decisions.

241.3 Third, a Board of 11 persons governs the Fund under Chapter 4 of the NHI Act. The Board is appointed by the Minister in terms of the NHI Act through a process requiring public nominations, and interviews and recommendations conducted by an *ad hoc* advisory panel. Board members are appointed for a period of five years and required to have appropriate technical expertise, skills and knowledge under section 13(5) of the NHI Act.

241.4 Fourth, the Fund's Board is required to submit to the Minister and Parliament a report on its activities for each financial year as determined by the Public Finance Management Act (section 51(1) to (3) of the NHI

Act). A copy of this report must be tabled in the National Assembly and the National Council of Provinces by the Minister (section 51(4) of the NHI Act).

241.5 Fifth, the Fund's CEO is appointed in terms of Chapter 5 of the NHI Act to be the administrative head of the Fund. They are directly accountable to the Board in terms of section 20(1)(a) of the NHI Act. The CEO reports to the Board on a quarterly basis and to Parliament on an annual basis in terms of section 20(1)(d) of the NHI Act. They must further submit to the Board an annual report of the Fund's activities each financial year (section 20(5) of the NHI Act).

241.6 Sixth, the Fund is accountable to the Minister on the performance of its functions and exercise of its powers under section 10(1)(m) of the NHI Act.

241.7 Seventh, the NHI Act establishes a complaints mechanism in section 42 of the NHI Act.

241.8 Eighth, in terms of section 11(1)(h) of the NHI Act, the Fund is empowered to investigate complaints against itself, health care service providers, health establishments and suppliers.

241.9 Ninth, under sections 7(5) of the NHI Act, if the Fund refuses to fund a health care service, it must give notice of the refusal to the user, provide them with a reasonable opportunity to make representations, consider those representations, and provide adequate reasons for its decision.

241.10 Tenth, users may request written reasons for any of the Fund's decisions under section 6(j) of the NHI Act and are entitled to lodge an appeal against Fund decisions under section 43 of the NHI Act. An Appeal Tribunal is established under section 44 of the NHI Act. It may confirm, vary, or set aside the relevant decision of the Fund or order that the Fund's decision be effected (section 45(2) of the NHI Act).

241.11 Eleventh, under section 10(1)(n) of the NHI Act, the Fund is obliged to undertake internal audit and risk management.

241.12 Twelfth, under section 50 of the NHI Act, the Auditor-General is required to audit the Fund's accounts and records annually.

241.13 Thirteenth, the Fund is required under section 10(1)(o) of the NHI Act to undertake research monitoring and evaluation of its impact on national health outcomes.

241.14 Fourteenth, a Stakeholder Advisory Committee will be comprised of representatives from statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers, as well as patient advocacy groups (section 27 of the NHI Act).

241.15 Fifteenth, the NHI Act preserves users' right to access information or records relating to their health that are kept by the Fund under section 6(c) of the NHI Act and users' right to information on the funding of health care services in the Republic under section 6(n) of the NHI Act.

241.16 Finally, the delegation of management authority to District Health Management Offices ("**DHMOs**") and hospital level will improve local accountability structures as confirmed by Prof McIntyre. I address these operational management issues further in the subsection to follow.

242 The NHI Act's removal of user fees at point of service will create transparency about entitlements.[14]

243 Further, as Dr Kutzin points out –

243.1 transparent financial and non-financial accountability in relation to public spending on health is one of the WHO's desirable attributes of health financing for UHC;[15]

243.2 the NHI Act is in line with international practice in terms of accountability provisions of autonomous public entities, balancing the expertise and flexibility required by such agencies with public accountability mechanisms.[16]

Quality assurance

244 There are several ways in which the NHI Act seeks to ensure and improve the quality of health care services:

244.1 **Accreditation**: The Fund may only pay health care service providers and establishments that are accredited in terms of the NHI Act. In order

[14] See also in this regard the affidavit of Prof McIntyre at paragraph 85.1.

[15] See paragraph 25.1.2 of his affidavit.

[16] See paragraph 53 of his affidavit.

to become accredited, service providers and establishments will need to meet several criteria under section 39(2) of the NHI Act, including prior certification by the Office of Health Standards Compliance.

244.2 Accreditation must be renewed every five years on the basis of compliance with the legislated criteria (section 39(7) of the NHI Act).

244.3 The Fund may also withdraw or refuse to renew accreditation if it is proven that the health care service provider or establishment (amongst others) delivers services of an unacceptable quality, infringes any code of health-related ethics or law, or fails to adhere to treatment protocols and guidelines (section 39(8) of the NHI Act).

244.4 **Contracting**: The NHI Act requires that the Fund concludes binding contracts with accredited health care service providers and establishments which contain a clear statement of performance expectation and need in respect of management of patients, the volume and quantity of services delivered and access to services (section 39(4) of the NHI Act). Performance must be monitored and evaluated and appropriate sanctions must be applied where there is deviation from contractual obligations (section 39(6) of the NHI Act).

244.5 **Payment**: In terms of section 10(1)(k) of the NHI Act, the Fund must ensure health care service providers, establishments and suppliers "*are paid in accordance with the quality and value of the service provided at every level of care*". The Minister is specifically empowered to make regulations to provide that payments are made on condition of compliance with quality standards of care or the achievement of

specified levels of performance and that whole or any part of payment be subject to the fulfilment of contractual conditions (section 41(4)(a) and (c) of the NHI Act).

244.6 Payment of compliant invoices will be within 30 days. This is provided for in Treasury Regulation 8.2.3 issued in terms of the Public Finance Management Act, 1999. Systems are being designed to automate processes pertaining to invoice verification and payment.

244.7 **Standard treatment guidelines and the formulary**: The NHI Act requires adherence by health care providers and establishments to treatment protocols and guidelines and further requires them to prescribe medicines and procure health products from the formulary (section 39(2)(c)(iii) of the NHI Act).

244.8 **Operational management**: The NHI Act requires certain changes to the operational management of service delivery. This is done through several provisions of the NHI Act:

244.8.1 Section 7(2)(f) provides for changes to the operational management of central hospitals.

244.8.2 Section 32(2)(b) provides for the designation of provincial tertiary and regional hospitals or groups of hospitals as semi-autonomous legal entities.

244.9 Section 32(2)(c) of the NHI Act provides for the establishment of DHMOs as government components to manage personal and non-

personal health care services. Their functions are further detailed in the Schedule to the NHI Act stipulating the amendments to the NHA.

244.10 Section 37 of the NHI Act establishes the Contracting Units for Primary Health Care ("**CUPs**"). This comprises district hospitals, clinics or community health centres and ward-based outreach teams and private providers organised in horizontal networks within a specified geographical sub-district area.

244.11 The CUPs will assist the Fund in various ways as set out in section 37(2) of the NHI Act.

245 All these various ways in which the NHI Act seeks to ensure and improve the quality of health care services will enable health care providers and facilities to be responsive to the strategic purchasing incentives and population health needs, and to ensure that they are accountable for their performance.[17]

246 Further, this will contribute to efficient service delivery and improved cost-effectiveness. Importantly, because the STGs, the Formulary and essential drug lists are evidence-based, it will improve the quality of care and enable better monitoring of treatment standards across both the public and private sectors.[18]

[17] See also in this regard the affidavit of Prof McIntyre at paragraph 78.

[18] See also in this regard the affidavit of Prof McIntyre at paragraph 79.4.

The reduced role of voluntary health insurance

247 The reduced role of voluntary health insurance is a critical aspect of the design of the NHI Act. It will simply not be possible to reap the efficiency and equity gains of a single-payer pooled system of health care financing if the role of VHI is not changed.

248 "*Complementary cover*" is defined in section 1 of the NHI Act as third party payment for personal health care service benefits not reimbursed by the Fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund.

249 Users may therefore continue to belong to a medical scheme. But medical schemes will only be able to cover health care benefits that are not "*reimbursable*" by the Fund.

250 Section 6(o) of the NHI Act protects the right of users to purchase health care services that are not covered by the Fund through a complementary voluntary medical scheme. Under section 33 of the NHI Act, once the NHI Act has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer "*complementary cover*" for services that are not reimbursable by the Fund.

251 Medical schemes would therefore be permitted to cover those health care services and supplies that are not part of the health care service benefits and types of services that have been determined by the BAC to be covered by the Fund in terms of section 25(5) of the NHI Act.

252 Medical schemes may also cover health care services and supplies that the Fund has refused to pay for in terms of section 7(4) of the NHI Act. That is to say, the service or supply is deemed by the Fund not to be medically necessary, there is no cost-effective intervention, or where the product or treatment is not provided for in the formulary or the complementary list approved by the Minister.

253 As Dr Kutzin explains at paragraph 26 of his affidavit, the UHC objectives of equity in the distribution of health system resources and service use by maximising redistributive capacity, as well as equity in funding the health system by raising revenues predominantly through public funding, imply that the financial role of voluntary health insurance should be reduced.

Phased implementation

254 The NHI Act will enable significant reform of the health financing system in South Africa. In order to do so responsibly, it is necessary that those changes be implemented in a progressive manner that allows for a measure of flexibility so that the system can be adapted to be responsive to change and lessons learned.

255 Section 57 of the NHI Act therefore requires that the NHI Act be implemented in two phases in a progressive and gradual manner.

256 Section 57(1)(b) of the NHI Act makes clear that the gradual implementation will be based on financial resource availability.

257 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 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.

258 There will be a period when both the Fund and medical schemes are permitted to cover similar services before the Minister declares the NHI Act to be fully implemented. This will be a necessary part of the process to protect health care users from being without cover during the process of moving from medical schemes to the Fund.

259 While the implementation of the NHI Act is yet to commence at the time of signing of this affidavit, aspects of the system are being piloted to inform implementation.

260 Between 2012 and 2017, the NDoH's NHI Programme piloted various health-strengthening interventions focused at the primary health care level across ten districts. There are also nine CUP sites where aspects of operational management systems, the primary health care model and capitation systems are being researched in practice. The successes and challenges of these processes have assisted to develop recommendations that will inform future steps geared towards implementation.

Conclusion on the necessity of NHI

261 The State is obliged ethically, morally and legally to reform the health care financing system to ensure more people in South Africa can access the quality health care that they need, to improve equity and equality, and to protect people from financial hardships.

262 These duties include the obligation to fix the problems in the private and public health care sector. The private sector has externalities that negatively impact the health care system as a whole. It is also to protect current users of the private health care sector who face a future where the affordability and efficacy of medical scheme coverage is declining and to ensure that users in the public health care sector have access to quality health care services without needing to worry about finances.

263 The NHI Act is a reasonable and rational legislative intervention that is designed to meet the State's duties in these respects. Its design is neither arbitrary nor rushed. It is the product of more than 20 years of policy development, consultation, research and work. It is informed by the best available evidence and international best practice. It is also calibrated to confront the unique problems that the South African health care system faces.

264 The implementation of the NHI Act will transform South African society. It will improve lives and grow the economy.

265 Middle income countries that have implemented NHI have benefited economically from a healthier population. International evidence demonstrates that a properly implemented NHI in countries such as Turkey, Brazil, Costa Rica, Thailand and South Korea, has resulted in significant and sustainable economic and social benefits. These benefits include having a healthier population, which in turn translates into a more productive and effective workforce that grows local business, attracts foreign investors and grows the domestic economy.

266 It must be recognised that the reforms that are required to implement NHI will necessarily raise conflict with those who have vested interests in retaining the inequities and inequalities of the current system, particularly those who profit enormously from the inefficiencies of the public sector and wastefulness of the private sector. This does not mean that the NHI Act is unlawful, unconstitutional or unreasonable.

267 As Dr Kutzin points out on the basis of his international experience, the NHI Act embodies the "*key drivers of progress*" towards UHC and "*the NHI Act is a reasonable measure designed to achieve the progressive realisation of UHC*", to "*address the problems with the current system of financing*" of health care in South Africa and particularly to *"act as a corrective measure against entrenched inequalities*" in health care financing.[19]

268 And, as Prof McIntyre explains on the basis of her 40 years' experience as a health economist, *"the design of the NHI Act is fully in line with lessons from international experience on how to ensure affordability and sustainability of UHC*". She says that NHI "*will address key problems with the current South African health system", and that it will "promote equity and efficiency*".[20]

[19] See affidavit of Dr Kutzin at paragraphs 35, 50.1 and 79.

[20] See the affidavit of Prof McInyre at paragraphs 93 and 97.

V THE GROUNDS OF SOLIDARITY'S CONSTITUTIONAL CHALLENGE

269 In this section, I address the grounds on which Solidarity challenges the NHI Act's constitutionality. Insofar as my response includes submissions of law, I reserve the right to supplement or modify them in written and oral argument.

The feasibility of NHI

270 Part E of Solidarity's founding affidavit is entitled "*The NHI Act is not Feasible*". It should at the outset be pointed out that feasibility or financial feasibility is not a basis for a constitutional challenge to a law. The assessments required in determining feasibility are policy-laden and polycentric in nature, far beyond the capabilities and legitimate constitutional boundaries of judicial intervention.

271 Solidarity argues that the NHI Act fails constitutionally because there is no rational relationship between the scheme adopted under the NHI Act and the achievement of a legitimate government purpose.

272 The thrust of Solidarity's argument is (a) that the feasibility and sustainability of the scheme is dependent on a money bill which is yet to be introduced and (b) that all evidence has shown that the NHI is, in any event, not feasible. Therefore the adoption of the NHI Act without a sustainable funding model, confirming the sufficiency of resources, cannot achieve a government purpose and is irrational and unreasonable.

Legislative overview

273 In paragraph 90 of its founding affidavit, Solidarity argues against the promulgation of the NHI Act, absent a money bill.

274 Section 213 of the Constitution provides that all money received by the National Government must be paid into the National Revenue Fund. Withdrawal from the National Revenue Fund is only permitted in terms of an appropriation by an Act of Parliament or through a direct charge against the National Revenue Fund, when it is provided for in the Constitution or an Act of Parliament.

275 That Act of Parliament is commonly known as a money bill. According to section 77(1) of the Constitution, a bill is a "*money bill*" if it: (a) appropriates money; (b) imposes national taxes, levies, duties, or surcharges; (c) abolishes or reduces, or grants exemptions from, any national taxes, levies, duties or surcharges; or (d) authorises direct charges against the National Revenue Fund, except a Bill envisaged in section 214 authorising direct charges. Only a money bill can address these and related matters.

276 Section 77 of the Constitution also establishes a special procedure for the passage of money bills. These are ordinarily passed according to the procedure in section 75 of the Constitution which deals with ordinary bills not affecting the provinces. Only the Minister of Finance can introduce money bills and an Act of Parliament is required to establish a procedure to amend money bills.

The NHI Act

277 Chapter 10 of the NHI Act regulates financial matters. Section 48, "*Sources of funding*", states that:

> *"The revenue sources for the Fund consist of—*
>
> *(a) money to which the Fund is entitled in terms of section 49;*
>
> *(b) any interest or return on investment made by the Fund;*

(c) *any money paid erroneously to the Fund which, in the opinion of the Minister, cannot be refunded;*

(d) *any bequest or donation received by the Fund; and*

(e) *any other money to which the Fund may become legally entitled."*

278 Section 49 of the NHI Act, *"Chief source of income"*, provides that:

"(1) The Fund is entitled to money appropriated annually by Parliament in order to achieve the purpose of the Act.

(2) The money referred to in subsection (1) must be—

(a) appropriated from money collected and in accordance with social solidarity in respect of—

(i) general tax revenue, including the shifting of funds from national government departments and agencies and the provincial equitable share and conditional grants into the Fund;

(ii) reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance;

(iii) payroll tax (employer and employee); and

(iv) surcharge on personal income tax, introduced through a money Bill by the Minister of Finance and earmarked for use by the Fund, subject to section 57; and

(b) calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act.

(3) Once appropriated, the revenue allocated to the Fund must be paid through a Budget Vote to the Fund as determined by agreement between the Fund and the Minister and subject to the provisions of the Constitution and the Public Finance Management Act."

279 Section 57(1) of the NHI Act provides that:

"(a) Despite anything to the contrary in this Act, this Act must be implemented over two phases.

(b) *National Health Insurance must be gradually phased in using a progressive and programmatic approach based on financial resource availability."*

280 Solidarity's argument is misplaced for the following reasons:

280.1 Parliament, as a matter of ordinary practice, appropriates money each year to all government agencies through an Appropriation Act, which is a money bill. For example, the Appropriation Act 40 of 2024 was enacted to appropriate money from the National Revenue Fund for the requirements of the State for the 2024/25 financial year. The Appropriation Act 40 of 2024 also prescribes conditions for the spending of funds withdrawn for the 2025/26 financial year before the commencement of the Appropriation Act for the 2025/26 financial year, and provides for incidental matters. A copy of the Appropriation Act 40 of 2024 is attached marked "**PAM4**", together with that part of Schedule 1 that deals with Vote 18 appropriating funds for Health.

280.2 Parliament further determines how these monies will be used in terms of the detail of the budget votes adopted by Parliament as well as other instruments such as the annual Division of Revenue Act ("**DORA**"). The DORA is also a money bill. In line with section 214 of the Constitution, the DORA forms a key link in the intergovernmental fiscal system and is annually legislated to provide for the equitable sharing of nationally raised revenue between national, provincial and local spheres of government. The DORA is published by National Treasury and is annually amended in line with fiscal policy developments for each Medium-Term Expenditure Framework period.

281 It is wrong for Solidarity to critique the NHI Act because there is no money bill. The NHI will be funded like all other government agencies i.e. through annual money bills. For these reasons, the complaint that there is no money bill fails out of the gate.

282 The NHI is already provided for in the National Health Budget. The recently published Vote 18 on the National Health Budget makes financial provision for current and future expenses related to the NHI. The Budget identifies the NHI as an ongoing focus area. For 2024/25, the national Parliament appropriated a budget of R62,219 million for the NDoH. R56,351 million of this amount consisted of transfers to provinces and municipalities (essentially conditional grants), leaving only the difference for national sphere direct spending. The NHI programme within the National Department was allocated R1,344 million, 2% of the total departmental budget. The allocation to the NHI is relatively small, but that is entirely appropriate to the stage of its implementation, bearing in mind that the NHI Act has yet to be brought into effect by the President in terms of section 59.

283 The inclusion of the NHI in the health budget, which is allocated and distributed in terms of the DORA, lays to rest the claims by Solidarity about the susceptibility of the NHI Act to challenge due to the absence of a money bill.

284 I also refer this Court to the expert affidavit of Dr Budlender where she explains in detail:

284.1 the appropriation of funds through the Appropriation Act (paragraphs 12 to 16 of her affidavit);

284.2 the distribution of the National Health Budget across national, provincial and municipal spheres (paragraphs 17 to 38 of her affidavit); and

284.3 the checks and balances that are built into the fiscal process and that promote accountability in the utilisation of public funds (paragraphs 39 to 46 of her affidavit).

285 In summary, the argument raised by Solidarity fails to appreciate the scheme of the NHI Act or the scheme of Chapter 13 of the Constitution whereby financial appropriations are budgeted for and made in the ordinary course for all organs of State and legislative entities. It also assumes, without more, that the absence of a money bill is a death knell for the NHI Act. That argument is wrong.

Rationality

286 In paragraphs 106 to 124, Solidarity argues that the NHI Act is irrational. This argument is closely tied to the complaint that is based on the absence of a money bill. Once the "*money bill*" argument falls away, the claim of irrationality and unreasonableness must fail for the same reasons.

287 Solidarity argues that the NHI Act is irrational because the stated purpose of the NHI Act is to achieve universal access to quality health care but that the scheme adopted in the NHI Act cannot achieve that purpose. Solidarity contends that in the absence of adequate funds (as evidenced in a money bill), the NHI Act is irrational.

288 I have explained above that NHI will be funded like all other government agencies i.e. through a money bill passed in the ordinary course.

289 The purpose of the NHI Act is the progressive realisation of the right to health care. This is a legitimate and rational purpose. That purpose will be realised through the legislative framework created by the NHI Act. The scheme of the NHI Act is detailed in a previous section of my affidavit and is plainly rational. In circumstances where provision has been made in the budget of the NDoH for the necessary resources to be deployed towards the implementation of the NHI Act, the NHI Act cannot be said to be irrational.

290 I emphasise that whilst Solidarity may disagree with the manner in which the NHI Act seeks to realise the right to health care, that does not make out a case for irrationality or any other legitimate ground for constitutional challenge, for that matter.

291 The further claim by Solidarity is that the NHI will not secure the support of private health facilities and health care providers and that the NHI Act is unsustainable and irrational in the result. This is based on the assumption that the medical profession will defy a law duly passed by Parliament and binding on those to whom it applies. This is no basis for a constitutional challenge, as will be elaborated upon in argument.

292 A rationality challenge tests whether there is a rational relationship between the purpose sought to be achieved and the means chosen to achieve the purpose. Under that test, the executive and legislature are given a very wide leeway in determining the means that are chosen and it does not matter if a court might have chosen a different means. The purposes sought to be achieved by the NHI Act include universal health coverage, access for all to quality health care services and products for free and according to need, the removal of inequity,

including racial and other forms of inequity in the health care system and the prevention of exposure of individual users of the health system to detrimental impact upon their personal finances. If regard is had to the affidavits of Professor McIntyre and Dr Kutzin, it is clear that the means chosen to achieve those entirely legitimate purposes, being the NHI Act, are rationally related to the purposes sought to be achieved and consistent with international best practice.

293 In conclusion, the rationality challenge is without merit.

Reasonableness

294 Solidarity argues that the NHI Act is unreasonable. Solidarity claims that the question of reasonableness requires a consideration of the available resources and that the Fund does not have sufficient funding available to it. As a starting point, I dispute that a constitutional challenge to a statute may be based on the ground of unreasonableness. I will nevertheless assume for purposes of the submissions that follow that it is a ground theoretically available in the context of a law affecting socio-economic rights in section 27(1) of the Constitution.

295 Against that backdrop, Solidarity's reasonableness argument is misguided for several reasons.

296 First, and based on the assumption referred to, Solidarity has failed to prove that the NHI Act is not feasible.

297 Second, the Constitutional Court has held that a wide latitude is given to the State in determining its social and budgetary priorities. A Court must be slow to interfere with rational decisions taken in good faith by the political organs and

medical authorities whose responsibility it is to deal with them. The passing of the NHI Act is precisely such a decision.

298 The mere fact that Solidarity disagrees with the scheme adopted by the government or disagrees with the idea of an NHI does not render the NHI Act unreasonable.

299 Third, our courts have provided ample guidance on what is a reasonable government programme in the context of socio-economic rights. A reasonable programme is one that is comprehensive and coordinated; capable of facilitating the realisation of the right, reasonable in both conception and implementation; and balanced and flexible and capable of responding to emergency situations.

300 The NHI Act satisfies these requirements. It provides a scheme for the administration of the NHI, which progressively realises the right to health through the marshalling of a single pool of resources administered by the Fund. The Fund will then implement these aims in accordance with regulations (that will be passed in due course). The level of detail in the NHI Act and provision for implementation-related aspects to be regulated provide precisely for the required balance, flexibility and responsiveness to new evidence regarding disease and its treatment, changing technology and emergency situations.

301 Fourth, Solidarity's reasonableness complaint mischaracterises the financing of government projects. In particular, it doesn't appreciate the budgeting process as I have explained above.

302 In practice, the NDoH prepares a budget first and receives funds from National Treasury based on the budget afterwards. The budget precedes the provision of funds. An argument that an Act must be fully costed and receive all the costs necessary for its implementation upfront before it is promulgated is illogical and bizarre, to say the least. No Act would survive constitutional scrutiny if Solidarity's "*money bill*" argument was upheld.

303 As I have said above, the NHI Act provides for staggered implementation based on available resources. Its implementation will be properly budgeted for annually according to its need and funds appropriated to it.

304 Section 27(2) of the Constitution refers to the duty to take legislative measures, within available resources, to achieve the progressive realisation of the rights in section 27(1) thereof. The Constitution contemplates that certain rights cannot be realised immediately. Section 27(2) of the Constitution requires that access to health care should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, improved over time.

305 The rollout of the NHI Act is intended to be gradual and therefore any assessment of feasibility must consider what the object of the Fund is at that time and the resources available to it at that time. Because the scheme is not implemented all at one go, but uses a phased approach, the feasibility and sustainability of the Fund must also be considered in light of that prevailing reality.

306 In this regard, I endorse what Dr Kutzin says in his affidavit at paragraphs 60 to 62, which may be summarised as follows:

306.1 Costing specific steps in the implementation process of NHI can be valuable. An example would be cost accounting to set provider payment rates under NHI. Another example would be costing specific investments such as new information systems.

306.2 The process of costing must, however, not be considered as a once-off but rather an ongoing exercise. Doing it on an ongoing basis as implementation proceeds is valuable because it takes into account new efficiencies achieved over time and allows for ongoing performance improvement processes. A once-off accounting exercise is of little value for the health system.

307 Dr Kutzin concludes as follows:

> *"In these circumstances, there was nothing inappropriate on the part of the South African legislature in introducing legislation that provides for well-established mechanisms for reducing the cost and improving the efficiency of the delivery of health care, providing in it for a phased implementation and allowing for costing to operate on an ongoing basis aligned with the budget cycle and the medium term expenditure framework, not on a single point estimate of the future cost of NHI".*

308 Extensive costing processes, as envisaged by Dr Kutzin have been undertaken and are ongoing on a continuous basis to plan for and implement NHI progressively and step-by-step. I refer in this regard also to the supporting affidavit of Prof Nicholas Crisp.

309 What Solidarity wants – to attach a once off price tag to NHI as a whole – is of little value. The very objective of the NHI Act is to change the cost structure and service delivery patterns that drive expenses in the health care system. Any

costing that used current or historical unit pricing would therefore fail to account for the efficiencies NHI is designed to achieve on a progressive basis. Trying to attach a single price to the entire NHI at any particular time will inevitably be inaccurate and misleading.

310 It is also inevitable that the pace at which NHI will be phased in, and the design of the benefit package, will need to be aligned with the available budget at the relevant time. Solidarity's costing approach is premised on a false assumption that NHI would simply be turned on overnight. Its argument, to an extent, also puts the cart before the horse. The available budget will necessarily determine the extent and pace of implementation.

311 Dr Budlender in paragraph of her affidavit also discusses this. Dr Budlender in paragraph 54 of her affidavit also discusses this. She notes that the Davis Tax Commission records that an accepted way of avoiding unaffordable costs while the rollout is still in progress is specifying the package of services that will be available. The package can then be expanded as more resources become available. Again, section 57(1)(b) of the NHI Act allows for this approach, involving reasonable, progressive implementation.

312 Prof Mcintyre in paragraph 93 of her expert affidavit states that the design of the NHI in the NHI Act is fully in line with lessons from international experience on how to ensure affordability and sustainability of UHC.

313 She explains, in simple terms, that the Fund will be funded through annual allocations from Treasury, and will, as the strategic purchaser, have to operate within the constraints of that pool of funds.

314 Further at paragraph 96 of her expert affidavit, Prof McIntyre explains that it is neither possible nor advisable to attempt to estimate the "*full cost*" of the NHI. Instead, the emphasis in any costing efforts should be on obtaining accurate cost data for each new phase of roll-out to allow careful budget impact analysis before implementation.

315 This approach is fully in line with the constitutional requirement in section 27(2) of the Constitution for the State to take reasonable legislative and other measures, within its available resource to achieve the progressive realisation of the right to have access to health care services.

The vagueness complaint

316 Solidarity complains that the NHI Act is vague.

317 In paragraphs 10 and 135 to 143 of the founding affidavit, Solidarity claims that the vagueness offends the rule of law in section 1 of the Constitution. It alleges that (a) the NHI Act "*fails at the first constitutional hurdle because the scheme that is created under the NHI Act is vague*" and reads like a policy document; and (b) specific features and sections of the NHI Act are also vague and uncertain.

318 Solidarity's argument does not hold water. Its claim of vagueness fails to meet the test for vagueness, both concerning the scheme of the NHI Act and concerning the specific sections. I address this in turn.

Test for vagueness

319 I am advised that the Constitutional Court has considered and established principles for determining whether a law is vague. These principles are as follows:

319.1 The rule of law requires that law must be written in a clear and acceptable manner; what is required is not perfect lucidity and absolute certainty but reasonable certainty.

319.2 The law must indicate with reasonable certainty to those who are bound by it, what is required of them so that they may regulate their conduct accordingly.

319.3 Mere shoddy draftsmanship, imprecision and opacity are not in themselves conclusive. To reach a point of a constitutionally fatal level of vagueness the provision must be utterly meaningless and unworkable, applying the ordinary rules of interpretation.

319.4 Flexibility and vagueness are not synonymous. The doctrine of vagueness must recognise the role of government to pursue legitimate social and economic objectives and should not be used unduly to impede the furtherance of such objectives by requiring a degree of precision or specificity to which the subject matter does not lend itself.

319.5 There is some intrinsic worth in laws being framed in general terms. A measure of generality and relative breadth may be necessary for the State to bring about effective regulation so as to combat the social concerns that the law seeks to address. For this reason, a very detailed

enactment might not provide the required flexibility and may obscure the legislative purposes behind a veil of detailed provisions.

320 Solidarity's complaint does not meet the test for unconstitutional vagueness.

321 The scheme of the NHI Act is not vague. To the extent that there is a measure of generality in the NHI Act, with certain aspects being left to regulation, this is reasonable and necessary taking into account the subject matter and purpose of the NHI Act.

322 Solidarity's argument on vagueness stems from its miscomprehension of the NHI Act. Solidarity has adopted a piecemeal and isolated reading of the NHI Act. It reads the NHI Act as a singular and standalone law, divorced from other relevant and complementary legislation, including anticipated delegated legislation.

323 In doing so, Solidarity fails to apply trite canons of interpretation that the NHI Act must be read as a whole and in conjunction with other laws, including the Constitution and the NHA; the Medicines and Related Substances Act, 1965; the Health Professions Act, 1974; the Allied Health Professions Act, 1982; the Nursing Act, 2005, the Medicines and Related Substances Control Act, 1965, and the Medical Schemes Act, 1998.

324 The NHI Act is clear in its purpose (section 2), which is the establishment of a Fund to achieve sustainable and affordable universal access to quality health care services. It is geared to work towards the realisation of substantial, systemic reform in the funding and provision of health care services and to address prevailing inequalities in accessing health care services.

325 The NHI Act is clear in its application (section 3) and population coverage (section 4). It details who is covered and excluded from the ambit of the NHI Act. It sets out succinctly that users must register to receive health care services (section 5) and that these users would then have several rights, including the right to receive necessary quality health care services free at the point of care from an accredited health care service provider or health establishment (section 6).

326 The scheme of the NHI Act is also clear. The NHI Act intends to administer health care services coverage (section 7), through the NHI Fund. The Fund's powers are listed in section 11 of the NHI Act and it has the primary purpose of taking necessary steps to achieve the objectives of the Fund (section 12). The Fund is governed by a Board that is accountable to the Minister (section 12) and empowered to delegate some of its duties and powers to its committees (section 23) and the Minister may establish an advisory committee (section 25) to guide the work of the Fund.

327 Against this backdrop, Solidarity cannot demonstrate that the scheme of the NHI Act is on its face vague. Instead, the NHI Act provides reasonable certainty to those affected by its provisions, its sections are sufficiently clear for the realisation of the purposes of the NHI Act.

328 I am advised that the standard for vagueness is high. Solidarity has quite plainly failed to meet that requirement. And to the extent that there is any imprecision in the NHI Act, which is in any event denied, it does not rise to the level of being *utterly meaningless and unworkable*.

329 The NHI Act requires flexibility on certain issues. A large component of Solidarity's complaint is that the NHI Act reads like a policy document. It is not clear what exactly that means. Solidarity seemingly complains that several details concerning the work of the Fund aren't expressly detailed in the NHI Act. There is however no requirement for a statute to prescribe everything. A statute does not require perfect lucidity but reasonable certainty.

330 A cardinal component of the vagueness doctrine is that it must not be used to hamper the efforts of the State. The State should not be limited by the vagueness doctrine in its capacity to enact laws that seek to implement systemic social reforms, like those that motivate the NHI Act.

331 The NHI Act is unique in the nature of reforms it seeks to implement and appropriate in its design to do so progressively. It is an important step towards improving the dignity and health of all in South Africa.

332 For these reasons, some flexibility is required in the realisation of that purpose and in implementing its functions. This is particularly so, where certain provisions implicate clinical judgement in individual cases, and where the Fund must meet evolving public health care needs within the State's budget and in accordance with evidence-based interventions. Evidence-based interventions change over time with improved technology and scientific understanding.

333 Legislating these issues in greater detail would create a level of inflexibility that is ill-suited to realising the right to health.

334 To follow, I address in turn Solidarity's complaints against the vagueness of specific provisions of the NHI Act.

Section 3(4) of the NHI Act

335 Section 3(4) of the NHI Act provides:

> *"The Act does not in any way amend, change or affect the funding and functions of any organs of state in respect of health care services until legislation contemplated in sections 77 and 214, read with section 227, of the Constitution and any other relevant legislation have been enacted or amended".*

336 Solidarity complains that section 3(4) of the NHI Act is vague.

337 It argues that the term "*any other relevant legislation*" is broad and no certainty is provided on the extent of the requisite legislative enactment or amendment that would trigger the effect on the funding and functions of organs of State in respect of health care services.

338 Solidarity also claims that making the NHI Act dependent on the passage of a money bill means that it is uncertain when the NHI Act will be capable of full implementation, if at all.

339 These complaints are baseless for the following additional reasons.

340 Section 3(4) of the NHI Act plainly states that the NHI Act does not alter existing government budgeting and financing. It confirms that funding and functioning of organs of State will continue as per legislation in terms of sections 77, 214, and 227 of the Constitution and any other relevant legislation. The term "*any other relevant legislation*" means legislation that is germane to the NHI Act that has been enacted or amended. There is respectfully nothing vague about this provision.

341 Section 3(4) of the NHI Act must be read in conjunction with other sections of the NHI Act that regulate the transitional arrangements. Section 57 of the NHI Act deals with the two Phases of implementation from 2023 to 2026 and then from 2026 to 2028 respectively. Section 59 of the NHI Act provides that different dates may be set for when different sections of the NHI Act will come into effect. This will enable the phased approach of implementation to take place.

"Health care services" and "necessary quality health care services"

342 Solidarity says that health care services to be purchased fall to be determined by the BAC, with the definition of "*health care service*" in the NHI Act "*being so broad and vague as to almost render it meaningless*".

343 Solidarity further argues that the entitlement of "*users*" to "*necessary quality health care services*" further creates uncertainty as to who will be the adjudicator of whether health care services are "*necessary*".

344 But these claims are misguided.

345 The NHI Act defines "*basic health care services*" as follows:

> *"services provided by health care providers which are essential for maintaining good health and preventing health problems including preventative services, primary health care, emergency medical services, diagnostic services, treatment services and rehabilitative services".*

346 The term "*basic health care services*" is referred to in:

346.1 Section 28(1)(c) of the Constitution about the child's right to basic health care services, which provision is noted in the Preamble of the NHI Act.

346.2 Section 4(3) of the NHI Act, which provides that *"[a]ll children, including children of asylum seekers or illegal foreigners, are entitled to basic health care services as provided for in section 28(1)(c) of the Constitution."*

347 "*Health care service*" is defined in the NHI Act as:

> *"(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution;*
>
> *(b) basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution;*
>
> *(c) medical treatment contemplated in section 35(2)(e) of the Constitution; and*
>
> *(d) where applicable, provincial, district and municipal health care services".*

348 Amongst many other references, the term "*health care service*" is also referred to in:

348.1 The long title of the NHI Act, which provides that the NHI Act is meant to *"achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution"* and *"to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users*".

348.2 The purpose of the NHI Act in the Preamble and in section 2 thereof, which refers to the goal of achieving "*sustainable and affordable access to quality health care services*".

348.3 Section 4(1) of the NHI Act, which requires the Fund, in consultation with the Minister, to purchase health care services as determined by the BAC.

348.4 Section 6(a) and (c) of the NHI Act, which entitles users *"to receive necessary quality health care services free at the point of care from an accredited health care service provider or health establishment upon proof of identity with the Fund"* and *"not to be refused access to health care services on unreasonable grounds"*.

349 The NHA applies a similar definition for the term "*health services*" that the NHI Act uses for "*health care service*".

350 Section 15(3)(b) of the NHI Act records that the Fund's Board must advise the Minister on *"the development of comprehensive health care services to be funded by the Fund through the Benefits Advisory Committee"*. The NHI Act defines *"comprehensive health care services"* 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"*.

351 Section 25(2) of the NHI Act provides for the establishment and powers of the BAC. It is appointed by the Minister and *"must consist of persons with technical expertise in medicine, public health, health economics, epidemiology and the rights of patients, and one member must represent the Minister."*

352 Section 25(5) of the NHI Act provides:

> *"The Benefits Advisory Committee must determine and review-*

(a) *the health care service benefits and types of services to be reimbursed at each level of care at primary health care facilities and at district, regional and tertiary hospitals;*

(b) *detailed and cost-effective treatment guidelines that take into account the emergence of new technologies; and*

(c) *in consultation with the Minister and the Board, the health service benefits provided by the Fund."*

353 The above provisions must be read with section 7(4) of the NHI Act, which sets out what the Fund may not pay for. This section provides:

"Treatment must not be funded if a health care service provider demonstrates that—

(a) *no medical necessity exists for the health care service in question;*

(b) *no cost-effective intervention exists for the health care service as determined by a health technology assessment; or*

(c) *the health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the Minister."*

354 The Minister is empowered to publish guidelines on the exercise of the BAC's powers and "*may prescribe additional functions*" to the BAC (section 25(7) of the NHI Act).

355 I point out that:

355.1 It remains (as has always been the case) the responsibility of health care providers to guide patients on what is "*necessary*" health care in accordance with evidence-based medicine. Whether a patient "*needs*" health care is and has always been determined by a health care practitioner's diagnosis of the patient's condition, and their prescription of the appropriate course of treatment.

355.2 The NHI Act does not interfere with this aspect of the health care provider and patient's relationship. What the NHI Act does do, is limit the services and supplies that the State will fund to those that are objectively medically necessary, cost-effective, and prescribed in the Formulary or complementary list (section 7(4)).

355.3 This is not dissimilar to how medical schemes operate which similarly determine and fund what is *"necessary"* under a member's benefit package.

355.4 Currently, medical schemes are also at liberty to adjust their benefits packages on a year-to-year basis and have a pre-determined list of benefits which are expressly included notwithstanding the members' contribution or the plan to which the member belongs and taking into account the Prescribed Minimum Benefits.

355.5 The rationale for this is based on various factors such as need, affordability, and availability of resources as well as costs of procedures. This is in line with what the BAC will also have regard to in the determination of the benefits packages, and in line with the State's duty to use its available resources to progressively realise the right to health care.

355.6 Under the NHI Act, a user remains at liberty to pursue treatments that are not funded by NHI, either at the users' own account or through purchasing complementary medical scheme coverage.

355.7 Solidarity complains that there is uncertainty for the position of a health care provider who establishes that the treatment in the standard treatment guidelines is sub-optimal for the patient's specific needs. There is no lack of clarity.

355.8 As is the case with medical schemes, 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 their health care provider considers it more optimal. The user will however have to pay for it out of pocket or through complementary insurance. The user is also entitled (as medical scheme members might do) to challenge a refusal by the Fund.

356 Viewed holistically and purposively, these provisions are not vague. They provide objective, intelligible standards to guide the Fund's and BAC's processes, against which the legality and rationality of any Regulations enacted in relation to them can be measured.

357 An acceptance of Solidarity's vagueness complaint would be to require the State to predetermine and render static in primary legislation the user's benefits. This would mean that the benefits package would be determined without reference to current and evolving evidence on demographic and epidemiological trends, technological advancements and improvements in medical science, and without reference to what the State's budget can afford. It would leave the Fund unable to respond timeously to epidemics like COVID-19, or to timeously introduce State funding for new forms of medical care that will protect and improve users' health and lives.

358 This is why the benefits packages ought to be determined in the manner stipulated by the NHI Act. The design of the NHI Act further ensures that stakeholders will be able to engage with the Fund on a continuous basis to motivate for the inclusion of new treatments or services in the benefits.

359 For these reasons, it would in fact undermine section 271(1) of the Constitution to require the State to define these services and supplies in primary legislation.

360 Dr Kutzin's independent expert evidence (at paragraphs 45 and 46 of his affidavit), which I endorse, affirms the necessity for flexibility in determining what amounts to "*health care services*" under the NHI Act:

360.1 He states that it is not advisable to define specific services to be covered in legislation rather than as a regulatory action. Health services and products change rapidly, and countries need to have in place mechanisms to assess new or alternative treatments for their cost effectiveness and budgetary impact. If they had to go back and pass a new law each time the benefit package needs to be altered, systems would get bogged down. Instead, such laws should spell out the processes that should be used including the regulatory requirements.

360.2 His affidavits set out examples from Switzerland, the United Kingdom, the Netherlands and Sweden that similarly recognise the necessity for regulatory flexibility in determining benefits packages.

360.3 The idea that a government, in a law, would interfere in the service provider-patient relationship by specifying what is "*necessary*" would be

considered a massive government overreach in most countries and certainly by the medical community.

360.4 What is covered under the NHI Act is a clinical assessment that is best left to specialist advisory committees. Dr Kutzin explains that the level of specification in the NHI Act is quite consistent with what is seen in other countries.

Section 33 of the NHI Act and the role of medical schemes

361 Section 33 of the NHI Act provides:

> *"Once 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."*

362 The NHI Act defines "*complementary cover*" as:

> *"third party payment for personal health care service benefits not reimbursed by the Fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund".*

363 These provisions must also be read with the amendments to the Medical Schemes Act 131 of 1998 as set out in the schedule to the NHI Act and in terms of section 58 of the NHI Act.

364 Solidarity argues that section 33 of the NHI Act is central to its vagueness concern in that it allows the Minister, at their discretion, to declare when the NHI Act is fully implemented, by consequence of which medical schemes will be restricted to providing "*complementary cover*". It argues that the continued role of medical schemes is unclear under the NHI Act.

365 Again, Solidarity is grasping at straws. The vagueness it complains of is addressed by a proper reading of the NHI Act.

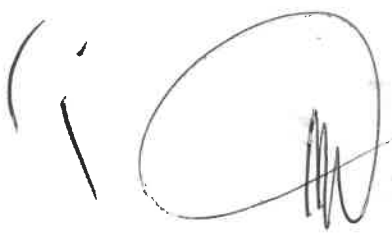
366 While the Minister is empowered under section 33 of the NHI Act to determine by regulation when the NHI Act is "*fully implemented*", they must do so lawfully, in terms of the NHI Act and compliant with the Constitution.

367 Section 57 of the NHI Act provides for a phased-in and progressive process of systems-building and institution-building. It also prescribes a gradual rollout of a progressively expanding package of care.

367.1 Section 57(1)(b) of the NHI Act requires the NHI Act to be *"phased in using a progressive and programmatic approach based on financial resource availability*".

367.2 Section 57(4)(f) of the NHI Act limits the objectives in Phase 1 of the NHI Act's implementation to the purchasing of health care service benefits to a limited extent "*which include personal health services such as primary health care services, maternity and child health care services including school health services, health care services for the aged, people with disabilities and rural communities from contracted public and private providers … at a primary health care level focusing on disease prevention, health promotion, provision of primary health care services and addressing critical backlogs*".

367.3 The Minister is empowered under section 55(1)(w) of the NHI Act to make regulations *on "the scope and nature of prescribed health care*



services and programmes and the manner, and extent to which, they must be funded".

368 The Minister's power under section 33 of the NHI Act must also be read in the context of the NHI Act as a whole, which indicates that the NHI Act would not be "*fully implemented*" until (amongst others) the following objectively determinable criteria are met:

368.1 the Fund and all other institutions and committees envisaged under the NHI Act are operational;

368.2 the systems established under the NHI Act can "*ensure the equitable and fair distribution and use of health care services*" (section 2(a) of the NHI Act);

368.3 the system is supported by sustainable funding (section 2(b) of the NHI Act);

368.4 "*strategic purchasing*" is fully operationalised through the pooling of funds for the purchase of comprehensive health care services from accredited and contracted providers for all users (section 2(c) of the NHI Act);

368.5 the Fund can fund comprehensive health care services that are of a sufficient quantity and quality to meet the needs of the populations identified in section 4 of the NHI Act;

368.6 the system can respect, protect and fulfil the rights of users under section 6 of the NHI Act;

368.7 the Fund has contracted with accredited health care service providers and establishments to an extent that is sufficient to provide comprehensive health care services for the covered population groups (section 7(2)(e) of the NHI Act);

368.8 the information platform is operational to enable the Fund to make informed (evidence-based) decisions on population health needs (section 40(1) of the NHI Act); and

368.9 a fully functioning complaints and appeals procedure is operational.

369 It also follows from a holistic reading of the NHI Act that supplementary medical scheme coverage will continue for a period while NHI is being phased in.

370 The Minister's powers to declare the full implementation of the NHI Act (and therefore to shift medical schemes to offering complementary cover only) must also comply with certain procedural requirements in law aimed at ensuring the right to procedural fairness of all affected by the legislation is respected and that their views may inform the decision-making process. The following provisions are relevant in this regard:

370.1 Section 55(2) of the NHI Act requires the Minister to publish any intended regulations such as those envisaged in section 33 in the Gazette for public comment, before their finalisation.

370.2 Whilst compliance with section 55(2) of the NHI Act will mean that there is no need to follow the notice and comment procedure provided for in section 4(3) of the PAJA, the Minister may, in addition, elect in terms of section 4(1)(c) and 4(2) of PAJA to convene a public enquiry before

making the decision contemplated in section 33 of the NHI Act, as a further means of affording affected parties the right to input into the decision-making process.

371 Section 33 of the NHI Act is therefore not vague. Read holistically and in conjunction with other laws, section 33 of the NHI Act provides sufficient guidance to the Minister and medical schemes taking into account the systemic reform necessitated by the NHI Act.

Complaints of unfettered authority

The role of the Minister

372 Under the heading "Rule by Decree", Solidarity complains that the role of the Minister in the NHI Act is excessive and undesirable. It bemoans the powers of the Health Minister in the following two respects:

372.1 that certain regulations could be published and finalised without public comment in terms of section 55(3) of the NHI Act.

372.2 that binding directives can be issued by the Fund in terms of section 56 of the NHI Act.

373 I deny these complaints for the following reasons:

373.1 Section 55(1) of the NHI Act provides that the Minister may after consultation with the Fund and the National Health Council contemplated in section 22 of the NHA, make regulations regarding a variety of issues.

373.2 Section 55(2) and 55(3) provides that:

> *"(2) The Minister must, not less than three months before any regulation is made under subsection (1), cause a copy of the proposed regulation to be published in the Gazette together with a notice declaring his or her intention to make that regulation and inviting interested persons to furnish him or her with their comments thereon or any representations they may wish to make in regard thereto.*
>
> *(3) The provisions of subsection (2) do not apply in respect of-*
>
> *(a) any regulation made by the Minister which, after the provisions of that subsection have been complied with, has been amended by the Minister in consequence of comments or representations received by him or her in pursuance of a notice issued thereunder; or*
>
> *(b) any regulation which the Minister, after consultation with the Board, deems in the public interest to publish without delay."*

374 The complaint by Solidarity is that certain regulations could be published and finalised without public comment in terms of section 55 of the NHI Act. Section 55(3) of the NHI Act must be read in light of section 55 as a whole and not be read in isolation.

375 Section 55(2) of the NHI Act provides that the Minister must, not less than three months before any regulation is made cause a copy of the proposed regulation to be published in the Gazette together with a notice declaring their intention to make that regulation and inviting interested persons to furnish them with their comments thereon or any representations they may wish to make in regard thereto. Therefore, section 55(2) of the NHI Act provides interested parties with an opportunity to make representations and is fully compliant with the requirement for ensuring procedural fairness in the making of regulations.

376 Thus, in the ordinary course, affected persons will always be heard in regulation-making process.

377 Section 55(3) provides for two entirely legitimate exceptions to the norm established by section 55(2).

377.1 Section 55(3)(a) provides for the situation where the Minister has, pursuant to a notice and comment procedure under section 55(2), amended the regulations to take into account representations that were made. What it excuses him from having to do is to re-publish draft regulations for a second round of comments. Absent section 55(3)(a), there is the potential for never-ending publication for commentary as new submissions are received and further amendments are effected. This would undermine the constitutional rights to procedurally fair administrative action of those who succeeded in influencing the content of the regulations in the first round.

377.2 Section 55(3)(b) provides for the situation where the Minister needs to issue regulations without delay. The exercise of the regulation-making power may need to be invoked urgently, for example to deal with a rapidly spreading epidemic or pandemic. It is entirely appropriate in those circumstances to have in place a provision that allows the Minister to act with expedition in order to ensure that the safety and health of the nation is protected.

377.3 Nor may I or my successor as Minister act unilaterally in those circumstances. I must first consult with the Board. Moreover, as Minister I may only exercise the power when I deem it to be in the public

interest. I would need to have a sound factual basis for deeming a matter to be in the public interest and my decision would be subject to review under PAJA.

377.4 PAJA, which codifies administrative law, contains a similar provision which allows non-compliance with procedural fairness in administrative action affecting the public, where it is reasonable and justifiable in the particular circumstances to do so. This is section 4(4)(a).

378 Section 55(3) is therefore not open to criticism.

The Fund's power to issue directives

379 Solidarity bemoans the Fund's ability to issue binding directives. The Fund's power to make a directive is derived from section 56 of the NHI Act.

380 Section 56 of the NHI Act states that:

> *"(1) The Fund may issue directives which must be complied with in the implementation and administration of this Act, and any directives so issued must be published in the Gazette.*
>
> *(2) Any directive issued under this section may be amended or withdrawn in like manner."*

381 Solidarity's complaint on this score is that there is no statutory guidance or limitations placed on the directives. But that is wrong. The power of the Fund to issue directives is not unconstrained.

382 In terms of section 10(1)(f) of the NHI Act, the purpose of the directives is limited to establishing mechanisms and issuing directives for the regular, appropriate

and timeous payment of health care service providers, health establishments and suppliers. This is hardly controversial or likely to lead to an abuse of power.

383 Section 19(4)(b) provides for the chief executive officer to hold office subject to directives of the Board. This too is hardly controversial or likely to lead to an abuse of power.

384 Section 39(11) of the NHI Act provides that the Fund may issue directives relating to the listing and publication of accredited health care service providers and health establishments and the periods of time applicable to health care service providers and health establishments where accreditation is withdrawn, not renewed or appealed. Again, this is hardly controversial or likely to lead to an abuse of power.

385 Where the issuing of directives under these provisions or the general provision in section 56 was materially to affect the rights of the public, the Fund would be obliged to follow a notice and comment procedure or hold a public enquiry in terms of section 4(2) or (3) of PAJA. That, again, would constrain any abuse of power.

386 Solidarity's further argument is that the ability of the Fund to issue directives is a law-making authority and is constitutionally impermissible.

387 The issuing of directives is a statutory power that must be exercised within the bounds of the NHI Act, the Constitution and PAJA, and can be judicially reviewed if unconstitutionally or unlawfully carried out.

388 Thus, Solidarity's complaint on this score must fail.

The powers of the provinces

389 Solidarity argues that the "*centralisation of the function of the* provinces *in delivering health care … infringes on their constitutional mandate*" (paragraph 78.8 of the founding affidavit). It argues that while the national government has the right to pass framework legislation on issues of national importance or which require uniformity, "*provinces must retain a meaningful role in deciding how to implement that legislation in their unique context*" (paragraph 146 of the founding affidavit).

390 Solidarity says that these principles are undermined for the following reasons:

390.1 the executive role of provinces is undermined by the implication of the NHI Act that provinces will not receive funding for health care anymore (paragraph 148 of the founding affidavit).

390.2 the establishment of the DHMOs as national government components strips provinces of their power to finance, plan and provide district health services (paragraph 149 of the founding affidavit);

390.3 the concentration of power in the Minister's hands leaves no room for meaningful cooperation with provinces on financing and delivery of health services (paragraph 150 of the founding affidavit);

390.4 provinces are excluded from governance structures of the Fund and from critical decision-making (paragraph 150 of the founding affidavit), and there is no provision for provincial health departments to be consulted on the NHI's design and implementation (paragraph 151 of the founding affidavit); and

390.5 the NHI Act as a whole undermines cooperative governance despite the fact that health services are a concurrent national and provincial function (paragraph 152 of the founding affidavit).

391 Solidarity is wrong that the NHI Act undermines the provinces' constitutional mandate.

392 Schedule 4 of the Constitution deals with functional areas of concurrent national and provincial legislative powers. It includes "*health services*" as a concurrent legislative competence. Schedule 5 of the Constitution deals with the functional areas of exclusive provincial legislative competence. The only relevant area of exclusive provincial legislative competence is "*ambulance services*".

393 Section 44(1)(a)(ii) of the Constitution confers the power on the National Assembly to pass legislation with regard to any matter including a matter within a functional area listed in Schedule 4.

394 Section 44(2) of the Constitution empowers Parliament to intervene by passing legislation on matters falling under Schedule 5 thereof, where it is necessary, amongst others, to maintain economic unity, to maintain national standards, to establish minimum standards required for the rendering of services, or to prevent unreasonable action being taken by a province that is prejudicial to another province or the country as a whole.

395 Section 44(3) provides that legislation with regard to a matter that is reasonably necessary for, or incidental to, the effective exercise of a power concerning any matter listed in Schedule 4 is, for all purposes, legislation with regard to a matter listed in Schedule 4.

396 Section 146(2) of the Constitution states further that national legislation that applies uniformly with regard to the country as a whole prevails over provincial legislation under certain conditions. These conditions include where the national legislation:

396.1 deals with a matter that cannot competently be regulated by individual provinces;

396.2 requires uniformity nationally by establishing norms and standards, frameworks or national policies; or

396.3 the national legislation is necessary for (amongst others) the maintenance of economic unity, and the promotion of equal opportunity or equal access to government services.

397 From this it is evident that where a matter requires regulation nationally or inter-provincially, as opposed to intra-provincially, the Constitution ensures that national government has been accorded the necessary power, whether exclusively or concurrently under Schedule 4, or through the powers of intervention accorded by section 44(2). Where provinces are accorded exclusive powers, these should be interpreted as applying to matters which may appropriately be regulated intra-provincially.

398 It is also important to bear in mind that the NHI Bill was tagged and passed as a section 76 Bill, meaning that the National Council of Provinces had the power to reject the Bill or pass it with its own amendments and force a process in terms of section 76(1)(d)-(k) of the Constitution. Yet the National Council of Provinces

passed the Bill as received from the National Assembly without amendments by eight votes to one.

399 The NHI Act does not undermine the powers of the provincial legislatures.

400 In operation, the NHI Act will redistribute money from the current multi-payer system of nine provincial health systems, tax rebates, levies, and conditional grants and consolidate them into one fund. I have explained the purpose of the pooling of funds and the single-payer system above.

401 Health care is a national priority and it is in the national interest for the NHI Act to coordinate spending on health care services for all. The provinces are unable independently to each to regulate these issues in a way that will fix the problems in health care financing that I have described above and to advance equity. National legislation is necessary for this purpose.

402 Provincial autonomy is in any event not absolute and does not exist in isolation. Alongside autonomy is a collective duty of the spheres of government for cooperation and interdependence, which are equally important when striving to achieve the fulfilment of constitutional objectives and the fulfilment of socio-economic rights such as the right to health care. What the Constitution demands is a balance, congruent with the principles of cooperative governance.

403 In what follows I will clarify three misapprehensions that Solidarity has about how the NHI Act works, that are evident from its arguments.

404 First, the purpose of the NHI Act is in the main not to centralise the delivery of health care. What the NHI Act does do is to centralise the funding and payment mechanisms for health care. Provincial departments of health will continue to

have a substantial role in the delivery of health care services albeit that there will be changes through NHI in the funding for and certain management functions in respect of the delivery of health care services.

405 Second, it is incorrect that consultation of, and involvement in critical decision-making by, provinces is not provided for. Solidarity's lack of understanding on this issue stems from its failure to understand how the health system and the government operate, and its failure to read the NHI Act in conjunction with other legislation, including the NHA.

406 By way of example, the National Health Council is established in terms of section 22(1) of the NHA. It includes all the relevant Members of the Executive Councils for Health. In other words, all provinces are represented on the National Health Council.

407 In terms of section 23 of the NHA, the National Health Council is responsible for advising the Minister on all policy matters that protect, promote and improve the health of the population. This includes (amongst many others) the targets, priorities, norms and standards relating to the equitable provision and financing of health services, efficient coordination of health services, equitable financial mechanisms for the funding of health services, user referral programmes, the development of norms and standards for the establishment of health establishments, and the implementation of national health policy.

408 Solidarity is therefore misguided in its assumptions that provinces will have no influence on the implementation and decision-making in relation to NHI. I do not operate as an island as the Minister of Health. The NHA mandates that I be

advised by the National Health Council on issues that will touch on almost every one of my functions under the NHI Act.

409 It is not necessary for the NHI Act to include separate requirements for consultation with provinces, when the framework for cooperation between myself, the NDoH and the provinces is already statutorily prescribed and operational.

410 The NHI Act nevertheless does provide extensively for provinces to play an important role and to influence the implementation of NHI. For example:

410.1 Section 55(1) explicitly requires me to consult with the National Health Council when making regulations under the NHI Act.

410.2 The National Health Council must also be consulted in the development and maintenance of the Formulary (section 38(4) of the NHI Act) and in developing the health care services that the NHI will fund (section 39(2)(c)(ii) of the NHI Act). These processes are closely linked to section 3(1)(d) of the NHA, which mandates the Minister to ensure the provision of essential health services for the population of the Republic. Those essential health services are prescribed after consultation with the National Health Council.

410.3 The amendments to the NHA in the Schedule to the NHI Act further require that I consult with the National Health Council in making regulations in relation to the fees to be paid to public health establishments for health services, amongst others.

411 The DHMOs also do not operate independently of the provinces, notwithstanding the fact that these are established as national government components. For example:

411.1 Section 31 of the NHA is amended in terms of the Schedule to the NHI Act to specify that the DHMOs submit their annual strategic medium term health and human resources plans to the Director-General "*in accordance with the guidelines determined by the National Health Council*".

411.2 The NHA further details the general functions of provincial departments of health in Chapter 4 thereof. The Schedule to the NHI Act amends section 25 of the NHA to add a function to the role of the heads of provincial departments of health to "*assist the District Health Management Office in controlling the quality of all health services and facilities*".

412 I am, moreover, obliged under the NHI Act to report annually to the National Council of Provinces (section 51(4)(b) of the NHI Act).

413 Rather than undermining cooperative governance, the NHI Act, as read with the NHA, envisages a unified health financing system which operates in a deeply collaborative and integrated manner with the provincial arms of government.

414 Third, while it is correct that over time, the full implementation of the NHI Act will mean that public funding for health care will progressively be channelled primarily through the Fund, the NHI Act does not terminate funding to provincial departments of health.

415 The NHI Act is not a money bill. It does not determine funding allocations. The extent to which funding is allocated to provincial departments of health will be determined through the ordinary processes and not by the Fund or the NDoH. Importantly, this will be done by Parliament.

416 If anything, the NHI Act envisages the continuation of provinces receiving some provincial equitable allocation. This is seen in section 35(4)(c) of the NHI Act, for example, which states that public ambulance services are to be reimbursed through the provincial equitable allocation.

417 To the extent that the implementation of the NHI Act will lead to changes in the allocation of health care-related functions and funding, this is constitutionally permissible.

418 Section 227(1)(a) of the Constitution states that *"each province is entitled to an equitable share of revenue raised nationally to enable it to provide basic services and perform the functions allocated to it."*

419 The National Legislature and Provincial Legislatures share concurrent legislative competence with respect to health services as listed in Schedule 4 to the Constitution. Section 125(2)(b) of the Constitution requires the executive authorities of the provinces to implement "*all national legislation within the functional areas listed in Schedule 4 or 5 except where the Constitution or an Act of Parliament provides otherwise*". In relation to health care services, the NHI Act and NHA are the statutes to look to in order to determine the extent to which *"an Act of Parliament provides otherwise*".

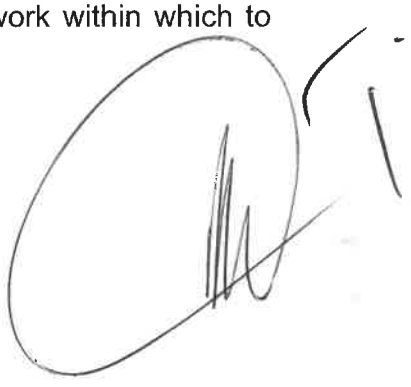
420 To the extent that the rendering of any health care services by a Province is not allocated to the national level by legislation that "provides otherwise", and is not paid for by the Fund pursuant to a contract for the provision of health care services, the provinces are entitled in terms of section 227(1)(a) of the Constitution to an equitable share of revenue raised nationally to enable the provinces to provide the services and perform the functions that legislation like the NHI Act and NHA require them to perform. Examples of provisions in the NHI Act that clearly contemplate the continued delivery by provinces of health care services or performance by provinces of health-related functions, are to be found in sections 31(2), 32(1)(c), 32(2)(a), 35(2) and 35(4)(c) of the NHI Act.

421 The NHI Act does not therefore intrude unconstitutionally on the provinces' executive authority, nor on their entitlements under section 227(1)(a) of the Constitution. To the extent that the NHI Act changes the range of functions performed by and health services delivered by the provinces, along with the mechanisms whereby they are reimbursed for doing so, the changes are necessary to achieve the purposes of the NHI Act, legitimate and compliant with the Constitution. It is relevant in this context that the NHI Act –

421.1 does indeed deal with matters –

421.1.1 that cannot be regulated effectively by legislation enacted by the respective provinces individually;

421.1.2 that to be dealt with effectively require uniformity across the nation, and the NHI Act provides a framework within which to achieve that unity; and



421.2 is necessary for the promotion of equal opportunity and equal access to government services.

422 I accordingly deny that the NHI Act is unconstitutional on the basis that "*infringes on [the provinces'] constitutional mandate*".

The position of asylum seekers

423 Solidarity complains that the NHI Act limits access to health care and is discriminatory against asylum seekers and non-citizens in South Africa.

424 I find it odd that Solidarity argues in one breath that the NHI Act is unreasonable, undermines human rights, and that the State lacks funds to implement it, while simultaneously arguing that more people should be covered by NHI funding. Nonetheless, I deny that the NHI Act's provisions on population coverage are unlawful.

425 Section 4(1) of the NHI Act stipulates that refugees, permanent residents, inmates, and certain categories of individual foreigners determined by the Minister of Home Affairs will have access to all the same health care benefits of South African citizens.

426 All children, regardless of their immigration status, are entitled under section 4(3) of the NHI Act to basic health care services under section 28(1)(c) of the Constitution. This includes children who are asylum seekers and illegal foreigners.

427 The only limits to NHI population coverage are in terms of sections 4(2), 4(4) and 4(5) of the NHI Act. Section 4(2) says that asylum seekers and illegal

foreigners will only have access to NHI-funded emergency medical services and services for notifiable health conditions of public health concern.

428 This does not mean that adult asylum seekers and illegal foreigners are prohibited from accessing other forms of health care. The limits to population coverage under the NHI Act also does not conflict with or amend the provisions of the NHA other than to the extent stipulated in the Schedules. It simply means that the Fund will only pay for asylum seekers and illegal foreigners' health care if it is emergency medical care or for a notifiable disease or if they are children, on the basis mentioned above.

429 The State's duty under section 27(2) of the Constitution is to progressively realise the right to health care within its available resources. Unfortunately, the State's resources are simply insufficient to allow for the Fund to pay for comprehensive health care benefits to foreigners who have not established their entitlement to refugee status or to foreigners who are unlawfully in the country.

430 If any person, regardless of the merits of their asylum application or the lawfulness of their presence in South Africa, were entitled to comprehensive health care services under the NHI Act, the Fund would simply become overwhelmed. It would disincentivise foreign nationals from entering the country lawfully (including through establishing legitimate entitlements to asylum claims) if the full spectrum of tax-payer funded health care services were available regardless of one's immigration status.

431 It would also be logistically unmanageable to register illegal (and therefore undocumented) migrants on the NHI system as ordinary users as these

individuals would inevitably lack verifiable identity documents as required in section 5(5) of the NHI Act. If the State were paying for comprehensive health care services for individuals who cannot properly be identified, this would encourage corruption and abuse of the system, and undermine the State's duty to account for the expenditure of public funds.

432 Section 4(2) of the NHI Act makes two constitutionally mandated exceptions. The first, which is funding for emergency medical care, is required in order for the State to uphold section 27(3) of the Constitution because no person may be refused emergency medical care. The second, which is the provision of treatment for notifiable conditions, is necessary in order to protect public health.

433 In paragraph 158 of the founding affidavit, Solidarity accepts that it is a legitimate government imperative that "*non-nationals may cause an undue financial burden to the State*". It claims, however, that there are "*less restrictive ways of ensuring that the State is not overburdened and at the same time of preserving the dignity of asylum seekers*". Solidarity does not identify what these less restrictive means are. I deny that there are less restrictive means of achieving the objectives of the limits to population coverage under the NHI Act.

434 The limits to population coverage accord with the State's duty progressively to realise the right to health within its available resources. The limits to NHI funding for asylum seekers and illegal foreigners are also fair, reasonable and lawful.

435 I point out further that in terms of section 4(1)(e) of the NHI Act, the Minister of Home Affairs is entitled, after consultation with the me or my successor, and the Minister of Finance, to determine additional categories of foreigners or

individual foreigners who would be entitled to have health care benefits purchased for them by the Fund.

436 A constitutional challenge based on exclusion of illegal foreigners or asylum seekers is premature until it is known what the stance is of the Minister of Home Affairs, after consultation with me and the Minister of Finance. Clearly the consultation obligations in this provision suggest that if there is adequate funding, healthcare services may well be purchased by the Fund for asylum seekers and, possibly, illegal foreigners.

437 There would also be nothing to stop an asylum seeker or illegal foreigner from securing health care services (outside of those already specifically available to them in terms of the NHI Act) from a health care service provider who is registered with a recognised statutory health professional council, but is not accredited by the Fund and whose fees are not paid by a medical scheme. This would include the full range of care, but would not be paid for by the Fund.

The NHI Act protects constitutional rights

Right to dignity and freedom and security of the person

438 Solidarity alleges that the NHI Act unjustifiably limits the rights of human dignity and/or freedom and security of the person of both the user as well as the medical professional in that they are not entitled to a medical professional of their choice. I deny these allegations.

439 First, I deny that the NHI Act restricts the right of users to access health care from a medical professional of their choosing. To the contrary, the NHI Act

expands accessibility and choice for users by widening the pool of health care providers that are available to all people without discrimination.

439.1 Section 5(1) of the NHI Act requires the user to register to receive health care services at an accredited health care service provider or establishment. Nowhere does the NHI Act restrict the user's right to register with a provider of their choosing.

439.2 In order to preserve the coherence and effectiveness of the capitation model of provider payment for primary health care services, the user is generally required to receive their NHI-funded primary care at the provider or establishment where they chose to register (section 7(2)(a) of the NHI Act). Section 7(2)(b) of the NHI Act nonetheless protects the portability of services if the user is unable to access care with their registered provider, while the unified health information system will improve the ability of users seamlessly to access care at different providers where it is required.

439.3 There is also nothing in the NHI Act which restricts a user from accessing specialist care from a provider of their choosing and hospital care at a facility of their choosing, provided that referral pathways are complied with.

439.4 With respect to the current users of the public health care system, NHI will, moreover, substantially expand access to the pool of health care providers, and the choice to use their services, to the majority of the population.

439.5 This will mean that a user can choose to register with their closest health care provider or establishment, whether those are private or public providers or facilities.

439.6 I note, moreover, that in the private sector as it currently operates, many medical scheme members are restricted to the use of their scheme's select network of hospitals and doctors or designated service providers. This is not a rights infringement.

439.7 Finally, the NHI Act does not prohibit health care users from accessing health care from unaccredited health care providers or establishments, nor does it prohibit unaccredited health care providers from providing health care services, provided that these services are not paid for through the medium of medical scheme membership and are paid out of pocket (unless they are complementary health services).

439.8 What the NHI Act does do once fully implemented, is to prohibit the NHI Fund from paying for services by unaccredited providers, and to prohibit medical schemes from providing coverage for services that are reimbursable by the Fund. An individual may continue to access health care services that are not reimbursable by the Fund from unaccredited providers and to pay for medical scheme membership to cover those complementary services. An individual may also pay out of pocket for services from an unaccredited provider which are reimbursable by the Fund if provided by an accredited, contracted provider.

439.9 The limits that the NHI Act applies to NHI-coverage and medical scheme coverage are necessary to ensure that the efficiency and equity,

gains I have described above in a risk-pooled single-purchaser system can be achieved.

439.10 There is also nothing in the NHI Act which prohibits a user from accessing a *"second opinion"* on a diagnosis as Solidarity alleges in paragraph 168 of the founding affidavit.

439.11 It is notionally possible that in the future regulations may be made that would pose limits on users' rights to access NHI funding for medically unnecessary repeat consultations. Even if this is so, the NHI Act protects the user's right to access such an additional consultation – it would simply be that the service would not be reimbursable by the Fund and would therefore be paid for through complementary medical scheme cover or out of pocket.

439.12 In any event, should such restrictions on repeat consultations be regulated in the future, Solidarity would have the opportunity to make submissions on the regulations before they are passed, and would further be entitled to challenge their legality if necessary. It is premature for Solidarity to speculate on the existence of restrictions that simply do not exist at present.

440 Prof McIntyre in her expert affidavit at paragraphs 75 and 76 states as follows:

> *"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 NHI.

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

441 I therefore deny that the right of dignity is infringed. In fact, the right to dignity will be advanced on a wide front. A larger portion of the population, who do not have adequate access to health care, will now have access to the same services as any other person, irrespective of their financial standing.

442 Section 12(2) of the Constitution provides that everyone has the right to bodily and psychological integrity, which includes the right (a) to make decisions concerning reproduction and (b) to security in and control over their body. The NHI Act will in no way impede or infringe this right. In fact, the NHI Act seeks to create a system that enables people to have access to health care so that they can make decisions concerning their reproduction. And security in and control over their bodies. There is nothing inconsistent with that purpose in the NHI Act.

443 The complaints by Solidarity seek to maintain the status *quo* where not enough people have sufficient access to health care, such that UHC is not achieved. I have illustrated through international best practices, international obligations and experts that the NHI Act is a reform that will enhance the dignity of all in South Africa and not a selective few who have the privilege of exclusivity in their health care choices.

444 I note my significant discomfort with Solidarity's allegations in paragraph 170 of the founding affidavit, where the deponent states that *"[a] medical profession (sic), irrespective of his or her worth or dedication will simply be 'assigned' patients by consequence of his or her location"*.

444.1 I have difficulty understanding precisely what Solidarity thinks the NHI Act does in this regard. No medical professional will be forced to treat any patient under the NHI Act. The NHI Act also does not speak to "*assigning*" patients to health care providers.

444.2 Nonetheless, these allegations exemplify the discriminatory and elitist ethos underlying Solidarity's case, which is deeply at odds with our Constitution. The allegations assume that medical professionals of "*worth and dedication*" exercise their dignity by treating only wealthy patients who can afford private health care. The allegations assume that it would undermine a health care provider's dignity and worth to allow the majority of less wealthy and mostly Black South Africans (who currently rely on public health care) to access their services with State funding. This kind of thinking has no place in our constitutional democracy.

445 The rights in section 10 and section 12 of the Constitution are not at all limited by the NHI Act. The NHI Act is, in fact, a rational and reasonable step to promote these rights.

Right to life

446 Solidarity alleges that the NHI Act unjustifiably limit's the right to life. It claims in paragraph 173 of the founding affidavit that the NHI Act will mean that "*scenarios similar to the facts in the well-known Soobramoney case will be more prevalent*" because people will not be permitted to access private medical schemes and health care will be compromised relative to affordability.

447 I deny the allegations. They are founded on a wholesale mischaracterisation of how the NHI Act operates.

448 The health care system as envisaged by the NHI Act is specifically underpinned by the need to provide health care irrespective of the user's financial position. The NHI Act therefore advances and protects the right to life.

449 The NHI Act also does not limit access to health care as suggested by Solidarity. If there is a benefit which a user would like to access which is not covered by the NHI Fund, the user is at liberty to pay for it out of pocket or access complementary medical scheme coverage (section 6(o) of the NHI Act).

450 This is similar to the scenario which plays out now with medical aids and has been implemented for many years without challenge. A simple example is that when a medical aid beneficiary has depleted their allocated funds (in a medical savings account for example), the beneficiary must pay out of pocket. Similarly,

if the service being sought is not on the list of Prescribed Minimum Benefits ("**PMB**"), the user may have to pay out of pocket.

451 Therefore, the right to life is not limited. The NHI Act aims to create a better life for all as instructed in the Preamble of the Constitution.

452 What appears to be the nub of Solidarity's complaint is its discomfort with the fact that the majority of the population who currently use the public health care system will be afforded access to private health care providers and facilities under the NHI Act, which are currently the exclusive domain of those who are better-off.

453 Solidarity's reference to the *Soobramoney* case is telling in this regard. Their true concern is not that an individual in kidney failure will be denied funding for dialysis treatment by the Fund, or that the individual would be restricted from funding dialysis treatment through complementary medical scheme coverage if NHI funding was refused. Their concern is rather that the privileged access to life-saving treatment that wealthy people enjoy today will be equalised under the NHI Act because poor people will also be able to access dialysis treatment in the private sector. Wealthy people's lives will no longer be treated as more valuable simply because of their financial status. That is not unconstitutional or a restriction on any person's right to life. To the contrary, the NHI Act in this way protects every person's life as equally valuable.

454 I should also point out that NHI will only be determined as fully implemented for purposes of section 33 once there is universal access by way of NHI contracted service providers to all the life-saving treatments that are ordinarily encountered in the South African population. Once fully implemented, if there are rare life-

threatening conditions that are not covered, these constitute complementary cover and may be provided by a medical scheme.

Freedom of association

455 Solidarity alleges that the NHI Act unjustifiably limits freedom of association.

456 I have addressed Solidarity's "*vagueness*" complaints above in relation to the provisions of the NHI Act that deal with medical schemes.

457 I have also explained the problems with health financing in the private sector above and why it is urgently necessary for the State to intervene.

458 The crux of Solidarity's remaining challenge on this issue is that the NHI Act undermines peoples' rights to freely associate with medical schemes and forces use of the NHI Fund (paragraphs 178 to 179 of the founding affidavit), and that the imposition of taxes under section 49 of the NHI Act is an unconstitutional form of compulsion (section 180 of the founding affidavit). I deny these allegations.

459 The Constitution stipulates that everyone has the right to freedom of association. The concept of freedom of association is a wide concept that is susceptible to different interpretations.

460 Two aspects of freedom of association can be identified. On the one hand, members of organisations have the freedom to decide with whom, why and when they want to associate. It is connected to the membership or admission requirements of organisations. On the other hand, everyone has the right to decide which organisations they wish to join. This aspect is connected to the

fact that individuals and groups can form and uphold certain associations connected to their social, cultural, religious and political convictions, which serves as a manifestation of their freedom of belief, religion, speech, expression, culture and language. It leads to a free society in which every individual can develop and realise themself.

461 The NHI Act is the legislative expression of a valid and constitutionally justifiable policy position and does not imply "*membership*" of a State Fund. All persons covered in terms of section 4 of the NHI Act may register as users of the Fund and thus receive State-funded health care services for free from a provider or establishment accredited by and contracted to the Fund. These include public and private health care providers.

462 Individuals are also not prohibited from being members of medical schemes. The NHI Act only limits what benefits those schemes can pay for in order to enable the risk pooling and efficiency gains of the single-payer system that are necessary in order to advance UHC.

463 The NHI Act therefore does not limit the right to associate. Even if it did so (which I deny), it is not done in an arbitrary manner and is reasonable and justifiable in an open and democratic society. The rationale is sound and in the public interest, for the common good.

464 In relation to Solidarity's taxation complaints, I note that section 49 of the NHI Act does not impose any taxes. The provision simply identifies the Fund's sources of income. The State's powers to impose taxes are dealt with in other laws. In any event, I deny that the imposition of taxes is a form of

unconstitutional compulsion or one which limits freedom of association as alleged by Solidarity.

465 I should also point out that the NHI Act creates new opportunities for people to express their freedom of association. Users would be entitled to associate around protecting users' rights. Providers would be entitled to associate to protect their rights in relation to the NHI Act. Indeed the NHI Act promotes this by creating a Stakeholder Advisory Committee in section 27. It provides as follows:

> *"The Minister must, after consultation with the Board and by notice in the Gazette, appoint a Stakeholder Advisory Committee comprised of representatives from the statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers as well as patient advocacy groups in such an manner as may be prescribed."*

Freedom of trade, occupation and profession

466 Section 22 of the Constitution provides that *"[e]very citizen has the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law*".

467 Solidarity levels a three-pronged attack on the constitutionality of the NHI, under section 22 of the Constitution. It claims that the NHI Act limits the right of health care professionals to choose their profession (paragraph 190 of the founding affidavit) because:

467.1 health care providers are subjected to vague and ambiguous accreditation requirements (paragraph 185 of the founding affidavit);

467.2 health care providers will be forced to adhere to the Fund's pricing regime for services thereby restricting their autonomy to regulate their own tariffs (paragraphs 187 – 188 of the founding affidavit); and

467.3 that *"available studies and research … tends to indicate that health care practitioners will emigrate in large numbers if subjected to the NHI system"* (paragraph 11.5 of the founding affidavit).

468 I deny that the NHI Act limits any person's rights under section 22 of the Constitution. To the extent that there is such a limitation (which I deny), it is reasonable and justifiable in an open and democratic society.

469 First, the NHI Act's accreditation criteria are clear. They are, moreover, rational, reasonable, and necessary to achieve the NHI Act's purposes.

470 Section 39(2) of the NHI Act sets out the accreditation criteria. These include that the health care service provider or establishment must:

> *"(a) be in possession of and produce proof of registration by a recognised statutory health professional council;*
>
> *(b) be in possession of and produce proof of certification by the Office of Health Standards Compliance; and*
>
> *(c) meet the needs of users and ensure service provider compliance with prescribed specific performance criteria, accompanied by a budget impact analysis, including the-*
>
> > *(i) provision of the minimum required range of personal health care services specified by the Minister in consultation with the Fund and published in the Gazette from time to time as required;*
> >
> > *(ii) allocation of the appropriate number and mix of health care professionals, in accordance with guidelines, to deliver the health care services specified by the Minister in consultation*

with the National Health Council and the Fund, and published in the Gazette from time to time as required;

(iii) adherence to treatment protocols and guidelines, including prescribing medicines and procuring health products from the Formulary;

(iv) adherence to health care referral pathways;

(v) submission of information to the national health information system to ensure portability and continuity of health care services in the Republic and performance monitoring and evaluation; and

(vi) adherence to the national pricing regimen for services delivered."

471 Solidarity does not appear to take issue with all of these accreditation criteria. It complains specifically about the requirements to meet users' needs, especially under section 39(2)(c)(vi) of the NHI Act, and the provision's reference to performance criteria and budget impact analysis (paragraph 186 of the founding affidavit).

472 These aspects of the accreditation criteria are necessary to establish the framework that will allow the Fund to conduct strategic purchasing in a way that protects users' best interests and to achieve the objects of the NHI Act.

472.1 For example, under the capitation system for primary health care services, health care providers will receive a payment per user registered to access care with them. As explained above, this payment mechanism incentivises health care providers to keep their patients healthy and prevent illness in order to maximise their profits.

472.2 There are risks, however, with all provider payment methods that need to be managed. Under capitation systems, it is important to manage the risk of under-provision of services. To manage this risk, the NHI Act therefore prescribes that in order to be accredited, the health care provider must meet users' health care needs in accordance with the prescribed performance criteria.

472.3 Those performance criteria are not fully detailed in the NHI Act and are best left to regulation as they will need to be adapted and adjusted over time in a consultative manner, and specified according to the nature of the services provided and funded by the provider or establishment. The sub-clauses of the provision provide guidance, however, on the nature of those performance criteria which will be prescribed.

472.4 These include that the health care provider is able to demonstrate that they are able to provide the "*minimum required range of personal health care services*" prescribed by the Minister, that they have an appropriate number and mix of health care professionals as prescribed, and that they adhere to prescribed treatment protocols. These types of performance criteria are necessary to ensure that the provider who has been paid to provide primary health care services for a certain community of registered users, is able to provide the kind of health care services that those users will require.

472.5 If health care providers do not have in place a responsible budgeting system, there is a risk of the capitation funding being exhausted too quickly and registered users left without adequate care. The Fund

therefore needs to ensure that to be accredited, health care providers have performed a "*budget impact analysis*" to demonstrate that a GP practice, for example, is sustainable and able to cover the costs of the prescribed mix of health care professionals and comply with prescribed treatment protocols under the capitation budget in a given period.

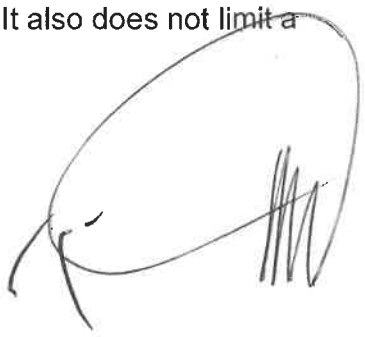
473 These accreditation criteria are described in the NHI Act at an appropriate level of detail to empower the Fund to operate effectively to achieve its purposes, and to guide the regulatory process. The regulations, in turn, will provide further detail to health care providers to enable them to meet the accreditation criteria.

474 The accreditation criteria in no way limit the health care professional's right to choose their profession. What they do is to govern the circumstances in which a provider or establishment may be accredited to receive State funds for their services.

475 Second, a health care provider's right to choose their profession is not limited by the requirement to adhere to the national pricing regimen, should the provider elect to be accredited and to contract to provide services under the NHI Act.

476 In any event, the right to choose one's profession or trade does not include the autonomy to regulate one's own payment rates. Tariffs are regulated in many professions.

477 It does not limit a doctor's right to choose their profession because they are paid a prescribed salary for their services in a public hospital. It also does not limit a



doctor's right to choose their profession if medical schemes prescribe the rates at which the schemes will reimburse them for their services.

478 To the extent that Solidarity's case is rather that the national pricing regimen will be so meagre and oppressive as to preclude people from choosing to enter the health care profession, this is wholly unsubstantiated and speculative. There is nothing in the NHI Act which even indicates a risk that oppressive rates would be set.

479 To the contrary, the Fund is required under section 11(2)(c) and (e) of the NHI Act to conduct its business in the best interests of users and to "*negotiate the lowest possible price for goods and health care services without compromising the interests of users*" (my emphasis). It would not be in the best interests of users for prices to be determined that are so oppressive or unreasonable as to inhibit health care professionals from entering or remaining in their professions. To do so would also be open to challenge as irrational or unreasonable. The aim of the NHI Act, after all, is to expand and improve access to quality health care services.

480 While it is true that one of the purposes of the NHI Act is to reduce the cost of health care in both the public and private sectors, it does not necessarily follow that all health care providers will necessarily earn less than they currently do.

481 To return to the example of capitation funding for primary health care, the provider payment mechanism does not apply a fee-for-service system as is currently applied in the private sector, nor does the NHI Act require the Fund to pay health care providers a salary as they might enjoy in the public sector currently. As the amount of money the provider or health care establishment

will receive is determined on a per-capita-of-users-basis, the provider's earnings or the establishment's profitability will be maximised by their adaptation to the economic incentives of the financing system.

482 It is insufficient and once again premature for Solidarity to level a constitutional attack on a provision of the NHI Act which is yet to be implemented and even more so when such implementation is yet to be determined by regulations. Some of the providers or facilities may be juristic persons and not entitled to invoke section 22 of the Constitution.

483 The regulation of prices of medicines is a wholly legitimate form of regulating the profession. The prevention of excessive profit-taking from the manufacturing, distribution and sale of medicines and the provision of health care services is more than an option for government. It is a constitutional obligation flowing from its duties under section 27(2).

484 I deny that NHI will lead to an exodus of health care workers from the country. Solidarity provides no objective support for these claims. They are entirely speculative assumptions.

485 In addition, it must be acknowledged that emigration of professionals across different sectors hinges on various subjective and objective factors which are specific to each individual.

486 Currently, there are South African health care workers who are working in Europe, the Middle East and Asia for better benefits. In any event, it is beyond the country's resources to compete with the salaries offered in some of these

countries. Moreover, the emigration occurs regardless, despite the existence of the current two-tier system.

487 I attach an article entitled "*South Africa and the Surgical Diaspora- A Hub for Surgical Migration and Training*", which I mark as Annexure "**PAM5**". The article shows the results of a cross-sectional observational study, combining individual-level data of 43,621 physicians from the Health Professions Council of South Africa with data from the registers of 14 high-income countries, and international statistics on surgical workforce, in order to quantify migration to and from South Africa in both absolute and relative terms. The article reveals the following:

487.1 South Africa is an important destination primarily for physicians originating from low-income countries. Two percent of all surgeons, anaesthesiologists, and obstetricians from low- and middle-income countries were registered in South Africa, and 6% in the other 14 recipient countries. A total of 1,295 (16%) South African surgeons, anaesthesiologists, and obstetricians worked in any of the 14 studied high-income countries.

487.2 Of 6,670 surgeons, anaesthesiologists, and obstetricians in South Africa, a total of 713 (11%) were foreign medical graduates, and 396 (6%) were from a low- or middle-income countries.

487.3 South Africa is an important regional hub for surgical migration and training. A notable proportion of surgical specialists in South Africa were medical graduates from other low- or middle-income countries, whereas migration out of South Africa to high-income countries was even larger.

488 The aforementioned study gives credence to the fact that, notwithstanding Solidarity's alleged concerns regarding a mass exodus of health-workers once the NHI Act is implemented, there are international doctors who are attracted to South Africa for the opportunities it presents to them.

489 The view expressed by Solidarity is short-sighted and disregards the factual scenario namely that South Africa has a national health system which international doctors find to be both inviting as well as conducive to opportunity and growth.

490 Therefore, there is no merit in this challenge.

Access to health care

491 Solidarity alleges that the NHI Act "*instead of progressively realising the right to health services enjoyed in the NHI Act acts as a regressive measure*" (paras 192 to 196 of the founding affidavit).

492 Section 27(1) of the Constitution enshrines the right to access health care services for "*everyone*". Section 27(2) of the Constitution mandates the State to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right. This constitutional principle acknowledges that, while immediate and universal access to health care may not be feasible given current resources, there is an obligation on the State to make consistent and effective efforts toward this goal over time.

493 The State has a concurrent duty to respect, protect, promote and fulfil the right to equality in section 9 of the Constitution. It must realise the right to access to health care progressively in a manner that advances substantive equality.

494 I have explained above how the NHI Act is enacted precisely as a mechanism to advance the progressive realisation of UHC and the rights to health and equality by establishing a more equitable, cohesive health system that integrates public and private health resources.

495 Far from limiting access to health care, the NHI Act aims to bridge disparities in health care access that are caused by economic and social inequalities and the externalities of the private health care financing system. By creating a unified health care financing system, the NHI Act will extend health care benefits to a larger population segment and reduce the inequities inherent in the current two-tiered system.

496 It is essential to distinguish between a measure that actively limits a right and one that reconfigures access to achieve broader, constitutionally-mandated social equity. The progressive realisation duty under section 27(2) of the Constitution underscores that the right to health care must evolve based on available resources and reasonable policies, which the NHI Act embodies.

497 Therefore, if progressive realisation is to be effectively assessed in the South African context, emphasis must be placed on assessing budgetary priorities in the light of human rights imperatives. This is the route government has chosen.

498 The NHI Act is a reasonable legislative measure to advance the right to access to health care. Amongst others:

498.1 I have demonstrated that the NHI Act is based on the best available evidence and international best practice to advance UHC.

498.2 The expert evidence that I have summarised above of Prof McIntyre, Dr Kutzin and Dr Budlender confirm that the NHI Act is a reasonable measure in light of South Africa's particular context, based on sound public health principles and sound health economics principles, and consistent with the guidance of the WHO, which is based on global research.

498.3 The NHI Act provides for those who are most vulnerable and have the greatest need of access to health care by placing need for health care as the determinant for access.

498.4 By integrating accessibility of all users to private and public health care services, the NHI Act advances the vision stated in the Preamble of our Constitution, amongst others, to *"heal the divisions of the past and establish a society based on … social justice"*, to *"improve the quality of life of all citizens and free the potential of each person"*, and to *"[b]uild a unified and democratic South Africa"*.

499 I also emphasise that the state of the private healthcare sector is not one of progressive realisation as envisaged in section 27(2). It caters for a decreasing percentage of the population because it is becoming increasingly unaffordable. The NHI Act is designed to address this problem too.

500 Insofar as it is suggested that the NHI Act will reduce existing entitlements for persons who are currently members of medical schemes I deny this for all of the reasons given in this affidavit. The healthcare system, with its focus on primary and preventive healthcare, and which aims to target the reduction of, amongst others, non-communicable diseases such as diabetes and

hypertension, will better achieve the progressive realisation of the right of access to healthcare services in section 27 for persons who are currently members of medical schemes. Nor will such persons be subject to the current regime where their medical schemes do not treat diseases such as tuberculosis and HIV.

501 Solidarity complains that the NHI Act lacks "*strong governance structures*" and will fall prey to management and governance failures. Again, I deny this. The governance architecture of the NHI Act has been carefully calibrated to ensure that NHI operates optimally.

501.1 Appointment criteria for various positions are expressly laid down in the legislation. (Section 25(2) and 26(2) for example)

501.2 Interviews for appointment to the board of the fund are conducted in public by an ad hoc advisory committee. (Section 13(2) and (3))

501.3 The criteria for the appointment of the chief executive officer are "experience and technical competence" and the appointment must be "the product of a transparent and competitive process". (Section 19(1))

501.4 There are various accountability mechanisms to which I have already referred.

501.5 Section 28 lays down criteria for appointment to statutory committees under the NHI Act and standards in relation to how members of such committees are to conduct themselves. It provides –

*"**28 Conduct and disclosure of interest***

(1) A person appointed as a member of a committee contemplated in this Chapter must-

(a) be a fit and proper person;

(b) have appropriate expertise and experience; and

(c) have the ability to perform effectively as a member of that committee.

(2) A member contemplated in subsection (1) must-

(a) act in a way that is impartial and without fear, favour or prejudice;

(b) not expose himself or herself to any situation in which the risk of a conflict between his or her official responsibilities and private interests may arise; or

(c) not use his or her position or any information entrusted to him or her for self-enrichment or to improperly benefit any other person.

(3) A member contemplated in subsection (1) who has a personal or financial interest in any matter in which such committee gives advice, must disclose that interest when that matter is discussed and be recused from the discussion."

501.6 Section 38(3)(g) requires the Health Products Procurement Unit to "*establish mechanisms to monitor and evaluate the risks inherent in the public procurement process*".

501.7 Section 40(1) requires that the information system established by the Fund must be designed to enable the Fund to "*make informed decisions ... fraud and risk management*".

501.8 Section 40(5) requires that "*[t]he information architecture must include a fraud and risk management mechanism*".

501.9 Section 20(2)(g) obliges the chief executive officer to –

> *"establish ... a Risk Management and Fraud Prevention Investigation unit within the national office of the Fund for the purposes of—*
>
> *(i) investigating complaints of fraud, corruption, other criminal activity, unethical business practices and abuse relating to any matter affecting the Fund or users of the Fund; and*
>
> *(ii) liaising with the District Health Management Office concerning any matter contemplated in subparagraph (i)."*

502 I accordingly deny that the Fund will be subject to poor governance. In any event, I am advised that an assessment of the constitutionality of legislation must be based on an assumption that legislation will be lawfully implemented.

503 To the extent that Solidarity questions the technical competence of the NDoH, this is not supported by the evidence. Two massive health care interventions have successfully been carried out by the NDoH in the recent past which give the lie to Solidarity's suggestion that the NDoH lacks technical competence.

504 One is the vaccination programme to deal with the Covid 19 Pandemic. The NDoH was responsible for purchasing the COVID-19 vaccine for South Africa. Government sourced, distributed and oversaw the rollout of the vaccines. Government as the sole purchaser of vaccines distributed it to provincial governments and the private sector. Administration of the vaccinations was free at the point of care.

505 The other is the rollout of antiretroviral therapy (ART) for the treatment of HIV. In November 2003, the South African cabinet approved *The Operational Plan*

for Comprehensive Treatment and Care for HIV and AIDS. It has been highly successful. Apart from the irrefutable demonstration of technical competence on the part of the public healthcare sector, the plan and its implementation is also relevant to this matter in the following respects:

505.1 The plan was adopted and implemented without it being possible beforehand to do a single figure, single point-in-time costing for the entire plan. No-one knew what its total cost would be. Indeed had a prediction been possible, if the total costs over time were known, including the current very considerable annual costs, the decision would in all likelihood have been that the plan was not affordable for South Africa. Yet the required annual budgeting for and appropriation of funds for the Plan have been successfully implemented year after year to ensure the full rolling out of the Plan.

505.2 The Plan has also been rolled out on the basis of phased implementation over time, with a gradual acceleration of its scale and reach. For many years now, South Africa's ARV programme has been and remains the largest of its kind in the world.

505.3 A very substantial component of the Plan (and the resources allocated to it) was devoted to developing the health care infrastructure to deliver care to so many people. The plan was to shore up national laboratories, and develop a network of accredited clinical facilities that would be dedicated to HIV care. Care to people with HIV would be provided via these clinical "*service points*".

505.4 South Africa was among the first African countries to adopt the policy of '*universal*', free access to ART following the WHO's guideline recommendation and has officially been implementing the policy since September 2016.

505.5 The phased in rollout of ART has saved millions of lives and allowed the State to do so progressively based on the availability of resources.

505.6 The prevention of mother to child transmission programme has been highly successful in reducing the national infection rate among children and babies. Another key benefit of the treatment plan has been the drop in the mortality rate of mothers infected with HIV.

Labour rights

506 Solidarity alleges that the NHI Act will limit the right to collective bargaining and render agreements which regulate medical scheme benefits nugatory.

507 Section 23(5) of the Constitution provides that:

> "*Every trade union, employers' organisation and employer has the right to engage in collective bargaining. National legislation may be enacted to regulate collective bargaining. To the extent that the legislation may limit a right in this Chapter, the limitation must comply with s 36(1).*"

508 Section 28(2) of the Labour Relations Act, 66 of 1995 ("**LRA**") states as follows:

> *"From the date on which the Labour Relations Amendment Act, 1998, comes into operation, the provisions of the laws relating to pension, provident or medical aid schemes or funds must be complied with in establishing any pension, provident or medical aid scheme or fund in terms of subsection (1)(g)."*

509 Section 28(2) of the LRA will require employers, employees, employer organisations, trades unions and pension and provident fund trustees to revisit their agreements, including collective agreements, to bring them in line with the new statutory regime.

510 Insofar as section 28(2) refers to compliance upon the *establishment* of a pension, provident or medical scheme, I submit that the statutory obligation is tacitly a continuing one.

511 Even if this is not so, the NHI Act will itself require employers, employees, employer organisations, trades unions and pension and provident fund trustees to revisit their agreements, including collective agreements, to bring them in line with the new statutory regime. All new legislation requires those regulated by it to adjust their affairs so as to accommodate the change in the law and to comply with it. Collective agreements do not have any special status that allows them to prevent new legislation from being passed. Collective agreements do not prevail over the Constitution or a binding statute.

512 Moreover, in the process of adjusting collective agreements to align with the NHI Act, employees will be fully entitled freely to exercise their collective bargaining rights in negotiating new arrangements and terms and conditions of employment to adjust to the new statutory regime.

513 Nor will the NHI Act operate to diminish employee rights to healthcare. If anything it will enhance them. Employees will be entitled to receive health care free at the point of service under the NHI Act. This is so whether or not their employers (or the employees themselves for that matter) comply with their obligations in terms of any payroll tax in terms of section 49(2)(a)(iv) that

requires a contribution by employers and employees to the Fund. Free health care also remains an entitlement whether or not the employers and employees make a voluntary contribution to the Fund. Employers can still subsidise employee cover for a medical scheme providing complementary cover.

514 Therefore employers' contributions to their employees' health care will not automatically cease when the NHI Act is fully implemented, although instead of being paid to a private medical aid scheme exclusively it may be paid to the Fund or towards complementary medical scheme coverage.

515 Prof McIntyre in her affidavit at paragraphs 55 speaks to the likely scenario under the NHI Act where she states the following:

> *"It is important to note that while tax payments would increase, contributions to medical schemes should decline. This will occur when medical schemes are transformed from being supplementary (covering the same services as will be available through the NHI) to being complementary (covering services outside the NHI entitlements). As all in South Africa will be entitled to services funded by the NHIF, current medical scheme members will not be faced with paying additional taxes as well as their existing contributions to medical schemes. If they chose to have medical scheme cover for services outside the NHI entitlements, these contributions would be much less than current medical scheme contributions."*

516 Solidarity has not discharged its onus of proving that the implementation of the NHI Act will in fact infringe workers' rights under the Constitution, or indeed under their collective bargaining agreements. Therefore, there is no need for a justification in terms of section 36(1) of the Constitution in this regard.

517 Even if I am wrong in this regard, any limitation on the right to bargain collectively is justifiable in terms of section 36(1) of the Constitution.

Property rights

518 Solidarity, at paragraphs 207 to 208 of its founding affidavit alleges that the NHI Act will limit medical scheme members' right to property under section 25 of the Constitution. It says that medical scheme membership *"is a form of saving, in the sense that payments are made in the expectation that, one day, when they are sick … their health care needs will be funded by virtue of the fact that others who are young and healthy are making contributions*."

519 I deny these allegations. They are premised, amongst others, on a lack of understanding of how medical scheme membership operates.

520 Private medical aid is a form of social insurance which is secured by a contract between the medical aid scheme and the individual in terms of which the individual pays a premium for a set of standardised minimum medical aid benefits. This is consistent with the definition of the "business of a medical scheme" in the Medical Schemes Act. It is defined in summary to involve undertaking, in return for a premium or contribution, the liability associated with (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.

521 At no point does the individual acquire property through their membership of a medical scheme. Medical scheme members are only entitled to coverage by the scheme for as long as their monthly contributions are paid.

522 It is correct that in economic terms, medical schemes operate through a form of risk pooling (i.e. that healthier members who have fewer health care needs subsidise the higher costs of sick members). It is not correct, however, that payments made by a medical scheme member in previous years or months vest any entitlement or right of that member to coverage in the future by virtue of that risk pooling.

523 A contractual relationship for medical insurance through a medical scheme would not amount to property and therefore section 25 of the Constitution is not applicable.

524 Even if I am wrong about this, I deny that there is any deprivation of property brought about by the NHI Act, given the entitlements to free health care that it provides. The entitlements (except in respect of complementary health services) takes the place of the undertaking that medical schemes currently give to members in return for a premium in the definition of "*business of a medical scheme*" in the Medical Schemes Act that I have referred to. And if there is a deprivation, it is not arbitrary, so there is in any event no breach of section 25(1). Nor does Solidarity assert that there is an expropriation of property as contemplated in sections 25(2) and (3). Even if they had done, there is no expropriation and even if there was, the free health care provided for in the NHI Act would constitute just and equitable compensation.

Limitations of rights

525 Solidarity alleges that I must justify the various constitutional infringements that they allege the NHI Act violates in terms of section 36 of the Constitution.

526 At the outset, I emphasise that Solidarity has not established that any of the rights in the Constitution have been infringed. Consequently, there is no necessity on my part to justify the alleged infringements.

527 To the extent that the NHI Act does limit any constitutional rights as alleged by Solidarity (which I deny), I submit that the limitation would be eminently reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom in terms of section 36 of the Constitution, taking into account all relevant factors including those listed in section 36(1)(a) to (e). Amongst others:

527.1 The NHI Act is a law of general application.

527.2 With reference to section 36(1)(a), whilst I deny that there is any limitation of fundamental rights, if this court finds that such limitation has been demonstrated in respect of any of the rights relied upon by Solidarity, I say that those rights are better promoted across the population and across all racial groupings by the reforms that the NHI Act will introduce.

527.3 With reference to section 36(1)(b), the NHI Act will dramatically improve equity across the entire population and will address historic unfair racial and other forms of discrimination in relation to the right to health care. This is a very important purpose of the NHI Act. Moreover, the NHI Act is separately capable of justification under section 9(2) of the Constitution.

527.4 I have demonstrated above that the NHI Act also serves important purposes of advancing individuals' rights to health care, life and human dignity.

527.5 With reference to section 36(1)(c), if there is any limitation of rights, it is the minimum necessary to achieve the constitutionally compelling justification for the NHI Act.

527.6 With reference to section 36(1)(d), there is patently a rational relationship between any confined limitation of rights that the NHI may bring about and the fundamentally important purposes that it promotes. Solidarity concedes that the NHI Act serves a "*laudable*" and important objective.

527.7 I have further shown that the NHI Act is a necessary intervention that is evidence-based in its efficacy to achieve its objective.

527.8 With reference to section 36(1)(e), I deny that there are any other less restrictive (without conceding that the NHI Act is restrictive) means to achieve the objectives of the NHI Act, particularly in light of the severe and unparalleled inequity that must be corrected in South Africa's health care financing.

527.9 What Solidarity postulates as less restrictive measures are the following:

527.9.1 a risk equalisation fund;

527.9.2 the Medical Schemes Amendment Bill (B58-2008);

527.9.3 the NHI hybrid model proposed by the High level Panel; or

527.9.4 To review the decision of the Board of Medical Schemes to prevent medical schemes from providing cheaper medical aid cover options.

527.10 A risk equalisation fund ("**REF**") is a financial mechanism used primarily in health insurance systems to ensure that funds are distributed more equitably among insurers. This process is particularly relevant in markets where insurers cannot deny coverage to individuals or households on the basis of their health status, such as during mandatory open enrolment periods, or in systems with community rating obligations. The primary goal is to balance the financial risk faced by insurers that may cover individuals with varying health needs and cost burdens.

527.11 In the South African context, this would mean that medical schemes provide data about the health profiles and associated costs of their principal members and their beneficiaries. This data includes age, sex, health status, and medical history that might affect the risk profile.

527.12 The REF would then conduct an assessment directed at determining the anticipated costs of covering members of each medical scheme based on these risk factors. The outcome is that funds are calculated and transferred from medical schemes with lower-risk, less costly members to those with higher-risk, more costly members.

527.13 The REF mechanism would be designed to sustain *existing* medical schemes. It would not enable the widespread expansion of coverage, especially for the most vulnerable and needy sections of the population, that the NHI Act will bring about. The REF proposals for the South African context were designed to sustain the current medical schemes environment rather than to enhance the country's trajectory on the path to realise UHC objectives through the phased implementation of NHI.

527.14 The implementation of the REF would not address fundamental structural challenges in the health system, namely fragmentation of funding pools and the need to provide financial risk protection for the most vulnerable sections of society. REF would seek to provide financial risk protection predominantly for the high risk members of medical schemes.

527.15 Therefore, REF is not a less restrictive means to achieve UHC. REF is not a method of achieving UHC primarily because its focus is on members of the population who already have medical aid and not on equitable health coverage for all members of the population.

527.16 The Medical Schemes Amendment Bill (B58 – 2008) was neither designed nor intended to address South Africa's need to achieve UHC. Instead, the Amendment Bill was intended to provide primarily for the introduction of a risk equalisation fund and its application to the medical schemes environment.

527.17 These measures were neither designed nor intended to support South Africa's move towards realising UHC. They were intended to streamline

and strengthen the existing medical schemes, without any objective to expand access to the most vulnerable sections of the population.

527.18 Therefore, the amendment bill is not a less restrictive means to achieve the purpose of the NHI Act, primarily being the achievement of UHC.

527.19 The High Level Panel on Assessment of Key Legislation and Acceleration of Fundamental Change report indicates that the State's attempt to establish National Health Insurance is a means to address the financial allocation of resources across all levels of government, correcting management problems, reducing disparities in access to quality health care and focusing on health outcomes.

527.20 The Panel further recommended that Parliament should express its support for the introduction of a system of UHC underpinned by the principles of access to health care as of right, social solidarity, equity, health care as a public good and social investment, affordability, efficiency, effectiveness and appropriate levels of care.

527.21 The NHI Act is therefore aligned with the recommendations of the Panel. If I have misunderstood the recommendations in arriving at this conclusion, then I deny that the recommendations of the Panel represent a less restrictive means of achieving the purposes of the NHI Act.

527.22 The Hybrid proposal does not seem to be supported by Solidarity (see paragraph 212). In any event, it is not a less restrictive means to achieve the purposes of the NHI Act as it does not deal with the inherent

structural issues that the NHI Act seeks to address. The Hybrid model accepts but does not address the underlying problem, which is the disparity in access to healthcare for the poor and unemployed.

527.23 The legislative framework provided for in the NHI Act is comprehensive in that it provides for the institutional and organisational reforms that are required to achieve a unified health system, not hybrid, that allows for the strategic realisation of the right to health for all. The implementation of NHI provides an opportunity to dismantle the disparity that exists between public and private health sectors in South Africa, and allows for the introduction of systems and processes that leverage all health sector resources, public and private, to the benefit of every member of society.

528 What is particularly compelling in the context of section 36 is the evidence of Dr Kutzin that the scheme of healthcare financing provided for in the NHI Act is consistent with best practice internationally in a number of other democracies. It will also bring about compliance by South Africa with its obligations in international law.

529 In the circumstances, if there is any limitation of rights brought about by the NHI Act, the limitation is patently justifiable.

Solidarity's procedural complaints

530 Solidarity raises two process-related complaints that it acknowledges fall under the remit of the exclusive jurisdiction of the Constitutional Court.

531 These complaints relate to:

531.1 The Parliamentary process that was followed leading up to the signing of the NHI Act; and

531.2 The President and his constitutional duties insofar as they relate to his decision to assent to and sign the NHI Act.

532 If Solidarity had advanced these complaints about the NHI Act as a basis for its constitutional challenge (which it does not) and to the extent that this Court might be inclined to consider them *mero motu* (of its own accord), I am advised that this Court would have been entitled to dismiss the procedural complaints raised by Solidarity on the basis that it lacks jurisdiction.

533 Section 167(4)(e) of the Constitution provides that:

> *"Only the Constitutional Court may—*
>
> *(a) ...*
>
> *(e) decide that Parliament or the President has failed to fulfil a constitutional obligation."*

534 Section 167(4)(e) of the Constitution is plain and speaks for itself. Only the Constitutional Court can determine the constitutionality of the conduct of the President and Parliament.

535 On its own version at paragraphs 215 to 217, Solidarity does not rely on the procedural complaints and concedes that this Court lacks the jurisdiction to do so. It states that it seeks no relief from this Court in respect of these two issues, but that it raises them purely to provide *"context to the consideration of the constitutionality of the NHI Act."*

536 These allegations should be dismissed on this basis alone. I nevertheless deal with them briefly below out of an abundance of caution.

The Parliamentary Process

537 The thrust of Solidarity's argument here is that the NDoH has not presented to the public justifications for rejecting the proposals submitted during the public participation process. Furthermore, the NDoH and the majority in Parliament did not substantively consider the submissions but treated the process as a procedural formality. Solidarity also claims that the Portfolio Committee saw the engagement as a tick-of-the-box exercise to ensure that the NHI Act gets passed.

538 First, Solidarity decries the public participation process and claims that it was flawed but has not cited the National Assembly, National Council of Provinces and the Provincial Legislatures. Each of these bodies has a constitutional obligation to facilitate public involvement in their legislative processes. The Constitutional Court has recognised that their obligations to facilitate public participation are contained, respectively, in sections 59(1)(a), 72(1)(a) and 118(1)(a) of the Constitution. It is inappropriate for Solidarity to criticise the parliamentary process in these proceedings, in the absence of proper notice to these bodies. They have been denied, through Solidarity's actions, an opportunity to defend their processes. In saying this, I do not assert a fatal non-joinder. Because Solidarity disavows a procedural challenge, there was no need to join either the National Assembly or the National Council of Provinces or their speaker and chairperson.

539 Second, Solidarity's complaints concerning the process that the NHI Act followed are vague and, in any event, incorrect. Despite making sweeping allegations against how the submissions received from the public were processed, Solidarity provides no details of which proposals and concerns it claims were ignored. It also lays no foundation for its claim that the NDoH was not open to influence from the public and adopted a blinkered approach.

540 I assure this Court that the process followed by both the National Assembly's Portfolio Committee on Health and the National Council of Province Social Services Committee was fair and transparent.

541 The Report of the Portfolio Committee on Health illustrates the fair and balanced approach adopted during the parliamentary process. This will be made available to the Court should it prove necessary.

542 The National Health Insurance Bill [B11 - 2019] was referred to the Portfolio Committee on 8 August 2019.

543 In facilitating effective public participation, the Portfolio Committee conducted nationwide, in-person public hearings in all nine provinces, from 26 October 2019 to 24 February 2020. The hearings were attended by 11 564 members of the public and stakeholders across 33 municipal districts.

544 A total of 961 oral submissions were heard by the Portfolio Committee. The Portfolio Committee conducted virtual public hearings from 18 May 2021 to 23 February 2022. In total, 114 stakeholders participated in the virtual public hearings. The Portfolio Committee received approximately 338 891 written submissions from the public.

545 The NDoH responded to the issues raised from the public hearings on 29 March 2022 and 17 November 2022.

546 The Portfolio Committee proceeded to conduct clause-by-clause deliberations on the Bill, from 1 June 2022 to 16 November 2022. On 22 November 2022, the Portfolio Committee considered its matrix on the consolidated public submissions and proposed amendments, to which the NDoH responded on 30 November 2022.

547 On 15 March 2023, the Portfolio Committee received legal advice from the Parliamentary Legal Advisor and the State Law Advisors on issues raised during public hearings and the Committee's deliberations on the clauses of the Bill. On 22 March 2023, the Portfolio Committee conducted a meeting to deliberate on the Parliamentary Legal opinion and the State Law Advisor's Opinion.

548 On 29 March 2023, the Portfolio Committee held a further meeting to discuss the final amendments to the Bill.

549 The public participation process and subsequent developments culminated in amendments to 35 clauses in addition to further changes to Schedule 1 of the Bill. It is patently incorrect to say that public participation was a mere formality and had no meaningful impact on the NHI Act.

550 The process of the NCOP was similarly robust and well-executed.

551 The Bill was referred to the Select Committee on Health and Social Services in the NCOP in June 2023.

552 Public hearings were held in all nine provinces from July to October 2023. Those comments were sent to the NDoH. On 31 October 2023, and 7 and 9 November 2023, there was a consideration of public submissions, and the Ministry responded to the public submissions. An overview of the timetable and submissions made before the NCOP will be available at the hearing, should this Court so require.

553 In sum, there is no merit in Solidarity's procedural complaints. The public participation process was compliant, and the submissions received informed the final version of the NHI Act. Various stakeholders, including Solidarity, made submissions. Solidarity's true complaint is that the final version of the NHI Act was not in line with its view. But that is no cause for complaint. The Constitutional Court has made clear that the Constitution obliges legislatures to facilitate public involvement. But that being involved does not mean that one's views must necessarily prevail. There is no authority for the proposition that the views expressed by the public during the public participation process are binding on the legislature, particularly where they are in conflict with the policies underlying the legislation.

554 I am advised that the government can certainly be expected to be responsive to the needs and wishes of minorities or interest groups, but our constitutional system of government would not be able to function if the legislature were bound by these views. Public participation in the legislative process, which the Constitution envisages, is supposed to supplement and enhance the democratic nature of general elections and majority rule, not to conflict with or even overrule or veto them.

The President's duties

555 Solidarity's argument on this score is two-fold:

555.1 First, it claims that the President violated his duties in terms of section 83 of the Constitution. Solidarity argues that whereas the President must safeguard the public from unconstitutional legislation, he has allegedly failed to consider the warnings of constitutionality and simply signed the NHI Act into law.

555.2 Second, there is a complaint that the President signed the NHI Act, subject to the proviso that it takes effect on a date fixed by the President and that different dates may be fixed in respect of the coming into effect of different sections of the NHI Act. According to Solidarity, the failure of the President to set a commencement date for the NHI Act creates confusion and legal uncertainty.

556 I am advised that Solidarity has not set out a basis for its claim that by signing the NHI Act into law, the President signed unconstitutional legislation. The President signed into law an Act that had gone through a rigorous public participation process and enjoyed the support of both houses of parliament. Their claim is made without any foundation and must be dismissed.

557 I am further advised that the President is empowered to set a date for the commencement date of an Act. The President is further empowered to determine different dates for different sections of the same Act. This practice is not unique to the NHI Act and has been the case with several acts such as the Climate Change Act, 2022 and the Companies Amendment Act, 2023.

558 For all these reasons, this Court should dismiss Solidarity's procedural objections.

The exclusion of the Competition Act

559 Section 3(5) of the NHI Act states that the "*fund is exempt from the Competition Act, 1998, to enable it to fulfil its mandate as a single purchaser and single payer as contemplated in section 2*".

560 Solidarity claims that this exemption offends section 217 of the Constitution, which requires an organ of State or any other institution identified in national legislation to contract for goods and services "*in accordance with a system which is fair, equitable, transparent, competitive and cost-effective*".

No jurisdiction

561 Solidarity's challenge on competition issues implicates and requires the interpretation of sections 4, 7 and 8 of the Competition Act 89 of 1998. These provisions all fall under Chapter 2 of the Competition Act. In terms of section 62(1) of the Competition Act, the Competition Tribunal and Competition Appeal Court share exclusive jurisdiction regarding the interpretation and application of Chapter 2.

562 The High Court thus lacks jurisdiction to determine this issue. It specifically may not enquire into and determine whether there is a case that the Fund as a monopsony purchaser may abuse its dominance in breach of section 8 of the Competition Act.

563 I address the substance of Solidarity's claims below without prejudice to the submission that this Court lacks jurisdiction to determine them.

Solidarity's competition challenge is unsupported by evidence

564 Solidarity's claims as they relate to competition issues are entirely speculative. It provides no evidence, least of all expert evidence to substantiate the alleged uncompetitive effects and the purported impacts thereof. The claims should be dismissed on this basis alone.

The exemption in section 3(5) of the NHI Act

565 Solidarity's case as it relates to section 3(5) of the NHI Act is flawed for at least four reasons:

565.1 First, section 3(5) of the NHI Act does not exempt the Fund from compliance with section 217 of the Constitution. The Fund need not be subject to regulation by the Competition Act in order to contract in a competitive, fair, equitable, transparent and cost-effective manner.

565.2 Second, the regulation of competition in markets under the Competition Act and the regulation of State procurement in section 217 of the Constitution are not comparable – the exclusion of the Competition Act cannot without more cause an infringement of section 217 of the Constitution.

565.3 Third, section 3(5) of the NHI Act does not exclude all "*transactions*" under the NHI Act from competition regulation as earlier drafts of the Bill did – it is only the Fund itself whose activities are excluded. All

accredited health care providers, health establishments and suppliers therefore remain subject to the Competition Act.

565.4 Fourth, the requirement in section 217 of the Constitution for organs of State and legislative entities to contract for goods and services *"in accordance with a system which is fair, equitable, transparent, competitive and cost-effective"* does not impose requirements on the State or the Fund to maintain a competitive market.

565.5 Section 217 of the Constitution does not preclude the State from being a monopsony purchaser. Nor does it preclude the State from determining the price that it is willing to pay for goods and services.

565.6 When procuring goods and services, the State frequently operates as a dominant purchaser and sometimes the only purchaser in that market. For example:

565.6.1 The Office of the Chief Justice is the only purchaser of online filing systems such as CaseLines and CourtOnline for use by the judiciary.

565.6.2 The South African Social Security Agency is the only purchaser of systems used for the payment of social grants.

565.6.3 The State may be the only purchaser of certain nuclear or military supplies.

565.7 The mere fact that the Fund is a monopsony purchaser cannot and does not in itself offend section 217 of the Constitution. This is the same

under sections 7 and 8 of the Competition Act. The mere fact that the Fund has monopsony power does not contravene section 8 of the Competition Act. The Competition Act only prohibits the abuse of a dominant position and not the fact of the dominant position.

565.8 Section 217 of the Constitution requires the State and legislative entities to contract through a system that is fair and competitive in the sense that suppliers are afforded equitable opportunities to sell to the State on a basis that is competitive with other suppliers, in order to ensure that the State's procurement advances cost-effectiveness and quality. The State may not foreclose the opportunity for suppliers to compete to supply goods and services to it (in accordance with the transparent terms that it sets for that procurement) other than through the provisions of the exceptions in section 217(2).

565.9 The NHI Act does not preclude compliance with these requirements of section 217 of the Constitution. To the contrary, as the expert affidavits show:

565.9.1 It will incentivise health care providers and facilities to compete with one another in the quality of their services to gain market advantage.

565.9.2 The transparent system of accreditation and contracting ensures the fairness of their opportunities to become suppliers to the Fund.

565.10 The HMI Report shows further that the private health care sector as it currently exists is not competitive in any event in a manner that promotes consumer interests, quality and cost-effectiveness. It shows, amongst others, the following.

565.11 Three hospital groups (Netcare, MedicClinic and Life) dominate the facilities market, which groups are able to distort and prevent competition. The concentration in the facilities market makes it more vulnerable to formal and informal collusion. There is also no scrutiny of the quality of their services and the clinical outcomes that they deliver. "*It is impossible for patients, funders or practitioners to exercise choice based on value (quality and price).*"

565.12 There is no standardised method to measure and to report on quality and health outcomes in the private practitioner markets. "*The public is uninformed and cannot compare outcomes across interventions and practitioners*". "*Funders too cannot contract on value for money*". Some market participants behave anticompetitively to the detriment of consumers and there is evidence of supplier-induced demand pushing up prices.

565.13 The parameters of competition are distorted in the funder market. The nature of competition on benefit design in the funder market is at the expense of competition on metrics which improve consumer welfare on, amongst others, value-for-money and service quality. Consumers are unable generally to easily compare options across funders. This results in funders having no pressure to compete on pro-consumer metrics or

to offer better products. The features of the funder market "*do not foster an environment conducive to competition on metrics which would result in positive consumer welfare outcomes*."

565.14 In contrast, the NHI Act is designed to address these deficiencies in the private sector. It will reform health care financing in a manner that has been shown internationally to improve health outcomes for the population, to improve the cost-effectiveness of services and supplies, and to improve quality of care. The expert affidavits affirm this.

566 Solidarity refers to submissions on the NHI Bill that raised concerns that the exemption in section 3(5) of the NHI Act would result in abuse of dominance or horizontal collusion contrary to the Competition Act. While this is not a challenge in Solidarity's application, it is in any event a misguided concern. It has no relevance to section 3(5) as it is formulated in the NHI Act (i.e. with the limited exemption granted to the Fund only).

566.1 The exemption in section 3(5) of the NHI Act cannot give rise to potential horizontal collusion in terms of section 4 of the Competition Act. Horizontal collusion is collusion by two or more competitors. The Fund cannot collude with itself.

566.2 All accredited health care providers, health establishments and suppliers remain subject to the Competition Act and may not collude.

566.3 Solidarity cannot and also does not show that the NHI Act necessitates or is likely to lead to horizontal collusion by suppliers in a way that offends section 217 of the Constitution.

566.4 Solidarity has not proven that the Fund as a monopsony purchaser is likely to abuse its dominance within the meaning of section 8 of the Competition Act. It does not even allege in what manner it would do so. It further provides no evidence or economic theory to make out such a case.

566.5 I deny that the Fund has any incentive under the NHI Act to abuse its dominance. To the contrary, the NHI Act requires the Fund to act in the best interests of users (section 11(2)(c) of the NHI Act) and to negotiate the lowest possible price for goods and health care services without compromising the interests of users or violating the provisions of this Act or any other applicable law (section 11(2)(e) of the NHI Act).

566.6 Even if Solidarity had shown that the Fund would abuse its dominance, it fails to demonstrate why this would offend against section 217 of the Constitution.

"Uncompetitive outcomes" contrary to section 217 of the Constitution

567 Regarding choice of health care providers:

567.1 Solidarity says that the exemption of the Fund from the Competition Act will result in uncompetitive outcomes in relation to the ability of users to choose health care providers.

567.2 Solidarity provides no evidence, expert or otherwise, to support this claim. It has failed to provide any explanation (even on an abstract basis) on how the NHI Act limits users' choice of health care providers.

567.3 The NHI Act in any event does not restrict users' right to choose their health care providers as I have set out above.

567.4 Even if it were true that the NHI Act restricted the right to choose one's health care provider (which I deny) Solidarity has neither shown how this offends section 217 of the Constitution nor how the exemption in section 3(5) of the NHI Act is the cause of that unconstitutionality.

567.5 I note, moreover, that in the private sector as it currently operates, many medical scheme members are restricted to the use of their scheme's select network of hospitals and doctors or designated service providers.

568 Regarding the use of selective contracting:

568.1 Solidarity says that the exemption of the Fund from the Competition Act will result in uncompetitive outcomes in relation to selective contracting.

568.2 Section 10(1)(d) of the NHI Act requires the Fund to "*enter into contracts with accredited health care service providers based on the health care needs of users*". Solidarity does not and cannot demonstrate how the Fund's contracting duties offend section 217 of the Constitution, nor how the exemption in section 3(5) of the NHI Act is the cause of that unconstitutionality.

569 Regarding the reduced role of medical schemes:

569.1 Solidarity says that the exemption of the Fund from the Competition Act will result in uncompetitive outcomes in relation to the role of medical schemes.

569.2 Again, the founding affidavit is silent on how Solidarity alleges this to be so. It makes no allegations, expert or otherwise, on how the role of medical schemes under the NHI Act is "*uncompetitive*" (or unfair, inequitable, untransparent or not cost-effective) in a manner that is non-compliant with the State's contracting duties under section 217 of the Constitution.

569.3 There is nothing in the NHI Act which anticipates the Fund contracting with medical schemes at all.

570 Regarding the reimbursement of service providers:

570.1 Solidarity says that the exemption of the Fund from the Competition Act will result in uncompetitive outcomes in relation to the reimbursement of service providers. While not a direct challenge on its own, Solidarity further refers to arguments made by other stakeholders that the price-setting mechanism in clause 11(2)(e) of the NHI Act infringes (amongst others) section 217 of the Constitution.

570.2 As is set out above, section 217 of the Constitution does not preclude the State or legislative entities from operating as monopsony purchasers or from determining the price that they are willing to pay for goods and services. Even the Competition Act does not prohibit —

570.2.1 monopsony power *per se*; or

570.2.2 the monopsony purchaser from setting a price at which it will contract, provided that the price set does not involve an abuse of dominance.

570.3 I am left to speculate on what Solidarity's case is here – how it contends that provider reimbursement is uncompetitive in a manner that offends section 217 of the Constitution. Solidarity has failed to make out a case in this regard.

570.4 I note that the NHI Act neither prescribes nor forecloses competition amongst suppliers, health care providers or establishments.

570.5 Insofar as health care benefits are concerned:

570.5.1 The economic logic of the provider payment system under a monopsony purchaser incentivises health care providers and establishments to compete with one another on patient outcomes and quality of care.

570.5.2 By way of example, the capitation system for primary health care will mean that health care providers and establishments are compensated per capita for their registered patients. This incentivises health care providers and establishments to keep those patients healthy and prevent illness (in order to reduce the cost of their care through repeat visits). It also incentivises health care providers and establishments to compete with one another to make their services more effective and desirable to users in order to gain greater market share by attracting the registration of more users.

570.5.3 The price-determination methods by the HCBPC under the NHI Act (as I have explained above) will, moreover, ensure cost-

effectiveness for the State, through a consultative process, without compromising the best interests of users.

570.5.4 In addition, health care providers and establishments will be afforded price or payment performance incentives (sections 10(1)(k) and 41(4)(a) and (c) of the NHI Act).

570.6 Solidarity does not complain about the reimbursement of suppliers of health care products. I note, however, that there is similarly nothing in the NHI Act which precludes the State from contracting in a manner that is fair, equitable, transparent, competitive and cost-effective.

571 Regarding the introduction of health-related innovations:

571.1 Solidarity says that the exemption of the Fund from the Competition Act will result in uncompetitive outcomes in relation to the "*effect on the timeous introduction of health-related innovations*."

571.2 Solidarity provides no evidence, expert or otherwise, to substantiate the claim. It is denied.

571.3 Solidarity provides no economic justification for why a multi-payer environment would lead to the more timely introduction of health-related innovations than a single-payer system. It is a baseless and incorrect assumption.

571.4 If anything, the NHI Act will incentivise innovation on behalf of the entire population. Amongst other things, the focus on quality health care

services and the introduction of standards to measure quality will more likely incentivise innovation.

572 Regarding the needs of specific populations and areas:

572.1 Solidarity claims that the exemption in section 3(5) of the NHI Act "would detract from a price negotiation system that would provide flexibility in pricing and adaptability to the needs of specific populations and areas".

573 Solidarity provides no evidence of this speculative outcome. To the contrary, the registration, accreditation, contracting and operational management systems in the NHI Act are designed to ensure that demographic and epidemiological health needs are identified and met.

Section 195 of the Constitution

574 Solidarity asserts that the NHI Act undermines section 195(1)(b) of the Constitution. This is because section 195(1)(b) enjoins the public administration to promote "*efficient, economic and effective use of resources*".

575 According to Solidarity, the NHI Act requires the setting up of a burdensome and costly set of administrative bodies, including the NHI Board and the various committees envisaged under the NHI Act. Solidarity argues that the NHI Act in section 57(3) empowers me or my successor to set up various "*interim committees*" to advise me on the implementation of the NHI scheme. It proceeds that in August 2022 the NDoH advertised 44 vacancies for technical specialists to assist with preparations for the functions of the NHI Fund. For that purpose, funds of the NDoH had been shifted. It argues that "*spending vast amounts of money on the creation of yet more bureaucratic structures when*

public health care facilities are in a dire state, and health care provision offered by the state is dismal, is simply reckless".

576 Section 195(1) provides that the public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles: (a) a high standard of professional ethics must be promoted and maintained; and (b) efficient, economic and effective use of resources must be promoted.

577 The appointment of technical specialists advances the realisation of section 195. The appointments ensure that capable and experienced professionals are appointed to build up the capacity of the Fund. The appointments also show that steps are being taken to ensure that systems and personnel will be in place when the NHI implementation is rolled out.

578 Section 195 of the Constitution, despite its importance, does not give rise to enforceable rights that can form the basis of a challenge to the validity of legislation. Even if it did provide a basis for such a challenge, there is nothing inconsistent between the NHI Act and the provisions in section 195. On the contrary, the NHI Act will promote the achievement of all nine of the principles listed in section 195(1)(a) to (i). I highlight –

578.1 Principle (b) requiring that efficient, economic and effective use of resources must be promoted – this is precisely what the pooling arrangements discussed in this affidavit achieve;

578.2 Principle (c) requiring that public administration must be development-oriented – attending properly to the healthcare needs of the majority of. the population will strongly promote human development;

578.3 Principle (d) requiring that services must be provided impartially, fairly, equitably and without bias – this is not so under the current bifurcated system; it will be so under the NHI Act;

578.4 Principle (e) requiring that people's needs must be responded to – people's health needs are not adequately responded to under the current bifurcated system, but will be under the NHI Act;

578.5 Principle (g) requiring that transparency must be fostered by providing the public with timely, accessible and accurate information – in the context of accessible individual health information, which can quickly be accessed and applied to diagnosing and treating a health condition, the information system (already the development of the system is well-advanced) operated by the Fund will be a game-changer.

579 Turning to Solidarity's complaint about having employed staff in anticipation of the NHI Act coming into force and ensuring readiness, an unavoidable reality of the NHI Act is that qualified, competent professionals will need to be hired in order to set up the Fund. Those individuals will need to be remunerated accordingly.

580 Solidarity's complainant against the 44 appointments is baseless. Solidarity has already been before this Court with that application and the Court dismissed its

application with costs. The judgment is reported as *Solidarity v Minister of Health* 2024 (5) SA 563 (GP).

VI AD SERIATIM RESPONSE

581 In what follows, I deal with the allegations contained in Solidarity's founding affidavit on a paragraph-by-paragraph basis. I do so only to the extent that it is necessary taking into account what I have already said above.

582 I deny the founding affidavit in every respect in which it is contradicted by or in conflict with what I have said above.

583 Where I neglect to deal with any specific allegation that is in contrast to or does not accord with what is stated in this affidavit, the allegation should be considered as denied.

Ad paragraphs 1, 2, and 3

584 Apart from denying that the contents of the affidavit are true and correct, the remainder of the allegations contained herein are noted.

Ad paragraph 4

585 Solidarity's understanding of the health system is not based on a proper or correct health system analysis.

586 I have explained in paragraphs 83 to 86 that South Africa not currently have UHC and that the statement that public health care is universally free at point of service for the entire population is inaccurate.

Ad paragraph 5

587 While I accept that there are significant and multifaceted challenges in the public health care sector, some of which NHI is designed to address, I deny the truth or accuracy of Solidarity's description of the public health care sector.

588 The public health care sector serves the majority of South Africa's population on less than half of the country's entire health care spend. The available funding is simply inadequate, and the inequity of access between the public and private sectors is unconstitutional. The NHI Act seeks to address these problems.

589 I deny that the public health care sector is the cause of inequity in access to health care. While the causes of inequity and inequality are complex and multi-faceted, the inequity and inequality cannot be corrected while maintaining the private health care sector funding model as it exists in South Africa today. Prof McIntyre at paragraph 97 of her affidavit, and Dr Kutzin at paragraph 40 of his affidavit, both confirm this.

590 I deny that Annexure "*AB2*" (the article by Prof Laetitia Rispel) supports Solidarity's allegations. A reading of the article indicates to the contrary. I also refer to the affidavit by Prof Rispel, which will be filed together with my affidavit, in further support of the allegations that I make to follow.

590.1 Solidarity misunderstands and misinterprets Prof Rispel's article.

590.2 Prof Rispel herself was surprised to see her article used in the manner Solidarity has done. She describes its use of her work as "*objectionable*".

590.3 Prof Rispel also affirms that Solidarity never consulted with her on its content nor sought to retain her as an expert.

590.4 The article was published almost a decade ago: it is by no means a current assessment of the South African health care system. The problems and challenges to which she refers have substantially been addressed to the full extent that budgetary constraints in the current system permit.

590.5 In her article, Prof Rispel in most instances provides a balanced view. She notes the significant progress in the public health care sector since 1994 and, if anything, stresses the importance of equity. She specifically records in the article her concern that I have similarly described in this affidavit that *"[a]lthough we spend 8.5% of our gross domestic product ... on health care, or [at the time of her writing] R332 billion in monetary terms, half is spent in the private sector catering for the socio-economic elite. The remaining 84% of the population, who carry a far greater burden of disease, depend on the under-resourced public sector*".

590.6 While Prof Rispel describes fault lines in the public health care sector that needed to be addressed, there is nothing in the article that implies NHI is unfeasible, or that the public health care sector was incompetent.

590.7 To the extent that Prof Rispel identifies fault lines such as staff shortages in the public health care sector and the "*crisis of inequalities and maldistribution of health workers*", these are precisely issues that NHI is designed to reform.

590.8 Her article does not suggest that NHI is a bad policy, that the NHI Act should not have been passed, or that it should be struck down by the courts.

590.9 To the contrary, she says in the penultimate paragraph of her article:

"The reforms envisaged by NHI provide exciting opportunities for health system change in South Africa, rarely available in most countries. The process requires the active participation of all stakeholders, including the Academy".

Ad paragraph 6

591 This is admitted.

Ad paragraph 7 to 7.3

592 I admit that the NHI Act introduces significant reforms for the financing of the entire health care system.

593 I however deny that this reform is disruptive in a negative or harmful manner and that it is something to be feared. To the contrary, as I set out in Part IV of this affidavit, and as confirmed by Dr Kutzin in paragraph 42 of his affidavit, the reform warranted.

594 I admit the remainder of the allegations insofar as they accurately record the provisions of the NHI Act.

Ad paragraph 8

595 I refer to what I state above regarding the importance of the reforms in the NHI Act.

596 I deny that the NHI Act is unclear.

597 I admit that:

597.1 the NHI Act establishes the Fund as a monopsony purchaser;

597.2 the Fund is excluded from the Competition Act under section 3(5) of the NHI Act; and

597.3 once the NHI Act is fully implemented, medical schemes will only be entitled to offer complementary cover under section 33 of the NHI Act.

598 It is unclear to me what Solidarity means when it says that services will be "*reimbursable*" subject to the conditions in section 8(2) of the NHI Act. Section 8(2) of the NHI Act describes those services which an individual will be required to pay for out of pocket or through private insurance.

Ad paragraph 9

599 For reasons already articulated in this affidavit, I deny that the NHI Act does not pass constitutional muster. I deny that Solidarity is entitled to the relief which it seeks.

600 I note that Solidarity considers the NHI Act to be "*morally praiseworthy in its intentions*".

Ad paragraphs 10 to 10.6

601 For reasons articulated at paragraphs 316 to 371, I deny that the scheme created under the NHI Act or any particular provision of the NHI Act is vague,

unconstitutional or offends the rule of law. Without undermining the generality of these denials, I state further as follows.

602 I admit that the benefits to which users will be entitled under the NHI Act are not defined in the NHI Act itself. The way in which these benefits will be determined are detailed in the NHI Act. As I describe above, and as confirmed in paragraphs 44 to 49 of Dr Kutzin's affidavit, it is a necessary feature of the NHI Act that the benefits are not defined in primary legislation in order to afford the flexibility required to fulfil users' right to access health care in line with the population's health care needs, the best available evidence and treatments at the time, and the Fund's budget.

603 I deny that Solidarity's understanding of the way in which money bills operate is correct or that the operation of the NHI Act is "*impossible*" or not feasible as alleged. I deal with this in paragraphs 270 to 315 above.

604 I deny that the NHI Act's phased implementation is in any manner unlawful or unconstitutional. To the contrary, the phasing in of the NHI Act in section 57 according to a "*progressive and programmatic approach based on financial resource availability*", is necessary and responsible in light of the scope of reforms undertaken, and in accordance with the State's duty under section 27(2) of the Constitution to achieve the progressive realisation of the right of access to health care services within the State's available resources.

605 I deny that section 33 of the NHI Act is vague or unclear.

606 I deny that it is unclear whether uncontracted health care providers or establishments "*will be prohibited from rendering health care services to the public*".

606.1 I deal with this above.

606.2 There is no provision in the NHI Act which prohibits the provision of health care of any kind.

606.3 What the NHI Act does require is that health care providers and establishments must be accredited and contracted with the Fund in order to receive payments for health care services from the Fund, and that medical schemes will be permitted to provide only complementary cover once the NHI Act is fully implemented.

Ad paragraphs 11 to 11.5

607 I deny that there is no rational relationship between the scheme adopted under the NHI Act and the achievement of a legitimate government purpose. I deny that the NHI Act's implementation is not feasible. I refer further to what I say in paragraphs 270 to 315 above in relation to the feasibility of NHI.

608 I deny that the NHI Act poses a threat to the existing access to health care of some or any current members of medical schemes. To the contrary, and particularly in light of the trajectory of private sector financing for health as I set out in Part IV above, NHI is a necessary intervention to protect medical scheme members from a denial of their right of access to health care with membership becoming increasingly unaffordable and inaccessible even to the small portion of the population who can currently afford it.

609 As Prof McIntyre states in paragraph 76 of 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.

610 I deny that "*health care practitioners will emigrate in large numbers if subjected to the NHI system*". This is a baseless and speculative claim. Solidarity fails to provide any of the alleged "*available studies and research*" to confirm these sensationalised claims to be true.

Ad paragraphs 12 to 12.5

611 I deny that the NHI Act is unconstitutional. I also deny that the Minister's powers are unlawful or arbitrary including in respect of central hospitals.

612 Section 7(2)(f)(ii) of the NHI Act does not circumvent statutory obligations in a way that is unconstitutional or unlawful. I am advised that it is a trite canon of interpretation that one must generally read legislation holistically and not in isolation. To the extent that there is a clear conflict (which I deny that there is in this case), section 3(3) of the NHI Act states that the NHI Act prevails except in the case of conflict with the Constitution, the Public Finance Management Act or any Act expressly amended in the NHI Act.

613 The categories of hospitals are covered by GNR.185 of 2 March 2012: Regulations: Categories of hospitals (Government Gazette No. 35101).

614 Regulation 2 deals with the categories. The following are categories of public hospitals—(a) district hospital; (b) regional hospital; (c) tertiary hospital; (d) central hospital; and (e) specialised hospital.

615 The Regulations already have a list of central hospitals. This is attached as Annexure "**PAM6**".

616 Therefore, my role in this regard is neither unconstitutional or arbitrary.

Ad paragraph 13

617 I deny the contents of the paragraph. I further refer to paragraphs 372 to 378 of this affidavit.

Ad paragraph 14

618 For reasons explained at paragraphs 389 to 422, I deny the contents of this paragraph.

Ad paragraphs 15 to 15.4

619 I deny the contents of the paragraph and refer to what I say at paragraphs 491 to 505 of this affidavit.

620 I reiterate that the NHI Act fulfils the State's duty to progressively realise everyone's right to access health services specified in section 27 of the Constitution. It is a reasonable and progressive measure.

621 I deal with the position of asylum seekers at paragraphs 423 to 437 above.

622 I deny that registration requirements are an infringement of the right to access health care services.

622.1 I note that the registration of users is dealt with in section 5 of the NHI Act, not section 4 as Solidarity alleges.

622.2 Currently, prospective members of medical schemes will typically be required to sign up for membership with their schemes and to give certain demographic information when doing so. During the underwriting process, prospective members may even be required to undergo blood tests and medical examinations.

622.3 Moreover, every time that a patient in the private sector consults with a new health care provider, they have to provide extensive personal information and their medical histories. These processes are time and resource intensive.

622.4 The NHI Act poses relatively minimal registration requirements in contrast. It requires certain biometric information and identification documents in addition to other requirements that may be prescribed under section 5(5). Once a user is on the system, they will not need to register again and will be able to access services seamlessly between different health care providers.

622.5 These are ordinary and necessary administrative procedures that will in the long run lighten the administrative burden on users when accessing health care.

622.6 I deny that current medical scheme members will be required to *"compete for access to health care"*. I note, however, that the allegation illustrates the elitism that underlies Solidarity's case. It seeks to stoke fear about wealthy people who currently access private sector care having to access health care in the same places as the poor, Black

majority. The exclusivity and inequity that Solidarity seeks to preserve is unconstitutional.

622.7 I deny that the structure of the NHI Act is "*bound to result in inefficiencies, delays and inequities*". The expert evidence of Prof McIntyre indicates that, to the contrary, the pooled risk pool and single-purchaser system will improve cost-effectiveness, minimise administrative inefficiencies, and advance equity.

622.8 I refer further to paragraphs 270 to 315 above, where I deal with Solidarity's complaints about the affordability and feasibility of NHI.

Ad paragraph 16

623 I deny that the rights alleged by Solidarity in this paragraph are infringed for the reasons more fully set out at above.

Ad paragraph 17

624 I deny the contents of the paragraph for the reasons more fully set out at paragraphs 525 to 529 of this affidavit.

625 I deny that any rights in the Constitution are infringed by the NHI Act. To the extent that there exists or is a threat of a limitation of rights (which I deny), such limitation would in any event be reasonable and justifiable in an open and democratic society for all of the reasons which I provide above.

626 I note that both Prof McIntyre and Dr Kutzin dispute (as do I) the claim that the solution to advancing UHC in South Africa is to simply "*fix the public health care sector*".

627 While I do not deny that there exist challenges in the public health care sector, I deny that those challenges are exclusive to the public sector. This includes the problems of maladministration and fraud, the incidence of which is rife in the private sector.

Ad paragraph 18

628 For reasons set out at paragraphs 574 to 580 of this affidavit, I deny that the NHI offends section 195 of the Constitution.

Ad paragraph 19

629 For reasons set out at paragraphs 559 to 573 of this affidavit, I deny that the NHI offends section 217 of the Constitution.

Ad paragraph 20

630 For reasons set out at paragraphs 530 to 536 of this affidavit, I deny the contents of this paragraph.

Ad paragraphs 21 – 39

631 I deny the truthfulness and accuracy of the annexures referred to in these paragraphs.

632 I deny that Solidarity may simply incorporate its submissions and presentations on the NHI Bill by reference. It does so in a manner to advance its shotgun approach to this litigation. The submissions and presentation were made in relation to the NHI Bill and not the NHI Act in its final form. Moreover, Solidarity

expressly (and with respect correctly) disavows reliance on any procedural complaints. They are therefore irrelevant to this application.

633 Solidarity's letters are irrelevant to this application because it expressly disavows any relief as well as this Court's jurisdiction to deal with its procedural complaints as they relate to the President.

634 I deny the relevance and accuracy of Solidarity's purported "*cost reports*".

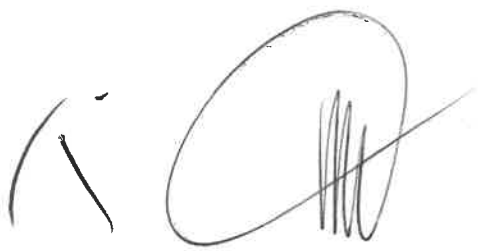
634.1 I have demonstrated above that, notwithstanding the clarity of the NHI Act, Solidarity misapprehends how the Fund will operate. It cannot assess the costs of a system that it fails to understand.

634.2 Solidarity has also failed to apprehend the economics of the NHI system as a whole. The system is designed to reduce the cost of services and supplies and improve existing administrative inefficiencies in both the public and private sectors. It is therefore a flawed exercise to do as Solidarity's "*cost reports*" do, i.e. to extrapolate future costs based on current costs of care in an inefficient and wasteful system.

634.3 I have further explained (as Prof McIntyre confirms in her affidavit) that Solidarity puts the cart before the horse in attempting to cost NHI. I also refer to what Dr Kutzin says in this regard in his affidavit at paragraphs 59 to 66.

634.4 I deny that NHI is unaffordable. What South Africa cannot afford is to continue with the health care financing system as it is.

635 The remainder of the allegations are noted.



Ad paragraphs 40 to 42

636 While I accept that the Court has jurisdiction to entertain Solidarity's application, I deny that the prematurity of the application is irrelevant for the reasons I set out in paragraphs 26 to 37 above.

Ad paragraphs 43 to 68

637 The contents of these paragraphs are admitted solely to the extent that they correctly state the provisions of the NHI Act and do not conflict with what I have said in this affidavit.

Ad paragraphs 69 to 88

638 I refer to what I say in paragraphs 530 to 558 above on Solidarity's purported procedural complaints.

639 I deny Solidarity's characterisation of the submissions made on the 2019 NHI Bill.

639.1 It is correct that most submissions principally endorsed the concept of UHC. I say that, however, subject to the proviso that some commentators, like Solidarity, fail to understand the core principles of UHC as I have set them out above.

639.2 There have been a wide range of views on the Bill. Some of which expressed concerns but many of which also expressed support.

640 I object to the manner in which Solidarity has annexed and seeks to rely on the submissions made by various parties on the Bill.

640.1 I deny that the selective submissions included are an accurate reflection of the tone of all of the submissions received.

640.2 I also deny the content of those submissions to the extent that they conflict with what I state in this affidavit.

640.3 Much of the content of these submissions amount to opinion evidence by individuals (or even unnamed authors on behalf of organisations) who have not been qualified to provide opinion evidence to this Court. Their opinions are also riddled with hearsay evidence, and are not supported by facts in the manner in which opinion evidence ought to be led.

640.4 These submissions are also irrelevant in light of Solidarity's express disavowal of any reliance on procedural complaints, and because these submissions were made on the Bill and not the final Act.

640.5 I object in particular to Solidarity's reliance on what it terms an "*expert review*" of the Bill by Prof Alex van den Heever and a presentation by him. Solidarity relies on the opinions in these annexures as if Prof van den Heever has been qualified as an expert in these proceedings. He has not been so qualified. Much like the work of Prof Rispel, Solidarity relies on its own interpretation of the report.

640.6 The manner in which Solidarity has sought to lead evidence in this case is prejudicial. To the extent that I answer to any of the allegations made by Prof van den Heever or any of the submissions by other parties on

the Bill, I do so because the State takes seriously its accountability to the Constitution and I do so without prejudice to my objections.

641 I deny that Solidarity's submissions, or those of any party, were ignored or inadequately considered. The NDoH addressed comments on the Bill thematically. I deny that the NdoH's response was insufficient, superficial or dismissive in the manner that Solidarity suggests.

642 The remaining contents of these paragraphs are admitted to the extent that they correctly reflect the executive and legislative process of the NHI Act and what I have said in this affidavit.

Ad paragraphs 89 to 104

643 For reasons set out at paragraphs 270 to 315 of this affidavit, I deny that the NHI Act is not feasible. In this regard, I also refer to the expert affidavits of Prof McIntyre, Dr Budlender and Dr Kutzin.

644 I repeat my objection to the manner in which Solidarity relies on Prof van den Heever's opinions in these proceedings. I deny that it is entitled to rely on his "*expert report*" as if incorporated in the founding affidavit for the reasons I give above.

645 Without prejudice to this objection, I refer to the responses to Prof van den Heever's views in the expert affidavits of Prof McIntyre and Dr Kutzin.

646 I note, moreover, that where Prof van den Heever has in fact appeared as an expert witness under oath in trial proceedings, the Court considered his evidence to be unpersuasive. I refer in this regard to the judgment in *TN obo*

BN v Member of the Executive Council for Health, Eastern Cape 2023 (3) SA 270 (ECB) where the Eastern Cape division of the High Court had the following to say about Prof van den Heever:

646.1 The Court noted several aspects of Prof van den Heever's evidence which it said "*are of concern*" and "*troublesome*" (para 137).

646.2 The Court criticised his opinions for being poorly justified, relying exclusively on "*words and figures from various reports*" from which he sought to draw conclusions (para 137). He also came to conclusions on important issues without considering the actual issues in question (para 139).

646.3 The Court criticised his reliance on hearsay evidence in support of his opinions (para 144).

646.4 While the Court expressed its regret at being critical of a person of Prof van den Heever's stature and qualifications, it highlighted a lack of independence in his evidence. It described him as becoming wedded to his views, being unwilling to make simple concessions, refusing to answer questions, answering others with lengthy and irrelevant hypotheses, and demonstrating a willingness "*to fortify his views in any way he could*" (para 144).

646.5 It further noted that there was evidence of his tendency of being publicly critical of departments of health (para 144).

646.6 The Court aligned itself with expert opinion that described Prof van den Heever's views as "*incautious*" and having a tendency to abstract

general critiques based on secondary information to make specific conclusions (para 151).

647 I submit that Prof van den Heever's views that are annexed to and repeated in the founding affidavit suffer similar flaws as those expressed by the Eastern Cape High Court.

Ad paragraphs 105 to 124

648 I deny that the NHI Act is irrational, arbitrary, unconstitutional or invalid. I refer further to paragraphs 286 to 293 of this affidavit.

649 I note that throughout the founding affidavit, Solidarity repeatedly notes the *"laudable"* aims and objectives of the NHI Act. It therefore admits that the NHI Act aims to achieve a legitimate government purpose.

650 I have demonstrated above that the NHI Act is a reasonable legislative measure to achieve those aims.

Ad paragraphs 125 to 134

651 I deny that the NHI Act is unreasonable and therefore unconstitutional and invalid and refer to what I set out at paragraphs 294 to 315 of this affidavit as it relates to reasonableness, and paragraphs 361 to 371 of this affidavit as it relates to the role of medical schemes.

Ad paragraphs 135 to 143

652 For reasons set out at paragraphs 316 to 371 of this affidavit, I deny that the NHI Act is vague and therefore unconstitutional and invalid.

Ad paragraphs 144 to 152

653 I deny that the NHI Act impedes upon the constitutionally protected powers of provinces. I refer further to paragraphs 389 to 422 of this affidavit. Further legal argument will be advanced on these issues.

Ad paragraphs 153 to 154

654 I deny that the Fund's powers under the NHI Act are unconstitutional and refer to what I say above in paragraphs 379 to 388.

Ad paragraphs 155 to 164

655 For reasons set out at paragraphs 423 to 437 of this affidavit, I deny that the NHI Act unjustifiably violates and/or limits the rights of asylum seekers and non-citizens.

Ad paragraphs 165 to 172

656 For reasons set out at paragraphs 438 to 445 of this affidavit, I deny that the NHI Act unjustifiably violates and/or infringes the rights in section 10 and section 12 of the Constitution.

Ad paragraphs 173 to 176

657 I deny the allegations. I refer further to what I say above at paragraphs 446 to 454 on Solidarity's complaints as they relate to the right to life.

Ad paragraphs 177 to 182

658 For reasons set out at paragraphs 455 to 465 of this affidavit, I deny that the NHI Act unjustifiably violates and/or infringes the right to freedom of association in section 18 of the Constitution.

Ad paragraphs 183 to 191

659 For reasons set out at paragraphs 466 to 490 of this affidavit, I deny that the NHI Act limits the right to freedom of trade, occupation and profession in section 22 of the Constitution, alternatively that any such limitation is constitutionally unjustifiable.

Ad paragraphs 192 to 198

660 I deny that the NHI Act:

660.1 unjustifiably violates and/or infringes the right to access to health care in section 27 of the Constitution;

660.2 is a regressive measure;

660.3 will deprive medical scheme members of access to health care; or

660.4 will be implemented in the absence of "*strong governance structures*".

661 I deny that Solidarity's vague references to "*governance failures*", "*improprieties*", "*unsatisfactory leadership*" and management, and corruption are either truthful or in any manner useful to assessing the constitutionality of the NHI Act.

662 I confirm that there are significant challenges in the public health care sector. This includes, as Solidarity notes, that the public health care sector is *"overburdened and under-resourced"*. I, however, deny that Solidarity offers an accurate or complete account of the public health care sector.

663 While it must be accepted that health outcomes in South Africa remain inadequate, there have been significant improvements in key markers of health outcomes since 1994, despite the public health care sector being so disproportionately under-resourced. This includes very significant improvements in life expectancy, maternal mortality, and mortality amongst children under five years.

664 I agree with Solidarity that the NHI Act cannot solve all of the problems in South Africa's public health care system. Indeed, the NHI Act has never been presented as a complete panacea to the problems of the system as a whole, or the public health care sector in particular. The NHI Act is, however, a critically important and necessary intervention with respect to the health care finance as one of the six pillars of the health care system that I have described above.

665 I refer further to paragraphs 491 to 505 above of this affidavit.

Ad paragraphs 199 to 206

666 For reasons set out at paragraphs 506 to 517 of this affidavit, I deny that the NHI Act unjustifiably violates and/or infringes the labour rights in section 23 of the Constitution.

667 I note that the State as an employer indeed makes contributions to State employees' medical schemes.

667.1 I refer to Dr Kutzin's affidavit at paragraphs, 32 and 55 to 56 where he describes the extent of the State's contribution to the private health care sector through these payments.

667.2 It is unreasonable, as Dr Kutzin says, for the State to maintain these explicitly inequitable subsidies and, in turn, to sustain inequitable health care coverage for currently underserved people.

667.3 Dr Kutzin states that it would be quite reasonable from his perspective as an international health economist for the State to target these inequitable subsidies as a priority for reallocation.

Ad paragraphs 207 to 208

668 For reasons set out at paragraphs 518 to 524 of this affidavit, I deny that the NHI Act violates and/or infringes any property rights in section 25 of the Constitution.

Ad paragraphs 209 to 214

669 As I explain in paragraphs 525 to 529 above, the NHI Act does not limit any fundamental rights. Any limitation that is brought about by the NHI Act (which I deny) is nonetheless justifiable in terms of section 36 of the Constitution for the reasons I have given.

670 Solidarity is deeply misguided about the notion of an "*expensive bureaucracy*". As I have demonstrated above (and as is confirmed in Prof McIntyre's affidavit), the creation of a single pool of funds under a single-payer will substantially reduce the massive wastefulness in administrative and non-health care related

costs that currently exists in the health care system. If anything, the NHI Act will reduce inefficiency and bring about considerable savings generally and in the administering of health care.

671 I deny that "*fixing the public health care sector*" is a solution to the problems that I have described in Part IV above. Prof McIntyre further addresses this misguided notion in her affidavit at paragraph 73.

Ad paragraphs 215 to 239

672 I have dealt with Solidarity's procedural complaints above. I note that Solidarity expressly disavows any relief in relation to its procedural complaints and correctly concedes that they fall outside of this Court's jurisdiction.

673 To the extent that I have dealt with the procedural objections above in denial of there having been any procedural irregularity, I do so without prejudice to the submission that these are not live issues that this Court may determine.

674 Solidarity's allegations in this regard are for atmospheric purposes and are wholly inappropriate particularly in the light of its failure to cite the relevant speakers of Parliament to account for their processes.

Ad paragraphs 240 to 245.4

675 For the reasons set out in this affidavit, I deny that Solidarity has made out a case for the relief it seeks from this Court. I reiterate that Solidarity has not made out a proper case for any prayer in its notice of motion for the following reasons:

675.1 First, the application is premature.

675.2 Second, the prayer 1 is an abstract challenge with no evidence entitling it to a declaration of constitutional invalidity of the entire NHI Act.

675.3 Third, both the main relief in prayer 1 and the alternative relief in prayer 2 lack the required specificity for the grant of the relief sought.

675.4 Fourth, Solidarity has failed to plead or prove that it meets the requirements of a temporary interdict.

675.5 Fifth, Solidarity has failed to justify its invitation to this Court to intrude into the constitutionally mandated functions of the executive, legislature and the President.

VII CONCLUSION

676 I respectfully request that the Court dismiss the application with costs as the application is without merit and lacks any legal basis.

677 The Court is further implored in its consideration of an appropriate costs order to have cognisance of the fact that Solidarity's abstract attack lacked not only reference to the impugned provisions of the NHI Act but any sound evidence to support its claims that the NHI Act will infringe upon constitutional rights.

678 It is not only improper but disrespectful to the Court hearing a matter of this magnitude and level of public interest, to expect of the Court to identify what provisions of the NHI Act should be set aside.

679 I submit that it is appropriate to deviate from the principle of immunisation or costs established in *Biowatch Trust v Registrar, Genetic Resources, and Others* 2009 (6) SA 232 (CC) for the following reasons:

679.1 The entire NHI Act has been subject to challenge without a proper constitutional basis for such wide-ranging relief;

679.2 Employing a shotgun approach, Solidarity improperly asks the Court to identify for it the allegedly unconstitutional provisions and then to declare them unconstitutional;

679.3 The DG and I have been seriously prejudiced in defending the shotgun-style application. We have had to file a defence of the entire statute, without knowing properly which parts of it are truly attacked and on what basis;

679.4 The prematurity and abstract nature of its challenge also warrants a departure from the *Biowatch* principle and an award of costs.

679.5 Solidarity's conduct in annexing to its founding affidavit great swathes of reports and submissions, most if not all of which were irrelevant to its challenge *inter alia* because they in many instances pertained to a Bill which was subsequently amended and passed into law, or because they were not seriously relied upon in the body of the founding affidavit, is also deserving of disapproval and forfeiture of the benefits of *Biowatch*.

WHEREFORE the first and third respondents asks that application be dismissed with costs, including the costs of three counsel, on scale C.

PAKISHE AARON MOTSOALEDI

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 Pretoria on this the 27th day of October 2024, and that the Regulations contained in Government Notice R.1258 of 21 July 1972, as amended, have been complied with.

COMMISSIONER OF OATHS

TSHEPO CHIPANE
EX OFFICIO COMMISSIONER OF OATHS
PRACTISING ATTORNEY
REPUBLIC OF SOUTH AFRICA
PRETORIA