Annexure NC1

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

GM

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
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

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REPLY TO SUPPLEMENTARY GENESIS REPORT

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**").

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

3 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.

4 This affidavit responds to the report marked Annexure "SSAA1" to the second supplementary answering affidavit filed on behalf of the Health Funders Association ("**HFA**"), which report is dated 27 October 2025 and titled "Stay application and response to Dr Crisp's Replying Affidavit" ("**the supplementary Genesis report**").

5 Notwithstanding that I hold the position that I do, I am able to, and have the expertise to, respond to the opinions expressed in the supplementary Genesis report on the basis of the positions I have held and now hold relating to the conception, origin and implementation of National Health Insurance ("**NHI**") and the NHI Act No. 20 of 2023. My opinions are also informed by the qualifications I hold and by my more than forty-year career in the field of public health. In this regard, a copy of my curriculum vitae is included with my supplementary replying affidavit.

6 I accept that I am not independent of the National Department of Health, but that does not, I am advised, preclude me from expressing the opinions that I do or the Court from accepting them, subject to consideration of the position that I hold.

7 Insofar as I express opinions in the field of economics and health economics in particular, these will be confirmed by a health economist, Professor Charles Hongoro, whose affidavit will be filed together with mine.

8 As pointed out in the supplementary replying affidavit, reliance will only be placed on this affidavit to the extent that the supplementary Genesis report, and the paragraphs of the supplementary answering affidavit based on it, are not struck out.

9 I have read the supplementary Genesis report. I deny it in each respect in which it conflicts with the founding, replying and supplementary replying affidavits that the Minister and I have deposed to.

10 Without detracting from the generality of that denial, I respond to the supplementary Genesis report as set out below.

Ad paragraph 1

11 I note that Genesis Analytics is briefed by ENS purportedly "to provide economic input to my replying affidavit".

12 Unfortunately, as pointed out in paragraphs 226 to 239 of the supplementary replying affidavit, the briefing instruction given by ENS as to the interpretation of the NHI Act that Genesis is to work off, is fundamentally flawed in multiple respects.

13 There is a further fundamental difficulty with the supplementary Genesis report. That is that Genesis would only be in a position to make the predictions that its report does, if it had full insight into the Minister's and the National Department of Health's ("**Department's**") internal work over several years on the planning and budgeting for the implementation of NHI and the NHI Act. Because they lack that, the report is fundamentally based on assumptions and predictions that lack a proper factual foundation. That is manifested by the absence of any reliable data on which they base the multiple negative predictions that they make throughout the report.

14 The consequence is that no reliance can be placed on the supplementary Genesis report at all.

15 Further, I confirm that it is correct "that the phased implementation of the NHI Act will insulate the HFA and the members of the medical schemes on behalf of whom it speaks from any immediate or medium-term impact".

Ad paragraph 2

16 I note that the supplementary Genesis report purports to provide analysis and commentary on what is set out in the replying affidavit. I

deny that what is set out in the replying affidavit "consists of Dr Crisp's positions". What is set out in the replying affidavit is the Minister and the Department's overview of the estimated times anticipated for coming into force and implementation of various provisions of the NHI Act. I accept that this takes into account my understanding, based on my long-standing involvement in a leadership capacity in the planning therefor.

17 Insofar as this paragraph refers to the First Genesis Report of 21 May 2025 ("**the first Genesis report**"), as HFA concedes, its contents and the Minister and Department's response to it are a matter for another day, if and when it is necessary to hear HFA's direct challenge in the High Court. My failure to respond to it here should not in any way be construed as an acceptance of the correctness of any component of it.

18 I deny that there is any likelihood of harm that may arise during the stay period.

19 I note further that the report purports to provide a brief response to the critiques levelled by me at the first Genesis report. I stand by those critiques to the extent that anything in the first Genesis report might, contrary to what I have set out above, be found to be relevant to the adjudication of the stay application.

GM

Ad paragraph 3

20 I admit this paragraph only to the extent that it is consistent with the provisions of the NHI Act.

21 Fundamentally, what Genesis fails to point out here and throughout the supplementary Genesis report is that the NHI Act is a reform that, as a matter of statutory compulsion "must be gradually phased in using a progressive and programmatic approach based on financial resource availability."[1]

22 Whether by design or neglect, this turning of a blind eye to what is perhaps the most important provision in the NHI Act, at least for present purposes, results in a completely flawed analysis in the supplementary Genesis report.

Ad paragraph 4

23 I deny this paragraph. What will build incrementally as the government moves towards full implementation is the introduction of a substantially improved health care system that aims to benefit and provide for all South Africans, ultimately, on a fair, just and equal basis.

Ad paragraphs 5 - 7

24 I deny that this is a fair summation of what is set out in the Minister's replying affidavit. I ask that the content and import of the replying

[1] Section 57(1)(b) of the NHI Act.

affidavit be determined from the replying affidavit itself and not from Genesis' summation of it.

Ad paragraph 8

25 I deny this paragraph. Whilst I accept that the stay of proceedings might delay the period it would take to finally determine the constitutional validity of the NHI Act, I am advised that the stay is unlikely to be in place for longer than a period of a year-and-a-half. However, what I say in this affidavit in explaining why the harm contended for by Genesis will not materialise applies equally if the period were to be for as long as five years, as HFA incorrectly contends.

26 I also refer to what I say later in this affidavit regarding the absence of any causal connection between the stay and the delay in the subsequent adjudication of the direct challenges in the High Court, should these ever prove necessary.

27 On a proper interpretation of the NHI Act, and section 57 in particular, the stay will most certainly not provide an "extended window [that] would enable substantial structural changes that would be difficult and costly to reverse." I say this for the reasons set out in the replying affidavit, in the supplementary replying affidavit and in this affidavit.

Ad paragraphs 9 - 11

28 I refer to my response to these paragraphs at paragraphs 226 to 239 of the supplementary replying affidavit. As I demonstrate there, the

instructions upon which the supplementary Genesis report is based, are founded on serious misinterpretations of the NHI Act.

Ad paragraph 12

29 I deny that there will be any significant tax and funding consequences during the period of the stay.

30 As pointed out in the replying affidavit, the 2027/2028 financial year is the earliest that the reallocation of funding from collecting a segment of medical scheme tax credits might take place. Even those dates are likely to prove over-optimistic. A drawn-out process of discussions with Treasury will impact upon both the coming into force of s 49(2)(a)(ii) and the implementation thereof. The most probable scenario is that s 49(2)(a)(ii) will not come into force during the period of the stay.

31 Assuming, optimistically, that it were to come into force towards the end of the 2027/28 financial year, i.e. before 31 March 2028, the probabilities are strongly that a stay will have been discharged. Moreover, this would require inclusion in the 2027/28 budget and a Money Bill in that year to mandate even a small change to qualification for medical tax credits.

32 It is at that point that the withdrawal of medical tax credits for only high income earners would begin.

33 I accept that the removal of medical tax credits for only high-income earners, the threshold being around R1 million annual income, would, according to Treasury, raise an amount in the region of R3.5 Bn.

34 However, assuming that is correct, the comparator used by Genesis in this paragraph of an amount of R280 Bn being required to be channelled into the NHI before the end of the stay is, on Genesis' own understanding of the implementation process, a gross exaggeration.

35 I firmly deny that "further tax increases [will] become inevitable ... during the delay occasioned by the stay". Genesis provides no factual basis whatsoever for this averment. Nor does it have any insight into the likely pace of implementation of NHI. It also fails to take into account s 57(1)(b) that *"National Health Insurance must be gradually phased in using a progressive and programmatic approach based on financial resource availability."*

36 The assertion that, during the period of the stay, "medical schemes will destabilise through cascading adverse selection, severely undermining health care access and affordability long before section 33 of the NHI is invoked" is based on no evidential foundation. That renders it little more than guesswork.

37 "Adverse selection" takes place when younger, healthier members of a medical scheme withdraw from the scheme if the premiums rise, because they tend to pay more in contributions than they claim (and by doing so, cross-subsidise older or sicker members of a scheme).

38 HFA asserts in its answering affidavit, based on the first Genesis report, that this escalates into an "actuarial death spiral" where increasing premiums accelerate withdrawals from a scheme

jeopardising its sustainability and that of "the entire medical scheme sector".

39 HFA and Genesis assert in the paragraph under reply in the stay that this process will complete itself during the period of the stay, because of the shortfall between the R3.5 billion and the required R280 billion, which will necessitate further tax increases.

40 As I have already pointed out, full implementation will certainly not be reached during the period of the stay, even taking into account HFA's flawed assessment of an impact over a five-year period. Nor will anything remotely like R280 billion be required. As I will elaborate upon later, R3.5 billion will be sufficient at the time it becomes available.

41 Before dealing with the precise financial implications, one must also point out that –

41.1 where the younger, healthier individuals are not high-income earners, they will not lose their tax credits until full implementation of the NHI, which will not be during the period of the stay;

41.2 there are long-standing, substantial problems with medical schemes and medical insurers, confirmed in the Health Market Inquiry, charging inflated premiums relative to benefits offered. This phenomenon may well be causing adverse selection and has nothing whatsoever to do with NHI.

42 Turning to the numbers, the amount of the medical tax credit is R364 per month for the main member, a further R364 per month for the first dependent and an additional R246 per month for each additional dependant, regardless of the number of dependents.

43 The maximum amount of the tax credit for a family with a taxpayer and two dependants is therefore R974 per month.

44 For a young healthy taxpayer who is earning R83,333 per month (i.e. based on an annual income of R1 million) it is highly unlikely that he or she will abandon their medical scheme or change their medical scheme plan on account of a consequential drop in income from R83,333 to R82,359 per month.

45 Moreover, it is assumed in this calculation that the taxpayer has two dependants. Many younger, healthy taxpayers will have no or fewer dependants. The drop in income if there are no dependants will be from R83,333 to R82,969. Again, it is highly unlikely that such a taxpayer would abandon his or her medical scheme on account of this financial impact of the withdrawal of the medical tax credits.

46 The other point that needs to be made is that the medical tax credits are not funds that are paid directly into medical schemes. Nor are they in fact deducted from income. The taxpayer will already have paid the full amount of premiums or contributions due to the medical scheme. A medical tax credit is a non-refundable tax rebate provided by the South African Revenue Service to help reduce a taxpayer's final

income tax liability. It operates as a credit against tax owed, not a deduction from income. The examples used above based on a reduction in income, are therefore for illustrative purposes only.

47 Seen against the stark reality of these numbers, which may not even materialise during the period of the stay, the assertion by Genesis that, during the stay, "medical schemes will destabilise through cascading adverse selection" is exposed as unfounded exaggeration and alarmism.

Ad paragraph 13

48 I dealt with these allegations regarding impact on investment and healthworker emigration in the replying affidavit and I repeat what I said there in response to paragraph 13. NHI has long been on the table, and its slow and gradual implementation is unlikely to have any significant impact in this regard during the period of the stay. All the more so, when immigration of healthcare practitioners is taken into account.

Ad paragraph 14

49 I deny this paragraph. These averments have been responded to in my answer to paragraph 12 above.

50 The instructions that Genesis has received to the effect that the strengthening of public hospitals and the like can be pursued without implementing the NHI before its constitutional validity is determined are not entirely correct. Substantial components of the healthcare

system strengthening are indeed taking place under existing legislation. But even those components are aimed at preparing the system for the introduction of NHI and budgetary allocations are motivated on that basis. As soon as implementation under the NHI Act, following commencement, takes place health system strengthening will also take place in terms of section 57(2)(a)(i) and from the budget allocated specifically for it. Taking the NHI Act out of the equation may reduce the budget for and purposes of health system strengthening.

Ad paragraphs 15 and 16

51 Once again, Genesis have received flawed instructions which vitiate their report.

52 It is highly unlikely that the stay would endure for up to three years until December 2028 or early 2029. The probable scenario is SAPPF's estimate of between a year and a year-and-a-half. That would take us until December 2026 or June 2027 if calculated from the time of signature of this affidavit.

53 In paragraphs 15.2 to 15.4, read with paragraph 16 of the supplementary Genesis report, Genesis suggests that the total period of impact of the stay is a period of five years because it will take another two years to deal with the direct challenges in the High Court.

54 This reasoning is incorrect. Absent any stay, the direct challenges could take two to three years or more to be adjudicated.

Implementation invariably accompanies the bringing into force of a statute. The period of implementation corresponding with the duration of the direct challenges has nothing to do with the stay.

55 It is accordingly incorrect to suggest that a delay of a predicted five years is attributable to the stay.

56 I accordingly deny that the "period of relevance is approximately five years". It is a period of between a year and a year-and-a-half.

Ad paragraph 17

57 Because of the flaw in the instructions given to Genesis, their purported analysis of the "significance of this delay" is flawed and unhelpful for the adjudication of the present stay application.

58 But even if the period of five years were to be used for the assessment, the catastrophic predictions by Genesis would not materialise.

Ad paragraph 18

59 I admit this paragraph. Total expenditure in the entire national health system at this point in time, however, is at close to R600 Bn. This remains subject to a similar (grossly inequitable) proportional spread where somewhere in the order of 51% to 53% of the expenditure is on the 14% to 16% of the population reliant on private healthcare.

Ad paragraph 19

60 The debate in this paragraph has nothing to do with the debate in relation to alleged harm during the period of the stay. It pertains to the scenario after section 33 has come into force in some 10 to 15 years time.

61 Moreover, whilst I admit that government does not intend to increase overall healthcare expenditure beyond 8,5% of GDP, I deny the remaining averments in this paragraph. They will be dealt with at the appropriate time, if this should prove necessary, in the direct applications in the High Court.

Ad paragraph 20

62 Once again I deny this paragraph. In any event, it also pertains to the period after section 33 comes into operation in 10 to 15 years time.

63 I reiterate that there will either be no reduction in medical scheme tax credits or a withdrawal of medical scheme tax credits for high income earners only, at the earliest towards the end of the stay period. I have indicated in the replying affidavit the estimated times when sections 49(2)(a)(i) to (iv) may come into effect. Save for tax credits, and only to the extent described, neither of the sources of income referred to in ss 49(2)(a)(iii) and (iv) will have any impact during the period of the stay as those provisions will not yet have come into force.

Ad paragraph 21

64 Again this paragraph deals with the period after the coming into force of section 33 in 10 to 15 years time. It has no relevance to the adjudication of the stay application.

65 Insofar as this paragraph refers to adverse selection and an "actuarial death spiral" I refer to what I have already said above in this regard.

Ad paragraph 22

66 The period with which the present application is concerned is the likely year to a year-and-a-half period of the stay. Even if it endures for three years as Genesis suggests, this will make no material difference.

67 As I have already pointed out above, adverse selection is not something that will materialise during the period of the stay. Indeed, it will not materialise. Taxpayers who are not high income earners will only be impacted once section 33 has been brought into force and implemented, by which time the echelon of younger taxpayers concerned, indeed all taxpayers, will be able to have a comprehensive package of their healthcare needs satisfied under the NHI and, in limited respects, complementary cover from medical schemes.

Ad paragraph 23

68 I admit this paragraph only to the extent that it is consistent with what is set out in the replying affidavit. I respectfully draw the Court's attention to what I say there.

Ad paragraphs 24 and 25

69 I deny that there are any problems with what is set out in the replying affidavit, including the four problems alleged in these paragraphs.

Ad paragraph 26

70 I admit that the withdrawal of tax credits from high income individuals who earn in excess of R1 million per annum will raise an estimated R3.5 Bn. I deny that R280 Bn extra will be required to "capture" all private sector spend under the shared resources model favoured by government.

71 I do not agree with the use of the adverb "only".

Ad paragraph 27

72 I deny the assertion, in footnote 3, that the estimate of R3.5 Bn is likely to be lower due to the alleged "tax leakage effect". A "tax leakage effect" is the loss of government revenue due to tax evasion, avoidance, and inefficiencies in the tax system. This may occur when individuals or companies fail to pay taxes they legally owe, resulting in money being "leaked" out of the economy and reducing the national income.

73 The alleged tax leakage effect will not eventuate as alleged here because the medical tax credit, as I have already noted, is a non-refundable tax rebate provided by the South African Revenue Service ("**SARS**") to help reduce a taxpayer's final income tax liability in

respect of qualifying medical expenses. It operates as a credit against tax owed, not a deduction from income.

74 The R3.5 Bn will be more than sufficient to comply with the implementation obligations set out in s 57 of the NHI Act. In this regard it must be borne in mind that the R3.5 Bn expenditure is supplemental to both existing budget–spend on personal healthcare services in the public sector, comprising the existing budget allocations to the provincial and national Departments of Health, and other public healthcare-related entities.

Ad paragraphs 27.1 to 27.4

75 I deny these paragraphs. The averments in this paragraph are based on the misconception that s 57 requires NHI to be substantially implemented by 2028. These averments ignore both the wording of s 57 and the main controlling provision in s 57(1)(b) which limits implementation to available financial resources.

76 Further, I refer to what I have said in both the replying and supplementary replying affidavits in regard to the correct interpretation of s 57.

Ad paragraph 28

77 This paragraph fails to take into account section 57(1)(b) which limits NHI implementation-spend to available financial resources.

78 Moreover, Genesis fails here to take into account existing health budgets. For example, Treasury added R6.7 Bn to the nine provinces' health budgets for the 2025/2026 financial year. This is part of the medium term budget policy statement and framework for which Parliament has allocated R20,773 Bn over the coming three years. Through the phased implementation of the NHI Act, components of this funding will in due course be shifted to the NHI Fund for purchasing benefits from healthcare providers. During the initial phase of the implementation, provision of enhanced services, paid through NHI, are supplemental to the provincial health departments' public healthcare spend until the shifting of those funds commences.

79 During phased implementation, the NHI Act does not compel immediate purchasing of full healthcare benefits by the Fund to anyone switching from private financing of their healthcare. The entitlement of everyone to free healthcare (of the published comprehensive package of benefits at that time) at the point of service is a target for the period after implementation of section 33 in 10 to 15 years time.

80 I accordingly deny this paragraph.

Ad paragraph 29

81 I note that the first Genesis report assumed that the NHI Act would administer its services at the same cost ratio of the Road Accident Fund, namely 6.9%. This is, with all due respect, an extraordinary

assumption to make. The global average cost of administering a single payer model with a common package, such as the NHI described in the Act, is 1.8% to 2%. The Road Accident Fund is notorious for its poor management, over-spending, lack of financial discipline and its purchasing from multiple different providers, many of which overcharge. Their administration is also reportedly overcomplicated and prone to making double-payments to medical schemes.

82 The 9% to 10% cost of administering South Africa's private medical schemes is indicative of why there is a need for NHI. The 2021 reported costs from the Council for Medical Schemes was R21bn. Assuming the top end of NHI administration costs of 2%, South Africa's private medical schemes come in at approximately 500% more expensive to administer.

83 Accordingly, Genesis' analysis begins, again, with a flawed assumption.

Ad paragraph 30

84 I deny this paragraph. For reasons I have already given, the comparison with the administration costs at full implementation is irrelevant for purposes of the adjudication of the stay application. The estimation of the proportion of administration costs covered at full implementation is in any event flawed by reason of the over-estimate of administration costs of the NHI based on the Road Accident Fund.

Ad paragraph 31

85 For the reasons given in response to the preceding paragraphs, I firmly deny that the R3.5 Bn increase is wholly insufficient to fund a modest implementation.

Ad paragraphs 32 and 33

86 I deny the allegations made by Genesis in this paragraph.

87 The Department's plans, the existing budgeting arrangements and the provisions of s 49 align with the process whereby the NHI is brought into operation in a phased manner as contemplated by s 57(1)(b). Indeed, s 49(2) makes express cross-reference to s 57.

88 Insofar as new and additional institutional bodies and frameworks are concerned, including administrative and information systems, these are already being paid for from the existing departmental budget and the expenses connected with these are, and will remain, relatively low because the systems are opensource and owned by the department.

89 The planning and budgeting most certainly leave room for enhancing healthcare for vulnerable groups, subject to progressive implementation.

90 My reference to health system strengthening initiatives and capital investment during the stay period, relates mainly to the digital system which has already been designed and is in the process of construction and roll-out in the public healthcare sector.

91 Insofar as capital expenditure on public hospitals is concerned, this is quantified and sequenced by the departmental infrastructure team and includes some projects that access funds from the National Treasury's BFI (Budget Facility for Infrastructure), which is an appraisal process for large-scale public infrastructure projects, valued at R1 billion or more, that require government fiscal support.

92 Budgeting does not apply only to the forthcoming financial year but is effected in terms of the medium-term expenditure framework ("**MTEF**"). The current MTEF commenced on 01 April 2025 (2025/26 financial year) and extends to the end of the 2027/2028 financial year (31 March 2028). That covers the likely period of the stay, and beyond it.

93 I have been intimately involved in the process of preparing the budgets for the medium-term expenditure framework and am well aware of how all of the expenditure referred to in this paragraph will be covered. That budgeting and planning process is designed to ensure that sufficient budget is available in the medium term for progressive implementation of NHI. There will most certainly not be "an immediate degradation of healthcare services in areas where budgets decrease". The additional allocations to the health departments for this current MTEF are R6,706 Bn (2025/26); R6,922 Bn (2026/27); and R7 145 Bn (2027/28).

94 As I have already pointed out, the R3.5 Bn is more than adequate for the phased implementation that is contemplated once it becomes available.

95 Genesis simply does not have a factual basis for the assertions that it makes in these paragraphs.

Ad paragraph 34

96 I deny that further tax increases will be required during the period of the stay.

97 I have already given the estimated dates by when the tax increases contemplated by ss 49(2)(a)(iii) and (iv) may commence and be implemented.

98 I deny that there will be a negative effect on the economy from the enhanced investment in healthcare. Enhanced investment in healthcare has positive consequences for the economy, including enhanced growth. A healthy population is best placed to ensure a healthy economy. There is ample global evidence of this.

99 I firmly deny that there will be degradation of healthcare access for the currently insured. The 35% of scheme members (roughly 3 million beneficiaries) who have only in-hospital cover will have greater cover than they enjoy now. The currently insured will remain in the position to pay for and access both public and private healthcare until the implementation of section 33 in 10 to 15 years time. This includes the care that some access from the public sector when their present cover

fails them. Once it is implemented, the currently insured will be able to retain insurance insofar as medical schemes provide complementary cover.

100 Insofar as the reference to adverse selection is concerned, I refer to what I have already said above. I deny that there will be adverse selection attributable to NHI.

101 Insofar as out of pocket costs are concerned, these will be eliminated under NHI for those services which are paid for by the Fund. That is a specific objective of NHI. The current position in the private healthcare sector is that patients dependent on medical schemes and insurance are already forced to pay unconscionably and increasingly large sums of money by way of out of pocket payments in order to receive the care that they need.

101.1 As was reported in the media on 18 September 2025, South Africans paid R43 Billion Out-of-Pocket for Medical Care in 2024.[2] This is about 15% of all spending in the private sector.

101.2 Part of the problem is with 'hospital-heavy benefits' which favour hospital care over primary healthcare, prevention, and screening. According to the Council for Medical Schemes (CMS) Industry Report for 2023 the largest portion of the spending is on hospitals (35,6%), specialists (27,7%), medicines (14,5%), other health professionals such as physios

[2] https://x.com/MooreSAfrica/status/1622837704856686592.

and dieticians (8,4%), general practitioner visits (5,2%) and the remainder went to other services.

101.3 Doctors often charge above scheme rates, or certain treatments are excluded entirely. Sometimes, the nearest in-network doctor or hospital is too far away, forcing members to use alternative providers and absorb the cost.

101.4 Cheaper products often attract younger members, leaving pools dominated by the elderly or chronically ill and premiums in those schemes skyrocket.

101.5 The media reported that on social media many South Africans reacted with frustration, sharing stories of paying thousands on top of their premiums for basic medicines or specialist visits.

102 Further, I deny that the purchasing mechanisms provided for in the NHI Act will result in a reduction in healthcare resources. The NHI Act is focussed on the expansion of primary healthcare and I accordingly deny that it will be reduced and that there will be poorer provision of hospital facilities. The NHI Act allows for historical failures in facility management in the public sector to be squarely addressed, and for the Fund to purchase care for anyone from private sector providers. This is one of the reasons for a restructured role of provincial health departments where these historical failures in facility management have occurred. I accordingly deny the averments in this paragraph. Moreover, they are made without any factual foundation for them.

103 Further, paragraph 34 is directed at the overall implementation of the NHI Act and bears no relevance to the narrow enquiry pertaining to the probable year to year-and-a-half period of the stay.

Ad paragraphs 35 and 36

104 I deny that the discussions pertaining to an income threshold for identifying those who will lose their medical tax credits is speculative. The department has been engaged in discussions with Treasury in this regard.

105 The argumentative assertion that there is "no commitment during the stay not to raise taxes more significantly than suggested by Dr Crisp" contemplates that it is within my power and that of the department freely to raise taxes as we see fit. That is based on a complete misapprehension of the legislative, fiscal, budgetary and other public finance arrangements in place to regulate taxation. There is no prospect that the Minister or the Department can simply insist on tax increases to be implemented during the next year to year-and-a-half of the probable period of the stay. Amongst other things, Treasury would simply not allow it. The Act is clear that any changes to taxes will require a Money Bill and that will need to be passed by Parliament. Nor is there any need to "raise taxes more significantly".

106 The further argumentative assertion that "nothing in the NHI Act stops the government from implementing whatever threshold for medical tax credits it deems fit and raising whatever additional taxes it requires" is

based on a complete misinterpretation of the NHI Act and the Constitution. Nor does Genesis have the legal expertise to make this assertion.

107 However, the main difficulty with this paragraph and its sub-paragraphs is that it is the availability of funding that drives the level of phased implementation in terms of s 57(1)(b) of the NHI Act, not the other way around. The available budget will determine the level of phased and gradual implementation. There is accordingly no foundation, either legal or factual, for the assertions made in this paragraph.

108 The further difficulty with these paragraphs is that they are based squarely on the incorrect legal advice which has been provided to Genesis.

Ad paragraphs 37 and 38

109 The averments in these paragraphs repeat averments made in previous paragraphs of the supplementary Genesis report and I refer to my responses to those averments above.

Ad paragraphs 39 and 40

110 I deny that the stay will lead to any significant increase in uncertainty or any impact on healthcare resources. I refer to what I have already said in this regard in the replying and supplementary replying affidavits as well as what I have said above. The stay promotes certainty because it focuses on the litigation which has the potential to provide

the fastest determinative answer. Absent the stay there is enormous uncertainty. This is because the litigation being pursued in the High Court may well prove to be in vain. This would be because an outcome in the Constitutional Court that results in the setting aside of the NHI Act will render all of the direct challenges in the High Court moot.

111 I accordingly deny these paragraphs.

Ad paragraphs 40.1 and 40.2

112 The issues raised in these paragraphs are based on the initial Genesis report and are matters that are not relevant to the adjudication of the stay application. The averments will be dealt with in due course to the extent necessary in the direct challenges in the High Court.

113 I deny that there is a real possibility of the rapid erosion of shareholder values. I have already shown in the replying affidavit that the example of Discovery demonstrates the opposite.

114 The truth of the matter is that the introduction of the NHI will provide substantial opportunities for private hospital investment including expansion into under-served areas. The NHI and the NHI Act embraces private providers of healthcare and ensures their long-term role, free of the current serious problems, including fraud, waste and abuse, besetting the private healthcare industry.

115 Insofar as the alleged potential impact on doctors and nurses is concerned, I dealt with this at some length in the replying affidavit and I stand by what I said there.

116 I deny the content of these paragraphs insofar as it contradicts what I have said previously, in the supplementary replying affidavit and in this affidavit.

Ad paragraph 41

117 This paragraph relies on the incorrect legal advice that Genesis has received. I dispute that legal advice based on the legal advice that the Minister and the department have received.

118 The litigation course underlying the stay application provides the most efficient and certain route to the determination of the constitutionality of the NHI Act.

119 As to the averments regarding healthcare providers and practitioners, I refer to what I have already said above and in the replying affidavit.

120 Moreover, on a fair, rational and unbiased assessment of the many advantages offered by NHI, there will be every opportunity for rewarding and fulfilling careers on the part of healthcare practitioners, in a system designed to achieve far better health outcomes. That reality will counter any negative perceptions for which Genesis contends.

Ad paragraphs 42 - 49

121 I am in agreement with the advice given to Genesis that averments not relevant specifically to the proposed stay of proceedings are not appropriately dealt with here. Unfortunately, in the preceding

paragraphs this has, with respect, been overlooked by Genesis and those who briefed them.

122 In the event that the direct challenges in the High Court proceed, the Minister will put up substantial expert evidence in response to that put up by Genesis in its initial report.

123 No inferences should be drawn from my failure to respond to the initial report here.

124 The debate in the stay application focusses entirely on what will and, more importantly, will not take place during the initial phased, gradual and progressive implementation of the NHI Act, subject to financial resource availability.

125 Accordingly, no purpose is served by my engaging in the debates referred to in these paragraphs based on full implementation. That is a matter for another day. No inferences should be drawn from my failure to respond to that debate here.

Ad paragraphs 50 - 53

126 These paragraphs set out the conclusions purportedly reached by Genesis.

127 In essence they repeat averments already made earlier in the supplementary Genesis report and I have already responded to those. In response, I refer to what I have said earlier in this affidavit and in the supplementary replying affidavit.

128 In particular, I deny that the granting of the stay would materially harm South Africa's healthcare system during the period of the stay.

129 Unfortunately, this averment along with all of the others set out in this concluding section are based on the flawed legal advice given to Genesis as to the operation of the NHI Act and in particular s 57 and 57(1)(b) thereof.

130 Genesis has failed entirely even to refer to s 57(1)(b), let alone to analyse its implications for the period of the stay application.

131 I have dealt at length why the R3.5 Bn that will become available from the withdrawal of medical tax credits for high income earners is sufficient and appropriate to achieve the phased, gradual and progressive implementation based on financial resources required by the NHI Act for this initial phase. Implementation will be timed to adjust to when that R3.5 Bn becomes available, in accordance with s 57(1)(b).

132 I have dealt also with the claim of adverse selection purportedly based on the withdrawal of medical tax credits for higher income earners. I have done so based on hard numbers. These discredit Genesis' predictions of imminent catastrophe.

133 I have dealt also with the assertion that the NHI will dampen investment and heighten emigration. It will do the reverse.

134 I accordingly deny the conclusions reached in the supplementary Genesis report.

DEPONENT

I hereby certify that the deponent knows and understands the contents of this affidavit and that it is to the best of the deponent's knowledge both true and correct. This affidavit was signed and sworn to before me at PRETORIA on this the 17TH day of NOVEMBER 2025, and that the Regulations contained in Government Notice R.1258 of 21 July 1972, as amended by R1648 of 19 August 1977, and as further amended by R1428 of 11 July 1989, having been complied with.

COMMISSIONER OF OATHS

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