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IN THE HIGH COURT OF SOUTH AFRICA
Gauteng Division, Pretoria

CASE NO: **2024-057449**

In the matter between:

SOLIDARITY TRADE UNION	Plaintiff / Applicant / Appellant
and	
MINISTER OF HEALTH ,PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA ,DIRECTOR - GENERAL, NATIONAL DEPARTMENT OF HEALTH,MINISTER OF FINANCE ,NATIONAL TREASURY	Defendant / Respondent

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Founding Affidavit

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ELECTRONICALLY SIGNED BY:

Registrar of High Court of South Africa , Gauteng Division,Pretoria

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

Case Number: 2024-057449

In the matter between:

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

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FOUNDING AFFIDAVIT

I, **ANTONIE JASPER VAN DER BIJL**, state under oath as follows:

PART A: INTRODUCTION

DEPONENT, KNOWLEDGE AND AUTHORITY

1 I am an adult male, and the deputy chief executive of legal matters of the applicant (Solidarity).

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2 I am authorised to depose to this affidavit on Solidarity's behalf, as appears from the resolution attached as annexure **AB1**.

3 To the best of my knowledge, the facts in this affidavit are true and correct. Where they do not fall within my personal knowledge, I have established them from documents and information under Solidarity's control, or which is available in the public domain. Where reliance is placed on information obtained from others, I point this out in the text. Where I make legal submissions, I do so on the advice of the applicant's legal representatives.

CONTEXT

4 Currently, the South African health system is divided into a between private health care (made available through private health service providers and largely funded by private health insurance in the form of medical schemes) and public health care (universally free health care provided at point-of-service for the entire population,

except for access to the hospital system which is subject to a means test). The public and private health systems developed in tandem and, taken together, enable universal access to health care.

5 However, the public health system is marred tolerance of ineptitude; leadership, management and governance failures; lack of a fully functional district health system (the main vehicle for the delivery of primary health care); and inability or failure to deal decisively with the health workforce crisis. This has negative consequences for patients, health professionals and policy implementation. Patients bear the brunt through negative experiences and sub-optimal health care. In this regard, I attach annexure **AB2**, a chapter written by Laetitia Rispel of the Centre for Health Policy, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg. The failures of the public health system have led to an inequality in access to health care, particularly access to timeous and high quality health care intervention.

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6 On 15 May 2024 the President of the Republic of South Africa (President) assented to, and signed in to law the National Health Insurance Bill [B11B-2019] (the NHI Bill), which then became the National Health Insurance Act 20 of 2023 (the NHI Act). For convenience, a copy of the NHI Act is attached and marked **AB3**.

7 The NHI Act represents a fundamental reform to the South African healthcare system: the scheme created under the NHI Act will disrupt both the public and private healthcare systems, it will necessitate massive reorganisation of the current

health care system, and it will require material structural change, at significant cost. The NHI Act itself recognises this, as is evident *inter alia* from:

7.1 section 3(4) that provides that funding of organs of state in respect of health care services is not amended, changed of affected 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*";

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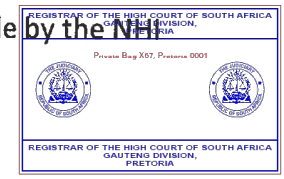
7.2 section 57, which contains extensive transitional provisions that include "*migration of central hospitals that are funded, governed and managed nationally as semi-autonomous entities*" (section 57(4)(a)); "*structuring of the Contracting Unit for Primary Health Care at district level*" (section 57(4)(b)); establishment of the National Health Insurance Fund (NHI Fund), including its governance structures (section 57(4)(c)); development of a Health Patient Registration System (section 57(4)(d)); a process of accreditation of health care service providers (section 57(4)(e)); and legislative reforms to a variety of statutes (section 57(4)(h));

7.3 section 58, which operates to repeal or amend provisions of no less than 11 statutes, including extensive amendments to the National Health Act 61 of 2003 (NHA) and the Medical Schemes Act 131 of 1998 (Medical Schemes Act).

8 The magnitude of the reform cannot be overstated: the NHI Act's central aim is the establishment of the NHI Fund that will act as a monopsony buyer of healthcare not subject to the provisions of the Competition Act 89 of 1998 (Competition Act), relegating the role of medical schemes to funding only such services as are not covered by the NHI Fund. What precisely those services will be remains unclear, but what is clear, is that the NHI Act prohibits alternative coverage through medical schemes for services covered by the NHI Fund, from a date yet to be determined by the Health Minister (NHI Act section 33) with services to be reimbursable by the NHI Fund to be subject to conditions set out in section 8(2) of the NHI Act.



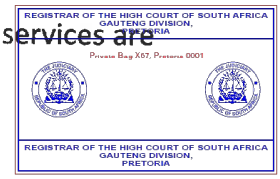
THIS APPLICATION

9 In terms of section 172(1) of the Constitution of the Republic of South Africa Act 108 of 1996 (Constitution), Solidarity seeks and order declaring the NHI Act invalid for being inconsistent with the Constitution. The NHI Act, though morally praiseworthy in its intentions, simply does not pass constitutional muster.

10 The statute, which does not provide for a clear funding model and which leaves the determination of health services to be purchased by the NHI Fund as monopsony buyer to a future endeavour, fails at the first constitutional hurdle. This, because the scheme that is created under the NHI Act is vague.

10.1 The health care services to be purchased fall to be determined by a Benefits Advisory Committee to be established under the statute (NHI Act section 4(1)), with the definition of *"health care service"* in the NHI Act itself being so broad and vague as to almost render it meaningless.

10.2 Coupled with this is the consideration that section 6(a) of the NHI Act simply entitles *"users"* to receive *"necessary quality health care services"*, with the question of who will be the adjudicator of whether health care services are *"necessary"* looming large.



10.3 The vagueness is exacerbated by the fact that the NHI Fund is dependent on a money Bill being introduced by the Finance Minister, as contemplated in section 49 of the NHI Act. Absent the approval of the requisite money Bill, the operation of the entire NHI scheme is impossible. Overlain with this consideration is the fact that the Davis Tax Commission Report, attached hereto as annexure **AB4**, confirms that the state does not have the available resources to implement the NHI Act, and that taxation solutions to ensure appropriate funding are inadequate or not feasible.

10.4 Millions of South Africans who presently enjoy access to health care in both the public and private sectors are faced with uncertainty on how the NHI Act will impact the levels of access to health care that they currently enjoy. That the NHI Act is, in many ways, drafted like a policy document, with proposed implementation over what some say may be decades, just adds

to the vagueness and uncertainty. Central to the vagueness concern is section 33 of the NHI Act, which allows for the Health Minister, at his or her discretion, to make a declaration on when the NHI is "*fully implemented*", by consequence of which medical schemes will then only be allowed to provide "*complementary*" cover. The NHI Act provides no guidance on any criteria which must firstly be satisfied before the Health Minister can make such a declaration, nor does the statute stipulate what the consequence of such a declaration will be, having regard to the fact that it does not state what "*health care services*" will be funded by NHI Fund, so that it remains uncertain for what "*complementary cover*" could or may be obtained in due course. Overall, the continued role of medical schemes remains unclear under the legislation.

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10.5 Furthermore, it remains unclear under the NHI Act whether any private medical institution or health care provider that does not contract with the NHI Fund (either by choice, or because the NHI Fund does not contract with them) will be prohibited from rendering health care services to the public.

10.6 For all of these reasons, the NHI Act offends against the rule of law, a foundational value enshrined in section 1 of the Constitution.

11 Closely associated with the constitutional issues arising from the vagueness of the statute, but quite independently, 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 governmental purpose – here, the establishment of the NHI Fund *"to achieve sustainable and affordable universal access to quality health care services"*.

11.1 The feasibility and sustainability of the scheme under the NHI Act is dependent on a money Bill which is yet to be introduced and passed by Parliament, this whilst all evidence has shown that such a bill is not feasible and will have disastrous consequences for the economy.

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11.2 As recently as on 8 May 2024, Treasury's Chief Director for Health and Social Development, speaking at a Board of Healthcare Funders (BHF) conference, highlighted fiscal constraints, hurdles to increased government health spending and means to secure funding for the NHI Fund and the need for realistic expectations about what the public sector can achieve.

11.3 The adoption of legislation that mandates the assumption of responsibility for the purchase of all health care services by the state (through the NHI Fund), without a sustainable funding model, cannot possibly achieve the stated governmental purpose. A system that purports to cover every eligible person in a country the size of South Africa would certainly need to be in possession of significant financial resources to meet even its most basic targets. That a clear funding model is not presented in the NHI Act is therefore a central concern. Moreover, that the targets, be they basic or otherwise, are barely outlined in the NHI Act, raises red flags on the

question whether the NHI Act will in any way be capable of achieving the stated intentions of this legislative intervention.

11.4 Despite its laudable aims, the NHI Act poses a threat to the existing access of at least some – especially members of medical schemes. The statute's proposed limitation of services provided by medical schemes is inconsistent with the state's duty to respect socio-economic rights and its coupled duty not to interfere with existing access, choice and resources to achieve access. The limitation on access to health care rights through the limitation on the role of medical schemes, which does not serve a legitimate purpose, is in breach of the state's duty to respect socio-economic rights.

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11.5 Available studies and research, some of the content, which is reflected in this application, tends to indicate that health care practitioners will emigrate in large numbers if subjected to the NHI system. The large-scale exodus of health care practitioners will have a detrimental effect upon the ability of the state to make health care progressively available, and to ensure that everyone is able to access appropriate health care timeously.

12 Added to these already significant constitutional shortcomings is the extensive powers that are conferred upon the Health Minister, including what Solidarity submits is the provision for unconstitutional and arbitrary decision-making. Foremost amongst these is the establishment of "*central hospitals*".

12.1 In terms of section 7(2)(f)(i) of the NHI Act, the Health Minister must request the Minister of Public Service and Administration (the PSA Minister) to consider and assist in the establishment of central hospitals as national government components in accordance with section 7(5) of the Public Service Act, 1994 (PSA), in order to ensure the seamless provision of health care services at hospital level.

12.2 In terms of section 7(5) of the PSA, the President is the authority that may designate a national government component. Further, in terms of section 7A of the PSA, an executive authority may only request the establishment of a government component in terms of section 7(5)(c) or (d) if the prescribed feasibility study is conducted and its findings recommended the establishment of such component. For the sake of completeness we attached the requirements of a feasibility study in terms of the PSA as annexure **AB5**.

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12.3 In terms of section 7A (2) as read with section 7A(3) no power, duty or function regarding the realisation of a right contemplated in section 26, 27, 28 or 29 of the Constitution may be assigned or delegated, allocated or transferred to the head of a government component other than powers conferred, or duties imposed, by national or provincial legislation.

12.4 The provisions of section 7(2)(f)(ii) of the NHI Act however seek to circumvent these statutory obligations and requirements by empowering the Health Minister to establish or designate central hospitals as organs of state in an appropriate form, where central hospitals are not established as national government components.

12.5 The provision does not incorporate any objective criteria by which the aforementioned power of the Minister must be exercised. It will allow for the establishment of central hospitals even if there is no feasibility study or even one which shows that the establishment of such organs/departments are not feasible. The powers conferred on the head of the central hospitals shall further not be regulated by any legislation, as required, seeing that section 7(2)(f)(iv) of the NHI Act states that the management of central hospitals must be *"semi-autonomous"* with *"certain decision-making powers, including control over financial management, human resources management, minor infrastructure, technology, planning and full revenue retention delegated by the national government"*.

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13 The extensive powers conferred upon the Health Minister and the NHI Board to make key decisions regarding healthcare financing, resource allocation, and service delivery. This concentration of legislative authority within the executive branch undermines the role of the legislature in enacting laws and overseeing the implementation of policies. It effectively transfers decision-making power from the elected representatives in Parliament to appointed officials. Importantly, while the

executive branch traditionally plays a role in implementing laws passed by the legislature, the NHI Bill gives the Health Minister, the NHI Board and committees of the NHI Board broad discretion to determine the details of how the NHI will be implemented, including the structure of the NHI Fund, benefit packages, and payment mechanisms. This concentration of power without sufficient checks and balances from other branches of government raises concerns about accountability and transparency in the decision-making process.

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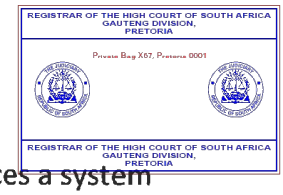
14 The NHI Act also otherwise fails constitutionally for its encroachment upon the constitutional principle of separation of powers. By centralizing healthcare funding and management under a national authority, the statute undermines the autonomy of provincial governments, which have their own constitutional mandates to manage healthcare services. This concentration of power at the national level disrupts the balance intended by the Constitution between national and provincial spheres of governance.

15 As if this were not enough, the NHI Act is also unconstitutional for its inconsistency with section 27 of the Constitution. Section 27(1)(a) grants everyone the right to have access to health care services, and section 27(2) imposes on the state the obligation to *"take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation"* of the right to access to health care services. This obligation includes the negative duty to avoid retrogressive measures. The NHI Act neither has the capacity to achieve the progressive realisation of access

to health care services, nor does it comply with the requirement that measures not be retrogressive.

15.1 Section 4 of the NHI Act provides for limits on those entitled to access health care services, amongst others through registration requirements currently not in place, and imposes limitations imposed upon health care services available to asylum seekers (with such limitations currently not being in existence).

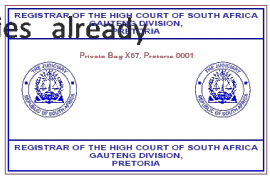


15.2 Instead of advancing access to health care, the NHI Act introduces a system that obligates those currently accessing health care through medical insurance and private funding to compete for access to health care offered through the state, with appropriate and timeous access to healthcare becoming dependent on the ability of the NHI Fund to contract with suitably equipped health care establishments. The centralised nature of the NHI is bound to result in inefficiencies, delays and inequities in service delivery. Instead of progressing access to health care services for all, the NHI manifestly diminishes access for at least some.

15.3 The measures introduced by the NHI Act are not within the state's available resources, as the difficulties concerning the proposed funding of the NHI Fund make plain. The expected financial burden upon tax payers, brought about by the intention to centralise health care purchasing to the exclusion of private medical insurance, will have a ripple effect. That effect includes

the effect of health practitioners electing to emigrate, and the effect of disincentivising private investment in health care facilities. In other words, the statute is not a step forward that can be shown as being capable of being funded by available state resources; rather it depends on additional taxation to prop up the system.

15.4 The NHI Act as legislative measure is not "*reasonable*" as contemplated in section 27 when regard is had, not only to the difficulties already highlighted, but also to the impact upon various existing rights.



16 Other constitutional rights unjustifiably infringed upon include:

16.1 the right to human dignity enshrined in section 10 of the Constitution, on the basis that the NHI Act, by obliging everyone to access health care services through the intervention and under the prescripts imposed by the NHI Fund, removes from the citizenry the opportunity to make their own decisions concerning health care;

16.2 the right to life enshrined in section 11 of the Constitution, given the financial constraints upon the NHI Fund and the consequent limitations on its ability to timeous access to life saving health care;

16.3 the right to freedom and security of the person enshrined in section 12 of the Constitution, since the state-imposed decisions about access to health care infringes upon the ability of individuals to make decisions concerning reproduction, and to security in and control of their bodies, inconsistently with sections 12(2)(a) and (b) of the Constitution;

16.4 the right to freedom of association enshrined in section 18 of the Constitution, given that those in need of health care are precluded from dis associating themselves from the NHI scheme, in particular because of the limitations that section 33 of the NHI Act places on the activities of medical schemes.

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16.5 the right to freedom of trade, occupation and profession protected under section 22 of the Constitution, for the impact that various provisions (including sections 39(2)(c)(vi) and 39(8)(g)) have on the choice of profession, in that the choice to practice as a health care profession is subjected to accreditation that may be withdrawn for reasons unrelated to the quality of service rendered;

16.6 labour rights enshrined under section 23 of the Constitution, for the impact that the legislation has upon existing collective bargaining agreements that provide for employer contribution to medical insurance for employees;

16.7 section 25 property rights, in the sense that medical scheme members who have contributed to medical schemes over many years in the expectation that they would turn to the medical schemes to fund their health care access needs at when the time came are, upon full implementation of the NHI scheme to be deprived of the benefits towards which they have contributed.

17 None of these limitations are justifiable in accordance with section 36. There are less restrictive means available to the state pursue the goal of universal access to high quality health care. The NHI envisages strengthening of the public health sector, which is a laudable goal. However, the strengthening of the public health sector cannot be achieved through the NHI Fund; what is required is that the public health sector must be *"fixed"*, *inter alia* by putting in place measures to address maladministration, fraud, corruption and the like.

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18 A further ground for challenging the constitutionality of the NHI Act is to be found in section 195(1)(b) of the Constitution. The provision enjoins the public administration to promote "*efficient, economic and effective use of resources*". 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. Even before that, the NHI Act in section 57(3) empowers the Health Minister to set up various "*interim committees*" to advise him on the implementation of the NHI scheme. Indeed, as a precursor to implementation of the NHI scheme, in August 2022 the Health Department advertised 44 vacancies for technical specialists to assist with

preparations for the functions of the NHI Fund. For that purpose, funds of the Health Department had been shifted. Salaries offered for those posts varied between R700 000 and more than R1 million per annum. These are just the costs of preparatory work by senior personnel. 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.

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19 Section 3(5) of the NHI Act, which exempts the NHI Fund from oversight by the competition authorities introduces a further basis for constitutional challenge. Section 217 of the Constitution requires that an organ of state or any other institution identified in national legislation, when contracting for goods or services, to do so in accordance with a system which is fair, equitable, transparent, competitive and cost-effective. The creation of a monopsony purchaser offends against section 217. As is discussed more fully below, the exemption of the activities of the NHI Fund in this matter will result uncompetitive outcomes in relation to *inter alia* (i) the ability of users to choose health care providers; (ii) selective contracting; (iii) the role of medical schemes; (iv) reimbursement of service providers; and (v) the effect on the timeous introduction of health-related innovations.

20 All of these grounds for constitutional challenge must be viewed in the context of the legislative process that preceded the President's assent to the law, and the President's actions in assenting to the law. Although, as I shall illustrate below, the Parliamentary Committee on Health (PCH) received unprecedented levels of input,

concern and comments from role players across the political spectrum, virtually no change was made to the legislation as it was pushed through the legislative process. Meaningful participation in the legislative process does not mean only that interested parties are given an opportunity to make presentations; it means that they are given a true opportunity to influence the legislative process. In the case of the NHI Act, the lawmakers simply rode roughshod over the many and varied concerns raised. The result is a statute that is inconsistent with the Constitution and which falls to be so declared and thus set aside.

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STRUCTURE OF THIS AFFIDAVIT

21 The remainder of this affidavit is divided into the following parts:

21.1 Part B: The parties, the applicant's standing and jurisdiction.

21.2 Part C: Overview of the NHI Act.

21.3 Part D: The legislative process

21.4 Part E: Feasibility of NHI;

21.5 Part F: NHI Act is unconstitutional;

21.6 Part G: A flawed process;

21.7 Part H: Conclusion.

PART B: THE PARTIES, STANDING AND JURISDICTION

THE APPLICANT

Identity of the applicant

22 The applicant is Solidarity Trade Union, a trade union registered in terms of the Labour Relations Act 66 of 1995. Its head office is situated at the corner DF Malan Drive and Eendracht Street, Kloofsig, Pretoria.

Standing

23 Solidarity approaches this Court in the interests of its members, in its own interest and in the public interest.

24 As regards Solidarity's members' interest:

24.1 Every South African will be affected by the vast reforms sought to be introduced by the NHI Act. Solidarity's more than 200 000 members are included in those who stand to be affected.

24.2 In addition, a vast number of Solidarity members are beneficiaries of various collective agreements which regulate private medical assistance for employees which requires from employers to make a contribution to the medical schemes of the employee's choice as regulated. The NHI affects the rights of Solidarity's members who are the beneficiaries of such collective agreements. Should it be required, copies of such collective agreements can be made available to the Court. For present purposes, I do not attach them, in order to avoid burdening the papers, which already include extensive annexures.

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25 Solidarity's own interest includes holding the government and its representatives to account when constitutional and other standards are breached. Solidarity has an interest in the principles of democracy and constitutionalism, as well as the rule of law.

26 The public interest being pursued is that of upholding the rule of law, the requirements of a properly functioning constitutional democracy. This is a matter that will have a significant impact on the socio-economic rights of all citizens.

27 In its own interest, in the interest of its members, and the public interest, Solidarity engaged in the legislative processes concerning the NHI Act:

27.1 Through submissions made during the public participation processes in relation to the NHI Bill, Solidarity raised a number of concerns about the constitutional validity of the envisaged statute, as evidenced by the submissions attached hereto as annexure **AB6**. The submissions must be read as if incorporated herein in full.

27.2 On 28 January 2022, Mr Connie Mulder made a presentation to the PCH, as part of the public participation process. A copy of the presentation is attached as annexure **AB7.1**. The presentation, which must be read as if fully incorporated herein, highlighted that the scheme proposed in the NHI Bill was unaffordable, unnecessary, and unworkable. I also attach and marked annexure **AB7.2** the summary of presentation and the response thereto as accessed from the Parliamentary Monitoring Group website at https://pmg.org.za/committee-meeting/34148/.

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27.3 Prior to signature, Solidarity wrote to President Ramaphosa regarding the constitutional invalidity of the NHI Bill on 5 October 2023, 5 December 2023 and 23 January 2024, attached as annexures **AB8.1, AB8.2 and AB8.3**, respectively; and

27.4 The Solidarity Research Institute further compiled three costs reports on the NHI scheme, the latest of which is attached hereto as annexure **AB9**, which indicated that South Africa cannot afford the NHI in any form and that the government should much rather invest in the current public health system.

28 When the President announced that he would be signing the statute into law on 15 May 2024, Solidarity directed a further letter to the President, warning of the constitutional challenge that would follow. A copy of the letter of 14 May 2024 is attached as annexure **AB10**.

29 After signature by the President, Solidarity directed a letter of demand to the President on 15 May 2024. A copy of the letter is attached as annexure **AB11**.

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30 There can be no doubt that Solidarity enjoys standing.

30.1 It has been recognised that workers and trade unions as their representative organisations are an important constituency in our national life. They, as with all South Africans, have an interest to ensure that public goods are secured in conformity with the law.

30.2 This application concerns the constitutionality of an Act of Parliament, and the interest in certainty in this regard demands that the application be entertained. The contested law will directly affect the interests of Solidarity's members, and by extension also Solidarity's own interests. The public interest is in any event undeniable: the NHI Act proposes a complete overhaul of the South African health system, moving from a decentralised system of healthcare to a centralised system of healthcare. The public generally, in common with Solidarity and its members, has an interest in

ensuring that the laudable intention to make healthcare progressively available, in compliance with section 27 of the Constitution.

THE RESPONDENTS

The first respondent

31 The first respondent is the Minister of Health (Health Minister). His office is located at Dr AB Xuma Building, 1112 Voortrekker Rd, Pretoria, Townlands 351-JR, Pretoria.

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32 The Health Minister is the cabinet member responsible for the administration of the NHI Act.

The second respondent

33 The second respondent is the President. The President's office is situated at Union Buildings, Government Avenue, Pretoria.

34 The President is cited in these proceedings because he has assented to the NHI Bill and has proclaimed the commencement date of the NHI Act, and by consequence of the powers which the President enjoys in terms of section 79 of the Constitution.

The third respondent

35 The third respondent is the Director-General of the National Department of Health (Director-General). Their office is located at Dr AB Xuma Building, 1112 Voortrekker Rd, Pretoria, Townlands 351-JR, Pretoria.

36 The Director-General is cited by virtue of his interest in these proceedings. The NHI Act in section 32 delineates the role of the National Department of Health (Health Department) under the statute.

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The fourth and fifth respondents

37 The fourth respondent is the Minister of Finance (Finance Minister).

37.1 In terms of section 5 of the Public Finance Management Act 1 of 1999 (PFMA), the Finance Minister is the head of the National Treasury and is also the executive functionary responsible for the Department of Finance.

37.2 The Finance Minister is served care of the State Attorney, Pretoria at 316 Thabo Sehume Street, Pretoria and electronically at mary.marumo@treasury.gov.za and percy.mthimkhulu@treasury.gov.za

38 The fifth respondent is National Treasury, established by section 5 of the PFMA. Treasury is served at 40 WF Nkomo Street, Pretoria and electronically at DGRegistry@treasury.gov.za.

39 The Finance Minister and Treasury are served by virtue of their interest in the proceedings. The financial implications of the NHI Act, particularly the taxation implications of the NHI Act underscore the interest of these respondents.

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JURISDICTION

40 This Court enjoys jurisdiction by virtue of section 172(2) of the Constitution, which confers on it the power to make an order concerning the constitutional validity of an Act of Parliament, subject to confirmation by the Constitutional Court.

41 In terms of section 81 of the Constitution, *"[a] Bill assented to and signed by the President becomes an Act of Parliament"*. The legislative process is complete, and so the Court is empowered to consider its constitutionality. It matters not that the statute has not yet been brought into operation:

41.1 section 172(2)(a) , which empowers the Court to declare Act of Parliament invalid, does not distinguish between those that have been brought into force and those that have not; and

41.2 nothing precludes this Court from considering the constitutional validity of a statute that has not yet been brought into operation.

42 In accordance with section 172(1)(a) of the Constitution, it is incumbent upon this Court to declare any law or conduct that is inconsistent with the Constitution to be invalid to the extent of its inconsistency.

PART C: OVERVIEW OF THE NHI ACT

Introduction

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43 A copy of the NHI Act is attached above as annexure AB2. The contents of the NHI Act must be read as if fully incorporated herein, and I do not intend to rehearse all sections. For purposes of this application, I highlight the following.

Purpose of the NHI Act

44 According to its Long Title, the NHI Act is:

> *"To achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution; to establish a National Health Insurance Fund and to set out its powers, functions and governance structures; to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users; to create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population; to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users; and to provide for matters connected herewith."*

The NHI Fund

45 In accordance with section 2 of the NHI Act, its purpose is to "*establish and maintain a National Health Insurance Fund in the Republic funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services by –*

(a) serving as a single purchaser and single payer of health care services in order to ensure the equitable and fair distribution and use of health care services;

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(b) ensuring the sustainability of funding for health care services within the Republic; and

(c) providing 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."

46 Section 9 of the NHI Act establishes the NHI Fund as "*an autonomous public entity, as contained in Schedule 3A to the Public Finance Management Act*", with the functions as set out in section 10(1). These include:

46.1 taking "*reasonable steps*" to achieve the objectives of the NHI Fund, and the attainment of universal health coverage (section 10(1)(a));

46.2 purchasing of health care services on behalf of users (section 10(1)(c));

46.3 determining payment rates for health care service providers, health establishments and suppliers (section 10(1)(g)); and

46.4 accounting to the Health Minister (section 10(1)(m)).

47 In accordance with section 10(3), the NHI Fund must perform its functions in accordance with the health policies approved by the Health Minister, and section 10(4) obliges the NHI Fund to support the Health Minister in fulfilling his or her obligation to protect, promote, improve and maintain the health of the population as provided for in section 3 of the NHA.

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48 In accordance with section 4(1), the NHI Fund must purchase health care services, the ambit of which is to be determined by a "*Benefits Advisory Committee*" (established under section 25 of the NHI Act), on behalf of (i) South African citizens; (ii) permanent residents; (iii) refugees; (iv) inmates; and (v) "*certain categories or individual foreigners determined by the Minister of Home Affairs*", and for the benefit of these "*users*" (section 7(1)). These persons, who are eligible to receive health care services, "*must register as a user with the Fund at an accredited health care service provider or health establishment*" (section 5(1)).

49 Section 7(2)(e) provides that the NHI Fund must enter into contracts with accredited health care service providers and health establishments at primary health care and hospital level (section 7(2)(e)).

50 The NHI Fund is to be governed by a Board (NHI Board), established in terms of section 12 and constituted as envisaged in section 13 of the NHI Act. The Board is accountable to the Health Minister.

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Committees

51 In accordance with section 25 of the NHI Act, the Health Minister must establish a committee known as the Benefits Advisory Committee. The composition of the Benefits Advisory Committee is not prescribed, save that it must consist of persons with technical expertise in medicine, public health, health economics, epidemiology, and the rights of patients and that one member must represent the Health Minister.

52 Section 26 envisages the appointment of a Health Care Benefits Pricing Committee, constituted as described in sections 26(1) and (2). This committee "*must recommend the prices of health service benefits to the Fund*" (section 26(3)).

53 Section 27 envisages the appointment of a Stakeholder Advisory Committee. The role of this committee is not set out.

Funding

54 Section 48 of the NHI Act provides that the *"revenue sources"* of the NHI Fund consist of:

54.1 money to which the NHI Fund is entitled to in terms of section 49 (i.e. money appropriated annually by Parliament, from money collected in respect of (i) general tax revenue; (ii) reallocation of funding for medical scheme tax credits; (iii) payroll tax; and (iv) surcharge on personal income tax, introduced through a money Bill by the Finance Minister and earmarked for use by the NHI Fund);

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54.2 any interest or return on investment made by the NHI Fund;

54.3 money erroneously paid to the NHI Fund which, in the opinion of the Health Minister, cannot be refunded;

54.4 any bequest or donation received; and

54.5 any other money to which the NHI Fund may become legally entitled.

Limitations on cover offered by the NHI Fund

55 As a starting point, only persons registered as a user of the NHI Fund are entitled to seeking health care services from accredited health care service providers or health establishments (section 4(4) and 5(8)). When a user seeks health care services, such user "*must*" receive the health care services from a health care service provider or health establishment at which the user had registered for purposes of receiving such services (section 7(2)(a)).

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56 A user "*must*" (i) first access health care services at a primary health care level as the entry into the health system; and (ii) adhere to the "*referral pathways prescribed*" for health care service providers or health establishments. If a user does not adhere to the "*prescribed referral pathways*", the user "*is not entitled to health care services purchased by the Fund*" (section 7(2)(d)).

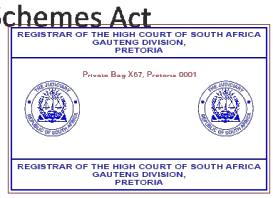
57 Health care services to be purchased by the NHI Fund are to be limited to those as determined by the Benefits Advisory Committee (established under section 25 of the NHI Act (section 4(1)).

58 In accordance with section 4(3) all children, including children of asylum seekers or illegal foreigners, are entitled to basic health care services. But more generally, an asylum seeker or illegal foreigner is only entitled to (i) emergency medical services; and (ii) services for notifiable conditions of public health concern. Reproductive

health is not included. The same restriction applies to foreign visitors not covered by a travel insurance contract or policy (section 4(5)).

The role of medical schemes

59 A user of healthcare services purchased by the NHI Fund is entitled to purchase health care services that are not covered by the NHI Fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act (section 6(o)).



The role of the Health Minister

60 The NHI Act vests extensive powers in the hands of the Health Minister.

61 The definition of "*this Act*" provides that it "*includes any regulation promulgated, directive or rule made or notice issued by the Minister*". The Health Minister is thus granted the power to make legislation.

62 The NHI Fund is obliged to purchase health care services "*in consultation with*" the Health Minister (sections 4(1) and 7(1)).

63 The Health Minister enjoys the power to prescribe additional requirements for the registration of foreigners as users of the NHI Fund (section 5(6)).

64 In accordance with section 7(2)(f)(ii), where central hospitals are not established as national government components, the Health Minister must establish or designate central hospitals as organs of state. Section 1 defines a "*central hospital*" as one "*designated as such by the Minister as a national resource to provide health care services to all residents, irrespective of the province in which they are located, and that must serve as a centre of excellence for conducting research and training of health workers*";

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65 Section 10(1)(m) provides that the NHI Fund must account to the Health Minister on the performance of its functions and the exercise of its powers. The NHI Fund must perform its functions in accordance with health policies approved by the Health Minister (section 10(3)), and the design of health care service benefits to be purchased by the NHI Fund must be determined "*in consultation with*" the Health Minister.

66 In the same vein, the NHI Board is accountable to the Health Minister (sections 12 and 15(1)), and is appointed by the Health Minister (section 13(1)(b)). The Health Minister also enjoys the power to appoint the panel that conducts interviews for appointment to the NHI Board (section 13(3)), and may remove an NHI Board member or dissolve the NHI Board (section 13(8) and (9)).Moreover, the Health Minister is empowered to appoint the Chairperson of the NHI Board (section 14(1)). Procedures of the NHI Board must be determined "*in consultation with*" the Health Minister (section 18(3)).

67 The Health Minister is further empowered to make appointment of various advisory committees as set out in Chapter 7 of the NHI Act. The Health Minister may also terminate a person's membership of any of the committees established in terms of the NHI Act (section 30(b)).

68 The Health Minister may make regulations regarding payment of health care service providers (section 41(4)), and in respect of the extensive list of matters set out in section 55(1)(a) to (zA) of the NHI Act.

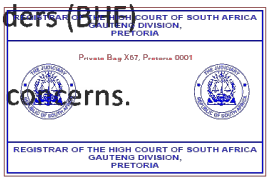
PART D: THE LEGISLATIVE PROCESS

69 The Health Minister introduced the NHI Bill to the National Assembly on 8 August 2019. A copy of the NHI Bill in the form first presented is attached as annexure **AB12**. The PCH opened its call for comments on 30 August 2019, with the last submission date for comments falling on 29 November 2019. The PCH reported that it received approximately 338 891 written submissions from the public.

70 Public hearings ensued from 18 May 2021 to 23 February 2022. In total, 114 stakeholders participated in the virtual public hearings. The Committee received oral presentations from individuals and various groups such as professional associations, civil society organisations, faith-based organisations, researchers, lobby groups, academics, traditional healers, public health entities, statutory bodies, government departments, sector experts, healthcare funders, medical aid schemes, healthcare administrators, hospital groups, political organisations, labour unions and other interested stakeholders.

71 Almost universally those who participated in the parliamentary processes supported the concept of universal health coverage, but many expressed concern about the proposal to achieve it, as set out in the NHI Bill. From the outset, concerns regarding the constitutionality of the NHI Bill were raised. I do not intend to provide an exhaustive list of issues raised. I attach the following, which must be read as if incorporated herein:

71.1 Annexure **AB13** is the submission of the Board of Healthcare Funders (BHF) dated 26 November 2019, which raised significant constitutional concerns.



71.2 Annexure **AB14** is the submission of the South African Human Rights Commission (SAHRC) of November 2019 that raised constitutional issues, not least those related to the retrogressive effect on access to health care for asylum seekers.

71.3 Annexure **AB15** is the presentation of the South African Medical Association (SAMA) done to the PCH in June 2021.

71.4 Annexure **AB16** is a presentation of the Institute of Race Relations (IRR) made to the PCH on 22 June 2021.

71.5 Annexure **AB17** is the presentation of Business Unity South Africa (BUSA) to the PCH on 29 June 2021.

71.6 Annexure **AB18** is the presentation of Momentum Health Solutions (Momentum) to the PCH on 14 July 2021.

71.7 Annexure **AB19** is the presentation of the Health Funders Association (HFA), also made on 14 July 2021.

71.8 Annexure **AB20** is the presentation of MSD, similarly made on 14 July 2021.

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71.9 Annexure **AB21.1** is the expert review of the NHI Bill presented by Prof Alex van den Heever, prepared in November 2019, and annexure **AB21.2** is the presentation of Prof Van den Heever made on 21 July 2021.

71.10 Annexure **AB22** is the presentation of the Helen Suzman Foundation (HSF) made on 28 July 2021

71.11 Annexure **AB23** is the submission of the FW de Klerk Foundation (FWDKF) of 29 November 2019.

71.12 Annexure **AB24** is the presentation of Lawyers for Human Rights (LHR)made to the PCH on 10 September 2021.

71.13 Annexure **AB25** is the submission of the Active Citizens' Movement submission of 10 September 2021.

71.14 Annexure **AB26.1** is the joint submission of Section 27 and Treatment Action Campaign, and annexure **AB26.2** is the Joint Oral Submission of these organisations made to the PCH on 1 December 2021.

71.15 Annexure **AB27.1** is the submission of The Public service Accountability Monitor of 29 November 2019, and annexure **AB27.2** is the presentation of that organisation made on 8 December 2021.

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71.16 Annexure **AB28.1** is the submission of Bonitas Medical Scheme, dated 27 November 2021, and annexure **AB28.2** is the presentation made on 25 January 2022.

71.17 Annexure **AB29** is the submission of Discovery Health made to the PCH on 25 January 2022.

71.18 Annexure **AB30** is the submission of Mediclinic presented to the PCH on 26 January 2022.

71.19 Annexure **AB31** is the presentation of the Democratic Alliance (DA) made to the PCH on 23 February 2022.

72 These and other presentations are accessible on the website of the Parliamentary Monitoring Group at https://pmg.org.za/bill/886/. What the presentations and submissions reveal, is that the concerns and criticism expressed came from organisations and individuals across the political spectrum. Solidarity most certainly did not stand alone in its objections raised as part of this process. Questions of constitutionality were raised throughout, for a wide variety of reasons.

73 Despite the wide-ranging concerns expressed by these and other organisations through the public participation process, the Health Department's response to the PCH public hearings of 29 March 2022 (attached as annexure **AB32**) was limited to:

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73.1 the role of provinces;

73.2 service delivery challenges: quality and ability to achieve accreditation;

73.3 funding and affordability;

73.4 role of medical schemes;

73.5 fraud and corruption; and

73.6 human resources for health.

74 Most noticeably on the question on costs, the following response was provided:

- *"The short answer is that a country spends as much on health care as it decides to: This requires*

  - *a health system designed to stay within the affordable envelope .*

  - *that the system is efficient (non-duplicative)*

  - *that optimal interventions and treatments are adopted (spend more on prevention, address intersectoral, social determinants of health, use the most appropriate technologies, etc)*

- *South Africa spends around 8,4% of GDP on health care*

  - *SA is currently the 33rd largest economy in the world*

  - *The current spend is high compared with peers (92nd in terms of per capita GDP)*

    - *[GDP Peers: Malaysia, Singapore, Philippines, Egypt, Denmark, Colombia and Bangladesh, Norway, Argentina, Israel]*

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- *[GDP per capita Peers: Lebanon, Colombia, Saint Lucia, Peru, Paraguay, Bosnia and Herzegovina]*

- *The problem is inefficiency (including fraud, corruption and medico-legal claims) in both public and private sectors.*

- *The question must rather be: "how do we reform the health system so that we spend no more than 8,4% of GDP to achieve "a health system that that ensures that all people have access to the health services they need, when and where they need them, without financial hardship"*

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75 The PCH on 18 May 2022 voted in favour of a motion of desirability of the NHI Bill.

76 Clause-by clause deliberations ensued on 1 June 2022, and continued to 9 November 2022.

77 On 17 November 2022, the Health Department provided its response to the clause by clause deliberations, as reflected in annexure **AB33.** It was general in nature, and simply rejected the concerns. Repeated reliance was place in what the NHI Bill was intended to achieve, but no deep-going engagement with fundamental concerns is evident.

78 On 22 November 2022, the PCH Content Advisor briefed the PCH on submissions received in relation to the NHI Bill. The matrix document consolidated and summarised stakeholder comments, recommendations and proposed amendments for each chapter and clause of the NHI Bill. I attach the matrix as annexure **AB34**. I highlight the following comments, raised in relation to the NHI Bill at the time:

78.1 The Preamble provides a vague description of how the NHI will be funded and much of the detail pertaining to the sustainability of the funding mechanisms related to the NHI is either lacking or unclear.

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78.2 The definition of "*health care service*" is vague and does not cover all health services, as clearly defined in the NHA.

78.3 The proposed system in the NHI Bill will not increase access to health care on a progressive basis. Rather it will deprive many of the access that they currently enjoy.

78.4 Clause 3(5) of the NHI Bill excludes the Competition Act, which exclusion and oversight by the Competition Commission could allow for potential abuse of dominance or horizontal collusion. The NHI Bill provides a possible violation of section 217 of the Constitution by excluding the Competition Act. This could be problematic and would detract from a price negotiation system that would provide flexibility in pricing and adaptability to the needs of specific populations and areas.

78.5 Clause 6, which deals with the rights of users, creates a risk of limiting coverage of services and/or increased costs for users who have to travel to other facilities should the facility they are meant to access not be/ no longer be accredited. There is further a lack of transparency as to what is available in respect of services, hence, nothing to prevent the State from withholding a reasonable standard of care under the "*available and appropriate*" clause.

78.6 The term "*unreasonable grounds*" in terms of clause 6(d) is not defined in the NHI Bill and it is, therefore, unclear under what circumstances the refusal of health services will be reasonable or unreasonable and whom at a health establishment will be charged with deciding when to refuse access to health service benefits.

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78.7 People must be free to pay for health care services in whatever manner they choose. A restriction on a person's freedom to pay for health care services amounts to a restriction on access to health care services. In addition, there is a constitutional right to freedom of association.

78.8 The centralisation of the function of the provinces in delivering healthcare, which is the second-largest function of all the provinces, at a national level infringes on their constitutional mandate.

78.9 The NHI Fund is empowered to issue directives (clauses 10(1)(f) and 56). In terms of administrative law principles, a regulatory body normally issues directives and the NHI Fund is not a regulatory body.

78.10 There is a view that clause 10(1)(g) results in direct market manipulation by Government in setting prices.

78.11 The price-seeing mechanism in clause 11(2)(e) is incompatible with many requirements of the Public Finance Management Act 1 of 1999 (PFMA) and Preferential Procurement Policy Framework Act, 2000 (PPPFA) and undermines section 217 of the Constitution;

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78.12 Clause 11(1)(h) suggests that the NHI Fund will investigate complaints against itself. No justification is given for this. A body that is independent of the NHI Fund, such as the Health Ombud, should investigate complaints against the NHI Fund;

78.13 The role of the Health Minister is excessive and undesirable. Clause 31 is potentially open to legal and constitutional challenges. The granting of extensive powers to the Health Minister has the effect of making key decisions subject to arbitrary political decision-making. The legal requirements and clinical elements of the system must be rational, objective, transparent, and not left to political intervention;

78.14 Two powers of the NHI Fund and the Health Minister is concerning from a constitutional and rule legislative perspective, namely:

78.14.1 That certain regulations could be published and finalized without public comment (clause 55(3)); and

78.14.2 That binding "*directives*" can be issued by the Fund (clause 56).

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78.15 The complementary nature of NHI and medical scheme benefits needs to be clarified, in line with the Medical Schemes Act Amendment Bill. There are significant uncertainties in the nature of coverage between medical schemes and the NHI Fund.

78.16 The prohibition on medical schemes to provide cover in parallel to the NHI Fund by the NHI formularies and national standardization of care through procurement and national pathways will lead to health care potentially being reduced for some patients. Limiting the role of medical aid schemes will not be sustainable.

78.17 Clause 33 of the NHI Bill probably constitutes an unconstitutional infringement on the right to healthcare as contemplated in section 27 of the Constitution;

78.18 The NHI Bill is contradictory in terms of how it would set prices (clause 10(10)(g), clause 39(8)(g) or negotiated prices (clause 11(2)(e).

78.19 Given that the state of many rural facilities, which are characterised by infrastructure decay and understaffing, there is a risk that many rural facilities will take a long time to meet the accreditation criteria. The NHI further does not clearly indicate what will happen to the facilities that do not immediately meet the criteria.

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78.20 There is uncertainty relating to how service providers will be compensated and how private practices would fit into the implementation of the NHI. The lack of clarity on the payment of providers is concerning, considering that health care provider will be the backbone of the NHI. Certainty on the payment of health care providers should therefore be a priority.

78.21 While a mandatory prepayment system is mentioned in the NHI Bill as a source of funding for the NHI Fund, it is not clear how this will be operationalized or what additional funding mechanisms will be provided by Treasury to support the NHI Fund.

78.22 The NHI Bill does not provide reliable costing estimates for the NHI Fund, nor does it offer a clear picture of what impact the NHI scheme will have on the taxpayer and whether it will be sustainable;

78.23 It remains unclear what the total cost of NHI scheme implementation will be and this will largely depend on the benefit package. While the NHI Fund will largely be based on income tax, given the large informally employed population in South Africa, particularly rural communities, it is unclear whether taxes will be sufficient to cover the NHI Fund's needs and whether sufficient government subsidies will be available to ensure access for vulnerable communities. Links between the country's budget and the NHI Fund's expenditure are virtually absent in the NHI Bill. The proposed taxes on employers and employees will place an already heavy tax burden on a shrinking tax base. Clarity in the form of a Treasury policy paper is urgently required in relation to the proposed funding mechanisms for NHI and risks of earmarking payroll tax.

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79 In its response to the comments and discussion on the NHI Bill dated 30 November 2022, attached hereto as annexure **AB35**, the Health Department indicated its acceptance of certain concerns, however limited, and the consequential amendments to the NHI Bill which it proposed, as well as rejection of other comments which amongst other included the following:

79.1 *"The Department supports Clause 2 of the Bill as it provides clarity for the purpose of the Act and no further changes are recommended. Clause 2 is consistent with the provisions of the Constitution as well as other relevant Acts such as the National Health Act, hence it is consistent with the*

obligations placed on the State to progressively meet the health entitlements of South Africans in an equitable and effective manner."

79.2 *"The Department does not agree with the recommendation by the Competition Commission, and other stakeholders, that the Fund should not be exempted from the Competition Act. Therefore, Clause 3(5) should not be deleted, but instead amended to ensure that: Only the Fund should be exempt from the Competition Act. However, all accredited and contracted heath care providers, health establishments and suppliers should be subject to the Competition Act because they should not be allowed to engage in anti-competitive practices in relation to the Fund or any other business. The proposed amendment in the schedule of the bill to the Competition Act achieves this."*

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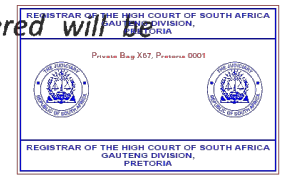
79.3 *"The Department disagrees with the assertion the Bill lacks transparency as to what services will be available and; hence, there is nothing to prevent the State from withholding a reasonable standard of care under the "available and appropriate" clause. Instead, it must be noted that Clause 10(1) (i) requires the Fund to collate utilisation data and implement information management systems to assist in monitoring the quality and standard of health care services, medicines, health goods and health related products purchased by the Fund. This shows transparency."*

79.4 *"Users will be entitled to comprehensive health care services that will be determined through the advice received by the Fund and the Minister from the Benefits Advisory Committee (BAC). This BAC will consist of various experts in the various domains of health care provision including amongst others medicine, public health, allied disciplines, nursing, epidemiology and the users of health care services. The BAC will also receive inputs from experts in Health Technology Assessment and the Health Products Procurement Unit. This is to ensure that the services covered will be comprehensive and evidence-based."*



79.5 *"The constitutional right to freedom of association is not restricted as the right to access health care for all people in the population as enshrined in Section 27 of the Bill of Rights is superior to a right to freedom of association."*

79.6 *"Concerns raised about Clause 10 (1)(g) and its potential to manipulate the market are unfounded. The NHI Fund in consultation with the Minister will determine its own pricing and reimbursement mechanisms as also provided for in Section 90 (u-v) of the NHA. As a single purchaser, the Fund must determine the rates that it can afford within the budget envelope. Acting as a single-payer and single purchaser, the NHI Fund will be able to reap the efficiency benefits of monopsony purchasing power and economies of scale and ensure that incentive structures for healthcare providers are integrated and coherent."*

79.7 *"There is concern that the Fund should not issue directives. The Department does not agree with the notion that only regulatory bodies can issue directives as was the case during the COVID-19 pandemic when directives were issued in the management of the pandemic. The Fund will be drafting Regulations for the Minister to publish in pursuit of its objectives. Directives will provide the Fund with flexibility to issue instructions for compliance with aspects of implementation and administration of the Act. Directives will not be contradictory to the spirit of the Act, may not contradict Regulations, and are reviewable and are not punitive but would allow regulated establishments under this Act to comply within specified time frames."*

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79.8 *"The implication of the provision is that "fully implemented" will be detailed in the Gazette that the Minister will publish at the relevant time through legally determined procedures. The requirement that the details be furnished in the Bill would make the Bill too prescriptive and potentially create legal hurdles in future. Allowing for such details to be included in the regulations provides for sufficient flexibility to outline what 'full implementation' implies as the roll-out plan progresses. The Department is of the view that Clause 33 should remain generic as is currently outlined in the Bill. This will allow sufficient regulatory provisions to be outlined as the implementation processes unfold. The Clause should not be amended into a prescriptive one."*

79.9 *"On sources of additional funding to the NHI Fund, Clause 49 (2)(a) of the Bill provides for sources of funding including the additional sources that will be mobilised. South Africa currently spends 8.8% of GDP on Health with 4.1% in the public sector serving more than 80% of the population and 4.7% in the private sector that serves less than 20% of the population. The 8.8% of GDP spending is way above what other countries of similar economic development spend on health care. Furthermore, as articulated by the WHO, while costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the exact number indicating the estimated costs. This is because evidence has shown that countries that have gone down this path have ended up tied to an endless cycle of revisions and efforts to dream up new revenue sources, thus focusing on issues that have more to do with tax policy than health policy. Therefore, focusing on the question of "what will NHI cost" is the wrong approach as it is better to frame the question around the implications of different scenarios for the design and implementation of reforms to move towards UHC."*

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79.10 *"Clause 49(2) provides a framework that outlines the options that government must pursue in raising revenue for the NHI Fund using a mandatory pre-payment system. The definition of mandatory prepayment is contained in the definition section. Mandatory prepayment refers to paying for health care before the person is sick and this is compulsory according to income levels. Chief sources of income for the Fund could be*

from general tax revenue from payroll, surcharge on taxable income, and complemented by employment based levies and other taxes as determined by the National Treasury. The determination of the actual extent of the taxation will be articulated in a Monies Bill that is developed and published by the National Treasury."

79.11 *"The revenue collected will be pooled to achieve financial and risk protection for the entire population. The 2019 SEIAS and the accompanying Memorandum of Objects in the NHI Bill has outlined the financial implications of the Bill to the State and made projections of the required funding envelope requirement for the medium term."*

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80 On 15 March 2023, the PCH held a virtual meeting with parliamentary legal advisers to discuss the overarching concerns surrounding the NHI Bill, which involved the NHI Bill's constitutionality. In the meeting, the parliamentary legal advisers gave a detailed breakdown of the ways in which several sections in the Bill potentially presented a constitutional challenge. This included the exclusion of asylum seekers and the restriction of the function of medical aid schemes. However, the Office of the State Legal Adviser differed. In an opinion, attached hereto as annexure **AB36** the Office of the State Legal Adviser defended the NHI Bill, making light of the concerns expressed. Once more the laudable intentions with the NHI Act were offered as a panacea to address all concerns. A copy of the minutes of the meeting is attached as annexure **AB37**. It must be read as incorporated herein.

81 The B-version of the NHI Bill of 24 May 2023 reflected limited changes, but did not address fundamental constitutional concerns raised in the public participation process.

82 The NHI Bill was passed by the National Assembly on 13 June 2023, and transmitted to the National Council of Provinces (NCOP) for concurrence.

83 On 20 June 2023, the Health Department briefed the NCOP Select Committee on Health and Social Services (the NCOP Committee), with further engagements following for the remainder of 2023.

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84 The NCOP received a total of 106 written submission (35 from individuals and 71 from stakeholder groups or organisations), and an additional 23 465 submissions were received from all provinces.

85 Ultimately, eight of the nine provinces mandated their representatives to vote in favour of the NHI Bill. The Western Cape did not submit its mandate.

86 The NHI Bill was passed by the NCOP and sent to the President for assent on 6 December 2023.

87 As I have already indicated, the President assented to and signed the NHI Bill into law on 15 May 2024.

88 On 16 May 2024, the Presidency published Government Notice No 4826 in *Government Gazette* No 50664. A copy of the notice (without the statute that accompanied, given that I have already attached the NHI Act hereinabove) is attached as annexure **AB38.** The notice read "*It is hereby notified that the President has assented to the following Act, which is hereby published for general information: - Act No. 20 of 2023: National Health Insurance, Act 2023*". The publication was not a Proclamation Notice, and in publishing the statute as aforesaid, the Presidency did not proclaim a date for the coming into operation of the NHI Act (or any sections thereof) as contemplated in section 59 of the NHI Act. As at the date of signature of this affidavit, the President has not published a proclamation to bring any section of the NHI Act into operation, as contemplated in section 59 of the NHI Act, read with section 81 of the Constitution.

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PART E: THE NHI ACT IS NOT FEASIBLE

89 One of the main concerns raised during the parliamentary process was that no proper feasibility study was done to determine whether the NHI is financially sustainable. Solidarity submits that absent any actual budgetary and financial confirmation that there are sufficient resources to implement the NHI, and maintain it, it is simply irrational and unreasonable that such a piece of legislation can be forced upon the people.

90 The reality is that absent the approval of a money Bill, which is yet to be introduced, the NHI Act is incapable of achieving its intended purpose. It is no counter to say that the NHI Act will be implemented in phases, based on financial availability. Such an argument goes against the effective and efficient use of state resources whilst also placing the health care services, which the people currently enjoy, at risk.

91 The lack of proper feasibility assessment and or engagement with questions of feasibility is evident from a series of documents.

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92 A 2015 White Paper, attached as annexure **AB39,** amongst other, dealt with the possible funding models of the NHI and the taxes which could be raised. The White Paper however did not indicate whether or not this was indeed feasible or sustainable.

93 A socio-economic impact assessment systems report (SEIAS) of 17 May 2017 is attached hereto as annexure **AB40**. The report stated that the NHI would be funded through a combination of general taxes augmented by NHI-specific taxes from employers and employees earning above a certain income threshold, a surcharge on taxable income as well as transactional taxes such as duties and excise taxes as well as taxes on carbon emission (at page 8). It indicated further that Treasury provided conditional support and wanted to retain a multi-payer environment seeing that they saw the fiscal space and sustainability of the NHI as a risk. A cost estimate at that time already indicated a funding shortfall, with no reference to any feasibility study being conducted.

94 The July 2017 SEISA report, attached as annexure **AB41** echoed the same stance on the possible implementation costs being that *"focusing on the question of 'what will NHI cost' is the wrong approach as it is better to frame the question around the implications of different scenarios for the design and implementation of reforms to move towards UHC"*. Similarly this report makes no reference or mention of any feasibility study that was conducted.

95 The financial implications of the NHI Act, even in its transitional phase, were made clear in the Memorandum on the Objects of the NHI Bill attached hereto as annexure **AB43**, as follows:

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"The Fund will be financed in various interrelated phases as determined in consultation with the National Treasury:

8.1 The costing/budgeting focuses on practical issues, rather than general models (three of which were previously contracted). The latest focuses on three issues:

(a) Quality of care improvement programme: A new funding component is required to accelerate quality initiatives, to support a stronger response post OHSC audit and also to support progressive accreditation of facilities for Fund. Amounts of R75 million, R125 million and R175 million will be considered for potential reprioritisation as part of the budget process.

(b) Establishment of the administration of the Fund: The preliminary costing is R57 million, R145 million and R287 million. These should be

seen as ideal and will probably be less given practical delays e.g. in passing Bill. Again in the short term these funds can largely be found through reprioritisation within the grant.

(c) *Actuarial costing model: Treasury commissioned a simplified intervention- based costing tool for 2019/20 which provides simple estimates of costs of a set of 15 or so interventions. These include for example removing user fees, extending chronic medicine distribution programme (CCMDD), extending ARV rollout, increasing antenatal visits, rolling out capitation model for General Practitioners (GPs), cataract surgery programme, establishing Fund. The full set of interventions costs in the longer term around R30 billion per annum. Interventions can be scaled up progressively as funding becomes available and does not need significant new funds in Budget 2020.*

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8.2 *Human Resource capacity is focussed in the first instance on statutory posts such as interns and community service, given problems in provinces funding these key posts and national interest in making sure these are fully funded.*

8.3 *Significant preliminary work that has commenced will be taken forward.*

8.4 *At the time the Bill was tabled, there was a rising Fund budget baseline (R4.2 billion was reprioritised from tax subsidy; NHI grant rises from R2.5 billion in 2019/20 to R3.1 billion in 2020/21) and under-spending in 2018/19 (around R600 million), which required that most of the short term funding for the above was derived from reprioritisation and rising baseline. The 2020/21 budget of R3.1 billion was already substantially above 2018/19 spending of R 1.7 billion.*

8.5 Once the Bill is enacted and the entity is created, the Fund and its Executive Authority will be able to bid for funds through the main budget as part of the budget process.

8.6 Consideration will be given to shifting some of the conditional grants such as the National Tertiary Services grant and the HIV/AIDS and TB grant from the Department to the Fund. Shifting grants is a budget process and no statutory amendments are required.

8.7 In a later phase consideration will be given to shifting of funds currently in the provincial equitable share formula for personal health care services (currently the main public health funding stream consisting of around R150 billion per annum) to the Fund. This will require amendments to the National Health Act, 2003. This will also depend on how functions are shifted, for example if central hospitals are brought to the national level.

8.8 Chapter 7 of the Fund White Paper details several new taxation options for the Fund, including evaluating a surcharge on income tax, a small payroll-based taxes as financing sources for the Fund. Due to the current fiscal condition, tax increases may come at a later stage of NHI implementation."

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96 I have already referred to and attached the expert report of Prof Van den Heever presented to the PCH. The report must be read as incorporated herein. I highlight the following:

96.1 In evaluating the rationale for the NHI Prof van den Heever concludes that *"the NHI policy framework lacks any documentation that clarifies the technical rationale for the policy proposals'* and that the *'official documentation demonstrates a clear misalignment between problem statements and subsequent policy proposals"* (at paragraph 185).

96.2 Prof van den Heever identified the following main concerns to the overall reform framework and proposals:

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"189.1. The rationale for the NHI framework has not been properly stated. At no point has a clear connection been made between the well-established weaknesses of the health system and the recommended policy framework. In fact, the evidence points to quite different sets of reforms – both within the public and private sectors.

189.2. The proposed reforms have not been the subject of feasibility studies that should normally accompany a set of proposals that propose to substantially disrupt pre-existing public and private sector health coverage regimes. It is deeply concerning the following studies have not been performed or made public:

189.2.1. *A technical review that clearly establishes the coverage failures in the current UHC framework in South Africa. As South Africa technically complies with the UHC, it is important to understand which UHC gap requires such a dramatic departure from existing forms of coverage. It is worth noting that the International Labour Organisation World Social Protection Report of 2017 found no coverage gaps in South Africa (International Labour Office, 2017, p. 368).*

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- *Legal health coverage deficit, % of population without legal coverage = 0%*

- *Percentage of the population not covered due to financial resource deficit = 0%*

- *Percentage of population not covered due to health professional staff deficit = 0%*

189.2.2. *An institutional feasibility study, which collates the evidence from international best practice and local empirical research to demonstrate how the public interest will be served. This should also demonstrate that the proposals represent the least disruptive route to the achievement of improved UHC. This study should, in particular, validate the claims made that a*

state-run monopoly purchaser operated by political appointments will produce efficiencies that are able to justify the intervention.

189.2.3. *The prescribed feasibility studies required for any consideration of government components as required by the Public Service Act of 2007. It is disconcerting that proposals have been made for poorly governed national entities without the required statutory evaluations. This is particularly needed as the NHI pilot appraisals indicated that nothing was learned concerning any proposed contracting units or health district structures (Genesis, 2019).*

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189.2.4. *A study that carefully considers the international evidence relating to the decentralisation of health functions, the systems of financial transfer required to preserve equity and the accountability regimes that ensure that services are planned, financed and managed in a manner that is responsive to the served population. It is deeply troubling that given South Africa's decent into institutionalised forms of corruption due to entrenched systems of patronage that no identifiable research of any form was performed in 10 years in this key problem area.*

189.2.5. *A financial feasibility study, which is capable of demonstrating: first, whether it is fiscally feasible to raise taxes to the levels required for a monopoly purchaser to guarantee social protection for the entire population without diminishing any person's current legitimate rights to health cover. Importantly, to the extent that any person's access to health is threatened or undermined without a rational public purpose, this can be deemed reckless and irrational.*

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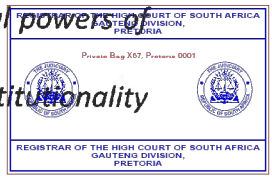
189.2.6. *A valid legal assessment of the constitutionality of the following proposals: first, the re-direction of the PES to national government; second, the emasculation of the powers allocated to provinces in terms of schedules 4(A) and 4(B) of the Constitution through national statute and the redirection of funds through national structures; and third, the prohibition of parallel coverage through medical schemes and even out-of-pocket purchases without any specified or determinable public purpose (noting that such prohibitions do not exist anywhere else in the world).*

189.3. *Finally, it is concerning that a substantial onus is placed on the general public to engage on policy proposals that have not passed though even the most rudimentary of policy appraisals.*

These are high-risk proposals that should have been properly vetted before being submitted to Parliament."

97 Prof van den Heever further listed the following central concerns with the proposed framework, aside from those already raised, as part of earlier analyses concerning the rationale:

"192.1. The framework substantially undermines the Constitutional powers of provinces to finance, plan and run health services. The constitutionality of this aspect of the framework is clearly in question.



192.2. The centralisation of the PES is effectively an intrusion by national government into the legitimate tax revenue of provinces to carry out their constitutionally mandated functions, which includes health services and ambulance services. The reference of schedule 4(a) to "health services" plainly requires that all aspects of the health services are legitimately the domain of provincial governments, including financing (raising and allocating funds), planning and service delivery. These powers include all personal health services (hospitals, clinics and transport services). A simple piece of plenary legislation cannot take precedence over the Constitution. Furthermore, the Constitution cannot be circumvented by stealth – which is plainly the purpose of the NHIB and related amendments to the National Health Act.

192.3. *The centralisation of purchasing, either via the NHIF or the DHMOs cannot reasonably be argued to improve efficiencies and local responsiveness. Communities have no say over any aspect of the proposed national framework, and the complaints regime is not independent (i.e. it is dominated by political appointments).*

192.4. *Successful models internationally involve local autonomous structures that are accountable for performance to communities through local governance structures (Bossert & Mitchell, 2011; Bossert, Mitchell, & Janjua, 2015; Rubio, 2011; Santín Del Río, 2004; Sumah et al., 2016; Yilmaz, Beris, & Serrano-Berthet, 2010). Moves that shift health systems toward decentralisation are technically sound, and also reflect the shift away from authoritarian forms of concentrated power (see for instance Smulovitz & Clemente, 2004).*

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192.5. *There is furthermore no evidence to suggest that the performance failures in the public health system have resulted from the absence of a purchaser-provider split operated by a monopoly purchaser. There is substantial evidence that the failures are attributable to governance weaknesses and the institutionalised systems of patronage that operate in eight out of nine provinces. This is motivated in the analysis presented above regarding the performance of the public health system.*

192.6. *While performance has been poor in eight of the nine provinces, the reason for the performance failures relate to correctable features of the governance framework – which include failures of national government. These are attributable to the patronage that has operated through political office-bearers.*

192.6.1. *The most appropriate and logical step-wise reform path would be to establish de-politicised health authorities at a provincial level to finance, plan and deliver healthcare.*

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192.6.2. *Instead, the NHI framework proposes to maintain the system of political appointments, but now to have these appointments placed within an organisational context where power is highly concentrated nationally in the hands of political office-bearers.*

192.6.3. *This essentially combines patronage with concentrated power. Such institutional models are universally predatory and cannot be justified on public interest grounds.*

192.7. *The degree of concentrated power in the hands of political appointees is unprecedented in South Africa, and represents both a threat to the viability of the health system, together with an existential threat to democracy.*

192.7.1. *It is plainly the intention of the political actors behind these proposals to concentrate upward of 8% of gross domestic product (GDP) in their hands. This may in fact be the primary impetus behind these proposals.*

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192.7.2. *While it is fiscally not possible for the intended financial concentration to emerge at the intended levels, the concentration of regulatory power is at least equivalent.*

192.8. *The attempt to replace medical schemes as purchasers of care for families with adequate incomes is also implausible and is fiscally unobtainable. It is quite probable that this is understood by Government, which is why they will not release into the public domain any financial feasibility assessment.*

192.8.1. *However, despite this, it appears as though the reform framework envisages disrupting the social protection framework offered through medical schemes prior to the*

establishment of a viable public scheme. This would be reckless and deserving of appropriate sanction in the courts.

192.8.2. *It is worth noting that there is not a single technical review of the financial viability of the NHI framework that has suggested it is feasible. This includes Government's own submissions to cabinet (Ministerial Task Team on Social Health Insurance, 2005).*

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192.8.3. *The health market inquiry (HMI) has, by way of contrast, offered a clear institutional approach to address weaknesses in the private sector, reflective of international best practice, which can be implemented without social risk or disruption to existing well-established health systems, and achieve a stable private contributory system as a key component of South Africa's UHC system.*

192.8.4. *Importantly, the HMI invested in significant research and consultation, unlike the NHI process. It would be irrational for government to favour a high-risk institutional reform that is not supported by evidence over a reform proposal, also carried out by official structures, which is backed up five-years of documented evidence gathering."*

98 In discussing the financial feasibility of the NHI, Prof Van den Heever commented as follows on the Davis Tax Commission report (already attached as annexure AB3):

"Over a period of 10 years the NHI process has been unable to generate a financial feasibility assessment of the NHI framework. After the publication of the 2017 White Paper on NHI the Davis Tax Commission (DTC) raised the following concerns which have to date not been addressed:

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'The large degree of uncertainty and lack of common understanding of how the NHI will be implemented and operate is of concern, given the magnitude of the proposed reform." (Davis Tax Commission, 2017, p. 42)

'Given the considerable size of projected funding shortfalls, substantial increases in VAT or PIT and/or the introduction of a new social security tax would be required to fund the NHI." (Davis Tax Commission, 2017, p. 44)

'The magnitudes of the proposed NHI fiscal requirement are so large that they might require trade-offs with other laudable NDP programmes such as expansion of access to post school education or social security reform." (Davis Tax Commission, 2017, p. 44)

'Given the current costing parameters outlined in the White Paper, the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth." (Davis Tax Commission, 2017, p. 44)'"

99 Prof Van den Heever concludes on this topic by stating the following:

"196. A constraint particularly arises where general taxes are raised from existing tax bases, which are predominantly from medical scheme members (directly or indirectly), in order to return to them a lower benefit (there are no scenarios where the benefit can be better) in a system they have not chosen. It is for this reason the various ministers in charge of this process ultimately gave up the pretence that they were doing any serious financial feasibility assessments.

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'[The minister of health] ... added that the budget for the NHI has yet to be confirmed, and that initial estimates of R256 billion were a thumb-suck by a local accounting firm. "We made a mistake on the figures. I then went to the World Bank and the World Health Organisation and they asked why am I trying to do this, it can't be quantified by any human being because the costs are so variable'. (Staff reporter, 2018)

197. The above comment by the former Minister of Health is seriously inaccurate. A financial feasibility analysis tests the key risk parameters of a reform proposal as part of a standard reality check. It is not required to exactly match required institutional expenditures. Over a period of 10 years a considerable amount of financial assessments could have been performed to validate whether the institutional reform matches the financial implications. However, according to the Minister, no such basic work was ever performed. Despite this, a reform trajectory that has no possibility of realisation is still pursued.

198. *Furthermore, the general increase in taxes is required to fund a covered group, medical scheme members. True UHC reforms focus on uncovered groups. But as South Africa has no uncovered groups, with those with adequate incomes largely funding their own care out of disposable incomes (not tax funds) in a regulated market, the justification for the tax increase and its associated forced nationalisation of cover, appear egregiously excessive and lacking in a rational public purpose.*

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199. *The contrived rationale that health professionals are concentrated in the private sector cannot be defended on the available evidence, and cannot be used as a rationale when in 10 years no serious attempt has been made to produce a valid analysis of the problem.*

200. *All the technical work to date, including all official inquiries and task teams, has confirmed that that a substantial medical scheme system must co-exist with a substantial public system for the foreseeable future. Given this, it would be irresponsible, irrational and reckless of government to disrupt both the public and private systems to achieve what is obviously unachievable. The only responsible way forward is to restructure the governance framework of the public health system, and properly regulate the private health system as proposed by the HMI."*

100 I also draw attention once more to the Solidarity report already attached as annexure AB9, which must be read as fully incorporated herein.

101 None of these issues have been resolved. And, despite the fact that the NHI Act has been signed into law, there is simply no indication that it is feasible to implement the statute. South Africans are already taxed to the hilt. Moreover, I highlight the following.

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102 Section 3(4) provides that the NHI 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*". In other words, pending the passing of a money Bill and the amendment to "*relevant legislation*", the funding of all health services remains unaffected and the functions of public health care service providers remain unaffected.

103 Leaving aside the question of what legislative amendment may be required as a precondition, the content of section 3(4) suggests that virtually no provision of the NHI Act can be brought into operation prior to the passing of the money Bill contemplated in section 3(4). This, because of the fundamental structural changes that are the building blocks of the NHI scheme as envisaged under the NHI Act. The NHI Fund must be established (section 9) and its Board appointed and remunerated (section 18). A CEO must be appointed (section 19). The NHI Fund can perform none of the functions assigned to it under section 10 without money. No structures can

be set up, no contracts can be entered into and no purchasing of health care services can occur. And so the entire structure of the NHI Act hinges on the passing of a money Bill. This, because the only source of funding that would be available at the outset is the "*chief source*" of funding as contemplated in section 49.

104 In circumstances where there is no money Bill passed, it cannot be said that the NHI Act is feasible in any way, shape or form.

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PART F: NHI ACT UNCONSTITUTIONAL

INTRODUCTION

105 In the introductory section of this affidavit, I set out an overview of grounds for advancing the case that the NHI Act is unconstitutional. In what follows, I provide additional submissions in support of the contention that the NHI Act is unconstitutional, without limiting the grounds for the constitutional challenge as set out hereinabove in any way.

IRRATIONALITY

106 The exercise of public power – including law making – should be rational and not arbitrary.

107 What is required for the rationality test to be satisfied is that the means chosen to achieve a particular purpose must reasonably be capable of accomplishing that purpose. Solidarity accepts that this does not require that the means chosen to be the best or only means by which the purpose can be achieved. But even accepting the low bar to be met in avoiding an irrationality challenge, the NHI Act does not pass muster, as follows.

108 The starting point in the evaluation must be the stated purpose of the NHI Act, which must be taken to be the statement of the "*legitimate governmental purpose*" to be achieved through the statute. It is against that purpose that the statute must be tested for rationality.

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109 The Long Title of the NHI Act asserts that it is an act to achieve universal access to quality health care services in South Africa in accordance with section 27 of the Constitution. To that end, it provides for the establishment of the NHI Fund and a "*framework for the strategic purchasing of health care services by the Fund on behalf of users*". The asserted aim of the legislation according to its Long Title is to "*create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population*".

110 The Preamble, for its part, states that the NHI is enacted *inter alia* in order to:

110.1 "*achieve the progressive realisation of the right of access to quality personal health care services*";

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110.2 *"ensure financial protection from the costs of health care and provide access to quality health care services by pooling public revenue in in order to actively and strategically purchase health care services based on the principles of universality and social solidarity"*; and

110.3 *"promote sustainable, equitable, appropriate efficient and effective public funding for the purchasing of health care services and the procurement of medicines, health goods and health related products from service providers within the context of the national health system"*.

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111 Section 2 of the NHI Act, in turn, provides that the purpose of the statute is to *"establish and maintain"* the NHI Fund, *"funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health services"* by serving as a single purchaser and payer of health care services to ensure *"equitable and fair distribution of health care services"* and the *"sustainability of funding for health care services within the Republic"*, by *"providing for equity and efficiency in funding by pooling funds and strategic purchasing of health care services, medicines, health goods and health related products from accredited and contracted health care service providers"*.

112 Read together, the Long Title, the Preamble and section 2 of the NHI Act set as the ultimate aim of the statute the achievement of universal access to quality health care health care in a manner that is sustainable and affordable, in order to ensure compliance with section 27 of the Constitution. The question that looms large is

whether the means chosen is reasonably capable of achieving that purpose. The answer to that question is, unfortunately, a resounding "*no*", as follows.

112.1 The NHI Act foresees purchasing of and payment for health services by a single purchaser. The ability of that single purchaser (the NHI Fund) to achieve equitable and sustainable universal access to health care – the stated intention - is dependent on:

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112.1.1 the requisite levels of funding being available to the NHI Fund to enable it to purchase quality health care services as and when "*users*" require such health care services, particularly bearing in mind the time-sensitive needs of users who requisite health care services; and

112.1.2 health facilities and health care providers from which the NHI Fund is to purchase health care services are of an appropriate standard, and thus meet certification and accreditation requirements.

112.2 Simply put, if the NHI Fund does not have access to adequate funds and/or is unable to contract with health care facilities and providers that meet the requisite standards, no degree of "*strategic*" and "*efficient*" purchasing will be capable of rendering the desired outcome and therefore achieving the purpose of access to quality health care for all.

113 In the circumstances, and at the very least, in order for the rationality test to be met, the NHI Act must provide for the necessary funding and identification of health care facilities and practitioners that meet the required standards. If not, the NHI Act must be read only as a statute that can achieve the purpose of setting up an expensive bureaucracy to be funded through allocation of funds away from the Health Department, detracting from the Health Department's ability to invest in the creation of new, and improvement to existing, health care facilities and the employment of health care practitioners whilst at the same time disincentivising private investment in health care facilities and the choice of health care professions as desirable.

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114 Underscoring the irrationality is section 3(4) of the NHI Act, which provides that the statute "*does not in any way amend, change or affect the funding and functions of state in respect of health care services, until legislation contemplated in section 77 and 214, read with section 227, of the Constitution and any other relevant legislation have been enacted or amended*".

115 What is required is a money Bill, and ultimately taxes to be imposed on the populace, to fund the NHI scheme. But, as the Davis Tax Commission report already referred to makes plain, the taxation is option is simply not feasible. Those conclusions are consistent with Solidarity's own research findings, already attached. and on which reliance will be placed at the hearing of this application.

116 Therein lies the fundamental problem. In the absence of a money Bill, there simply is no basis to conclude that the NHI Act has the capacity to achieve the stated intended outcomes. The scheme created under the NHI Act cannot be shown to be capable of securing universal access to quality healthcare through an identified funding mechanism that can support the required health care spending. Nor is the NHI Act a panacea to address the lack of sufficient health care facilities and health care practitioners that has plagued the public health system since before the dawn of democracy.

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117 I am advised that, litigation concerning the constitutionality of amendments to legislation regulating claims made against the Road Accident Fund (RAF), the Constitutional Court held that fixed tariffs for claims relating to medical care to be paid by the RAF were uncapable of achieving the purpose - the setting of a tariff that would enable innocent victims of road accidents to obtain the treatment they require. For that reason, the Constitutional Court considered that the means selected was not rationally connected to the objectives sought to be achieved, namely the provision of reasonable healthcare to seriously injured victims of motor accidents.

118 The situation, quite simply, is no different in the case of the NHI Act. It is a notorious fact, supported by the work of the Davis Tax Commission and Solidarity's own research, that the means to fund the NHI Fund are simply not available. The entire scheme under the NHI Act depends on the setting up of an expensive bureaucracy, and then purchasing of health care services from a sufficient number of private

health care establishments and health care practitioners who would have to be willing to enter into contracts for them to render services against appropriate remuneration. If the standard applied in the RAF case – the adequacy of the measures to allow access to required treatment – is applied, the legislation must be found to fall short on the rationality test.

119 In the circumstances prevailing in our country, the measure chosen (the NHI Fund) is neither sustainable nor affordable (and it cannot be shown to be); it is detrimental to universal access to health care access for "*everyone*", not to speak of it being detrimental to access to "*quality*" health care services.

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120 This is not a question of not liking the notion of an NHI Fund, or of Solidarity contending that there are other, more appropriate means that could have been selected; the complaint in the present case is a complete absence of a rational relation between the means selected and the objective sought to be achieved.

121 Vague and sweeping statements about the obligations imposed on the state under section 27 of the Constitution do not support a conclusion that the NHI is rational. What is not clear is the connection between the stated government objective (sustainable and affordable universal access to quality health care services for all in the Republic of South Africa) and the creation of the NHI Fund, and the prohibition on medical scheme cover in respect of serviced funded by the NHI Fund. In other words, it is not clear in what way the creation of a single purchaser model supports the stated objective.

122 Indeed, despite its laudable aims, the NHI Act poses a threat to the existing access of at least some – especially members of medical schemes. The statute's proposed limitation of services provided by medical schemes is inconsistent with the state's duty to respect socio-economic rights and its coupled duty not to interfere with existing access, choice and resources to achieve access. The limitation on access to health care rights through the limitation on the role of medical schemes, which does not serve a legitimate purpose, is in breach of the state's duty to respect socio-economic rights.

123 Van den Heever reports "*In reviewing country typologies, no reform similar to that proposed in the NHIB could be found. When pursuing [Universal Health Coverage] strategies, countries tend to prioritise serious coverage gaps, with discrete schemes established for that purpose. Where countries have substantial free public systems, strategies tend to focus on incremental budget improvements and decentralisation. No country could be found that attempts to improve their general tax funded public systems by collapsing private coverage coupled with a dramatic increase in general taxes.*"

124 Differently put: at no point has a clear connection been made between the well-established weaknesses of the health system and the response offered by the NHI Act. In fact, the evidence points to quite different sets of reforms required to achieve the stated objective – both within the public and private sectors.

REASONABLENESS

125 The "*reasonableness*" standard is a standard specific to certain constitutional rights, including the right to health care under section 27 of the Constitution: under the provision, the state is obliged to take "*reasonable*" measures to achieve the progressive realisation of access to health care. However, reasonableness is also a standard more generally to be applied in the evaluation of the appropriateness of action adopted by the political branches of Government to comply with constitutional duties or achieve legitimate state purposes. Reasonableness also falls to be considered in the assessment of the evaluation of the limitation of constitutional rights.

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126 The coupling of the reasonableness standard with the question of available resources requires a consideration of the available resources. The reasonableness of the NHI Act depends on financial feasibility. And yet there is no evidence of financial feasibility. Here I emphasise the absence of a clear plan on sources of funding, the absence of a money Bill and he tax burden. I reiterate reference to the Davis Tax Commission report and the Solidarity research already attached.

127 A central issue that arises in the context of reasonableness as contemplated in section 27 in particular is the future role of private health care and medical schemes once the NHI is implemented. As I have explained, section 33 of the NHI provides that, once the "*National Health Insurance*" has been "*fully implemented*", medical

schemes may only offer "*complementary cover*" for services not reimbursable by the NHI Fund.

128 In submission, the limitation of the role of medical schemes is counter to the section 27 constitutional injunction upon the state to make access to health care progressively available through "*reasonable*" measures. The available evidence, not least the analysis of the Davis Tax Commission, makes clear that there will simply not be sufficient funding available to the NHI Fund to meet the health care needs of all South Africans. Preventing South Africans from purchasing medical scheme coverage to allow them to access health care in addition to that which may be offered through the NHI will axiomatically curtail their access to health care.

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129 Crucially, by preventing those who can afford it from using medical scheme cover, and forcing them into the NHI system, has the effect of increasing the burden on public funding which taxpayers need to cover. Limiting the rights of citizens to purchase additional health insurance is not necessary to achieve the objectives of the NHI. It would also be globally unprecedented as in virtually every other country with some form of national health insurance, citizens are free to purchase additional private health insurance cover, including cover that overlaps with services covered by the national system.

130 There is a further concern: the eroding sentiment of the NHI Act is well-documented. The flight of health care professionals to avoid the oppressive effect of the NHI Act is not a remote possibility; it is a reality. I refer to the Solidarity submissions already

attached, which reflect the sentiments of health care practitioners, and which indicate the reality that our country will be denuded of critical skills in the health care sector as a direct consequence of the NHI Act. Erosion of health care capabilities, in turn, undermines the section 27 obligation to make health care progressively available and thus cannot be evaluated as a reasonable measure.

131 Moreover, although the current public health care system has many challenges negatively affecting the delivery and quality of health care services, everyone, at least in theory, has some basic access to health care services. The NHI is therefore not a measure intended to facilitate access where there is none, but rather one that seeks to enhance the quality of existing access to health care services, particularly for those that may not be able to afford the best available health services that patients currently using medical schemes enjoy.

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132 The NHI Act endeavours not merely to facilitate access but to raise barriers to the means by which individuals can realise such access without direct assistance from the state. The NHI Act's limitation of medical schemes' ability to provide coverage for covered benefits is devoid of any specific, socio-economic or legally motivated reason. Save for the criticism levelled against the spiralling costs of medical aid, costs which are often passed down to beneficiaries, there has yet to be an explanation for the decision to limit the services to be covered by medical schemes. The limitation is simply not reasonable.

133 Whilst the cessation of subsidies for medical schemes may be required for the successful implementation of an NHI scheme, the same cannot be said of restrictions on the services covered by them. The framing of the NHI Act, together with the characterisation of its purpose, indicates that the limitation serves no apparent legal or economic purpose. If anything, it merely compels, without any reason, current users of medical schemes to depend entirely on the NHI, as long as the service is covered by it.

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134 The legitimacy of the restriction on the services to be covered by medical schemes is questionable at best. In fact, it is unconstitutional. In accordance with Constitutional Court precedent, the obligation to realise envisioned access to socio-economic rights does not fall in the exclusive province of the state. The state equally has an obligation to provide a legislative landscape that empowers other agents, including private individuals and organisations, to realise this right on their own.

VAGUENESS

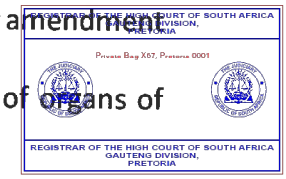
135 The NHI Act is vague in various respects. For purposes of this application, I highlight the following.

Section 3(4)

136 Section 3(4) of the NHI Act provides that the statute does not 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, as read with section

227, of the Constitution and any other relevant legislation have been enacted or amended.

136.1 The first issue that arises from section 3(4) is determining the moment when the funding and functions of organs of state in respect of health care services will be amended changed or affected. This is because of the broad and vague reference to "*any other relevant legislation*". No certainty is provided on the extent of the requisite legislative enactment or amendment that would trigger the effect on the funding and functioning of organs of state in respect of health care services.



136.2 What is clear, though, is that legislation contemplated in sections 77 and 214, read with section 227 of the Constitution, must be enacted before any funding or functioning of an organ of state can be affected.

137 Since everything hinges on the passing of the money Bill, great uncertainty is created. The uncertainty extends not only to how and when the NHI Act will be capable of full implementation, but indeed to the question whether it will at all be capable of implementation. If no appropriate money Bill is passed, then it cannot.

Medical schemes and selective contracting with health care practitioners and facilities

138 The NHI Act provides no detail on the position of medical schemes under the regime created by the statute. This creates legal uncertainty. Whilst the statute perceives

of single purchaser of health care services, it provides at the same time that complementary cover may be offered in respect of services not covered by the NHI. Moreover, on the assumption that the state cannot prohibit access to health care, it would have to be so that persons not eligible for registration as a user would be entitled to purchase full medical cover. It cannot be so that the state is a single purchaser, even under the scheme of the NHI Act. But at the same time it is simply unclear what the limits of medical scheme cover would be under the NHI Act.

139 Coupled with this is the uncertain position of health care facilities and health care practitioners under the NHI Act. Under a single purchaser system, what is the position of health care practitioners with whom the NHI Fund has not contracted? Does the NHI Act preclude health care practitioners and facilities from rendering services outside the NHI scheme? Are health care practitioners and health care establishments obliged to contract with the NHI Fund in order to render health care services? The legal uncertainty is untenable.

140 In amplification of the foregoing, I highlight that section 38 empowers the NHI Fund to accredit and contract with certified public and private sector health care providers that meet certain quality, performance and operational criteria. These criteria are not specified in the primary legislation but left to be determined through Ministerial regulations. Furthermore, relevant provisions of the NHI Act suggest that the NHI Fund will have a large degree of discretion over which health establishments to contract with, and that funding flows will be channelled primarily through hospitals

and new sub-district structures (Contracting Units) rather than individual or group medical practices.

141 If large numbers of private practices cannot obtain NHI contracts on sustainable terms, they may be forced to close down, reducing access to services. Even if they can remain in business serving non-NHI patients under the limited duplicative cover permitted, their freedom to operate will still have been significantly constrained. Under the present heading, I highlight this simply to underscore the uncertainties creates by the NHI Act.

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142 Moreover, section 39(2) states that one of the conditions for a health care provider to be accredited and reimbursed by the NHI Fund is "*adherence to treatment protocols and guidelines, including prescribing medicines and procuring health products from the Formulary*". Section7(4) goes even further - it bars the Fund from paying for any treatment where "*no cost-effective intervention exists*" for the health care service according to health technology assessment, or the health care product or treatment is not included in the Formulary. This suggests that, to be paid by NHI, health professionals must abide by the clinical protocols, standard treatment guidelines and approved lists of medicines and devices determined by the Benefits Advisory and Health Technology Assessment Committees. Again, uncertainty is created on the position of health care providers who establish that the approved treatment is sub-optimal for the patient's specific needs.

The transitional provisions and the phased approach

143 I have alluded to the fact that the statute reads like a policy document in many ways. Nowhere is this more evident than in the transitional provisions. Full legal argument will be presented at the hearing of this application, but I highlight for present purposes that the *"phased"* approach with vague and uncertain steps to be taken within particular periods stipulated creates no certainty at all as to the operation of the various systems under the NHI Act. Legal certainty, and therefore the rule of law is undermined. This is coupled with the vast powers of regulation and direction given to the Health Minister and the NHI Fund. In the absence of published regulations and directives, it is quite simply not possible to have legal certainty.

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IMPEDING UPON THE POWERS OF THE PROVINCES

144 The Constitution establishes three spheres of government - national, provincial and local - which are "*distinctive, interdependent and interrelated*" (section 40(1)). It divides government responsibilities between the three elected levels or spheres of government.

145 Schedules 4 and 5 of the Constitution set out the different "*functional areas*" of government responsibility. Health services is a concurrent national and provincial competence, appearing in Part A of Schedule 4. This means Parliament and the provincial legislatures can both make laws on health issues. National legislation that applies uniformly across the country prevails over provincial legislation if the matters

listed in section 146(2) apply - for example, if the national legislation is necessary to maintain national security, economic unity or essential national standards.

146 The provinces have both legislative and executive authority over health services in terms of sections 104 and 125 of the Constitution. The Constitutional Court has recognised that these provisions confer original power on the provinces, and has held that the constitutional scheme does not envisage the provinces' exclusive executive authority being eroded by national legislation in concurrent areas, save in limited circumstances envisaged in section 44(2). Moreover, national legislation must be objectively necessary to fulfil one of the purpose necessary in section 44(2). The Constitutional Court has warned against national legislation that would encroach upon the core of provincial powers or undermine the authority of the provinces. Consequently, while Parliament has the power to pass framework legislation on matters of national importance or that require uniformity, provinces must retain a meaningful role in deciding how to implement that legislation in their unique contexts.

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147 The NHI Act raises several concerns from this constitutional perspective.

148 It would appear from the provisions of the NHI Act that provincial health services will not receive funding for health care as revenue for further appropriation by provincial legislatures. Instead, it seems that provincial health services would receive revenue in the form of health service reimbursements – much in the way that private health care providers receive them. Technically, this means that the national government

appropriates funds for the NHI Fund, which then buys either the provincial or private health services. The executive role of the provinces is thereby undermined.

149 Moreover, the establishment of District Health Management Offices (DHMO) as *"national government components"* through amendment of the NHA effectively strips away the powers of provinces to finance, plan and provide district health services, and allocates those powers to the Health Minister. It is unclear how these offices will interface with current provincial and district health authorities and what the lines of accountability will be.

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150 Overall, the concentration of powers in the Health Minister and the NHI Fund leaves little room for meaningful cooperation with provinces in crucial decisions about the financing and delivery of health services. The Health Minister and the NHI Fund can unilaterally determine core aspects like the health care benefits to be covered, the payment mechanisms and rates for health care providers, and the budget allocations to different levels of care. Notably, provinces appear to be largely excluded from the governance structures of the NHI Fund, which will make critical decisions affecting provincial health departments and facilities.

151 In addition, there is no provision for provincial health departments to be consulted on key aspects of the NHI's design and implementation, such as the registration of users, contracting of providers, health care benefits offered and funding mechanisms. Provinces are essentially relegated to passive recipients of nationally-determined policies.

152 These and other features of the NHI Act suggest a worrying neglect of the constitutional principles of cooperative governance. While the NHI Act obviously deals with a matter - health services - that is a concurrent national and provincial function, it fails to create a genuine partnership between the relevant organs of state in the two spheres. Instead, it vests an alarming degree of unilateral control in the national government, with little regard for the impact on provinces and their ability to effectively perform their health functions.

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RULE BY DECREE

153 Section 56 of the NHI Act which allows for the NHI Fund to issue directives which must be complied with in the implementation and administration of the NHI Act. No statutory guidance or limitations are placed on the directives which may be issued. In accordance with the definition section of the NHI Act, such directives are part of law. Law-making authority is thus given to the NHI Board, which is constitutionally impermissible.

154 More generally, the NHI makes extensive provision for ministerial regulation, without imposition of statutory limits. I refer the Court to the discussion on the content of the NHI Act insofar as it confers Ministerial regulation-making power which amounts to law-making power that travels beyond the ordinary implementation or operationalisation of a statute. Full submissions on the regulation making powers of the Health Minister will be presented at the hearing of this application.

THE POSITION OF ASYLUM SEEKERS

155 The NHI Act is aimed at ensuring universal access to healthcare services by introducing the NHI Fund, which will purchase health care services from both public and private sectors on behalf of the population (NHI Act section 2). This means that both the public and private sectors will be open to all persons who are registered users under the NHI Fund. However, not everyone will have access to the same services, as is highlighted in section 4 of the NHI Act.

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156 Section 4 of the NHI Act treats asylum seekers differently from citizens, permanent residents and seemingly on par with undocumented migrants.

157 A conservative approach towards the social protection of non-citizens in South Africa is problematic, because (i) social services are guaranteed to everyone in the Constitution; and (ii) South Africa has ratified many international instruments that protect asylum seekers' access to social services. It is for this reason that the NHI Act, which provides for differential treatment for asylum seekers in clause 4, raises a constitutional issue.

158 In differentiating between the services available to asylum seekers on the one hand and South Africans, refugees and permanent residents on the other, clause 4 of the Bill also unfairly discriminates against asylum seekers. While the concern that non-nationals may cause an undue financial burden to the state may be a legitimate one,

it is argued 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.

159 Moreover, whilst the Immigration Act 13 of 2002 (Immigration Act) is silent on health rights for asylum seekers, the NHA does not exclude asylum seekers. In terms of section 4(3) of the NHA, all persons who are not members of medical schemes are entitled to free primary health care services at public health establishments. Pregnant women, lactating mothers and children are entitled to free health care services at public hospitals and clinics (NHA section 4(3)). These services are available to all, regardless of nationality or immigration status. Moreover, according to a directive issued by the National Health Department in 2007, refugees and asylum seekers (documented or undocumented) are entitled to free HIV treatment.

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160 Not all health services are provided free of charge – people pay for hospital services as defined in the patients' fee schedule. The National Uniform Patient Fee Schedule exempts the following persons from paying full fees for hospital services: non-citizens who are permanent residents, non-citizens with a temporary or work permit, and illegal foreigners from the SADC region (subject to a means test based on their income to determine the subsidization of fees, in the same way as South African citizens). Asylum seekers fall under temporary permit holders. This means that, while health services are not entirely free, asylum seekers currently do not have to pay the full amount for health services. They are entitled to free primary health care services including free HIV treatment and are exempt from paying full fees for hospital services.

161 The NHI Act amends the NHA by limiting the services that are currently available to asylum seekers. Under the NHI Act, asylum seekers will have access only to free emergency medical services and services for notifiable conditions of public health concerns (NHI Act section 4(3)). The emergency medical services that will be available are narrowly defined as "*health services provided by any private or public entity dedicated, staffed and equipped to offer pre-hospital acute medical treatment and transport of the ill or injured*" (NHI Act s 1). Emergency medical health services as envisaged by the NHI Act will not cover primary health care services. They are to be understood as treatment for a sudden catastrophe that calls for immediate medical attention necessary and available to avert that harm. Notifiable conditions of public health concern, on the other hand, are medical conditions, diseases or infections of public health importance, such as tuberculosis and the recent Covid-19 pandemic (see Regulations Relating to the Surveillance and the Control of Notifiable Medical Conditions, published by way of Government Notice 604 in *Government Gazette* 40945 of 30 June 2017). The scope of services available to asylum seekers under the NHI scheme will thus be narrower than the access that is currently available to them.

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162 The retrogression exemplified in the treatment of asylum seekers is inconsistent with section 27.

163 The provision that excludes asylum seekers from the protection that they currently enjoy is no different from case precedent where the Constitutional Court struck down legislation denying social assistance to non-citizens as discriminatory and unreasonable.

164 Another issue arises in respect of the limitation of services to which asylum seekers are entitled. If the position adopted is that asylum seekers, by virtue of not being entitled to access health services through the NHI Fund, would be able to purchase health care services privately or that they could (subject to financial ability to do so) purchase medical cover, the position created would be one that discriminates against citizens. Quite simply, it would mean that asylum seekers would have the ability to turn to private health care practitioners without the restrictions imposed under the NHI scheme, whereas citizens would be compelled to be subjected to such restrictions.

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SECTION 10 HUMAN DIGNITY/ SECTION 12 FREEDOM OF SECURITY OF THE PERSON

165 Section 10 of the Constitution declares that every person has human dignity and has the right to have their human dignity respected. The right to human dignity is the right to be treated with inherent and infinite worth, which includes each person's right to be treated as an individual capable of setting and pursuing their own goals and ambitions. The right also safeguards a person's reputation built upon his or her own individual achievements. The obligation of the state is to respect the decisions

that each person has made for themselves. The state must treat each person as ends in themselves and not merely as a means to an end.

166 Section 12(2)(a)and (b) of the Constitution declares that everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction and to security in a control over their body.

167 The NHI Act unjustifiable limits these rights. It impairs the human dignity of both the "*user*" as well as the medical professional from whom medical treatment is sought. The user is not entitled to a medical professional of his or her choice seeing that they are obliged to follow the statutory "*pathway*" failure by which the Fund will not pay for the services rendered. To the extent that it might be argued that each user is entitled to register at his or her primary health care provider, this is of no assistance. The user is only entitled to services "*within a reasonable time*" and when specialist services are needed no such election can be made by the user.

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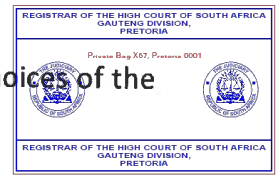
168 No provision is made in the NHI Act to obtain a second opinion on any diagnosis made by a physician. Most likely such an individual will be required to lodge an appeal and await the outcome. In the alternative such a user will have to approach a court, at his or her own expense, to challenge the diagnosis or failure to provide a second opinion.

169 In light of the fact that the NHI Fund is to operate in the most cost effective way possible, it is only logic that individuals will not be entitled to recurring or assistance treatment as and when they so choose but that it will be regulated. Individuals

seeking fertility treatment or assistance will not be able to obtain same at their convenience, if such a service is to be provided under the NHI one should add. Users will most likely be subjected to a predetermine schedule or programme which will limit their access to any assistance.

170 A medical profession, irrespective of his or her worth or dedication will simply be "*assigned*" patients by consequence of his or her location.



171 The impugned provisions vest in the state the power to override the choices of the individual in an unjustifiable manner.

172 In this context, I also reiterate the position of asylum seekers, which similarly infringes upon the dignity rights of this class.

SECTION 11 RIGHT TO LIFE

173 Solidarity submits that under the NHI Act, scenarios similar to the facts in the well-known *Soobramoney* case will be more prevalent, seeing that individuals will not be able to rely on private medical schemes for assistance and the health care system under the NHI Act will be based on affordability rather than care.

174 Inevitably section 33 prevents medical schemes from being in a position to facilitate access to life-saving treatments, interventions or health care services for their members, who currently enjoys those services.

175 This should further be viewed in light of the limited resources which the State will be able to generate under the, yet to be presented, money Bill as envisaged under section 49 of the NHI Act. When patients can only expect to be provided with health care services within a "*reasonable time*" it is inevitable that persons will be unable to timeously access life-saving treatments interventions which will result in a loss of life.

176 I refer also to restrictions on health care practitioners, and the risk of them losing accreditation on the basis of not following the prescribed limits of intervention set by the NHI Fund.

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FREEDOM OF ASSOCIATION SECTION 18

177 Everyone has the right to freedom of association. This includes the freedom not to associate. Associational freedom prevents the State from determining the most basic contours of people's lives through coercion. The contention which was advanced by the State legal advisors that section 27 "*trumps*" the right to freedom of association is with respect disingenuous, especially of regard is had to the fact, that the NHI Act has by no persuasive means revealed that it has any prospects of realising the rights to health care services.

178 Section 33 of the NHI Act infringes on the right to freedom of association as people cannot make use of a medical scheme that suits their health profile and financial means.

179 People are compelled to make to make use of the NHI Fund which removes their right to choice, individual freedom, autonomy of association and therefore the freedom of association for purpose of health care.

180 The imposition of taxes upon the people, as directed by the section 49, is another form of compulsion to subscribe to the Fund and there is no election which an individual can exercise.

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181 There exists no provision under the NHI Act for any form of exemption from the NHI Fund and a failure to register as a user will effectively render a person without any form of health care services.

182 Solidarity submits that the NHI Act unfairly and unreasonably limits a person's rights to freedom of association and by consequence their right to access health care services. Full legal argument will be presented at the hearing of this application.

FREEDOM OF TRADE, OCCUPATION AND PROFESSION SECTION 22

183 Section 22 of the Constitution provides that *"Every 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."*

184 I am advised that section 22 requires a distinction to be made between regulation impacting on an individual's choice of a trade, occupation or profession on the one hand, and regulation of the practice of a trade, occupation or profession on the

other. Freedom to choose an occupation cannot be restricted by law unless the restriction is justifiable in terms of the section 35 limitation clause. Regulation of the practice of a trade occupation or profession is subject to a less stringent standard of justification. Practice can be regulated by law provided the law is rational.

185 The NHI Act imposes a number of vague and ambiguous requirements on service providers to be able to be accredited to the fund. I have already alluded to herein above.

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186 Section 39(2)(c)(vi) states that in order to be accredited by the NHI Fund, a health care service provider or health establishment, must meet die needs of users and ensure service provider compliance with prescribed specific performance criteria, accompanied by a budget impact analysis, including adherence to the national pricing regime for services delivered.

187 Section 39(8)(g) states that the Fund may withdraw or refuse to renew the accreditation of a health care service provider or health establishment if it is proven that the health care service provider or health establishment, fails to adhere to the national pricing regime for services delivered.

188 The autonomy of a service provide to regulate his or her tariffs are prohibited by the NHI Act, they will be compelled to make use of a fixed regulated tariff within the trade, occupation or profession.

189 Service providers will be at the mercy of the NHI Fund.

190 The effect of the NHI Act on the practice of health care professions in South Africa is such that it ultimately limits the right to choose the profession. This may particularly so for the reasons discussed hereinabove under the vagueness heading, which creates a high degree of uncertainty on the ability of health care practitioners to choose the health care professions if the NHI Fund does not contract with them.

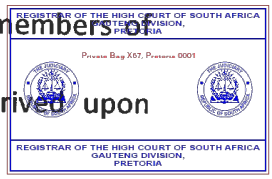
191 Full legal argument will be presented at the hearing of this application.

ACCESS TO HEALTH CARE SERVICES SECTION 27

192 In terms of section 27 of the Constitution, *"everyone"* has the right to have access to health care services, and the State must take reasonable legislative and other measures, within its available resources, to achieve the *"progressive realisation"* of this right.

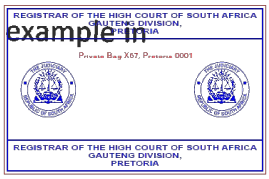
193 Despite the intended purpose of the NHI Act as advancing the right to access to healthcare, the statute achieves precisely the opposite, and infringes on the right to have access to health care services; instead of progressively realising the right to health services enjoyed by *"everyone"* the NHI Act acts as a regressive measure, as I have already discussed hereinabove.

194 Added to the concerns already raised is the undeniable fact that the NHI Act represents state conduct that deliberately meddles with existing access to health care services currently enjoyed by those economically better positioned (i.e. those who enjoy access to health care through medical cover or those who are able to pay for medical services out of their own pocket). I attach annexure **AB44**, being the Council for Medical Schemes Industry Report published in 2023. The extent of private medical cover, and thus the extent of the impact on medical scheme members will be evident from a consideration that about 9 million members of medical schemes currently enjoy cover of which they will be deprived upon implementation of the NHI scheme.



195 The duty to respect includes much more than refraining from conduct directly or indirectly impairing existing access. Where persons possess socio-economic resources and are accordingly capable of fulfilling their socio-economic rights on their own, the negative duties created by socio-economic rights preclude government from interfering with their ability to both possess and utilise those resources. Differently put, the duty to respect requires of the state to refrain from engaging in conduct or enacting measures in violation of individuals' integrity or infringing upon their freedom to use those material or other resources available to them in a way they find most appropriate to satisfy individual, family, household or community needs. It thus entails the obligation on the state to respect a person's choice and the ability to go about acquiring the object of a socio-economic right such as access to health care.

196 Moreover, the pursuit of Universal Health Coverage requires strong and robust governance structures: institutional structures and governance have a direct impact on quality of care, and when they are weak, quality drops and health service delivery fails. In the absence of strong governance structures, the reforms will be inimical to the section 27 right. Concerns regarding the extent and the scope of the powers accorded to the Health Minister (discussed hereinabove) must be considered in the context of broader governance failures in the country and reports concerning improprieties related to the conduct of Health Ministry incumbents, for example in relation to the Covid-19 pandemic.



197 Many inspiring policies have been introduced since South Africa became a democracy, however, due to poor implementation and lack of evaluation, they are not effectively being utilised. This, because there has been a tolerance of unsatisfactory leadership, management and governance failures. Corruption has additionally contributed to mistrust of the government and inadequate health care funding. Secondly, there is a lack of fully functional public health care facilities, so that the public health care facilities are overburdened and under-resourced. The inability of the government to improve the health worker shortage is the third factor in understanding the poor implementation of health care policies. Low remuneration, high living costs, poor working conditions and lack of career advancement opportunities contribute to unmotivated staff. These issues cannot be addressed by the NHI Act.

198 I refer the Court also to the discussions on the absence of rationality and reasonableness, which touches also on the infringements upon section 27.

LABOUR RIGHTS SECTION 23

199 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 section 36(1)."

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200 There exists at present numerous collective agreements which requires from employers to contribute towards medical schemes to which employees belong which further ensure the employees right to health care services.

201 As an example the Public Service Co-ordinating Bargaining Council (PSCBC) is the main bargaining council for the public service sector. Parties to the PSCBC include the State as employer and several trade unions. A number of collective agreements have been concluded under the auspices of the PSCBC including those that regulate medical assistance for public service employees.

202 More specifically Part III of the Annexure to PSCBC Resolution 3 of 1999, required the employer, the Government, to pay two thirds of an employee's subscription to a registered medical scheme, up to a maximum amount.

203 Further to this clause 7.2.1 of Resolution 2 0f 2004 required the employer to set aside sufficient funds to restructure and make provision for the granting of medical assistance to employees. The medical assistance was to be implemented with effect from 1 January 2006.

204 Resolution 1 of 2006 was concluded in June 2006 in order to give effect to clause 7.2.1of the 2004 Resolution and certain general principles including, to ensure greater accessibility by providing affordable medical cover to all employees, to ensure greater accessibility by providing affordable medical cover to all employees, to promote enrolment of employees to the GEMS and to ensure cost-effective medical cover to employees on GEMS over the long term.

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205 Medical aid subscription benefits, forms part of the standard costs to company salary which an employee is, in most cases, entitled to.

206 The NHI Act will limit the right to collective bargaining, it will most definitely render collective agreements which regulates medical scheme benefits nugatory and of no use, seeing that Medical schemes under the NHI Act will only be able to provide "*complementary cover*". The cancellation of these collective agreements will negatively impact the salaries of employees which will most likely be reduced by the amount equivalent to the monthly contribution to the medical schemes.

PROPERTY RIGHTS SECTION 25

207 The regulation of the medical scheme industry, in order to advance social solidarity, is built on a system where the young and healthy contribute at the same level as the sick and elderly. Medical schemes members pay their contributions over many years, even when the cover may not be necessary. In practical terms, they pay towards the treatment of the sick and elderly who require greater and more expensive health care interventions. It is a form of saving, in the sense that the payments are made in the expectation that, one day, when they are sick and elderly, their health care needs will be funded by virtue of the fact that others who are young and healthy are making contributions.

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208 Section 33 of the NH Act, which limits the role of medical schemes to complementary cover, deprives members of medical schemes, some of whom made contributions over many years, of their ability to claim from the fund. At the hearing of this application, it will be argued more fully that this amounts to a deprivation of property.

NO JUSTIFIABLE LIMITATION OF RIGHTS

209 In view of the extensive rights limitations described hereinabove, it falls to the respondents to explain why the rights limitations introduced by the NHI Act are to be considered reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, by reference to relevant factors as set out in section 36(1) of the Constitution.

210 To the extent that the respondents seek to offer such an explanation in the answering papers, Solidarity shall respond to the offered justification in reply. For present purposes I simply say that there can be no doubt that there are less restrictive means available to the Government to achieve the goal of making quality health care services universally accessible. The starting point would be to avoid setting up an expensive bureaucracy. The dire state of public health care infrastructure is a matter of public record, as is the inadequate staffing of public health facilities. The NHI Act itself recognises this, with the transitional provisions in section 57 requiring the "*implementation of health strengthening initiatives*".

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211 If the answer is that the current public health care system cannot be "*fixed*", then the rational conclusion should be that the NHI Act cannot succeed. If the answer is that the public health care system is indeed capable of providing the necessary health care services if certain measures are put in place to address maladministration, fraud, corruption and unprofessional services (which Solidarity submits is possible), then there is axiomatically a less restrictive alternative.

212 Moreover, the High Level Panel on the Assessment of Key Legislation on the Acceleration of Fundamental Change[1] under the chairmanship of former President Kgalema Motlanthe reported an alternative model to achieve universal coverage on 17 November 2017. The model is essentially the culmination of the work that was done by the Social Health Insurance Ministerial Task Team in 2003. The first step in

[1] Terms of reference for the High Level Panel on the Assessment of Key Legislation and the Acceleration of Fundamental Change, available at https://www.parliament.gov.za/high-level-panel-reference-mandate

this regard was the introduction of a Risk Equalisation Fund and the Medical Schemes Amendment Bill (B58-2008) was introduced to Parliament but not processed. This was after the Polokwane Resolution of 2007. The NHI hybrid model was proposed by the High level Panel, but this is not the only model that could be applied to achieve UHC.

213 A further alternative is to review the decision of the Board of Medical Schemes to prohibit medical schemes from providing cheaper medical aid cover options. Access to affordable medical aid will not only ease the current burden of the public health sector but will ensure that more people will enjoy adequate health care services.

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214 In the circumstances, it cannot be gainsaid that the NHI Act unjustifiably infringes on numerous rights which cannot be justified under the provisions of section 36, most notoriously because there exist less restrictive alternatives which the state has simply failed to pursue and perhaps more obviously because the state has a duty to refrain from interfering with social and economic rights which the people currently enjoy.

PART G: A FLAWED PROCESS

INTRODUCTION

215 I am advised that the process-related challenges fall within the exclusive jurisdiction of the Constitutional Court, in terms of section 167(4)(e) of the Constitution, which

provides that only the Constitutional Court may decide that Parliament or the President has failed to fulfil a constitutional obligation.

216 In the circumstances, and 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.

217 Nonetheless, I briefly deal with Solidarity's position in relation to the flaws in the Parliamentary process and the failure of the President to fulfil his constitutional obligations. I do so in circumstances where the facts relating to these matters provide important context to the consideration of the constitutionality of the NHI Act. Solidarity reserves the right to approach the Constitutional Court in a separate application in due course, for relief based in the procedural flaws and constitutional failures.

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THE PARLIAMENTARY PROCESS

218 Legislative bodies have considerable discretion to determine how to fulfil the duty to facilitate public involvement in the law-making process. Solidarity also accepts that public involvement does not mean that the inputs offered should necessarily have an impact on the outcome legislation.

219 That said, it is an undeniable fact that the Constitution contemplates that the people will have a *voice* in the legislative organs of state, not only through elected representatives, but also through participation in the law-making process. The

participation of the public in the law-making process provides vitality to the functioning of a representative democracy. It enhances the civic dignity of those who participate by enabling their voices to be heard *and taken account of*, and promotes a spirit of democratic and pluralistic accommodation calculated to produce laws that are likely to be widely accepted and effective in practice. It therefore strengthens the legitimacy of the legislation.

220 For this reason, the mere fact that the views of the public as expressed in the public participation process are not binding on the legislature does not equal the conclusion that those views can be ignored at will, for that would be contrary to the constitutional aim of public participation to secure effective laws.

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221 The importance of public participation in relation to the NHI Act cannot be overstated. The statute, which is disruptive in its intent and effect (if implemented), affects not only the means by which anyone in South Africa is to gain access to health care, but has fundamental implications for health care professionals.

222 The importance of meaningful participation is underscored by the importance of the legislation in question, and its impact on the public.

223 Particular participation deserves mention in the present context.

224 Solidarity submits that the manner in which this Act came into existence is a reason for concern. The Department of Health has not presented the public with the justifications for rejecting valuable proposals made nor reasonable answers to their concerns raised.

225 Evidently the Department of Health and the majority within Parliament did not view the public participation process as one of influence, to receive and consider proposals, but rather as a procedural formality.

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226 Even faced with two conflicting legal opinions, the Portfolio committee were not detracted and saw the engagement simply as another tick of the box to ensure that the NHI Bill gets passed.

THE PRESIDENT FAILED IN HIS CONSTITUTIONAL DUTIES

227 The President has failed in his duties under sections 81 and 83 of the Constitution.

<u>The President's failure under section 83 of the Constitution</u>

228 The President, as the Head of State, is responsible to uphold, defend and respect the Constitution as the supreme law of the Republic of South Africa (Constitution section 83).

229 Consistently with this duty, and in accordance with section 79(1) of the Constitution, the President must, "*if [he] has reservations about the constitutionality of the Bill, refer it back to the National Assembly for reconsideration*". This duty is reiterated in section 84(2) of the Constitution.

230 The President's power and duty to refer a bill back on the grounds that he has reservations about its constitutionality acts as a safeguard of the rights of the public: the role of the President in the law-making process is to guard against unconstitutional legislation. The President represents the people in this process.

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231 In the present instance, the President simply failed to appreciate his duty as representative of the people and his responsibility to guard against unconstitutional legislation. Rather than seriously engaging with constitutional concerns raised by a variety of groups, including Solidarity, and warnings that the constitutionality of the NHI Act would be challenged by way of litigation if he were to sign it into law, the President arranged a public ceremony for signature. As a precursor to the signature, the President offered remarks that underscored his failure to take seriously the concerns arising.

<u>The President's failure under section 81 of the Constitution</u>

232 Section 81 of the Constitution provides that:

"A Bill assented to and signed by the President becomes an Act of Parliament, must be published promptly, and takes effect when published or on a date determined in terms of the Act."

233 The first part of the provision (until the word "*promptly*") deals with promulgation through the publication of a statute. It contains a procedural norm that the President is obliged to ensure that a statute signed by him is "*published promptly*". The President may therefore not, once he has decided to sign a statute into law, postpone the taking effect of a law adopted by Parliament by unduly delaying its publication.

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234 The second part of the provision (from "*and takes effect …*") stipulates the substantive norms for the commencement of a statute. There are two possible dates upon which a statute can take effect, that is the date when it is published, or a date determined in terms of the statute. The provision thus establishes a presumption that a statute commences on the date of its publication unless the legislature has specified another commencement date in the statute itself. The commencement date of legislation is part of the contents of the statute: it falls in the scope of power of Parliament to determine such a date when adopting the legislation. The rationale for this provision is to lay down a specific date for commencement to create legal certainty about the exact date when such legislation becomes legally binding and enforceable.

235 The NHI Act, in terms of section 59(1), provides that it "*takes effect on a date fixed by the President by proclamation in the Government Gazette*", subject to the proviso that "*different dates may be fixed in respect of the coming into effect of different provisions of this Act*". That proviso is, in turn, made subject to section 57 of the NHI Act, which contains so-called transitional arrangements. Ostensibly, then, the NHI was not intended to come into operation upon publication.

236 Solidarity adopts the position that section 59(1) of the NHI Act is constitutionally unsound, in and of itself:

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236.1 The express wording of section 81 of the Constitution envisages that the legislature is empowered to itself set a date for the commencement of a statute as part of the legislative process, not that it is entitled to delegate the authority to set the commencement date to the President.

236.2 Importantly, section 44(1) of the Constitution vests legislative authority upon the National Assembly, and limits the power to assign legislative powers to "*any legislative body in another sphere of government*" (section 44(1)(a)(iii)). If, as section 81 of the Constitution envisages, the power to set a commencement date for a statute is a legislative power conferred upon the legislature, that power is not capable of being assigned or delegated to the President, a member of the Executive.

236.3 Conferment of the power to set the commencement date of the NHI Act upon the President is also inconsistent with section 55(2)(b), which obliges the National Assembly to maintain oversight of the Executive, "*including the implementation of legislation*". Insofar as section 59 confers upon the President (i.e. the Executive) to postpone or indefinitely delay the commencement of the legislation, the provision nullifies the power of the Legislature to maintain oversight that the Executive implements legislation adopted by Parliament.

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237 However, for present purposes, Solidarity is bound by judgments of the Constitutional Court that have treated as permissible under section 81 of the Constitution for the Legislature to empower the President to set determine the commencement date of a statute.

238 In circumstances where the President is taken to be lawfully empowered to set the commencement date of legislation, then that power must be read together with section 85(2)(a), which obliges the President to implement legislation, and the section 83(b) duty upon the President to "*uphold, defend and respect the Constitution as the supreme law of the Republic*". It is inconsistent for the President to assent to and sign a Bill (Constitution sections 79(1) and 84(2)(a)), which then becomes law, and which must be promptly published for the sake of legal certainty (Constitution section 81), only to render a statute unimplementable by failing to set a commencement date as required in the statute.

239 Section 59 of the NHI Act, read with section 81 of the Constitution, obliges the President to set a commencement date for the NHI Act, or at least certain provisions of the NHI Act. The failure to set a commencement date constitutes a failure by the President to comply with his duties. The failure creates confusion and legal uncertainty, which simply adds to the various constitutional difficulties with the NHI Act elaborated upon in this affidavit.

PART H

RELIEF

240 I am advised and submit that a court is required to declare any law that is inconsistent with the Constitution "*invalid to the extent of its inconsistency*".

241 In the present instance, entire statute falls to be declared invalid, on the basis that the scheme created under it is vague, over and above which it is dependent on extensive powers conferred on the Health Minister, inconsistently the with rule of law and separation of powers under the Constitution. Fundamentally, the scheme created under the NHI Act bears no rational relationship to the stated governmental purpose, over and above which the scheme as a whole and certain sections infringe upon constitutional rights. Foremost among the grounds for declaring the NHI Act unconstitutional is the consideration that it is on a collision course with section 27 of the Constitution.

242 In the alternative, Solidarity will ask the Court to set aside as unconstitutional and invalid such provisions of the NHI Act as are found to have these qualities.

243 In circumstances where an order is granted declaring the statute or any part of it to be unconstitutional, the declaration must be referred to the Constitutional Court. Moreover, in submission, the effect of the declaration ought to be that no further steps are to be taken to implement or bring into operation the NHI Act, and Solidarity asks accordingly that the President be interdicted and restrained from taking any steps pending such confirmation proceedings that would have the effect of bringing the NHI Act or any part thereof into operation.

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244 Solidarity further seeks a costs order, including costs attendant upon the employment of two counsel, on the Part C scale. As this founding affidavit evidences, the application raises complex constitutional issues, with significant consequences. In the circumstances I am advised that the employment of two counsel was necessary and a cost award on Scale C is warranted.

PRAYER

245 Solidarity prays for the relief set out in the notice of motion, namely:

245.1 declaring the NHI Act in its entirety to be unconstitutional and therefore invalid;

245.2 *alternatively*, declaring identified provisions of the NHI Act to be unconstitutional and invalid;

245.3 referring the declaratory order as aforesaid to the Constitutional Court for confirmation;

245.4 granting just and equitable relief pending Constitutional Court 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 thereof.

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION,
PRETORIA
Private Bag X67, Pretoria 0001
REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION,
PRETORIA

WHEREFORE the applicant prays for an order in the terms set out in the notice of motion to which this affidavit is attached.

DEPONENT

Thus signed and sworn to before me at Pretoria on this the 24th day of MAY 2024 by the deponent who has declared that he has read the contents of this affidavit and knows and understands the contents therein and that he has no objection to taking the oath in the prescribed form and considers the oath to be binding on his conscience.

ROBERT JOHN ROXBURGH
COMMISSIONER OF OATHS
FSF LAW CHAMBERS
CNR BROOKLYN ROAD AND BROOKS ST
MENLO PARK, PRETORIA
PRACTISING ATTORNEY. R.S.A.

COMMISSIONER OF OATHS

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