IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

Case No: 2025-125411

In the matter between:

THE MINISTER OF HEALTH	First Applicant
THE DIRECTOR GENERAL, NATIONAL DEPARTMENT OF HEALTH	Second Applicant

and

THE PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	First Respondent
THE MINISTER OF FINANCE	Second Respondent
NATIONAL TREASURY	Third Respondent
SOLIDARITY TRADE UNION	Fourth Respondent
BOARD OF HEALTHCARE FUNDERS OF SOUTHERN AFRICA NPC	Fifth Respondent
SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM	Sixth Respondent
HOSPITAL ASSOCIATION OF SOUTH AFRICA	Seventh Respondent
THE SOUTH AFRICAN MEDICAL ASSOCIATION NPC	Eighth Respondent
HEALTH FUNDERS ASSOCIATION	Ninth Respondent
SAKELIGA NPC	Tenth Respondent

In re:

Case No: 2024-057449

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

And in re:

Case No: 2024-058172

BOARD OF HEALTHCARE FUNDERS OF SOUTHERN AFRICA NPC Applicant

and

THE PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA First Respondent

THE MINISTER OF HEALTH Second Respondent

And in re:

Case No: 2024-11209

SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM Applicant

and

THE PRESIDENT OF THE REPUBLIC
OF SOUTH AFRICA First Respondent
THE MINISTER OF HEALTH Second Respondent
THE MINISTER OF FINANCE Third Respondent
NATIONAL TREASURY Fourth Respondent

And in re:

Case No: 2025-020969

HOSPITAL ASSOCIATION OF SOUTH AFRICA Applicant

and

THE MINISTER OF HEALTH First Respondent
THE MINISTER OF FINANCE Second Respondent
THE PRESIDENT OF THE REPUBLIC
OF SOUTH AFRICA Third Respondent

And in re:

Case No: 2025-045340

THE SOUTH AFRICAN MEDICAL ASSOCIATION NPC Applicant

and

THE MINISTER OF HEALTH First Respondent
THE PRESIDENT OF THE REPUBLIC
OF SOUTH AFRICA Second Respondent
SPEAKER OF THE NATIONAL ASSEMBLY Third Respondent

Q.M

CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES Fourth Respondent

And in re:

Case No: 2025-083348

HEALTH FUNDERS ASSOCIATION Applicant

and

THE MINISTER OF HEALTH First Respondent

THE MINISTER OF FINANCE Second Respondent

NATIONAL TREASURY Third Respondent

PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA Fourth Respondent

And in re:

Case No: 2025-134493

SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM Applicant

and

MINISTER OF HEALTH First Respondent

PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA Second Respondent

MINISTER OF FINANCE Third Respondent

NATIONAL TREASURY Fourth Respondent

And in re:

Case No: 2025-147065

SAKELIGA NPC	Applicant
and	
MINISTER OF HEALTH	First Respondent
MINISTER OF FINANCE	Second Respondent
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Third Respondent
SPEAKER OF THE NATIONAL ASSEMBLY	Fourth Respondent
CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES	Fifth Respondent

---

APPLICANTS' SUPPLEMENTARY REPLYING AFFIDAVIT

TABLE OF CONTENTS

INTRODUCTION 8

FURTHER AMENDED NOTICE OF MOTION 11

THE STAY APPLICATION 12

Sakeliga's approach 12

SAPPF, HFA and HASA's responses to the Stay Application 15

THE CONSOLIDATION APPLICATION 21

Sakeliga's position on consolidation 21

HFA's responses to the Consolidation Application 21

SAKELIGA'S CONDITIONAL COUNTER APPLICATION 22

The interdict is prevented by the provisions of the NHI Act and the Constitution ..23

The relief is imprecise and overbroad 24

The relief undermines the very purpose of the stay application 25

Sakeliga has failed to justify the conditional counter-application or to meet the requisites for an interim interdict 25

AD SERIATIM REPLY 28

Ad Sakeliga's answering affidavit 28

Ad HFA's second supplementary answering affidavit dated 28 October 2025 52

Ad HASA supplementary answering affidavit dated 24 October 2025 82

Ad SAPPF second supplementary answering affidavit dated 27 October 2025 ..115

Ad SAPPF's third supplementary answering affidavit dated 3 November 2025 ..120

CONDONATION FOR LATE FILING 130

PRAYERS 131

I, the undersigned,

NICHOLAS GILMOUR CRISP

state under oath as follows:

1 I am the Deputy Director General: National Health Insurance at the National Department of Health ("**NDoH**"), my further details appearing at paragraph 1 of the founding and replying affidavits. I am duly authorised to depose to this affidavit on behalf of the applicants.

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

3 I have read and reply to the following affidavits to follow:

3.1 the answering affidavit filed on behalf of the tenth respondent ("**Sakeliga**"),

3.2 the further (second) supplementary answering affidavits filed on behalf of the ninth respondent ("**HFA**") dated 28 October 2025;

3.3 the further (second) supplementary answering affidavits filed on behalf of the seventh respondent ("**HASA**") dated 24 October 2025;

3.4 the further (second) supplementary answering affidavits filed on behalf of the sixth respondent ("**SAPPF**") dated 27 October 2025; and

3.5 the third supplementary answering affidavit filed on behalf of SAPPF dated 3 November 2025.

4 Any allegations which I do not reply to in this affidavit, and which are inconsistent with what I say in the founding, supplementary founding, and replying affidavits and this affidavit, must be taken as denied.

5 In the remainder of this affidavit, I use the abbreviations and definitions used in the previous affidavits that I have deposed to in support of the Minister's application or as otherwise defined here.

INTRODUCTION

6 The parties who oppose the Minister's application would have it that the interests of justice dictate an outcome in which:

6.1 the Constitutional Court and this Court will deliver judgments on the same or similar issues in a disorderly timeline, leading to potentially conflicting judgments between the Courts and within this Court, and multiple appeal processes running concurrently thereafter;

6.2 the Court and the parties will invest substantial human and financial resources in running litigation that may shortly become academic; and

6.3 ordinary litigants who rely on the Court to determine consequential disputes in their lives (personal injury claims, RAF claims, disputes about children, evictions, repossessions and the like) will have their matters delayed in service of a mass of complex High Court applications running in parallel streams that may ultimately become moot.

7 This outcome is not in the interests of justice. It does not advance the right to a fair hearing, nor constitute the efficient use of scarce judicial and party resources.

8 The need for this supplementary replying affidavit comes about as a result of the late joinder (by consent) of Sakeliga as a respondent to this application.

9 Sakeliga has filed an answering affidavit in which it opposes the stay application for largely the same reasons as the other parties who oppose it. I do not repeat the justifications for the stay application and why the Minister contends that it is in the interests of justice that the application succeeds. Instead, I reply thematically and only further as is necessary to specific issues that are unique to Sakeliga's answer.

10 It is noteworthy that Sakeliga does not oppose the consolidation application but resists any conditions being attached to the consolidation order. I have similarly dealt with these issues in my previous affidavits and do not repeat those averments here.

11 In addition to opposing the stay, Sakeliga has included in its answering affidavit a conditional counter-application in which it seeks orders interdicting the implementation of the National Health Insurance ("**NHI**") Act, 2023 ("**Act**" or "**NHI Act**") in the event that the Court grants the Minister's application to stay the relevant High Court applications. The Minister opposes this relief.

12 All the respondents, apart from Sakeliga, already filed their answering affidavits prior to Sakeliga being joined. However, these parties were afforded an opportunity to, if they so wished, file supplementary answering affidavits in order to deal with the consequences of Sakeliga's inclusion in the Minister's application. Rather than confine themselves to this narrow issue, HASA, HFA and SAPPF have abused this opportunity and filed lengthy affidavits in which they attempt to re-argue the merits of their respective main applications and

introduce new matter. They do so in a coordinated fashion, based on a tenuous claim that they are entitled to respond to "new matter" in the replying affidavit filed on the Minister's behalf.

13 I deny that any aspect of my replying affidavit exceeds permissible bounds or constitutes new matter such that the respondents should be permitted to file further affidavits. In the replying affidavit I did no more than to answer allegations made in the various answering and supplementary answering affidavits. While the Minister persists in his view that the expansive content of HASA, HFA and SAPFF's affidavits are an abuse of process, he accepts that the Court may, nonetheless, wish to have regard thereto in making its decision. For this reason, the Minister does not oppose the filing of those affidavits, save to oppose HASA's attempt to introduce a new expert report, as well as all averments relevant to that expert report.

14 To the extent, moreover, that I deal with substantive issues in the parties' respective main applications, I do so without prejudice to the Minister's right to answer to those allegations fully in due course in his answering affidavit(s), duly supported by expert evidence. I do so further without prejudice to my submission that this is unnecessary and that it would be, with respect, inappropriate for the Court to pre-empt the adjudication of the merits in this stay and consolidation application.

15 In the remainder of this affidavit:

15.1 I contextualise a further amended notice of motion which will be filed together with this affidavit.

15.2 I address thematic issues raised in Sakeliga's answering affidavit and the further supplementary answering affidavits under the stay application and consolidation application.

15.3 I reply paragraph by paragraph to the foresaid affidavits to the extent required.

FURTHER AMENDED NOTICE OF MOTION

16 Due to the new NHI-related applications filed subsequent to the launch of this application, the Minister filed an amended notice of motion.

17 A further amended notice of motion was included with the filing of the replying affidavit on 17 September 2025. A signed copy of that affidavit was filed on 26 September 2025.

18 No objections were made to these amendments.

19 A further and final amended notice of motion will be filed with this supplementary replying affidavit. The amendments to the notice of motion are also necessary in order to include Sakeliga in the relief sought.

20 The Minister circulated a copy of the further amended notice of motion to Sakeliga and the other parties and did not receive any objections to the version that will be filed with this affidavit.

THE STAY APPLICATION

Sakeliga's approach

21 Sakeliga's case in opposition to the stay relief relies on, first, anticipating the substantive orders that it seeks in its main application; second, hyperbole and speculation; and third, unwarranted disparaging remarks directed at the Minister and at me.

22 First, I deny that Sakeliga is entitled to anticipate the substantive issues raised in its main application to the extent that it does. The Minister reserves his right to answer to the merits of Sakeliga's main application in full in due course, and with the support of expert evidence in doing so.

23 I do not answer to specific allegations made in the PriceMetrics reports. These will be answered in full in due course, and with the support of expert evidence. For present purposes, I deny the accuracy and reliability of the assumptions made, the reasoning applied, and the conclusions reached, in those reports.

24 As I have set out in my previous affidavits, there are a vast number of factual disputes that are anticipated in each of the High Court applications. These concern highly technical questions of policy preference. The applications call on the Court to predict how health financing reforms enacted through NHI will impact on the economy on both macro and micro scales, on healthcare workers, on access to health services and supplies, on financing for healthcare, and on the right to equality, amongst many others.

25 Not only do the applications raise factual disputes which have the potential to be referred to oral evidence, but extensive expert evidence is relied upon by most, if not all of the parties.

26 It would be wholly inappropriate, with respect, for the Court to anticipate those factual disputes (not to mention the disputes amongst experts) in an interlocutory application. To do so would undermine the fairness of the hearing to come, promote duplicative litigation, possibly result in conflicting judgments, inhibit legal certainty and diminish the efficient and orderly administration of justice.

27 Second, Sakeliga's claims are exaggerated and little more than fear-mongering based on speculative figures.

28 The Minister's stay application does not "stop" any applicants from accessing court. A stay is not akin to the court closing its doors on a litigant. It does not entrench an "improper hierarchy of rights". Nor does it otherwise obstruct a fair hearing in due course. It simply provides for a sensible ordering of the several concurrent litigation processes to prevent contradictory judgments and potentially wasted judicial and party resources through potentially pointless litigation.

29 The stay application, and the progressive, phased implementation of the Act that will occur in the interim, does not lead to the wild and grossly exaggerated outcomes alleged by Sakeliga, ranging from complete national economic collapse to death, suicidality, drug abuse and violent crime.

30 Had Sakeliga, or any of the parties for that matter, sincerely anticipated that the implementation of NHI would have the dire, immediate effects that they claim,

they would not have hesitated to bring urgent applications to stop the implementation of the Act as soon as it was enacted. The fact that none of them have done so, almost two years after the Act was passed by the National Council of Provinces and eighteen months since it was assented to by the President, indicates that the speculative and unjustified claims of imminent economic and health systems' collapse are hyperbolic and not seriously made. In any event, they lose sight of the following important factors:

30.1 Government is fully in control of the pace of implementation of the NHI, subject to the NHI Act.

30.2 Section 57(1)(b) expressly provides that NHI will be gradually phased in using a progressive and programmatic approach based on financial resource availability.

30.3 The NHI is specifically designed to address the dual nature of the current healthcare system, in which a grossly disproportionate allocation of resources serves a small proportion of the population. It can therefore never be harmful to the public interest, the economy or the health system; and

30.4 The initial steps that will be taken in the upcoming years will not disturb the current system of healthcare service provision. Indeed even if the NHI Act were to be declared invalid in its entirety, there will through the implementation of NHI up to that point have been significant strengthening of the health system.

31 As I explained from paragraph 69 of my replying affidavit, the implementation of the Act that is planned during the period of the stay concerns primarily:

31.1 establishing administrative institutions like the Board of the Fund and advisory committees;

31.2 improving public health infrastructure and systems; and

31.3 enhancing healthcare for the vulnerable groups specified in the Act.

32 Thus, even if Sakeliga's economic analysis was correct (which is denied), nothing done in these early stages of implementation could ever have the disastrous impact that Sakeliga claims.

33 Third, I deny all of Sakeliga's gratuitous disparaging remarks against the Minister and against me. The claims that the Minister is "cynical", "irresponsible", "fiscally irresponsible", abusing court process, abusing his executive authority, engaging in "Stalingrad tactics" and has an "ulterior purpose" are regrettable and offensive. So too is the baseless allegation that I am "not being open and transparent with the Court".

34 These allegations ought to be struck for being scandalous, vexatious and irrelevant.

SAPPF, HFA and HASA's responses to the Stay Application

35 SAPPF, HFA and HASA's most recent supplementary answering affidavits are answered primarily in the paragraph-by-paragraph responses.

36 Purely by way of introduction, I mention the following aspects of their latest supplementary answering affidavits.

37 In paragraph 15 of its second supplementary answering affidavit, SAPPF reiterates its opposition to the stay of its High Court frontal challenge pending the decision of the Constitutional Court in the relevant proceedings. It also opposes the grant of the stay of its High Court frontal challenge pending the decision of the Constitutional Court in the Second BHF application. It opposes the stay of the HC frontal challenge pending the withdrawal or final adjudication of SAPPF's HC review application.

38 In support of its position, SAPPF continues to argue that there is a distinction between a substantive challenge to the NHI Act, as in the HC frontal challenges, and the second BHF CC application, which is a narrow challenge that turns on a different inquiry.

39 It claims that the second BHF CC application turns on whether the process of adopting the NHI Bill complied with constitutional standards of participatory democracy. As opposed to this, the substantive challenges ask whether the substance of the NHI Act itself complies with constitutional rights, legality and rationality.

40 SAPPF argues that there is thus no risk of duplication, inconsistency, or wasted judicial effort in allowing the substantive challenges to proceed in parallel with the Second BHF CC application. This argument misses the point.

41 If the Constitutional Court upholds any of the challenges before it – it would set the Act aside in its entirety and remit the matter to the President or Parliament

(as the case may be). That would render the high court challenges moot and result in a waste of all judicial and party resources expended in respect thereof. Despite SAPPF's assertions to the contrary, that concern is only prevented through the grant of the stay.

42 If the second BHF CC application was allowed to run alongside the substantive challenges, and the frontal challenges, there would be a risk of the Courts running parallel inquiries and making conflicting decisions. If the substantive challenges were decided first and the High Court found in favour of the Minister on the frontal challenges, and upheld the Act, only for the Constitutional Court to later set the Act aside, it would cause the very negative consequences that the Minister seeks to prevent through the bringing of the stay.

43 A finding by the Constitutional Court on any of the alleged procedural failings would render the High court substantive challenges moot. This risk of mootness is not speculative. It is real. SAPPF would surely not have brought its own Constitutional Court proceedings if it considered them to be speculative.

44 In paragraph 43, SAPPF argues that because it has abandoned its relief in prayers 3 and 4 of the High Court review application, it has decoupled the review application from an inquiry into the constitutionality of the Act. I am advised that this does not cure the risk of conflicting decisions and does not prevent duplication of judicial resources. In any event it has not proceeded with the amendment application necessary to achieve its decoupling.

45 In its second supplementary answering affidavit, HFA raises contentions that are similar to those made by the other respondents.

46 In paragraph 21, the HFA sets out four bases for its opposition to the stay application. It complains that even on a conservative estimate the proposed stay would persist for several years, there is no risk of conflicting judgments, and the stay would cause prejudice.

47 HFA's arguments about excessive delay and potential prejudice lack evidence or substantiation and are overstated. I emphasise that should this Court be concerned about delay while a stay is in place, there are options available to moderate any potential prejudice in the Court's order, should the relevant respondents motivate for it.

48 In addition, the complaint of delay is misplaced in light of the general acceptance that the implementation of the NHI Act will take many years. The NHI Act presupposes a gradual realisation or a phased approach. As previously explained, this is embedded into the Act through, amongst others, section 57(1)(b) which requires that "National Health Insurance must be gradually phased in using a progressive and programmatic approach, based on financial resource availability."

49 HFA also claims that there is no risk of conflicting judgments. This, they argue, is because the SAPPF challenge concerns the decision of the President to assent to the Act, which is different from the constitutional challenge to the substantive provisions. A similar claim is made with reference to the BHF public participation application, namely that it does not have an overlap with the other challenges.

50 The aforementioned argument is flawed and has been comprehensively addressed in the replying affidavit. The responses provided therein are incorporated herein by reference.

51 HFA argues that severe prejudice would result from the impact of the stay relief. They argue that the stay relief is an effective embargo on challenging the NHI Act in the High Court. It would, they claim, inhibit the Court from exercising its core constitutional function. Conversely, the HFA claims that no prejudice would be visited on the applicants if the stay relief is not granted.

52 HFA's attempt to introduce a new expert report and the averments that it makes on the basis of that report are dealt with in the paragraph-by-paragraph section of the affidavit.

53 Even under the most optimistic projections and assuming optimal funding for implementation, full enactment of the Act is will not be achieved within the next five years. It is not anticipated or required, either statutorily or in terms of the Department's planning and budgeting, that full implementation will be realized during the period of the stay.

54 Any possible prejudice mentioned by the respondents can be appropriately addressed through careful judicial supervision and case management. If indeed the Court is concerned that an indefinite stay risks prejudice to the affected parties, the Court may put supervisory orders in place, including that the grant of the stay is subject to a directive that requires the Minister to file an affidavit at regular intervals explaining the progress of the Constitutional Court litigation, as well as progress in the implementation of the NHI Act, and permitting the relevant respondents to file an affidavit in response.

55 This would enable the Court to reassess the impact of the stay on the interests of justice on an ongoing basis. In any event, no party would be precluded from approaching the Court to uplift the stay if circumstances change.

56 On the flip-side, true prejudice is to be suffered by the applicants, this Court, and those vulnerable groups dependent on the short-changed public healthcare sector, if the stay is not granted. That prejudice is absolute and cannot be managed through case management. The prejudice will lead to undue burden on judicial and State resources, including the vulnerable groups referred to earlier.

57 I emphasize that all of the costs incurred in and other resources expended on that litigation will be a waste if the NHI Act is set aside in its entirety. These costs will come at the expense of the vulnerable groups that are meant to be the primary beneficiaries of the NHI Act, will seriously impact on the administration of justice and risk wasting scarce judicial resources, which might more appropriately have been employed facilitating the achievement of the rights in terms of section 34 of the Constitution of the other parties who are before the High Court in other matters.

58 It is also of significance that the applications in the Constitutional Court are all potential knock-out blows in respect of the entire NHI Act. Not so the direct challenges in the High Court. Whilst ostensibly seeking to challenge the Act in its entirety, the reality of those applications is that, at best for them, they would knock out particular subsections or sections of the Act, given the nature of the attacks. This will be elaborated upon in argument.

THE CONSOLIDATION APPLICATION

Sakeliga's position on consolidation

59 Sakeliga does not object to consolidation. It objects only vaguely to "restrictive conditions proposed by the Minister". I assume these objections are in respect of prayer 7.4 of the original notice of motion (paragraph 8.4 in the amended notice of motion). The Minister's position on that prayer is indicated in the replying affidavit.

HFA's responses to the Consolidation Application

60 In paragraph 35, HFA claims that no case has been made out for a consolidation. It further claims that the consolidation relief would not be convenient as all the benefits sought by the Minister could be obtained through effective case management.

61 It argues that conversely, the consolidation relief would cause prejudice as it would result in cases capable of quick resolution being slowed down by those that are bogged down by interlocutory disputes etc.

62 I reiterate that HFA's complaints in relation to consolidation, with respect, reflect an unwillingness to be bound by measures that would make the litigation process more manageable. If anything, its attitude shows that consolidation is required at this stage because the parties are not likely to be cooperative in managing the litigation themselves.

63 HFA's argument seeks to secure the fastest outcome possible for itself while causing the utmost chaos in the court administration system. The approach

adopted by HFA ignores the real impact of such vast litigation on the court system, the human and other resources involved, and the further impact on access to justice.

64 The solution proposed by the applicants is measured and reasonable. Any opposition to the consolidation relief is unsustainable and ignores the crippling consequences likely to follow if no consolidation is granted.

SAKELIGA'S CONDITIONAL COUNTER APPLICATION

65 In summary, the Minister opposes Sakeliga's "conditional counter application" on, inter alia, the following bases:

65.1 The interdict is prevented by the provisions of the NHI Act.

65.2 The interdict sought is imprecise and overbroad.

65.3 Sakeliga has failed to demonstrate the existence of a *prima facie right* which requires protection pending the outcome of its constitutional challenge. This requirement assumes prominence where the decision sought to be interdicted is executive in nature and policy-laden and the interdict has implications for the doctrine of separation of powers. This is such a case. Sakeliga is thus required to demonstrate strong prospects of success in the main application, which it has failed to do.

65.4 Sakeliga has failed to demonstrate a well-grounded fear of irreparable harm.

65.5 The balance of convenience does not favour the grant of the interdict. In this regard, Sakeliga has failed to meet the heightened "OUTA threshold" for such relief.

The interdict is prevented by the provisions of the NHI Act and the Constitution

66 Both the commencement of the NHI Act by the President in terms of section 59(1) and (2) and its implementation have to take into account the provisions regulating its phased implementation. In terms of section 57 implementation must, subject to section 57(1)(b) take place initially in two phases. These phases are hard-wired into the Act, with Phase 1 being laid down in section 57(2)(a) as being for a period of four years from 2023 to 2026, and phase 2 being laid down in section 57(2)(b) as being for a three year period from 2026 to 2028.

67 If the interdict sought prohibiting the Minister, the Director-General of the Department of Health and the President from "implementing or giving effect to" the NHI Act pending the stay were to be granted, the Court itself would be acting contrary to these statutory provisions. It would also force the Minister, the Director-General and the President to breach their obligations. Their obligations arise not only in terms of the NHI Act but also in terms of various provisions of the Constitution, which will be listed fully when the matter is argued. At this point I refer to section 7(2), 8(1), 27(1) and (2), 81, 84(1) and 85(2)(a) and (e).

68 Accordingly the grant of the interdict sought is prohibited by the NHI Act itself and by the Constitution.

The relief is imprecise and overbroad

69 The conditional counter-application seeks a drastic and overbroad interdict that Sakeliga has failed to substantiate.

70 Sakeliga appears to have given little consideration to the precise terms of the relief that it seeks and there is an inherent inconsistency between its notice of motion and its answering affidavit. For example:

70.1 Prayer 1 of its notice of motion indicates that the interdict would apply solely against the Minister and the President, for the duration of the stay sought by the Minister. Even if this prayer succeeds, to the extent permitted by the existing legislative framework, the NDoH and other state functionaries would be at liberty to implement the Act and make provision for its implementation.

70.2 Contrary to this, at paragraph 121 of its answering affidavit, Sakeliga says that "[t]hese facts require a conditional interdict/ structural order, pausing further rollout steps pending final determination of all constitutional challenges." This implies that:

70.2.1 Sakeliga seeks a structural interdict of an undisclosed nature that would seemingly extend beyond the terms of its notice of motion;

70.2.2 the interim interdict would not be limited to the Minister and President but would apply universally to "pause further rollout steps" (the scope of "rollout steps" being undefined); and

70.2.3 the interim interdict would apply until "final determination of all constitutional challenges", not just the period of the stay of proceedings.

71 The relief sought is also vague and uncertain. Prayer 1 seeks to interdict the President and Minister from "implementing and/or giving effect" to the NHI Act. Not only is this far-reaching relief unsubstantiated, but it is unclear whether this is indeed to prevent the President from bringing provisions of the Act into force.

The relief undermines the very purpose of the stay application

72 In substantiating the basis for its conditional counter-application, Sakeliga appears to rely on the allegations it makes in its main application, including making reference to two expert reports that it files with its main application.

73 If the Minister were compelled to answer the detailed and technical evidence made in Sakeliga's main application on an interlocutory basis in this application, it would undermine the very purposes of granting the stay application. That is, to save incurring potentially wasted costs in answering to applications that may be rendered moot in due course.

74 The Minister thus objects to the conditional counter-application in its totality.

Sakeliga has failed to justify the conditional counter-application or to meet the requisites for an interim interdict

75 Sakeliga has neither shown that its relief is just and equitable nor that it is in the interests of justice, nor that it has met the requirements for the grant of an interim interdict.

76 Sakeliga claims that the facts in support of the relief have been canvassed by the parties to date and that the Minister and President have "dealt with such an interdict". I deny this.

77 Sakeliga was required to substantiate the grounds for its conditional counter-application in its own affidavit. It has failed to do so. This failure ought to disentitle it from the relief it seeks without more.

78 If Sakeliga were entitled to rely on unidentified portions of the other parties' affidavits in support of its application, this would be prejudicial to the Minister who has no means of knowing the case that he is called upon to answer.

79 Further to this, the balance of convenience does not favour the granting of the interdict. In this regard:

79.1 The entire health system in South Africa is in serious trouble, in both the public and the private sectors.

79.2 The Minister details this in his answering affidavit in the Solidarity application. In the private sector, this is evident in the declining proportion of people in South Africa who can afford medical scheme coverage, the declining proportion of scheme members who have comprehensive coverage, the growing burden of copayments, and other aspects.

79.3 A host of reforms are required to fix these problems. NHI is one (important) component of those reforms.

79.4 Every day that these reforms are delayed, more people in South Africa are placed at risk of not receiving the healthcare that they need, and of incurring catastrophic monetary loss in seeking private care.

80 I further deny Sakeliga's allegation that any steps to implement the NHI Act will have been "for nought" and the funds so expended would have been wasted if the Act is ultimately set aside on review. The exact opposite is true. I set this out in detail in my replying affidavit.

81 There are many reforms in the NHI Act that are essential and without them, some of the things that even opponents of the NHI want to see implemented will lack a statutory mandate. This includes, for example, procurement harmonisation and digital integration.

82 I address the remainder of Sakeliga's allegations on its conditional counter-application in the *ad seriatim* section of this affidavit below. These canvass a range of irrelevant issues that Sakeliga raises. They take Sakeliga's case no further.

83 If anything, Sakeliga's approach is an indication that the relief sought by the Minister is necessary. The parties continue to demonstrate an intent to drown the court in successive applications and to raise irrelevant matters in support of efforts to resist the sensible management of the litigation.

84 The Minister prays that Sakeliga's conditional counter application is dismissed, with an appropriate order as to costs.

AD SERIATIM REPLY

85 I reply only to the specific paragraph references that follow to the extent that it is strictly necessary, taking into account what I say in the founding papers, my replying affidavit and above. To the extent that any of the answering affidavits conflict with what I say in my previous affidavits and this affidavit, I ask that those averments be taken as denied.

86 Insofar as Sakeliga seeks to "answer" to the President's answering affidavit, I deny that it is entitled to do so. These paragraphs of its affidavit should be struck out. The same are answered herein without prejudice to the Minister's rights.

Ad Sakeliga's answering affidavit

Ad paragraphs 8 to 14

87 The Minister has filed a notice to oppose Sakeliga's constitutional challenge and will answer it in due course. For present purposes, I point out that:

87.1 Sakeliga has not even come close to establishing that the NHI Act does not meet the low threshold for rationality.

87.2 The NHI Act was passed to progressively realise the right of access to adequate healthcare as contained in section 27(1)(a). Sakeliga has not established that the NHI unjustifiably limits this right.

Ad paragraphs 15 to 20

88 Sakeliga's effort to pre-emptively litigate the merits of its application is inappropriate. The Minister reserves his right to answer to Sakeliga's allegations fully in due course.

89 For present purposes, I deny the accuracy and validity of the reasoning, conclusions and opinions of Sakeliga and PriceMetrics.

90 The Minister will in due course produce additional expert evidence to further substantiate this denial. Further to this, I refer to the Minister's answering affidavit and the expert affidavits filed in the Solidarity application for an explanation of single-payer systems and the health economics rationale behind them.

91 Insofar as Sakeliga and PriceMetrics refer to GDP-per capita, "strong fiscal capacity" and comprehensive health care resources as necessary preconditions for the implementation of single-payer systems, they elevate correlation to causation.

92 Countries with fewer resources can least afford to waste scarce health funding on duplicative payment mechanisms and forego the efficiency opportunities of single payer systems. This is why, globally, the general consensus amongst health economists is that moving away from multi-payer systems is necessary to make progress towards Universal Health Coverage ("**UHC**").

93 I agree that effective governance and sophisticated information systems are necessary components of effective single-payer systems. This is embedded in the NHI Act. In his answering affidavit to the Solidarity application, the Minister addresses how the Act creates the framework for effective governance of the

Fund. The Minister further details the significant advances that have already been made to progress the sophisticated health information systems that will inform the implementation of the Act and the Fund's work.

94 The NDoH is working closely with international counterparts and institutions like the World Health Organisation to learn from experience about the systems and institution-building that are necessary for NHI.

95 As the Minister will in due course answer in finer detail to the various applications, should this prove necessary, it suffices to say presently that public health experts agree that single payer health financing systems are not a luxury reserved for wealthy nations.

96 I attach, by way of many examples, a summary of The Elders' Charter for Equitable and Sustainable Universal Health Coverage as Annexure "**SRA1**". The Charter establishes several precepts for the achievement of UHC, endorsed by international leaders, and formulated with expert partners from across civil society, academic and the public health community. While the Charter recognises differences in countries' political and economic realities, the precepts consistently promote single-payer or single-insurer systems as a necessary precondition for UHC. For example:

96.1 Precept 2 says that "[p]rovided the pertinent governance is effectively put in place, social insurance is best organised through a nationally consolidated institution that insures into a single pool of all individuals and purchases on their behalf the needed health services."

96.2 Precept 4 records that "[c]ompetition among providers — with transparent and fair rules — to supply the services demanded by the single insurer/purchaser on behalf of the beneficiaries of UHC, should be a key feature of the system in order to foster efficiency, quality and innovation." (own emphasis.)

97 It is not clear what Sakeliga seeks to achieve by referring (even obliquely) to the SIU investigation into corruption at Tembisa Hospital. The Minister of Health has no control over the disbursement of funds allocated to provinces. Thus, the alleged fraudulent handling of funds at Tembisa Hospital, while an issue of enormous concern to us, is something over which the NDoH has no control. Indeed, this is one of the issues which the NHI Act is specifically intended to address through section 32 which will allow the NDoH and the Minister to intervene in the co-ordination and planning of health care services rendered by provinces, districts and municipalities.

98 I deny that South Africa does not have sufficient human resources or adequate infrastructure to implement a single-payer system.

99 Insofar as social solidarity is concerned:

99.1 I am advised and submit that our Constitution articulates a vision for social solidarity and substantive equality.

99.2 I point out that certain private sector participants who have the most to lose financially due to the reform of the most dysfunctional parts of our healthcare system are seeking to obstruct and oppose the Act.

99.3 I deny, however, that there is any generalised lack of support from medical practitioners as Sakeliga claims.

Ad paragraphs 21 to 68

100 The assumptions made by Sakeliga and PriceMetrics are incorrect. These assumptions demonstrate how poorly correlated their analyses are to the actual provisions of the Act.

101 Section 57 sets out the progressive and phased implementation of the NHI Act. Further detail to this would be inappropriate to legislate considering that the pace of implementation is dependent on a number of facts, including budgetary constraints. In addition, I have detailed in my replying affidavit the NDoH's anticipated next steps.

102 Section 57 and in particular section 57(1)(b) gives the State the ability and imposes the obligation to synchronize progressive and phased implementation of the NHI with available funding, which means that there is no "funding shortfall" for the implementation of the NHI.

103 Furthermore, the cost implications of the NHI Act is an issue raised by all the parties in their substantive applications. It is an issue on which extensive expert evidence will be led. The Minister's answering affidavit and my supporting affidavit in the Solidarity application deals with costing of NHI. I refer to the answers that are given there. The Minister intends to expand on the issue and respond with further detailed expert evidence in due course, should this prove necessary, and reserves the right to do so.

104 For present purposes, I deny the accuracy and reliability of Sakeliga's reasoning, conclusions and opinion.

105 The fact that South Africa faces financial constraints is precisely why it cannot afford to continue running an inefficient, wasteful and inequitable healthcare system. NHI is designed to improve efficiency, affordability, access and equality in the healthcare system. The features of the NHI system are informed by decades of policy formulation, domestic and international expertise, and are tailored to the South African context.

106 Sakeliga purports to present a veneer of objectivity through its citation of figures, calculations and economic theory. It is in substance however, a highly subjective ideological manifesto that is premised on unsound economic theories and assumptions. The Minister will demonstrate the flaws in Sakeliga and PriceMetrics' opinions in due course through expert and other evidence, to the extent necessary.

107 Sakeliga's assumptions of inevitable tax hikes, and the consequences on household income and the economy, are based on a misunderstanding of how public finance works, and the implications of section 49 of the NHI Act. I refer for present purposes to the expert affidavit of Dr Debbie Budlender included with the Minister's answering affidavit to the Solidarity application. That evidence will be duly amplified and expanded on in answer to the remaining applications and expert evidence in due course.

108 There is no evidence to support the contention that the implementation of NHI will contract the South African economy. On the contrary, evidence from other

countries shows that improving health care expenditure may accelerate economic growth. This will be dealt with in expert evidence in due course.

109 For the court's comfort in the time being, I attach an article as Annexure "**SRA2**", based on a case study in Jordan and referencing other works that shows how increases in health care expenditure may lead to improved standards of living and increased GDP, accelerating economic growth. It is certainly not a valid economic assumption for Sakeliga to claim that if South Africa were to increase its health expenditure that this would lead to economic decline.

110 Furthermore, there is no evidence that the full implementation of NHI (whenever that occurs) will require a substantial increase in South Africa's total health expenditure. Having considered the issue closely, the NDoH does not consider that full implementation of the NHI will require that more than 8.5% of GDP is spent on health. What NHI does however require is that the bulk of that expenditure on health is done through a publicly-funded single-payer system.

Ad paragraphs 69 to 69.4.2

111 I deny that Sakeliga is entitled to the relief it seeks in its main application and I deny that the NHI infringes the Constitution as alleged. The Minister has opposed Sakeliga's application and will answer to it fully in due course.

112 Suffice to say for present purposes that:

112.1 There are no "rational flaws" in the NHI Act. The implementation thereof is not unaffordable.

112.2 While it is true that the State has limited resources available to it, the State is obliged to progressively realise the right of access to adequate healthcare for all (and not only for those who can afford it). This is simply impossible under the current system. Thus the NHI Act is a measure designed to progressively realise the right under section 27(1) of the Constitution.

112.3 The NHI Act was passed by Parliament and has the support of cabinet. The commitment to implement (and thus fund) the NHI has already been made by government.

112.4 I do not know the context under which previous Ministers made comments about the NHI. I can only refer to the commitment by Parliament and the executive to implement it.

112.5 Sakeliga assumes that there are "procurement inefficiencies" and that this will plague implementation of the NHI.

112.6 It is disputed that there will be shortages and supply concentration or that South Africa will not have sufficient market power in global healthcare markets.

112.7 The argument that the NHI limits other socio-economic rights or that it impedes the State's ability to realise other rights is fallacious. So too is the alarmist allegation that the NHI will lead to severe job losses and increased unemployment.

Ad paragraphs 73 to 76

113 I deny that a temporary stay of the affected applications will undermine the South African constitutional order. If this were so, any stay application would be unconstitutional. On the contrary, I am advised that the Constitutional Court has recognised that courts may grant a stay in exercise of their inherent powers under the Constitution, in order to control their own proceedings.

Ad paragraphs 77 to 79

114 Sakeliga makes the extraordinary argument that it will not be wasteful for the State respondents to defend the High Court applications if they are ultimately rendered moot. Sakeliga suggests that there is social benefit in ventilating the issues even if they never get to hearing, which benefits the public and even Parliament.

115 I accept that there is an incidental benefit to public law litigation of allowing transparency on public interest issues. That is an incident of open justice. It is not a reason, however, to litigate on academic issues (which our courts consider to be contrary to the interests of justice) or to risk wasted costs on issues that may become academic in due course.

116 Sakeliga's reasoning is contradicted by its own claim that the "resolution of [live] disputes is the purview of the Court".

Ad paragraphs 80 to 88

117 The stay application does not prevent the determination of the parties' substantive applications. What it does is to, amongst others:

117.1 ensure that the parties and Court do not waste time and resources running the applications if the Act is declared invalid in any event by the Constitutional Court; and

117.2 if the applications in the Constitutional Court are unsuccessful, to allow for this Court to benefit from any findings that the Constitutional Court may make on substantive and procedural criticism of the Act to inform its judgment.

118 In either event, the dispute between the parties is either eliminated entirely (if the Constitutional Court applications are upheld) or reduced and guided by a final judgment of the highest Court (if the Constitutional Court applications are dismissed).

Ad paragraph 89

119 I deny the allegations.

Ad paragraphs 90 to 91

120 I deny that I have provided opinion and hearsay evidence. In any event, I deny that my opinion, insofar as it is given on issues of the financial implications of the NHI Act, would be inadmissible. My qualifications and 42 years' of experience qualifies me to comment on issues of public health, health economics and public finance, to the extent that I do so.

121 I have an MBChB degree from the University of Cape Town, an MMed (Community Health) from the University of the Witwatersrand ("**WITS**") and a Diploma in Occupational Health, also from WITS. The study of health economics

formed part of my MMed (Masters) degree. I am an Honorary Professor in Health Systems and Public Health at the University of Pretoria.

122 I have extensive experience working in government and engaging the public finance system.

123 This experience includes working as the Regional Director of the Department of National Health and Population Development for Northern and Eastern Transvaal (Limpopo and Mpumalanga) from 1989 to 1993; working as the Superintendent General of the Department of Health and Welfare, Northern Province (Limpopo) from 1995 to April 1999; leading in the establishment of the National Health Laboratory Service, the reform of the Medicines Control Council and the Medicines Regulatory Authority into the South African Health Products Regulatory Authority; planning of the new Limpopo Central Hospital; working as special advisor to Minister Barbara Hogan; leading the Covid-19 vaccination programme in South Africa; and my current role as Deputy Director-General of the NHI Branch of the NDoH.

124 I have worked on NHI in both Nigeria and Ghana in a consulting capacity.

125 I am a lifetime member of the College of Medicine. I was awarded a Lifetime Achievement Award by the Public Health Association of South Africa and was recently made a Fellow of the African Institute of Public Health Professionals.

126 I attach a copy of my curriculum vitae which I mark as Annexure "**SRA3**".

127 In contrast, the deponent to Sakeliga's affidavit discloses no qualifications in matters of public health or health economics, nor any experience in public finance.

Ad paragraphs 92 to 93

128 I deny the allegations.

129 The Minister has answered to the case he was called to meet in the Solidarity application. To the extent that answering the remaining High Court applications requires more detailed information, it will be provided in due course.

Ad paragraphs 95 to 101.3

130 Sakeliga both criticises me for not saying enough about the technicalities of the parties' "financial feasibility" arguments in the substantive applications (the answering affidavits for all but Solidarity due subject to the outcome of the stay application), and for saying anything at all about these issues.

131 I deny that implementing the Act would bring about wasted expenditure if the Act is ultimately declared unconstitutional. My reasons are stated in the replying affidavit and above and below.

132 Sakeliga's argument is not rooted in fact or in the provisions of the Act, which indicate the nature and extent of implementation that will actually occur in the next few years.

Ad paragraphs 101.3 to 101.5

133 On Sakeliga's version, any decision by Parliament and the fiscus to allocate a greater or lesser proportion of the annual budget to one portfolio over another is an infringement of constitutional rights. This is nonsensical.

134 In South Africa, about 15% of government spend is on health. In contrast, in countries like Canada, health care is the largest expense for provincial, territorial and local governments, making about 34.2% of the spending in 2023.

135 The NHI Act is not a money bill. The extent to which budget will be allocated to the implementation of NHI is a function of the ordinary budgetary and legislative process. The budgetary process, as set out in the Constitution and the Public Finance Management Act, 1999 ("**PFMA**"), is not the subject of constitutional attack in any of the applications. The allegations are wholly irrelevant to the substantive disputes raised in the High Court applications, more so to the stay application.

Ad paragraph 102 to 103

136 I deny that the NHI Act will lead to long-term economic contraction. There is no evidence to substantiate this claim.

137 The remainder of the allegations are irrelevant. The size of the public service, the Madlanga Commission, and State Capture have nothing to do with the Minister's application.

Ad paragraphs 104 to 107

138 I deny the allegations.

Ad paragraphs 108 to 109

139 Sakeliga complains that the Minister and President are independently represented in the litigation. Sakeliga goes so far as to describe it as an abuse of process that the Minister and President have independently opposed the NHI-

related applications. I deny these allegations. They have neither a basis in law nor in reason.

140 It is both permissible and appropriate in this litigation for the Minister and the President to be represented independently in light of the differences in their roles, knowledge, interests, and institutional representation, as well as the varied relief sought against them. Each has a right to legal representation. No adverse inference can be drawn from their exercise of that right even if their positions may align on a number of issues.

Ad paragraphs 110 to 113

141 The deponent makes gratuitous and unsubstantiated allegations against the Minister (and the President), which are denied.

142 The Minister is entitled, and indeed obliged, to implement the Act upon it being brought into force by the President, notwithstanding the pending litigation. The rule of law demands that he does so. It is an absurd proposition that an organ of State or minister who is diligently and dutifully implementing laws duly passed by Parliament could ever be accused of "unconscionable" conduct or an "abuse of executive power and authority".

Ad paragraphs 114 to 116

143 Sakeliga has failed to make out a case for the relief that it seeks.

144 I deny that the facts in support of its application have been set out by other parties or addressed by the Minister. At no stage has any party made out a case for an interdict.

Ad paragraphs 117 to 128

145 I deny that the Minister's application creates any hierarchy of constitutional claims. In this regard:

145.1 As I set out in my replying affidavit, the applications before the Constitutional Court are not "purely procedural". BHF, in both of its applications, raises substantive complaints against the Act. Similarly, the High Court applications are not purely "substantive constitutional challenges", they too make procedural complaints.

145.2 In any event, the grant of the stay would not create a hierarchy or "selectively restrict judicial access". It would do exactly what is done in any stay application, namely pragmatically and in the interests of justice pend litigation. Here it would pend litigation until the outcome of potentially duplicative litigation that has the potential to render moot or predetermine aspects of the pended matter(s).

146 The stay relief does not immunise the NHI Act from scrutiny. That is exactly what is happening in the ongoing Constitutional Court litigation. The stay relief would simply mean that it is subjected to scrutiny in a sensible manner, as overseen by the Chief Justice in respect of the Constitutional Court litigation and Justice Neukircher in the High Court. Ultimately, the stay relief will allow the final determination of the constitutional complaints against the NHI Act in the Constitutional Court, which is the court of final instance, in the appropriate sequence.

147 A stay does not create any perverse incentives in future matters. The nature and scope of the litigation by the private sector against the NHI Act is unprecedented. There is no comparison with other matters.

148 I deny that Sakeliga's conditional counter-application would provide "protective interim relief", and I deny that "[n]o prejudice would result from staying the implementation of the NHI Act". In this regard:

148.1 The implementation steps that are scheduled to proceed under the period of the stay threaten no party's interests and least of all rights.

148.2 Even if it were so that the commercial interests of the parties were protected by an interdict, it would be at the expense of the public interest which is served by implementation of the Act which concerns necessary improvements to the healthcare system, and the interests of vulnerable groups whose care is to be prioritised in the early implementation stages.

148.3 Setting up the administrative structures of the Fund does not cause harm. Health systems must be administered. The 71 medical schemes collectively spend around R21 billion annually on administration themselves.

Ad paragraph 129

149 Sakeliga's reasoning is difficult to follow.

150 The Minister does not allocate funds. Parliament allocates funds to provinces and provincial legislatures in turn allocate funds to health services.

Ad paragraphs 130 to 131

151 Sakeliga lacks an understanding of how the healthcare system operates and is funded, and how NHI will operate. Its reasoning on "restoring accountability" if implementation is stayed in contrast with accountability under NHI is therefore non-sensical.

152 Under the NHI, provincial departments of health will continue to deliver healthcare services. The Fund, however, will only pay provincial departments for services that are in fact delivered. The financing system under NHI will, moreover, have mechanisms to ensure the quality of those NHI-funded services. This, if anything, advances accountability, and will reduce fruitless and wasteful expenditure in provincial departments of health.

153 Improvements need to be made in the public healthcare sector. This must occur regardless of NHI. The need for public sector improvement does not, however, change the need for health financing reform in South Africa. The ways in which the accreditation, certification and payment mechanisms operate under NHI will, if anything, further incentivise and necessitate improvements in the public sector.

154 Sakeliga and PriceMetrics also misrepresent what the Auditor General of South Africa ("**AGSA**") reported. The AGSA reports on unauthorised expenditure and fruitless and wasteful expenditure. Audit reports that highlight material irregularities, irregular expenditure, and non-compliance with legislation may be indicators of corruption, but that determination is made by other law enforcement agencies.

155 The Road Accident Fund ("**RAF**") is a different body to, and has an entirely different structure from, the NDoH, provincial departments of health, and the Fund.

156 Every year R30 billion is lost to fraud in medical schemes. Sakeliga should be concerned with this R30 billion annual fraud, waste and abuse in the medical schemes rather than the NHI, which has built-in measures to combat fraud.

Ad paragraph 132

157 With respect, Sakeliga's proposals betray its lack of understanding of public health, the operation of the national health system, and public finance.

158 The NHI Act does not aim to "reform public sector health care". It seeks to reform the "national health system" as defined in the National Health Act through implementing health financing reforms. The national health system includes both the public and private health sectors.

Ad paragraph 132.1

159 Eliminating and reducing waste is a valid objective. The NHI Act will advance this objective.

160 Reducing waste is a particularly critical issue in the private sector. The Competition Commission's Health Market Inquiry revealed the extent of wasteful over-servicing and its impact on the price of care and medical scheme membership in South Africa.

161 However, Sakeliga is misinformed about the causes of vacant posts in the public health sector. Wasteful expenditure is not the cause of vacancies. Amongst

others, it is decades of austerity that has caused the problem. Treasury and the Department of Public Service and Administration allowed annual conditions of employment ("**COE**") increases far above inflation and beyond the allocations that were made to provincial departments of health budgets. The departments were told to cover these statutory COE commitments from within their budgets.

162 COE budgets are in any event not automatically transferable to Goods & Services and vice versa. Within limits the Accounting Officer or Treasury may do that. Significant budget amendments are the purview of Parliament. Even if waste were eliminated, it would not lead to a filling of vacancies in the public health sector.

Ad paragraph 132.2

163 Sakeliga's claims are, with respect, uninformed. The repair and maintenance of essential infrastructure is already ongoing, to the tune of R11 billion annually. This includes well over 8 000 maintenance and construction projects that are ongoing. The backlog, however, is estimated to be closer to R250 billion.

Ad paragraph 132.3

164 There is no need to reinstate maintenance and procurement budgets. They all exist to the extent of the budget allocations in every province. The problem is that these budgets are woefully inadequate and in most provinces are managed by other government departments and not the health departments.

Ad paragraph 132.4

165 Anti-corruption and audit controls exist at provincial health departments but at times fail to detect problems at facilities level. Efforts are being made to tighten these controls dramatically since the SIU uncovered the novel ways in which corruption was taking place at Tembisa hospital.

Ad paragraph 132.5

166 These are all in the public domain and are all provided to the AGSA. Findings are in turn all submitted to and scrutinised in Legislatures and Parliament. The fact that fraud is not detected at the time it occurs does not mean that a department lacks transparent expenditure reports, audit committees and auditors.

Ad paragraph 132.6

167 All public sector COE and performance is regulated by the Public Service Act. It is unclear to me what is provided for in the Public Service Act which Sakeliga alleges is not being done or should be done.

Ad paragraph 133

168 This case is not about low-cost benefit options ("**LCBOs**").

169 Health economists with whom the NDoH has consulted do not support LCBOs.

170 The Council for Medical Schemes ("**CMS**") has recently presented an LCBO Report. It recommends against LCBOs and for the phasing out of existing exempted products.

171 Based on the CMS report, LCBOs will not expand coverage or benefit the vulnerable portion of the population targeted by LCBOs. It will, however, enable massive profits for entities offering LCBOs.

172 In essence, LCBOs will allow people to visit general practitioners but leave them to rely on the public sector for hospital care. LCBOs would offer no coverage for prescribed minimum benefits ("**PMBs**"). The pressure on the public healthcare sector is at hospital level, not at the primary healthcare level. LCBOs will therefore deprive low paid employees of resources without any real benefit in accessing healthcare or improved health outcomes.

Ad paragraph 133.1

173 There are already statutory permissions for affordable medical aid "plans". It is unclear what benefits Sakeliga proposes lower cost, lower benefit plans would cover. The term "basic hospitalisation" lacks meaning.

Ad paragraph 133.2

174 These are currently "exemption" products which means that they do not need to cover PMBs and they are not medical aids. They are tag-along insurance products usually only viable because they are combined with funeral and other forms of insurance cover.

Ad paragraphs 134 to 134.1 and 134.3

175 I deny that Sakeliga's proposals on private medical training are viable.

176 I note that the nursing colleges are currently permitted as long as they are registered and managed within the law.

177 I deny that "private hospitals are centres of excellence". Private hospitals do not report outcomes and they have no clinical supervision hierarchies or any form of curriculum and research structures. As demonstrated in the Competition Commission's Health Market Inquiry, private hospitals are geared to over service. This will only teach bad habits to students.

178 This notwithstanding, there is nothing stopping private hospitals from applying to the Health Professions Council of South Africa ("**HPCSA**") for accreditation to train Registrars in any speciality. Such private hospitals would need to demonstrate that they have the necessary clinical faculty, research and service capacity.

179 I deny that Sakeliga's ideas would "immediately address workforce shortages".

180 Sakeliga's suggestion to allow "more skilled doctors and nurses from abroad" is difficult to understand. The Department of Labour manages the "'scarce skill" policy and register. Presently, healthcare professionals from abroad may come and work here. They must register with our professional councils, and they must have a job. The provinces employ many foreign professionals from over 100 countries.

181 I have further difficulty understanding Sakeliga's claim that "[c]urrent restrictions limit foreign-trained personnel". What is currently limited is the permission for healthcare workers who fail the exams with professional councils to practice in South Africa.

Ad paragraph 134.2

182 The Minister appointed an Advisory Committee to investigate all of these issues. They are complex policy issues for a variety of reasons. They are irrelevant to the Minister's application and are irrelevant even to the determination of Sakeliga's substantive application.

Ad paragraph 135

183 Sakeliga's ideas have nothing to do with NHI and the reform of health financing.

Ad paragraphs 136 to 136.10

184 I deny the allegations.

185 Sakeliga has not established a clear right to interdict an Act passed by Parliament and signed by the President, with fixed time periods for implementation linked to particular years.

186 There is no apprehension of harm. In this regard:

186.1 The implementation of the NHI Act will not infringe any rights nor will it lead to an economic contraction. It is the interdicting of implementation of the NHI Act and bringing into force, that will breach the NHI Act and the Constitution and breach fundamental rights.

186.2 More particularly, Sakeliga does not engage at all with the implementation that is statutorily prescribed and planned for in the upcoming years (i.e. for the likely period in which a stay may operate and

beyond). These actions cannot by any means be considered a threat to the economy or to legally recognised rights.

187 The balance of convenience does not favour the courts interdicting the implementation of an entire Act on an interlocutory basis. In this regard:

187.1 I have dealt with the implementation of the NHI Act under Phase 1 in my replying affidavit.

187.2 It is unclear how the interdict would conserve funds.

188 The Minister's stay will not shut the Court's door to any party. It simply subjects the process, as is permitted under our constitutional dispensation, to a rational ordering of judicial determinations. The applications that are sought to be stayed have not been brought on urgency.

189 I am advised that the parties would in any event be entitled to approach the Court at any time during the stay to uplift it if circumstances change, so as to influence the interests of justice.

Ad paragraph 136.11

190 I deny that Sakeliga has good prospects of success in its main application. The Minister reserves his right to answer to it in full in due course. In any event, it would not be appropriate for this Court to anticipate the merits of the constitutional challenge, which raises complex questions for determination, and conclude that Sakeliga has good prospects of success, or indeed the clearest of cases, before the Minister files his answering affidavits, supported by expert evidence. The Constitutional Court has cautioned High Courts against doing this

in considering interim relief applications, especially to restrain the exercise of constitutional and statutory powers, and the performance of constitutional and statutory functions.

191 Sakeliga's claim that the State parties have "not put up any evidence to contradict" its main application is non-sensical. I am advised that Sakeliga's application is under case management and that the filing of further affidavits has been pended subject to the outcome of this application.

Ad HFA's second supplementary answering affidavit dated 28 October 2025

Ad paragraph 4

192 I deny that the information provided in the replying affidavit is new. I deny further that it departs in any way from the position adopted in the founding affidavit. It responds directly and legitimately to the supplementary answering affidavits and their unwarranted assertions of harm and prejudice during the period of the stay.

193 What is distinctly new and impermissible evidence is the new report from Genesis Analytics (Pty) Ltd ("**Genesis**") marked as "SSAA1" ("**the supplementary Genesis report**"). Application will be made at the hearing of the stay and consolidation application for its striking out, along with the affidavits accompanying it, and the allegations made in HFA's affidavit which refer to it.

Ad paragraph 5

194 I deny the allegation of a "rolling, ever expanding moratorium on access to [the High Court]". The additional High Court challenges make no difference because the stay is linked to the litigation taking place directly in the Constitutional Court.

Once this Court has heard the stay application and granted a stay, the Constitutional Court cases to which the duration of the stay is linked, will be fixed. Accordingly, I deny that "[e]ach new constitutional challenge becomes a fresh pretext to prolong both the length and scope of the stay."

195 As I have pointed out in my response to HASA, the litigation in the Constitutional Court is progressing expeditiously and would, in any event, invariably be heard ahead of any appeals or confirmation requests coming from the High Court.

196 Moreover, it is inconceivable that the Constitutional Court would not hear –

196.1 both the SAPPF and BHF direct access reviews; and

196.2 both the BHF and the Premier of the Western Cape public participation challenges;

together.

197 Indeed, it is very likely that all four challenges will be heard together because they all seek the primary relief of setting aside the NHI Act.

Ad paragraph 7

198 I deny this paragraph for the reasons set out in the founding, replying and this supplementary replying affidavit.

Ad paragraph 8

199 Clear prejudice has been demonstrated not only to the Minister and the Department, but also to the public and the courts if the stay is not granted.

Ad paragraph 11

200 I note the sub-paragraphs without admitting them.

Ad paragraphs 12 and 13

201 I admit that Justice Neukircher issued a directive regarding the filing of the replying affidavit, the amended notice of motion and the supplementary answering affidavits. I deny, however, that she has already granted leave for the filing of this supplementary answering affidavit of HFA insofar as it introduces patently new evidence, in particular a new expert report. No leave was granted to file new expert evidence.

Ad paragraphs 14 to 16

202 Rule 6(5)(e) allows the filing of a further affidavit if the court permits it in the exercise of a discretion. It does not permit the introduction of new expert evidence.

203 The amendment to the notice of motion barely affects HFA. It is a formal amendment to accommodate the addition of Sakeliga to the litigation and the parliamentary process challenge of the Premier of the Western Cape. It most certainly does not justify the introduction of a new expert report.

204 I deny that the replying affidavit either introduces new facts or adopts a novel stance. I refer to what I have said in response to HASA. What is said in the replying affidavit responds directly and legitimately to averments made in the answering affidavits and is entirely consistent with and within the scope of what was averred in the founding affidavit. I accordingly deny these paragraphs.

205 The prejudice to the Minister is patent. No expert affidavit was attached to the replying affidavit. The introduction of a fresh expert report at this late stage in the proceedings leaves the Minister irreparably prejudiced. It falls to be struck.

Ad paragraphs 17 to 20

206 Subject to what I have said above, I have no objection to the late filing of HFA's supplementary answering affidavit, excluding the expert report and the references to it in the affidavit. The Minister has run into similar difficulties in terms of meeting the court timetable and correspondence has been addressed to the parties in this regard. Condonation will similarly be sought by the Minister.

Ad paragraphs 21 to 23

207 I deny these paragraphs. The High Court supervisory mechanism of a report at regular intervals that has been proposed by the Minister is patently appropriate, fair to all the parties and in the interests of justice.

Ad paragraph 24

208 I admit these paragraphs only to the extent that they are consistent with what is set out in the Minister's replying affidavit. I ask that the Court have regard only to the Minister's replying affidavit in determining its content.

Ad paragraph 25

209 There is no need for the Minister to provide an undertaking beyond that which he has already provided in relation to section 33 of the NHI Act. There are multiple logical consequences that flow from that undertaking, which will be protective of the interests of those benefitting from or participating in the private healthcare

sector. These have already been pointed out in earlier affidavits. For example, the amendments to the Medical Schemes Act envisaged in section 58 read with the schedule to the Act, cannot be commenced. The President has supported the Minister's undertaking and will doubtless ensure that he does not introduce sections of the Act in terms of section 59(2) in conflict with the Minister's undertaking.

210 Moreover, beyond the protection afforded by the undertaking given, there is the concrete protection provided by section 57(1)(b) of the NHI Act providing for gradual and progressive implementation and, crucially, based on financial resource availability.

211 The Minister and the President are further precluded by the Constitution, the rule of law and the principle of legality from proceeding irrationally in any decision-making relating to the commencement and implementation of the Act. This too prevents them from taking any decisions which might result in the alarmist and doomsday-type suggestions advanced by the HFA and Genesis. All of the respondents' affidavits proceed on the assumption that the Minister and the President will exercise their powers recklessly, in bad faith, irrationally and unconstitutionally. As will be elaborated upon in argument, there is clear authority that a case cannot be decided on that basis.

Ad paragraph 26

212 I deny that the statements in the replying affidavit are "legally meaningless".

213 I have already explained the relationship between the Minister of Health and the President in the latter's decision-making process regarding the bringing into force

of the various sections of the NHI Act. Nothing in the replying affidavit suggests any entitlement on the part of the Minister to bind the Minister of Finance, National Treasury or Parliament on matters of taxation. The fact that the Minister cannot do so is also protective of the interests represented by the respondents because those parties must, similarly, act constitutionally, rationally and in compliance with the provisions of section 57(1)(b) requiring gradual and progressive implementation based on financial resource availability. The Minister of Finance, National Treasury and Parliament are in a position to control financial resource availability.

Ad paragraphs 27 to 31

214 I admit these paragraphs only to the extent that they are consistent both with what I said in the replying affidavit and with the provisions of the NHI Act to which they refer.

Ad paragraph 32

215 I admit that government must make substantial progress towards NHI implementation over the next few years. However, it is the nature, content and pace of that implementation which needs to be taken into account. As appears from the NHI Act itself and, in particular from the provisions of section 57(1)(b), that is a process which by reason of the limitations built into the statute itself cannot manifest in the kinds of harm and prejudice asserted by HFA during the period of the stay.

216 I deny that there is any backtracking by me from the time periods in the legislation. Indeed, the assertions in this paragraph contradict assertions made by HFA earlier in their affidavit. Further, I deny any unworkability or unfeasibility.

Ad paragraph 33

217 I deny that the proposed stay is open-ended. It is patently finite. It ends with the adjudication of the first direct constitutional challenge in the Constitutional Court that is decided against the Minister and the other parties cited (assuming all four of the direct or direct access challenges are not heard and decided together). Absent that, it terminates with the final adjudication of the direct or direct access Constitutional Court challenges, or at an earlier date when the High Court decides to discharge it.

Ad paragraph 36

218 I accept that I am not an independent witness and that my views reflect those of the Minister and the Department.

219 However, having worked on the NHI closely since 2019, firstly as a contracted consultant, and then in a leadership position from June 2021, with primary responsibility for the preparation of budgets, I have a deep understanding of precisely how the National Health system will operate and how the implementation of the NHI Act will play out. That understanding is built upon by my involvement in public health (including budgeting for it) for a period in excess of 40 years and my qualifications in public health. I refer in this regard to paragraphs 120 to 126 above.

220 I am advised that my opinions may in these circumstances be taken into account by this Court. This will be elaborated upon in argument.

221 I deny that my opinion is "manifestly inadequate" or that I have not set out the detail of the data or the facts upon which my opinions and conclusions are based. In any event it is confirmed in all material respects by Professor Hongoro.

Ad paragraph 37

222 I refer above to what I have said regarding the Minister's intention to seek the striking out of the supplementary Genesis report on the basis that it is inadmissible new evidence.

223 Moreover, the report is built on a manifestly unstable foundation in that it–

223.1 sets out at paragraphs 9 to 11 the legal instructions given to Genesis as to the interpretation of the NHI Act, which are incorrect in several material respects; and

223.2 leaves out of account entirely the most important provision of all, being section 57(1)(b) of the NHI Act, which shows that Genesis' attention has either not been drawn to it by the legal team instructing it or it has deliberately not been referred to by Genesis.

224 This will be elaborated upon in argument.

Ad paragraph 38

225 I admit that the NHI Act mandates structural changes to the South African healthcare sector. The allocation of specific years to the two implementation

phases must be read together with section 57(1)(b) of the NHI Act, requiring phased, progressive and gradual implementation subject to financial resource availability.

226 I firmly deny the interpretation of section 57 that is proffered in this paragraph. This will be dealt with in legal argument. Amongst the errors in it are that the establishment and operationalisation of the NHI Fund is regulated by section 57(5) and is to be achieved by the end of 2028 not 2026 as suggested by the deponent. I refer further to what I have said above about the process of gradual commencing of purchasing by the Fund, once it has been established and operationalised.

227 I did not provide an estimate in the replying affidavit of the size of South Africa's vulnerable population as being 43 million people, or 70%. There is no official definition of "vulnerable" and no source is quoted for the cited figures.

228 I am on record, however, as stating that the public healthcare service is responsible for about 53 million of South Africa's population of about 63 million people.

229 Subject to what I have said above, I deny this paragraph.

230 I deny the correctness of the conclusions reached and the reasons for them in the initial report of Genesis. I deal with it below.

Ad paragraph 40

231 I deny that there is any "new approach" to implementing the NHI Act set out in the replying affidavit. Not only is what I say there correct, but it is entirely aligned

with the express provisions of the NHI Act and with what is contained in the founding and replying affidavits.

Ad paragraph 41

232 I deny that "major negative effects will arise during the period of the stay".

Ad paragraph 42

233 For the reasons already given above, the supplementary Genesis report should be struck in its entirety because it is patently new matter that was impermissibly introduced at the latest possible stage in the proceedings.

234 Nor does it provide a foundation for the HFA's purported concerns regarding the implementation of the NHI Act, not only because it is incorrect in its analysis, but also because it is based on a flawed interpretation of the NHI Act.

235 Paragraph 9.1 of the supplementary Genesis report asserts that section 57 of the NHI Act requires extensive progress by the end of phase 1 and phase 2, in 2026 and 2028 respectively. I deny that this constitutes extensive progress as conceived by Genesis, particularly with reference to the speculative harmful effects it wrongly predicts. Progress by the end of 2026 and 2028 will be entirely regulated by section 57(1)(b) which permits only gradual phasing in according to a progressive and programmatic approach, restricted in all respects by financial resource availability. Section 57(1)(b) is peremptory, using the word "must".

236 With reference to paragraph 9.2 of the supplementary Genesis report, government is only obliged to pay for comprehensive health care services once the Minister makes the assessment that is described in section 33 of the NHI Act.

Pursuant to the undertaking given, that cannot happen during the period of the stay and is in any event estimated to take place at the earliest in some 10 to 15 years' time.

237 The definition of "comprehensive health care service" in the NHI Act is defined very differently to the way in which medical schemes tend to understand and apply the term "comprehensive" in relation to health care coverage. The NHI Act does not refer to any obligation for the Fund to pay for "comprehensive tertiary care".

238 With reference to paragraph 9.3:

238.1 Section 57(2)(a)(iii) of the Act only requires during the first phase "the undertaking of initiatives which are aimed at establishing institutions that must be the foundation for a fully functional fund". (own emphasis)

238.2 Section 57(2)(a)(v) of the Act requires only preparation for the establishment of the Fund as a schedule 3A entity and preparation for developing and implementing administrative and personnel relationship arrangements. (own emphasis)

238.3 Section 57(2)(b)(i) of the Act requires only "the continuation of health system strengthening initiatives" during phase 2.

238.4 Section 57(2)(b)(ii) of the Act requires only "the mobilisation of additional resources when necessary". (own emphasis)

238.5 Section 57(2)(b)(iii) requires, in phase 2, only "the selective contracting of healthcare services from private providers", which may be done by the

Department, and all of the foregoing is subject to section 57(1)(b) of the Act.

238.6 The committees referred to in s 57(3) of the Act that "may be", not "must be" established during phase 1 are only "interim committees" whose function is to advise the Minister on implementation of NHI.

238.7 The objectives that are identified in section 57(4)(a) to (g) of the Act are all subject to the strict limitation imposed by section 57(1)(b) and by the provisions of section 57(5) which only envisages the establishment and operationalisation of the NHI Fund by the end of 2028.

239 With reference to paragraph 9.3 of the supplementary Genesis Report, I deny this. The only institution that is expressly required to be established by the end of 2028 is the Fund. As far as information systems are concerned, their establishment is already far advanced and this work will continue without adding any particular burden, before and after commencement of section 57.

240 With reference to paragraph 10 of the supplementary Genesis Report, it is incorrect that "phase 1 requires major changes to existing legislation as specified in section 57(4)(h)". Section 57(4)(h) of the Act requires only the initiation of legislative reforms. The initiation of legislative reforms begins long before a Bill even reaches the Cabinet, let alone Parliament. Section 57(4) does not require the passing of any statute during phase 1 or phase 2 and the Minister has made it clear that he will not request the President to commence any provision effecting changes to the Medical Schemes Act in line with the undertaking he has given in relation to section 33. This is dealt with above and in the replying affidavit.

241 In particular, there will be no amendment "to exclude maternal and child healthcare services from the range of services that medical schemes may offer". This would, moreover, be in conflict with the Minister's undertaking.

242 With reference to paragraph 10.2 of the Genesis supplementary report, this represents yet another fundamental misinterpretation of the NHI Act and of section 57 in particular. Once again, those advising Genesis have ignored section 57(1)(b). Nowhere does section 57(2)(a)(iv) or section 57(4)(f), even leaving aside section 57(1)(b), require the purchasing of healthcare services for "all women and children who are all classified as vulnerable". This interpretation is plain wrong. It vitiates the subsequent reasoning and expression of opinions by Genesis accordingly.

243 Important in this regard, and not properly taken into account by Genesis or HFA, is that the public healthcare sector is already providing healthcare services to all of these vulnerable sections of the population not covered by medical insurance in terms of existing budgets, and it is doing so at scale. What section 57 envisages is enhancement of these existing services to vulnerable groups and ultimately paying for this care through a different system.

244 What is also important to bear in mind in this context is that already only, on average, somewhere in the order of fewer than 50,000 women deliver babies in the private healthcare sector annually, as against an average 950,000 women delivering in the public healthcare sector.

245 With reference to paragraph 11 of the supplementary Genesis Report, it is incomplete and unclear what point is being made. In any event, section 57(4)(f) of the Act does not oblige the Fund to purchase the healthcare service benefits

referred to. It does not identify the purchaser. The Fund will not have been established during phase 1 and therefore the purchasing of healthcare service benefits will, to the extent not covered by provincial health departments, be effected by the NDoH through conditional grant funding.

246 Moreover, as I have indicated, there is no obligation imposed by section 57 of the Act to purchase healthcare service benefits for all of the aged, children, those requiring maternity services, people with disabilities and rural communities.

Ad paragraphs 43 to 46

247 I deny these paragraphs in every respect. Paragraphs 43 to 46 are based on a new expert report, the supplementary Genesis report dated 27 October 2025, forming annexure "SSAA1" to HFA's second supplementary answering affidavit.

248 The Minister will apply for the striking-out of the supplementary Genesis report, along with paragraphs 43 to 46. He will do so on the basis that it was filed (i) in breach of the court directive permitting the filing of supplementary answering affidavits arising out of the joinder of Sakeliga, (ii) in the absence of any authority sought or granted for the parties to file new expert reports at this stage of the proceedings (iii) impermissibly late in the exchange of affidavits and (iv) without a justifiable basis for doing so, having regard to the content of the replying affidavit.

249 I have incorporated my reply to the supplementary Genesis report in a separate affidavit, annexure NC1, bearing in mind that, as I am advised, I must plead over notwithstanding the strike out application. My denial of paragraphs 43 to 46 of HFA's supplementary founding affidavit is based on what I have said in reply to

the supplementary Genesis report in annexure NC1. I also refer in response to the supplementary Genesis report and paragraphs 43 to 46, to the affidavit of Professor Charles Hongoro, an expert health economist, who has provided expert evidence on the matters raised in the supplementary Genesis report.

250 The Minister will only ask this Court to have regard to annexure NC1 and the expert report of Professor Hongoro in the event that it declines to strike out paragraphs 43 to 46 of HFA's second supplementary answering affidavit and the supplementary Genesis Report, or if paragraphs 43 to 46 and the supplementary Genesis report remain part of the record for any other reason.

Ad paragraph 47

251 I deny this paragraph.

252 I deny that the NHI Act limits certain existing healthcare entitlements.

253 I explained the position in relation to asylum seekers and foreign nationals in the replying affidavit. I stand by what I said there.

Ad paragraphs 48 to 55

254 I deny these paragraphs.

255 There is harm to the constitutional order and the rule of law by <u>not</u> granting the stay. The NHI Act is already subject to intense constitutional scrutiny by the constitutionally ordained apex court for the scrutiny of legislation, by way of the direct challenges. The constitutional order, the rule of law and the orderly conduct of the case load of the Gauteng Division, Pretoria, is seriously prejudiced by the conduct of litigation of enormous proportions that may well turn out to be

pointless in the event that any of the direct challenges in the Constitutional Court succeed.

256 I have already explained in the replying affidavit and in my response to HASA the prejudice that will be suffered by both the NDoH and the population that it services if potentially pointless litigation of unprecedented scale is allowed to continue before there is any need for it. Substantial human and other resources, not only financial resources, are potentially and unnecessarily and wastefully diverted to the complex litigation that awaits the High Court.

257 In the event that the Constitutional Court dismisses all of the direct and direct access challenges, then I agree with HFA that the necessary resources must be diverted to defending the High Court litigation.

258 The comparison between litigation costs and the expenditure on the implementation of the NHI that is posited here is based on HFA's flawed understanding of the legal position. It also overlooks the fact that the expenditure on implementation of the NHI Act during the course of the stay will be expenditure that is of lasting benefit to the public health system even if the NHI Act is ultimately set aside.

259 Insofar as HFA criticises the expenditure on advertising in respect of the NHI, this has been appropriate, modest and none of it has resulted in any audit findings against the Department by the Auditor-General.

260 I accordingly deny all of the averments in these paragraphs.

Ad paragraphs 56 to 68

261 I deny these paragraphs.

262 To the extent that they rely on material in the supplementary Genesis Report, I will seek their striking out at the hearing of this matter. By indicating in the replying affidavit that the initial focus would be enhancing healthcare for vulnerable groups such as children, women, people with disabilities, the elderly and rural communities, I did not say that they would, overnight, all be provided with free healthcare under the NHI Act. This notion is born of HFA's (and Genesis') patently flawed legal advice to this effect.

263 So to extend healthcare services would be in breach of the provisions of section 57 of the Act and, in particular, section 57(1)(b), in breach of the requirements of the PFMA, in breach of the budgetary limits that are placed on the NDoH, and reckless and irrational.

264 That is the further difficulty with the supplementary Genesis report. It is based on an assumption that the Minister and the relevant decision-makers in the NDoH will proceed on an irrational basis in breach of the NHI Act and the Constitution. They will not.

265 Nor is there any legislative basis for suggesting, as HFA does in paragraphs 59 and 60, that the NHI Act is to be interpreted on the basis that once contracting units for primary health care are established in a given area they will be compelled to provide services to all individuals in that area. Section 57 of the Act simply does not say this.

266 To the extent that the implementation of the NHI Act requires a gradual, phased and progressive approach, the NHI Act of necessity contemplates that the existing system of financing public health will gradually be replaced by the scheme contemplated by the NHI Act.

267 There is no reason for that to give rise to the incurring of unnecessary expense. The approach will be an integrated and rational one to ensure that this is not so.

268 The reference in section 57(4)(g)(ii) of the Act to the expansion of personal health services purchased is a further indication of the gradual and progressive implementation approach required.

269 Further, I deny the allegations of risk and complexity regarding the phased implementation of the NHI Act.

270 I deny that section 57(5) of the Act envisages that full-scale operation of the NHI must be implemented by the end of phase 2. I have already described in response to HASA how the provisions of section 57(1)(b) will be respected in this regard.

271 The repeated assertion that everyone, everywhere (or the "overwhelming majority") must be provided with all required healthcare services paid by the Fund by the end of December 2028, is based on the flawed legal advice provided to HFA and Genesis.

Ad paragraphs 69 to 78

272 I deny these paragraphs. To the extent that any of the submissions therein are reliant on the supplementary Genesis Report, the Minister will seek their striking out.

273 I have already dealt with the institutions and committees that are required (or, more accurately, not required) to be established by the end of 2026. The only institutions that the Minister "may establish" by the end of 2026 are the "interim committees" mentioned in section 57(3) of the Act.

274 Section 7(2)(f) of the NHI Act provides that the Minister must request the Minister of Public Service and Administration "to consider" and assist in establishing central hospitals as "national government components". It provides further that where central hospitals are not established as national government components, the Minister must "establish or designate central hospitals as organs of state in an appropriate form".

275 The work involved in carrying out the duty in section 57(4)(b) of the Act to "structur[e] the Contracting Unit for Primary Health Care at district level in a cooperative management arrangement with the district hospital linked to a number of primary healthcare facilities" (public and private) involves several components which need only be commenced during the period ending December 2026 (just over 12 months away), including structural design, identification of facilities with which there must be cooperation, determination of the areas of jurisdiction for the contracting units and establishment of limited numbers of such units for testing on a proof-of-concept basis.

276 This is well under way at nine sites across the country, one in each province.

277 There is no definition of "facility" in the NHI Act or the National Health Act. The NDoH interprets this to mean a "health establishment" as defined in section 1 of the National Health Act.

278 With reference to paragraph 71, it is incorrect to suggest that by the end of 2026 "each part must be integrated into an overall system that will need to be operationalised, with multiple parts working in synchrony". Again, this is based on an entirely flawed interpretation of the legislation, including section 57(1)(b) and 57(5), amongst others.

279 The averments contained in paragraph 72 are based on a complete misunderstanding and misinterpretation of section 57.

280 I also dispute the statistic of 70% of the South African population constituting vulnerable groups insofar as it is used without reference to the source of that figure or definition of vulnerability employed.

281 I stand by what I said in the replying affidavit and firmly deny that, as suggested in paragraph 73, "the delay caused by the stay will enable government to effect large-scale changes to the management and organisation of vast areas of the public health system, impacting existing economic networks and business and millions of individuals, and all the changes are at risk of reversal if the constitutional challenge succeeds". Once again, this is extreme hyperbole based on a misreading of section 57 of the NHI Act and a disregard of section 57(1)(b). No democracy in the world would be able to bring about changes of the order contended for in the space of a year or two. Any attempt to do so would be

irrational. Nor does the legislation require it. I have already dealt above with the initiation of legislative reforms in section 57(4)(h) and deny the averments made in this regard.

282 The allegations imply that the deponent anticipates NHI will cause all public health employees to move to the Fund or NDoH. This is not what section 32 of the NHI Act or the scheme of the Act contemplates at all.

Ad paragraphs 75 to 78

283 I deny these paragraphs. They repeat points already made by HFA and I refer to my responses to those averments above.

Ad paragraphs 79 to 83

284 It is not just because of the Minister's undertaking in relation to section 33 of the Act that the alleged harms will not eventuate. This is so as a matter of interpretation of the NHI Act, particularly section 57, and because of the factual scenario that has been provided regarding the estimated dates by when different provisions will be brought into force and implemented.

285 So too, the harms contended for will not eventuate because of constitutional constraints that are placed on the Minister to act lawfully, rationally and consistently with section 27(1)(a) and (2) of the Constitution.

286 The undertaking by the Minister does, however, provide an important guarantee for the medical schemes and those reliant on them. It is also a confidence building measure and a clear indication that the Minister puts his money where his mouth is. The remaining averments in this paragraph are inadmissible to the

extent that they rely on the supplementary Genesis Report and stand to be struck, alternatively, repeat argument already made earlier in the affidavit and I refer to my response to those averments above.

Ad paragraphs 84 and 85

287 The President is obliged to bring the Act, or sections of it, into force and the Minister is obliged to implement those provisions that are commenced.

288 The options proposed in these paragraphs are accordingly not viable.

289 Paragraphs 87 to 123 of HFA's supplementary answering affidavit respond on a paragraph-by-paragraph basis to the replying affidavit. In response to those paragraphs, I stand by what I have said in the founding affidavit, replying affidavit and above in this supplementary replying affidavit. I do not respond where it requires me to repeat what I have already said and I respond only where it is strictly necessary. To the extent that any of the averments are based on the supplementary Genesis report, I will seek their striking out at the hearing of this matter.

Ad paragraph 87

290 HFA's claims demonstrate how deeply misguided it is on basic understandings of public health, which misguided assumptions are replicated by Genesis.

291 I firmly deny that the uninsured South African population bears a lesser burden of disease than the insured population and that they are at lower risk. The opposite has consistently been documented.

292 The poor in South Africa have a far greater health burden than the rich. There is a stark socioeconomic gradient in health outcomes, with poor health and disability concentrated among socio-economically disadvantaged groups. The poor (and uninsured) population faces systemic disadvantages across the entire spectrum of health and healthcare access.

293 I refer to two studies below simply to demonstrate how far-fetched HFA and Genesis' claims are. I do not attach these studies so as not to overburden the Court but make reference to the citations and links where they can be accessed for the sake of transparency:

293.1 Ataguba JE, Akazili J, McIntyre D. Socioeconomic-related health inequality in South Africa: evidence from General Household Surveys. Int J Equity Health. 2011 Nov 10;10:48. doi: 10.1186/1475-9276-10-48. PMID: 22074349; PMCID: PMC3229518 (available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC3229518/), states that "[s]tudies on the burden of ill-health in South Africa have shown consistently that, relative to the wealthy, the poor suffer more from more disease and violence." It states further in its results that, "[t]he burden of the major categories of ill-health and disability is greater among lower than higher socio-economic groups. Even non-communicable diseases, which are frequently seen as diseases of affluence, are increasingly being reported by lower socio-economic groups."

293.2 In Elizabeth Biney, et al "Inequalities in morbidity in South Africa: A family perspective", SSM - Population Health, Volume 12, 2020, 100653, ISSN 2352-8273, https://doi.org/10.1016/j.ssmph.2020.100653 (available

at:https://www.sciencedirect.com/science/article/pii/S2352827320302901), it is stated that "[t]he consensus in the social determinants of health literature is that there is a distinct socioeconomic gradient in health in favour of advantaged groups, regardless of how it is measured". It states further that, in South Africa, "those at the lower end of the socioeconomic ladder, suffer much more diseases and premature death than the affluent. Wealth, whether measured at the individual or household level, is a powerful determinant of health, as poverty increases the incidence of diseases in vulnerable populations."

294 Assuming (without conceding) that I am wrong, it suggests that there are catastrophic problems in the private healthcare sector. That is to say, the deponent's version would imply that, despite more than six times per person of health-spend going to those who rely on the private healthcare sector, this population still bears the greater burden of disease. Rather, it is more likely that supplier-induced demand is generating a false "burden".

Ad paragraph 95

295 Capital investment in public healthcare infrastructure is expressly enabled by the NHI Act, particularly insofar as section 57(2)(a)(i) mandates the continuation of the implementation of health system strengthening initiatives.

296 It is important to note, however, that the NHI fund has no mandate for infrastructure development. This remains the assigned function of the various health departments.

Ad paragraphs 96 and 97

297 By saying in paragraph 78 of the replying affidavit that there would be no additional demand on the public purse during the 2025/26 and 2026/27 financial years, I did not mean that there would be a budgetary freeze on expenditure on NHI. Budget increases over the years in respect of NHI can be anticipated, but not in a manner that will impose any NHI-specific demands on taxpayers that they would not otherwise have borne, absent NHI. Section 49 of the NHI Act anticipates a shifting of funds from national government departments and agencies and the provincial equitable share and conditional grants into the Fund before any other funding is added from any other source.

Ad paragraphs 98 to 100

298 I stand fully by what I said in the replying affidavit in regard to the Competition Commission's Health Markets Inquiry. These paragraphs in fact seek to deflect attention from the points that I correctly made in paragraph 96 of the replying affidavit. My points have gone unanswered by HFA, and must therefore be taken as proven.

299 I deny that the means of achieving the goal of UHC reflected in the NHI Act is in any way irrational, unreasonable or unconstitutional.

Ad paragraph 101

300 I deny the allegations. I am not aware of HFA requesting any roadmap, nor of the NDoH or Minister declining it.

301 In any event, the Minister has publicly and transparently reported on implementation plans of the Competition Commission's Health Market Inquiry. This is information in the public domain that is accessible to the deponent. For example:

301.1 The Minister gave a media briefing on 24 February 2025 in which he presented on the topic "Health Markey Inquiry – what next?". It detailed the recommendations which were receiving ongoing attention and explained unfolding actions.

301.2 The NDoH has responded to a number of questions in Parliament on the implementation of the recommendations from the Health Market Inquiry.

301.3 On 12 August 2025, I presented to the National Economic Development and Labour Council ("**NEDLAC**") on the Health Market Inquiry. I set out the recommendations and the NDoH's response actions relating to the recommendations in my presentation.

Ad paragraphs 109 and 110

302 I firmly deny that anything that I said in the presentation made to the National Council of Provinces on 17 August 2024 is inconsistent with anything I have said in the replying affidavit. Indeed, this statement is typical of the misrepresentations and misleading content of not only HFA's supplementary answering affidavit but those of other respondents too. I invite the Court to scrutinise annexure "SSAA3" to HFA's supplementary answering affidavit in its totality.

303 What HFA does is resort to the misleading strategy of not quoting sections of the presentation which give meaning to the quoted sections and thereby seek

deliberately to convey the wrong impression to this court. What in fact appears in the relevant part of the presentation, which has been deliberately omitted by HFA, is the following:

> "The time horizon for function shifts is multi-year. Statutory changes and budget cycles will dictate the pace to financing reform and fund shifts. The source of funds for NHI are described in the Act and are essentially appropriated funds in the annual budgets adopted by this Parliament. This includes: ...
>
> [Then follows the three bullets quoted by HFA in this paragraph.]"
>
> (own emphasis)

304 As appears from the above introductory portion which has been deliberately omitted, specific reference is made to the gradual implementation subject to the available budget.

305 I also refer to the introductory part of my presentation where I said:

> "We are able to gradually phase in the NHI using a progressive and programmatic approach based on financial resource availability, as required in the Act."

306 Again, any mention of this part of the presentation is studiously avoided by HFA.

307 Also of importance is that this presentation was made in August 2024. The fact that HFA has attached it shows that it was fully aware of everything that I said there. This demonstrates that what I said in the founding and replying affidavits regarding the fact that the gradual and progressive implementation of NHI is nothing new and has been known to the respondents for a long time is correct. Indeed, they monitor every public statement that I make without fail.

308 I accordingly deny the misleading impression sought to be created in this part of HFA's affidavit.

Ad paragraphs 111 and 112

309 These averments are not based on a proper interpretation of the NHI Act, or on a proper understanding of the manner of its coming into force and implementation. They are accordingly irrelevant to the adjudication of the stay and consolidation application.

310 In any event, I deny them.

Ad paragraph 113

311 I accept that Genesis has considered cost savings. There is also endless scope for disagreement on what could be considered a reasonable efficiency target. I nonetheless disagree that Genesis adequately accounts for all possible efficiencies under NHI. The NHI Act enables significant efficiencies. For example:

311.1 The systemic shifting of care to focus on primary health care has been shown to achieve considerable savings over time. Genesis does not adequately account for this.

311.2 There are also immediate systemic savings to be anticipated from design and control of perverse incentives, including in reducing duplicative administrative costs, reducing money lost to fraud, waste and abuse in the private sector, moderating over-servicing incentives in the private sector, and leveraging price advantages.

311.3 The primary healthcare model and referral pathways will reduce expenses from clinically unnecessary specialist consultations.

311.4 The anticipated savings from reducing duplicative administrative costs are significant under a single purchaser system. The Council for Medical Scheme data for 2023/24 shows the cost of running some 71 separate schemes is somewhere in the region of R21 billion. Current data does not separate provincial administration, but the NDoH estimates this to be at least R2 billion per year. These costs will be significantly reduced under a single fund.

311.5 The use of the Fund to procure health products and the diligent use of Health Technology Assessment is anticipated as having efficiency savings of between R10 to R15 billion.

Ad paragraphs 114 and 115

312 Many medical scheme members access services at public health facilities.

313 There is plenty evidence of this. For example, Charlotte Maxeke Johannesburg Academic Hospital provided the NDoH with a list of 20 patients who were admitted for treatment despite being variously Discovery, LA Health, Bankmed, GEMS, and Momentum members. These patients gave a variety of reasons for their need to access care in the public sector, including that the medical scheme plans did not cover the services required, day-to-day funds were depleted, the patient's plan did not cover their chronic condition or therapeutic services, and others. I do not provide a copy of this list as it contains confidential information

of patient names and scheme membership details. I will produce this for the Court if required to do so as appropriately redacted.

314 Further evidence exists, moreover, in the fact that provincial departments of health collect money from medical schemes whose members make use of their hospital services. I attach a summary of provincial departments' revenue collection for this year thus far, which I mark as Annexure "**SRA4**".

Ad paragraphs 116 and 117

315 These issues were fully addressed in the replying affidavit. I deny the averments in these paragraphs, save that it is correct that South Africa needs more doctors and nurses.

Ad paragraphs 118 to 122

316 I stand by what I said in the replying affidavit regarding Discovery Health's share price and by the other averments in paragraph 237 of the replying affidavit. HFA's averments in this regard in their answering affidavit have been shown to be demonstrably incorrect.

317 The attempt to explain this away in these paragraphs fails.

318 I accordingly deny these paragraphs.

Ad paragraph 124

319 I ask that the stay and consolidation application be granted in accordance with the latest amended notice of motion.

Ad HASA supplementary answering affidavit dated 24 October 2025

Ad paragraph 10

320 The replying affidavit filed on behalf of the Minister represents a legitimate reply to the averments in the various answering affidavits filed by the respondents. I deny that it introduces new factual issues.

321 I accept the entitlement of HASA to file its two supplementary answering affidavits pursuant to the directions of Justice Neukircher.

Ad paragraph 14

322 I confirm that the failure to include Sakeliga in the relief pertaining to consolidation was made in error and that an amended notice of motion to address this error has been circulated to the parties, and will be filed.

Ad paragraph 18.1

323 In the most important respect, namely the relief sought, the Premier's application before the Constitutional Court is no different from the direct challenge applications. This is because they all seek the setting aside of the NHI Act in its entirety. It is for this reason that if the Premier of the Western Cape is successful in his direct access challenge in the Constitutional Court, all of the High Court applications, including HASA's High Court application, would immediately become moot (assuming they had not become moot on account of an earlier ruling in one of the other Constitutional Court direct access challenges).

324 Prayer 1 of HASA's application in the High Court reads as follows:

"1. The National Health Insurance Act 20 of 2023 is declared to be unconstitutional and invalid and is set aside."

325 Prayers 1 and 2 of the notice of motion in the Premier of the Western Cape's direct access challenge in the Constitutional Court reads as follows:

"1. It is declared that Parliament failed to comply with its constitutional obligation to facilitate public involvement, as require by section 72(1)(a) of the Constitution before passing the National Health Insurance Act 20 of 2023 ('the NHI Act').

2. The NHI Act is declared invalid."

326 The primary relief claimed is accordingly identical. I accept that the causes of action upon which the primary relief is sought in each application differs. That does not detract from the compelling logic of the stay application.

327 Save as aforesaid, I deny this paragraph.

Ad paragraph 18.3

328 I dispute HASA's estimates of the duration of the proceedings discussed in this paragraph as well as the grossly exaggerated prediction of the potential duration of the stay. I say so for the following reasons:

328.1 As regards the Minister and the President's appeals on the points of law in the BHF and SAPPF High Court review applications, applications for leave to appeal and the answers to them have been filed, directions have been issued by the Constitutional Court, the record has been filed, the applicants' written submissions have been filed and the first and second respondents' written submissions are due to be filed on Wednesday

12 November 2025. Once the respondents' written submissions have been filed, the matter will be ripe for allocation of a hearing date.

328.2 As regards the BHF and Premier's direct access applications based on the alleged failure of public participation, preparation of answering affidavits are well underway. There can be no dispute as to the Constitutional Court's jurisdiction to hear those challenges, based on well-established precedent. It is inevitable that the similarity of the applications will result in them being heard together. There is every possibility of the matters being heard in the course of next year.

328.3 Because the Constitutional Court's jurisdiction in such matters is settled, there is no prospect of remittal of these public participation challenges to the High Court, as HASA suggests. In the circumstances, the predictions that the stay could be in place for 6½ years on a best-case scenario, and 11 years on a worst-case scenario, are gross exaggerations and should be disregarded.

Ad paragraph 19

329 I stand by what I said in paragraphs 17 and 18 of the Minister's replying affidavit. HASA's insistence on being able to run separate High Court challenges, will profoundly compromise the orderly administration of justice in the Gauteng Division, Pretoria. It is something which should be avoided at all costs. The stay offers the opportunity for doing so.

Ad paragraph 20

330 I deny that the interests of justice demand that HASA's application and the other direct challenges application proceed forthwith. The interests of justice favour the grant of the stay application.

331 The stay will indeed allow any further direct challenges in the High Court to accumulate and be managed and consolidated with the existing applications. That is essential for their orderly disposal.

332 If the stay is discharged because one of the Constitutional Court challenges succeeds, all of the stayed applications will become moot. If the stay is set aside because all of the Constitutional Court challenges fail, or for any other reason, it is appropriate that the focus then shifts to the High Court challenges. The likelihood is that all direct challengers will have lodged their applications by then and that no further applications will be filed. This will allow for as orderly as possible a disposal of the direct challenges, although the scale of the litigation will be immense. At least in those circumstances, it will be known that the litigation is not pointless.

Ad paragraph 21

333 I deny that prejudice (let alone severe prejudice) will be caused by the Minister's planned implementation, as explained in the replying affidavit.

334 I stand by what I said in paragraph 19.4 of the replying affidavit.

335 The example of a judicial supervisory control measure (whereby the Minister files an affidavit every 12 months explaining progress in the Constitutional Court

litigation as well as progress in the implementation of the NHI Act and permitting the respondents to file an affidavit in response) is a perfectly sensible one. This would indeed enable the Court to reassess the impact of the stay with reference to the interests of justice on an ongoing basis. If shorter intervals than a year are required, then so be it.

336 In any event, no party would be precluded from approaching the Court to uplift the stay if circumstances demand it.

337 I accordingly deny this paragraph.

Ad paragraph 22

338 The heading above this paragraph is a misnomer. I dispute that there are new factual issues raised. The respondents all made overblown averments regarding harm that might be suffered during the period of the envisaged stay. It was entirely appropriate that the Minister respond to those allegations to correct them in reply, as is his right. This was necessary both for purposes of allowing the fair adjudication of the dispute on correct facts and because these overblown averments have the potential to cause unnecessary alarm.

339 The replying affidavit accordingly represents a legitimate response to the issues raised. This notwithstanding, the Minister does not object to the filing by HASA of its further supplementary affidavit in accordance with the timetable laid down by Justice Neukircher. I should also point out that the facts in the replying affidavit regarding progressive implementation are also not new in the sense that it has long been in the public domain and was anticipated in my founding affidavit. Indeed, it is written into the statute.

Ad paragraph 23.2

340 I stand by the allegation that HASA and the other respondents have adopted a strategy of lawfare and the reasons I gave for saying so in my replying affidavit. Indeed, on a conspectus of the litigation already pending in the High Court and the Constitutional Court, the matter speaks for itself.

Ad paragraph 26

341 I deny each allegation in this paragraph. The position as explained in the replying affidavit is neither contradictory with the founding papers, nor is it unlawful, vague or such as to "cause immense prejudice to HASA's members and the public during the stay".

Ad paragraph 27

342 I admit these averments only to the extent that they are consistent with the Minister's founding affidavit.

Ad paragraph 28

343 I deny that that was all that the Minister said. This is apparent from my response to the next paragraph.

Ad paragraph 29

344 I deny this paragraph. In order to contextualise my denial, it is helpful to start by quoting from the Minister's founding affidavit as follows:

> "172. I note that to date no provision of the NHI Act has been brought into effect as the President is empowered to do under s 59 of the Act.

173. Once the President does so, implementation is required to take place progressively, over many years, and in terms of available funds under s 57 of the NHI Act. There will be no 'overnight switch' for NHI as some of the parties seem to imply.

174. Implementation of the NHI Act will largely start with the establishment of administrative and governance structures for the Fund, the process of which itself will take years. Insofar as constitutionally empowered bodies determine and allocate a budget for these activities to occur, that is a decision which will be made by those constitutionally empowered bodies, considering, insofar as it is relevant, any risk that pending litigation may impose to the outcomes of that expenditure.

175. Other work that continues concurrently, which relates to readying the health system for NHI, can hardly be considered prejudicial or a threat to any party. These activities are in the public interest regardless of NHI and cover conduct like strengthening the public health system and continuing to build health information systems that already exist, and which will be used to inform eventual NHI implementation." (See Caselines 001-96 ff)

345 What the above extract demonstrates is that the deponent is misleading the Court in claiming that the Minister suggested that "they would commence implementation without delay". What is quoted from paragraphs 172 to 175 of the founding affidavit aligns squarely with s 57(1)(b) and s 59(2) of the NHI Act.

346 I should also point out that in these paragraphs of the Minister's founding affidavit and in paragraph 82 of the President's answering affidavit, they were responding to an insistence on the part of some of the respondents that the President provide a comprehensive undertaking that he would not implement the NHI Act at all. HASA has twisted the Minister and the President's explanations as to why they could not provide such a comprehensive undertaking into an alleged assertion

by them that the Act would be implemented in its entirety. Once again, this is misleading.

347 Paragraph 82 of the President's answering affidavit provides no support whatsoever for the assertion made by the deponent in this regard. Paragraph 82 appears at Caselines p 002-34. It includes the following:

> "The President and the Minister have offered this undertaking in good faith in order to facilitate the orderly and proper ventilation of these legal challenges while permitting the groundwork to proceed to be laid for this legislation should these challenges ultimately fail materially to halt the legislation. This by all estimates is a 10 to 15 year process."

348 What this demonstrates is that it is, with respect, important that this matter be decided on the basis of what the Minister and the President have said in their affidavits, not on the basis of what the respondents say they have said.

Ad paragraph 30

349 I have responded to HASA's assertions as set out in paragraph 30 in the replying affidavit and the Minister and I stand by what has been said. HASA's claims of "immense prejudice" are deliberately overblown and quite wrong.

Ad paragraph 31

350 I deny that the information regarding implementation is "introduced" by the Minister or that it constitutes a "proposal". It reflects planning that has long been in place and is anticipated in the founding affidavit.

351 I accordingly deny this paragraph to the extent that it is inconsistent with the replying affidavit.

Ad paragraph 32

352 Again, I object to the use of the word "introduces". Subject to that, I admit this paragraph and its sub-paragraphs only to the extent that they are consistent with the replying affidavit. I ask the Court to rely on the replying affidavit rather than the deponent's misleading representations of it.

Ad paragraph 33

353 I deny the characterisation of the answering affidavit as a revelation by the Minister "for the first time". It was implicit in the unwillingness of the President to provide an undertaking not to proclaim the Act and the Minister's unwillingness to decline to implement the entire Act that it would be brought into effect in the near future.

354 Subject to that, I admit this paragraph to the extent that it aligns with the replying affidavit. However, I respectfully ask the Court to rely on the replying affidavit and not HASA's rendition of it.

Ad paragraph 36

355 I admit this paragraph and its sub-paragraphs only to the extent that they are consistent with the replying affidavit and the provisions of the NHI Act. Once again, I respectfully ask the Court to have regard to the replying affidavit and not HASA's rendition of it. By way of example, HASA says the following in paragraph 36:

> "The Minister provides a timeline for when he intends to request the President to commence certain provisions. In 2026 / 2027 (ending 31 March 2027) the following provisions <u>will</u> commence (para 75)."

356 This is to be contrasted with paragraph 75 of the replying affidavit which reads substantially differently:

> "The only provisions that may come into effect in the following financial year, 2026 / 2027, are sections 3, 5, 32, 34, 37 and in very limited respects not affecting medical schemes or correctional services, s 58, read with the schedule."

357 Once again, HASA's summation is misleading.

Ad paragraph 37

358 This paragraph purports to paraphrase paragraphs 71 and 76 of my replying affidavit. It bears little resemblance to those paragraphs, and I am therefore compelled to quote them and to deny this paragraph to the extent that it diverges significantly from them:

> "71 It is not envisaged that funds will be allocated under s 49(1) and 49(2)(a)(i) and (ii) before the NHI Fund is established in terms of s 9 of the NHI Act. Until that time the existing allocations to the NHI activities in the National Department of Health are appropriated in the annual budget."

359 Paragraph 76 reads:

> "76 The Fund will need to be established to begin administrative preparations and transfer of staff from the National Department of Health. The earliest that this might take place is in the 2027 / 2028 financial year, for which purposes sections 9 to 11 may be brought into effect. Purchasing of healthcare services by the Fund is not envisaged until 2029 /30, with the exception of the proof of concept work that is ongoing in a few sites to test the integrated approach to capitation payment for primary health care, so that is the earliest that s 35 might be brought into effect."

360 I should add that the limited purchase of healthcare services and procurement of medicines, health goods and health-related products to an extent consistent with the gradual implementation of the NHI Act is already a function of the NDoH managed under my branch in the department.

Ad paragraph 38

361 Once again HASA's submission is inaccurate. The relevant part of paragraph 76 is set out above and says that "the earliest that s 35 might be brought into effect" is 2029/30.

Ad paragraphs 39 and 40

362 Once again, the summation is misleading. The relevant paragraph of the replying affidavit reads as follows:

> "81. At this point in time, it is not envisaged that s49(2)(a)(iii) will be brought into force until 2030/2031 and s 49(2)(a)(iv) until the 2040/41 financial year or later. These provisions accordingly present no basis for claiming that there will be financial harm to members of medical schemes during the period of the stay and for a long time after that."

Ad paragraph 41

363 Paragraph 77 of the replying affidavit is again summarised by the deponent in a misleading fashion. I admit the paragraph only to the extent that it coincides with the wording of paragraph 77, which is to be found at CL009-53.

Ad paragraph 42

364 I firmly deny that the relevant paragraphs of the replying affidavit represent "a new glide path for implementing the NHI Act". I refer to what I have already said in this regard and deny each averment in this paragraph.

Ad paragraph 43

365 I deny this paragraph. I have discussed the gradual implementation of the NHI Act publicly on numerous occasions. What is set out in my replying affidavit is entirely consistent with this.

366 I deny that my replying affidavit contradicts my presentation to Nedlac on 12 August 2025. I also deny that the presentation envisaged commencement of the NHI Act by the end of August 2025. Neither the Department nor the President had any such expectation. This inaccurate assertion is based on an incorrect conclusion from the relevant part of the PowerPoint presentation which HASA attaches to its initial answering affidavit (CL006-98). The bullet headed "Proclamation targeted for end August 2025" quite plainly refers to the draft regulations referred to in the immediately preceding bullet. I can make the full copy of the PowerPoint presentation to the court should it so require. The portion upon which HASA relies to draw its incorrect conclusion reads as follows:

> "Draft Regulations
>
> - Completed : 10 February 2025
> - Presented at National Health Council (NHC) for noting
> - Translated into fourth language : English, Sepedi, Afrikaans, isizulu : 05 November 2024
> - Published for comment : 06 March 2025

- Comments closed 06 June 2025
- Finalised comment incorporation 04 August 2025

- Proclamation targeted for end August 2025
- Followed by regulations coming into effect and process commencing."

367 It is quite clear from this that what was referred to was the proclamation target of the sections of the Act that will enable these regulations and not the Act as a whole. HASA's attempt to construe it differently is mischievous.

Ad paragraph 44

368 I deny that there are difficulties with what was set out in the replying affidavit. I also deny that it is correctly characterised as "the Minister's new plan".

Ad paragraphs 45 and 46

369 I deny these paragraphs.

370 They are based on a misinterpretation of section 59 of the Act read with section 57.

371 Section 59(1) simply provides that the NHI Act takes effect on a date fixed by the President by proclamation in the Government Gazette. Section 59(1) is subject to the Act in its entirety and it is subject to, and to be read together with, section 59(2).

372 Logically, and as a matter of necessary interpretation, the President may not proclaim a date for commencement of the statute which ignores its express provisions. This is the effect of the locked-in dates provided for in the NHI Act.

Section 59(2) confirms the President's duties in this regard. It allows him to delay the commencement of certain provisions of the NHI Act but makes this subject to section 57 where the lock-in periods are prescribed.

373 I deny, for the reasons given, that the President has the power to ignore s 57 of the Act when applying section 59(1).

374 Logically, the President cannot be bound by section 57 of the Act when commencing the Act in stages, but not be bound thereby when commencing the Act as a whole. This will be elaborated upon in argument.

Ad paragraph 47

375 The President was only in a position to sign and assent to the National Health Insurance Bill on 15 May 2024. It was therefore not possible to commence it in 2023. That fact cannot dictate the interpretation of the Act.

376 These matters will be elaborated upon in argument.

377 I accordingly deny paragraph 47.

Ad paragraph 48

378 I accordingly deny that the President may either rationally or lawfully undertake not to proclaim the entire NHI Act.

Ad paragraph 49

379 Once again, the assertions in this paragraph are based on a misinterpretation of section 59(1) and (2) of the NHI Act. Patently, a provision which is peremptory in one context cannot simultaneously be non-peremptory in another context.

HASA's concession that the 2023 to 2026 and 2026 to 2028 dates "operate as firm deadlines" is noted.

Ad paragraph 50

380 I admit this paragraph.

Ad paragraph 51

381 I deny that there is any "new plan" as alleged, and that the replying affidavit is "impermissibly vague".

382 Further, I deny that what is set out in the replying affidavit either frustrates or fails to achieve the objectives set in section 57(4) or (5) of the NHI Act.

383 What HASA has either turned a blind eye to, or has overlooked, in particular, is that all of the provisions of section 57 of the Act, indeed the entire Act, must be read subject to section 57(1)(b) which provides that:

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

Ad paragraph 52

384 I deny that there is any "proposal" contained in the replying affidavit.

385 Further, I admit this paragraph only to the extent that it aligns with the replying affidavit.

Ad paragraph 53

386 I deny that there is any contradiction as alleged or at all.

Ad paragraph 54

387 HASA misinterprets this section. Section 57 must be interpreted holistically.

388 I deny that the purchase (not procurement) of healthcare and hospital services by the Fund is a mandatory requirement for phase 1, particularly when read with section 57(1)(b).

389 It is clear from section 57(5) of the NHI Act that the purchase of the healthcare services envisaged in phase 1 need only be by the Fund if it has already been established and operationalised in phase 1. If not (and section 57(5) of the Act allows until the end of 2028 to establish and operationalise the Fund) they may be and will be purchased by the NHI Branch of the NDoH by way of enhancement of what is being provided on an ongoing basis by the national and provincial departments of health under the National Health Act 61 of 2003.

390 I accordingly deny the remaining averments in this paragraph.

Ad paragraph 55

391 The averments in this paragraph are based on the same misunderstanding and misinterpretation as that contained in paragraph 54.

392 I repeat what I said in response to that paragraph.

Ad paragraph 56

393 I deny this paragraph. Section 57(5) of the NHI Act provides as follows:

> "Objectives that must be achieved in Phase 2 include the establishment and operationalisation of the Fund as a purchaser of healthcare services through a system of mandatory prepayment."

394 The plan is that by the end of March 2028, administrative preparations and transfer of staff from the NDoH will be effected, with a view to the establishment and operationalisation of the Fund by the end of 2028.

395 Once established, the Fund will proceed with expanding the proof-of-concept work at test sites, implementing the integrated approach to capitation payment for primary healthcare. That will be facilitated by bringing into force of sections 9 to 11 in the 2027 / 2028 financial year.

396 Having been established and operationalised, the purchase of healthcare services by the Fund in terms of section 35 can then commence on a more substantial scale from 1 April 2029. That process will, however, remain subject to section 57(1)(b) which requires a gradual phasing-in based on financial resource availability.

397 It is correct that mandatory prepayment for health is a financial model where individuals contribute to a pooled fund, typically through taxes, to guarantee access to healthcare services for all. I deny, however, that mandatory prepayment necessarily means taxation such as to require the implementation of a new payroll tax and surcharges on personal income tax to fund the purchase of healthcare services. Once again, the deponent overlooks the compulsory provisions of section 57(1)(b) of the Act. Importantly, section 49(2)(a) expressly cross-refers to section 57, so it to is subject to section 57(1)(b).

398 Having regard to that provision, the reference to mandatory prepayment in section 57(5) of the Act does not dictate the bringing into force in terms of section 59(2) of sections 49(2)(a)(iii) and (iv) prior to the dates referred to in paragraph 81 of my replying affidavit.

399 This does not in any way suggest that the Fund will not be established as a purchaser of healthcare services through a system of mandatory prepayment in accordance with section 57(5) of the Act. I deny that there will be any violation.

400 Further, I deny that the Minister intends instructing or is entitled to instruct the President which sections to bring in force, and when. As the President has pointed out in his answering affidavit in paragraph 79 (CL002-33):

> "The President does not act in isolation in considering and determining whether to bring legislation into effect or in determining whether to implement the legislation. This decision is of necessity influenced, amongst other things, by the readiness of the relevant department responsible for implementing the legislation. This applies with particular force in respect of legislation with the scope of the NHI Act."

401 The Minister is responsible for communicating readiness to the President. It is by that mechanism that the pace of bringing into force of the NHI Act in terms of section 59(2) can be regulated.

402 The President himself, as expressly required in terms of section 59(2) of the NHI Act, will be required to have regard to section 57(1)(b) governing gradual phasing in subject to financial resource availability in his proclamation of commencement dates of different sections of the NHI Act.

Ad paragraph 57

403 HASA is mistaken in the allegation that the replying affidavit is vague.

404 There is simply no basis to allege that the Minister will implement the NHI Act by impermissibly directing the President how to act and claiming he will have made the decision. I refer to what I said in the previous paragraph in this regard.

405 The information regarding implementation as set out in the replying affidavit does not suggest unlawful conduct at variance with section 57 of the Act. I say this for the reasons I have already given.

406 There is no material risk that the Minister will change his plan or speed up implementation. Section 57(1)(b) is clear. It places a strict limitation of phased, gradual and progressive implementation, linked to "financial resource availability".

Ad paragraph 59.3

407 Before section 33 is commenced and implemented, taxpayers will fund the NHI in the same way that their taxes have always contributed to public healthcare. However, this will be in a manner which respects section 57(1)(b) and which does not require them to pay additional taxes for both private healthcare and healthcare under the NHI. As pointed out in the replying affidavit, the Minister is acutely aware of the implications of doing otherwise. The flexibility of implementation of the NHI Act allows this to be respected.

408 For the reasons I have already given, I deny that the Minister's approach violates section 57(5) of the Act.

409 I refer further to what I have already said regarding how healthcare services are purchased prior to the Fund's commencement of doing so in terms of section 35 of the Act.

410 The further issues raised in this paragraph will be dealt with in argument.

Ad paragraphs 59.4 and 59.5

411 I deny these paragraphs.

412 What was pointed out in the replying affidavit was that, firstly, there is no risk of harm that arises from the grant of the stay and, secondly, that the statute itself does not permit the satisfaction of certain respondents' demands that the President and the Minister provide an undertaking not to bring into force or to implement the entire statute.

413 What the replying affidavit demonstrates is that the Minister's undertaking not to implement section 33 is an appropriate, lawful and helpful measure designed to ensure that there will be no prejudice to medical schemes and their members and those whose incomes are reliant on their existence, during the period of the stay and well beyond.

414 These paragraphs of HASA's supplementary answering affidavit overlook the fact that special provision is made for the vulnerable groups referred to in section 57(2)(a)(iv) and 57(4)(f). The President and the Minister cannot ride roughshod over the rights and legitimate expectations that are created by these provisions, by the grant of an undertaking not to commence or implement the Act as a whole.

415 In particular, for the reasons given in the replying affidavit, I deny that there is any risk of harm.

Ad paragraph 60

416 This paragraph repeats averments already made regarding the operation of section 57(5) and I refer to what I have already said above in this regard.

Ad paragraph 61

417 The replying affidavit never purported to be all-encompassing in explaining the time of coming into effect and implementation of every section of the statute. What was set out there is sufficient to demonstrate that the harm contended for by the respondents will not materialise.

418 The sections of the NHI Act not referred to in the replying affidavit will be commenced and implemented in accordance with the requirements of section 57(1)(b). I accordingly deny this paragraph.

419 I also refer in this regard to what I said by way of introduction of the topic in paragraph 74 of the replying affidavit:

> "I provide some further examples of predicted implementation dates to make the point that, even if the court were to accept the allegations of unconstitutionality of various provisions, they do not present a threat of harm as alleged during the likely period of any stay."
>
> (own emphasis)

420 Insofar as there has been publication of regulations, I refer to section 14 of the Interpretation Act.

Ad paragraph 62

421 I deny this paragraph. It repeats arguments already made earlier in the supplementary answering affidavit and I refer to my response to those arguments above.

Ad paragraph 65

422 I deny this paragraph.

423 Whilst allegations of risks and prejudice abound in the HASA's papers, no evidence has been put up in this regard.

424 The approach to implementation dictated by section 57(1)(b) of the NHI Act ensures that commencement and implementation of the NHI Act is brought about in a manner that is gradual and does not undermine legal certainty and public trust.

425 Further, I deny that the NHI represents piecemeal health reform. The reference to other legislation in paragraph 65.2 is irrelevant.

426 As regards paragraphs 65.3 to 65.5, I deny that the experience of the private healthcare sector represents an appropriate comparator for the NHI Act and its implementation.

427 To the extent that the further averments in paragraph 65 repeat arguments already dealt with in the replying affidavit and above, I refer to what I have said there.

Ad paragraph 66

428 To the extent that this paragraph repeats averments made earlier in HASA's supplementary answering affidavit, I refer to what I have said earlier.

429 There is no evidence to sustain the assertion of "immense prejudice" to medical schemes and their beneficiaries during this stage.

430 As pointed out in the replying affidavit, targeting only high income earners who earn around a million rand a year for the withdrawal of tax credits will certainly not have the catastrophic consequences HASA contends for. The impact per individual is minimal and manifestly within their capacity at that income level to absorb it. The Democratic Alliance has recognised this, as I have already pointed out.

431 I deny that the NHI Act is "entirely unconstitutional". It is constitutional legislation that is directly aimed at achieving the objectives of and the values underlying, amongst others, sections 9 and 27(1)(a) of the Constitution, so as to address the profound inequality in South Africa's healthcare system. The scale of the inequality is one of the worst in the world.

432 There is no evidence to suggest that persons earning around a million rand a year would downgrade from more expensive medical aid plans to cheaper plans. I firmly deny this.

433 Once again, the averments in this paragraph are alarmist and exaggerated and I deny them. I firmly deny that the Minister intends to take substantive steps towards defunding and shrinking the role of medical schemes in the immediate future. This implies patent dishonesty on his part in his affidavits. No basis is laid

for this spurious allegation, which is irresponsibly made. His undertaking as well as the content of the replying affidavit make clear that he has no such intention. Section 57(1)(b) of the NHI, the rule of law, the principles of legality and rationality, and the Bill of Rights all constrain the Minister in this regard. Surprisingly, all of the respondents overlook this fact.

434 I deny the averments regarding the material risk to HASA from a stakeholder and investor perspective. This was dealt with in detail in the replying affidavit. There is no evidence to sustain the allegation that anything is likely to have "severe negative consequences for the ongoing viability of private hospitals". They will continue to thrive and generate a substantial income.

Ad paragraph 67

435 I deny this paragraph. In particular I deny that there has been the formal taking of any decision in terms of section 49(2)(a)(ii) of the NHI Act (which provides for the reallocation of funding for medical scheme tax credits).

436 The evidence in the replying affidavit in this regard explained what is envisaged at the point in time when section 49(2)(a)(ii) of the Act is brought into effect. Naturally, the authorities acting in terms of that provision will be bound to comply with the Constitution and the law in its implementation.

437 I deny that there will be any arbitrariness.

Ad paragraph 69

438 I repeat what I said in response to the previous paragraph. The content of my replying affidavit in this regard related to future decision-making.

439 Section 49(2)(a)(ii) of the Act has not yet been brought into force so there can be no suggestion of unlawful decision-making under it.

Ad paragraph 70

440 I deny that there has been any formal decision-making under section 49(2)(a)(ii) of the Act regarding medical tax credits. I repeat what I have already said in this regard. Were the Minister not to adhere to anything in the replying affidavit or this affidavit, it would form a basis for seeking the lifting of the stay.

Ad paragraph 71

441 I deny this paragraph. There is no evidence put forward by HASA or anybody else that the Minister "plans to cause immense prejudice to provincial health departments in the next two years." The deponent assumes that the Minister will act recklessly and unlawfully. As explained, there are multiple constitutional safeguards to prevent him from implementing legislation in this way. Centralisation in accordance with the NHI Act will be done in a manner which does not operate to the detriment of provincial healthcare departments. If funding is drawn away from provincial health departments, it will be accompanied by a diminution in their responsibilities in respect of which budgetary allocations are required.

442 In any case, importantly, the Fund will be required to pay for the services that provincial departments of health render, as opposed to the money passing from National Treasury through the Provincial Treasury and then to the provincial department of health.

Ad paragraph 72

443 I deny that sections 2 and 4 of the NHI Act unconstitutionally take away powers from the provinces. This will be dealt with to the extent necessary in argument.

444 I accordingly deny all the averments in this paragraph. In particular, I deny that there is any basis for, or truth to, the suggestion that with effect from 1 April 2026 the Minister will usurp provinces' healthcare powers. Provinces retain a particularly important role under the NHI Act. I deny that they face prejudice.

445 I am aware from my regular engagement with the provincial departments of health that, save for the provincial government of the Western Cape, they are strongly supportive of the NHI Act.

446 I firmly deny that "provincial health departments may be forced to close or significant pare resources". Again this is alarmist and unsubstantiated speculation. Court cases cannot be decided on that basis.

Ad paragraph 73

447 The averments in this paragraph are based on the incorrect and alarmist averments in the preceding paragraph. There will be no need to re-establish provincial departments because they will not be forced to close.

448 I deny that HASA's challenges must be accepted as good for purposes of the disposal of this application. This is a matter for argument.

449 To the extent that this paragraph repeats averments made earlier in the application, I refer to my response to those averments in the replying affidavit.

Ad paragraph 74

450 I deny that section 49 of the NHI Act is unconstitutional for the reasons that have already been set out in the Minister's answering affidavit in Solidarity's direct challenge. This will be elaborated upon in legal argument and it is unnecessary for me to repeat it here.

451 Further, I deny the repeat allegation of prejudice for the reasons already set out above and in the replying affidavit.

Ad paragraphs 75 and 76

452 I deny the allegation of vagueness.

453 As the Constitutional Court has pointed out :

> "The doctrine of vagueness does not require absolute certainty of laws. The law must indicate with reasonable certainty to those who are bound by it what is required of them so that they may regulate the conduct accordingly. The doctrine of vagueness must recognise the role of government to further legitimate social and economic objectives and should not be used unduly to impede or prevent the furtherance of such objectives. As the Canadian Supreme Court observed after reviewing the case law of the European Court of Human Rights on the issue:
>
> > 'Indeed ... laws that are framed in general terms may be better suited to the achievement of their objectives, inasmuch as in fields governed by public policy circumstances may vary widely in time and from one case to another. A very detailed enactment would not provide the required flexibility, and it might furthermore obscure its purposes behind a veil of detailed provisions. Modern State intervenes today in fields where some generality in the enactments is inevitable. The substance of these enactments remains nonetheless intelligible. One must be wary of using the

> doctrine of vagueness to prevent or impede State action in furtherance of valid social objectives, by requiring the law to achieve a degree of precision to which the subject-matter does not lend itself. A delicate balance must be maintained between the societal interests and individual rights. A measure of generality also sometimes allows for greater respect for fundamental rights, since circumstances that would not justify the invalidation of a more precise enactment may be accommodated through the application of a more general one.'"[1]

454 That dictum of the Constitutional Court is entirely apposite in the present circumstances of the NHI Act and fully justifies the manner in which it has been framed.

455 I deny the legal argument advanced in paragraphs 75.1 to 75.3. This will be dealt with at the appropriate time.

456 The same applies to the specific sections mentioned in paragraph 76.

Ad paragraphs 77 and 78

457 Once again these paragraphs raise arguments from HASA's direct challenge regarding section 55 of the Act, which empowers the Minister to pass regulations. I deny the unconstitutionality averred here. This is in any event not a reason to refuse the stay.

458 Further, I deny the allegations of prejudice for the reasons already set out in the replying affidavit and above.

---

[1] Affordable Medicines Trust and others v Minister of Health and others 2006 (3) SA 247 (CC) at para 108.

Ad paragraphs 79 and 80

459 The same averments as made in respect of the preceding two paragraphs apply to these paragraphs. As pointed out in the replying affidavit, the gradual implementation of the NHI Act while the stay is in place will be for the public good, particularly for those sections of society that are vulnerable, and I accordingly deny the allegation of "immense prejudice".

Ad paragraph 81

460 HASA's expert evidence and the inevitable factual disputes pertaining to it, can be dealt with at the appropriate time and if it should prove necessary at all, depending on the outcome of the Constitutional Court litigation.

461 For the reasons already given in the replying affidavit and this affidavit, I deny that implementation of the NHI Act in the limited way that will take place during the stay creates any risk of unnecessary or fruitless expenditure.

462 Indeed, none of the expenditure on preparation for the NHI to date has been found by the Auditor-General to be either unnecessary or fruitless.

Ad paragraphs 82 - 87

463 The Minister's legal costs are but a small part of the prejudice faced by the Minister if the respondents are allowed to press ahead with potentially fruitless litigation on the expansive scale which they collectively do. Responding to the litigation has diverted and will increasingly divert an enormous amount of human and other resources, including my own and those of the Minister, that could be

better spent attending to the healthcare needs of particularly the vulnerable groups who will benefit from implementation of the NHI.

464 Accordingly, the analysis purportedly set out in the paragraphs under reply on the basis that legal expenses are the Minister's only prejudice, is fundamentally flawed.

465 I have already explained why the nature of the implementation during the stay will be beneficial, regardless of the outcome of all of the litigation. No evidence has been put up that contradicts that.

466 I accordingly deny these paragraphs.

467 Moreover, the gradual and limited nature of the implementation during the period of the stay, amongst other things, means that there is no substance to HASA's assertion that no court will be able to grant HASA effective relief in the event that the NHI is found constitutionally wanting. In any event, the stay represents the fastest and most sensible route to clarifying, at least in part, the legal validity or otherwise of the NHI Act as a whole.

Ad paragraph 88

468 I deny the averments in this paragraph.

469 The assertions regarding the demands to be placed on taxpayers during the period of the stay have already been dealt with at length above and in the replying affidavit. I refer to my response to those assertions above.

470 If the stay is lifted on account of the four applications serving before the Constitutional Court all having failed, the respondents, the Minister and, perhaps

most importantly, this Court will know that the expansive litigation it is engaging with is worthwhile. Until such time as the Constitutional Court, which is already seized with these matters, has dealt with them, there is no basis upon which the court can be reassured that the respondents' litigation in the High Court is not completely pointless. The courts are not set up for, nor do they have the resources to justify, adjudicating potentially pointless litigation.

471 Insofar as the reference to disputes of fact is concerned and the likely need for the matter to go to trial, it is not the Minister alone who makes this averment. Solidarity in their answering affidavit seem to accept this scenario. Unfortunately, the respondents are in many respects the authors of their own (and everyone else's) predicament. Had they been disciplined in their approach, they would have applied to intervene in Solidarity's single application. Instead, by each bringing separate, overlapping challenges and casting them in ways that are destined to result in major factual disputes, they have created a litigious behemoth. Pursuing potentially pointless litigation of that order of magnitude is not something that the courts can, with respect, countenance.

472 The remaining averments in this paragraph are denied.

Ad paragraph 89

473 The averments in this paragraph repeat averments already made and I refer to what I have already said in this regard.

Ad paragraphs 90 to 92

474 I firmly deny that the Minister admits that a stay cannot be granted if the executive implements the NHI Act in the interim. What the replying affidavit and this affidavit demonstrate is that the harm contended for by the respondents does not exist.

475 For the reasons already given, I deny that it is a response raised for the first time in reply. In any event, there is no prejudice because the respondents have had ample opportunity to respond in their supplementary answering affidavits.

476 It is the respondents, not the Minister, who have misunderstood the President's powers under the NHI Act. HASA's interpretation of section 59 is entirely unsustainable.

477 I deny that there is any vagueness or prejudice.

478 I deny the remaining averments in these paragraphs.

Ad paragraph 93 to 100

479 I set out in detail in the replying affidavit why I said that the respondents had adopted a strategy of lawfare aimed at tying up the Minister and the Department in overwhelming litigation.

480 I explained what I meant by the term and provided evidence to support what I said.

481 I stand firmly by what I said. I also point out that a conspectus of the litigation is perhaps the most clear evidence of the stratagem of lawfare.

482 I note that HASA studiously avoids the evidence I put up in this regard from Sakeliga who encouraged health care businesses to "steer as far as possible away from overcompliance and pre-compliance with NHI" and to "support well-structured opposition to buy time and repeal the NHI Act or render it functionally impotent". That is nothing else than a stratagem of lawfare, if not Stalingrad tactics.

483 I also pointed out what had been said to me openly in conversation with the leaders of some of the challengers of the NHI Act.

484 I accordingly deny all of the averments in these paragraphs.

485 HASA's over-reaction in these paragraphs to my complaint of lawfare is also evidence of its accuracy.

486 To the extent that some of the averments in these paragraphs repeat arguments raised earlier in the affidavit, I refer to my responses above.

487 With reference to paragraph 97, I accept that in the long run, the NHI Act will substantially restructure the healthcare sector so as to bring about a sea change in the stark inequality that currently besets it. The further allegations in this paragraph are denied.

488 For the reasons I have already given, it is not open to the President not to proclaim the commencement of the NHI Act in terms of section 59.

489 With reference to paragraph 100, HASA is not even willing to subject itself to the discipline of a consolidation of the direct challenges in order to, in a small way, render them slightly less unmanageable.

490 I accordingly deny that HASA's proposal regarding case management represents a sufficient reason not to grant the stay.

Ad paragraph 101

491 I have already dealt with the incorrect allegation regarding new factual material and the fact that the Minister has no objection to the admission of HASA's supplementary further answering affidavit.

Ad SAPPF second supplementary answering affidavit dated 27 October 2025

Ad paragraphs 12 to 14

492 I deny SAPPF's characterisation of its role in the litigation and its characterisation of the Minister's application.

493 I deny in particular that the Minister's application seeks to or has the effect of "deferring judicial scrutiny", that the stay relief is contrary to the rule of law, or is in any manner a request for the Court to refrain from performing its constitutional mandate. On the contrary, the necessary and appropriate exercise of a court's power to control its own procedure is an exercise of the Court's constitutional mandate.

494 As the Constitutional Court has explained, and as will be expanded on in argument, the right of access to court exists within the context of broad policy considerations as well as rules and procedures to regulate and give effect to the right. Some of those considerations may relate to the proper use of limited judicial resources, the need for efficiency in the administration of justice, and the

recognition that the same conduct may at times give rise to multiple causes of action which are all capable of achieving the same end.

Ad paragraphs 15 to 19

495 I ask the Court to rely on the relief and the reasons for it as articulated in the Minister's affidavits and last amended notice of motion, and not SAPPF's rendition thereof.

496 I deny that the Minister claims that the stay would "prevent additional constitutional challenges from being instituted at a later stage". To the contrary, the Minister suggests that if new applications were filed that challenge the constitutionality of the NHI Act frontally in the High Court, the period of the stay would ensure that those challenges may be drawn into the same consolidated process as the current High Court applications, assuming the Constitutional Court applications are unsuccessful in setting the Act aside and the issue remains live. That is not to say that any party would be prevented from filing new applications thereafter. It is only an indicator of the opportunity that the stay presents for a court in rationalising a growing mass of litigation in which more applications may still be filed.

Ad paragraph 20

497 SAPPF's argument is internally incoherent. It both assumes in paragraph 19 that parties who wish to challenge the Act have already done so, and claims in paragraph 20 that there will be "interminable" efforts to stay the High Court proceedings as new applications are filed.

498 The Minister does not suggest in his notice of motion or otherwise that any new application filed in the High Court would automatically be stayed and/or consolidated. If this Court does grant the stay and consolidation relief sought, and if new frontal challenges are filed in this Court, it would be incumbent on the Minister to seek court orders (whether by agreement or otherwise) staying and consolidating those new matters if it were in the interests of justice to do so.

Ad paragraphs 21 to 25

499 I deny that the Second BHF CC application is unrelated to the substantive constitutional challenges to the NHI. SAPPF ignores the overlap in the applications, as well as the risk of mootness.

500 SAPPF's forced attempt to draw a distinction where a real risk of wasted judicial resources may materialise must be rejected.

Ad paragraphs 26 to 27

501 I refer to what I say above regarding the timing and likely manner of hearing of the Premier of the Western Cape's application in the Constitutional Court.

502 The BHF's Constitutional Court challenge to the parliamentary process will inevitably be heard together with the Premier's application. There can be no debate that these applications fall within the ambit of the exclusive jurisdiction of the Constitutional Court. There is in effect no impact of the inclusion of the Premier's application in the notice of motion to the ultimate likely duration of the stay.

Ad paragraphs 28

503 I deny that the inclusion of Sakeliga or the Premier's applications in the relief sought have any real impact on SAPPF at all.

504 I deny that SAPPF has been or will be prejudiced by the hearing or grant of the Minister's stay application. Certainly, no case is made out for "severe", "manifest" prejudice as the deponent claims.

505 I further deny that SAPPF has been or will be prejudiced by the Minister having taken arguable points of law in response to its and BHF's applications challenging the President's decision to sign and assent to the NHI Bill. The appeal against Justice Twala's judgment on those points of law will be heard in due course by the Constitutional Court, which has indicated its intention to set the matter down for hearing.

Ad paragraphs 29 to 33

506 The Minister had no control of the timing or fact of new applications that were filed. It was rational and necessary for the Minister to amend his notice of motion to include the newly filed applications while affidavits were still being exchanged. SAPPF's exaggerated claims of infinite procedural interruption are unavailing.

Ad paragraph 34

507 I deny the allegations.

508 The stay is in the interest of justice as it would make way for the final determination of legal questions that may very well be dispositive of the issues that exist between the parties.

Ad paragraph 35

509 Since SAPPF's fourth answering affidavit was filed, the Constitutional Court has issued directives in its review application. I attach a copy of those directives, which I mark as Annexure "**SRA5**".

Ad paragraphs 36 to 37

510 I admit these paragraphs insofar as they accurately record the Constitutional Court's directives.

Ad paragraphs 38 to 39

511 While I am advised that it remains a possibility that the Constitutional Court will decline to grant the Minister and President direct leave to appeal to it against Justice Twala's judgment, I submit that it is highly unlikely that it would do so after inviting written submissions and indicating its intention to set the applications down for hearing. The speculative "protracted appeal process on the points of law" is therefore even more far-fetched than before.

512 I deny that it will take an "extraordinary length of time" to resolve the issues between the parties for reasons that I have addressed before.

Ad paragraph 40

513 It would have been nonsensical for the Constitutional Court to hear, at the same time, an appeal (in which the requirement to produce a record of the President's decision is in issue, amongst others) and the merits of the first BHF CC application (in which the production of that record is sought).

Ad paragraphs 41 to 42

514 I deny the allegations.

Ad SAPPF's third supplementary answering affidavit dated 3 November 2025

515 *Ad paragraphs 5 to 15*

516 The Minister's further amended notice of motion, which was filed on 26 September 2025, accords precisely with the unsigned further amended notice of motion which was annexed to the Minister's replying affidavit of 17 September 2025. The signed copy of the further amended notice of motion was duly filed on 26 September 2025 as had been agreed in case management.

517 I admit that SAPPF's attorneys were not timeously served the Minister's replying affidavit via email. I have addressed this above.

518 I deny that SAPPF has a right to file a further affidavit to deal with the Minister's replying affidavit. I further deny that the Minister's replying affidavit "ventures into fresh factual terrain" in a manner not foreshadowed in the founding papers. I deal with this above in reply to HASA and HFA's second supplementary answering affidavits.

519 Nonetheless, for the reasons also set out above, the Minister will not oppose the admission of SAPPF's fourth answering affidavit.

520 If anything, the parties' assumption of a right to answer to the Minister's replying affidavit (and SAPPF's lack of restraint by filing a fourth affidavit of over 100 pages) demonstrates that SAPPF is engaging in the very "lawfare tactics" that it so vehemently denies.

521 It further underlines the necessity of this Court implementing the stay that the Minister seeks in order to prevent these matters from being litigated in a wholly unmanageable manner.

Ad paragraphs 16 to 23

522 I deny the allegations.

523 I persist with what I say in my prior affidavits and in this affidavit on the mootness and jurisprudential overlap between the Constitutional Court and High Court applications.

524 In SAPPF's first and original High Court application, it brought its challenge against the President's assent and signature, and its review of the NHI Act, as alternative relief in a single application. It filed a single affidavit substantiating the alternative prayers. SAPPF's strategy in its first application thus demonstrates its own assumption that the relief is inextricably bound. Its protestation that these are distinct issues – having now sought to separate and litigate those claims concurrently in two courts – is disingenuous.

525 The Minister reserves his right to raise a plea of *lis pendens* in response to BHF's and SAPPF's successive applications that seek in effect the same relief on different grounds.

Ad paragraphs 24 to 26

526 SAPPF's argument and characterisation of the effect of the stay application is non-sensical and is denied.

527 The parliamentary process challenges brought by BHF and the Premier of the Western Cape are without question issues on which the Constitutional Court enjoys exclusive jurisdiction. The Minister and President further consider that an application to review the President's signature to and assent of a Bill is similarly a matter of the Constitutional Court's exclusive jurisdiction. There is, by constitutional design, no first instance adjudication of these applications in the High Court, nor any appeal from the Constitutional Court.

528 In any event, the stay does not prevent the High Court applications from being adjudicated. It simply subjects the concurrent litigation to an efficient and sensible sequencing.

Ad paragraphs 27 to 29

529 I provided further details on the implementation plans for the NHI Act in the replying affidavit in response to the allegations of prejudice made in the answering affidavits. I deny that it is "impermissible new matter".

530 I have dealt with these allegations above in reply to HASA and HFA's second supplementary affidavits. The Minister's plans to implement the NHI Act accord with section 57 of the Act.

Ad paragraphs 30 to 38

531 I deny that the Minister's implementation plans conflict with the NHI Act in any manner. I have addressed this above.

532 I deny that any prejudice will follow in the period of the stay by virtue of implementing the NHI Act or otherwise.

533 While the NHI Act is yet to be brought into force, there are aspects of Phase 1 of the Act that are incidentally ongoing already under other constitutional and statutory mandates, and in terms of the Minister's and NDoH's lawful powers which are exercised in anticipation of the Act coming into effect, as confirmed in *Solidarity v Minister of Health and Others* [2024] ZAGPPHC 156; 2024 (5) SA 563 (GP). For example:

533.1 Health systems strengthening is ongoing through provincial health budgets and under the NDoH budget.

533.2 The NDoH has been developing the draft governance regulations. Work is ongoing to develop other aspects of draft regulations. This will mean that the development of the enabling legislative framework will be at an advanced stage once the Act is brought into effect. Schedule 1 amendments will be effected once the NHI Act is brought into effect by the President. Each amendment will be effected on its own date as provided for in section 59(2) of the NHI Act. This will take into account the undertaking the Minister has given in relation to section 33.

533.3 Budgeting and planning for the establishment of administrative and personnel arrangements to constitute the Fund is ongoing. Drafts of the entity design and operational policies have been prepared. Some staff have been employed within the NDoH to posts that will be required for ongoing health reforms.

533.4 The ways in which personal health care services will be purchased for vulnerable groups has already been trialled through the nine "CUP sites".

These sites are documenting methods of switching to capitation payments for primary health care services.

533.5 The migration of central hospitals is being managed through the National Health Council. This will be a complex process but health systems strengthening is underway and delegations are underway.

533.6 The development of the health patient registration system is underway. Implementation has already occurred in over 3 500 facilities. The training of users of the system is being accelerated across all provinces.

533.7 A draft accreditation framework is being developed.

534 The Minister has not and does not intend to "defer, dilute or reorder" statutory milestones in section 57 of the NHI Act, nor is the plan "extra-statutory". The implementation plans demonstrate the NDoH's and Minister's alignment with section 57 of the Act, including its requirements for a gradual and progressive approach to implementation.

535 There is also no indication that the President will exercise his power under section 59 of the NHI Act in an irrational manner to subvert the statutory framework.

536 A stay of implementation, whether by choice of the Minister or President or Court order, would subvert the scheme of the NHI Act absent a final finding on the constitutionality thereof. This would occur in a context where the urgency to reform South Africa's ailing health system is pressing.

Ad paragraphs 39 to 44

537 I strongly deny the allegations of inconsistency and contradiction. SAPPF's allegations that I have either lied to Parliament or to this Court are untrue and are recklessly made.

538 SAPPF's misrepresentation of my presentation to the Standing Committee on Appropriations demonstrates that its claims cannot be believed. Its allegations are incorrect and misleading. The attachment at "FSAA6" demonstrates this. I will further provide the transcript of my presentation if so required.

539 In my presentation, I was at pains to explain that the diagram in slide 33 was illustrative. There is nothing to indicate that I conveyed "a settled fiscal design".

540 Slide 33 makes this clear. It says in red text in the heading to the graph "Illustrative (10 yr, 15 yr, or more)". The timetable in fact has old dates from the initial illustrative plan from before the NHI Act was passed.

541 Again, on slide 34, the header on the right-hand side of the table says "ILLUSTRATIVE PHASING IN OF FUNDING CHANGES AND INDICATIVE AMOUNTS (2023 RAND)". (own emphasis)

542 It is clear from the diagram on slide 34 that there are a host of conditions that need to be fulfilled and work that needs to be done for funds to shift.

543 I was explaining to the Committee that this is complex. I was not laying out a signed off implementation plan on the removal of medical tax credits.

544 Slide 35 states further:

- Slow removal of medical tax credits offer a source of funding if it is earmarked (into a separate fund for developing NHI)
- Thresholds for systemic withdrawal of medical tax credits have been estimated by Treasury and there are options

(Emphasis added).

545 I also spent an hour after the meeting with DA Member of Parliament, Mr Andrew Bateman, discussing this.

546 I persist in the allegations I made in my replying affidavit on the removal of medical tax credits. My presentation to Parliament does not contradict this.

547 The Appropriations Committee asked the Minister and the NDoH to explain the funding model for NHI. I explained what is in the NHI Act and how it may be implemented.

548 The discussions between the Minister, the NDoH and Treasury are ongoing. These discussions remain that medical tax credits should not be suddenly removed or reduced and that they should be withdrawn from high income earners in the first instance. Neither the Minister nor I have proposed or would propose otherwise.

549 As my presentation to the Standing Committee on Appropriations explained, the reallocation of funding for medical tax credits remains a potential source of funding for NHI under section 49(2)(a)(ii) of the NHI Act.

550 There is still a requirement for a Money Bill. Neither the Minister nor the NDoH has the power to "dismantle the current tax-credit regime", not under the NHI Act or otherwise, not "imminently" nor in the future.

551 SAPPF does not understand how appropriations and public finance operate. I refer to the expert affidavit of Dr Deborah Budlender as annexed to the Minister's answering affidavit in the Solidarity application for a more detailed explanation.

Ad paragraphs 45 to 50

552 The Minister reserves his right to answer to these allegations more fully in his answering affidavits in due course to the SAPPF applications, including with the support of expert evidence.

553 In any event, I deny the allegations, which I have dealt with in my replying affidavit. SAPPF's efforts to revisit these issues again in its fourth answering affidavit are an abuse of process.

554 I deny that the NHI Act will limit healthcare practitioners' ability to determine appropriate care or shift decision making power in any manner different to what currently exists in private and public healthcare today.

555 The NHI Act does not empower the Fund or any body established under the Act to dictate or determine what a patient needs or what treatment should be prescribed.

556 What the Fund can do (in terms of the Act and with the designated bodies established under the NHI Act) is to determine what it can and will pay for. This is what all national health insurance systems do in any country. It is a necessary incident of providing healthcare equitably to a population with limited funds that the funder must set boundaries on what it can and cannot pay for. Medical schemes do exactly the same today.

557 If, for example, the Fund does not pay for a particular course of treatment because there is "no medical necessity", there is no cost-effective intervention, or the treatment is not included in the Formulary, patients remain entitled to access that treatment or medication through medical scheme coverage or to pay for it out of pocket.

558 SAPPF's description of how the Fund and NHI will operate have no basis in fact or in law.

Ad paragraphs 51 to 55

559 SAPPF's efforts to revisit these issues again in its fourth answering affidavit are an abuse of process.

560 I persist with the allegations I make in my replying affidavit.

561 SAPPF seeks unreasonably to draw dramatic and misleading conclusions from an opinion poll that is neither crafted nor executed to produce empirically reliable results.

562 From the work that the NDoH has been conducting and from empirically reliable studies that the NDoH has considered, the indications are that when people are able to receive accurate information about changes like the NHI, they are able to engage and respond without overreacting.

563 To the extent that SAPPF misrepresents how NHI will operate under oath in these proceedings, it can be assumed that it is doing the same in its communications to its members. If a doctor were informed, for example, that NHI would remove all clinical discretion and decision making (a false statement

SAPPF makes in its affidavits), specialist doctors would understandably be concerned and fearful. SAPPF itself is generating uncertainty and anxiety amongst its members by inaccurately communicating the implications and effects of NHI on its terms.

564 SAPPF's opinion poll is indeed unreliable as factual representation of the implications or effect of the NHI Act. I refer to what I said in the replying affidavit in this regard.

Ad paragraphs 56 to 63

565 SAPPF's approach in filing a lengthy, fourth and wholly unnecessary answering affidavit in these proceedings exemplifies the very lawfare tactics it so vehemently denies. Its abuse of court process is further evident by it having brought four separate applications seeking in essence the same relief (the setting aside of the NHI Act). The Minister reserves his right to raise a plea of *lis pendens* in relation to these applications.

566 I deny that the Minister (or the President for that matter) sought to "avoid a reckoning on the merits of NHI" by raising points of law in BHF's and SAPPF's High Court applications challenging the President's assent to and signature of the NHI Bill. I also deny that such an allegation is reflected in Justice Twala's judgment. These allegations only demonstrate the hyperbole and inaccuracy of SAPPF's claims. BHF itself has accepted that the Minister's and President's applications for leave to appeal are arguable and raise important constitutional issues. The Constitutional Court is well on its way to setting them down for hearing, having issued directions requiring the filing of heads of argument.

567 The Minister has at no stage delayed or obstructed the determination of SAPPF's or BHF's applications to challenge the President's decision. Had SAPPF and BHF brought their applications in the correct forum, they may well have been decided already. Those applications are in any event not subject to the stay or consolidation application.

CONDONATION FOR LATE FILING

568 The Minister respectfully seeks condonation for the late filing of this affidavit.

569 The deadline for filing which was agreed in case management was Friday, 7 November 2025. However, due to circumstances beyond the Minister's control, he was unable to meet this deadline.

570 My availability was significantly constrained during the allocated 10 court days for preparing this affidavit due to the following reasons:

570.1 I was engaged in intensive preparations for the G20 Health Minister's meeting held in Polokwane from 4 to 7 November 2025.

570.2 I suffered a bereavement in my immediate family, necessitating travel between Gauteng and the Western Cape to manage family commitments and funeral arrangements.

571 These factors limited my ability to provide instructions on the new factual matters, including expert evidence, introduced in the respondents' answering and supplementary answering affidavits.

572 The respondents were afforded over a month to prepare their supplementary answering affidavits, while the Minister was only allocated 10 court days to reply.

This timeline has proven particularly onerous due to the parties filing extensive new matter. This meant that the Minister must respond to four supplementary answering affidavits totalling approximately 250 pages (including annexures and a new expert report) in addition to Sakeliga's answer of some 185 pages (including annexures and reports). That is 435 pages in total.

573 HFA filed their supplementary answering affidavit three calendar days late, which delayed the Minister's ability to respond. Additionally, the Minister only received SAPPF's further supplementary affidavit on 3 November 2025 (through no fault of SAPPF), comprising 102 pages. These delays had a knock-on effect on the Minister's ability to reply within the allocated time.

574 During the period of the delay, I had to consult with the Minister's counsel team and provide responses on all of five affidavits. The Department also had to engage and consult with potential expert witnesses. Some of the experts consulted were also attending the G20 summit with limited availability.

575 The delay was neither wilful nor negligent. The grant of condonation will in any event not prejudice the respondents, as it will not impact the timing for the delivery of heads of argument or hearing date.

576 In light of the above, the Minister respectfully requests that condonation for the late filing be granted. The Minister's rights remain reserved.

PRAYERS

577 The Minister asks that the relief sought out in his further amended notice of motion that is filed with this affidavit is upheld.

578 He further prays that Sakeliga's conditional counter-application is dismissed.

579 Finally, he prays that condonation is granted for the late filing of this affidavit.

NICHOLAS CRISP

SIGNED and SWORN to before me at JOHANNESBURG on this ____ day of _____ 2025, the deponent having acknowledged that he knows and understands the contents of this affidavit, that he has no objection to taking the prescribed oath and that he considers the oath to be binding on his conscience.

_____
COMMISSIONER OF OATHS

BALOYI MAKHANANA QUILLON
COMMISSIONER OF OATHS
Practising Attorney (RSA)
52A Brecher Street
Sunnyside, Pretoria

SRA1

The Elders

CHARTER FOR EQUITABLE, INCLUSIVE AND SUSTAINABLE UNIVERSAL HEALTH COVERAGE



THE ELDERS

The Elders are independent leaders using their collective experience and influence for peace, justice, and human rights worldwide. The group was founded by Nelson Mandela in 2007.



MARY ROBINSON
CHAIR



BAN KI-MOON
DEPUTY CHAIR



GRAÇA MACHEL
DEPUTY CHAIR



GRO HARLEM BRUNDTLAND



ELBEGDORJ TSAKHIA



ZEID RAAD AL HUSSEIN



HINA JILANI



ELLEN JOHNSON SIRLEAF



RICARDO LAGOS



JUAN MANUEL SANTOS



ERNESTO ZEDILLO

Martti Ahtisaari, Lakhdar Brahimi, Fernando Henrique Cardoso and **Jimmy Carter** are Elders Emeritus.

Kofi Annan (1938-2018) was a founding member of The Elders and served as Chair from 2013-2018.

Desmond Tutu (1931-2021) was a founding member of The Elders and served as Chair from 2007-2013.

Ela Bhatt (1933-2022) was a founding member of The Elders.

> **UHC is an essential element of a prosperous society, as well as a driver of social justice, human rights and inclusive economic growth.**

5 Foreword

6 Introduction

9 Precepts

10 Genuine Universality

12 Effective and Equitable Universal Insurance

14 Primacy of Public Financing for UHC

16 Efficient Delivery of Quality Health Services

18 Progressive Realisation of UHC

Cover image: COVID-19 testing in Madagascar, 2020.
Photo: World Bank / Henitsoa Rafalia



Ernesto Zedillo and Gro Harlem Brundtland visit a health centre in Indonesia, 2017. Photo: Agoes Rudianto.



FOREWORD

At the heart of Universal Health Coverage (UHC) lies a fundamental proposition: access to healthcare is a human right, and no-one should be denied the care they need because of their financial circumstances.

This is the basis on which The Elders prioritised UHC in their global advocacy agenda from 2016, and is the starting point for our new focus from 2023 on Pandemic Prevention, Preparedness and Response.

The political imperative to achieve UHC has been made even more urgent in the context of the COVID-19 pandemic and the stark inequalities it has both exposed and exacerbated. For the millions of people who have been pushed into poverty by the pandemic, UHC can literally be a lifeline.

Over the past six years The Elders have undertaken visits to countries including South Africa, India, Indonesia, Ethiopia, Tanzania and the United States to support UHC reforms at state and regional levels, and to meet health practitioners and patients at the community level to gain a representative and holistic understanding of each constituency's needs and aspirations.

Throughout this period, with the assistance of expert partners within civil society, academia and the public health community, we have also been developing and refining a rigorous understanding of what UHC should mean in practice. This has helped shape our thinking about how heads of state and government can oversee the implementation of UHC, unencumbered by dogma, ideology or the influence of vested interests.

This Charter on Equitable, Inclusive and Sustainable UHC is the culmination of our work on this subject, and I am enormously grateful to my fellow Elder Ernesto Zedillo for his tireless efforts in this endeavour, together with his colleagues at the Yale Center for the Study of Globalization.

His five precepts of UHC – its universality, the need for equitable and comprehensive insurance, public financing, efficient service delivery, and progressive realisation – comprise a practical, accessible and flexible framework for politicians, policymakers, health professionals, workers and patients alike.

This Charter will act as a bedrock for The Elders' ongoing work on Pandemic Prevention, Preparedness and Response. The principles of justice, inclusivity and sustainability at its core will inform our advocacy in public and private, now and for many years to come.

Mary Robinson



Members of the Army and Air National Guard from across the United States were activated under Operation COVID-19 to support federal, state and local efforts in March, 2020 (Photo: Sgt. Amouris Coss / U.S. Army National Guard)



Ban Ki-moon and Gro Harlem Brundtland visit a healthcare centre in India. Photo: Hemant Chawla

INTRODUCTION

The Constitution of the World Health Organisation adopted in 1946 stated that:

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

This tenet has evolved over time to have as its practical expression the goal of universal health coverage (UHC) – **all people have access to the health services they need, when and where they need them, without financial hardship**. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

An international consensus on the meaning of UHC has developed gradually over the years, notably at landmark events like the 1978 Alma-Ata Declaration, the WHO's 2010 World Health Report and the 2015 "Agenda for Sustainable Development," which included a target to achieve universal health coverage for all by 2030.

The commitment to achieve UHC by 2030 was strongly reaffirmed in a high-level political resolution adopted by the UN General Assembly in the autumn of 2019, which occurred just a few weeks before the first outbreak of COVID-19.

Even before the pandemic, ensuring non-discriminatory access to essential health services should have been of paramount importance for all countries. However, the case for taking seriously the pursuit of UHC, both as a right and as a collective moral obligation, has been made even more patent by the global experience of COVID-19.

How many lives would have been saved, how much human suffering would have been avoided, and what economic and social losses would have been prevented, if more countries had made more progress towards UHC by early 2020?

This question cannot be answered, but the painful experience of COVID-19 has made it even more critical to achieve UHC to better prepare for and respond to the future pandemics which will undoubtedly come.

The importance of UHC to people and communities goes beyond safeguarding people's health. It is also an essential element of a prosperous society, as well as a driver of social justice, human rights and inclusive economic growth.

In addition, UHC can be one of the essential components of a substantive and consequential social contract between the people and the government of a nation that underpins the feasibility and legitimacy of broader transformative reforms.

Yet the question remains whether most countries – notwithstanding the purported willingness of their societies and governments – were, are, or will be on the right course to attain UHC.

The 2019 UN Declaration on UHC endorses a focus on service accessibility; equitable distribution of essential medicines and technologies; increases in overall health funding; protection from financial burden; the rights of vulnerable groups; growth of the health workforce; and strong health system governance.

All these actions are indeed necessary, but are not alone sufficient to be on the right track to equitable, inclusive and sustainable UHC. A host of constraints and other complex challenges must be overcome.

Each country's history; capacities, present and future; and political willingness of its leaders, will influence decisively the particular design and construction for an equitable, inclusive and sustainable way to UHC.

The commitment to UHC involves a series of intricate policy decisions – some politically very challenging, even with significant income redistribution consequences.

Although there are many options within each of these sets of decisions, all of which entail trade-offs, only some of the options will support a path toward achieving the goals of equity, inclusiveness and sustainability inherent to UHC.

Fortunately, there is now a wealth of evidence and knowledge about the key features that will take countries closer to a system that provides truly universal, equitable health coverage.

Consequently, there is a substantial opportunity to take stock and distil the global experience and practical knowledge gained over the past several decades of working toward UHC, and with a broader human development, economic, and political perspective.

With this in mind, The Elders and the Yale Center for the Study of Globalization (YCSG) have endeavoured to synthesise that experience and knowledge into a set of concise criteria, principles or precepts indispensable for developing strategies and policies to advance countries unequivocally towards UHC.



A mother and child at a health center in Bangladesh. Photo: Rafiue Qadigir Alleyne / World Bank

PRECEPT 1

GENUINE UNIVERSALITY

The commitment to Universal Health Coverage must be unequivocal. Effective universality must be ensured. There can be no room for nuances that could allow for any form of economic and social exclusion or discrimination.

PRECEPT 2

EFFECTIVE AND EQUITABLE UNIVERSAL INSURANCE[1]

UHC requires effective and equitable universal social insurance. Provided the pertinent governance is effectively put in place, social insurance is best organised through a nationally consolidated institution that insures into a single pool all individuals and purchases on their behalf the needed health services.

PRECEPT 3

PRIMACY OF PUBLIC FINANCING FOR UHC

A system of public and prepaid financing from general taxation is best to achieve and sustain UHC. Furthermore, with this form of financing, UHC will contribute to fostering economic development with more and better paid jobs, not informal and precarious ones.

PRECEPT 4

EFFICIENT DELIVERY OF QUALITY HEALTH SERVICES

UHC requires a well-organised, adequately regulated, seriously supervised and fully accountable system of providers of the needed – people-centred and high-quality – services. Ultimately, the system should consist of a multiplicity of both public and private providers, all subject to precise and homogeneous standards of quality and accreditation. Competition among providers – with transparent and fair rules – to supply the services demanded by the single insurer/purchaser on behalf of the beneficiaries of UHC, should be a key feature of the system in order to foster efficiency, quality and innovation. Governments must have the pertinent policies to train, recruit, retain and retrain regularly the competent, committed and motivated health professionals required by the UHC system.

PRECEPT 5

PROGRESSIVE REALISATION OF UHC

In practice, because of resource constraints no country can achieve UHC immediately but a path to achieve it progressively should be determined and pursued from the outset. Achievement of UHC, even if done progressively, is dependent on creating the conditions for accomplishing dynamic economic growth along with inclusive, equitable and sustainable development, as well as effective rule of law.

[1] The term "insurance" is used herein in its broader meaning (a means of guaranteeing protection or safety) not its narrower standard commercial meaning.



Graça Machel and Ricardo Lagos visit a health centre in Ethiopia, 2019. Photo: Kora Image

PRECEPT ONE
GENUINE UNIVERSALITY

The commitment to Universal Health Coverage must be unequivocal. Effective universality must be ensured. There can be no room for nuances that could allow for any form of economic and social exclusion or discrimination.

The WHO Constitution expressly articulates the principle that access to health care is a fundamental right. This means that exclusion of any individual, whether explicit or implicit, is unacceptable.

Consequently, universality means that the necessary health care services are afforded to all persons, unequivocally and without favouritism.

The principle was operationalised by the WHO into the concept of UHC, i.e. a system that provides all people with access to needed health services of sufficient quality to be effective – including prevention, promotion, treatment and rehabilitation – and ensures that the use of these services does not expose the user to financial hardship.

This definition has three crucial elements that are deeply consequential:

- UHC must be for all people.
- UHC provides the needed health services at sufficient quality.
- UHC entails insurance for all – constituted either formally or not formally as an insurance plan – that guarantees access to those services without any risk of financial distress.

The term "insurance" is used here in its broadest meaning – the means of guaranteeing protection or safety – not the narrow commercial one. The concept used in this Charter also encompasses systems that are not denominated or constituted formally as standard insurance plans, for example the models operating in Sweden and the United Kingdom. Regardless of whether the insurance arrangement is implicit or explicit, the important thing for UHC is to remove financial barriers and assure that everyone is protected from financial distress .

Yet many existing health policies, even in systems that purport to adhere to the principles of UHC, may often explicitly exclude some groups for practical, fiscal or political reasons.

For example, the principles of equity and inclusivity under UHC are violated when, for any reason including budgetary ones, health insurance schemes permanently exclude, or cover only partially, informal workers -- usually a large and vulnerable group. Instead, **informal workers must have the same right to insurance and access to health services as formal, well-organised workers**.

Explicit exclusions may also be politically motivated, such as when policies permit entitlements only to citizens and legal immigrants, leaving others without those benefits. Undocumented migrants represent a uniquely vulnerable sub-group, experiencing particular barriers to health related to their background as well as insecure living and working conditions. **UHC implies that health needs must be met regardless of migrant status**.

Implicit exclusions occur when coverage does not match certain specific needs, or when physical or cultural barriers and discriminatory attitudes and practices are allowed to persist that effectively limit access to the care that is needed. Inequities and cultural practices related to stigma around disease, such as HIV/AIDS and mental health, are a source of implicit exclusion, as are inequities and cultural practices related to gender discrimination. Although women may not be explicitly excluded from coverage, they are implicitly excluded when the benefits package does not cover those conditions that are unique to women and often represent their most pressing health needs.

The principle is also violated when the elderly and disabled populations suffer from implicit exclusions. Even in well-performing health systems, people with disabilities do not have their needs properly recognised and face several obstacles, like financial and cultural barriers, including misconceptions about disabilities as well as access to buildings and lack of transportation.

Health inequity and exclusion cannot be solved within the health system alone. Better anti-discrimination and civil rights laws with proper enforcement, are also a necessary, although not sufficient, step to achieve the equity and inclusiveness in UHC. More active citizen and civil society engagement against discrimination is also needed.

Fundamentally, realising the right to health requires progress on health care as well as on the underlying determinants of health. This requires attention to the broad, community-wide focus on the essential social and economic conditions in which people live, not just to the immediate needs of any one individual.



Gro Harlem Brundtland and Ricardo Lagos visit a hospital in South Africa, 2019

PRECEPT TWO
EFFECTIVE AND EQUITABLE UNIVERSAL INSURANCE

UHC requires effective and equitable universal social insurance. Provided the pertinent governance is effectively put in place, social insurance is best organised through a nationally consolidated institution that insures into a single pool all individuals and purchases on their behalf the needed health services.

UHC means that **every individual must have access to and insurance for needed health services, irrespective of that individual's particular health and economic situation**.

This means that **UHC is first and foremost about providing insurance to every individual in the country**.

This universal insurance, which can be explicit or implicit – in other words, a formal or not formal insurance plan, is an indispensable element of a genuine UHC system.

For UHC to exist, insurance must be compulsory for all; but this requires that the cost of insurance, for those in society who cannot afford it, must be subsidised by the rest.

Voluntary insurance should be avoided; poor people will not take it because invariably they cannot afford it.

Those who are more prosperous will also tend not to join a voluntary system, precisely to avoid sharing the risks – health and financial – of the worse off in the population. This kind of outcome is known as **"adverse selection"** and constitutes a key conundrum that must be solved in the process of building a UHC system.

The most effective way to prevent adverse selection is to make it **legally mandatory for all individuals to have health insurance**, with the proviso of subsidising the premium of those who cannot pay for it. Nearly all countries that have achieved population coverage of 90 percent or higher have legally mandated participation in health coverage.

Clearly, compulsory participation would not be fair or feasible for the poor without subsidies to make participation affordable. **Subsidisation is therefore an essential element of UHC policies** to ensure the full and equitable inclusion of the poor in the health system.

A national pool with all risk shared and the burden distributed across the entire population provides the highest degree of predictability, risk-sharing, and equity.

With one insurer, it is easier to regulate and enforce the equal protection included by the UHC system at any given time.

One single insurer would also have the capacity to effectively supervise the services delivered by each provider to ensure they comply in quantity and quality with UHC standards. This constitutes a powerful instrument to fix a "market failure" practically immanent to the demand and supply of health services.

The failure is the one of "asymmetric information": that is, information held, on the one hand, by patients and, on the other, by the providers of the health services. In health care, due to asymmetry of information, **patients do not have the knowledge to be an effective purchaser**.

A single insurer/purchaser not only offers a better capacity to guarantee the quality of the product (the needed health services) but also, very importantly, it provides **market power** to acquire it at a cost lower than would be the case in a system with multiple insurance pools.

Unlike other markets for goods and services, health care must be regulated, both on its supply and demand sides, to make sure that it achieves its health objectives, certainly its UHC aspirations.

A single entity, properly financed and governed, should be able to stimulate a competitive and cost-effective provision of the UHC benefits that can be financially sustained and enhanced over time.



Ernesto Zedillo and Gro Harlem Brundtland visit a health centre in Indonesia, 2017
Photo: Agoes Rudianto

PRECEPT THREE
PRIMACY OF PUBLIC FINANCING FOR UHC

A system of public and prepaid financing from general taxation is best to achieve and sustain UHC. Furthermore, with this form of financing, UHC will contribute to fostering economic development with more and better paid jobs, not informal and precarious ones.

If compulsory participation and subsidisation are indispensable to achieve true UHC, then **any voluntary contribution or payment, certainly out-of-pocket payments at the time of service, should be discarded** as coherent and legitimate sources of financing.

The case for eliminating out-of-pocket payments for health services at the time of delivery is overwhelming. This form of health financing discriminates, first and foremost, against the poor, who will either forego necessary treatment for lack of means to pay for the service, or suffer a catastrophic impact by paying a large share of their modest income to get the needed services.

Public funding is the most equitable and efficient path toward the progressive realisation of UHC.

Given that public funding is essential to achieve equitable and sustainable UHC, **governments are faced with pressure to match political commitments to UHC with fiscal commitments**. This requires prioritising health within the budget and taking on the political obstacles to freeing up fiscal space, and ultimately improving overall revenue collection to secure adequate funding for UHC and other government priorities.

The obvious link between UHC and economic development consists of the benefits that countries derive when their populations have broad access to high quality health services.

However, there are other links that if ignored and left unattended may unduly limit the positive economic benefits from a healthier labour force. These links are associated with the **dependency of access to health insurance on employment status and the mechanisms used to finance UHC**. These links are relevant to all countries, but are particularly important in developing ones with large informal sectors.

In order to maintain the UHC principles of fairness and equity, it is essential that all citizens' financial contribution to the system – either through taxation or combined with specific mandatory contributions for insurance – are unrelated to an individual's medical circumstances and risks, or employment status. Funding health from public resources is the only way to meet these criteria, and as such, public funding is the most equitable and efficient path toward the progressive realisation of UHC.

Many countries have historically funded UHC through earmarked payroll taxes, largely because of the historical connection between health protection and labour. **Payroll tax-funded coverage, however, creates the dual problem of distortions in the labour market and often explicit exclusions of those not employed in the formal labour market.**

Employer-based health insurance may generate "employment lock," "job lock" or "entrepreneurial lock." When a country moves away from employer-based health insurance, studies show that occupational mobility increases and, in some cases, it enables workers to move into better and higher paid jobs.

Lower formal employment will translate into a combination of more informal employment and higher unemployment, a mix that depends very much on country characteristics. The key point is that **reduced formal employment will hurt economic performance**, since most studies show that informal jobs are on average less productive and consequently worse paid than formal ones.

Informal workers pose **difficult trade-offs** for governments seeking UHC. Because these workers will never be covered if health services are funded only from payroll taxes, many countries have created **parallel systems of health service provision** funded from general taxation. The result is a segmented health system.

Parallel and distinct mechanisms to provide health services to workers cause smaller and thus insufficient risk-pooling along with higher administration expenses, making the overall system costlier. In general, services for formal workers are better than for informal ones, thus betraying the objective of equity inherent to genuine UHC articulated in Precept One.

The combination of population aging and the epidemiological transition will put increasing pressures on health systems everywhere in the world. Additionally, despite its central importance to social welfare, health competes with other priorities for resources.

UHC requires public funding to avoid out-of-pocket expenditures, ensure mandatory participation, prevent adverse selection, and make the pooling of risks through the largest possible population. For coverage to be truly universal, entitlement must be de-linked from employment, and from direct contributions more generally.

Equity and efficiency considerations jointly support the proposition that UHC needs to be mostly funded from general tax revenues.



Ban Ki-moon, Ricardo Lagos and Mary Robinson visit Zuckerberg San Francisco General Hospital in California, 2018

PRECEPT FOUR
EFFICIENT DELIVERY OF QUALITY HEALTH SERVICES

UHC requires a well-organised, adequately regulated, seriously supervised and fully accountable system of providers of the needed – people-centred and high-quality – services. Ultimately, the system should consist of a multiplicity of both public and private providers, all subject to precise and homogeneous standards of quality and accreditation. Competition among providers – with transparent and fair rules – to supply the services demanded by the single insurer/purchaser on behalf of the beneficiaries of UHC, should be a key feature of the system in order to foster efficiency, quality and innovation. Governments must have the pertinent policies to train, recruit, retain and retrain regularly the competent, committed and motivated health professionals required by the UHC system.

The universality principle of UHC is aspirational for many countries and may not be immediately feasible given constraints. These countries should prioritise their investments in UHC and make step-by-step progress over what may take a number of years – i.e. **progressive realisation** of UHC.

With progressive realisation, a UHC framework is stated explicitly as an over-arching goal for universal population coverage, starting with a comprehensive essential service package provided in a way that does not present any risk of financial hardship for any user. Certain population groups or services should be included rapidly, but with a clear strategy to expand towards universality as fiscal and other resource constraints ease.

It is crucial, though, to define at the outset the elements of the system that must be universal from the beginning, such as data systems comprising all patient activity, the planned trajectory of unified benefits and of core public health functions to be organised on a system-wide basis. Along the same lines, it is important to state as soon as possible the path for the progressive universalisation of services for key communicable diseases and in general basic primary care.

Once a country has unequivocally taken the political decision to pursue and achieve UHC, robust planning for transiting from its available health system to the one that will deliver UHC must be undertaken.

It is important to stress, again, that simply advancing in the provision of health services and reducing the financial stress stemming from their use may not imply progressive realisation of UHC. Just extending coverage for some and even reducing financial risk, if not done with a view, and clear strategy, to achieve universality (as defined in Precept One), may in fact deviate from its progressive realisation.

Progressive realisation of UHC recognises that fiscal and other capacities are limited and prioritisation is required. Unquestionably it is necessary to clearly target certain groups, like the poorest of the population, for the provision of health services, but it should be done without deepening the fragmentation of the health system because this would make it even harder to eventually consolidate the system as required by UHC.

Progressive realisation demands explicit commitments from the government, with mechanisms to hold it accountable for progress. First, the government is obliged to develop, and constantly update, plans, policies, and processes to ensure the path is clear for maintaining progress toward UHC commitments. Second, the government must allocate more resources to UHC as the budget envelope increases, and make the most effective use of those resources. And very importantly, the government has the obligation to protect UHC progress even during times of crisis.

Information about government decisions and actions for the progressive realisation of UHC should be transparent and accessible via freedom of information laws. The public's role is to actively hold the health authorities accountable; and institutions, such as Ombuds offices, courts and other independent review mechanisms, are required to enforce health rights in practice.

Given the importance of understanding the personal experiences of vulnerable people in accessing needed care, the information used for policy decisions should include qualitative measures. Participatory models are needed that involve representation for all citizens, particularly members of vulnerable populations, in policy development and decision-making processes at all levels.

The progressive realisation of UHC in any particular country will depend critically on whether progress is consistently pursued and achieved in other crucial aspects of its development. A stagnant or sluggish economy will make it much harder, or even impossible, for the state to obtain the resources needed to advance towards UHC through general taxation.

Achieving UHC and the economic and social conditions it enables also need effective rule of law, including respect for the principle of equality before the law.

All the reforms needed to enable a successful strategy to achieve UHC, and with it a prosperous and equitable economy, transit through the formation of solid and effective institutions. As countries and their political leaders commit to seriously go after UHC they also do so to achieve an even greater good: sustained, sustainable and inclusive development. This and its essential component, UHC – Amartya Sen's affordable dream – will be the prize for embracing this undertaking.



Gro Harlem Brundtland speaking at the UN General Assembly Seventy-fourth session high-level meeting on Universal Health Coverage, 2019
Photo: UN Photo/Kim Haughton

PRECEPT FIVE
PROGRESSIVE REALISATION OF UHC

In practice, because of resource constraints no country can achieve UHC immediately but a path to achieve it progressively should be determined and pursued from the outset. Achievement of UHC, even if done progressively, is dependent on creating the conditions for accomplishing dynamic economic growth along with inclusive, equitable and sustainable development, as well as effective rule of law.

The universality principle of UHC is aspirational for many countries and may not be immediately feasible given constraints. These countries should prioritise their investments in UHC and make step-by-step progress over what may take a number of years – i.e. **progressive realisation** of UHC.

With progressive realisation, a UHC framework is stated explicitly as an over-arching goal for universal population coverage, starting with a comprehensive essential service package provided in a way that does not present any risk of financial hardship for any user. Certain population groups or services should be included rapidly, but with a clear strategy to expand towards universality as fiscal and other resource constraints ease.

It is crucial, though, to define at the outset the elements of the system that must be universal from the beginning, such as data systems comprising all patient activity, the planned trajectory of unified benefits and of core public health functions to be organised on a system-wide basis. Along the same lines, it is important to state as soon as possible the path for the progressive universalisation of services for key communicable diseases and in general basic primary care.

Once a country has unequivocally taken the political decision to pursue and achieve UHC, robust planning for transiting from its available health system to the one that will deliver UHC must be undertaken.

It is important to stress, again, that simply advancing in the provision of health services and reducing the financial stress stemming from their use may not imply progressive realisation of UHC. Just extending coverage for some and even reducing financial risk, if not done with a view, and clear strategy, to achieve universality (as defined in Precept One), may in fact deviate from its progressive realisation.

Progressive realisation of UHC recognises that fiscal and other capacities are limited and prioritisation is required. Unquestionably it is necessary to clearly target certain groups, like the poorest of the population, for the provision of health services, but it should be done without deepening the fragmentation of the health system because this would make it even harder to eventually consolidate the system as required by UHC.

Progressive realisation demands explicit commitments from the government, with mechanisms to hold it accountable for progress. First, the government is obliged to develop, and constantly update, plans, policies, and processes to ensure the path is clear for maintaining progress toward UHC commitments. Second, the government must allocate more resources to UHC as the budget envelope increases, and make the most effective use of those resources. And very importantly, the government has the obligation to protect UHC progress even during times of crisis.

Information about government decisions and actions for the progressive realisation of UHC should be transparent and accessible via freedom of information laws. The public's role is to actively hold the health authorities accountable; and institutions, such as Ombuds offices, courts and other independent review mechanisms, are required to enforce health rights in practice.

Given the importance of understanding the personal experiences of vulnerable people in accessing needed care, the information used for policy decisions should include qualitative measures. Participatory models are needed that involve representation for all citizens, particularly members of vulnerable populations, in policy development and decision-making processes at all levels.

The progressive realisation of UHC in any particular country will depend critically on whether progress is consistently pursued and achieved in other crucial aspects of its development. A stagnant or sluggish economy will make it much harder, or even impossible, for the state to obtain the resources needed to advance towards UHC through general taxation.

Achieving UHC and the economic and social conditions it enables also need effective rule of law, including respect for the principle of equality before the law.

All the reforms needed to enable a successful strategy to achieve UHC, and with it a prosperous and equitable economy, transit through the formation of solid and effective institutions. As countries and their political leaders commit to seriously go after UHC they also do so to achieve an even greater good: sustained, sustainable and inclusive development. This and its essential component, UHC – Amartya Sen's affordable dream – will be the prize for embracing this undertaking.

This publication is an abridged version of the document, *Charter for Equitable, Inclusive and Sustainable Universal Health Coverage*, prepared at the Yale Center for the Study of Globalization under the direction of a member of The Elders, Ernesto Zedillo. The Associate Director of the Center, Haynie Wheeler, contributed to the planning, organisation and execution of the study, which can be found at https://ycsg.yale.edu/universal-health-coverage. Proper acknowledgements of experts consulted and authors of working papers, as well as the relevant bibliography, are available in the same link. However, special recognition must here be given to Cheryl Cashin whose expertise and thoughtful observations are reflected throughout the document and who was herself the author of various working papers. Also of critical importance were the contributions of ideas by Santiago Levy and Joseph Kutzin. Financial support for the realisation of the study by the Rockefeller Foundation and Citi is gratefully recognised.

> **The Elders can speak freely and boldly, working both publicly and behind the scenes.**
>
> **They will reach out to those who most need their help.**
>
> **They will support courage where there is fear, foster agreement where there is conflict and inspire hope where there is despair.**
>
> **Nelson Mandela**, 2007, Founder of The Elders

The Elders

theElders.org

Follow The Elders:

- twitter.com/theelders
- facebook.com/theelders
- instagram.com/theelders_org
- youtube.com/user/theeldersorg
- linkedin.com/company/the-elders-foundation

The Elders Foundation

3 Tilney Street, London, W1K 1BJ +44 (0) 207 013 4646

Registered charity in England and Wales. Reg. No. 1132397

Published in December 2022 :· Designed by coastline.agency

SRA2

Healthcare Expenditure and Its Impact on Economic Growth: A Case Study of Jordan



Ibrahim Khrais and Anas Mahmoud Ali Suleiman

Abstract There is a near-unanimous view in current socioeconomic discourse that allocating public expenditure to health care expenditure is a top priority. In this article, we examine the causal relationship between health care expenditure and economic growth. This connection is multi-faceted, as it is a driver of economic growth and is a fundamental moral calling that requires greater resources to be spent on improving health care expenditure. Moreover, the importance comes from the fact that health care expenditure is part of broader economic policy. We therefore define this association in a broader perspective, taking into account the direction of causality, and then approach this association through an applied modeling approach. Our case study approach aims to explain these causal relationships through evidence. In doing so, we will show that the causal analysis we have performed can be applied to improve health care expenditure and thus improve economic growth more generally. The benefits are not only defined, but also clearly defined. The results indicate that, in general, the direction of the relationship is from health care expenditure to economic growth. This means that increasing the level of health care expenditure leads to a higher standard of living. Our empirical exercise shows that each 1% increase in health care expenditure will result in a 0.5% increase in gross domestic product (GDP). This study concludes that the country should pay attention to increasing the level of health care expenditure by allocating more funds to invest in health care infrastructure. In addition to the current pressing concerns about unemployment and slow economic growth, this study also suggests that improving health care expenditure will accelerate economic growth. The recommendations apply to any country with similar socio-political arrangements.

I. Khrais (✉)
Department of Business Administration, Zarqa University, Zarqa, Jordan
e-mail: ikhrais@zu.edu.jo

College of Business Administration, University of Business and Technology, Jeddah 21448, Saudi Arabia

A. M. A. Suleiman
Economics Department Student, Zarqa University, Zarqa, Jordan

© The Author(s), under exclusive license to Springer Nature Switzerland AG 2024

A. Hannoon and S. Reyad (eds.), *Frontiers of Human Centricity in the Artificial Intelligence-Driven Society 5.0*, Studies in Systems, Decision and Control 226,
https://doi.org/10.1007/978-3-031-73545-5_81

Keywords Healthcare · Expenditure · Economic Growth · Jordan

1 Introduction

When it comes to the allocation of public funds, healthcare expenditure deserves the heightened attention it receives. It is widely recognized that healthcare expenditure is a critical aspect of public expenditure. The significance of prioritizing public expenditure on healthcare is evident for two key reasons. Firstly, in order to implement the most effective policies, it is essential to allocate limited public resources towards well-defined objectives. Secondly, healthcare plays a crucial role in promoting well-being and driving economic development, while also serving as a moral imperative that demands equitable distribution. Furthermore, the implications of appropriately allocating healthcare funds extend far beyond its immediate impact. Not only is healthcare the largest sector of public expenditure, but it also lacks viable alternatives in both the short and long term. Lastly, strategic and efficient allocation of public funds towards healthcare can yield substantial short-term improvements in overall well-being.

For the foreseeable future, the significance of healthcare expenditure in local economic development will persist due to the absence of viable alternatives and the potential consequences for social care. The objective of this article is to specifically emphasize the interrelated impact of healthcare expenditure on prosperity and economic growth in Jordan.

1.1 Study Significance

The significance of this study lies in both its theoretical and practical implications. Theoretically, it highlights the crucial role of the healthcare sector in today's economic landscape. From a practical standpoint, it argues that the healthcare sector, considered as a fundamental component supporting the ethical and epistemological foundations of production methods (productive health expenditure) and as a central element of the healthcare system in terms of service offerings (productive health consumption), can serve as a catalyst for robust economic growth and the fulfillment of essential public needs. Furthermore, it emphasizes that healthcare expenditure and investment should not be viewed as isolated fiscal actions, but rather as integral elements of state economic policy. Lastly, the study underscores the value of an applied model as a valuable tool for comprehending the intricate nature of healthcare expenditure and its impact on the trajectory of economic growth. Without a comprehensive understanding of the multidimensional aspects and consequences of healthcare expenditure, policymakers may overlook its importance due to its high cost and status as a budgetary item.

1.2 Study Objectives

- The study seeks to comprehend the actuality of healthcare expenditure in Jordan and its contribution to attaining economic growth.
- Utilizing quantitative methods, a model can be developed to depict the correlation between healthcare expenditure and economic growth.
- In order to ensure the accuracy of the model and analyze the findings, it is necessary to conduct thorough testing and validation.

1.3 Study Problem and Its Elements

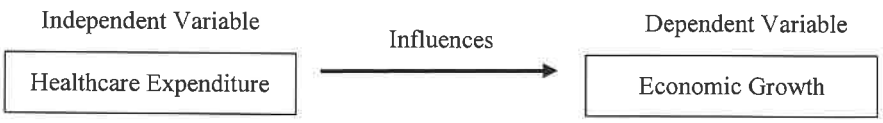
The problem of the study revolves around posing the following main question:

- Can directed public expenditure on the healthcare sector in Jordan lead to an increase in economic growth?
- This main question gives rise to the following sub-questions:
- Is there a causal relationship between expenditure on the health sector and economic growth?
- What is the direction of the relationship between healthcare expenditure and economic growth?

1.4 Study Hypothesis

In studying the impact of directed public expenditure on the healthcare sector in achieving economic growth in Jordan, the null hypothesis (H0) states that there is no statistically significant effect, with a significance level ($P \geq 0.05$).

1.5 Study Model



1.5.1 Type and Nature of the Study

The primary objective of this study is to analyze the intricate connection between healthcare expenditure and its influence on economic growth. By employing both quantitative and applied methodologies, the study aims to enhance our understanding of the relationship between these two conceptual variables. This research endeavors

to bridge the gap between theory and reality, providing valuable insights into the causal links between healthcare expenditure and economic growth in the Jordanian context. By examining the impact of investments in the health sector on various macroeconomic indicators, this study highlights the potential for significant societal impact. The findings of this research not only contribute to our understanding of this issue but also provide policymakers with the necessary information to make informed decisions and drive economic development in the region.

2 Theoretical Framework

- Concept of Health: The idea of health is universally sought after, as no one desires to be without good health. According to the World Health Organization, good health encompasses both physical and mental well-being, extending beyond the mere absence of illness or imbalance [1]
- Health Economics: Health Economics is a field within economics that examines the application of economic principles to healthcare, making it easier to analyze and understand. It offers guidelines for assessing whether these applications improve or diminish the effectiveness and equity of healthcare distribution [2].
- Health Expenditure: The allocation of funds towards healthcare is widely recognized as a vital public expenditure, serving as a cornerstone in the well-being of individuals within society. Moreover, it acts as a catalyst to stimulate economic growth and promote various activities in a country's economy, especially those related to the health sector [3].
- Individual Share of Health Expenditure: The health care spending index is an important parameter used to evaluate and compare health care spending. The activity is necessary to conduct a health care expenditure study and evaluation and will be used during the period of research on the health care sector [3].
- Impact of Health on Economic Activity and Its Significance: The significance of health and its impact on economic activity cannot be overstated. Health and the expenditure associated with it play a pivotal role in shaping the growth and productivity of a nation. The connection between an individual's health status and their ability to contribute to the economy is both logical and undeniable. A society that prioritizes and promotes good health among its citizens is more likely to experience robust economic growth. Conversely, societies plagued by the prevalence of diseases or inadequate healthcare face the grim reality of hindered economic progress [2].

  Figure 1 illustrates healthcare expenditure by region (billion dollars).

- Economic Growth: The examination of economic growth has held a prominent position in the examination of economic existence and operations. The expansion of Gross Domestic Product (GDP) acts as a metric to illustrate the rise in the

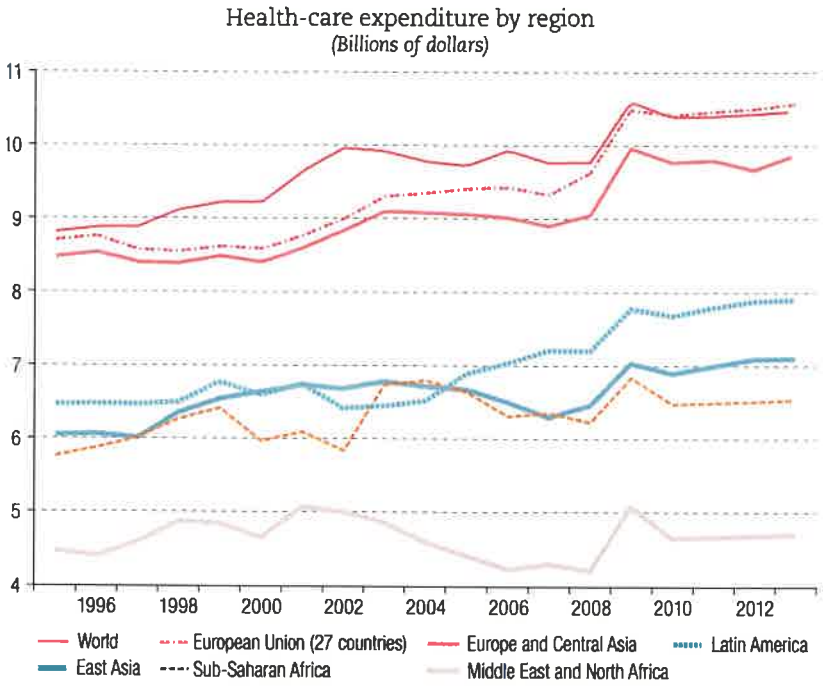


Fig. 1 Healthcare Expenditure By Region (Billion Dollars) *Source: Health-care expenditures, economic growth and infant mortality: evidence from developed and developing countries Abdelhafidh Dhrif

manufacturing of commodities and services within a particular nation during a designated timeframe. François Perroux characterized economic growth as the "continuous increase in real gross or net income" [4].

- Investment in the Health Sector and Economic Growth: Contrary to outdated beliefs that label the health sector as non-productive and separate from economic growth, it actually plays a vital role in both economic activity and society as a whole. Investing in the health sector not only benefits economic activity but also fulfills the needs of the community [15]. The impact of health on the economy can be seen directly and indirectly. Directly, it involves analyzing healthcare expenditures and how they contribute to economic activity. Indirectly, it involves recognizing the value of human capital and the impact of a healthy workforce. This highlights the significant role of the health sector in driving economic growth, particularly in times of economic challenges such as inflation, recession, and global crises [5, 6].

2.1 Previous Studies

- Mushkin (1962): The primary objective of this study was to emphasize the significance of allocating public funds towards healthcare as a catalyst for economic advancement. The findings of the study indicated that investing in healthcare, which can be viewed as a form of capital, has the potential to stimulate higher rates of economic growth. As a result, the study recommended a boost in targeted expenditure on the healthcare sector [7, 14].
- Grossman (1972): Building upon Mushkin's concepts, Grossman conducted a study with the objective of expanding and refining his ideas. The study ultimately established that health can be equated to a form of capital, constructing a framework that treats good health as a durable asset. As a result, the study emphasized the importance of strategically investing in the well-being of individuals [8].
- Barro (1996): The objective of this study was to construct economic growth models that integrate human capital. The findings of the study indicated that augmenting health expenditure, or health capital, leads to an elevation in overall health, thereby positively influencing growth rates. Furthermore, the study proposed enhancing various components of physical human capital, such as health expenditure and general education levels, as a means of improvement [9].
- Bouhousi Majdoub, Suleiman Elias, and Aress Ammar Study (2017): During the period of 1995-2013, an analysis was conducted to examine the cause-and-effect connection between health sector expenditure and economic growth in Algeria. The findings of the study revealed that the relationship between economic growth and overall health expenditure was unidirectional, with economic growth influencing health expenditure rather than the reverse. In light of these results, the study proposed the importance of diversifying the economic framework through the establishment and promotion of value-added production initiatives. By doing so, health expenditure can effectively contribute to the growth process by enhancing individual productivity [10].
- Aïcha Infal and Fatima Zrawat Study (2021): The primary objective of this study was to examine the impact of health expenditure on economic growth. The findings of the study revealed that individuals who enjoy good health exhibit enhanced work performance and productivity. Consequently, the study strongly advocated for a collaborative effort between the public and private sectors to bolster the significance of health in attaining optimal growth rates [11].
- Zohia Lmoushi Study (2022): The objective of this study was to analyze the influence of health economics on the gross domestic product of Algeria from 2000 to 2020. The findings of the study revealed a correlation between the gross domestic product and health economics, leading to the recommendation of promoting investments in the healthcare industry, augmenting expenditure, and ensuring equitable allocation of financial resources within the healthcare sector [12].

2.2 Study Methodology

The chosen research methodology involves structuring the study as a case study, which allows for a comprehensive examination of the qualitative analysis of a specific context, specifically Jordan. This approach enables a closer investigation of the unique features and characteristics of the context that may impact the relationship between health care expenditure and economic growth. By employing a case-based inquiry strategy, the main objective is to determine the direction and nature, if any, of the causal relationship between health care expenditure and economic growth within the specific institutional, political, and economic framework of Jordan. In addition, this study contends that it has the potential to uncover the intricate empirical details regarding the correlation between healthcare expenditure and economic growth. It offers substantial evidence and references from relevant analytical fields to support this claim. Furthermore, the study provides a comprehensive outline of the specific areas that will be explored in depth. It acknowledges the significance of various factors within the relationship, including total healthcare expenditure, per capita expenditure, different economic growth rates, policy parameters, and sociocultural foundations. Understanding these aspects is crucial in determining the nature of the relationship between healthcare expenditure and economic growth, which is not inverse but rather equitable. To fulfill its promise of a thorough analysis, the study proposes a case study approach that will allow for an examination of the causal mechanisms and dynamics. This in-depth assessment will greatly contribute to a better understanding of how health expenditure contributes to economic growth, particularly in Jordan compared to other nations.

2.3 Data Collection Methods

The data for this study were collected through the examination of various sources, including:

- Different databases
- Statistical data
- Published research
- Books and publications related to the study's topic

2.4 Statistical Methods Used

The focus of this article will be on the utilization of descriptive statistical methods to organize, comprehend, and present data. Descriptive statistics are a vital tool for effectively presenting and comprehending the unique components of a data set, exposing the fundamental characteristics of the variable being examined. Through

the implementation of these techniques, researchers can accurately represent and interpret the central tendencies, variability, and distribution patterns of variables, resulting in a concise yet comprehensive depiction of the data set. This detailed description greatly aids in extracting crucial conclusions following analysis.

2.5 *Analysis and Hypothesis Testing*

The data will then be reviewed and analyzed to evaluate and interpret the findings: the given analytical data set will be analyzed using standard measurement techniques. During this process, the predictions of equations in conventional form will be followed. An essential part of this is carefully examining the data and using well-established measurement methods. This helps ensure that the results are robust and reliable. Good researchers document the activities they undertake very carefully, which helps others reproduce their work [13].

Table 1 illustrates healthcare expenditure and Gross Domestic Product (GDP) in Jordan for the period 2000–2020.

Table 2 presents various measures according to the following:

Among these measures for both GDP/Health are the following:

GDP:

- Mean: 26.27
- Median: 27.13
- Highest level (2019): 44.50
- Lowest level (2000): 8.46

Health:

- Mean: 265.89
- Median: 298.64
- Highest level (2012): 342.94
- Lowest level (2000): 161.23

Figure 2 illustrates the time series of Gross Domestic Product (GDP) and healthcare expenditure data for the period 2000–2020.

Based on the examination of the time series data from 2000 to 2020, which illustrates the changes in public health expenditure and GDP growth in Jordan, it can be observed that both variables follow a similar pattern. This finding aligns with economic theories that propose a positive correlation between economic growth and investment in public health.

Table 3 indicates a transition to statistical analysis by transforming the data into natural logarithms.

Figure 3 represents the data spread using the best linear regression.

Table 1 Healthcare expenditure and Gross Domestic Product (GDP) in Jordan for the period 2000–2020

Years	GDP (dollar per billion)	Health expenditure per capita
2000	8.46079	161,23510742
2001	8.975812	171,82507324
2002	9.582513	175,38461304
2003	10.19563	172,24946594
2004	11.41171	186,10636902
2005	12.589	196,46897888
2006	15.05698	199,64881897
2007	17.11044	219,40531921
2008	22.65873	289,98577881
2009	24.53788	333,80767822
2010	27.1338	319,84109497
2011	29.52415	338,34609985
2012	31.63456	342,94042969
2013	34.45444	320,86730957
2014	36.84764	306,806427
2015	38.58702	303,23452759
2016	39.89255	286,503479
2017	41.60844	323,55337524
2018	43.37086	322,12417603
2019	44.50301	314,88452148
2020	43.57992	298,6446228

*Source: Compiled by the researchers using specific data from the World Bank for the period 2000–2020

Based on the figure above, it is evident that the data points are distributed in a linear fashion. As a result, the determination of the equation will rely on the principles of simple linear regression.

Simple linear regression model is estimated using the formula $y = \beta 1 + \beta 2x + u$, where:

- GDP represents Gross Domestic Product,
- C is the constant term for estimation,
- Health represents healthcare expenditure.

The estimated model is GDP = 12.619 + 2.022 HEALTH.

Table 4 provides the results of the analysis according to GDP = C(1) + C(2)* HEALTH, representing the data analysis results for healthcare expenditure and economic growth in Jordan.

Table 2 Various measures

	GDP	Health expenditure
Mean	26.27218	265.8983
Median	27.13380	298.6446
Maximum	44.50301	342.9404
Minimum	8.460790	161.2351
Std. Dev	13.23400	67.17950
Skewness	-0.034050	-0.445585
Kurtosis	1.468083	1.456116
Jarque–Bera	2.057483	2.780540
Probability	0.357457	0.249008
Sum	551.7159	5583.863
Sum Sq. Dev	3502.775	90,261.71
Observations	21	21

Source: Compiled by the researchers – Eviews

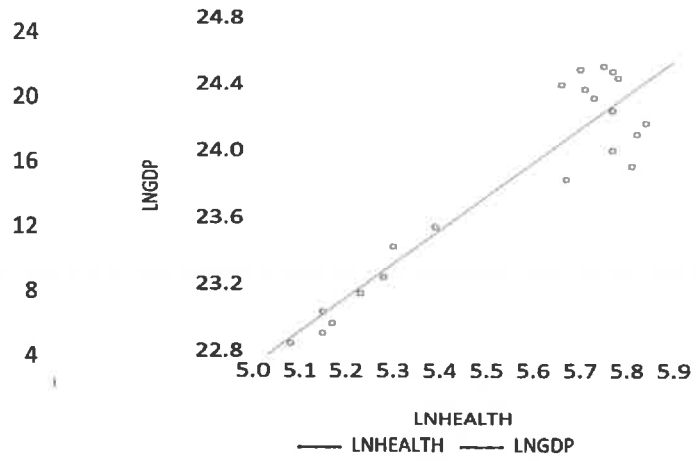


Fig. 2 The time series of Gross Domestic Product (GDP) and healthcare expenditure data for the period 2000–2020. * Source: Compiled by the researchers using EViews

According to the data presented in the table, there is a strong correlation between healthcare expenditure and Gross Domestic Product (GDP) growth. A 1% increase in healthcare expenditure is associated with a 2.02% increase in GDP. The t-Statistic, which surpasses the critical t-table value, allows us to reject the null hypothesis (H0: $\beta 2 = 0$), affirming the existence of a significant relationship between healthcare expenditure and GDP growth. Furthermore, the R2 value reveals that 86.7% of the

Table 3 A transition to statistical analysis by transforming the data into natural logarithms

Years	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
lnGDP	22.86	22.92	22.98	23.05	23.16	23.26	23.44	23.56	23.84	23.92	24.02
lnhealth	5.08	5.15	5.17	5.15	5.23	5.28	5.3	5.39	5.67	5.81	5.77
Years	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	
lnGDP	24.11	24.18	24.26	24.33	24.38	24.41	24.45	24.49	24.52	24.5	
lnhealth	5.82	5.84	5.77	5.73	5.71	5.66	5.78	5.77	5.75	5.7	

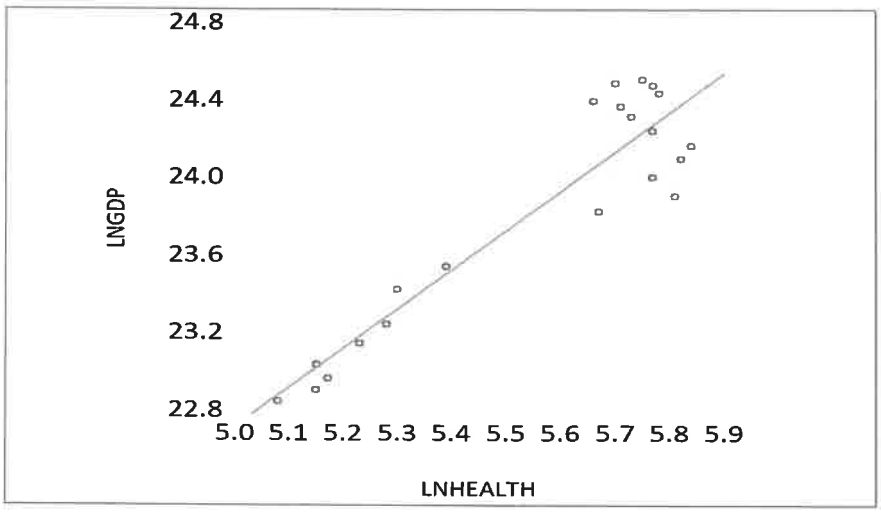


Fig. 3 The data spread using the best linear regression. * Source: Compiled by the researchers using EViews

Table 4 The results of the analysis according to GDP = C(1) + C(2)* HEALTH

Variable	Coefficient	Std. Error	t-Statistic	Prob
C	12.61934	1.009301	12.50304	0.0000
LNHEALTH	2.022088	0.181674	11.13030	0.0000
R-squared	0.867025	Mean dependant var		23.84000
Adjusted R-Squared	0.860026	S.D. dependant var		0.598356
S.E. of regression	0.223864	Akaike info criterion		−0.065167
Sum squared resid	0.952183	Schwaraz criterion		0.034311
Log likelihood	2.684256	Hannan-Quinn criter		−0.043578
F-statistic	123.8837	Durbin-Watson stat		0.373399
Prob(F-stastistic)	0.000000			

Actual	Fitted	Residual
22.8600	22.8915	-0.03154
22.9200	23.0331	-0.11309
22.9800	23.0735	-0.09353
23.0500	23.0331	0.01691
23.1600	23.1949	-0.03486
23.2600	23.2960	-0.03596
23.4400	23.3364	0.10360
23.5600	23.5184	0.04161
23.8400	24.0846	-0.24458
23.9200	24.3677	-0.44767
24.0200	24.2868	-0.26679
24.1100	24.3879	-0.27789
24.1800	24.4283	-0.24833
24.2600	24.2868	-0.02679
24.3300	24.2059	0.12410
24.3800	24.1655	0.21454
24.4100	24.0644	0.34564
24.4500	24.3070	0.14299
24.4900	24.2868	0.20321
24.5200	24.2463	0.27366
24.5000	24.1452	0.35476

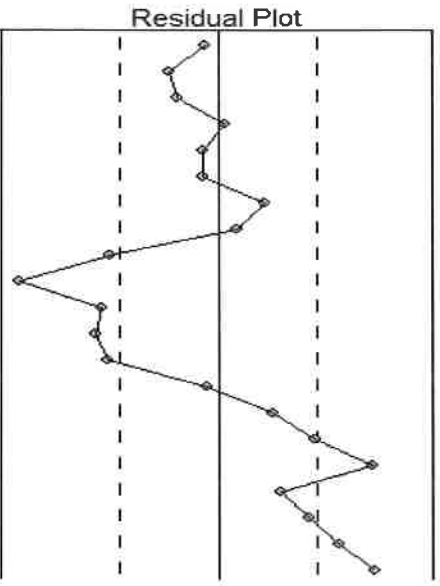


Fig. 4 The residuals for the estimated equation. Source: Compiled by the researchers using EViews

variation in GDP can be attributed to healthcare expenditure. Additionally, the F-Statistic and its corresponding probability lend support to the validity of the model.

Figure 4 illustrates the residuals for the estimated equation, confirming that the residuals align well with the conditions of a simple linear regression.

The estimation was subjected to the Durbin-Watson statistic test, which yielded a result of 0.373. This value, being closer to 0 than 2, suggests the presence of autocorrelation in the errors. Such a finding contradicts the fundamental assumptions of the Least Squares method used for estimating the equation. To address this concern and ensure compliance with the conditions of the estimation method, the "first differences" of both variables in the series will be employed to derive the final results.

The Table 5 illustrates the following:

1. In the case of a 1% increase in healthcare expenditure, the Gross Domestic Product (GDP) will increase by 0.5012%.
2. The t-Statistic resulting from the estimation equals 3.877, corresponding to a probability of 0.0011. Thus, rejecting the null hypothesis and moving to the alternative hypothesis.
3. The coefficient of determination (R2) indicates that the independent variable (healthcare expenditure) explains 45.51%, with the remaining variance attributed to other factors not mentioned in the study.
4. The adjusted R2 is 42.49%.
5. The F t-Statistic resulting from the estimation is 15.03, consistent with the probability.

Table 5 Illustrates the re-estimation based on the first differences in the series (growth rates)

Variable	Coefficient	Std. Error	t-Statistic	Prob
C	0.066460	0.011284	5.889985	0.0000
D(LNHEALTH)	0.501276	0.129262	3.877983	0.0011
R-squared	0.455185	Mean dependant var		0.082000
Adjusted R-Squared	0.424918	S.D. dependant var		0.062205
S.E. of regression	0.047173	Akaike info criterion		−3.175362
Sum squared resid	0.040055	Schwaraz criterion		−3.075789
Log likelihood	33.75362	Hannan-Quinn criter		−3.155925
F-statistic	15.03875	Durbin-Watson stat		1.790936
Prob(F-stastistic)	0.001102			

Source: Compiled by the researchers using EViews

6. In the case of healthcare expenditure being equal to 0, GDP will increase by 0.066.
7. The Durbin-Watson statistic result is 1.79, which is close to 2 and indicates no serial correlation problem.

According to this estimation, the form of the equation is expressed as:

$$\Delta(\text{GDP}) = 0.066 + 0.50\Delta(\text{HEALTH})$$

The figure above provides the following information:

1. In the case of a 1% increase in health expenditure, the Gross Domestic Product (GDP) will increase by 0.5012%.
2. The t-Statistic resulting from the estimation is 3.877, which aligns with the probability of 0.0011. Thus, the null hypothesis is rejected in favor of the alternative hypothesis.
3. The R-squared coefficient indicates that the independent variable (health expenditure) explains 45.51%, while the remaining variation is attributed to other unspecified factors in the study.
4. The adjusted R-squared is 42.49%.
5. The F t-Statistic resulting from the estimation is 15.03, which is consistent with the probability.
6. In case health expenditure equals 0, the GDP will increase by 0.066.
7. The Durbin-Watson test result is 1.79, which is closer to 2 than 0, indicating the absence of serial correlation issues.

The Jarque–Bera normality test, depicted in Fig. 5, demonstrates that residuals conform to a normal distribution. With a probability value of 0.82 exceeding the 5% threshold, it can be concluded that residuals follow a normal distribution. Furthermore, Table 6 displays the LM test for autocorrelation.

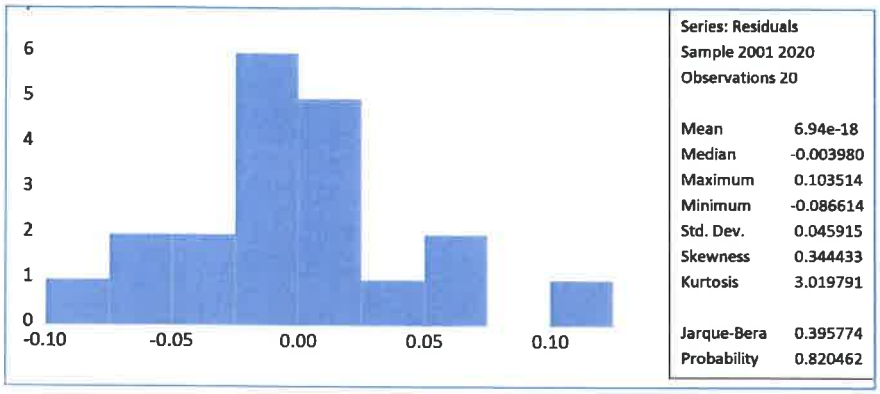


Fig. 5 the Jarque–Bera normality test

Table 6 LM test for autocorrelation

Breusch-Godfrey Serial Correlation LM Test: Null hypothesis: No serial Correlation at up to 2 lags			
F-statistic	1.719704	Prob. F(2, 16)	0.2106
Obs*R-squared	3.538593	Prob. Chi-square(2)	0.1705

Table 6 presents the LM test for autocorrelation, and based on the test results, the value of 0.21 indicates that the model is free from the problem of autocorrelation in residuals. Thus, the estimated model aligns with the least squares method.

Table 7 shows the heteroscedasticity test, and the graph above indicates that the estimation does not suffer from heteroscedasticity issues.

To address the first and second sub-questions, Granger causality will be utilized. Granger causality determines the causal relationship between variables and the direction of causality, whether it is:

1. From health expenditure to Gross Domestic Product (GDP)
2. From GDP to health expenditure
3. Bidirectional causality between health expenditure and GDP

Table 8 illustrates the Granger causality test.

The Table 8 indicates the following:

Table 7 Xxx

Heteroskedasticity Test: Breusch-Pagan-Godfrey Null hypothesis: Homoskedasticity			
F-statistic	1.673100	Prob. F(1, 18)	0.2122
Obs*R-squared	1.700901	Prob. Chi-Square(1)	0.1922
Scaled explained SS	1.366455	Prob. Chi-Square(1)	0.2424

Table 8 The Granger causality test

Null Hypothesis:	Obs	F-Statistic	Prob
D(LNHEALTH) does not Granger Cause D(LNGDP)	19	0.00263	0.9597
D(LNGDP) does not Granger Cause D(LNHEALTH)		4.18614	0.0576

1. There is no causality relationship from health expenditure to Gross Domestic Product (GDP).
2. There is a causality relationship from GDP to health expenditure.

3 Results and Recommendations

3.1 Results

- The findings of the research indicate that investment in healthcare has the capacity to positively influence the Gross Domestic Product (GDP). A mere 1% rise in healthcare expenditure can result in a 0.5% boost in GDP, thereby fostering economic expansion. This correlation is evident across a range of different contexts.
- The study established a causal link between GDP and health expenditure, indicating that changes in GDP have a direct impact on healthcare expenditure.
- The results of the estimation align with the requirements for obtaining the most accurate estimate through the Ordinary Least Squares (OLS) method, validating the influence of health and healthcare levels in contributing to GDP growth in Jordan from 2000 to 2020.

3.2 Recommendations

- Promote the growth of expenditure and investment within the healthcare industry.
- Enact a comprehensive strategy that prioritizes both economic efficiency and the fair distribution of healthcare services.
- By prioritizing the development of infrastructure that directly and significantly benefits various segments of society, we can observe tangible improvements in both the standard of living and economic growth.

References

1. The World Health Organization constitution, World Health Organization https://www.who.int/ar/about/accountability/governance/constitution

2. Dhrifi, A.: Health-care expenditures, economic growth and infant mortality: evidence from developed and developing countries. CEPAL Rev. **7**, 75–78 (2018)
3. Health Expenditure World Health Organization https://www.who.int/data/nutrition/nlis/info/health-expenditure
4. François Perroux: L'économie du XXème siècle, p. 155 (1964), France
5. Brika, S., Choug, F., Chaibainou, S.: Dynamic and causal relationship between the monetary mass, the exchange rate and inflation in algeria during (1990–2014). Zarqa J. Res. Stud. Hum. **18**(1), 17–33 (2018)
6. Al-Dhahrawi, M.: The impact of the fluctuations in the global prices of crude oil and the global financial crisis in the profitability of Jordanian transportation sector's companies. Zarqa J. Res. Stud. Hum. **20**(2), 390–401 (2020)
7. Health as an Investment, Mushkin, https://www.journals.uchicago.edu/doi/abs/10.1086/258730
8. Muurinen, M., Jaana: Demand for Health A Generalised Grossman Model J. Health Econ. **1**(1), 5–27 (1982)
9. Barro, R., Robert, J., Lee, J.-W.: International measures of schooling years and schooling quality. Am. Econ. Rev. **86**(2), 218–223 (1996)
10. Bahoussi, M., Ilyes, S., Aries, A.: Standard modeling of the causal relationship between public expenditure on the health sector and economic growth under the Vagner Act (Algeria Case Study 1995–2013). Econ. Vis. Mag. **7**(2), 13–27 (2017)
11. Dinaoui anfel Aicha, Zerouat fatma zohra: The impact of health government expenditure on economic growth in Algeria Standard study for the period (2000–2019). Econ. Environ. Mag. **4**(2), 58–85 (2021)
12. Musleh Al-Sartawi, A.M.A., Abd Wahab, M.A, Hussainey, K. (eds.): Global Economic Revolutions: Big Data Governance and Business Analytics for Sustainability, Second International Conference, ICGER 2023, Sharjah, United Arab Emirates, February 27–28, 2023, Revised Selected Papers. Communications in Computer and Information Science, vol. 1999 (2024). Springer, Cham. https://doi.org/10.1007/978-3-031-50518-8
13. Lemochi, Z.: Estimating the impact of the health economy on the gross domestic product in Algeria Applying the ARDL model for the period (2000–2020). J. Financ. Account. Adm. Stud. **9**(2), 1286–1305 (2022)
14. Al-Sawaie, K.: Principles of Econometrics, Dar AlKetab ElThaqafi, pp. 34–108 (2018). Jordan
15. Al-Sartawi, A., Al-Qudah, A., Shihadeh, F. (eds.): Artificial intelligence-augmented digital twins transforming industrial operations for innovation and sustainability. In: Kacprzyk, Janusz (ed.) Studies in Systems, Decision and Control, Vol. 503 (2024). Springer International Publishing, Cham. https://doi.org/10.1007/978-3-031-50518-8

SRA3

ABBREVIATED CURRICULUM VITAE

Nicholas Gilmour Crisp

PERSONAL DETAILS

Name	:	Nicholas Crisp (5912225014084)
Date of Birth	:	22 December 1959
Place of birth	:	Queenstown, Eastern Cape, RSA
Marital Status	:	Married (to Nicole)
Family	:	3 adult daughters and five grandchildren
Nationality	:	South African
Current Position		Deputy Director General: National Health Insurance (National Dept of Health
Home Address:		45 Buckingham 26 Lion Rd Sterrewag 0181 Pretoria and "Paddavlei farm", Vanwyksdorp, Western Cape +27 (0)82 375 3770 (mobile) nicholas.crisp@health.gov.za

ACADEMIC QUALIFICATIONS

1978 - 1983	:	MBChB - University of Cape Town
1987 - 1991	:	MMed (CH) - University of Witwatersrand
1989 - 1990	:	Dip Occupational Health - University of Witwatersrand

PROFESSIONAL REGISTRATION

Registered Non-clinical (Community Health Specialist) with Health Professions Council of South Africa

EMPLOYMENT RECORD

1983 - 1984:	South African Medical Services (SAMS) - Employed as Intern at 2 Military Hospital and later at Letaba Hospital in Gazankulu, South Africa
1985 - 1988:	Department of Health and Welfare, Gazankulu, South Africa Employed as Medical Officer at Letaba Hospital
1988:	Department of Health and Welfare, Gazankulu, South Africa Employed as Medical Superintendent of Shiluvana Hospital
1989:	Research Officer (NITD) National Institute for Tropical Diseases.
1989 - 1993:	Department of National Health and Population Development, South Africa. Employed as Regional Director, Northern and Eastern Transvaal
1993 - 31 March 1995:	Deloitte & Touche, Pretoria, South Africa Principal Consultant
01/04/1995 - 30/04/1999:	Superintendent General, (Head of Department) Department of Health and Welfare, Northern Province, South Africa.
01/05/1999 – 30/08/05:	Self Employed (Yezo Consultants CC and Edge to Edge 1291 CC)
From 01/09/2005:	Private Businesses: o Member of Yezo Investments CC

	○ Member of Edge to Edge 1291 CC ○ Executive Director: Benguela Health Group (Switzerland) ○ Managing Director: Benguela Health (Pty) Ltd (SA)
01/07/2011 – 30/10/2014:	Executive, EOH Abantu Pty Ltd (Benguela acquired)
01/11/2014 – 05/06/2021	Free-lance public health consultant
January 2017 – Aug 2019	Semi-retired Public Health consultant, small farmer and involved in community development
March 2019 – July 2019	Non-executive Director - PPO Serve (PHC company)
06/06/2021 – DATE	Deputy Director General: National Health Insurance (National Dept of Health)

HIGHLIGHTS IN PROFESSIONAL CAREER

- Facilitating the establishment of a comprehensive immunisation programme and maternal and child service in the rural areas of the South African Lowveld. (1985 to 1989)
- South African delegate to Africa Region Annual Malaria Meeting at WHO Afro, Brazzaville in March 1993.
- Invited guests to attend 2 week discussion and planning session on health reform in South Africa, held in Mexico and Cuba in August 1993.
- Assisted a prominent national non-governmental organisation, the National Progressive Primary Health Care Network (NPPHCN) with a pre-election national advocacy programme for health, developed questionnaire for political parties and evaluated responses.
- Member of a National Health Expenditure Review committee in 1994/95.
- Developed an approach to human resource policy determination and planning for health care including collaborative work on development of modelling and projection techniques for doctors on behalf of the Medical Association of South Africa.
- Facilitated establishment of the National AIDS&HIV Control Agency in Nigeria in 2004.
- Special Adviser to Minister Barbara Hogan, MP, Minister of Health South Africa 2008/09.
- Teaching and mentoring interested and committed medical students and post graduates since 2012 (ongoing).

My professional life started when I went to work at Letaba Hospital in the former Gazankulu homeland. This was the epicentre of the last polio epidemic in South Africa and I went with the hope of learning rehabilitative and reconstructive orthopaedic surgery.

During this time my experiences with the polio patients, neonatal tetanus and a massive measles epidemic amongst refugees from Mozambique drew me into immunisation, child health and the public health management required to combat preventable illnesses.

I learnt a great deal of clinical skills at Letaba Hospital and Shiluvana Hospital before becoming Regional Director for what was Northern Transvaal. In this position I learnt the politics of health first-hand and was constantly at loggerheads with my employer, primarily over the evolving policies on private health care. Eventually I resigned in September 1993 and attempted a life in a corporate consulting business. This was stressful because the company was focussed on making money and not on facilitating good health services. Fortunately, the 1994 elections brought new opportunities and in May 1994 Dr Joe Phaahla, the new MEC for Health in Northern Province (now Limpopo) asked me to return to the province and help build the services that we had been striving for in the previous dispensation. I returned on secondment as leader of the Strategic Management Team (SMT) and thoroughly enjoyed building the new integrated Department of Health and Welfare. Subsequently my application for HoD of the department was successful and I remained another 4 years in Limpopo.

Superintendent General: Department of Health and Welfare: Northern Province, now Limpopo (South Africa): 1 April 1995 to 03 April 1999

- Member of Provincial Health Restructuring Committee (PHRC) at the national level.
- Member of the Welfare Committee, Departmental Committee on Developmental Social Services (DCDSS) created at a national level for the planning and co-ordination of all social security and welfare services of all provinces.
  - *Instrumental in the introduction of a hospital facilities audit which was subsequently adopted nationally for all provinces.*
  - *Instrumental in the establishment of an out-sourced procurement, warehousing and distribution system for pharmaceuticals.*
  - *Initiated the development of a satellite medical campus in the Northern Province. Co-chairperson of Joint Management Committee (JMC) between Northern Province and the Medical University of Southern Africa, MEDUNSA.*
  - *In the 1998/99 financial year the direct financial accountability is for a budget of R3,7 billion (+/- US$ 700 million); with responsibility for a staff complement of almost 26 000 people providing*

services at 42 hospitals (12500 beds), 22 health centres and 360 clinics plus the welfare services.

- *Appointed by the Minister of Health, Dr NC Dlamini Zuma, as Chairperson of the Interim Board of the South African Institute of Medical Research (SAIMR). (01 Jan 1999 to date)*
- *Appointed by the Minister of Welfare, Ms G Fraser Moleketi, to the President's Committee for the Victims of Violence.*

I left Limpopo at the end of my contract for personal reasons and started an independent consulting business to strengthen helath services in Africa.

Self Employed Management Consultant (Yezo Consultants CC):
1st May 1999 to September 2005

- *Contracted on behalf of the Department of Health as Project Leader to restructure all of the public health sector pathology laboratories into one national parastatal. Estimated national turnover is R800m and involves about 5000 staff of SAIMR, university joint appointments and provincial departments. I had been Chairman of the Board of the SAIMR for 2 years (1997 and 1998). The end product was the* ***National Health Laboratory Services (NHLS).***
- *Contracted on behalf of the Department of Health to assist with the development of policies for the* ***appropriate evolution of tertiary health services****.*
- *Contracted by Health Systems Trust to co-edit the 1999 Health Review.*
- *Contracted by Health Systems Trust to co-edit the 2000 Health Review.*
- *Contracted by the UK-DFID (Nigeria) to perform an* ***Institutional Audit of the Federal Ministry of Health in Nigeria*** *(Sept 2000), and to advise DFID on the management of donor funding to Nigeria's health system (Feb 2001).*
- *Contracted by DFID (SA) to assess the outputs of the SA Health Know How Fund (Jan 2001).*
- *Contracted on behalf of the Department of Health to assist with the* ***development of conditional grant financing mechanisms*** *and monitoring. (May 2001).*
- *Extra-ordinary Associate Professor in Health Management, University of Pretoria, School of Health Systems and Public Health. (2000 – 2004)*
- *Contracted by the University of Pretoria and the Council for Scientific and Industrial Research (CSIR) to facilitate the drafting of a Business Plan for the establishment of an* ***Institute of Technology for Health (ITH).***
- *Contracted by the UK-based Health Partners International (HPI) to assist the Ministry of Health in Tanzania with preparing for a* ***Situation Analysis of the Laboratory Services in Tanzania****. (June 2001).*
- *Contracted by the UK-based Health and Life Science Partners (HLSP) as a Technical Assistant in their team contracted by the Department for International Development (DFID) in Nigeria to implement a* ***Change Agent Programme (CAP) and Resource Centre****. (Oct 2001 to March 2003).*
- *Contracted by* ***UNICEF Supply Division*** *in Copenhagen, Denmark, to participate as a temporary consultant during an interagency meeting with World Health Organisation, UNAIDS, Medicine Sans Frontieres to discuss supply issues related to AIDS care drugs, especially the Programme on Mother to Child Transmission (PMTCT) and antiretroviral therapy (ART). (Oct 2001).*
- *Contracted by UK Department for International Development (DFID) in South Africa as the Team Leader for the design of the new DFID assistance programme to the South African Health Department. (Nov 2001).*
- *Contracted by UK Department for International Development (DFID) in the UK to assist with the development of the* ***official DFID policy on Measles Immunisation and elimination****. (Dec2001).*
- *Contracted by Medical Care Development International (MCDI) in Washington DC to assist with a* ***World Bank Human Resources Consultancy*** *in the Ministry of Health and Social Welfare of* ***Lesotho****. (May 2002 to July 2003).*
- *Contracted by Dept of Public Service and Administration to perform an audit of the legislative changes and impact in the Health Sector in South Africa. 2002*

- *Contracted by Dept of Public Service and Administration to perform a review of the management problems in the delivery of health services in the Eastern Cape Province. 2002.*
- *Contracted by the Board of the South African National Health Laboratory Service* ***(NHLS)*** *to assume duties as* ***Acting Chief Executive Officer*** *(Nov 2002 to Aug 2003).*
- *Co-opted by DFID Nigeria as a member of an International Review Panel on "Drivers of Change in Nigeria". April 2003.*
- *Contracted by DFID Nigeria to assist with the restructuring of the* ***National Action Committee on AIDS in Nigeria****. Nov 2003 to Dec 2004.*
- *Contracted by the UK-based HLSP Consulting Partnership in the Transformation of Health Services (PATHS) to assist with services in Enugu State, Nigeria. (Dec 2003).*
- *Contracted by the UK-based HLSP Consulting Partnership in the Transformation of Health Services (PATHS) at the request of the Federal Minister of Health of Nigeria to serve on a* ***Committee for the Repositioning of the Federal Ministry of Health****. (April - July 2004).*
- *Contracted by South African National Department of Health as the National Project Manager to lead the design of the* ***Transfer of Forensic Mortuaries from SA Police Services to Health*** *departments. (April 2004 to August 2005)*
- *Contracted by the Health Reform Foundation of Nigeria (HERFON) to assist with arranging and facilitating a Federal Ministry of Health (FMOH) study tour to study Tertiary Health Services in South Africa. (Sept - Nov 2004)*
- *Contracted by DFID (Nigeria) to assist the Health Reform Foundation of Nigeria (HERFON) with Strategic Planning and development of a Business Plan for 5 years (6-11th February 2005)*
- *Contracted by Partnership for Transforming of Health Systems (PATHS) to assist the* ***National Health Insurance Scheme (NHIS) in Nigeria*** *with organisational review and development (14-22 March 2005)*

Much of the work that I had been involved in during this time was as an individual and in other agencies' teams. I decided to join forces with two friends/colleagues, Prof Dan Ncayiyana and Ms Esme Prins, and establish our own consulting business, Benguela Health (Pty) Ltd.

Managing Director: Benguela (and other business interests) September 2005 to June 2011

- Co-owner of a property investment and management company since 2001 (Edge to Edge 1291 CC) and co-owner of property development company (Robfair Investments, No. 251 CC)
- Member of a health commodities export and trading company since 2003 [Medicura International CC, subsequently established Medsupply Investment Holdings (Pty) Ltd and Medsupply Trading (Pty) Ltd] with partners, business ceased and no longer trading pending closure.
- From May 2005 established an international health consulting firm, Benguela Health Group, with partners. This includes a South African subsidiary company [Benguela Health (Pty) Ltd] and working in the capacity of Managing Director since operationalising in September 2005: My personal project involvement since this time includes:
  - *Contracted by South African National Department of Health as the National Project Manager to lead the implementation of the* ***Transfer of Forensic Mortuaries from SA Police Services to Health departments****. (November 2005 to March 2006)*
  - *Contracted by University of Cape Town to conduct an assessment of the OR Tambo Fellowship Programme for senior managers. (October 2005)*
  - *Designed and ran a short course on "Consulting in the Local and International Health Systems Environment" for the* ***University of Stellenbosch Business School MBA programme*** *(May 2005 and again in April 2006)*
  - *Contracted by Options to lead the Output-to-Purpose Review (OPR) of the Nigerian* ***"Promoting Sexual and Reproductive Health for HIV/AIDS Reduction"*** *(PSRHH) programme. (November 2005)*
  - *Contracted by the Health Reform Foundation of Nigeria (HERFON) to assist with "Design of a Methodology for Producing an Annual National (Nigeria) Health System Review. (November 2005)*

- *Contracted by South African Gauteng Provincial Department of Health to facilitate the drafting of an **"Agreement between Gauteng Department of Health and Three Universities"** for regulating the relationship in the provision of academic health care. (April 2005 to Jan 2006)*
- *Contracted by a private pathology company in South Africa (Pathcare) to advise on strategic business issues. (April 2005 to Feb 2006)*
- *Contracted by the Partnership for Transforming Health Systems (PATHS) on behalf of DFID (Nigeria) to assist with a **review of the organisational structure of the National Programme on Immunisation (NPI)** in anticipation of its planned dissolution. (Feb 2006)*
- *Contracted by DFID (Nigeria) to lead an Inception **Review of the Strengthening of the Nigerian Response to HIV/AIDS Programming** (SNR). (March 2006)*
- *Consortium Joint Venture with Ernst & Young to conduct a due diligence of several services in Gauteng Province Health Department in South Africa. (April to Sept 2006). The aim was to prepare for transfer of PHC from municipalities to the PDOH.*
- *Contracted by Western Cape Department of Health to review all studies done on the costs of tertiary health care and training of students in the health platform (Phase 1) and to design a costing model for the same (Phase 2). (August 2006 to July 2007)*
- *Contracted by the Financial & Fiscal Commission to draft a discussion paper and to develop a **"Framework for Assessing Function Shifts"** between spheres of government. (Oct 2006 to March 2007.)*
- *Contracted by **Namibia Institute of Pathology (NIP)** to facilitate the development of a strategic plan for the next 5 years. (Oct 2006)*
- *Contracted by HLSP Consulting (UK) to assist the Hon Minister of Health in Nigeria with **Reform in the Federal Ministry of Health** (Dec 2006). (interviewing and placing of senior management personnel)*
- *Contracted by HLSP Consulting (UK) to assess the **National Primary Health Care Development Agency (NPHCDA)** with a view to incorporating the functions of the **National Programme on Immunisation (NPI).** (February 2007)*
- *Contracted by HPI (for DFID's PRRINN Programme) to provide institutional strengthening of the integrated **National Primary Health Care Development Agency (NPHCDA)** (Sept, Oct 2007)*
- *Contracted by University of Stellenbosch to assess the impact of the Western Cape Comprehensive Service Plan (CSP) on their teaching responsibilities. (September 2007)*
- *Lead Consultant on a project of the South African Department of Health Review of Public and Private Health Sector Training and Production Costs for Health Science Graduates; and **National and Provincial Public Health Human Resource Expenditure** (DFID funded) (Sept 2007 to May 2008)*
- *Lead Consultant on a project of the South African National Department of Health to **model the Human Resource requirement for the health sector in the country** (DFID funded) (Oct 2007 to Sept 2008)*
- *Lead Consultant on a project of the South African National Department of Health to document the **Human Resource trends for the health** sector in the country since 1994 (DFID funded) (Oct 2007 to Sept 2008)*
- *Lead Consultant on a project of the Eastern Cape Office of the Premier (South Africa) to assess the **PHC services** in the province (May 2008 to June 2008)*
- ***Acting Chief Executive Officer of the South African National Health Laboratory Service (NHLS)** from 16th July 2008 to 31st Oct 2008*
- *Assisted Namibia Institute of Pathology (NIP) with Strategic planning (Dec 2008)*
- ***Special Adviser to Ms Barbara Hogan, MP, Minister of Health**, South Africa (Dec 2008 to May 2009)*
- *Contracted by PRRINN project (Nigeria) to support the **National Primary Health Care Development Agency (NPHCDA)** with evaluation of their organisational structure, preparation of executive job descriptions and inputs on change management. (May to August 2009)*
- *Technical assistance to Debswana diamond mining company (Botswana) in the preparation of a strategic evaluation of their health care services and commitments. (June 2009)*
- *Appointed by Minister Aaron Motsoaledi, MP, Minister of Health, South Africa to assist with **costing of the proposed Occupations Specific Dispensation (OSD)** and to manage projects*

*to improve the efficiency and long-term viability of the **Medicines Control Council and Medicines Regulatory Authority (MRA.)** (June 2009 to Dec 2009)*

- *Appointed to Technical Working Group of the Nigerian Federal Ministry of Health to develop the **National Strategic Health Development Plan 2010 to 2015 (NSHDP)**, and subsequently to develop a toolkit to assist Local Govt, State and Federal Ministries and parastatals to develop costed plans. Conducted training of 40 consultants and 140 officials on the use of the toolkit. Developed an M&E management tool for the NSHDP. (June to August 2009)*
- *Requested by the Nigerian Federal Minister of Health, Prof Osotimehin, to facilitate a team-building and strategic direction workshop for the senior management of the **Nigerian Federal Ministry of Health**. (January 2010)*
- *Appointed to conduct an institutional review and to make recommendations on improving efficiencies of the **AIDS programme component, NASCP**, in the Nigerian Federal Ministry of Health. (April – May 2010)*

Since mid-2010 supervised the following projects

- *Designing and establishing a **comprehensive health referral system in KwaZulu Natal**. (Atlantic Philanthropies)*
- *Consortium partner in the Southern African Regional Access to Pharmaceuticals (SARPAM) Programme of DFID*
- *Oversight and supervision of projects under the auspices of the Strengthening South Africa's Response to HIV and AIDS (SARRAH), specifically:*
  - *assisting with the **Human Resources for Health (HRH) Strategy** 2011 – 2015*
  - *development of standards for the new **Office for Health Standards Compliance (OHSC)***
  - *development of organisational design, job descriptions, etc for the new **Office for Health Standards Compliance (OHSC)***
  - *development of details related to the revised specialist professional staffing of the PHC system*
- *Development of a strategic health plan for the Royal Bafokeng Nation*
- *Development of a plan for Improvement of the **Eastern Cape PHC** services in four sub-districts*
- *Facilitated the drafting of the **Enugu State Health Law (Nigeria)***

Our company was acquired by a listed company, EOH, and I became an Executive Manager in a unit of EOH Abantu (Pty) Ltd.

Executive Manager: EOH Abantu (Pty) Ltd

Acquired from Benguela in July 2011

- *Oversight and quality assurance of several projects under the **Enhancing Nigeria's Response to HIV and AIDS (ENR) Programme**. This is a GBP100m 6 year programme to work with the Federal and 7 State governments. Benguela is responsible, with Options UK, for institutional strengthening.*
- *Managing a four year non-for-profit project, funded by The Atlantic Philanthropies, for the **KwaZulu Natal Department of Health** to investigate, develop and roll out a comprehensive **referral system** between levels of care within and outside of the district health system (taking into account PHC Reengineering and contracting of private providers) and including links to emergency medical services*
- *Investigated and prepared a report and recommendations on the development and establishment of the **South African Department of Health Central Procurement Authority (CPA)***
- *Project Manager for the establishment of a new independent **Health Products Regulatory Authority in South Africa (SAHPRA)**. (March 2010 to July 2012) Prepared a detailed business plan for the NDOH*
- *Assisted with the drafting of the **South African National Human Resources for Health (HRH) Plan** and modelling of projected personnel needs. (Sept and Oct 2011)*

- *Expert to lead an **Infrastructure Unit Support Systems (IUSS) Project Expert Panel** to develop the Guidelines for Primary Health Care Facility Accommodation for the reengineered PHC system in the NHI*
- *Contracted to DfID's ENR programme in Nigeria to review the existing **Organizational and Capacity Assessment Tools (OCATs)** and develop a standardized national assessment tool, including the re-weighting of domains and refinement of the scoring system for the OCA process employed by ENR Programme (and other donor programmes) (January 2012)*
- *Follow-up assignment to training of trainers in the use of the new **National Harmonized Organisational Capacity Assessment Tool (NHOCAT)** and the implementation of OCA at the Federal Level, including the conducting of an Organisational Capacity Assessment (OCA) for Federal level institutions using the new NHOCAT and providing NACA with an initial technical assistance in documenting and warehousing national OCA processes and results. (May 2012)*
- *Sub-contracted to Deloitte as a part of their team to provide a **costing of the NHI for the Actuarial Society of South Africa (ASSA)** (August 2012)*
- *Contracted to DfID's ENR programme in Nigeria to design, construct and implement an electronic dashboard for tracking the performance of the national health sector HIV response and to provide support and advice to NASCP on use of the dashboard and efficient management of the whole HIV MIS (collection, collation, analysis, transmission, storage, use & feedback) to drive effective implementation/utilization of the dashboard. (August 2012)*
- *Specialist member of the team appointed by **Development Bank of Southern Africa (DBSA)** to development of a Master Plan for the purpose, location and capacity of **Nursing Colleges / Schools** (2012)*
- *Sub-contracted to Deloitte as a part of their team to undertake a **comprehensive review of the Occupation Specific Dispensation (OSD)** for various categories of health professionals (2012)*
- *Provided the professional services to perform technical work and develop a national plan to deliver tertiary health services in South Africa (**National Tertiary Health Service Plan**) (Nov 2012 – Sept 2013)*
- *Provided the professional services to perform technical work and develop a national plan to train health science trainees on the public health service delivery platform (**National Health Science Training and Development Plan**) (Nov 2012 – Sept 2013)*
- *Consortium partner with PWC as administrator with the purpose of assisting **Gauteng Department of Health** to be better equipped to deliver on their mandate of providing quality healthcare to all. (2013 on-going)*

When my contract period at EOH came to an end, having recognised that I am not comfortable with private corporate life, I decide to free-lance once again.

Free-lance Consultant

From 01 November 2014 to June 2021:

- *Developed a Local Government Capacity Organisational Assessment Tool (OCAT) for Maternal, Neonatal and Child Health (DfID's MNCH2 Programme) in Nigeria together with MannionDaniels. (November 2014)*
- *Working with EOH to develop a **South African 10 Year Health Infrastructure Masterplan for Development Bank of South Africa (DBSA).** (Nov 2014 to October 2016).*
- *Assisted South African National Treasury and National Department of Health with the costing of the implementation of the **Nelson Mandela Children's Hospital (NMCH)** in Johannesburg. (March to May 2016)*
- *Appointed by the **South African National Treasury to manage a Remuneration Analysis and Modelling project.** Analysed most government departments, over 1m personnel and assisted with development of predictive remuneration model. (March 2015 to August 2016)*
- *Appointed by the South African Minister of Health, Dr Motsoaledi, to serve on one of the National **Health Insurance (NHI) Working Committees**, considering packages of care. (2016)*
- *Assisted MSO with revitalisation of **Ghana National Health Insurance Scheme** (2017)*

- *Supporting the consulting team developing the business case to National Treasury for the erection of the **Limpopo Central hospital** (2017 – 2019)*
- *Supporting the consulting team developing the business case for National Department of Health to rebuild **Siloam Hospital** (2018 –2019)*
- *Analysis of the cost of employment 10-year trends and challenges for Limpopo Health Department (July/August 2018)*
- *2019: Member of the **Minister of Health's Committee on Human Resources for Health.***
- *Appointed by the DVC as **Chairperson of the Committee to Review the Deanery of the Faculty of Health Sciences at University of Cape Town (UCT)** February 2019*
- *Transition management consultant to **South African Health Products Regulatory Authority (SAHPRA)** from 01 Feb 2019 to July 2019)*
- *Assisted with the preparation of the **South African Presidential Health Summit** (2018), the activities of the NHI War Room, responsible for Pillar3: Infrastructure. (2019)*
- *Contracted to design the administrative and operational capacity for the **South African NHI Fund** office and development of an Implementation Plan. (August 2019 – ongoing)*

Period of Semi-retirement

After surviving severe malaria, contracted in Nigeria, I decided to slow down and travel less in Africa, and to engage in free-lance public health consulting work in South Africa.

From 01 January 2017:

- Moved to Vanwyksdorp as a permanent resident in 2010: erected two dams, laid irrigation and planted 400 olive trees, 30 fruit trees and commenced small-scale farming in preparation for retirement; renovated old house
- Opened guest accommodation 'Paddagaste' in mid-2012
- Voluntarily involved in community projects:
    - Installation of 'Lilliput sewerage system to 100 households
    - Rugby Club field upgrades and uniform/equipment sponsorships
    - Chairman of Vanwyksdorp Water User Association (2012 to date)
    - Member of Kannaland Water and Sanitation Forum (2017)
    - Various coaching and mentorships
    - Chairman of Vanwyksdorp Development Institute NPC board
- In March 2016 bought a small portable sawmill and started felling alien trees in watercourses on the Rooiberg mountains and sawing these Bluegums into planks. The wood took about 9 months to dry. In this period our small team learnt a lot and improved our skills – but it was very part-time.
- From January 2017 started expanding the woodwork workshop and reorganised the sawmill operation (moved it to town and commenced carting logs).
- Opened 'The Gallery' and 'Vanwyksdorp Wood & Furniture' 16 June 2017:
    - The Gallery is an outlet for local arts, crafts and produce in town
    - Vanwyksdorp Wood & Furniture is a contribution to entrepreneur development for local woodworkers as it gives them a workshop to work in and to incubate their small businesses
- From late 2017 to end 2018: Chairman of the board of the Vanwyksdorp Development Institute NPC (www.vwddi.co.za), a not for profit company aiming to develop the skills and lives of people living in the broader Gouritz Cluster Biosphere Reserve (GCBR) area (http://www.gouritz.com/).

- Continuing with ad hoc public health consulting assignments.
    - South African Health Products Regulatory Authority (SAHPRA) implementation
    - Developed the NHI Fund Business Case for the Minister of Health (Minister Zweli Mkhize)
    - Co-developed Accelerated Infrastructure Plan for Health
    - Assisting with COVID response

Deputy Director General: National Health Insurance (National Dept of Health)

From 06 June 2021 to date:

- Managed the National COVID-19 Vaccination Programme

- Steered the administrative process of the National Health Insurance Bill through Parliament until assent of the Act as the National Health Insurance Act, 2023 (Act No. 20 of 2023)

PUBLICATIONS AND CONFERENCE PRESENTATIONS

Few publications in international journals on nutrition, immunisation and district health systems and conference publications both in South Africa and abroad

Several research projects in the field of health Systems Planning and Management

Attended numerous national and international conferences as speaker and delegate

AWARDS

South African Institute of Health Care Managers (SAIHCM) Top 10 Influential Leaders in Health Care Management 2009/10

Public Health Association of South Africa, PHASA, Lifetime Achievement Award 2023

HOBBIES AND LEISURE

- Road and trail running
- Woodwork (making furniture from the harvested wood)
- Supporting local community development projects

May 2025

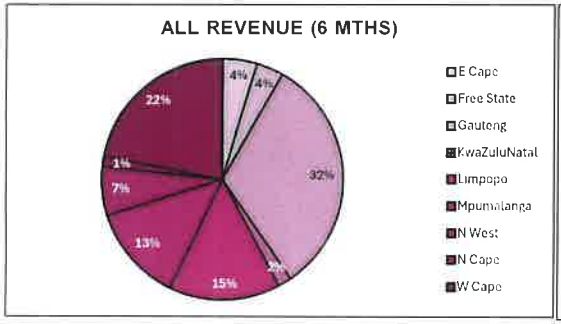
NG
G.M

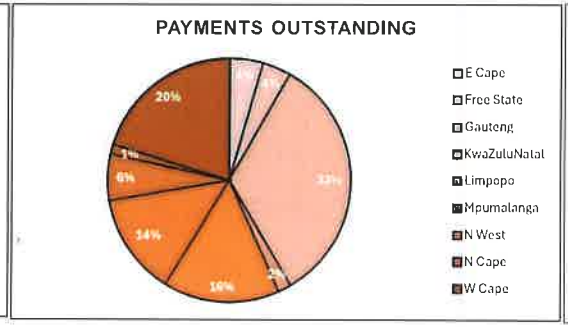
SRA4

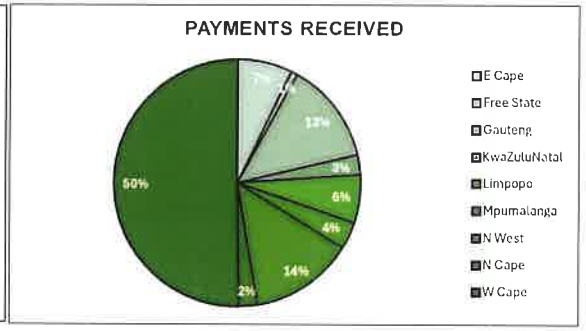
Revenue 06 October 2025 **6 months**

Funder	Payment Received	E Cape	Free State	Gauteng	KwaZuluNatal	Limpopo	Mpumalanga	N West	N Cape	W Cape
Medical Schemes	R 80 779 890		R 926 913					R 6 242 026	R 1 304 231	R 72 306 721
RAF	R 143 720 167	R 18 166 255	R 864 775	R 31 605 501	R 5 764 689	R 16 006 444	R 8 936 018	R 16 102 142	R 1 302 895	R 44 971 446
WCA	R 3 302 297		R 1 312					R 9 663	R -	R 3 291 321
SANDF	R 4 391 690		R 134 406					R 2 102 345	R 14 008	R 2 140 931
SAPS	R 4 520 059	R -	R 208 006	R -	R -	R -	R -	R 3 123 075	R 20 182	R 1 168 796
DOJ & CD	R 5 436 685	R -	R -	R -	R -	R -	R -	R 2 176 289	R 3 260 396	R -
DCS	R 16 845 943	R 257 000	R 105 578	R 2 778 000	R 1 075 000	R 220 000	R 169 000	R 5 674 365	R 184 000	R 6 383 000
GRAND TOTAL	**R 258 996 731**	**R 18 423 255**	**R 2 240 990**	**R 34 383 501**	**R 6 839 689**	**R 16 226 444**	**R 9 105 018**	**R 35 429 905**	**R 6 085 712**	**R 130 262 216**

Funder	Payment Outstanding	E Cape	Free State	Gauteng	KwaZuluNatal	Limpopo	Mpumalanga	N West	N Cape	W Cape
Medical Schemes	R 109 111 574		R 7 844 925					R 42 963 000	R 5 286 105	R 53 017 545
RAF	R 3 777 352 902	R 122 611 309	R 105 739 778	R 1 375 966 377	R 49 427 970	R 643 095 284	R 590 420 910	R 154 315 000	R 37 602 958	R 698 173 317
WCA	R 84 165 777		R 2 052 489					R 4 582 000	R 3 712 344	R 73 818 944
SANDF	R 27 907 972		R 8 785 165					R 11 049 000	R 3 114 625	R 4 959 182
SAPS	R 32 897 845	R -	R 3 740 331	R -	R -	R -	R -	R 16 241 000	R 839 231	R 12 077 283
DOJ & CD	R 285 136 968	R 70 054 927	R 29 684 095	R 73 841 818	R 23 872 915	R 33 027 210	R 1 026 260	R 14 044 000	R 6 949 389	R 32 636 353
DCS	R 58 347 573	R -	R 9 270 376	R 7 454 000	R 3 013 000	R 176 000	R 782 000	R 26 794 000	R 3 000	R 10 855 197
GRAND TOTAL	**R 4 374 920 612**	**R 192 666 236**	**R 167 117 159**	**R 1 457 262 195**	**R 76 313 885**	**R 676 298 494**	**R 592 229 170**	**R 269 988 000**	**R 57 507 652**	**R 885 537 822**







Funder	Payment Received and Outstanding	E Cape	Free State	Gauteng	KwaZuluNatal	Limpopo	Mpumalanga	N West	N Cape	W Cape
Medical Schemes	R 189 891 465	R -	R 8 771 838	R -	R -	R -	R -	R 49 205 026	R 6 590 336	R 125 324 266
RAF	R 3 921 073 070	R 140 777 564	R 106 604 553	R 1 407 571 878	R 55 192 659	R 659 101 729	R 599 356 928	R 170 417 142	R 38 905 853	R 743 144 763
WCA	R 87 468 074	R -	R 2 053 801	R -	R -	R -	R -	R 4 591 663	R 3 712 344	R 77 110 266
SANDF	R 32 299 662	R -	R 8 919 571	R -	R -	R -	R -	R 13 151 345	R 3 128 633	R 7 100 113
SAPS	R 37 417 904	R -	R 3 948 337	R -	R -	R -	R -	R 19 364 075	R 859 413	R 13 246 079
DOJ & CD	R 290 573 653	R 70 054 927	R 29 684 095	R 73 841 818	R 23 872 915	R 33 027 210	R 1 026 260	R 16 220 289	R 10 209 785	R 32 636 353
DCS	R 75 193 516	R 257 000	R 9 375 954	R 10 232 000	R 4 088 000	R 396 000	R 951 000	R 32 468 365	R 187 000	R 17 238 197
GRAND TOTAL	**R 4 633 917 344**	**R 211 089 492**	**R 169 358 149**	**R 1 491 645 696**	**R 83 153 574**	**R 692 524 939**	**R 601 334 188**	**R 305 417 905**	**R 63 593 364**	**R 1 015 800 037**

SRA5

CONSTITUTIONAL COURT OF SOUTH AFRICA

REGISTRAR OF THE CONSTITUTIONAL COURT OF SOUTH AFRICA
P/Bag X1, Constitution Hill, Braamfontein 2017
2025 -11- 06
CC-001
REGISTRAR OF THE CONSTITUTIONAL COURT OF SOUTH AFRICA

Case CCT 214/25

In the matter between:

SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM Applicant

and

PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA First Respondent

MINISTER OF HEALTH Second Respondent

DIRECTIONS

The Chief Justice has issued the following directions:

1. The conditional application for review will be held in abeyance by this Court pending the determination of the applications for leave to appeal in CCT 128/25 and CCT 129/25.
2. If, following this Court's determination of the applications for leave to appeal in CCT 128/25 and CCT 129/25, the applicant decides not to persist with the application in this Court, the applicant must file a notice of withdrawal complying with rule 27 of this Court's Rules.
3. Further directions may be issued.

NOKUBONGA MTHETHWA
REGISTRAR
CONSTITUTIONAL COURT

TO: WEBBER WENTZEL
Attorneys for the Applicant

90 Rivonia Road
Sandton
JOHANNESBURG
Tel: 011 530 5220 / 011 530 6220
Email: martin.versveld@webberwentzel.com / prelisha.singh@webberwentzel.com / glenn.penfold@webberwentzel.com / alexandra.rees@webberwentzel.com / junaid.nyker@webberwentzel.com
Ref: M Versveld / P Singh / G Penfold / 4008778

AND TO: OFFICE OF THE STATE ATTORNEY, PRETORIA
Attorneys for the First Respondent
SALU Building
316 Thabo Sehume Street
PRETORIA
Tel: 012 309 1670
Email: rsebelemetsa@justice.gov.za / ramatics@gmail.com / pskhonde@justice.gov.za

REGISTRAR OF THE CONSTITUTIONAL COURT OF SOUTH AFRICA
P/Bag X1, Constitution Hill, Braamfontein 2017
2025 -11- 06
CC-001
REGISTRAR OF THE CONSTITUTIONAL COURT OF SOUTH AFRICA

AND TO: KGOSANA ATTORNEYS
Attorneys for the Second Respondent
Chambers @ Valley Road
133 Valley Road
Sunnyside
PRETORIA
Tel: 012 326 1452 / 063 655 9347
Email: info@kgosana-attorneys.co.za / makule@kgosana-attorneys.co.za

AND TO: WERKSMANS ATTORNEYS
Attorneys for the Applicant in CCT 254/24
96 Rivonia Road
Sandton
JOHANNESBURG
Tel: 011 535 8198 / 011 535 8424
Email: nkirby@werksmans.com / hmichael@werksmans.com / bmoti@werksmans.com / sphakathi@werksmans.com
Ref: Mr N Kirby / Ms H Michael / BOAR3329.73