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IN THE HIGH COURT OF SOUTH AFRICA
Gauteng Division, Pretoria

CASE NO: **2025-125411**

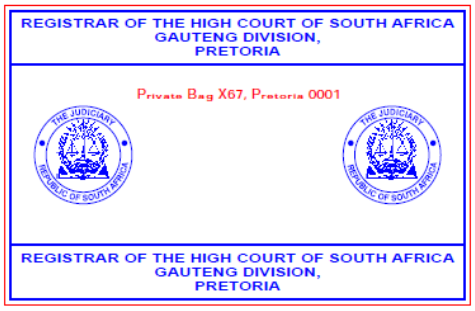
In the matter between:

THE MINISTER OF HEALTH ,THE DIRECTOR GENERAL NATIONAL DEPARTMENT OF HEALTH	Plaintiff / Applicant / Appellant
and	
THE PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA ,THE MINISTER OF FINANCE ,NATIONAL TREASURY ,SOLIDARITY TRADE UNIOIN ,BOARD OF HEALTHCARE FUNDERS OF SOUTHERN AFRICA NPC ,SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM ,HOSPITAL ASSOCIATION OF SOUTH AFRICA ,THE SOUTH AFRICAN MEDICAL ASSOCIATION NPC ,HEALTH FUNDERS ASSOCIATION	Defendant / Respondent

---

Answering Affidavit

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

IN THE HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, PRETORIA)

CASE NO: 2025-125411

In the application 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**

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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**

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

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

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THE PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA **First Respondent**

THE MINISTER OF HEALTH **Second Respondent**

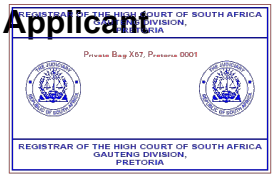
THE MINISTER OF FINANCE **Third Respondent**

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**

CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES **Fourth Respondent**

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And in re:

Case No: 2025-083348

HEALTH FUNDERS ASSOCIATION **Applicant**

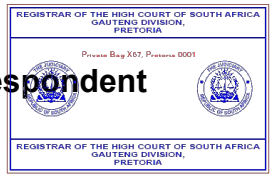
and

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**

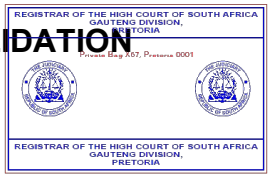
MINISTER OF FINANCE **Second Respondent**

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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**

FILING NOTICE

DOCUMENT TO BE FILED:



1. **SAKELIGA'S ANSWERING AFFIDAVIT IN THE STAY AND CONSOLIDATION APPLICATION**
2. **CONFIRMATORY AFFIDAVIT – WASSENAAR PJ**
3. **NOTICE OF MOTION IN CONDITIONAL COUNTER-APPLICATION**

DATED at PRETORIA on 17 OCTOBER 2025.

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REF: C ERASMUS/ J KEUS/X64/2025



IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE NUMBER 2025-125411

In the application 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

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GAUTENG DIVISION,
PRETORIA

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

2 RVL

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

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

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

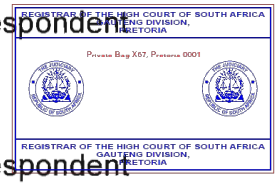
3

RVL

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

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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

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

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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SAKELIGA'S ANSWERING AFFIDAVIT IN THE STAY AND CONSOLIDATION APPLICATION

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

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

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I, the undersigned,

RUSSELL VICTOR LAMBERTI

hereby make oath and say that:

1. I am an adult male economist. I am a director of and the Chief Economist of the tenth respondent ("**Sakeliga**").

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2. The facts in this affidavit are true and correct. Such facts fall within my personal knowledge, unless otherwise indicated or where the contrary is evident from the context hereof. Where I make legal submissions herein, I do so on the advice of the legal representatives of Sakeliga.

3. I am duly authorised to oppose this application on behalf of Sakeliga.

4. I have read the founding affidavit, supplementary founding affidavit and replying affidavit deposed to by **NICHOLAS GILMOUR CRISP** ("**Dr Crisp**"), on behalf of the first and second applicants, and answer thereto herein below.

5. I have also read the answering affidavits (and, where applicable, the supplementary answering affidavits) filed by the respective respondents participating in this application.

6. As far as reasonably possible, I adopt in the present affidavit the same terms as defined in the founding affidavit. I will refer to the first and second

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applicants, collectively, as "**the Minister**".

7. In this affidavit, I will:

7.1. First, provide an overview of Sakeliga's constitutional challenge to the NHI Act;

7.2. Second, set out the grounds of Sakeliga's opposition to the stay application;

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7.3. Third, set out the grounds in support of Sakeliga's conditional counter-application, which arises only if the court grants an order staying the constitutional challenges;

7.4. Fourth, set out the reasons why Sakeliga does not, in principle, oppose a consolidation. Sakeliga does, however, oppose the further conditions initially sought by the Minister in his notice of motion, and which the Minister, in his replying affidavit, appears to have left to the discretion of the court. Sakeliga will briefly record the reasons why such conditions are inappropriate;

7.5. Finally, I answer only certain paragraphs raised by the Minister and/or the President in their affidavits to the extent not dealt with in the sections referred to above.

A. AN OVERVIEW OF SAKELIGA'S CONSTITUTIONAL CHALLENGE

8. In Sakeliga's challenge to the NHI Act, Sakeliga principally seeks orders that it be declared that:

8.1. the NHI Act is not rationally connected to the purpose of the NHI Act and is therefore irrational and unconstitutional;

8.2. the NHI Act is in breach of section 27 of the Constitution and unconstitutional in that:

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GAUTENG DIVISION,
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8.2.1. the implementation of the NHI Act is not within the state's available resources;

8.2.2. the implementation of the NHI Act unjustifiably infringes other socio-economic rights such as the right to housing, water, social security and education;

8.2.3. the NHI Act is neither coherent and coordinated nor reasonably conceived and implemented, and is not a reasonable legislative measure as contemplated in section 27 of the Constitution;

8.2.4. the implementation of the NHI Act results in a regression in access to health care services;

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8.3. the state has failed to take reasonable economic and governance measures, within its available resources, to achieve the progressive realisation of access to health care as contemplated in section 27(1)(a) of the Constitution;

8.4. the NHI Act is inconsistent with sections 1, 2, 7, 8, 10, 12, 14, 18, 22, 25, 26, 27, 29 and 36 of the Constitution;

8.5. the NHI Act is unconstitutional and invalid.

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9. A copy of Sakeliga's complete notice of motion is attached by Dr Crisp to the replying affidavit marked "**RA1**" (at CaseLines, p. 009-102).

10. Sakeliga has launched its application on behalf of its members and in the public interest.

11. In support of its application, Sakeliga commissioned the services of Professor Jannie Rossouw, Dr Fanie Joubert and Mr Michael Holland of PriceMetrics (Pty) Ltd ("**PriceMetrics**"), an independent economic research firm, to conduct an independent economic and fiscal affordability analysis in respect of NHI.

12. Professor Rossouw, Dr Joubert and Mr Holland each hold advanced degrees in economics, and have decades of experience, both academic and professional, across the public and private sectors.

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13. I am an economist and have practised as such for 20 years in South Africa, specialising in global and South African macroeconomic research, fiscal policy research and economic policy analysis.

14. Sakeliga's challenge is based on and supported by three expert reports prepared by PriceMetrics. In the first report, Mr Holland provides an overview of health care services in South Africa. This report provides the context of the challenge, and I do not attach it hereto.

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(a) No objective conditions necessary for the implementation of the NHI Act are present in South Africa

15. In the second report, Mr Holland provides a comparative international review of South Africa and 16 countries with single-payer health care funding systems. A copy of this report is attached, marked "**SL1**".

16. The report shows that, in general, a successful comprehensive single-payer system that achieves a high degree of 'universal health coverage' (UHC) must meet the following criteria:

16.1. a high GDP per capita, which defines the country as a high-income country;

16.2. a strong fiscal capacity that provides sufficient and efficiently collected tax revenue to finance the health care needs of the whole population;

16.3. comprehensive health care resources, including health professionals,

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pharmaceutical products, medical infrastructure (clinics, hospitals, other health establishments), and health information systems;

16.4. strong governance of the health system: a highly competent and relatively incorrupt government and public sector bureaucracy to administer the system, including sophisticated information systems to monitor and control costs and fraud, effective reimbursement procedures for health care providers, and regulation of health outcomes;

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16.5. high levels of stakeholder acceptance and political consensus over the electoral cycle, given the large funding requirements. In particular, there must be a strong commitment from health care professionals and suppliers of health care services (health establishments) and products (pharmaceutical companies and medical equipment suppliers). There needs to be a reasonably high level of social solidarity among a country's population, which accepts the heavy cross-subsidisation of health care (i.e., high/middle-income households, the healthy, and younger people supporting low-income households, the unhealthy, and the elderly).

17. None of these conditions, which are necessary for even the partial or progressive implementation of the NHI Act, are present in South Africa.

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18. As set out in detail in Sakeliga's founding affidavit in its constitutional challenge with reference to the PriceMetrics reports:

18.1. South Africa does not have a high per capita income. It is a middle-income country. The difference between South Africa and the country with the lowest single-payer per capita income, Portugal, is stark. In 2021, Portugal had an annual GDP per capita of over $24,000. South Africa's was approximately a quarter of that at $6,843 in 2021. South Africa's GDP per capita has, in fact, dipped since 2021. In aggravation of this, South Africa is not even on the road to becoming a high-income country in the short to medium term, based on current economic policy and performance. South Africa's economy has stagnated since 2014 with declining GDP per capita in most years. It is practically impossible for South Africa to achieve a similar level of GDP per capita similar to other single-payer countries to enable the implementation of NHI in the next 10-15 years, let alone the next 50 years. In fact, no middle-income country has achieved single UHC with a fully-fledged single payer system, as envisaged in the NHI Act.

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18.2. South Africa does not have strong and sustainable fiscal capacity. The South African government's health care expenditure as a percentage of GDP in 2021 was 5.5%. Countries with single-payer systems and among the highest government spending on health care in the world tend to spend no more than 6-10% of GDP on health care. This constraint arises from the crucial trade-offs that governments are forced to make in their budgets to meet obligations in other areas,

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such as education, defence, policing, housing, and so on. These constraints are magnified in South Africa. I return to this aspect below.

18.3. In addition, there are other constraints on fiscal policy, including:

18.3.1. A high, growing, unsustainable debt-to-GDP ratio, exceeding 75% in 2024, and substantially above international norms for emerging markets. According to the latest IMF forecast, government debt will increase to nearly 89% of GDP without including a provision for NHI.

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18.3.2. The country also has a very narrow personal tax base and relatively high marginal rates (top rate of 45%) for a middle-income country, indicating scant room for tax increases. The current number of individual taxpayers in South Africa is 7.4 million, representing 18% of the working-age population of 41.6 million and 12% of the total population of 63 million.

18.3.3. South Africa's unemployment rate, one of the highest in the world, together with its large youth and growing old-age population represents an already extremely high level of dependency on the employed population and denies the government the substantial tax revenue that would be required which is a considerable constraint on potential tax revenue.

18.4. Collectively, these constraints on fiscal policy place hard limits on the capacity of the government to finance the NHI Fund, considerable enough to practically preclude the NHI from meeting its objectives of universal health coverage.

18.5. South Africa lacks the high-quality governance and administrative capacities necessary from the government departments and agencies that manage the system. There is strong evidence of high levels of corruption and administrative inefficiencies in the state health sector. This is illustrated most recently by the Special Investigating Unit's recent exposure of three coordinated syndicates responsible for the looting of R2 billion meant for health care at the Tembisa Hospital alone.

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18.6. South Africa does not have sufficient human resources (i.e. medical practitioners – doctors, nurses, etc.) and lacks the necessary health care infrastructure for a single-payer system. The NHI cannot be implemented without adequate public sector health infrastructure and facilities.

18.7. The NHI lacks broad stakeholder support. Apart from a lack of support from the very medical practitioners required to implement the NHI scheme, notable support for the ideal of universal health coverage is undermined by a lack of trust amongst the public that the government is able to implement NHI successfully given its poor track record in managing other public services and public enterprises. Single-payer

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countries tend to have moderate to high trust in government, along with capable governance. South Africa lacks both – it has low trust and poor governance.

18.8. Moreover, all countries with single-payer health systems (except for some provinces of Canada) allow private-sector health insurance in order to create more fiscal space.

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19. The results of this comparison are tabulated below.

Table 3: Summary Table of Criteria Comparison – South Africa and Single-Payer Countries

Summary Table: Comparison of key criteria
South Africa and countries with single-payer healthcare systems

Country	GDP / capita ($)		Govt Health spend / capita ($)	Employment-to-Population Ratio (%)	World Governance Indicators (-2.5 to +2.5)	Nurses per 1000 people	Doctors per 1000 people	Edelman Trust in Govt (%)	Single-payer legislation allows private insurance?
South Africa	6 843	Middle-income	377	28%	-0.3	5.0	0.8	22%	Effectively No
Bahrain	27 148	High-income	778	57%	0.7	2.3	0.8	..	Yes
Canada	52 497	High - income	4 757	53%	1.6	10.3	2.5	51%	Partial
Cyprus	33 734	High-income	2 592	52%	0.6	4.6	3.6	..	Yes
Denmark	69 728	High - income	6 314	51%	2.1	10.6	4.4	..	Yes
Finland	53 099	High - income	4 248	48%	1.9	19.3	4.4	..	Yes
Iceland	69 326	High - income	5 685	59%	1.5	15.8	4.4	..	Yes
Italy	36 853	High-income	2 564	40%	0.6	6.5	4.1	46%	Yes
Kuwait	34 044	High-income	1 704	59%	0.2	4.6	2.3	..	Yes
Norway	93 073	High - income	7 847	53%	1.8	18.9	5.2	..	Yes
Portugal	24 711	High-income	1 725	48%	0.8	7.8	5.8	..	Yes
Slovenia	29 187	High-income	2 027	48%	0.8	10.6	3.3	..	Yes
Spain	30 818	High-income	2 342	44%	0.7	6.5	4.5	36%	Yes
Sweden	61 175	High - income	5 846	52%	1.8	11.5	4.3	57%	Yes
Taiwan	33 100	High-income	2 218	50%	1.4	6.5	2.3	..	Yes
UAE	43 360	High-income	1 475	64%	1.2	6.4	2.9	86%	Yes
UK	46 897	High - income	4 752	49%	1.4	9.2	3.2	37%	Yes

Sources: World Bank Development Indicators; World Governance Indicators; Edelman Trust Barometer; Legislation from single-payer countries; NHI Act

20. These are not opinions or unsupported facts. They are objective facts supported by publicly available data which strike at the heart of the rationality of the NHI Act.

(b) Economic analysis and fiscal affordability analysis

21. The third PriceMetrics report provides an economic and fiscal affordability analysis of the NHI Act. A copy of this report is attached, marked "**SL2**.

22. In terms of the NHI Act, national health insurance will be phased in over a period of time, with a time frame of 15 years (at the most) mentioned as the phasing-in period. However, the NHI Act provides no timeframe for phasing-in of the provisions of the NHI Act, which complicates economic and fiscal calculations about its cost once fully phased in and operational. To overcome this limitation, assumptions about dates for fully phased-in NHI were used to compile the report, i.e., 2028 and 2039.

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23. The NHI Act envisages the financing of the NHI will be from a variety of sources, including general tax revenue, the shifting of funds from the provincial equitable share and conditional grants into the Fund; the reallocation of funding for medical scheme tax credits towards the financing of national health insurance; a payroll tax (employer and employee); and a surcharge on personal income tax. These taxes will be raised on top of tax rates that are already high in South Africa and will negatively impact the country's economic growth prospects.

24. A further complication and shortcoming of the NHI Act is that no indication of its total cost implications, once fully implemented, was provided when the NHI Bill was considered in Parliament.

25. The memorandum published with the NHI Bill considered in Parliament

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avoids, in Section 8 (Financial Implications for the State), any mention of the full cost of providing fully implemented national health insurance services.

26. The 2017 White Paper does not even show inflation adjustments of the 2010 estimates for implementation to 2017 values (the publication date of the White Paper), thus creating a false impression of actual implementation costs. Nevertheless, the 2010 values (adjusted for inflation) are used in the PriceMetrics report as the government's estimates, as no other value(s) have since been provided by the government. To the contrary, the Minister of Health merely ridiculed other estimates of the cost of fully implemented national health insurance made by private sector institutions without providing his own estimates.

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27. This is a critical omission on the part of the South African government, the Minister of Health, and legislators. Large-scale government social programmes such as the full implementation of national health insurance generally require substantial fiscal capacity or fiscal space to be affordable. In addition, they should be accompanied by a detailed and up-to-date cost-benefit analysis of their feasibility/infeasibility within the fiscal framework. Such an analysis should have a transparent methodology and conclusions that can be publicly scrutinised and verified.

(c) <u>South Africa's economic environment</u>

28. The analysis in the report shows that South Africa's economic performance has seriously declined for nearly two decades, and the general trend in the country's public finances is at or close to unsustainable levels, even before

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considering the NHI.

29. South Africa is in a long-term low-growth state, which provides little scope for costly new government initiatives.

30. To the contrary, any scope in government finances should rather be used to contain the government's rising debt burden and the interest payable on this, as these aspects impact negatively on South Africa's fiscal and economic stability.

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31. The current fiscal position dictates that the government should reduce expenditure and/or increase revenue to avoid a possible fiscal crisis.

32. Since 2008, the South African government has increased social grant expenditure and civil service remuneration, while interest payments on government debt increased with rising government debt levels. These items together currently account for more than 70% of government revenue, from a level of 55% in 2008.

33. A continuation of this growth trend will bring South Africa to a fiscal cliff, i.e., the point where these expenditure items will account for all government revenue. Neither fiscal capacity nor fiscal scope exist within the current revenue and expenditure framework for additional spending commitments.

34. The forecast of future trends in the economy projects continued low economic growth. This is based on the recent performance of the economy, the

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anticipated global economic environment, and on current and planned economic policies. It shows that even 2,0% per annum growth is beyond the economy's ability in the short-term, and the long-term growth potential is about 1,5% per annum. This, in turn, affects state finances, and the analysis shows little fiscal scope or capacity within the current government expenditure framework.

(d) <u>The funding shortfall for NHI</u>

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35. In 2028 values, the estimate of the annual funding gap, based on the government's 2015 and 2017 White Papers, is some **R483,1 billion** for full implementation of NHI as envisaged in the NHI Act.

36. I pause to note that this funding gap estimate, based on the government's own cost estimates, while very large in fiscal terms (as will be shown herein below), is arguably still conservatively small given the experts' own calculations and those of numerous other credible published values documented in the PriceMetrics report. These alternative calculations produce considerably higher estimated funding gaps. The conclusions herein below of the negative economic impacts of the fiscal and taxation burden of the NHI can therefore be considered relatively conservative or moderate, i.e. they may well underestimate the harms.

37. A calculation of combinations of revenue-raising options from various alternative tax increases to fund this gap is summarised in Table 1, depicted below. The numbers in the table are reported in billions of rands. The order of magnitude of the required increases shows beyond any doubt that raising this

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amount of tax will place a debilitating burden on South Africa's economy and consumers.

Table 1: Additional Revenue Sources for the South African Government to Fund an NHI Funding Gap of R483,1 billion in 2028

Personal income tax surcharge		
10% surcharge	20% surcharge	31% surcharge
95.5	191.0	295,7
Value-added tax		
+ 1 percentage point	+ 2 percentage points	+ 3,5 percentage points
40.3	80.6	142,1
Payroll tax		
2% on income above R212544	2% on income above R212544	2% on income above R212544
45,3	45,3	45,3
.		
Medical aid tax credits already deducted in funding gap calculations		
Totals		
181,1	316.9	483,1

Source: Own calculations

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38. Table 1 (above) provides combinations of options that can be used to fund the projected NHI shortfall of R483,1 billion in 2028. It can be restructured to show other combinations or to show how different amounts can be raised to fund the estimated shortfall in 2028 NHI funding, but the same principles will apply.

39. The conclusion is that an extra funding requirement of **R483,1 billion** will place a great burden on South Africa's economy, equal to an increase of some 15% to 20% in total taxation estimated for 2028.

40. The objective of raising the shortfall of R483,1 billion is achieved in this instance by:

40.1. a surcharge of 31% in personal income tax;

40.2. an increase of 3,5 percentage points in VAT; and

40.3. a payroll tax of 2% on taxable income above R212 544 per annum.

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41. The State's assumption that the extra personal income tax burden of 31% on each individual taxpayer (each taxpayer paying 31% more on their tax bill), combined with a payroll tax and a VAT increase, will not have any impact on consumption and saving by individuals is clearly wrong.

42. Funds for taxpayers to pay this extra tax will have to be sourced from either reducing their consumption, reducing savings or a combination of both.

43. Put differently, and to illustrate: based on the 2024/25-tax tables, a person earning annual taxable income of R857 900 will pay an additional R77 889,98 per annum in tax, given the implementation of a surcharge of 31 per cent. This amounts to an additional R6 490,83 per month income tax on a monthly taxable income of R71 491,67 (i.e., some 9,1%), on top of the current income tax burden of R20 938,17 per month (R251 258 per annum) that will be sourced by means of less consumption, less saving or a combination of both.

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44. In other words, the new annual tax burden of R329 148 (R251 258 + R77 890) would be 31% higher than the tax burden of R251 258 before the increase.

45. This increased tax burden will have a severely negative impact on real economic activity (for instance, economic growth, company profits, and other taxes) and behaviour (for instance, spending patterns, saving, hours worked, emigration, etc), thus reducing other tax revenues.

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46. In recent years, South Africa has experienced a decline in tax buoyancy, implying that tax rate increases resulted in smaller-than-expected revenue increases. This brings to mind the theoretical concept of the Laffer curve, which shows that tax rates can be raised to a level where the total taxes collected actually start to decline owing to the harmful economic effects of higher tax rates.

47. Although difficult to calculate in practice, this complicates the picture as one cannot guarantee that higher tax rates will necessarily result in the additional revenue, as calculated. This aspect might become more prominent in South Africa when applying the draconian tax hikes required to fund the shortfall/deficit estimated in Table 1 (above). In short, South Africa's fiscal capacity to raise taxes is decidedly limited.

48. I note that this is another reason to consider the negative economic and fiscal conclusions herein below as relatively conservative or moderate, i.e. they may well underestimate the harms.

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49. The impact of the reduction in personal household expenditure, a higher VAT rate and a payroll tax on income above R212 544 on the domestic GDP will, to some degree, be offset by an increase in government expenditure on health care through the NHI, as well as possible saving on private medical contributions and related medical costs by individuals.

50. It is, therefore, necessary to calculate the impact of a reduction in household disposable income and the additive effect of the increase in government expenditure on health care through NHI. However, a calculation of these aspects can only be based on the current economic environment and statistics. Given the complications discussed above, it cannot account for declining tax buoyancy and Laffer curve effects, i.e., a reduction in personal income taxes collected owing to an increase in the tax rate on income, resulting in work hours substituted for leisure hours. As is shown in the report, South Africa had a negative experience in tax buoyancy (i.e. validating Laffer curve effects) when a new marginal tax rate of 45% was introduced.

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51. The last increase in the marginal rate (from 41% to 45%) implied an increase of 4 percentage points, or 9,76%, in the maximum marginal tax rate. In the calculations above, an increase of more than three times greater than this is suggested by means of a tax surcharge of 31% for full NHI implementation by 2028.

52. At the lowest marginal tax rate of 18%, this implies an increase in the effective marginal tax rate to 23,58%. In the highest income tax bracket, this implies a staggering increase in the marginal rate from 45% to 58,95%. This would raise

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South Africa's marginal tax rate to the second-highest in the world after the Ivory Coast (60%) and above Finland.

53. Econometric models can be used to quantify the possible second-round effects of higher taxes and spending on economic performance. For this study, the experts work with time series data, which means that a time series econometric model is appropriate.

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54. Two econometric models were run:

54.1. The first one considered household disposable income, in which the impact of the taxation shocks (necessitated by the funding gap) was quantified; and

54.2. A second model for GDP was used, in which the combined effects of changes in disposable income and government consumption expenditure were calculated.

55. As far as the impact on aggregate household disposable income is concerned, the experts estimate a real decline starting at R63,8 billion in 2025 and increasing to a decline of R364,0 billion in 2028 as NHI is phased in over four years. For 2028, this amounts to a decline of 4,3%, compared to economic activity in 2027, once fully phased in.

56. The severity of this estimated drop becomes evident when comparing it to the previous largest contraction in real household disposable income of -5,1%

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recorded in 2020, during the COVID-19 lockdowns and declared State of Disaster.

57. Using nominal values, this effectively means that in order to fund the 2028 shortfall of R483,1 billion, the risk is that household disposable income could drop by as much as **R500,7 billion** – implying a clearly irrational decision on the part of the state.

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58. To quantify the growth impact, a second econometric model was run using, among others, household disposable income and government consumption expenditure as explanatory variables.

59. In this case, the results from the first model (i.e. for disposable income) were used as input (forecast values) for GDP forecast estimates. Government consumption expenditure (G) was hypothesised to have a stimulatory impact on GDP, and to forecast G, Professor Rossouw, Dr Joubert, and Mr Holland assume a nominal growth rate of 6% per annum (i.e., 1.5% real increase in GDP and an average annual inflation rate of 4.5%). The additional taxes raised (i.e. the value of the estimated funding gaps) were also added for each year.

60. The results indicate that the dampening effect of lower household disposable income will outweigh the additional consumption from an increase in government expenditure.

61. Compared to a base case forecast, real GDP growth for Year 1 (which, in the

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report, is assumed to be 2025) is expected to increase by a meagre 0,1% y:y, compared to an expected rise of 1,3% in the base case scenario.

62. The growth performance worsens over the forecast horizon as the increased tax burden takes effect, with the 2028 figure indicating an annual contraction in GDP of more than 4,0%. To put this into perspective, in 2020, during the height of the COVID-19 economic lockdowns, South Africa's GDP contracted by 6,2% in real, inflation-adjusted terms (see Figure 1, depicted below).

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Figure 1: Estimated Impact of Phased in NHI on Real GDP Growth



*Own forecasts. Source: SARB and StatsSA data.

63. I point out that such a contraction is not a temporary feature where the economy bounces back after the crisis dissipates, as demonstrated in the COVID-19 acute lockdown period "dip" in Figure 1 above, when economic activity recovered quite quickly in 2021/2022. The contraction referred to by PriceMetrics is self-inflicted damage to the economy over the long run. It will lead to a long-term contraction of South Africa's GDP, which will have

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prolonged severe effects not only on health care but on all sectors within the economy.

64. In nominal terms, GDP in 2028 is estimated to be around R1,01 trillion less than the baseline forecast scenario, the latter excluding the extra tax burden to fund fully implemented national health insurance.

65. Put differently, the cumulative effect of a phased-in NHI by 2028 will result in South Africa's GDP being around 10,7% smaller compared to the baseline model without NHI.

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66. Prolonged and severe economic contractions of this magnitude are considered structural economic depressions which profoundly alter the long-term wealth and income-producing prospects of communities within a country. Historically, contractions of this magnitude lead to, amongst others, severe job losses and increased long-term unemployment, widespread business failure and loss of livelihoods, and broad-based declines in the quality of life as measured by diminishing access to nutritious food, clean water, adequate sanitation systems, secure housing, and many other important goods and services.

67. Such economic failure not only deals a particularly harsh blow to those who are already poor, vulnerable, and less economically mobile, but it also, ironically, takes an enormous health toll across the population through deteriorating nutrition and sanitation, rising stress levels, increased

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depression and suicide, worsening alcoholism and drug abuse, and considerable aggravation of violent crime.

68. Professor Rossouw, Dr Joubert, and Mr Holland conclude that, with continued population growth and other demands on the economy, a decline in economic activity owing to the increased tax burden required to fund a fully implemented NHI is clearly not affordable currently or in South Africa's longer-term economic future. Proceeding down the path of implementing NHI which is ultimately not affordable shall inevitably result in wasted expenditure.

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(e) <u>Sakeliga's constitutional challenge</u>

69. Based on the above, Sakeliga challenges the constitutionality of the NHI Act on several grounds, including *inter alia*:

69.1. <u>the NHI Act is irrational and an unreasonable legislative measure:</u>

69.1.1. There are a number of rational flaws with the NHI Act. The stated purpose of achieving "affordable" and "sustainable" universal access to health care is limited by two economic realities: firstly, that the state has limited resources available to it; and secondly, that the provision of any health care necessarily involves the private sector and is subject to voluntary action and market forces. The late Minister Mboweni stated in 2019 that due to the macroeconomic and fiscal outlook, the NHI is unaffordable.

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69.1.2. In 2021, Minister Godongwana stated that, based on limited costing estimates, the NHI would require R40 billion per year in additional funding and that there is insufficient capacity in the health sector to work substantively on NHI.

69.1.3. 70% of government revenue is already allocated to social grant expenditure, civil service remuneration and interest payments on government debt.

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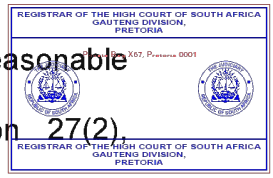
69.1.4. This does not even account for other government expenditure on critical services such as housing, water and sanitation, policing, and education, budget areas which already face major constraints. The creation of the NHI Fund will necessarily and inevitably compete for and draw on state resources and funding currently dedicated to social grants, the civil service, housing, water and sanitation, policing, and education. This is exactly what is contemplated in section 49 of the NHI Act.

69.1.5. At a time when the state must urgently implement financial stabilisation measures to avoid serious fiscal deterioration and the concomitant risks of financial, economic, and social instability, the NHI Act does the opposite.

69.1.6. Being unaffordable, the NHI will ruin both government finances and health care funding, leaving far too few

resources available to provide adequate population-wide health care coverage to the currently uninsured and insured alike.

69.2. the failure of the state to take reasonable other (economic and governance) measures to progressively realise access to good quality health care:



69.2.1. Sakeliga challenges the state's failure to take reasonable other measures, as contemplated in section 27(2), including economic and governance measures, to establish the conditions necessary to expand access to good quality health care (see paragraphs 16 to 19 above).

69.3. <u>that the NHI Act is premised on a flawed cost-saving rationale:</u>

69.3.1. The alleged rationale behind a single-payer system is that a single, dominant buyer can drive prices of goods and services down for the benefit of the user. So, it is argued that the Fund can (and will) achieve cost savings through concentrated buyer power (monopsony effects) and regulated pricing. This rationale is flawed as *inter alia* (i) state procurement inefficiencies negate theoretical savings, (ii) supplier margin erosion creates shortages and supply concentration, (iii) South Africa has limited market power in global health care markets.

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69.4. the NHI Act is an unjustifiable limitation on other socio-economic rights:

69.4.1. There are less restrictive means to achieve the same outcome within the framework of the Constitution. Due to the immense cost to implement the NHI, the NHI Act necessarily and inevitably limits the other socio-economic rights in the Bill of Rights. This limitation is unjustifiable. Health care is dependent on many other factors, such as a healthy environment, clean water for drinking and bathing, healthy food, adequate shelter and housing (including proper sewerage systems and waste services), education relating to health and hygiene, and, in the case of the most vulnerable communities, income transfers and private charity to obtain food and the most basic commodities.

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69.4.2. The NHI Act will not advance or progressively realise the right of access to health care but will adversely affect the state's ability to deliver every other constitutional imperative. Moreover, the deleterious effect on South Africa's economy will lead to severe job losses, increased unemployment and a greater number of people who will be dependent on the state for social grants, which the state will be even less able to afford.

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B. A STAY IS NOT IN THE INTERESTS OF JUSTICE

70. The Minister advances four grounds in support of a stay of the constitutional challenges:

70.1. A concern for expending public money to advance litigation that might be rendered moot;

70.2. The alleged undesirability for the High Court and Constitutional Court to conduct parallel enquiries into the constitutionality of the NHI Act;

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70.3. The allegation that a stay is akin to a separation in terms of rule 33(4) of the uniform rules of court; and

70.4. An alleged lack of prejudice to the constitutional challengers.

71. Sakeliga accepts that the Minister advances the same grounds in respect of Sakeliga's application. I proceed on the basis of this assumption.

72. Sakeliga submits that a stay of the constitutional challenges is not in the interests of justice for the reasons already canvassed in the answering affidavits of Solidarity, SAPPF, HASA and the HFA. Sakeliga aligns itself with such grounds. In the interest of brevity, I do not repeat those grounds herein. In addition, Sakeliga relies on the facts of its own application to further advance such grounds of opposition and, where necessary, add further grounds of opposition.

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(a) <u>The stay application undermines South Africa's constitutional order</u>

73. Legislation and the exercise of executive authority may be challenged and subjected to constitutional scrutiny.

74. This is not some lofty notion or ideal. It is a cornerstone of a constitutional order and is necessary to protect citizens and residents against excesses of state power.

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75. It is this fundamental tenet of a constitutional order that underpins both the supremacy of the Constitution and the rule of law as contemplated in section 2 of the Constitution, the right of access to court in terms of section 34 of the Constitution, and the Court's duty in terms of section 172 of the Constitution.

76. It is this fundamental nature of constitutionalism which means that responsible litigation expenditure incurred by the executive in defence of constitutional challenges cannot be said to be wasteful.

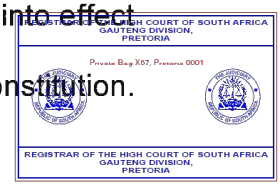
77. Sakeliga does not share the Minister's cynical view that, if this litigation is rendered moot, all of this will have been for nought.

78. The disputes between the constitutional challengers and the Minister in respect of the NHI Act run deep and have never been properly ventilated. I respectfully submit that the court has a duty to get to the burning issue in dispute between the parties.

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79. The progress of the constitutional challenges allows for a proper and substantiated ventilation of the disputes between the parties, even prior to a hearing date and without recourse to substantial judicial resources. This will be to the benefit of the parties in understanding each side of the argument, for the benefit of the Court, alternatively for the benefit of Parliament in its deliberation. In this respect, merely on the basis of the constitutional challenges, Dr Crisp states in his replying affidavit (without conceding the point) that sections 4(2) and 4(5) of the NHI Act will not be brought into effect until such time as they are amended and brought in line with the Constitution.



80. The stay application is, in effect, an indefinite stay of serious constitutional challenges subject to a plethora of speculative contingencies and possibilities which shuts the doors of the court to the constitutional challengers and permits the executive to continue with far-reaching, unconstitutional conduct. Such unconstitutional conduct is exactly the sort of excesses of state power and authority that the Constitution contemplates may and ought to be challenged.

81. This is a constitutional imperative which is, with respect, wholly destructive of the stay application.

82. Even if Sakeliga is wrong in this regard (which is denied), if there is to be a stay, it must be tempered by an adequate and concomitant restraint of the excess of state power. I return to this aspect below.

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(b) <u>The mere possibility of mootness is not a sufficient reason for a stay</u>

83. Sakeliga submits that the mere possibility that the substantive challenges may at some undefined future date be rendered moot is insufficient to grant either a stay or for the court to indefinitely delay the progression and hearing of the substantive challenges.

84. Mootness can only be taken into account by the court upon its occurrence, and the work of the courts cannot be paralysed by the mere possibility thereof.

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85. Indeed, the resolution of disputes is the purview of the Court. This is all the more apposite in constitutional matters where the Courts have the exclusive right to declare laws or conduct inconsistent with the Constitution. The parties cannot refer their dispute for arbitration or mediation. The only manner in which anything akin to such a process can be achieved is by the ventilation of the issues in dispute through the exchange of affidavits.

(c) <u>Responsible governance requires a determination of the constitutionality of the NHI Act</u>

86. The burning issue which the court is called upon to determine is the constitutionality of the NHI Act.

87. This is a live dispute between the constitutional challengers and the state respondents. The determination of this dispute is clearly in the public interest as it will substantively inform, not only the conduct of the executive in the short-term, but also of Parliament.

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88. If Sakeliga (and the other applicants in the constitutional challenge) are correct and the NHI Act is set aside due to its unconstitutionality, then Parliament is properly enabled to give due regard to the scheme and the issues of constitutionality.

89. The Minister's avoidance of the substantive challenges and targeted litigation strategy, which is intended to avoid dealing with such challenges, is irresponsible. Moreover, the continued implementation of the NHI Act is fiscally irresponsible.

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90. Dr Crisp makes the bold statement that he has been deeply and centrally involved in the financial and fiscal planning around the implementation of NHI Act and that he is *"…therefore very well acquainted with the financial and fiscal implications of every envisaged phase of the implementation of the NHI Act".* Dr Crisp goes so far as to <u>assure</u> the court that the *"…harms purportedly foreshadowed in these and subsequent paragraphs of the HFA's answering affidavit will not eventuate."* (Replying Affidavit, paras 205-206, CaseLines p. 009-86.)

91. Dr Crisp's statements are wholly unsubstantiated and constitute inadmissible opinion and hearsay evidence. Dr Crisp, a medical doctor by profession, can only be relying on the evidence of some other unknown person/s whose qualifications and expertise in financial and fiscal matters are not stated, and the probative value of which is not placed before the Court.

92. As far as Sakeliga is aware, Dr Crisp has only put up medium-term costing

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estimates in respect of the 2020/21, 2021/22 and 2022/23 financial years in answer to Solidarity's application.

93. Dr Crisp's failure and, indeed, reluctance to disclose to the Court the financial and fiscal implications of every envisaged phase of the implementation of the NHI Act, particularly in respect of the period for which the stay is sought, shows that Dr Crisp is not being open and transparent with the court.

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94. Proper economic modelling and analysis, as set out in the PriceMetrics reports above, demonstrates unequivocally that the NHI is inappropriate for South Africa's political, social and economic reality, is financially impossible to achieve, and ruinous to pursue. Therefore, attempting to implement the NHI will destroy what good there is in health care in South Africa without any other option or alternative. The failure on the part of the state to conduct rational analysis and justification through proper, prior economic modelling, has very real, dire consequences.

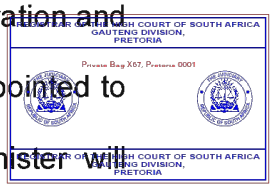
95. Insofar as the Minister may contend that Dr Crisp is somehow not required to have disclosed such information to the Court, this is denied:

95.1. A central pillar of a number of the constitutional challenges to the NHI Act is the rationality and reasonableness of the NHI Act. The financial and fiscal implications of the implementation of the NHI Act are squarely challenged and thus highly relevant to the Court's consideration of the interests of justice. This ought to have been placed upfront in the Minister's founding affidavit;

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95.2. The waste of state resources is central to the Minister's stay application. The costs of the litigation will plainly pale in comparison to the costs of progressive implementation of the NHI Act, not to mention that the state is intent on establishing the NHI Fund together with the associated bureaucracy, administration and personnel. If the substantive challenges to the NHI Act are rendered moot by a decision of the Constitutional Court, then the empowering legislation which provided for the establishment of the bureaucracy, administration and personnel falls away and, with it, the jobs of the people appointed to these positions. This snap-back scenario (which the Minister will cause by continuing with implementation of the NHI Act) is plainly not in the interests of justice and risks throwing the Minister into a raft of further litigation – this time at the behest of the NHI Fund's former employees and trade unions.



95.3. Finally, I ask rhetorically, why is it necessary for Dr Crisp to have given such assurance? The court can judge this aspect for itself.

96. If 'potential mootness' and the conservation of state resources is the Minister's and the President's true concern as stated in support of the stay application, this militates squarely against the implementation of the NHI Act. Out of that very same concern, the President would not bring the Act into operation or permit the allocation of substantial resources and reorganisation of state health care until such time as the constitutional challenges are squared away.

97. Importantly, the Minister ought to have already been in possession of the

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necessary resources to justify the NHI Act and defend the substantive challenges thereto. There is no delay or significant cost to the state in placing the financial and fiscal information which Dr Crisp admits to be in his possession, in the form of an affidavit and presented to the Court in opposition to the substantive challenges.

(d) <u>The infringement of Constitutional rights</u>

98. It is abundantly clear that the Minister and the President are pursuing the NHI Act above all. While the Minister may have the luxury of doing so as health is his portfolio, the President and the Minister of Finance do not.

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99. As shown by PriceMetrics, the state simply does not have the fiscal capacity to implement the NHI Act. Stated differently, the state has insufficient resources to cover its existing expenditure, let alone spend even more in pursuit of NHI.

100. This is the fiscal cliff where the state cannot borrow more money, and raising taxes has a diminishing effect.

101. Before Sakeliga is accused of fear-mongering, I point out:

101.1. The reality of South Africa's constrained fiscal capacity and the fiscal cliff has been acknowledged by the Minister of Finance. I attach hereto a press article in this respect, marked "**SL3**".

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101.2. It is for exactly this reason that, earlier this year, the Minister of Finance sought to raise value-added tax. This was, however, met with ardent political and legal opposition and ultimately led to the Minister of Finance abandoning this idea. This shows that the government is unable to raise taxes for the implementation of the NHI Act. At the very least, the state is constrained in doing so. (I point out that the Western Cape High Court convened a full court on an urgent basis to hear the legal challenge in respect of the suspension of the VAT hike and was not hamstrung by the possible mootness of such challenges based on either executive or Parliamentary decision-making).

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101.3. The corollary of this conundrum is that the state necessarily and inevitably must shift funds from other programmes in order to give effect to the NHI Act, thereby infringing other Constitutional rights such as housing, social security, social assistance, water, and education. The 'shifting' of funds is not some benign move – it has consequences for other Constitutional rights.

101.4. This is plainly retrogressive, unreasonable, and out of kilter with the Constitutional injunction in sections 7(2) and 27(2) of the Constitution.

101.5. This undermines the Minister's statement that he is acting in the interests of the poor and vulnerable. The poor and vulnerable will be worse off as more funds are allocated to NHI.

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102. This is the unfortunate reality of the current state of South Africa's economy. Worse, there are no indications that this economic situation will change in the short or medium term. There is, however, strong evidence as set out in the PriceMetrics report that the implementation of the NHI Act will lead to a long-term contraction.

103. The current and medium-term economic reality is not the doing of the challengers to the NHI. The blame, if any, is to be squarely placed at the feet of the government's disastrous economic policies and governance failures over the past 15 years: the President's own remarks of 'nine wasted years', state capture, the assassination of whistleblowers, wide spread corruption, an already bloated public service, the government's inability to maintain financial accountability over public funds, and the recent Madlanga Commission, are all testament to these failures.

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(e) <u>The terms of the proposed stay are prejudicial</u>

104. Without derogating from Sakeliga's objection to any stay of the substantive challenges, Sakeliga records that the terms of the proposed stay, in particular, that the substantive challenges would be required to await the final determination of the procedural challenges, are highly prejudicial and unnecessary.

105. If the Constitutional Court does not set aside the NHI Act, pursuant to BHF, the SAPPF or the Western Cape Government's challenges (and bearing in mind that the state's stated principal concern is mootness), then the various High Court challenges stand on equal footing in the High Court and ought to

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be permitted to proceed. They plainly address different and unrelated aspects. As the SAPPF states, its substantive frontal challenge is self-standing and independent. The same applies to the Sakeliga constitutional challenge and the other constitutional challenges.

C. THE STATE'S ABUSE OF THE PROCESSES OF COURT

106. The Minister and the President are both at pains to explain their *bona fides* in seeking the stay. However, Sakeliga submits that the Minister and the President's *bona fides* ought to be judged by their conduct, and not their words.

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107. I refer to paragraphs 23 to 34 of the SAPPF's answering affidavit (CaseLines, p. 005-11 to 005-15). While Sakeliga is not a party to such proceedings, it is abundantly clear that the Minister and the President's conduct in such proceedings has the singular purpose of raising every technical objection and hurdle to any judicial consideration of the NHI Act.

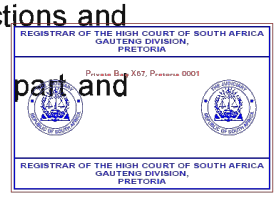
108. For the Minister's part, the Minister opposes the applications to review the President's decision to assent to and sign the NHI Bill. The Minister's opposition and conduct in that litigation is exactly the same as the President's. The Minister could have easily and, Sakeliga submits, responsibly have left the President to oppose such applications. The Minister did not do so but duplicated process and costs in respect thereof.

109. It is the same in this stay application. The President and the Minister could

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logically and sensibly have decided to split their opposition to the various applications – the President opposes the review applications, which concern his decisions, and the Minister opposes the substantive challenges, which concern the substance of the NHI Act, and falls under the purview of the Minister.

110. In truth and in fact, the state respondents are engaged in Stalingrad tactics – avoid the determination of the real dispute through a series of objections and appeals and drag the matter out for years. The stay application is part and parcel of this strategy.



111. The clear ulterior purpose behind such strategy is the continued implementation of the NHI Act, while any challenge thereto is held up in Court. This is, with respect, an unconscionable abuse of executive power and authority. It is for this reason that the Minister seeks a stay in the broad and extended terms set out in the amended notice of motion. It enforces piecemeal litigation, each step taking years to resolve, compounding the prejudice to both the review challenges and the substantive challenges – all while the Minister carries on with 'business as usual'. Again, this is the pursuit of the NHI Act by the Minister and the President above all else.

112. Sakeliga is advised and submits that the court has a duty under section 173 of the Constitution to protect its own processes against such abuse.

113. The protection of the Court's processes is best served in a manner which facilitates the expeditious resolution of disputes and the adjudication of the

constitutional matter within the power of this Court. This militates against a stay.

D. THE CONDITIONAL COUNTER-APPLICATION

114. Together with this affidavit, Sakeliga files a conditional counter-application in which Sakeliga seeks an order that, in the event that the court grants a stay of the constitutional challenges, the President and the Minister are interdicted from implementing the NHI Act.

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115. The facts in support of such relief have been canvassed by the parties in the affidavits filed to date. The Minister and President have both dealt with such an interdict, and the challengers to the constitutionality of the NHI Act have largely done so indirectly. The filing of the conditional counter-application formalises this as a possible remedy for the Court. Sakeliga will rely on the aforesaid facts read together with the facts set out in this affidavit in support of the relief in the conditional counter-application.

116. Sakeliga is advised and submits that, in constitutional matters, the court is empowered to make any order that is just and equitable.

117. The stay that is sought by the Minister that allows only a procedural challenge to proceed while deferring substantive constitutional challenges undermines section 34 of the Constitution by selectively restricting judicial access on issues that are equally rooted in the Constitution. It creates an artificial hierarchy of constitutional claims (procedure over substance) that is strange

to basic constitutionalism. Furthermore, a stay that places on hold the court's determination of the merits of the constitutional challenges to the NHI Act, all while NHI rollout continues, unjustifiably limits effective, timeous access to the courts. It effectively deprives the constitutional challengers of a remedy whilst the constitutional breaches continue. In aggravation, such approach risks leaving the applicants in the constitutional challenges with hollow relief by entrenching irreversible consequences before adjudication. The interests of justice under section 173 of the Constitution therefore favour refusing a stay or, at minimum, conditioning any stay with interim protections that preserve meaningful relief (section 172(1)(b) of the Constitution). Justice delayed is justice denied.

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118. A stay that permits continued implementation of the NHI while deferring adjudication of the substantive constitutional challenges offends the principle of legality and the supremacy of the Constitution. Legality and rule of law are compromised. Courts ought not to allow the state to press ahead under a serious constitutional cloud while simultaneously withholding determination on the merits of such challenges. In practical effect, such an order would immunise the impugned scheme from scrutiny and entrench consequences that may very well later be declared constitutionally invalid, an outcome at odds with sections 1(c) and 2 of the Constitution. It also substitutes the Constitution's requirement of legality for mere case-management convenience and creates perverse incentives for the state to pursue delay through procedural stays in future. In these circumstances, the interests of justice require either refusing a stay or, at a minimum, coupling any stay with

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protective interim relief that preserves the constitutional position pending determination on the merits.

119. The Minister seeks relief in his interests. Even if it is found that the Minister is not simply attempting to delay the constitutional challenges, and is seeking to advance the interests of the state, this is not the yardstick against which the stay is to be considered. The court must regulate its own process in the interests of justice, not in the interests of the state. A stay here would entrench prejudice (to the public and the applicants in the constitutional challenges) by enabling continued rollout while delaying adjudication of substance, contrary to the court's section 173 mandate.

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120. The state's stance in the present application for a stay of the constitutional challenges effectively asks the court to privilege the state's preferred litigation sequencing of challenges over the rule of law under the Constitution.

121. Whilst Sakeliga submits that a stay ought not to be granted for all of the multitude of compelling reasons already raised, if the court considers a stay, it must, in terms of section 172(1)(b), fashion just and equitable relief that averts ongoing constitutional harm. These facts require a conditional interdict / structural order, pausing further rollout steps pending final determination of all constitutional challenges.

122. Section 34 of the Constitution guarantees the protection of the judicial process to the applicants in the constitutional challenges. The state seeks impermissibly to stop the aforesaid applicants from accessing court to enforce

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their constitutional rights, whilst at the same time continuing to implement the NHI Act (being the very legislation that the applicants are challenging). In aggravation, the *modus* adopted by the state parties regarding the stay of the frontal challenges whilst the procedural challenges proceed serves to allow for, and approve of, an improper hierarchy of constitutional rights. This is in itself unconstitutional. Should the court incline to grant a stay of the constitutional challenges, the only manner in which to balance and mitigate the harm is to grant an order staying the implementation of the NHI Act.

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123. The Minister seeks to stall the judicial process and the Constitutional challenges pending before the court. Where the Minister seeks to stay the judicial process, it is appropriate that the implementation of the NHI Act be stayed.

124. The Minister tenders not to implement section 33 of the NHI Act. Such tender does not go far enough. No prejudice would result from staying the implementation of the NHI Act.

125. In addition, the President and the Minister have both expressed their (ostensibly) serious concerns about the waste of public resources as the challenges to the NHI Act make their way through the Courts and envisage that such challenges may be rendered moot. According to the Minister, the NHI Act will thereafter be a bill and will not have the status of law. On the Minister's and President's versions, any steps taken to give effect to and implement the NHI Act will similarly have been for nought and the funds expended on establishing a now defunct NHI Fund would be better spent on

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the provision of health care. The state's own stated concerns, motivations and case support the relief in the conditional counter-application.

126. The Minister states that he is legally obliged to give effect to the NHI Act once brought into effect by the President. However, the Minister also says that he will not request the President to implement either sections 4(2) or 4(5) of the NHI Act until they have been amended to address any alleged unconstitutionality.

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127. There is nothing that legally precludes the Court from interdicting the President from exercising the powers under section 59 on an interim basis to address the other unconstitutional provisions of the NHI Act.

128. The reasons provided in support of the stay by the Minister and the President render this the clearest of cases for such interim relief on a just and equitable basis. It is consistent with the views expressed by the Minister and the President. If genuine and sincere in such views, then neither the Minister nor the President ought to oppose such conditional interim relief as it will resolve both their concerns for the conservation of public funds and ensure that the Department of Health's existing budget is spent on health care.

129. The Minister will be free to allocate funds year-on-year, which would otherwise have been wasted on the implementation of the NHI Act and the establishment of the NHI Fund, for the upgrading of hospitals and purchase of medical equipment within the existing health framework which will undoubtedly benefit the poor and vulnerable in our society, for so long as the stay is in effect.

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130. In addition, there are several lawful and cost-effective initiatives which the government can pursue within the existing legal framework, which will expand access to health care and ensure that the poor and vulnerable in society are taken care of, including the following, for example:

Reform public sector health care mismanagement:

131. The Auditor-General and the PriceMetrics reports indicate that billions are lost annually to corruption and waste. Restoring accountability directly improves service delivery and resource efficiency. Public sector failure, rather than a lack of a central fund, is the immediate barrier to access. Indeed, as shown in the founding affidavit and the PriceMetrics reports, fraud, corruption, and misallocation are likely to be exacerbated by a central fund. This is already evident in other state bodies, such as the failing Road Accident Fund.

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132. The following outlines a non-exhaustive set of steps that can be taken to reform the public sector health care:

132.1. Eliminate financial waste to fill vacant posts for doctors, nurses, and specialists, particularly in provincial hospitals, where financial waste has forced staff cuts;

132.2. Repair and maintain essential infrastructure — many facilities are poorly maintained and falling into disrepair;

132.3. Reinstate maintenance and procurement budgets to ensure the

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availability of medicines and equipment;

132.4. Implement effective anti-corruption and audit controls at provincial health departments;

132.5. Publish transparent expenditure reports and enforce disciplinary action where procurement or human resource fraud occurs;

132.6. Provide more effective incentives for hospital managers to increase performance and service standards.

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Authorise Low-Cost Benefit Options (LCBOs)

133. A proposal which is widely supported by economists and medical schemes as a rapid way to extend private coverage to millions of uninsured people is the authorisation of medical schemes and insurers to offer low-cost benefit options and health insurance. This would rapidly expand coverage and incentivise innovation and competition in the low-income market. The government could:

133.1. Permit affordable medical-aid plans for low-income earners. These plans would cover aspects of basic hospitalisation and primary care.

133.2. Authorise primary healthcare insurance products that are currently unhelpfully subject to regulatory restrictions.

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Decentralise and allow private medical training and placement to increase health care supply

134. This would free up government medical school spaces for disadvantaged students while dramatically expanding overall capacity. Private hospitals are centres of excellence, ideally positioned for clinical training. This would lessen the burden on provincial government budgets while ensuring new doctors gain experience in high-quality environments. The current government monopoly on internships creates artificial shortages despite private sector willingness to absorb trainees. This would immediately address workforce shortages by allowing more skilled doctors and nurses from abroad to practice in South Africa. Current restrictions limit foreign-trained personnel despite desperate shortages. In this respect, the government can:

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134.1. Authorise private sector medical training to ramp up the production of medical and healthcare skills;

134.2. Authorise private sector medical internships and stop forced state medical internships. Assigning qualified doctors awaiting internship positions to private hospitals and allowing community service completion in private facilities.

134.3. Authorise more, and more streamlined, foreign healthcare professional recruitment.

135. This is all the more reason to stop the implementation of the NHI Act in the

interim period while any stay is in effect.

136. Even if Sakeliga is wrong in respect of the grant of interim relief on a just and equitable basis under section 172(1)(b) of the Constitution, Sakeliga meets the trite requirements for the grant of an interim interdict:

136.1. Sakeliga has a clear right of access to the Court under section 34 of the Constitution which includes the right to have its dispute heard and determined within a reasonable time.

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136.2. Sakeliga further has a clear right to challenge the NHI Act under *inter alia* sections 2 of the Constitution and 172(1)(a) of the Constitution.

136.3. Even if the Court is not satisfied with the above-stated rights alone, Sakeliga is advised and submits that where the conduct of the state results in the infringement of fundamental rights, the court will step in to protect such rights.

136.4. As stated above, the implementation of the NHI Act will necessarily and inevitably infringe on other socio-economic rights.

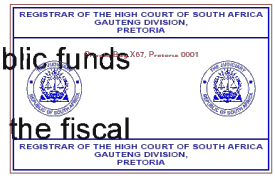
136.5. In the interests of Sakeliga's members, there is simply no reason to subject the welfare of the entire nation to a self-inflicted economic contraction in the short term, together with the economic fallout thereof, including retrenchments, greater dependence on social security and assistance, and diminished tax revenue.

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136.6. Sakeliga's apprehension of harm in the interim is well-founded and reasonable.

136.7. The balance of convenience overwhelmingly supports the grant of interim relief. The objectives of Phase 1, as contemplated in section 57(4) of the NHI Act, are sweeping, far-reaching and expensive. On the Minister's version, all of this will have been in vain.



136.8. It is not only in the narrow interest of the conservation of public funds and resources but also serves to protect the economy from the fiscal cliff in the interim. There is no prejudice to either the Minister or the President. Both will be able to continue to give effect to their constitutional obligations and duties within the existing legal framework. Any delay in giving effect to the NHI Act can be suitably catered for by way of a request for an expedited hearing date of the constitutional challenges. Given the public interest and the number of parties involved, the applications will in any event require a special motion court allocation. In this respect, our Courts have not shied from difficult constitutional matters and have adequately accommodated such matters within the existing demands on the Court.

136.9. Sakeliga, and indeed the President and Minister as well, have no adequate alternative legal remedy. The Minister's present undertaking does nothing to prevent the serious economic harm and the serious disruption and harm that will be caused by the snap-back scenario described already.

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136.10. If a stay is granted, the doors of the court will be shut to Sakeliga and the other challengers. There is no other basis on which Sakeliga will obtain the relief it seeks. As for the President and the Minister, their only remedy to restrain the exercise of their executive powers is by way of an interdict granted by the court.

136.11. Finally, given the basis of Sakeliga's challenge to the constitutionality of the NHI Act, Sakeliga has good prospects of success in its challenge. The implementation of the NHI Act is not a reasonable legislative measure, the state has failed to take reasonable economic and governance measures which could otherwise have created the necessary fiscal capacity for the NHI Act, the NHI Act is not within the state's available resources, and the implementation thereof is not progressive but retrogressive and will have progressively deleterious consequences on the economy. The state has not put up any evidence to contradict the case made out by Sakeliga in the constitutional challenge.

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E. THE CONSOLIDATION APPLICATION

137. Sakeliga is not opposed to a consolidation of the applications. In Sakeliga's view, consolidation is primarily for the convenience of the Court. Sakeliga has no objection to this happening now or once the applications are ripe for hearing. In either event, the progression of the matter will require reasonable case management as has occurred in respect of this stay application.

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138. However, Sakeliga records its objection to the restrictive conditions proposed by the Minister in respect of the consolidation. These conditions are inimical to the concept of consolidation and would result in a strange consolidated but separate application. Ultimately, it is the Court that has to determine the applications based on the totality of the evidence before it.

139. In his replying affidavit, it appears that the Minister no longer earnestly persists with the conditions of consolidation but leaves this to the discretion of the Court.

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140. Sakeliga does not oppose consolidation but opposes any conditions being attached to such consolidation order.

F. THE ALLEGATIONS IN THE MINISTER'S AND PRESIDENT'S AFFIDAVITS

141. I will now deal *seriatim* with certain allegations contained in the Minister's founding affidavit and replying affidavit, as well as the President's answering affidavit. Insofar as any allegation, conclusion or inference drawn in any of these affidavits is inconsistent with what is stated in this affidavit, such allegation, conclusion or inference is denied.

(a) The Minister's founding affidavit

Ad paragraph 29 thereof

142. It is evident that there are various possible outcomes to the litigation in the

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review applications. The issues raised in the review applications are not the same as the issues raised in the Constitutional challenges. There is further substantial uncertainty regarding precisely how long the review applications will take to resolve and determine, but it is likely that they will take a substantial period of time.

Ad paragraph 30 thereof



143. I deny that the applications are of unprecedented volume, factual density and constitutional complexity. However, even if this so, courts cannot close their doors to a litigant entitled to approach a particular court. The solution to substantial and complex applications is not to refuse to hear a litigant or to delay the prosecution of matters properly before the court.

Ad paragraph 103 thereof

144. While Sakeliga takes significant issue with section 33 of the NHI Act, it is not the sole important concern. For the reasons already addressed, I deny that the undertaking of the Minister is significant or goes far enough.

Ad paragraphs 112 to 118 thereof

145. I deny that the state parties are *bona fide* in seeking the relief that they do in the present application.

146. There is no evidence that the NHI Act will achieve its stated goal of universal

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health care or funding access to health care. As stated above, none of the conditions necessary for the implementation of the single-payer system contemplated in the NHI Act are present in South Africa. South Africa is not even on the road to achieving these conditions and will not be in the next 10 to 15 years without sweeping, growth-friendly economic reforms, accountable governance and transparent financial control.

147. If implemented, the NHI Act will deepen the inequality and poverty in South African society as a whole due to the adverse effect it will have on the economy. This goes far beyond the Minister's narrow consideration in respect of the provision of health care alone.

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148. Any research on the part of the state (which the Minister fails to deal with) failed or ignored the reality of the South African economy.

149. All Acts that have been struck down in the constitutional era have been passed by the democratically elected Parliament of South Africa.

Ad paragraph 119 thereof

150. I deny that the Minister is truly acting on behalf of the poorest and most vulnerable of our society based on a narrow pursuit of NHI. Furthermore, the Minister seeking an indefinite delay of constitutional challenges does not constitute the upholding of constitutional rights or duties.

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Ad paragraph 124 thereof

151. I deny that the facts underpinning the present application are exceptional as alleged or at all.

Ad paragraph 134 thereof

152. These considerations apply equally to the implementation of the NHI Act and the snap-back of government reorganisation if the NHI Act is set aside.

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Ad paragraph 135.9 thereof

153. Sakeliga and PriceMetrics have compiled all source documents relied upon in Sakeliga's founding affidavit and PriceMetrics' reports. Sakeliga can make its source documents available to the Minister and any other party electronically upon request.

Ad paragraphs 135.12 to 135.14 thereof

154. The location or residency of the state's expert witnesses in other countries is no longer the hurdle that it once was. If court proceedings can occur over MS Teams, so can the Minister's consultations with Dr Kutzin and the London of School of Economics.

Ad paragraph 135.15 thereof

155. The reliance on costed models does not introduce a heightened level of factual

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complexity. In respect of the PriceMetrics reports, the models produced by PriceMetrics employ standard econometric modelling.

Ad paragraph 172 thereof

156. It is correct that, to date, the President has not brought any sections of the NHI Act into effect. In the replying affidavit, the Minister confirms that the first phase of implementation of the NHI Act is imminent and that the Minister will advise the President to bring sections of the NHI Act into effect, with the continued progressive implementation thereafter.

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Ad paragraph 174 thereof

157. In the event of mootness, the empowering legislation establishing the Fund, permitting the employment of officials and staff in the administrative and governance structures of the Fund, and work on legislative reforms will dissipate.

(b) The President's answering affidavit

Ad paragraphs 100 and 103 to 107 thereof

158. These considerations apply equally to the implementation of the NHI Act and the snap-back of government reorganisation if the NHI Act is set aside.

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(c) The Minister's replying affidavit

Ad paragraphs 16.1 and 16.3 thereof

159. Sakeliga has agreed to the joinder and to the formalistic amendment to the Minister's amended notice of motion to include Sakeliga's application. I attach hereto letters from Sakeliga's attorneys in respect of the joinder and the amendment of the notice of motion as "**SL4**" and "**SL5**", respectively.

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Ad paragraphs 51.4 and 51.5 thereof

160. Sakeliga admits the press articles attached as RA4 and RA5 to the Minister's replying affidavit.

161. Sakeliga has no qualms about the fact that it is diametrically opposed to the NHI Act on principle and for good reason. Sakeliga is free to publicly express its views thereon, as the Minister has done.

162. Notwithstanding the above, Sakeliga has launched an earnest substantive challenge to the NHI Act based on the independent research and analysis of PriceMetrics.

163. The Minister is not called upon to answer Sakeliga's press articles but the challenges laid out in Sakeliga's founding affidavit.

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Ad paragraphs 59 and 60 thereof

164. Sakeliga's statement quoted here is clearly a call for calm in the face of the uncertainty created by the NHI Act. There is nothing in this statement that is premised on an indefinite stay. The sufficiency of time is premised on Sakeliga's experience in other constitutional litigation and that Sakeliga's and the other challengers' applications would be heard within a reasonable time.

G. CONFIRMATORY AFFIDAVITS

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165. Mr Peter Wassenaar of Kriek Wassenaar and Venter Inc., Sakeliga's attorneys, will confirm the content of this affidavit insofar as it relates to him and depose to a confirmatory affidavit in this respect. Mr Wassenaar's confirmatory affidavit will be filed together with this affidavit.

H. CONCLUSION

166. As the Minister himself knows, where the diagnosis is wrong, the treatment will be ineffective in curing the disease and may cause death.

167. Parliament, the President, and the Minister have made the wrong diagnosis in respect of the NHI Act as the means to achieve widespread health care services coverage in South Africa or even as a means to expand access to health care.

168. This is not only retrogressive in respect of access to health care. It will drag

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the economy down and with it, the welfare of all South Africans.

169. The interests of justice require the constitutional challenges to be heard and militate against the delay / stay relief sought by the Minister.

WHEREFORE the tenth respondent prays that:

(a) The court dismiss the stay application with costs, including the costs of two counsel on Scale C;

(b) Alternatively, in the event that the court is minded to grant a stay of Sakeliga's application, Sakeliga prays for an order in terms of the counter-application that shall be filed together with this affidavit.

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DEPONENT

I certify that the deponent has acknowledged that he knows and understands the content of this affidavit which was signed and sworn to, before me, at Stellenbosch on this 17th day of October 2025, the Regulations contained in Government Notice No. R. 1258 dated 21 July 1972 (as amended) and Government Notice No. R.4648 dated 19 August 1977 (as amended) having been complied with.

COMMISSIONER OF OATHS

FULL NAMES:

JOHANNES SCHEEPERS
Commissioner of Oaths
Practicing Attorney R.S.A.
Van Zyl Scheepers Attorneys
34 Dorp Street, Stellenbosch

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ADDRESS:

CAPACITY:



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PriceMetrics

Assessment of the Feasibility of NHI as a Single-Payer Health System in South Africa: A Comparative International Review

21 May 2025

Mike Holland

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I. Executive Summary

1. This report is a comparative review of South Africa and 16 countries with single-payer health care funding systems. The purpose is to compare South Africa's characteristics, experience, and performance with these countries to assess the likelihood of National Health Insurance ("NHI") as a single-payer health care funding system meeting its objectives in the National Health Insurance Act of "achieving sustainable and affordable universal access to quality health care services" in South Africa.

2. The 16 countries are Bahrain, Canada, Cyprus, Denmark, Finland, Iceland, Italy, Kuwait, Norway, Portugal, Slovenia, Spain, Sweden, Taiwan, the United Arab Emirates, and the United Kingdom.

3. Single-payer systems are relatively rare globally and **do not exist** outside high-income countries. There are good reasons why comprehensive single-payer systems are the exception rather than the rule and do not exist in middle-income (such as South Africa) or low-income countries. The requirements for success are demanding and beyond the capabilities and resources of governments in these countries.

4. In addition to having high GDP per capita, countries with functional, comprehensive single-payer systems also fulfil the following criteria:
   4.1. A strong fiscal capacity and efficient, broad-based revenue collection mechanisms that provide sufficient tax revenue to finance the population's health care needs.
   4.2. Comprehensive health care resources, including health professionals, pharmaceutical products and medical infrastructure (clinics, hospitals, other health establishments, and information systems).
   4.3. A highly competent and relatively incorrupt government and public sector bureaucracy to administer the system, including sophisticated cost control, fraud detection, payment, and adjudication systems.
   4.4. High levels of stakeholder acceptance and political consensus in the health care industry, particularly over the electoral cycle, given the substantial funding requirements.

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5. The following six criteria are used to assess whether the NHI is a feasible strategy to achieve universal health coverage in South Africa: (1) Affordability, given the current level of **GDP per capita** in the country; (2) Strong and sustainable **fiscal capacity**; (3) High-quality **governance and administrative capacities**; (4) Sufficient **health care resources**: skilled health care practitioners and physical capital; (5) Broad **stakeholder support**; (6) Willingness to allow the **participation of the private sector** to create more fiscal space and reduce the burden on a narrow taxpayer base.

6. The table below summarises the results of the comparative review.

Table 1: Summary of Comparison Indicators South Africa and Single-Payer Countries

Country	GDP / capita ($)		Govt Health spend / capita ($)	Employment-to-Population Ratio (%)	World Governance Indicators (-2.5 to +2.5)	Nurses per 1000 people	Doctors per 1000 people	Edelman Trust in Govt (%)	Single-payer legislation allows private insurance?
South Africa	6 843	Middle-income	377	28%	-0.3	5.0	0.8	22%	Effectively No
Single-payer median	40 106	High-income	2 578	51%	1.3	8.5	3.8	49%	Yes

Source: World Bank, Edelman and own calculations

7. South Africa falls significantly short of the human, financial, and governance resources necessary to sustain single-payer health care funding systems in other countries. GDP per capita is only 17%, and total employment is roughly half of the median for single-payer countries. As a result, fiscal capacity is far below what is necessary in single-payer systems. Moreover, governance standards are sorely lacking to sustain the successful administration of a complex single-payer system, which, in South Africa, would already be handicapped by severe shortages of skilled medical personnel and inadequate infrastructure. Despite these severe shortcomings, along with weak stakeholder support for the NHI, the NHI Act aims to establish one of the most comprehensive single-payer systems in the world, effectively eliminating private medical insurance markets.

8. This comparative analysis shows that the NHI, as a single-payer health care funding system, is unaffordable, unworkable, and therefore unattainable in South Africa. Moreover, international experience confirms that a single-payer health care funding system is unnecessary for countries to achieve universal health coverage.

9. The South African government's decision to force the public into a single-payer health care funding system from the current multi-payer funding arrangements, therefore, appears irrational, irresponsible, and inappropriate given the system's severe resource deficits, given that multi-payer and hybrid systems are better suited to middle-income countries, and given that countries have demonstrated that high levels of health coverage can be achieved with fewer resources in alternative multi-payer and hybrid systems.

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II. Introduction and background

10. This report assesses the likelihood of National Health Insurance ("NHI") as a single-payer health care funding system meeting its objectives in the National Health Act of "achieving sustainable and affordable universal access to quality health care services"[1] in South Africa. The assessment is based on a review and analysis of health care characteristics, experience, and performance in 16 countries that have adopted single-payer health care funding systems to meet health care objectives. One objective may include Universal Health Coverage ("UHC") as defined by the World Health Organization.[2]

11. A country's health care system is a network of institutions (laws and regulations), organisations, policies, activities and resources established to deliver health care services to a population. As can be expected, countries' health systems vary widely in size, structure and scope. The reasons include the level of a country's economic development and resources; its political, social, and cultural environment; the relative role of the public and private sector involvement in the provision of health insurance and health services; government regulatory and policy choices; and demographic and epidemiological factors such as ageing populations, rising obesity and disease burdens such as AIDS.

12. Despite this heterogeneity, there are broadly two types of health care funding systems worldwide: single-payer and multi-payer models. Hybrid health systems combine elements of state single-payer and private multi-payer funding systems.[3]

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i. Single-payer health care funding systems

13. A single-payer system is typically described as a health care financing and reimbursement model in which the government or a mandated public agency is the sole purchaser of health care services. It receives funds through taxation and directly reimburses health care providers. The following criteria are commonly used to define a single-payer system.
    13.1. A single public entity (typically the government) is responsible for paying for health care services. Funding is primarily derived from taxation (general tax revenue or earmarked health taxes) or mandatory contributions from employers and individuals.
    13.2. The system purports to provide universal health coverage (UHC), claiming that all legal residents can access health care services. In theory, access is equal regardless of income, employment status, or health condition. Enrolment in the system is automatic or mandatory, eliminating financial barriers to access, such as insurance premiums. Health care services are either free at the point of use or require minimal out-of-pocket payments.
    13.3. Health risks and costs are pooled across the entire population, with the intention of maximising equitable access to health care.
    13.4. The private sector often provides health care insurance cover, for example, medical aid schemes and specialist insurance, but, given free government health care, it is limited in scope, generally providing supplemental coverage (e.g. faster access to medical specialists; elective surgeries) or complementary health care not covered by the government (dental care, optical care, elective plastic surgery).

ii. Multi-payer health systems

14. A multi-payer system is a health care financing model in which multiple organisations—such as private sector health insurance companies, government agencies, and employers (through their own or open plans) provide and manage full or partial health care coverage for residents in a country. Under this system, individuals voluntarily – or are forced – to purchase health insurance through private markets, employer contributions, or subsidised payments to public sector health plans. Governments in multi-payer systems regulate insurance markets to varying degrees.

15. The features of a multi-payer system include:
    15.1. Multiple financing sources. A combination of private insurers, employer-sponsored plans, government subsidies, and out-of-pocket payments from individuals covers health care costs.

[1] National Health Act, Section 2, "The purpose of this Act is to establish and maintain a National Health Insurance Fund in the Republic funded through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services by— (a) serving as **the single purchaser and single payer of health care services** in order to ensure the equitable and fair distribution and use of health care services; (emphasis added).
[2] The World Health Organization defines Universal Health Coverage (UHC) as: "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO." Source: various WHO publications.
[3] Australia, Japan, and Singapore are often considered as having hybrid health systems.

15.2. Competitive health insurance markets. Individuals can choose between different private and/or public insurance plans, fostering competition among insurers to improve quality and control costs.

15.3. Government regulation and oversight. Governments in developed (high-income) countries tend to regulate health insurance and provider payments extensively with the intent of increasing coverage among low-income and vulnerable populations; some set price controls on medical services and products or try to prevent practices such as denying coverage based on pre-existing conditions.

15.4. Mixed public-private provider networks. Health care services are delivered by both private and public hospitals, clinics, and physicians, leading to a diversified health care infrastructure.

16. Most countries currently have a multi-payer health system, including South Africa.

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III. Analysis and assessment of single-payer systems and the NHI

17. Single-payer health care funding systems are rare globally. There are only 18 countries with fully-fledged single-payer systems out of 195 countries[4] in the world (9% of the total). This study excludes from the analysis the closed command economies of Cuba and the Democratic People's Republic of Korea (North Korea)[5], leaving 16 single-payer countries.[6] The 16 countries comprise Bahrain, Canada, Cyprus, Denmark, Finland, Iceland, Italy, Kuwait, Norway, Portugal, Slovenia, Spain, Sweden, Taiwan[7], the United Arab Emirates, and the United Kingdom.

18. The single-payer health system is uncommon among all regions of the world:
    18.1. 11 countries of 49 countries in Europe[8] (22% of the total).
    18.2. 4 countries of 48 countries in Asia (8% of the total).
    18.3. 1 country of 35 countries in North and South America (3% of the total).
    18.4. No country in Africa (54 countries).

19. Importantly, fully fledged single-payer systems **do not exist** outside high-income countries: all 16 single-payer countries are classified by the World Bank as high-income countries.[9] Single-payer systems are relatively rare in high-income countries: only 16 (18%) of the 88 high-income countries worldwide.

20. There are good reasons why comprehensive single-payer systems are the exception rather than the rule and do not exist in middle-income (such as South Africa) or low-income countries. The requirements for viability are demanding and are beyond the capabilities and resources of governments in these countries. In a single-payer system, the responsibility for providing health insurance that finances the delivery of health care falls solely on the state without any substantial funding or other contributions from the private sector to relieve the pressure on fiscal policy.

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21. In general, a successful comprehensive single-payer system that achieves a high degree of UHC must meet the following criteria:
    21.1. A high GDP per capita, which defines the country as a high-income country.
    21.2. A strong fiscal capacity that provides sufficient and efficiently collected tax revenue to finance the health care needs of the whole population.
    21.3. Comprehensive health care resources, including health professionals, pharmaceutical products, medical infrastructure (clinics, hospitals, other health establishments), and health information systems.
    21.4. Strong governance of the health system: a highly competent and relatively incorrupt government and public sector bureaucracy to administer the system, including sophisticated information systems to monitor and control costs and fraud, effective reimbursement procedures for health care providers and regulation of health outcomes.

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[4] Source United Nations classification.

[5] The two countries are unique in the world in having totalitarian governments that do not use markets and price signals to allocate resources in their economies. Private sector health insurance is prohibited unlike all other single-payer countries (with the partial exception of Canada). Consequently, health care resources are allocated by diktat without public participation or reflecting their economies' opportunity costs of those resources. Nor do they have free labour markets. The government uses its monopsonist power to reduce health professionals' salaries below what would be earned in competitive markets. These policies can be enforced because while some Cuban and North Korean doctors work overseas, neither country allows emigration of health professionals without the permission of the state (https://www.hrw.org/news/2020/07/23/cuba-repressive-rules-doctors-working-abroad and https://www.hrw.org/report/2024/03/07/a-sense-of-terror/stronger-than-a-bullet-the-closing-of-north-korea-2018%E2%80%932023). These policies are in contravention of the United Nations Universal Declaration of Human Rights, article 13(2): "Everyone has the right to leave any country, including his own, and to return to his country." Given these unique circumstances the countries are not considered in the comparison of South Africa with other single-payer countries.

[6] There are some variations in the number of countries defined as single-payers by health economists and policy analysts. For example, countries such as Ireland (transitioning), New Zealand, Saudi Arabia, Japan, and South Korea are included in some definitions. Some definitions exclude Middle East countries such including Bahrain, Kuwait and UAE because the UHC excludes the large expatriate populations. There is a consensus among health economists and policy analysts that there are no more than 15-20 countries that have fully-fledged single-payer health systems.

[7] Taiwan is often excluded from cross-country international data sources such as the World Bank for international political reasons. Missing data for Taiwan for this report is obtained from official statistics from the Taiwanese government or other international data reporting agencies reporting data for Taiwan. These sources are: National Statistics Republic of China (Taiwan); Ministry of Health and Welfare (Taiwan); Commonwealth Fund; The Lancet.

[8] Europe includes Russia, Georgia and Turkiye but excludes Kazakhstan and Azerbaijan.

[9] The World Bank currently defines a high-income country where annual Gross National Income (GNI") is $14 005 in 2023. GNI, formerly Gross National Product ("GNP") is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. It's value for most countries is very similar to Gross Domestic Product ("GDP") which is the sum of gross value added by all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of the products. GNI and GDP can generally be used interchangeably for most purposes.

21.5. High levels of stakeholder acceptance and political consensus over the electoral cycle, given the large funding requirements. In particular, there must be a strong commitment from health care professionals and suppliers of health care services (health establishments) and products (pharmaceutical companies and medical equipment suppliers). There needs to be a reasonably high level of social solidarity among a country's population, which accepts the heavy cross-subsidisation of health care (i.e., high/middle-income households, the healthy, and younger people supporting low-income households, the unhealthy, and the elderly).

22. In addition, the population must generally accept several notable disadvantages and trade-offs of a single-payer system compared to the world's predominantly multi-payer systems. Based on empirical international evidence, these include:
    22.1. Longer waiting times and rationing of health care. Since single-payer systems offer free health care at the point of service, price signals are eliminated as a rationing system, leading to excess demand and limitations on the market availability of health care services.[10]
    22.2. Forced limitations on patient choice. Under a single-payer model, health care providers operate within government-imposed guidelines, limiting patient autonomy in choosing doctors, hospitals, and medical treatments, as well as restricting practitioner autonomy in selecting patients and working conditions.[11]

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23. Given these arduous and well-known requirements and features of single-payer systems, it is surprising and concerning from an efficiency and effectiveness perspective that the government has adopted a single-payer NHI system, as none of the conditions necessary to implement such a system are sufficiently present in South Africa. This decision is neither rational nor reasonable under present conditions. Good governance would, *inter alia*, aim to foster the realisation of such conditions before a single-payer system could be rationally contemplated. It is even more surprising and concerning when the features of the NHI are compared to other single-payer systems. According to President Ramaphosa, the government is committed to a comprehensive and unique single-payer system. At the signing of the NHI Act, the President stated that the government wants "a Rolls-Royce health care system for all."[12] If fully implemented, the NHI would include the following distinctive features compared to other single-payer systems.
    23.1. First, the NHI intends to cover a range of health care benefits that surpass those offered in all other single-payer countries. For example, the Department of Health has stated that the range of benefits provided will exceed those benefits currently offered by medical aid schemes and existing prescribed minimum benefits: "It is important to bear in mind that the NHI benefits are not confined like most current medical scheme benefits" and "The range of cover of benefits will be much better than under the current system."[13]
    Consequently, the benefits are intended to exceed the current benefits of medical aid schemes, although the government has not disclosed the actual range of health care services that will be covered.
    The NHI, therefore, intends to offer some services not fully covered by other single-payer countries. For example, the NHI benefits are purported to include a range of free dental and optical care benefits that are not, or are rarely, available in existing single-payer systems in the world and probably every other health system.
    For example, Canada's Medicare, probably the closest model to the NHI, restricts routine oral (dental) and optical benefits.[14] A survey by the OECD concluded that most high-income countries (single-payer and multi-payer countries) currently implement UHC with partial dental coverage, resulting in disparities in access to care and oral health outcomes. The survey found that of 29 OECD countries, only five (Austria, Mexico, Poland, Spain and Turkiye) covered the full cost of dental care.[15] Optical care is also limited: while some single-payer health systems offer subsidised or free eye exams and prescription glasses or contacts, many have limitations on the scope of benefits. These limitations can include restrictions on the type of eyewear covered, the frequency of coverage, and the maximum benefit amount.

[10] OECD (2023), *Health at a Glance 2023: OECD Indicators*, OECD Publishing, Paris and OECD (2020), Waiting Times for Health Services: Next in Line, OECD Health Policy Studies, OECD Publishing, Paris.
[11] Ibid.
[12] Source: https://www.dailymaverick.co.za/article/2024-05-15-we-want-to-build-a-rolls-royce-health care-system-for-all-says-ramaphosa-on-signing-nhi-bill-into-law/
[13] Department of Health (U.D.) Understanding the National Health Insurance (NHI), Frequently Asked Questions.
[14] Dental services are incompletely covered by Medicare. "Coverage varies by provinces and differentially extends to groups such as indigenous peoples, veterans, low-income families and other vulnerable populations. The status of dental coverage can be attributed at least in part to the belief that maintaining good oral health and seeking treatment are up to the individual." https://pmc.ncbi.nlm.nih.gov/articles/PMC7652557/
[15] Ibid.

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23.2. Second, the NHI intends to offer a comprehensive range of benefits free of charge at the point of service.[16] The Department of Health has stated, "All users will be able to access health care services without paying anything at the point of care, regardless of their socioeconomic status," and "the NHI Fund will pay the clinic, GP or hospital. You will not pay anything when receiving care."[17]
In contrast, existing single-payer countries, although committed to universal health coverage in removing hardship from the cost of health care, charge co-payments for some services. Scandinavian countries such as Denmark, Norway and Sweden require patients to pay co-payments for most services. For example, Norwegians pay for a primary care visit, for specialist visits, and up to a set amount for prescription drugs. At the same time, there is a cap on total annual out-of-pocket spending.[18]

23.3. Third, the NHI will have the unique feature of being coercive in effectively prohibiting private health insurance. Section 33 of the NHI Act states, "Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund." In practice, Section 33 will prevent medical aid schemes and other insurers from operating. Given the typical high proportion of fixed costs of insurance providers and the law of large numbers applying to all insurance, medical schemes and other insurers will not be able to offer the range of services to attract sufficient numbers of policyholders to be profitable, given the comprehensive medical benefits that the NHI Fund will offer. All other single-payer countries, except some provinces in Canada, allow private sector health insurance to exist alongside state national health insurance.[19]

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24. Importantly, a single-payer system is not necessary to achieve universal health coverage. Other systems, including multi-payer and hybrid systems (Australia), have also achieved high levels of UHC. Figure 1 shows 44 countries that have a high World Health Organization (WHO) Universal Health Coverage Service Coverage Index (SCI) of 80% or over. UHC is compared to GDP per capita in US dollars. Of the 44 countries, the majority, 28 (64%), do not have single-payer systems. The graph shows that both single-payer systems (coloured green) and multi-payer or hybrid systems (coloured black) can facilitate high levels of universal health coverage in wealthy countries.

25. The graph also shows that single-payer systems require high GDP per capita – they are all high-income countries as classified by the World Bank. The single-payer system country with the lowest GDP per capita is Portugal at $24,711 in 2021, and the next lowest is Spain at $30,818 GDP per capita.

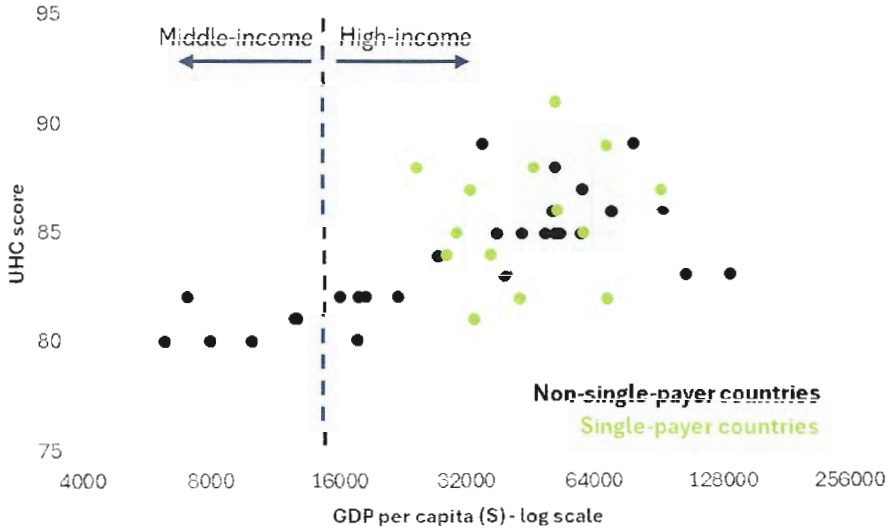
26. In contrast, levels of the UHC SCI Index can be achieved by multi-payer or hybrid systems at GDP per capita substantially below those of single-payer countries. The graph shows that 10 (36%) out of the 28 non-single-payer countries had incomes below $20,000 per capita, and six of these countries were middle-income countries with GDP per capita below the World Bank's high-income threshold of $14,005 per capita. Evidently, high levels of UHC can be achieved by middle-income countries with multi-payer or hybrid health systems. Colombia, for example, has the lowest GDP per capita of this group at $6,332 and a UHC score of 80 – this is a lower GDP per capita than South Africa (a GDP per capita in 2021 of $6,843 and a UHC SCI score of 71).

27. In summary, South Africa's government, through the NHI, has committed to an extreme version of a single-payer health system in an attempt to achieve sustainable and affordable universal access to quality health care services. The key features of its policy are:
27.1. The government is attempting to introduce a type of health insurance system in South Africa, a middle-income country, which has not been successfully implemented by any middle-income country before. No middle or low-income country has a fully-fledged single-payer health system.
27.2. The level of benefits that it plans to introduce is so comprehensive that it exceeds the range of benefits of all the high-income countries currently with single-payer health systems.
27.3. NHI is unique in that it is coercive. Although not completely in principle, the NHI effectively and practically prohibits private health insurance. All other single-payer countries allow a role for private sector insurance to ease the pressure on fiscal policy and the burden on taxpayers while also offering more choice to consumers.

[16] The NHI Act defines "comprehensive health care services" means health care services that are managed so as to ensure a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services across the different levels and sites of care within the health system in accordance with the needs of users;" According to the Department of Health it will cover services at primary, secondary, tertiary, specialized and quaternary levels (Department of Health (U.D.) Understanding the National Health Insurance (NHI), Frequently Asked Questions.
[17] Department of Health (U.D.) Understanding the National Health Insurance (NHI), Frequently Asked Questions.
[18] Source: https://www.commonwealthfund.org/blog/2019/universal-health-coverage-eight-countries
[19] The same conclusion is reached in the expert report (paragraphs 67-70 of the report) by ME Swan-Calvert, part of the HASA Notice of Motion to the High Court applying for an order to have the NHI Act to be declared unconstitutional and set aside.

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Figure 1: Comparison of Countries with a UHC SCI Index of 80+ and GDP per Capita (US dollars) 2021



Source: World Bank

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28. Besides being over-ambitious to the point of hubris, the choice of a single-payer health system appears irrational given that international experience and evidence shows that a single-payer system is not necessary to achieve high levels of health coverage and that a multi-payer system is likely to be substantially more affordable to achieve the government's health care objectives.

29. Given this analysis and evidence, is the NHI feasible or realistic for meeting the government's universal health coverage objectives? The following section analyses several key requirements of single-payer systems, such as the NHI. It assesses South Africa's ability to meet these requirements.

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IV. Requirements if South Africa is to achieve universal health coverage through a successful single-payer health system

30. The following criteria are used to assess whether the NHI is a feasible strategy to achieve universal health coverage:
    30.1. Affordability, given the current level of GDP per capita in the country.
    30.2. Strong and sustainable fiscal capacity.
    30.3. High-quality governance and administrative capacities.
    30.4. Broad stakeholder support.
    30.5. Sufficient health care resources: human resources and physical capital.
    30.6. Willingness to allow the participation of the private sector to create more fiscal space and reduce the burden on a narrow taxpayer base.

i. Affordability given the country's current level of GDP per capita

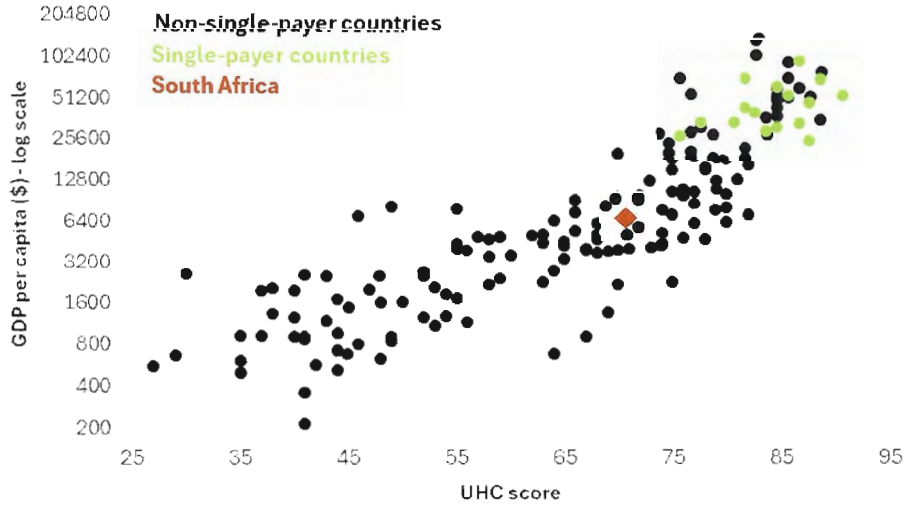
31. Countries with universal health coverage - whether multi-payer, single-payer, or hybrid health care funding systems - spend considerably more on health care per capita and have a higher ratio of health expenditure to GDP than other countries. To afford this expenditure, these countries need high per capita incomes to fund health care provision. In 2021, Portugal, the country with the lowest single-payer per capita income, had an annual GDP per capita of over $24,000.

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32. Applying these criteria, the NHI single-payer model will not achieve the government's objectives. No middle-income country has achieved universal health coverage with a fully-fledged single-payer system. South Africa is classified as a middle-income country by the World Bank with a GNI per capita of $6,480 and a GDP per capita of $6,022 in 2023[20], less than half of the World Bank's lower threshold of a high-income country of $14,005 GNI per capita.

33. The problem facing middle-income countries, including South Africa[21] (coloured red), aspiring to achieve universal health coverage, whether single-payer (coloured green) or multi-payer and other systems (coloured black), is shown in Figure 2. The graph shows the relationship between the World Health Organization's UHC SCI and GDP per capita on a semi-log scale. For many of these countries, national income is simply too low to afford universal health coverage.

Figure 2: Comparison of the WHO Universal Health Coverage Service Coverage Index and GDP per Capita (US Dollars) 2021



Source: World Bank

[20] South Africa's GDP per capita of $6,843 reported earlier in the report was for 2021. GDP per capita in dollars declined considerably from 2021 to 2023 due to slow growth and exchange rate fluctuations. Source: World Bank

[21] The calculations of the UHC SCI score for South Africa have been investigated as not reflecting the true extent of universal health coverage. A recent comprehensive report concludes that the score of 71 substantially overstates the actual level. The authors of the report have based on a detailed review of the data calculated a score of 60.5. If correct, and the analysis is convincing, the task of the NHI to achieve UHC is much more difficult than the above graph indicates.
The report is available at
https://www.hst.org.za/publications/South%20African%20Health%20Reviews/20%20SAHR_2019_Health%20and%20related%20indicators%202019%20interrogating%20the%20UHC%20service%20coverage%20index.pdf

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34. The recent growth and projected growth of South Africa's economy provide further evidence that South Africa's GNI and GDP will not be high enough to afford NHI. Figure 3 shows that annual real GDP has stagnated in the last ten years, with declining GDP per capita during most years. The average standard of living is lower in 2025 than in 2014. The latest IMF forecast for South Africa[22] is for continued low growth in 2025 and 2026, with little improvement by 2030. Living standards are unlikely to improve significantly in the next five years.

Figure 3: Growth in GDP and GDP per Capita 2014-2024 and Forecast to 2030



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2030
GDP	1.4	1.3	0.7	1.2	1.6	0.3	-6.2	5.0	1.9	0.7	0.6	1.0	1.3	1.8
GDP per capita	-0.3	-0.7	-0.3	0.5	-0.2	-1.3	-7.7	3.4	0.5	-0.6	-0.7	-0.2	0.1	0.6

Source: StatsSA

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35. These trends show clearly that it is practically impossible for the country to achieve a sufficient level of GDP and GDP per capita, similar to other single-payer countries, to enable the implementation of NHI in the next 10-15 years. Even achieving this level within 50 years would require a substantial improvement in South Africa's economic growth potential.

ii. Strong and sustainable fiscal capacity

36. In a single-payer system, the burden of funding lies with taxpayers. The typical features of the system, such as free and comprehensive health care at the point of service for the entire population of a country, necessitate significant government expenditure. In practice, it is observed that the funding burden tends to increase over time as the cost of free-at-the-point-of-service health care provision grows faster than output in many other sectors of the economy for most countries.[23]

37. Figure 4 shows the relationship between the UHC SCI and government expenditure on health care per capita in US dollars (log scale). Single-payer countries are coloured green, other health systems are black, and South Africa is coloured red. The substantial gap between South Africa and existing single-payer countries is clearly shown in the graph.

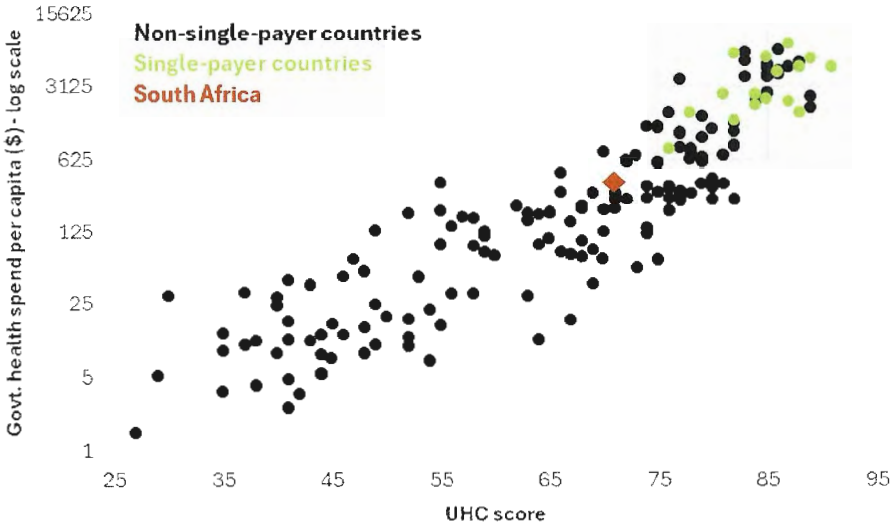
38. The South African government spent $377 on health care per capita in 2021, only around 11% of the single-payer country average of nearly $3,554 per capita and 14% of the median single-payer country of almost $2,600 per capita. Excluding the three Middle Eastern oil-producing countries of Bahrain, Kuwait, and UAE,[24] the average and median government health spending in single-payer countries is over $4,000 per capita, over 10 times greater than in South Africa.

39. Given this very substantial spending gap, one of the key questions for the NHI is whether the government can raise and spend a comparable amount of revenue on health care as existing single-payer countries.

[22] IMF World Economic Outlook, April 2025.
[23] Source: OECD (2023), *Health at a Glance 2023: OECD Indicators*, OECD Publishing, Paris, Figure7.6. The average annual increase in real health care expenditure in 38 OECD countries was 3.4% during the period 2019-23. All single-payer OECD countries had average annual real increases in health care expenditure during the period.
[24] Per capita spend for these countries is distorted because their public health insurance covers only citizens, not the whole population. These countries have a relatively high expatriate population.

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Figure 4: Comparison of the WHO Universal Health Coverage Service Coverage Index and Government Health Expenditure per Capita (US dollars) 2021

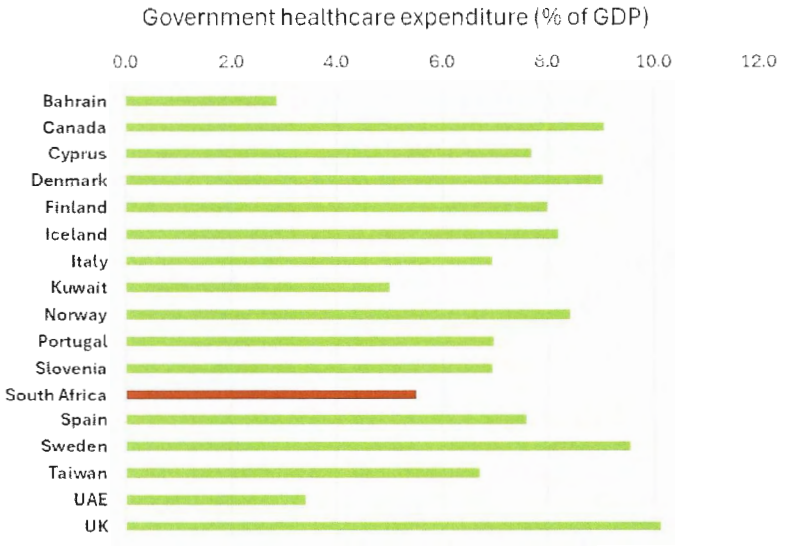


Source: World Bank

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40. Figure 5 compares South Africa and other single-payer countries for domestic general government health expenditure as a percentage of GDP in 2021. The South African government's health care expenditure is 5.5% of GDP. Government health care spending in existing single-payer countries, excluding the Middle East countries[25], averages just over 8% of GDP.

Figure 5: Domestic General Government Health Expenditure (% of GDP) 2021



Source: World Bank

41. While Figure 4 shows that government health care expenditure in South Africa ($377) falls well short of the single-payer country average, Figure 5 shows that South African government health care expenditure as a proportion of GDP at 5.5% is quite similar to single-payer countries, though still below the full-sample average of 7.3% of GDP. Figure 5 shows that even countries with single-payer systems and among the highest government spending on health care in the world tend to spend no more than 6-10% of GDP on health care. This constraint arises from the crucial trade-offs that governments are forced to make in their budgets to meet obligations in other areas, such as education, defence, policing, housing, and so on.

[25] The ratio for these countries is distorted because their public health insurance covers only citizens, not the whole population. These countries have a relatively high expatriate population. Also see footnote above.

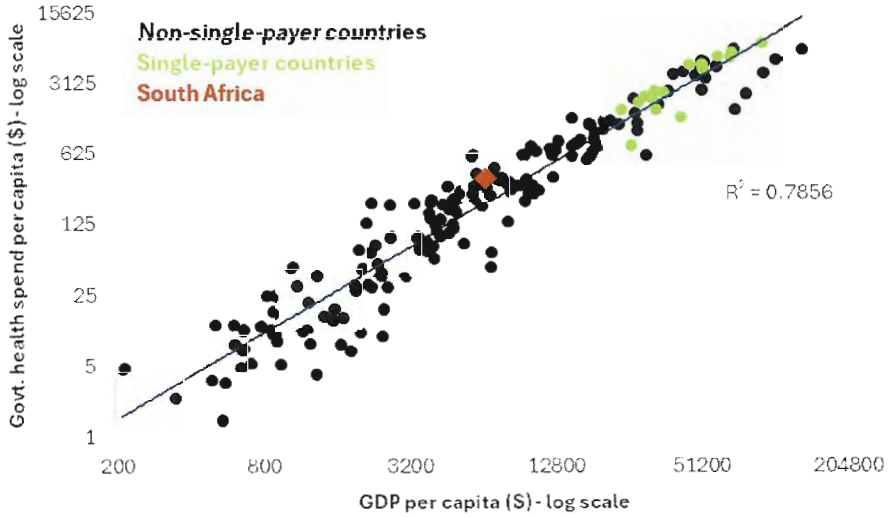
42. Even if South Africa expanded health care spending to the average single-payer level (excluding Bahrain, Kuwait, and UAE) of just over 8%, government health care spending per capita would only rise to $561 from $377. Despite this considerable – nearly 50% – increase in government health care expenditure, it would still fall well short of the single-payer country median expenditure of $2,600 per capita, or the median excluding Bahrain, Kuwait, and UAE of just over $4,000 per capita.

43. In other words, even if the South African government were to escalate health care spending by almost 50% to comparable levels in wealthy single-payer countries as a percentage of GDP, it would still be spending only around one-sixth to one-fifth of single-payer countries in absolute terms. This shortfall is a clear indication that the constraint on more government health care spending is not that the government is allocating too little to health care but that South Africa's GDP, or per capita income level, is simply too low to sustain the taxation and government spending required by a single-payer system.

44. Figure 6 confirms that the size of economic output heavily influences government health care spending. The graph shows, unsurprisingly, that GDP per capita and health care spending per capita are highly correlated. Productive countries can afford to raise more taxes and spend more on health care, while less productive countries are constrained in their taxing and spending capacity. Single-payer countries are coloured green, other health systems are black, and South Africa is coloured red. The R-squared value reported on the chart strongly indicates that GDP size explains nearly 80% of the cross-country variation in government health care spending.[26]

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Figure 6: Comparison of GDP per Capita and Govt Health Expenditure per Capita (US dollars) 2021



Source: World Bank

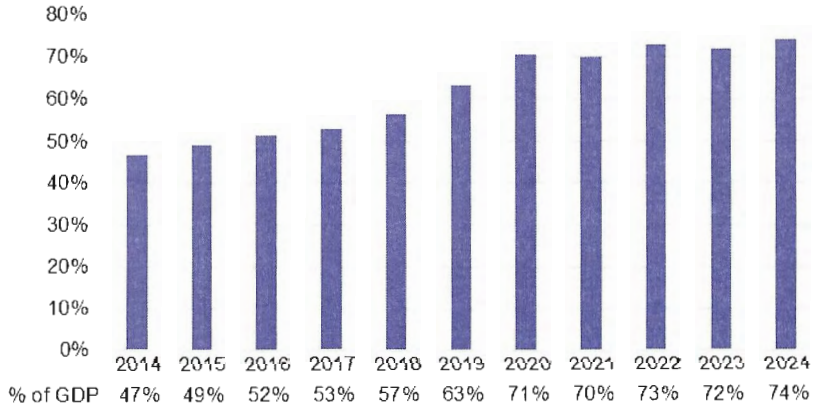
45. It is evident, therefore, that if the South African government wishes to implement a single-payer system, GDP per capita would need to expand by around 4-5 times, or 300-400%, from current levels. As noted in the section above, this would take several decades, even at high real GDP growth rates.

46. There are other constraints on fiscal policy that, collectively, in the context of low economic growth, are highly unlikely to provide adequate funding for the NHI fund or render NHI affordable.[27] These include the following:
    46.1. A high, growing, unsustainable debt-to-GDP ratio, exceeding 75% in 2024, and substantially above international norms for emerging markets.[28] Figure 7 shows the rising trend from 2014 to 2024. According to the latest IMF forecast, government debt will increase to nearly 89% of GDP without including a provision for NHI.

[26] R-squared (R^2) measures how well a regression line fits scatterplot data, indicating the proportion of variance in the dependent variable explained by the independent variable, ranging from 0 (no variance explained) to 1 (all variance explained).
[27] These issues are covered in more detail in our report *Economic Analysis and Fiscal Affordability Analysis of the National Health Insurance Act, Act No 20 of 2023.*
[28] The OECD estimates for the emerging economies the sustainable government debt/GDP threshold is lower than developed countries at 30 to 50% of GDP, as they are exposed to capital flow reversals. Empirical cross-country evidence by the OECD suggests different debt thresholds, defined as the turning point at which negative effects of debt on the economy kick in.

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Figure 7: South Africa – Government Debt to GDP 2014-24



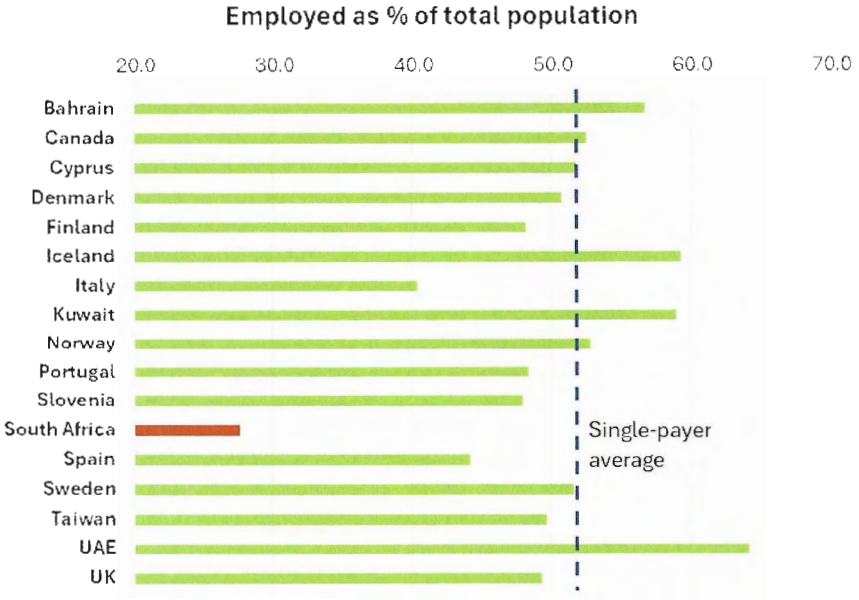
Source: Trading Economics

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46.2. The country also has a very narrow personal tax base and relatively high marginal rates (top rate of 45%) for a middle-income country, indicating scant room for tax increases. The current number of individual taxpayers in South Africa is 7.4 million, representing 18% of the working-age population of 41.6 million and 12% of the total population of 63 million. Similarly, there is a narrow corporate income tax base.

46.3. A low proportion of employed persons compared to the working-age and total population is a considerable constraint on potential tax revenue. Figure 8 shows the ratio of employment to total population for South Africa and current single-payer countries.

Figure 8: Comparison of the Ratio of Employment to Total Population in South Africa and Single-Payer Countries 2023



Source: World Bank

47. The graph shows South Africa's low employment ratio to the total population, reflecting the country's unemployment rate – one of the highest in the world – as well as its large youth and growing old-age population. This ratio represents an already extremely high level of dependency on the employed population. Such a low level of employment denies the government the substantial tax revenue that would be required to fund, inter alia, the NHI fund, as well as other expansions in government expenditure.

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48. Collectively, these constraints on fiscal policy place hard limits on the capacity of the government to finance the NHI fund, considerable enough to practically preclude the NHI from meeting its objectives of universal health coverage.

iii. High-quality governance and administrative capacities

49. A single-payer health system requires the following attributes from the government departments and agencies that manage the system[29]:
    49.1. A capable and honest public administration, including sophisticated information systems, strong claims processing capabilities and efficient fraud detection mechanisms.
    49.2. Clear governance structures, well-defined decision-making authorities, and high levels of transparency and accountability.
    49.3. Robust governance, low corruption, and effective management (e.g. cost containment mechanisms) of large-scale public financing and health care delivery.

50. South Africa falls well short of these criteria, indicating that the country will lack the necessary administrative capacity in the NHI Fund and the Departments of Health at various levels to implement the NHI successfully.
    50.1. There is strong evidence[30] of high levels of corruption and administrative inefficiencies in the public health sector, including weak capacity in provincial and district health management. Examples are the annual reports of the Auditor-General that regularly identify high levels of irregular expenditure and unauthorised, fruitless and wasteful expenditure.[31]
    50.2. South Africa exhibits inadequate institutional capacity to manage large-scale and complex public sector administrative systems. Currently, government departments have weak information systems and fragmented health data management.

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51. Underlying these deficiencies is a tolerance of inept performance and leadership, management and governance failures in the public health sector at all levels; the lack of a fully functional district health system, which is the main vehicle for the delivery of primary government health care; and an inability or failure to deal decisively with the health workforce crisis of under-staffing and poor morale.

52. Another problem that will likely harm the success of the NHI is the excessive power given to the Minister of Health in the NHI Act, which allows for a high level of political interference in the NHI Fund. For example, the Act gives the Minister unvetted powers to make far-reaching health regulations without necessary oversight.

53. These governance and administrative capacity weaknesses are reflected in worldwide indicators of governance published by the World Bank.[32] The indicators cover several governance dimensions, including government effectiveness, regulatory quality and control of corruption. The following graphs show, on a scale from -2.5 to +2.5 (higher is better), the performance of South Africa compared to countries with single-payer health systems.

54. Figure 9 shows how the country compares on the Government Effectiveness measure in 2023. The indicator captures perceptions of the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies.

55. South Africa has a negative value of -0.26, reflecting poor levels of government effectiveness and is well below the values of the single-payer countries. It provides further evidence that the country currently has an administrative capability and capacity far from the standard demanded to manage the complexity of introducing and running a single-payer health system.

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[29] These necessary attributes are barriers to universal health insurance in middle income and low-income countries. For a discussion and evaluation see Banerjee, A., Finkelstein, A., Hanna, R., Olken, B.A., Ornaghi, A., & Sumarto, S. (2021). The Challenges of Universal Health Insurance in Developing Countries: Experimental Evidence from Indonesia's National Health Insurance, *American Economic Review, 111(9): 3035-3063.*

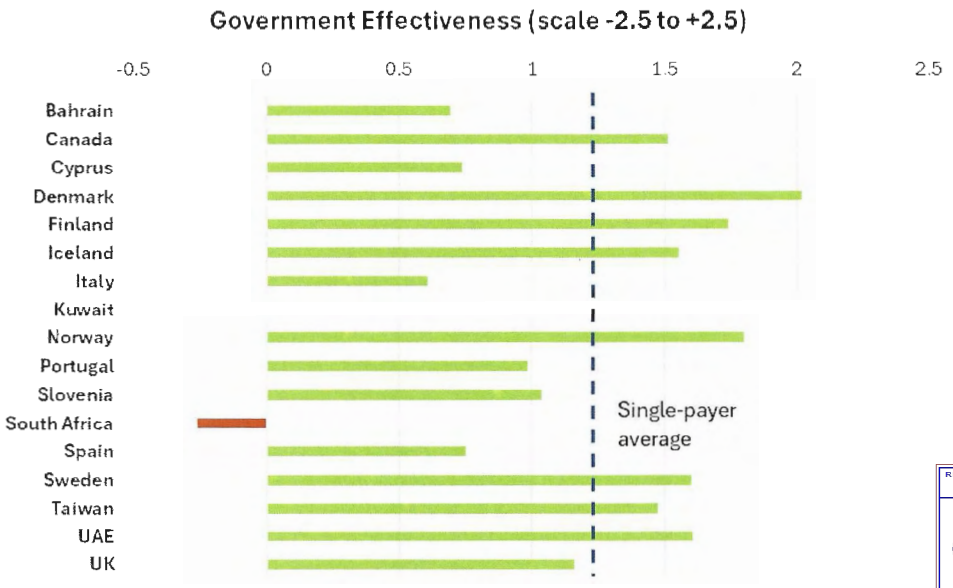
[30] Examples are Auditor-General https://pfma-2023-24.agsareports.co.za/pages/health-sector and https://www.hst.org.za/publications/South%20African%20Health%20Reviews/2%20Analysing%20the%20progress%20and%20fault%20lines%20health%20sector%20transformation%20in%20South%20Africa%20.pdf and https://www.chp.ac.za/Portals/0/FINAL%20Exploring%20Corruption%20in%20SA%20Health%20sector.pdf

[31] Source: Auditor-General https://pfma-2023-24.agsareports.co.za/pages/health-sector

[32] https://www.worldbank.org/en/publication/worldwide-governance-indicators
The WGI are based on existing data sources produced by more than 30 think tanks, international organisations, nongovernmental organisations and private firms around the world The data sources (1) produce original primary data using their own well-defined methodologies, (2) report respondents' perceptions of relevant dimensions of governance, (3) cover multiple countries, and (4) are regularly updated. The data reflect the diverse views of tens of thousands of survey respondents and experts worldwide. WGI combine these into aggregate indicators of six dimensions of governance for over 200 economies over the period 1996–2023: Voice and Accountability, Political Stability and Absence of Violence/Terrorism, Government Effectiveness, Regulatory Quality, Rule of Law and Control of Corruption.

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Figure 9: World Governance Indicators: Government Effectiveness 2023



Source: World Bank

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56. Figure 10 shows South Africa's score on the Regulatory Quality indicator. The indicator captures perceptions of the government's ability to formulate and implement sound policies and regulations that facilitate and promote private sector development. It is a particularly important indicator given the role of the state under the NHI as a monopsonist in the purchase of health care products and services. Again, South Africa has a negative score of -0.22, indicating poor regulatory quality far below the standard of all single-payer countries.

Figure 10: World Governance Indicators: Regulatory Quality 2023



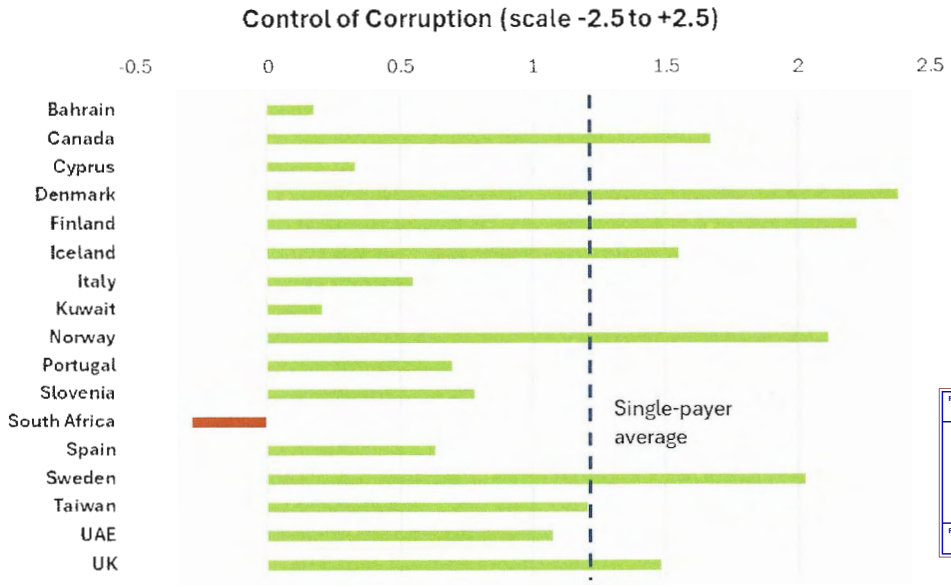
Source: World Bank

57. The final governance indicator, shown in Figure 11, is Control of Corruption, which captures perceptions of the extent to which public power is exercised for private gain, including petty as well as grand forms of corruption, and "capture" of the state for sectional interests. Not surprisingly, given the recent history of state capture and other levels of corruption in the country, South Africa's value is -0.28, reflecting poor control of corruption and performing poorly against the standards of single-payer countries. That the NHI Fund has unfettered market

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power and a statutory monopoly and monopsony (The Fund will be exempt from the Competition Act[33]) does not, given such governance weaknesses, bode well for the successful implementation of NHI.

Figure 11: World Governance Indicators: Control of Corruption 2023

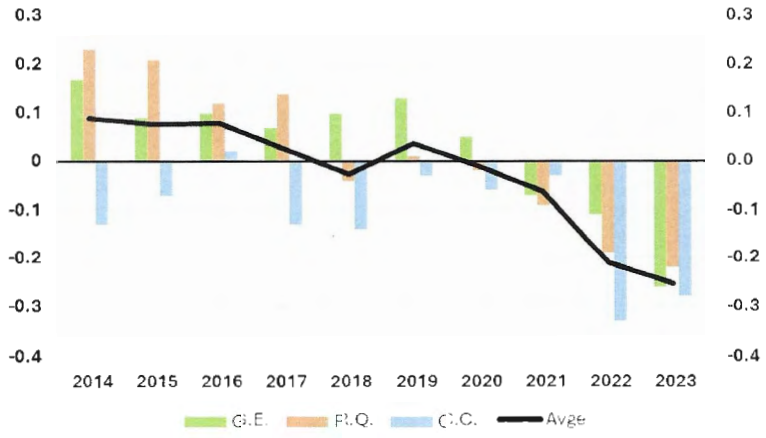


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Source: World Bank

58. All three aforementioned governance indicators have deteriorated in the past decade, indicating weakening state governance and administrative capacity. Figure 12 provides values of the indicators from 2014 to 2023, and the average for the period. In the last three years, all the indicators and, consequently, their average have deteriorated rapidly, showing increasingly poor governance standards.

Figure 12: Trend in South African Governance Indicators: Government Effectiveness (GE), Regulatory Quality (RQ) and Control of Corruption (CC) 2014-23



Source: World Bank

59. In summary, these independent governance indicators compared to the standards upheld in single-payer countries, along with trends over time, provide compelling evidence that the NHI Fund, which will have one of the, if not *the*, largest and most complex budgets allocated to any government department or public agency in the country, is highly unlikely to be able to achieve the governance standards and administrative capacity to implement the NHI successfully.

[33] The NHI Act, Section 3(5), "The Fund is exempt from the Competition Act, 1998 (Act No. 89 of 1998), to enable it to fulfil its mandate as a single purchaser and single payer as contemplated in section 2."

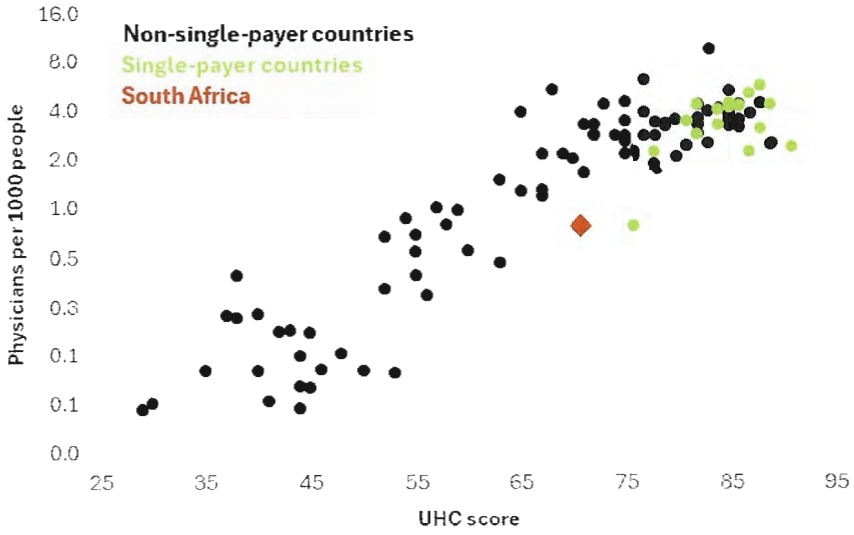
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iv. Sufficient health care resources: human resources and physical capital

60. Sufficient health care resources, including human resources (health professionals), widespread availability of medicines, and investments in physical infrastructure (health care establishments) and information systems are essential for the successful functioning of any health system. Adequate health care provision requires large-scale and continuous investments in these resources and medical technologies.

61. No health system can function without its workforce. Figure 13 compares the availability of physicians, a critical element of any health system, between South Africa (coloured red), single-payer countries (green) and other health systems (black) in 2021, based on World Bank data. The graph on a semi-log scale shows the relationship between physicians per 1,000 people and the UHC SCI for a sample of 107 countries. The graph shows that, generally, to achieve a high degree of universal health coverage provided by single-payer countries, there needs to be a minimum ratio of at least 2.0 physicians per 1,000 people. The average for the single-payer countries in the graph is 3.6 physicians per 1,000 people.

Figure 13: Physicians per 1,000 Population, 2021



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Source: World Bank

62. In contrast, the graph shows South Africa, like many middle- and low-income countries, is under-resourced compared to single-payer countries, with 0.8 physicians per 1,000 people (coloured red). This ratio is 22% of the average in single-payer countries. To achieve the level of single-payer countries, South Africa would, therefore, need to increase its current number of available doctors by around 350%. At 0.8 physicians per 1,000 people in South Africa, this implies around 50,000 physicians, a large subset of the estimated 53,773 medical practitioners in 2024.[34] This, in turn, means that another 175,000 physicians are needed to reach the average number of physicians per capita in other single-payer countries.

63. The sheer scale of this shortage is brought into stark relief when one considers that the average annual increase in registered medical practitioners was under 3,000 over the last four years.[35] There are currently 10 medical schools in South Africa, with an additional one planned to begin admitting students in 2028. Additionally, some students receive part of their qualifications in Cuba. The annual output of graduates is approximately 3,500, including Cuban-trained students.[36] However, because of National Treasury budget constraints on health expenditure, not all these doctors enter the public health service.[37] Moreover, the number of new graduates entering health care practice is somewhat offset by older doctors retiring and taking posts overseas.

64. These data show that South Africa produces, annually, at most 1.7% (3000) of the new doctors it needs in total (175,000). Given that population growth in South Africa is approximately 1.5% per annum, the rate of training of new doctors will not materially increase the number of doctors per capita. Compared to other single-payer countries, the current shortage of doctors and the wholly inadequate existing capacity to train new doctors

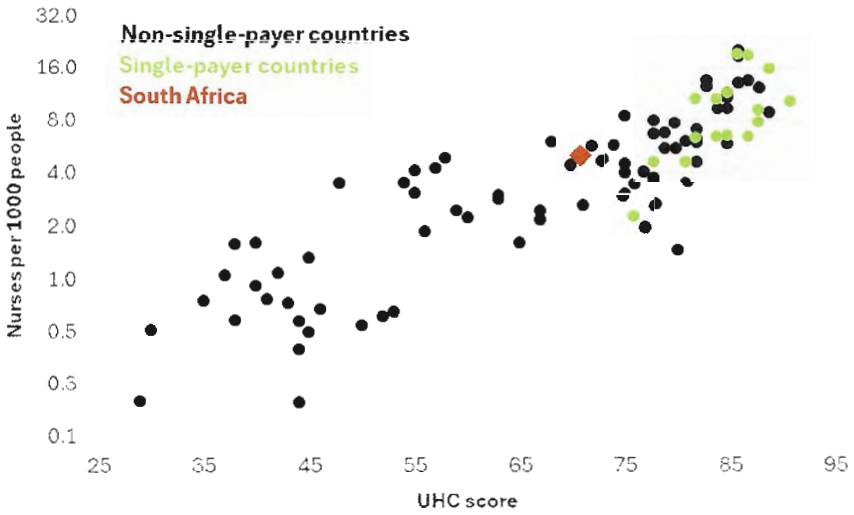
[34] HPCSA Annual Report 2024
[35] Ibid.
[36] https://bhekisisa.org/health-news-south-africa/2025-03-12-update-budget-2025-jobs-for-only-800-of-1-800-unemployed-
[37] Ibid.

shows clearly that South Africa has no realistic prospects of obtaining anywhere near enough medical practitioners to support a comprehensive single-payer system such as the NHI.

65. Crucial personnel constraints prohibiting successful implementation of the NHI in the foreseeable future include:
    65.1. The shortage of doctors, particularly in the public health sector;
    65.2. limitations on the medical schools' capacity for training;
    65.3. restrictions on the recruitment of foreign physicians; and
    65.4. The risk of emigration or exit from the profession.

66. A sufficient number of nursing staff is also essential for effective universal health coverage. Figure 14 shows the relationship between the number of nurses and midwives per 1,000 people and the UHC SCI in 2021 for 93 single-payer (coloured green) and other countries (black), based on World Bank data.[38]

Figure 14: Nurses and Midwives per 1,000 Population 2021



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Source: World Bank

67. The graph shows a strong association between the number of nurses in a country and its level of health coverage. The minimum ratio for single-payer countries, excluding the outlier, oil-producing countries of Bahrain, Kuwait and UAE, where the single-payer system applies only to citizens of the country[39], is 6.5 nurses and midwives per 1,000 people, and the average is 10.6 per 1,000 people.

68. South Africa, and many middle-income and low-income countries, have a lower ratio of nurses and midwives, reflecting resource funding constraints or a lack of capacity to train them. South Africa's ratio (coloured red) is 5.0 per 1,000 people, around half of the average single-payer country ratio. To meet median single-payer standards under the NHI, nursing personnel per capita would need to at least double. Given the profession's current capacity to train nurses, this is highly unlikely to occur in the next 10-15 years.[40]

69. Health care infrastructure is the backbone of any successful health system. However, much of the public sector health establishments and other infrastructure is dysfunctional[41]:
    69.1. A substantial number of public health facilities, many of them old, have not been adequately maintained or upgraded.
    69.2. Some district hospitals and community health centres are ill-equipped to offer comprehensive services, often because of broken equipment, inadequate sanitation facilities, lack of medicines and consumables, or unclean water.
    69.3. Many facilities lack modern diagnostics and IT systems for patient records, patient referrals and supply chain management.
    69.4. Rural and township areas frequently lack clinics, hospitals, and emergency care facilities.

[38] The South African data is for 2020.
[39] See footnote 6
[40] https://ahasa.org/nursing-shortage-in-south-africa-implications-and-strategies-for-addressing-a-growing-health care-crisis/
[41] Some problems of infrastructure in the public sector are outlined at https://pmc.ncbi.nlm.nih.gov/articles/PMC6556866/
A summary of weaknesses in public sector health infrastructure is contained in UHAC (2025) Universal Health care Access in South Africa.

70. These problems occur because of poor governance and administrative capacity in public health management, covered earlier in this report, as well as a lack of funding for necessary investments in health facilities, particularly in primary health care. The effects include delays in infrastructure procurement, under-expenditure on infrastructure, and stalled or abandoned projects. Frequent non-compliance with infrastructure norms and standards also leads to a declining quality of medical infrastructure.[42]

71. Altogether, although there are developed-world standard hospitals and other health establishments in the private sector, South Africa lacks the necessary health care infrastructure for a single-payer system. National Treasury currently has no plans for major health infrastructure upgrades.[43] The NHI cannot be implemented without adequate public sector health infrastructure and facilities.

v. Broad stakeholder support

72. A single-payer health care funding system, which amounts to the nationalisation of health insurance, requires broad acceptance and support by the public.

73. Requirements in this regard for the implementation of a single-payer system include:
    73.1. A strong political commitment: governments would have to prioritise universal health care over other public sector spending policies over a long period, which generally requires substantial increases in health care expenditure as a percentage of GDP and per capita spending (discussed above);
    73.2. Strong political consensus: there would need to be sustained political support by major parties over electoral cycles, as implementation takes many years and frequent alterations to policy frameworks are highly disruptive to long-term planning and implementation.
    73.3. Public trust in government institutions: society must generally have confidence in the state's ability to administer health care financing and delivery services effectively.
    73.4. Social solidarity: there must be a willingness by broad sections of society, especially those who bear the bulk of the tax burden, to accept cross-subsidisation and redistributive taxation (i.e., high- and middle-income households, the healthy, and younger people supporting low-income households, the unhealthy, and the elderly).

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74. A broad societal consensus on introducing the NHI in South Africa does not exist.
    74.1. The largest political party by vote share, the African National Congress (ANC), along with several other parties, support the NHI. Still, other parties, notably the second partner in the government coalition, the Democratic Alliance (DA), oppose it.[44] The DA has filed a complaint with the Public Service Commission against the NHI, highlighting its concerns about its impact on public administration, and it has pledged to repeal the NHI if it is elected outright into national government or becomes dominant in a governing coalition. Given that it is the second-largest party in the country and a member of the so-called 'GNU' coalition government, its potential to stall or delay the implementation of the NHI strongly negates the policy stability necessary for single-payer systems.
    74.2. Major health care service providers and health insurers oppose the NHI. The Hospital Association of South Africa ("HASA"), representing many health care establishments, the South African Medical Association ("SAMA") representing medical practitioners, the South African Private Practitioners' Forum ("SAPPF") and the Board of health care Funders ("BHF") have all launched legal action against the NHI Act. Some civic society organisations also plan to take legal action against the Act. The NHI will not be successful without the buy-in of medical practitioners and the private hospital sector. The profoundly serious risk is that, should the government begin implementing NHI, many medical practitioners will leave the profession or emigrate, jeopardising existing health care delivery in both the public and private sectors.
    74.3. While there is notable support for the ideal of universal health coverage, there is also a lack of trust amongst the public that the government would be able to implement the NHI successfully, given its record in managing other public services and public enterprises such as Eskom and Transnet. A recent study of health care in the country states, "There is overwhelming evidence that the quality of health care in South Africa has been compromised by various challenges that impact negatively on health care quality… Decline in quality health care has caused the public to lose trust in the health care system in

[42] Ibid.
[43] Cf. National Treasury Medium Term Budget Statement, October 2024.
[44] The DA believes the NHI violates constitutional principles governing public administration; will undermine the existing health care system; potentially leading to a decline in quality and access to care, especially for those relying on medical aid; and will lead to inefficient and uneconomic resource allocation, potentially straining the public health care system. https://www.da.org.za/2023/05/50-reasons-why-the-nhi-will-never-work

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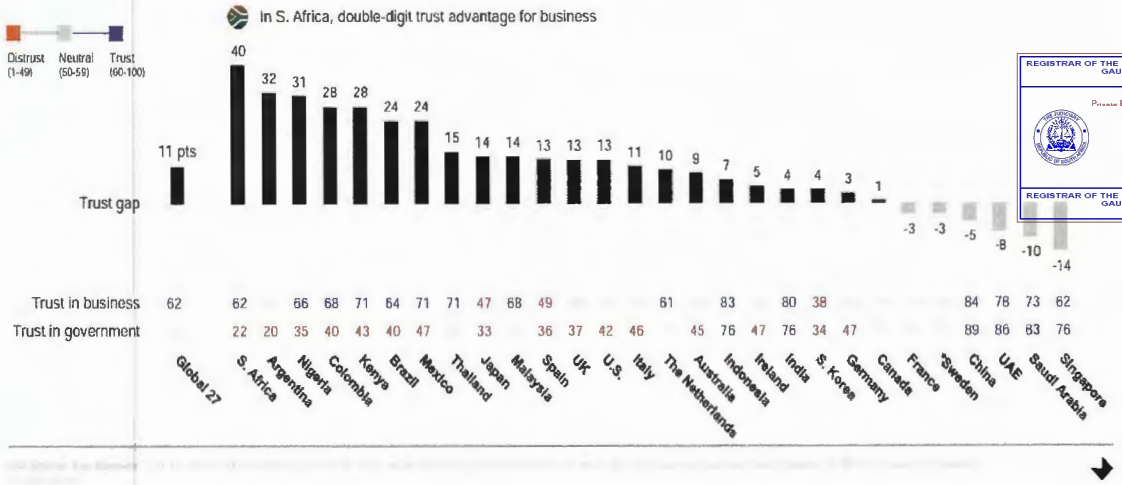
South Africa."[45] Given the increases in taxation that the government has stated must occur to begin implementing the NHI, there is widespread scepticism that the NHI will achieve its objectives, which risks further undermining public support for the NHI.

74.4. There is also opposition from many members of the public who have medical aid and justifiably fear they will experience inferior quality health care if NHI is implemented.

75. Figure 15 is taken from the 2023 Edelman Trust Barometer.[46] The survey shows that the public in South Africa has amongst the lowest reported trust in its government institutions and leadership globally yet reports high trust in the country's business institutions and leadership. Only 22% in South Africa trust the government, compared to the global sample average of 51%, whereas trust in business, at 62%, is on par with the global average.

Figure 15: Edelman Trust Index – Government vs Business 2023

Percent trust, and the percentage-point difference between trust in business vs government



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Source: Edelman Trust Index, Edelman

76. Figure 16 is a scatterplot comparing countries by their quality of governance and trust in government institutions. Single-payer countries (green dots) tend to have moderate to high trust in government, along with capable governance. The scatterplot shows that South Africa (red dot) lacks both, being in the bottom left-hand "low trust/poor governance" quadrant..

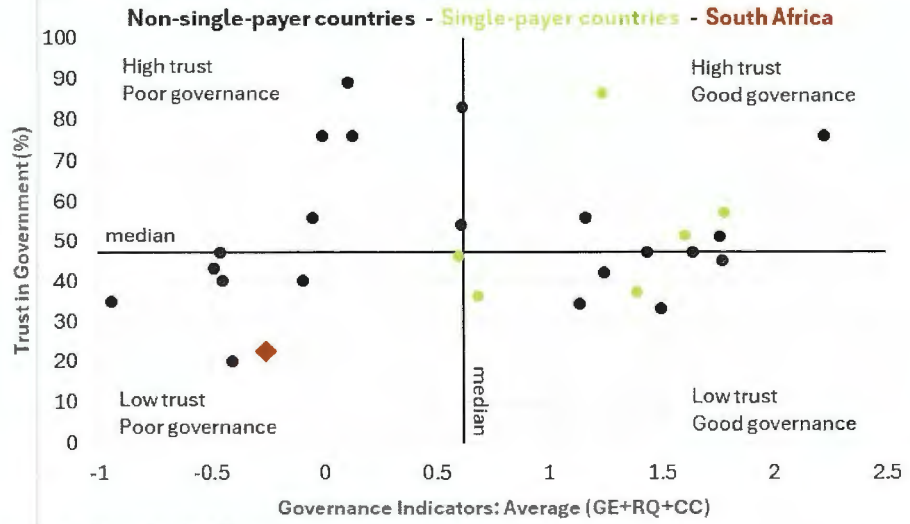
77. Collectively, there appears to be broad support for the goal of universal health coverage, but strong opposition to NHI by several major stakeholders. Health care practitioners' and private hospitals' extensive concerns with the NHI must be addressed effectively if the health care system is to function well.

[45] Maphumulo, W.T. & Bengu, B.P. (2019). Challenges of quality improvement in the health care of South Africa post-apartheid: A critical review. *Curationis*, 29;42(1). https://pmc.ncbi.nlm.nih.gov/articles/PMC6556866/

[46] Edelman Trust Barometer. (2023). S. Africa Report. In Edelman Trust Barometer (pp. 2–10). https://www.africa.edelman.com/sites/g/files/aatuss536/files/2023-03/2023%20Edelman%20Trust%20Barometer_S.%20Africa%20Report-final.pdf

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Figure 16: World Bank Governance Indicators (avg. of Control of Corruption, Government Effectiveness, and Regulatory Quality) vs. Edelman Government Trust Index 2023



Sources: World Bank; Edelman Trust Index

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vi. Willingness to allow the participation of the private sector

78. All countries with single-payer health systems, except for some provinces in Canada, allow private-sector health insurance. This is summarised in Table 2. The reasons include relieving pressure on public finances by creating more fiscal space and recognising that many consumers demand greater choice in health care services or higher-quality health care (e.g., faster, better, or innovative medical treatments) that are not covered, or cannot be covered, by public health insurance.

79. In contrast, the NHI will effectively lead to the end of private health insurance, such as medical aid schemes, as explained earlier in this report. Besides leading to opposition from important stakeholders, the total reliance on a single-payer system will place a maximum burden on government finances, undermining the affordability of NHI and denying consumers the choice of health insurance and medical care.

Table 2: Does Legislation Allow for Private Health Insurance? – South Africa and Single-Payer Countries

Table: Does single-payer legislation allow for private medical/health insurance?			
Country	Private Health Insurance	Country	Private Health Insurance
Bahrain	Yes	Portugal	Yes
Canada	Partial	Slovenia	Yes
Cyprus	Yes	South Africa (NHI)	Effectively No
Denmark	Yes	Spain	Yes
Finland	Yes	Sweden	Yes
Iceland	Yes	Taiwan	Yes
Italy	Yes	UAE	Yes
Kuwait	Yes	UK	Yes
Norway	Yes		
Sources: Legislation from single-payer countries; NHI Act			

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V. Conclusions

80. The assessment of the South African government's ability to successfully implement the NHI to achieve the objectives of universal health coverage is based on a review of several criteria observed in existing functional single-payer health systems across the world:
    80.1. Affordability, given the current level of GDP per capita in the country;
    80.2. Strong and sustainable fiscal capacity;
    80.3. High-quality governance and administrative capacities;
    80.4. Sufficient health care resources, including human resources and physical capital;
    80.5. Broad stakeholder support; and
    80.6. A willingness to allow the participation of the private sector to create more fiscal space and reduce the burden on a narrow taxpayer base.

81. The results of this comparison are summarised in the Table below (Table 3). South Africa and the NHI fail to meet all these criteria.

82. In summary, international experience shows that the NHI, as a single-payer health system, is unaffordable, unworkable, and unattainable. The NHI will not meet the government's objectives for universal health coverage in South Africa, given substantial existing deficits in income levels, taxation capacity, health care resources, governance capability, and socio-political solidarity.

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83. Moreover, international experience confirms that a single-payer health care funding system is unnecessary for countries to achieve universal health coverage.

84. The South African government's decision to force the public into a single-payer health care funding system from the current multi-payer funding arrangements, therefore, appears irrational, irresponsible, and inappropriate given the system's severe resource deficits, given that multi-payer and hybrid systems are better suited to middle-income countries, and given that countries have demonstrated that high levels of health coverage can be achieved with fewer resources in alternative multi-payer and hybrid systems.

Table 3: Summary Table of Criteria Comparison – South Africa and Single-Payer Countries

Summary Table: Comparison of key criteria
South Africa and countries with single-payer healthcare systems

Country	GDP / capita ($)		Govt Health spend / capita ($)	Employment-to-Population Ratio (%)	World Governance Indicators (-2.5 to +2.5)	Nurses per 1000 people	Doctors per 1000 people	Edelman Trust in Govt (%)	Single-payer legislation allows private insurance?
South Africa	6 843	Middle-income	377	28%	-0.3	5.0	0.8	22%	Effectively No
Bahrain	27 148	High-income	778	57%	0.7	2.3	0.8	..	Yes
Canada	52 497	High - income	4 757	53%	1.6	10.3	2.5	51%	Partial
Cyprus	33 734	High-income	2 592	52%	0.6	4.6	3.6	..	Yes
Denmark	69 728	High - income	6 314	51%	2.1	10.6	4.4	..	Yes
Finland	53 099	High - income	4 248	48%	1.9	19.3	4.4	..	Yes
Iceland	69 326	High - income	5 685	59%	1.5	15.8	4.4	..	Yes
Italy	36 853	High-income	2 564	40%	0.6	6.5	4.1	46%	Yes
Kuwait	34 044	High-income	1 704	59%	0.2	4.6	2.3	..	Yes
Norway	93 073	High - income	7 847	53%	1.8	18.9	5.2	..	Yes
Portugal	24 711	High-income	1 725	48%	0.8	7.8	5.8	..	Yes
Slovenia	29 187	High-income	2 027	48%	0.8	10.6	3.3	..	Yes
Spain	30 818	High-income	2 342	44%	0.7	6.5	4.5	36%	Yes
Sweden	61 175	High - income	5 846	52%	1.8	11.5	4.3	57%	Yes
Taiwan	33 100	High-income	2 218	50%	1.4	6.5	2.3	..	Yes
UAE	43 360	High-income	1 475	64%	1.2	6.4	2.9	86%	Yes
UK	46 897	High - income	4 752	49%	1.4	9.2	3.2	37%	Yes

Sources: World Bank Development Indicators; World Governance Indicators; Edelman Trust Barometer; Legislation from single-payer countries; NHI Act

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PriceMetrics

Economic Analysis and Fiscal Affordability Analysis of the National Health Insurance Act, Act No 20 of 2023

Professor Jannie Rossouw, Dr Fanie Joubert and Mike Holland

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19 December 2024

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Executive Summary

This report is an economic and fiscal capacity assessment of the affordability of the National Health Insurance ("NHI") Act, Act No 20 of 2023, signed by President Cyril Ramaphosa shortly before the general election of 29 May 2024. The Act is a further step towards the government's objective of universal health coverage ("UHC") and follows the issuing of a Green Paper in 2011 and two White Papers in 2015 and 2017.

Implementing the NHI Act will lead to fundamental changes in the provision of health care services in the country, affecting all South Africans. As the 2017 White Paper states, "NHI represents a substantial policy shift that will necessitate massive reorganisation of the current health care system to address structural changes that exist in both the public and private sectors."

The principles of the NHI Act are universal access to health care services; comprehensive coverage of health care services (with some anticipated exclusions); protection from the financial risk of paying for health care services (services will be free at the point of care) and the NHI as the single purchaser and single payer of health care services. Importantly, the Act states that when the NHI has been fully implemented, medical schemes may only offer complementary coverage for services not reimbursed by the Fund.

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In terms of the NHI Act, national health insurance will be phased in over a period of time, with a time frame of 15 years often mentioned as the phasing-in period. However, the NHI Act provides no timeframe for phasing-in of the provisions of the NHI Act, which complicates economic and fiscal calculations about its cost once fully phased in and operational. To overcome this limitation, assumptions about dates for fully phased-in NHI were used to compile this report, i.e., 2028 and 2039.

The NHI Act envisages the financing of the NHI will be from a variety of sources, including general tax revenue, the shifting of funds from the provincial equitable share and conditional grants into the Fund; the reallocation of funding for medical scheme tax credits towards the financing of national health insurance; a payroll tax (employer and employee); and a surcharge on personal income tax. These taxes will be raised on top of tax rates that are already high in South Africa and will negatively impact the country's economic growth prospects.

A further complication of the NHI Act is that no indication of its total cost implications, once fully implemented, was provided when the NHI Bill was considered in Parliament. The memorandum published with the NHI Bill considered in Parliament avoids, in Section 8 (*Financial Implications for the State*), any mention of the full cost of providing fully implemented national health insurance services. This is a serious omission on the side of the government, as it seems irresponsible to expect members of Parliament to consider a Bill without any indication of its full cost (once fully implemented) or the impact of the increases in taxation that will be necessary to raise the funding required.

The general public, members of Parliament who considered the Bill, and South African taxpayers in particular have consequently not been informed on the estimated or envisaged cost of the NHI, other than to have to refer to the 2017 White Paper, which provides a broad total estimate of the cost in 2025/26 when the NHI is expected to be fully operational, **based on 2010 values**. The 2017 White Paper does not even show adjustments of the 2010 estimates for implementation to 2017 values (the publication date of the White Paper), thus creating a false impression of actual implementation costs. Nevertheless, the 2010 values (adjusted for inflation) are used in this report, as no other value(s) have – at the time of writing – since been provided by the South African authorities. To the contrary, the Minister of Health merely ridiculed other estimates of the cost of fully implemented national health insurance made by private sector institutions without providing his own estimates.

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This is a critical omission on the side of the South African government and the minister of health. Large-scale government social programmes such as the full implementation of national health insurance generally require substantial fiscal capacity or fiscal space to be affordable. In addition, it should be accompanied by a detailed and up-to-date cost-benefit analysis of its feasibility/infeasibility within the fiscal framework.

The analysis in this report shows that South Africa's economic performance has seriously declined for nearly two decades, and the general trend in the country's public finances is at or close to unsustainable levels, even before considering the NHI. South Africa is in a long-term low-growth state, which provides little scope for costly new government initiatives. To the contrary, any scope in government finances should rather be used to contain the government's rising debt burden and the interest payable on this, as these aspects impact negatively on South Africa's fiscal stability and international credit risk rating.

The current fiscal position dictates that the government should reduce expenditure and/or increase revenue to avoid a possible fiscal crisis. Since 2008, the South African government has increased social grant expenditure and civil service remuneration, while interest payments on government debt increased with rising government debt levels. These items currently account for more than 70% of government revenue, from a level of 55% in 2008. A continuation of this growth trend will bring South Africa to a fiscal cliff, i.e., the point where these expenditure items will account for all government revenue. Neither fiscal capacity nor fiscal scope exist within the current revenue and expenditure framework for additional spending commitments.

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Our forecast of future trends in the economy projects continued low economic growth. This is based on the recent performance of the economy, the anticipated global economic environment, and on current and planned economic policies. It shows that even 2,0% per annum growth is beyond the economy's ability in the short-term, and the long-term growth potential is about 1,5% per annum. This, in turn, affects state finances, and the analysis shows little fiscal scope or capacity within the current government expenditure framework.

The report focuses on estimating funding gaps for two time periods, that is, 2028 and 2039, although this executive summary deals only with the estimates for 2028 for the sake of brevity. The 2039 estimates are discussed in the report.

In 2028 values, our estimate of the annual funding gap, based on the 2015 and 2017 White Papers, is some R483,1 billion for full implementation of NHI as envisaged in the NHI Act. A calculation of combinations of revenue-raising options from various alternative tax increases to fund this gap is summarised in Table 1. The order of magnitude of the required increases shows beyond any doubt that raising this amount of tax will place a debilitating burden on the South African economy and consumers.

Table 1 provides combinations of options that can be used to fund the projected NHI shortfall of R483,1 billion in 2028. It can be restructured to show other combinations or to show how different amounts can be raised to fund the estimated shortfall in 2028 NHI funding, but the same principles will apply. The conclusion is that an extra funding requirement of R483,1 billion will place a significant burden on the South African economy, equal to an increase of some 15% to 20% in total taxation estimated for 2028. The objective of raising the shortfall of R483,1 billion is achieved in this instance by a surcharge of 31% in personal income tax, an increase of 3,5 percentage points in VAT and a payroll tax of 2% on taxable income above R212 544 per annum. In this analysis, corporate tax as a source of revenue is not included, as the NHI Act does not mention an increase in this form of taxation as a revenue source.

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Table 1: Additional Revenue Sources for the South African Government to Fund an NHI Funding Gap of R483,1 billion in 2028

Personal income tax surcharge		
10% surcharge	**20% surcharge**	**31% surcharge**
95.5	191.0	295,7
Value-added tax		
+ 1 percentage point	**+ 2 percentage points**	**+ 3,5 percentage points**
40.3	80.6	142,1
Payroll tax		
2% on income above R212544	**2% on income above R212544**	**2% on income above R212544**
45,3	45,3	45,3
Medical aid tax credits already deducted in funding gap calculations		
Totals		
181,1	316.9	483,1

Source: Own calculations

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The assumption that the extra personal income tax burden of 31% on each individual taxpayer (each taxpayer facing an extra tax burden of 31%), combined with a payroll tax and a VAT increase, will not have any impact on consumption and saving by individuals is clearly wrong. Funds to pay this extra tax will have to be sourced from either reducing consumption, reducing savings or a combination of both. Put differently: based on the 2024/25-tax tables, a person earning annual taxable income of R857 900 will pay an additional R77 889,98 per annum in tax, given the implementation of a surcharge of 31 per cent. This amounts to an additional R6 490,83 per month income tax on a monthly taxable income of R71 491,67 (i.e., some 9,1%), on top of the current income tax burden of R20 938,17 per month (R251 258 per annum) that will be sourced by means of less consumption, less saving or a combination of both.

This increased tax burden will have an adverse impact on real economic activity (for instance, economic growth, company profits, and other taxes) and behaviour (for instance, spending patterns, saving, hours worked, emigration, etc), thus reducing other tax revenues. In recent years, South Africa has experienced a decline in tax buoyancy, implying that tax increases resulted in smaller-than-expected revenue increases. This brings to mind the theoretical concept of the Laffer curve, which shows that tax rates can be raised to a level where the total taxes collected actually start to decline owing to higher tax rates. Although difficult to calculate in practice, this complicates the picture as one cannot guarantee that higher tax rates will necessarily result in the additional revenue as calculated. This aspect might become more prominent in South Africa when applying the draconian (required) tax hikes estimated in Table 1. In short, South Africa's fiscal capacity to raise taxes is limited.

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The impact of the reduction in personal household expenditure, a higher VAT rate and a payroll tax on income above R212 544 on the domestic GDP will, to a degree, be offset by an increase in government expenditure on health care through the NHI, as well as possible saving on private medical contributions and related medical costs by individuals. It is, therefore, necessary to calculate the impact of a reduction in household disposable income and the stimulatory effect of the increase in government expenditure on health care through NHI.

However, a calculation of these aspects can only be based on the current economic environment and statistics. Given the complications discussed above, it cannot account for declining tax buoyancy and Laffer curve effects, i.e., a reduction in personal income taxes collected owing to an increase in the tax rate on income resulting in work hours substituted for leisure hours. As is shown in this report, South Africa had a negative experience in tax buoyancy when a new marginal tax rate of 45% was introduced.

The last increase in the marginal rate (from 41% to 45%) implied an increase of 4 percentage points, or 9,76%, in the maximum marginal tax rate. In the calculations above, an increase by means of a tax surcharge of 31% is suggested for full NHI implementation by 2028. At the lowest marginal rate of 18% this implies an increase in the effective marginal rate to 23,58%. In the highest income tax bracket, this implies an increase in the marginal rate from 45% to 58,95%. This would raise South Africa's marginal tax rate to the second-highest in the world after the Ivory Coast (60%) and above Finland.

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Econometric models can be used to quantify the possible second-round effects of higher taxes and spending on economic performance. For this study, we work with time series data, which means that a time series econometric model is appropriate. Two econometric models were run. The first one considered household disposable income, in which the impact of the taxation shocks (necessitated by the funding gap) was quantified. Then, a second model for GDP was used, in which the combined effects of changes in disposable income and government consumption expenditure were calculated.

As far as the impact on household disposable income is concerned, we estimate a real decline starting at R63,8 billion in 2025 and increasing to a decline of R364,0 billion in 2028 as NHI is phased in over the next four years. For 2028, this amounts to a decline of 4,3%, compared to economic activity in 2027, once fully phased in.

Figure 1: Estimated Impact of Phased-in NHI on Real GDP Growth



*Own forecasts. Source: SARB and StatsSA data.

The severity of this estimated drop becomes evident when comparing it to the previous largest contraction in real household disposable income of -5,1% recorded in 2020, during the Covid-19

lockdowns. Using nominal values, this effectively means that in order to fund the 2028 shortfall of R483,1 billion, the risk is that household disposable income could drop by as much as R500,7 billion – clearly an irrational decision.

To quantify the growth impact, a second econometric model was run using, among others, household disposable income and government consumption expenditure as explanatory variables. In this case, the results from the first model (i.e. for disposable income) were used as input (forecast values) for GDP. Government consumption expenditure (G) was hypothesised to have a stimulatory impact on GDP, and to forecast G, we assume a nominal growth rate of 6% per annum (i.e., 1.5% real increase in GDP and an average annual inflation rate of 4.5%). The additional taxes raised (i.e. the value of the estimated funding gaps) were also added for each year.

The results indicate that the dampening effect of lower household disposable income will outweigh the consumption stimulus from an increase in government expenditure. Compared to a base case forecast, real GDP growth for 2025 is expected to increase by a meagre 0,1% y:y, compared to an expected rise of 1,3% in the base case scenario. The growth performance worsens over the forecast horizon as the increased tax burden takes effect, with the 2028 figure indicating an annual contraction of more than 4,0%. To put this into perspective, in 2020, during the height of the Covid-19 crisis and concomitant economic lockdowns, South Africa's economy contracted by 6,2% (see Figure 1). In nominal terms, GDP in 2028 is estimated to be around R1,01 trillion less than the baseline forecast scenario, the latter excluding the extra tax burden to fund fully implemented national health insurance. Put differently, the cumulative effect of a phased-in NHI by 2028 will result in the South African economy being around 10,7% smaller compared to the baseline model without NHI. History has shown that contractions of this magnitude lead to, amongst others, severe job losses, increased unemployment and loss of confidence in the economy.

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We, therefore, conclude that, with continued population growth and other demands on the economy, a decline in economic activity owing to the increased tax burden required to fund a fully implemented NHI is clearly not affordable currently or in South Africa's longer-term economic future.

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Chapter One

Features of the NHI

Introduction

The National Health Insurance ("NHI") Act (Act 20 of 2023) was signed by President Cyril Ramaphosa on 15 May 2024, but has not yet been proclaimed. The objectives of the Act are "(t)o achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution; to establish a National Health Insurance Fund and to set out its powers, functions and governance structures; to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users; to create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population; to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users; and to provide for matters connected herewith."[1]

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At the time of signing the Act, President Ramaphosa stated that "(w)hat we're trying to build is the Rolls Royce system of health care for all South Africans … ."[2] This research report provides a more sobering picture of the economic realities facing the country. Using the president's metaphor, the report finds that South African taxpayers can neither afford the purchase price of the Rolls Royce nor its maintenance.

The World Health Organization defines Universal Health Coverage ("UHC") as: "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO."[3]

The principles of the Act are universal access to health care services; comprehensive coverage of health care services (with some anticipated exclusions); protection from the financial risk of paying for health care services (services will be free at the point of care) and the NHI as the single purchaser and single payer of health care services. The Act states that when the NHI has been fully implemented, medical schemes may only offer complementary cover for services not reimbursed by the Fund.[4]

The envisaged implementation of the NHI is (likely) over several years, divided into different phases. Initially, the preparatory work for the implementation of the NHI will be done. This will be followed by the phased implementation of the provisions of the Act. No firm timeline has been provided for the phased implementation, as is discussed again in detail later in this report.

The NHI will be funded from a variety of sources, including general tax revenue; the shifting of funds from the provincial equitable share and conditional grants into the Fund; the reallocation of funding for medical scheme tax credits towards the funding of National Health Insurance; a payroll tax (employer and employee); and a surcharge on personal income tax. These aspects are also discussed elsewhere in this report. The South African Revenue Service will be responsible for revenue collection related to the Fund.

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[1] Republic of South Africa. 2024. *National Health Insurance Act, Act No 20 of 2023*. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.saflii.org/za/legis/consol_act/nhia20o2023261.pdf

[2] Pongweni, T. 2024. 'We want to build a Rolls-Royce healthcare system for all,' says Ramaphosa on signing NHI Bill into law. *Daily Maverick*. 15 May. https://www.dailymaverick.co.za/article/2024-05-15-we-want-to-build-a-rolls-royce-healthcare-system-for-all-says-ramaphosa-on-signing-nhi-bill-into-law/

[3] World Health Organization, various publications.

[4] Republic of South Africa, 2023. NHI Act. Section 33.

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The cost and affordability of the NHI

The implementation of the NHI will lead to fundamental changes in the provision of health care services in the country, affecting all South Africans. The 2017 White Paper states, "NHI represents a substantial policy shift that will necessitate massive reorganisation of the current health care system, to address structural changes that exist in both the public and private sectors."[5] However, it is also explained in this report that no up-to-date calculations or estimates of the cost of NHI, once fully implemented, have been provided by the South African government.

Given the lack of up-to-date information on the cost of full implementation of the NHI, the report considers various cost estimates of the NHI. This analysis shows that the full implementation of NHI will put undue strain on the fiscus, which is already under pressure owing to low economic growth and high population growth. Growth in the tax revenue of the South African government is dependent on economic growth, which has been subdued for more than a decade. The future growth performance of the economy is, therefore, one of the aspects on which the funding of the NHI is dependent, given the link between economic growth and growth in the government's tax revenue. South Africa's economic performance and outlook are discussed in more detail in the next chapter.

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[5] Department of Health, 2017, *National Health Insurance for South Africa: Towards Universal Health Coverage*, page 3.

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Chapter Two

The economic environment

Introduction

Large-scale government social programmes such as the NHI generally require substantial fiscal capacity[6] or fiscal space[7] to be successful. The long-term source for adequate public expenditure of this kind is economic growth. High rates of increase in GDP allow governments to invest substantially over time in health infrastructure and services to meet the intensive demand for resources that universal health care policies need to be viable and sustainable. Conversely, low rates of economic growth make it very difficult to fund health expenditure adequately to meet expectations and can lead to serious or disastrous failures of the policy to provide the desired health outcomes for a country's citizens.

The argument is outlined in the 2017 White Paper: "A significant expansion in social expenditure programmes requires a sustained increase in economic growth, and the extent of this growth will determine whether large tax policy adjustments are required to fund NHI. Strong economic growth will limit the need for additional tax measures."[8]

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The tax increases and other funding mechanisms envisaged for the NHI as set out in the Green Paper[9], White Papers[10] , and the NHI Bill[11] are vague and lack detail. There is information on the anticipated growth in the average annual per cent real increase in projected NHI expenditure in the 2017 White Paper. For the period from the 2010/11 fiscal year to the 2015/16 fiscal year, the increase was 4,1% per annum in real terms, and for the period 2015/16 to 2025/26, the projected increase was 6,7% per annum.

These are ambitious objectives even in a fast-growing economy. The 2017 White Paper provided scenarios of economic growth of 5,0%, 3,5%, and 2,0% per annum. The 5,0% growth rate assumption is completely unrealistic for the economy (the South African economy has never achieved that rate of growth for such a period). The 3,5% growth rate assumption indicates that the NHI would consistently require a diversion of resources to the NHI that would be challenging for the economy. The 2,0% per annum assumption indicates that expenditure on the NHI from 2025/26 to 2027/28 would be over three times the growth in the economy, which many would consider a burden that would be impossible to achieve and fiscally irresponsible. The degree to which these projections were unrealistic is evident from South Africa's actual economic growth performance over this period. On average, the domestic annual economic growth rate hovered around 1% per annum for this period.

This chapter assesses the rate of growth in the economy that is reasonable to expect given the recent performance of the economy and current and planned economic policies. It shows that even 2,0% per annum growth is beyond the ability of the economy in the short-term, and the long-term growth potential is (at best) 1,5% per annum.

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[6] The fiscal capacity of a country refers to the government's ability and willingness to mobilise public revenues, which in turn allows it to spend money on public services and programs, including health. Source: McIntyre, D and Kutzin, J. 2016, *Health Financing Country Diagnostic - A Foundation for National Strategy Development*, WHO.

[7] Fiscal space is defined as the budgetary room that allows a government to provide resources for public purposes without undermining fiscal sustainability. Source: WHO various publications.

[8] Department of Health, 2017, *National Health Insurance for South Africa: Towards Universal Health Coverage*, page 39, paragraph 197.

[9] Department of Health, 2011, *National Health Insurance in South Africa: Policy Paper*.

[10] Department of Health, 2015, *National Health Insurance: Towards Universal Health Coverage* and Department of Health, 2017, *National Health Insurance for South Africa: Towards Universal Health Coverage*.

[11] Republic of South Africa July 2019, *National Health Insurance Bill*.

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Recent trends in the South African economy

The South African economy expanded strongly in the first decade of this century up to the global financial crisis of 2008, including GDP increasing by over 5,0% annually for three consecutive years during that period. In 2008, average living standards measured by per capita income were 21% higher in real terms than in 2000 and 27% higher than in 1994. The global financial crisis of 2008 and the subsequent Great Recession interrupted this high growth rate trend, and real GDP fell in 2009. From 2010 to 2013, there was a recovery in the economy, although growth rates were lower than in the previous decade. However, since 2013, there has been a significant decline in economic growth to low levels and a technical recession in the first half of 2018. The average low rate of growth has continued since 2019 despite the large swings during the Covid-19 lockdown and its aftermath. The result is that real per capita incomes have declined or remained stagnant for every year since 2013.[12] In 2023, real per capita income was R76 444, some 5,0% lower than in 2013.[13]

There are several reasons for the decline in the rate of economic growth, including falling productivity and low consumer and business confidence arising from structural rigidities in the economy; corruption, wasteful and irregular spending in the public sector; a decline in public sector governance and institutional capabilities; policy uncertainty; a regulatory environment that hampers private fixed investment; inefficiencies in state-owned enterprises ("SOEs") increasing the costs of key inputs in production and in the case of Eskom a long-term recurrent inability to supply electricity reliably until earlier in 2024; a rising real cost of capital; labour market rigidities; insufficient competition in product markets; and some long-term distortive effects of the Covid-19 lockdown.

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The changes in real GDP and other measures of the performance of the economy are shown in Table 2. One of the most concerning trends in the last few years has been the slow growth or decline in Gross Fixed Capital Formation, or in other words, fixed investment in the economy. Low rates of investment lead to a reduced rate of increase in productive capacity in the economy and lower productivity, harming the future growth of the economy. The major cause of the poor investment performance is lower spending by the public sector, both government departments and SOEs.

The fall in the rate of economic growth has led to an increase in the rate of unemployment. The economy has increased job numbers for a number of years, with employment rising from an average of 13,8 million in 2010 to 16,4 million in the third quarter of 2019[14] and to 16,7 million by the second quarter of 2024[15]. However, this initial increase in employment, followed by stagnation, has been insufficient to absorb the growth in the labour force during the period. The result has been an increase in the rate of unemployment from 24,7% in 2013 to 29,1% in the third quarter of 2019 and a further increase to 33,5% by the second quarter of 2024.[16]

The expanded definition of unemployment, which includes people who have given up looking for work, was 38,5% in the third quarter of 2019 and increased to 42,6% by the second quarter of 2024. For young people in the age group 15-24, the situation is even worse, with an unemployment rate of 60,8% in the second quarter of 2024.[17]

Coinciding with lower rates of economic growth, South Africans have experienced higher interest rates for borrowing money for buying consumer products on credit and funding homes, while companies have also faced rising finance costs. During the Covid-19 lockdown, the prime overdraft rate declined to 7,0%

[12] SA Reserve Bank. 2024. *Quarterly Bulletin*. June. S-160.

[13] Ibid. and own calculation.

[14] StatsSA *Quarterly Labour Force Survey*, Quarter 3, 2019 page 1 and QLFS Trends 2008-2019Q3.

[15] StatsSA. 2024. *Quarterly Labour Force Survey (QLFS) Q2:2024*. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.statssa.gov.za/publications/P0211/Presentation%20QLFS%20Q2%202024.pdf

[16] Ibid.

[17] Ibid.

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but subsequently increased to 11,75%[18] owing to increased inflationary pressure in the economy. Since the third quarter of 2024, the prime overdraft rate has declined, owing to a decline in the central bank's repurchase rate.

Table 2: The South African Economy: Summary of Recent Performance 2019 to 2025

	2019	2020	2021	2022	2023	2024*	2025**
Real GDP (% change)	0.3%	-6.2%	5.0%	1.9%	0.7%	1.0%	1.5%
Real Gross Fixed Investment (% change)	-1.7%	-14.8%	-0.4%	4.8%	3.9%	-5.8%	1.0%
Exports (% change)	-3.3%	-12.0%	9.7%	6.8%	3.7%	-6.2%	1.5%
Imports (% change)	0.6%	-17.6%	9.6%	15.0%	3.9%	-5.6%	2.0%
Inflation (average) CPI	4.1%	3.3%	4.6%	6.9%	5.8%	4.6%	4.5%
Unemployment rate (annual average)	25.8%	29.2%	34.0%	33.3%	32.1%	32.1%	32.0%
Current account: % of GDP (annual average)	-2.6%	2.0%	3.7%	-0.5%	-1.6%	-1.3%	-1.0%
Interest rates							
Prime overdraft rate end of period	10.12%	7.70%	7.05%	8.80%	11.50%	11.63%	10.80%
Long-term (10-15 y) bond annual average	9.15%	9.83%	9.98%	11.44%	11.53%	11.25%	10.50%
Exchange Rates							
Dollar-rand exchange rate (average)	14.44	16.45	14.77	16.35	18.67	18.25	18.50
Euro-rand exchange rate (average)	16.17	18.76	17.48	17.19	19.95	20.00	19.00

*Own estimate based on data from 2024Q1 and 2
**Own forecast
Source: StatsSA, SARB and own calculations

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The rand exchange rate has depreciated substantially against major world currencies since 2013, making the country's imports, such as fuel, consumer goods, and capital equipment for investment, much more expensive. The U.S. dollar/rand exchange rate increased from an annual average of R9,65 in 2013 to an average of R18,45 in 2023.[19] However, the rand is noted to be a volatile currency but has increased in value since the announcement of South Africa's Government of National Unity after the May 2024 general election.

Trends in the external sector of the economy show that South Africa continued to run a current account deficit where exports of goods and services were lower than its imports of goods and services. The current account deficit narrowed during the Covid-19 lockdown, from 2,9% of GDP in 2018 to 1,6% in 2023, with surpluses shown in 2020 and 2021.[20]

More encouraging is the trend in consumer inflation. The rate of inflation accelerated after the Covid-19 lockdown to an annual rate of 6,9% in 2022 and 6,0% in 2023.[21] Sound monetary policy resulted in a further decline in the rate of inflation, to a level of 2,8% in October 2024.[22] Inflation is expected to remain at or near the central bank's target level of 4,5% for the next year or two. This declining trend in the rate of inflation creates scope for further declines in the general level of borrowing rates in South Africa.

Most importantly for the funding of the NHI, the recent and sustained decline in the performance of the economy has had a serious effect on public finances, as is explained elsewhere in this report.

[18] SA Reserve Bank. 2024. Op cit. S-32.
[19] Ibid. S-112.
[20] Ibid. S-157.
[21] Ibid. S-149.
[22] StatsSA. 2024. *Statistical Release P0141: Consumer Price Index October 2024*. 20 November. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.statssa.gov.za/publications/P0141/P0141October2024.pdf

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Projection of future trends in the South African economy to 2028

In this section, we outline our projection of the likely performance of the South African economy for the period to 2028. We first cover a forecast of the global economic environment for the period based on the latest IMF *World Economic Outlook* (October 2024)[23]. Next, we discuss the economy's growth prospects and its impact on employment, inflation, interest rates, the balance of payments and the rand exchange rate. Finally, we discuss the implications for public finances and the prospects for finding fiscal space for the funding of the NHI.

Global economic environment

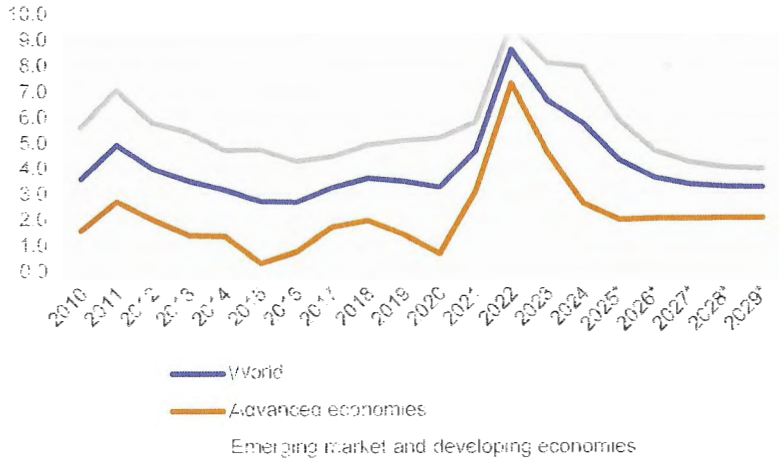
South Africa has a relatively open economy, with exports and imports together accounting for around 60% of GDP and, by emerging markets standards, highly liquid money, capital and foreign exchange markets. The economy is therefore affected substantially by trends in world output and trade as well as international interest rates, the exchange rates of major economies in the world and world trends in commodity prices for the country's mineral exports.

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The current world economic outlook is unfavourable for the South African economy. Firstly, global economic growth remains relatively subdued, especially world trade, reducing the potential for growth in the volume of exports and for substantial rises in mineral and other commodity prices during the next few years. This is exacerbated by expectations that the US might introduce an array of import tariffs once Mr Donald Trump assumes the Presidency in the US.[24]

Secondly, inflation in developed countries and many emerging markets is expected to continue at lower levels compared to South African inflation. This is evident, among others, from the fact that South Africa's inflation target is higher than the inflation targets of developed economies.[25] It is against this background that the Governor of the South African Reserve Bank, Mr Lesetja Kganyago, made recent remarks about lowering the inflation target. [26]

Figure 2: Global Inflation, Average Consumer Prices: 2010 to 2029



*IMF forecasts
Source: IMF *World Economic Outlook* October 2024

Tables 3 and 4 show recent trends in the world economy and the IMF's forecast for the period 2025 to 2029.

[23] International Monetary Fund, *World Economic Outlook*, October 2024, various pages.
[24] Ermey, R. 2024. Trump's tariff plan: Why he's pushing for them, and how they might end up raising prices. *CNBC*. 7 November. https://www.cnbc.com/2024/11/07/trumps-tariff-plan-how-tariffs-work-why-they-might-increase-prices.html
[25] *Central Bank News*. n.d. Inflation Targets. https://www.centralbanknews.info/p/inflation-targets.html
[26] https://mg.co.za/business/2024-10-26-having-hit-the-4-5-goal-kganyago-eyes-lower-inflation-target/

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Table 3: Recent Trends and Forecasts of World Economic Growth, Trade Prices and Interest Rates

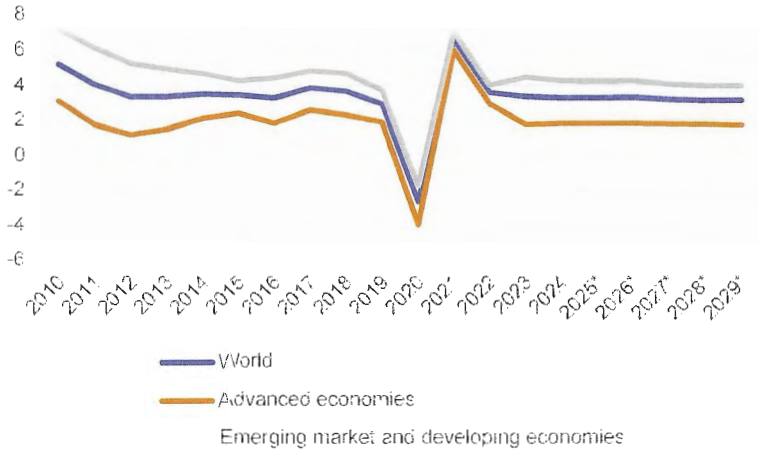
	2001-10	2011-20	2023	2024	2025	2029
World output (annual per cent change)	3,9%	2,9%	3,3%	3,2%	3,2%	3,1%
World trade volume: annual per cent change	5,0%	2,5%	0,8%	3,1%	3,4%	3,3%
Consumer prices: Advanced Economies	2,0%	1,4%	4,6%	2,6%	2,0%	2,0%
Consumer prices: Emerging market and Developing Economies	6,6%	5,2%	8,1%	7,9%	5,9%	4,0%
Interest rates: World long-term real interest rate %	1,9%	-0,2%	-1,3%	0,8%	1,4%	1,2%

Source: IMF *World Economic Outlook* October 2024

As far as the growth outlook for 2025 and beyond, the IMF notes that 'Global growth is expected to remain stable yet underwhelming'.[27] One must take cognisance of the fact that, to a large extent, the world is still adjusting after the Covid-19 pandemic, lockdowns and recent geo-political events. Although the global inflationary shocks experienced between 2021 and 2023 have subsided, services price inflation remains elevated in many regions. The IMF notes that "with cyclical imbalances in the global economy waning, near-term policy priorities should be carefully calibrated to ensure a smooth landing". It adds that "five years from now, global growth should reach 3.1 percent - a mediocre performance compared with the pre-Covid-19 average."[28]

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Figure 3: Global Gross Domestic Product, Constant Prices: 2010 to 2029



*IMF forecasts
Source: IMF *World Economic Outlook* October 2024

Despite various indicators pointing towards a possible slowdown (and even recession)[29] for the US, data coming out of the world's largest economy continues to surprise positively. A so-called 'soft landing' also seems more evident – that is, policymakers managing to bring inflation under control without causing a recession. Deloitte notes that "(d)espite persistent concerns surrounding the durability of growth and interest rate policy, the US economy remains fundamentally strong… (t)he boom in factory construction will continue to boost the economy's potential in the coming years. In the short term, a faster pace of interest rate cuts by the Fed should allow households to take on more debt and support continued growth in consumer spending."[30]. As mentioned above, the Trump presidency is likely to lead to a higher debt ceiling, which, in the short term, will mean elevated government consumption levels.

[27] https://www.imf.org/en/Publications/WEO/Issues/2024/10/22/world-economic-outlook-october-2024
[28] https://www.imf.org/en/Publications/WEO/Issues/2024/10/22/world-economic-outlook-october-2024
[29] See for instance https://www.morningstar.com/news/dow-jones/20241021480/us-economy-set-for-slower-growth-leading-indicators-say
[30] https://www2.deloitte.com/us/en/insights/economy/us-economic-forecast/united-states-outlook-analysis.html

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All these factors should be supportive of US growth, which the IMF now expects to dip only slightly to around 2,2 % in 2025 (see Table 4).

Table 4: Recent Trends and Forecasts of World Economic Growth: Selected Countries and Regions

Annual per cent change	2001-10	2011-20	2023	2024	2025	2029
World Output	3,9%	2,9%	3,3%	3,2%	3,2%	3,1%
United States	1,7%	1,9%	2,9%	2,8%	2,2%	2,1%
Euro area	1,2%	0,6%	0,4%	0,8%	1,2%	1,2%
United Kingdom	1,6%	0,7%	0,3%	1,1%	1,5%	1,3%
Japan	0,6%	0,4%	1,7%	0,3%	1,1%	0,5%
Emerging Markets and Developing Economies	6,2%	4,1%	4,4%	4,2%	4,2%	3,9%
China	10,5%	6,8%	5,3%	4,8%	4,5%	3,3%
India	7,5%	5,2%	8,2%	7,0%	6,5%	6,5%
Sub-Saharan Africa	5,9%	3,2%	3,6%	3,6%	4,2%	4,4%
South Africa	**3,5%**	**0,8%**	**0,7%**	**1,1%**	**1,5%**	**1,5%**

Source: IMF *World Economic Outlook* October 2024

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In contrast to the slowdown in the US, growth in 2025 in the Euro Area, the UK and Japan is expected to outperform their respective 2024 levels. The overarching driving forces behind these expectations are that real wages will boost consumption, and that a gradual loosening of monetary policy should support investment. [31]

Turning to emerging markets and developing economies, structural factors and high debt levels are likely to lead to a decline in economic growth in China. The expectation is that China will continue its gradual slowing in economic growth from 4,8% in 2024 to 4,5% in 2025 and to just above 3% by the end of the decade. Similarly, growth in India is also expected to ease to around 6,5% in 2025, as the economy 'normalises' to its potential growth level, following the phasing out of various Covid-19-period stimuli measures. However, growth in other emerging and developing countries (e.g. Eastern and Central Asia) is forecasted to accelerate as the effect on the region of temporary disruptions to oil production and shipping is assumed to fade away. [32]

Sub-Saharan African economic growth is expected to be above the average of the world in the next few years, although rates are expected to vary substantially by country. This comes on the back of an easing of global supply shocks, while conflicts and civil unrest (e.g. Sudan and Mozambique) and extreme weather continue to dampen the outlook. [33]

The exception to the growth trends in emerging markets and developing countries, as well as sub-Saharan countries, is South Africa. Table 4 shows that the IMF expects continued low rates of growth, significantly below the average in Sub-Saharan Africa. Although the forecast for the country is a growth rate in GDP of 1,5% in 2025 compared to an estimate of 1,1% in 2024, the IMF sees economic growth remaining below 2,0% p.a. over the next few years.

The above outlook for global growth will further have a mixed impact on the South African economy. General positive sentiment from 'risk-on' factors can be expected, while slower growth in especially the US, China and India will dampen demand for South African goods and services. Other trends in the world economy should also be considered. Inflation in developed countries and many emerging markets is expected to continue at lower levels compared to South Africa, making the country's exports less

[31] IMF World Economic Outlook, October 2024, p.11-12
[32] Ibid, page 13.
[33] Ibid, page 13.

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price competitive over time and imports more price competitive, leading to possible strains on the current account of the balance of payments and the attractiveness of South Africa to foreign investors. International money and capital market interest rates are expected to remain very low, with negative real interest rates in many developed countries. In South Africa, interest rates will be considerably higher, reflecting the need to compensate investors for the higher rate of domestic inflation and also the strain on public finances from an expected substantial increase in government debt management costs. The result will be a higher cost of capital than in many countries, weakening the incentives for new fixed investment in the economy.

Projections for the South African economy to 2028

In addition to the global factors outlined in the previous section, the economic prospects in the next few years are largely constrained by domestic conditions. The long-term rate of growth of an economy (or potential growth) depends on technological development and political and economic institutions that determine the incentives to invest in new productive capacity and improve productivity in the economy.

As far as growth limiting factors are concerned, the SA Reserve Bank lists load-shedding, logistical challenges, and policy uncertainty, although load-shedding has been alleviated since the second quarter of 2024. According to the central bank, these factors "weighed heavily on economic activity and sentiment, depressing business credit appetite and household spending".[34] However, looking forward, the SA Reserve Bank notes various improvements, including "(p)rivate investment in renewable energy, increased maintenance by Eskom and transmission system development, along with reforms in ports and rail, should further reduce energy and logistical constraints. As the economy's productive potential improves and inflation eases, so too will corporate and household balance sheets, further improving sentiment and investment beyond the network sectors" [35]. It should, however, be evident that various of these reforms are likely to take some time (and funding) to implement without necessarily guaranteeing the envisioned outcomes.

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In its latest *Monetary Policy Review,* the SARB states: "The economy's growth potential[36] is projected to average 1.4% over the forecast horizon (i.e. until 2026) against a steady-state potential growth rate of 2.5% (see Figure 4). This compares poorly to South Africa's emerging market trading partners, whose potential growth estimates range between 2.0% and 6.5% over the same period". [37]

Earlier work by the National Treasury further highlights the need for structural reforms in the economy. In its document, *Economic transformation, inclusive growth, and competitiveness: Towards an Economic Strategy for South Africa*, it states, "(t)he combination of low growth and rising unemployment means that South Africa's economic trajectory is unsustainable. Government should implement a series of growth reforms that promote economic transformation, support labour-intensive growth, and create a globally competitive economy. We start by highlighting five fundamental building blocks of sustainable long-run growth and then identify a series of specific and detailed reforms to raise potential growth.

These growth reforms are organised according to the following themes: (i) modernising network industries; (ii) lowering barriers to entry and addressing distorted patterns of ownership through increased competition and small business growth; (iii) prioritising labour-intensive growth in sectors such as agriculture and services, including tourism; (iv) implementing focused and flexible industrial and trade policy; and (v) promoting export competitiveness and harnessing regional growth

[34] South African Reserve Bank (SARB), Monetary Policy Review, October 2024, page 5

[35] Ibid, page 5

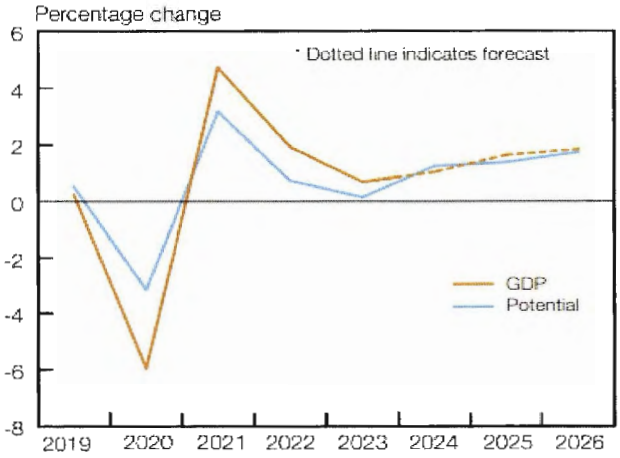
[36] Potential growth is the rate of GDP growth that could theoretically be achieved if all the productive assets in the economy were employed in a stable inflation environment. It is derived from the South African Reserve Bank's (SARB) semi-structural potential output model. The measurement accounts for the impact of the financial cycle on real economic activity and introduces economic structure via the relationship between potential output and capacity utilisation in the manufacturing sector (Monetary Policy Review, October 2024, page 52 and 54.

[37] South African Reserve Bank (SARB), Monetary Policy Review, October 2024, page 25.

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opportunities. We estimate the economy-wide impact of the proposed interventions over time based on when they can realistically be implemented and find they can raise potential growth by 2–3 percentage points and create over one million job opportunities."[38]

Figure 4: South Africa's Potential Growth Estimates



Source: SARB, Monetary Policy Review, October 2024, page 23

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The National Treasury has for a considerable time been committed to restoring public and investor confidence in government finances. Back in its 2019 *Medium Term Budget Policy Statement* ("MTBPS"), it stated that "policy certainty and a conducive business environment are critical to support the confidence of businesses and households. As far as structural problems are concerned, it identified "high levels of inequality, spatial disparities, low levels of education, the uneven quality of public services and inadequate state capacity. Remedial measures in the MTBPS include stabilising SOEs and solving their governance failures; managing "the massive risk to the economy and the fiscus associated with Eskom;"[39] and improving spending efficiency and reducing waste in public sector spending."[40]

This message has been reiterated in various Budgets since 2019. In the 2024 National Budget, it is stated that "(g)overnment is staying the course on the fiscal strategy outlined in the 2023 Medium Term Budget Policy Statement ("MTBPS") and will achieve a primary budget surplus (meaning revenue exceeds non-interest spending) in 2023/24, with debt stabilising by 2025/26". It adds that this will help it in "promoting economic growth and supporting the most vulnerable members of society."[41]

As far as its outlook is concerned, the National treasury forecasts a 'jump' in GDP to 1.7% in 2025, after which the figures rise only marginally to 1.9% by 2027 (see Table 5). Evident from the above analysis is that all three organisations (IMF, SARB and NT) expect growth to remain pegged in a range of between 1.5% to 2.0% per annum over the next few years.

The views of the SA Reserve Bank and National Treasury are shared by the IMF. Back in 2019, that is, before the Covid-19 lockdowns, the organisation stated that higher growth can come only from major economic reforms, arguing for a gradual but meaningful and growth-friendly fiscal consolidation to stabilise public debt. Measures should include reducing the public wage bill, downsizing and eliminating wasteful spending by public entities, expanding the tax base, and strengthening tax administration. Monetary policy should continue to be data-dependent and carefully monitor inflation risks. Structural

[38] National Treasury, *Economic transformation, inclusive growth, and competitiveness: Towards an Economic Strategy for South Africa.* National Treasury: Pretoria.
[39] Ibid, page 6.
[40] Ibid, page 12.
[41] National Treasury, 2024 Budget Review, Chapter 3, page 23.

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reforms are needed to regain investors' trust, lift growth potential, and foster job creation. Priorities include revamping the business models of state-owned enterprises, improving competition in the product market by reducing entry barriers and streamlining regulations, and increasing labour market flexibility."[42]

Table 5: The South African Economy: Projected Economic Performance 2020 to 2027

Calendar year	2021	2022	2023	2024	2025	2026	2027
Percentage change	Actual			Estimate	Forecast		
Final household consumption	6.2	2.5	0.7	1.2	1.8	1.7	1.9
Final government consumption	0.6	0.6	1.9	1.4	0.9	-0.4	-0.1
Gross fixed-capital formation	-0.4	4.8	3.9	-2.5	4.7	4.2	3.8
Gross domestic expenditure	4.9	4.0	0.8	0.5	2.0	1.7	1.9
Exports	9.7	6.8	3.7	-1.6	3.1	3.1	3.1
Imports	9.6	15.0	3.9	-3.2	4.1	2.8	3.0
Real GDP growth	**5.0**	**1.9**	**0.7**	**1.1**	**1.7**	**1.7**	**1.9**
GDP inflation	6.3	5.2	4.8	4.2	5.0	4.6	4.5
GDP at current prices (R billion)	**6 220.2**	**6 655.5**	**7 024.0**	**7 396.7**	**7 897.6**	**8 404.1**	**8 953.6**
CPI inflation	4.6	6.9	5.9	4.6	4.4	4.5	4.5
Current account balance (% of GDP)	3.7	-0.5	-1.6	-1.8	-2.1	-2.2	-2.5

Source: National Treasury, 2024 MTBPS, Chapter 2, Page 11

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Although some progress has been made as far as, e.g. Eskom and Transnet are concerned, the bulk of these recommendations and commitments still need to be addressed. This casts some doubt on whether the political commitment and competence exist in government departments to implement the structural reforms necessary to improve the potential growth rate of the economy substantially above its current level. The May 2024 elections brought a major shift in the political landscape in South Africa as the ruling ANC party, for the first time since 1994, lost its outright majority. In the aftermath of the elections, and largely in necessity to assist with decision-making, the Government of National Unity ("GNU") was formed. In reaction to this, President Ramaphosa stated that "the principles and programme that underpin the GNU extends beyond the institutions of the State" and that it was "an opportunity for all South Africans to work together more closely and with greater purpose to ensure that we build a South Africa for all. This provides a firm basis for greater stability, coherence and a focus on implementation". [43] It is especially the last-mentioned item, namely implementation, which seems to be a crucial (yet missing) part of the government's track record.

Financial markets reacted positively to the 2024 General elections. Most notable is the improvement in the 10-year bond yield by around 200 basis points in the aftermath of the election (see Figure 5). In addition, the Rand appreciated against major currencies after the elections, that is, until the news broke about Mr Trump's victory in the US elections, which supported the dollar and placed most emerging market currencies under pressure.

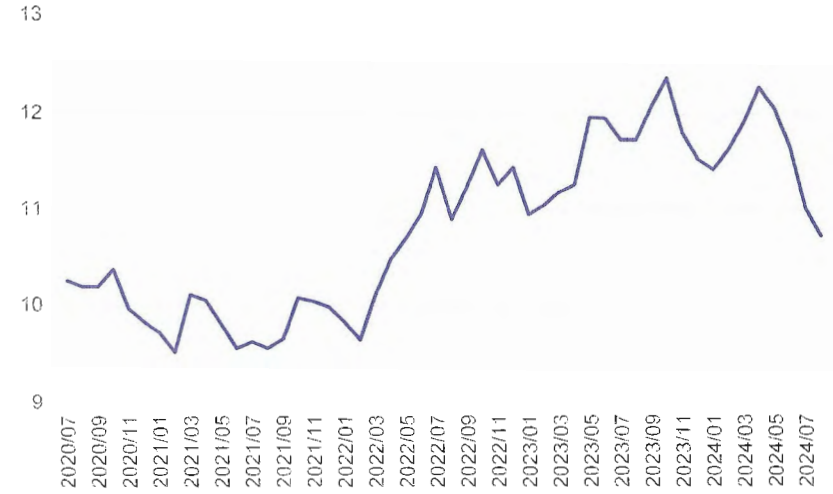
Credit rating agencies provide detailed information about the sovereign risk associated with a country. South Africa's ratings were lowered significantly between 2012 and 2020, with all three major rating agencies (i.e. Fitch Ratings, S&P Global and Moody's) currently rating South Africa well below investment grade (see Figure 6). Following the 2024 elections, S&P Global gave its approval to the formation of the GNU by (unexpectedly) raising its outlook on SA's sovereign risk rating from stable to positive in November 2024[44]. However, its rating remains three notches below investment grade, in so-called 'junk' status. Fitch Ratings was less optimistic following the 2024 MTBPS, citing, amongst others, continued pressure from public sector pay and commitments to SOEs as risks to the fiscal outlook. It was also sceptical of the National Treasury's growth projections (as given in Table 4). [45]

[42] IMF, *World Economic Outlook*, October 2019, pages 27-28.
[43] https://www.sanews.gov.za/south-africa/gnu-government-united-action-and-purpose
[44] https://www.businesslive.co.za/bd/national/2024-11-15-sandp-surprises-as-it-raises-sas-credit-rating-outlook-to-positive/
[45] https://www.businesslive.co.za/bd/economy/2024-11-05-fitch-sceptical-about-medium-term-budget/

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Figure 5: Yield on Government Bonds: Duration 10 to 15 years, 2020 to 2024

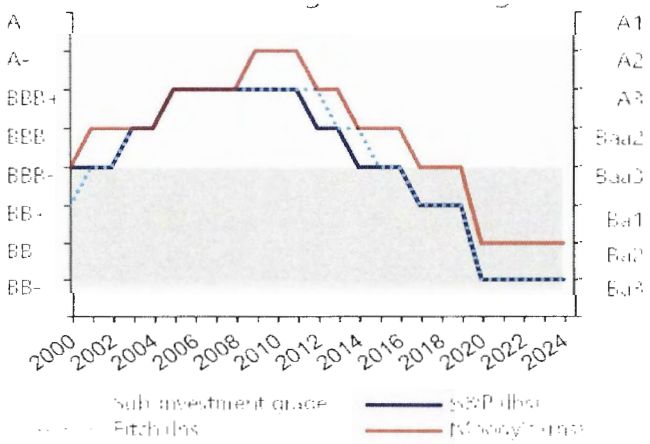


Source: SARB

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Important is that, despite the slightly improved outlook, the expected rate of economic growth is too low to reduce the current rate of unemployment. A continued commitment by the SA Reserve Bank to monetary discipline and current inflation expectations is assumed, with consumer inflation forecasts to remain subdued around the mid-point of the current inflation target of 3-6% per annum. Long-term interest rates are likely to remain elevated, reflecting the growing government debt burden and the need to maintain positive real interest rates for investors. The positive and significant inflation differential between the economy and developed countries is likely to lead to a (long-term) depreciation of the Dollar/Rand and Euro/Rand exchange rates.

Figure 6: South Africa's Sovereign Credit Ratings



Source: https://www.citizen.co.za/business/more-positive-sp-ratings-outlook-thanks-to-more-policy-certainty/

Implications for public finances and the NHI

This sombre outlook for the South African economy has major implications for public finances and the funding of the NHI. The projected slow rate of economic growth limits the extent to which government revenue is likely to rise. In turn, this limits the scope to fund additional large government spending programmes and, in fact, provides evidence of the need for serious action by the Government to reduce the growing and unsustainable government budget deficit and debt burden in the next few years. The full implementation of the NHI will therefore be dependent on funding by means of higher tax rates on a subdued economy. This matter is assessed in detail in chapters 3 and 4 of this report.

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Chapter Three

Fiscal capacity to implement the NHI - government revenue and expenditure

Introduction

The main challenge in assessing the fiscal capacity of the South African government to implement the NHI Act is that no official estimate or assessment of cost implications at the time of full implementation had been made or provided by the South African government. In the Memorandum accompanying the National Health Insurance Bill (NHI Bill) when it was considered in Parliament, the relevant section[46] dealing with the financial implications for the state merely states that:

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

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

(a) Quality of care improvement programme: A new funding component is required to accelerate quality initiatives, to support a stronger response post OHSC audit and also to support progressive accreditation of facilities for Fund. Amounts of R75 million, R125 million and R175 million[47] will be considered for potential reprioritisation as part of the budget process.

(b) Establishment of the administration of the Fund: The preliminary costing is R57 million, R145 million and R287 million.[48] These should be seen as ideal and will probably be less given practical delays e.g. in passing Bill. Again in the short term these funds can largely be found through reprioritisation within the grant.

(c) Actuarial costing model: Treasury commissioned a simplified intervention-based costing tool for 2019/20 which provides simple estimates of costs of a set of 15 or so interventions. These include for example removing user fees, extending chronic medicine distribution programme (CCMDD), extending ARV rollout, increasing antenatal visits, rolling out capitation model for General Practitioners (GPs), cataract surgery programme, establishing Fund. The full set of interventions costs in the longer term around R30 billion per annum.[49] Interventions can be scaled up progressively as funding becomes available and does not need significant new funds in Budget 2020.

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

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

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

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[46] Section 8 of the *MEMORANDUM ON THE OBJECTS OF THE NATIONAL HEALTH INSURANCE BILL, 2019*, p57. https://www.parliament.gov.za/project-event-details/54

[47] Presumably three years from promulgation of the NHI Act but not stated clearly.

[48] Presumably three years from promulgation of the NHI Act but not stated clearly.

[49] It is assumed that the base year for this costing model for "15 or so interventions" is the 2019/20 fiscal year. It is unclear what "15 or so interventions" should imply to mean, as only seven aspects are mentioned. This really seems like a very unscientific way to present a Bill to Parliament. In addition, adjusted for inflation from February 2020, the current value of R30 billion is some R37,4 billion.

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8.5 *Once the Bill is enacted and the entity is created, the Fund and its Executive Authority will be able to bid for funds through the main budget as part of the budget process.*[50]

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

8.7 *In a later phase consideration will be given to shifting of funds currently in the provincial equitable share formula for personal health care services (currently the main public health funding stream consisting of around R150 billion per annum) to the Fund. This will require amendments to the National Health Act, 2003. This will also depend on how functions are shifted, for example if central hospitals are brought to the national level.*[51]

8.8 *Chapter 7 of the Fund White Paper details several new taxation options for the Fund, including evaluating a surcharge on income tax, a small payroll-based taxes as financing sources for the Fund. Due to the current fiscal condition, tax increases may come at a later stage of NHI implementation.*[52]

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Any questions about the legality of Parliament accepting legislation without the disclosure of the full financial implications for the fiscus is a matter best left for consideration by the legal profession. However, this omission from the Memorandum accompanying the NHI Bill implies that a best estimate of funding should be made to calculate the fiscal implications of the NHI Act, once fully implemented. This matter is considered in more detail in the next chapter.

Nevertheless, several matters are highlighted above by means of footnotes that should be repeated in the text of this assessment, given their importance. First, mention is made of a costing model for "15 or so interventions". It is unclear what "15 or so interventions" should mean, as only seven aspects are mentioned in the Memorandum. To present a Bill to Parliament in this way lacks scientific rigour.

Secondly, it is literally stated that the NHI Fund and its Executive Authority will, once the Bill becomes law and the entity is created, start a bidding process (which is not elucidated or explained) " … for funds through the main budget as part of the budget process." The Memorandum is quiet about the question of what will happen to the NHI Fund, the Executive Authority or the NHI in its totality if this bidding process is unsuccessful.

Thirdly, the envisaged impact on the provinces was not explained in the Memorandum that accompanied the NHI Bill. Lastly, tax increases are clearly envisaged without any explanation of the impact of higher taxes on the South African economy.

In a hearing of the Parliamentary Standing Committee on Health on 30 November 2022, Dr Nicholas Crisp, the Deputy Director-General of the National Department of Health ("NDOH"), explained, *inter alia*, that the advice that the NDOH " … have received after talking to economists and the W.H.O.[53] is that NDOH would be going down a rabbit hole if they try and determine the cost for something that is going to take 25 years to stabilise and get equity, even if the country tried to achieve universal health coverage in ten or fifteen years, just as some countries had done, this would not be advisable (sic)."[54]

[50] This is a most serious shortcoming in the Memorandum accompanying the NHI Bill. It is literally stated that the NHI Fund and its Executive Authority will, once the Bill becomes law and the entity is created, a bidding process (which is not elucidated or explained) will have to follow " … for funds through the main budget as part of the budget process." The Memorandum is quiet about the question what will happen to the NHI Fund, the Executive Authority or the NHI in its totality if this bidding process is unsuccessful.

[51] The impact of this aspect on the provinces was not explained in the Memorandum that accompanied the NHI Bill.

[52] Tax increases are clearly envisaged.

[53] World Health Organization.

[54] Parliamentary Monitoring Group. 2022. *National Health Insurance (NHI) Bill: Health Department response to concerns, with Deputy Minister.* Meeting of the Parliamentary Standing Committee on Health. 30 November. https://pmg.org.za/committee-meeting/36195/

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By his own admission, Dr Crisp alludes to the fact that a full cost estimate of NHI, once fully implemented, has not been made. Given this admission, it is surprising that government officials criticise cost estimates of other parties, despite lacking their own estimates.

The cost of full implementation, discussed in the next chapter, should be viewed against this lack of transparency by the government on the total cost of a fully implemented NHI. It seems, based on the statement of Dr Crisp alluded to above, that the government does not have a reliable estimate of the full cost of a fully implemented NHI. It, therefore, seems that the government might be embarking on a journey without a clear understanding of the cost of the journey.

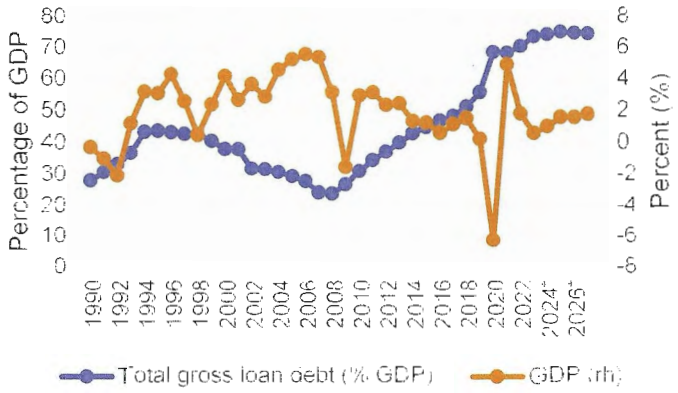
The cost estimates used in this report should be viewed against the background of the government's current levels of and trends in revenue, expenditure and borrowing requirements (annual deficit before borrowing), and fiscal constraints. An analysis of these trends in the government's fiscal position shows limited scope to increase revenue, with a concomitant increase in the deficit before borrowing over the last decade.

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The National Treasury has issued warnings about tax buoyancy[55] as far back as February 2018. In the 2018 *Budget Review*,[56] the National Treasury stated that "(t)ax buoyancy, which declined over the past two years, may not increase as quickly as projected."[57] The National Treasury added that "(b)uoyancy of personal income tax appears to have run its course."[58] This confirms that the ability of the government to raise more revenue by means of taxation is limited.

This increase in the deficit before borrowing has increased the level of government debt from around 25% of the country's GDP some 15 years ago to a current level of about 75% of GDP, as is shown in Figure 7. This increase in government debt levels increased the interest burden of the South African government.

Figure 7: GDP Growth and Government Debt/GDP Ratio, 1990 to 2027



Source: Own calculations from SARB and StatsSA data.
*National Treasury Forecasts from 2024 MTBPS

At the same time, South Africa's economic growth trajectory declined, with potential economic growth estimated to average around 1% to 1,5% per annum. Earlier research[59] published in 2014 reported the

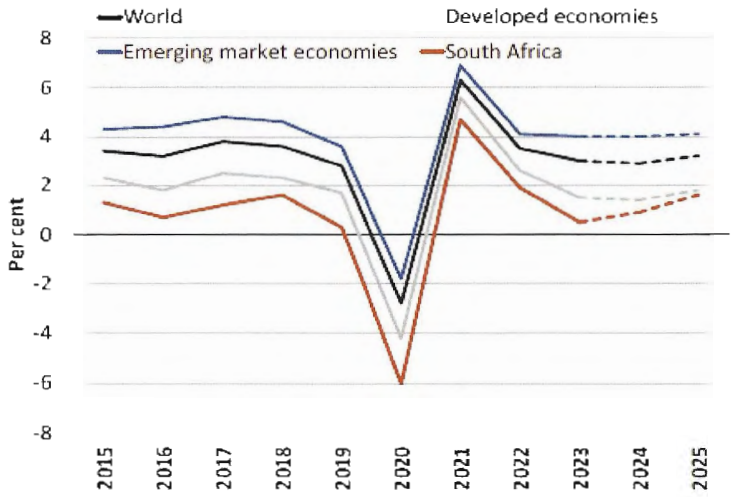
[55] Tax buoyancy is the relationship between total tax revenue collections and economic growth. This measure includes the effects of policy changes on revenue. A value above 1 means that revenues are growing faster than the economy; a value below 1 means they are growing below the rate of GDP growth.
[56] National Treasury. *2018 Budget Review*. https://www.treasury.gov.za/documents/national%20budget/2018/default.aspx
[57] Ibid, page 29.
[58] Ibid, page 3.
[59] Anvari, V., Ehlers N. and Steinbach, R. 2014. A semi-structural approach to estimate South Africa's potential output. *South African Reserve Bank Working Paper Series. WP/14/08*. November. SA Reserve Bank: Pretoria.

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maximum potential growth of the economy as no higher than 2,5% per annum. Subsequent to the research of 2014, South Africa's potential economic growth rate declined even further. The SA Reserve Bank stated in its October 2019 *Monetary Policy Review* that "potential growth has slumped to around 1% in the context of supply constraints (especially electricity shortages) and depressed business confidence."[60] In the ensuing period (2014 to 2023), South Africa's average annual economic growth rate was 0,8%. This meant that South Africa's growth started to lag global growth, as well as that of its emerging market peers (see Figure 8).

Figure 8: South Africa's Economic Growth Performance Compared Internationally rate, 2015 to 2025



Source: Budget Review, 2024, page 12

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Funding for the full implementation of the NHI Act must be found against the background of rapidly increasing government debt levels, notably over the past 15 years. The key matter for consideration is the affordability of the NHI, given the time frame for implementation.

South Africa finds itself in a bind as far as its state finances are concerned. Given the pressure to stabilise (or lower) debt levels, this leaves little room for additional expenditure pressures. Any potential additional expenditure items thus need to be carefully considered. Since the global financial crisis of 2008, the South African government has run deficits (requiring increased borrowing) in an attempt to stimulate domestic demand and economic growth. During the economic crisis owing to the Covid-19 lockdown in 2020, the annual budget deficit of the government increased to record levels. This conforms to measures taken by various other countries during periods of economic contraction. However, these measures, if they are recommended at all, should typically be short-term (i.e., one- to two-year) interventions, while it seems as if South Africa is indefinitely continuing with high deficit spending.

Government debt has now increased to levels where additional borrowing at the same rate as before is no longer an option. The government has no option but to consider more conservative fiscal policy, which implies closing the deficit before borrowing as a percentage of GDP to more reasonable and sustainable levels and, therefore, also reducing the level of government debt as a percentage of GDP over time through lower deficits before borrowing.

Fiscal restraint is sometimes described as *austerity policy*, which the *Encyclopaedia Britannica* defines as "… a set of economic policies, usually consisting of tax increases, spending cuts, or a combination of the two, used by governments to reduce budget deficits. Austerity measures can, in principle, be used at any time when there is concern about government expenditures exceeding government

[60] South African Reserve Bank, Monetary Policy Review, October 2019. page 1.

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revenues. Often, however, governments delay resorting to such measures because they are usually politically unpopular. Instead, governments tend to rely on other means — for example, deficit financing, which involves borrowing from financial markets — to mitigate budget deficits in the short run, a decision that usually necessitates the adoption of harsher austerity measures in the long run".[61]

With an estimated budgeted deficit before borrowing of some 4,7% of GDP in the 2024/25 fiscal year and with government debt increasing from around 25% of GDP to more than 75% of GDP since 2014, the South African government has clearly not followed an austerity policy. In the narrowest sense of the definition, an austerity policy would imply a government running a balanced budget (expenditure not exceeding revenue).

The South African government funds its annual budget deficit by borrowing primarily in the domestic capital market, but some borrowing is also done in international capital markets[62]. The borrowing incurs interest costs, which are included in the budget as expenditure items. Continuing budget deficits lead to increases in outstanding government debt and increased interest payments.

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Budget deficits can be seen as supportive of future economic growth, for example, if they are used to finance government investment in infrastructure. However, excessively large annual budget deficits that persist for too long can harm the economy, particularly in instances where borrowed funds are used for current expenditure rather than expenditure of a capital nature. Such deficits can lead to the "crowding out" problem: the offsetting of a change in government spending by a change in private sector spending in the opposite direction. Government has fallen into a "consumption trap", with civil service remuneration, social grants payments, and interest on government debt comprising the bulk of expenditure. While government expenditure, and particularly government consumption, has grown, investment expenditure by the government has stagnated.

In addition, higher government debt and its financing can lead to concerns by buyers of government debt that the government will find difficulty in the future to pay interest and repay the loans it has incurred. While the government can resort to an inflationary monetary policy and the printing press to pay local debtholders (i.e., by reducing the real value of debt, debt repayment and interest payments on such debt), this is not an option for government debt denominated in foreign currency. Moreover, "monetising the debt" will be inflationary in the long run, as was the case in Zimbabwe, where the inflation rate peaked at 4 800 billion per cent per annum.

When a government faces serious fiscal challenges with expenditure persistently exceeding revenue and further borrowing no longer an option (the current lack of fiscal space that South Africa faces), the remaining options are to (i) reduce expenditure; or (ii) increase taxation to raise more revenue. As is shown below, the South African government has used the latter option extensively. However, higher taxes can lead to distortions in the tax base, reduced incentives to save and invest (e.g. high marginal rates of tax) and lower tax revenues, particularly in instances where tax buoyancy drops below 1.

Following the introduction of a new marginal tax rate of 45% on taxable income above R1,5 million[63] per annum in the 2017/18 fiscal year, it was reported in the 2018 *Budget Review* that "(i)n recent years. South Africa has experienced a decline in tax buoyancy – the relationship between tax revenue growth and economic growth".[64] This experience with tax buoyancy calls to mind the Laffer curve, developed by Prof Arthur Laffer, which shows that tax rates can be raised to a level where the total tax collected can decline owing to further increases in the tax rate. This is depicted in Figure 9. The Laffer curve, in

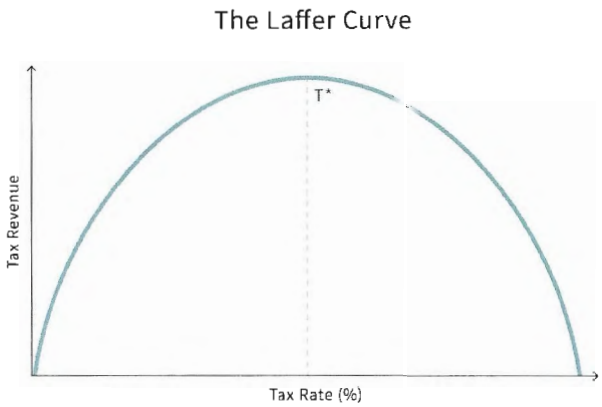
[61] *Encyclopaedia Britannica*. Online at https://www.britannica.com/topic/austerity [Accessed on 3 November 2019].
[62] Government borrowing in international capital markets serves a number of purposes, *inter alia* to set a sovereign benchmark for other borrowers of the country in the international capital market.
[63] Some R2,04 million in current values, after adjustment for inflation.
[64] National Treasury. 2018. *Budget Review*. National Treasury: Pretoria.

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its simplest form, indicates that people who have such choices will work less as tax rates increase, thus substituting income (which becomes very small after payment of tax) for leisure.

This is indeed a risk that South Africa faces: Tax collections can decline as tax rates are increased. Other than taxpayers substituting income for leisure, high tax rates might also encourage emigration of high-income earners. In practice, it is difficult to determine specifically where a country finds itself on the Laffer curve. Tax buoyancy is, therefore, often used to approximate the Laffer curve concept and remains one of the best indications of whether a country has passed the top of the Laffer Curve.

Figure 9: An illustration of the Laffer Curve

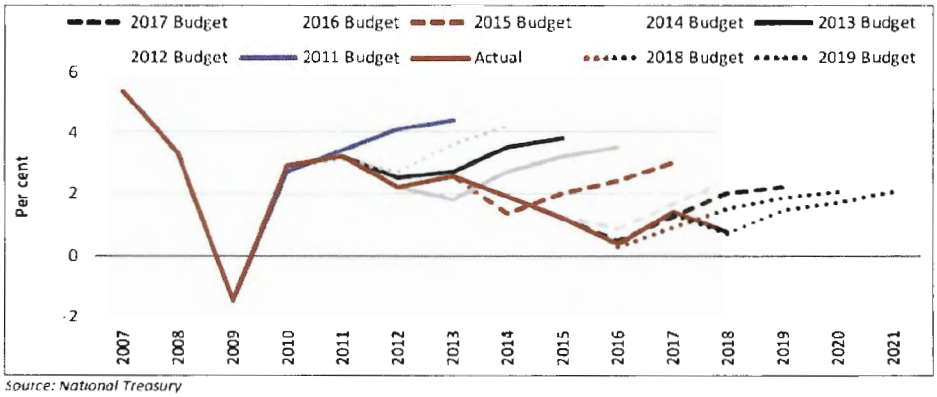


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Source: Own analysis

There seems to be a persistent over-optimism regarding budget forecasts by the National Treasury. For example, over the past decade, the South African government has repeatedly overestimated economic growth (see Figure 10 below), which again resulted in an overestimation of expected tax collections. This is problematic since actual (lower) economic growth figures then resulted in lower-than-budgeted tax revenue. In addition, it meant that the (actual/realised) decline in revenue collection was not met by a concomitant decline in government expenditure, thus resulting in larger-than-expected budget deficits and increased government borrowing.

Figure 10: Revisions to the National Treasury's Real GDP Growth Forecast



Source: National Treasury

In respect of debt levels, the OECD states that "(d)ebt sustainability largely depends on economic growth, the interest rate and the capacity of governments to run primary balances that ensure that the government meets its liabilities."[65] A particular concern is that South Africa experiences persistently low economic growth, implying that large deficits before interest costs lead to sharp increases in the

[65] OECD, 2015, *Prudent Debt Targets and Fiscal Frameworks*, OECD Economic Policy Paper No. 15, page 6.

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debt/GDP ratio of the country. This problem is exacerbated in instances where population growth exceeds GDP growth.

The government debt guidelines of the OECD suggest that beyond a debt threshold, government debt can undermine economic activity and the ability to stabilise the economy. Different channels through which debt can affect the economy are assessed. Empirical evidence gathered from the literature shows that:[66]

(i) high government debt levels are associated with lower growth (when the government debt/GDP ratio is above 80 to 100% of GDP), though causality is probably running both ways;
(ii) the ability to stabilise the economy decreases at a government debt/GDP debt ratio above a level of about 75% of GDP;
(iii) when a specific role for government debt in financing public infrastructure is taken into account, estimations find a positive but limited "optimal" government debt level at about 50 to 80% of GDP; and
(iv) government debt provides a safe asset in a very liquid market, thus easing liquidity constraints. Therefore, low levels of government debt are welfare-enhancing.

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Empirical cross-country evidence by the OECD suggests different debt thresholds, defined as the turning point at which negative effects of debt on the economy kick in, for three groups of countries:[67]

(i) For higher-income countries, a government debt/GDP threshold range of 70 to 90% of GDP is considered sustainable.
(ii) For Euro Area countries, the debt threshold is lower, as they do not control monetary policy. Given the no-bail-out clause, the absence of debt pooling, a higher dependency on foreign financing and difficulties in adjusting to shocks, the sustainable government debt/GDP ratio threshold is 50-70%, which is aligned to the Maastricht conversion criteria prescribing a debt threshold level of 60% of GDP.
(iii) For the emerging economies, the sustainable government debt/GDP threshold is even lower at 30 to 50% of GDP as they are exposed to capital flow reversals.

The OECD states that "(t)hese debt thresholds are used to anchor prudent debt targets. Prudent debt targets should be set to avoid an overshooting of the debt thresholds in the case of large adverse shocks. Prudent debt targets take into account uncertainties surrounding macroeconomic variables and are thus country-specific."[68] As an emerging economy, South Africa's government debt/GDP ratio is clearly not aligned with the thresholds suggested by the OECD.

The IMF points out that most countries have fiscal rules for prudent debt management, stating that "(f)iscal rules have become more common worldwide over the past two decades. In the early 1990s, only five countries had fiscal rules in place. By the end of 2015, the number of countries with at least one national or supranational fiscal rule surged to 92, of which more than 60 percent were emerging market and developing economies."[69] The IMF adds that "(c)eilings on public debt are a common feature of rule-based fiscal frameworks. As of 2015, about 70 countries worldwide had a fiscal framework with an explicit cap on public debt. Debt rules are generally set in gross rather than net terms (gross debt minus financial assets) because it is hard to determine which government assets are truly liquid, particularly in times of financial stress. Also, the concept of net debt is less transparent than gross debt and more difficult to communicate to the public. Gross debt ceilings can vary significantly across

[66] Ibid. pages 6-7.
[67] Ibid.
[68] Ibid.
[69] International Monetary Fund Fiscal Affairs Department 2018, *Fiscal Policy – How to Calibrate Fiscal Rules: A Primer* pages 2-3, International Monetary Fund.

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countries but frequently range between 60 percent and 70 percent of GDP. The clustering of ceilings around these values reflects the strong representation of supranational rules. About three-quarters of countries with a debt ceiling are members of supranational unions. For instance, the European Union and the Eastern Caribbean Currency Union impose a debt ceiling of 60 percent of GDP, while the Central African Economic and Monetary Community and the West African Economic and Monetary Union both impose a cap of 70 percent of GDP on public debt. In the East African Community, member countries have adopted a debt ceiling of 50 percent of GDP in net present value terms during the convergence process toward the East African Monetary Union. Excluding supranational rules, the 60 percent threshold remains the most common among national debt rules."[70]

The IMF adds that "(m)ost fiscal frameworks rely on additional rules to operationalize their debt ceilings. This occurs because debt trajectories are not directly controlled by policymakers. More than 80 percent of countries with a debt ceiling also have rules imposing constraints on the (nominal or structural) budget balance; among those, almost a third also have expenditure ceilings in their fiscal frameworks. For nominal budget balance rules, the 3 percent deficit ceiling is dominant throughout the world; it has been adopted by the European Union, the West African Economic and Monetary Union, and the East African Community."[71]

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South Africa's current government debt/GDP ratio and budget deficit/GDP ratios exceed the prudential guidelines suggested by the IMF. In its 2018 *Survey of South Africa* (page 15), the IMF stated that "(r)enewed spending pressures (e.g., education subsidies, public sector wages, and materialization of SOE contingent liabilities) would worsen public finances and could trigger additional rating downgrades and increase financing costs. Continued policy uncertainty would dampen capital inflows, investment, and growth. Protracted low growth would weaken the domestic financial system."[72]

The government debt/GDP ratio is projected to be at a level of 75% of GDP in the 2024/25 fiscal year, according to the 2024 MTBPS statement.[73] At the same time, the budget deficit/GDP ratio will remain above 3% over the medium term to the 2027/28 fiscal year.[74]

South Africa is vulnerable to shocks both in terms of its budget deficit/GDP and government debt/GDP ratios. A large amount of money must be borrowed each year to fund the deficit, while maturing government debt must also be refinanced annually. Nominal interest rates in South Africa are relatively high compared to developed countries and some of its peers because of higher inflation and the rising debt level. This is an additional fiscal risk because of vulnerability to global financial conditions, levels of risk aversion by international investors and sovereign risk ratings.

The South African government seems to be lacking the political will (and ability) to significantly curb government expenditure in line with the prospects of subdued tax revenue collections. An additional concern is that the government also seems to lack the political will to solve the problems facing State-owned Enterprises ("SOEs"), which will continue to drain government resources. However, in the past six months, the performance of Eskom[75] and Transnet[76] improved, which might relieve the pressure for SOE bailouts on the South African government.

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[70] Ibid.
[71] Ibid.
[72] Ibid.
[73] National Treasury. 2024. *Medium Term Budget Policy Statement* (MTBPS). p18. Chrome extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.treasury.gov.za/documents/mtbps/2024/mtbps/FullMTBPS.pdf
[74] Ibid. p25.
[75] *ESKOM 2024.* Eskom marks 200 days of loadshedding suspension that has led to predictions of 2% GDP growth for South Africa. 13 October. https://www.eskom.co.za/eskom-marks-200-days-of-loadshedding-suspension-that-has-led-to-predictions-of-2-gdp-growth-for-south-africa/
[76] Neethling, B. 2024. Transnet back on track. *Daily Investor.* 18 October. https://dailyinvestor.com/south-africa/66720/transnet-back-on-track/

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Government expenditure and guarantees

Table 6 shows how the size of the South African government in the economy, measured in terms of percentages of GDP, continues to increase. The continued increase in the revenue of the South African government relative to GDP, as well as the growth of expenditure relative to the GDP, show that government activities grow at a faster rate than the GDP. In itself, this is an early warning of a government approaching the limits of its ability to raise revenue and spend.

Table 6: South Africa: Consolidated Government Revenue and Expenditure per Fiscal Year, Percentage of GDP 2019 to 2024 end March (End of Previous Fiscal Year)

% of GDP	2019	2020	2021	2022	2023	2024
Revenue	23,5	23,5	22,0	24,7	25,1	24,3
Expenditure	27,7	29,6	31,8	29,8	29,7	28,9
Deficit (-) surplus (+)	-4,2	-6,1	-9,8	-5,1	-4,6	-4,6
Primary balance	-0,9	-2,5	-5,7	-0,9	0,0	0,4
Interest payments	-3.6	-4.1	-4.2	-4.6	-5.1	-5.1
Total gross loan debt	51,4	57,1	70,1	67,6	70,5	74,1

Source: SARB Quarterly Bulletin, September 2024, page S-156

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A further issue that limits the ability of the South African government to increase expenditure or to assume new expenditure commitments is the precarious financial state of SOEs, some of which are kept operational on the basis of government guarantees. The financial failure of SOEs operating with such guarantees implies that the guarantees will be called upon and payable immediately. Although these are contingent liabilities rather than actual liabilities of the government, the financial failure of any entity with a guarantee will place considerable additional pressure on the fiscus. Guarantees granted to SOEs are reported in Table 7.

Table 7: South African Government Guarantees to Selected SOEs, 2023/2024 Fiscal Year (February 2024)

	R billion
Eskom	326,6[77]
Transnet	50,5
SANRAL	37,9
TCTA	25,0
SA Airways	19,1

Source: National Treasury, 2024, Budget Review Chapter 7: 81

Total government expenditure is budgeted to amount to R2,368 billion in the 2024/25 fiscal year. A functional analysis of the main components of this government expenditure is shown in Table 8. It transpires that the eight most important expenditure components account for some 82,6% of budgeted government expenditure for the 2024/25 fiscal year. Also notable is that at 16,1% of total government expenditure, debt service cost is by far the largest of these items. Therefore, the government has limited space to reconfigure expenditure (or to reprioritise expenditure) to provide for additional expenditure on health within its current expenditure framework.

[77] Total exposure to Eskom is R354,0bn due 'to adjustments to inflation-linked bonds as a result of inflation rate changes and accrued interest' (2024 National Treasury)

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Table 8: Functional Analysis of the Main Components of South African Government Expenditure, 2024/2025 Fiscal Year

Functional expenditure component (including remuneration expenditure)	R billion	Percentage of total expenditure
Debt service cost	382,1	16.1%
Basic education	324,4	13.7%
Social protection (including social grants)	298,3	12.6%
Health	271,8	11.5%
Community development	265,3	11.2%
Economic regulation and infrastructure	146,1	6.2%
Post-school education and training	143,9	6.1%
Police services	125,0	5.3%

Source: National Treasury, 2024, Budget Review Chapter 5: 49

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Continued capacity to raise taxes and increase income

From the analysis of fiscal scope and fiscal capacity, it is clear that the government cannot assume further expenditure commitments without raising additional revenue. This will imply a combination of tax increases and bracket creep (taxpayers not being compensated for the impact of higher taxation on higher wages aimed at compensating for price increases emanating from inflation), the same approach as was used in the recent past. As a percentage of GDP, South Africa's tax burden measured 24% in 2024/25. The budgeted tax burden raised over different types of revenue sources is shown in Table 9.

Table 9: Budgeted Revenue Sources of the South African Government, 2024/25 Fiscal Year (February 2024 Estimates)

Revenue source	Amount
Personal income tax (mainly individuals)	R738.7
Corporate tax	R302.7
Value-added tax	R476.7
Tax on international trade and transactions	R78.6
Non-tax revenue	R41,9
Other (balancing item)	R308.1
Minus SACU transfer	- R89.8
Total	R1815,0

Source: 2024 National Budget, Review, Chapter 4: 36

It is evident from Table 9 that the largest tax burden is carried by personal taxpayers. Table 10 from the *2024 Budget Review* also shows that this tax burden is carried disproportionally by a small number of personal income-tax payers.

In the 2024/25 fiscal year, 14,2 million people are registered as taxpayers, but only some 7,4 million of these taxpayers earn incomes above the tax threshold of R95 750 per annum for persons under the age of 65.[78]

[78] National Treasury. 2024. 2024 *Budget Review, Chapter 4: 40.* National Treasury: Pretoria.

Table 10: Personal income Taxpayers, 2024/25 Tax Year (February 2024 Estimates)

Taxable bracket	Registered individuals		Taxable income		Income tax before any relief		Tax relief from proposals		Final income tax payable	
R thousand	Number	%	R billion	%	R billion	%	R billion	%	R billion	%
R0 - R96[1]	6 832 031	–	286.9	–	–		–		–	
R96 – R150	1 596 335	21.5	193.3	5.9	16.3	2.2	–	0%	16.3	2.2
R150 – R250	1 514 988	20.4	299.5	9.2	21.9	3.0	–	0%	21.9	3.0
R250 – R350	1 132 341	15.3	336.5	10.3	42.9	5.8	–	0%	42.9	5.8
R350 – R500	1 315 092	17.7	548.9	16.9	92.5	12.5	–	0%	92.5	12.5
R500 – R750	988 658	13.3	599.6	18.4	132.2	17.9	–	0%	132.2	17.9
R750 – R1 000	371 316	5.0	322.3	9.9	87.6	11.9	–	0%	87.6	11.9
R1 000 – R1 500	292 810	4.0	351.4	10.8	109.1	14.8	–	0%	109.1	14.8
R1 500 +	197 866	2.7	605.1	18.6	236.2	32.0	–	0%	236.2	32.0
Total	7 409 406	100.0	3 256.7	100.0	738.7	100.0	–	0%	738.7	100.0
Grand total	14 241 437		3 543.6		738.7		–		738.7	

1. Registered individuals with taxable income below the income tax threshold
Source: National Treasury

Historical perspective on income tax rates in South Africa

South Africa was historically characterised by a higher marginal tax rate on a smaller income base than is currently the case.[79] In the early 1970s, the effective marginal tax rate was 72% (60% maximum marginal tax rate plus a 20% tax surcharge), reached on a taxable income of R28 000 per annum. Adjusted for inflation, R28 000 is equal to a current value of about R2,17 million, whereas the maximum marginal tax rate of 45% in South Africa is currently reached at a taxable income level of R1 817 001.

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When the previous maximum marginal tax rate of 72% applied, South Africa had a much narrower tax base. One example is fringe benefits that were not taxed, as is currently the case. This exemption resulted in distorted income patterns, as taxable income was forfeited in favour of non-taxable fringe benefits. Nevertheless, with the inclusion of taxable fringe benefits, the current value where the level of 72% was reached is equal to some R3,26 million taxable income per annum.

In addition, married couples were taxed jointly on their household income at the time when the effective maximum marginal tax rate was 72%. As a result of the inclusion of fringe benefits in the tax base for individual taxpayers, the tax base expanded, while the tax base also changed with respect to married couples. The net result over time of these amendments to taxation is that South African taxpayers pay lower marginal taxes than was the case some 45 years ago, but higher average taxes.

Joint taxation of married couples is no longer the case in South Africa, but still applied in a number of countries, which results in a larger number of "families paying tax at the maximum marginal rate."[80] Countries which still apply the principle of "family tax" or joint taxation of married couples (the tax base is the couple's joint income) include France, Germany, Belgium, Switzerland and the US.[81] These different approaches to taxation (and specifically in respect of the calculation of the tax base) confirm that international comparisons of taxation should be done with the necessary caution.

It should also be pointed out that South Africa had no VAT or any similar point-of-sale tax in the early 1970s. South Africa had a high marginal personal income tax rate at a time in history when many countries in the world similarly had particularly high tax rates, with high levels of tax evasion, as tax evasion provided a "high rate of return", irrespective of the cost of evasion. South Africa's move to lower

[79] SA Reserve Bank. 2019. *Tax Chronology of South Africa: 1979–2019. Supplement to the South African Reserve Bank Quarterly Bulletin June 2019*. SA Reserve Bank, Pretoria. Available online at https://www.resbank.co.za/Lists/News%20and%20Publications/Attachments/6922/Tax%20Chronology.pdf. As far as this report is concerned, this SARB publication is incomplete in two respects: (i) The maximum marginal tax rate is reported as 60% for the 1971/72- to the 1978/79-fiscal years, but a tax surcharge of 20% applied in certain of these years, bringing the effective marginal rate to 72%, is not mentioned; and (ii) It is not reported that the tax base of tax payers was increased substantially in the second half of the 1980s when fringe benefits were included in the tax base for personal income tax payers.

[80] Bierbrauer, F, Boyer, P, Peichl, A and Weishaar, D. 2023. The road to individual taxation. CEPR. 7 June. https://cepr.org/voxeu/columns/road-individual-taxation

[81] Ibid.

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marginal personal tax rates, but with higher average personal tax rates, followed international trends in this regard.

At the current level of 45%, South Africa's maximum marginal tax rate is not necessarily out of sync with the rest of the world. It is higher than in countries such as Argentina (35%), Chile (40%), New Zealand (39%) and Turkey (40%), but lower than in countries such as Austria (55%), Belgium (50%), Denmark (52,07%), Finland (55%)[82] and The Netherlands (49,5%).[83] South Africa's maximum marginal personal income tax rate is higher than the average for European countries with membership of the Organization for Economic Co-operation and Development ("OECD"), where the average statutory top personal income tax rate is 42,8% in 2024.[84] In the United States, the average combined state and federal top income tax rate for the 50 U.S. states and the District of Columbia is 42,32%.[85] Trading Economics shows South Africa's maximum marginal income tax rate of 45% as the highest of all countries in Africa.[86] This leaves an impression that South Africa is indeed pushing at the upper limit of international marginal personal income tax rates.

This comparison focuses only on the maximum marginal tax rates in various jurisdictions. It does not highlight the income level at which these rates are reached or any exemptions that might apply – for instance, deductible retirement contributions. It also does not focus on the number of tax brackets or purchasing power parity at the level where the marginal rate is reached. However, it does show that South Africa's maximum marginal personal income tax rates are indeed well above general averages for different groups of countries. South Africa runs the risk of being on the "wrong side" of the Laffer curve, i.e., finding itself in an area where further personal income tax increases will yield less, rather than more, revenue to the government. An increase in personal income tax as a source of income to fund the NHI is nevertheless explored in the next chapter.

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VAT is a widely used form of taxation, with more than 170 countries levying such a consumption tax on goods and services.[87] The EU countries with the highest standard VAT rates are Hungary (27%), Croatia, Denmark, and Sweden (all at 25%), while Luxembourg has the lowest rate of 17%[88]. The EU's average VAT rate is 21,6%.[89] Some EU countries have lower VAT rates on certain items, while some items are VAT exempt, in both instances to alleviate pressure on poorer households.[90] The US does not have VAT at either the federal or state level.[91] Among African countries, the highest VAT rates are in Madagascar and Morocco, at 20%, while Eritrea has the lowest, at 5%.[92]

At first glance, it might therefore seem that there is scope for increasing South Africa's VAT rate. However, when the VAT rate was increased by one percentage point to 15% in the 2018/19 fiscal year,

[82] In Finland, the rate of 55% is applicable to residents. For non-residents, the maximum marginal tax rate is 35%.

[83] PWC. *Personal income tax (PIT) rates*. https://taxsummaries.pwc.com/quick-charts/personal-income-tax-pit-rates. PWC states that "(t)he headline PIT rate is generally the highest statutory PIT rate, inclusive of surtaxes but exclusive of local taxes. This comparison of tax rates should therefore be treated with some circumspect, as special conditions might apply, e.g. federal and state taxes and differences between employment income and other (for instance rental income or interest received) income.

[84] Mengden, A. 2024. *Top Personal Income Tax Rates in Europe, 2024*. Tax Foundation. https://taxfoundation.org/data/all/eu/top-personal-income-tax-rates-europe-2024/

[85] Ibid.

[86] *Trading Economics*. List of Countries by Personal Income Tax Rate. https://tradingeconomics.com/country-list/personal-income-tax-rate?continent=africa

[87] Mengden, A. 2024. VAT Rates in Europe, 2024. *Tax Foundation*. 30 January. https://taxfoundation.org/data/all/eu/value-added-tax-2024-vat-rates-europe/

[88] Ibid.

[89] Ibid.

[90] Ibid.

[91] *FONOA*. The American Exception: Why the US Has No VAT System. https://www.fonoa.com/blog/the-american-exception-why-the-us-has-no-vat-system

[92] *Trading Economics*. List of Countries by Sales Tax Rate. https://tradingeconomics.com/country-list/sales-tax-rate?continent=africa

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this increase was met with considerable resistance.[93] Every increase of one percentage point in the VAT rate will increase tax revenue by about R47,6 billion per annum, based on the budgeted VAT receipts for the 2024/25 fiscal year. However, given the reaction to the VAT increase announced in 2018, there is doubt whether the South African government has the capacity to increase VAT further in the near future. An increase in the VAT rate as a source of revenue to fund the NHI is nevertheless explored in the next chapter.

Total government revenue for the 2024/25 fiscal year from corporate tax is budgeted to amount to R302,7 billion.[94] The corporate tax rate is currently 27%, implying that each percentage point of the corporate tax rate provides income of about R11,2 billion per annum. This implies that an increase in the corporate tax rate of three percentage points to 30% will raise annual government revenue by some R33,6 billion.

In any consideration of an adjustment of the corporate tax rate, it should be borne in mind that a country's corporate tax rate should remain competitive in the quest to attract international investment. South Africa's current corporate tax rate of 27% is higher than the global average rate. The Tax Foundation shows that "(t)he worldwide average statutory corporate income tax rate, measured across 181 jurisdictions, is 23,45%. When weighted by GDP, the average statutory rate is 25,67%. The average top corporate rate among EU Member States is 21,13%, and 23,73% in OECD countries.[95]

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The same source reports that "(i)n 1980, corporate tax rates around the world averaged 40,18%, and 46,83% when weighted by GDP. Since then, countries have recognised the impact that high corporate tax rates have on business investment decisions; in 2023, the average is now 23,45%, and 25,67% when weighted by GDP, for 181 separate tax jurisdictions".[96] In its attempts to attract international investment, international corporate tax rates place a limitation on the ability of the South African government to increase rates. An increase in corporate tax as a source of income to fund the NHI is nevertheless explored in the next chapter.

Other sources of government revenue (sin taxes, excise duty, fuel levy, etc) are normally increased in each annual budget. Taken together, these tax sources make an important contribution to government revenue, although the impact of each individual tax is relatively small. Taken together, these forms of indirect tax amount to about R171,6 billion[97], or 10,0% of main budget revenue in the 2024/25 fiscal year. In this instance, a sensitivity is a resistance to further increases in the fuel levy resulting in higher fuel prices, [98] while any increase in excise duties on tobacco products will increase cigarette smuggling and the sale of illicit cigarettes.[99] Nevertheless, even if the tax rates on these items are raised by a (very substantive) 10%, total government revenue will increase by only some R17,1 billion per annum. An increase in these smaller tax items as a source of income to fund the NHI is therefore not explored in the next chapter.

Summary and conclusion

This chapter assesses South Africa's fiscal capacity to implement the NHI but finds that no up-to-date official estimate or assessment of cost implications of full implementation of the NHI has been provided by the South African government.

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[93] See for instance Madia, T. 2018. 'You are playing with fire,'Cosatu warns govt on VAT increase. *Fin24*. 1 March. https://www.fin24.com/Budget/Budget-and-Economy/you-are-playing-with-fire-cosatu-warns-govt-on-vat-increase-20180301-2

[94] Subsequently revised downwards to R219,0 billion.

[95] Enache, C. 2023. Corporate Tax Rates around the World, 2023. *Tax Foundation*. 12 December. https://taxfoundation.org/data/all/global/corporate-tax-rates-by-country-2023/

[96] Ibid.

[97] Amount calculated by subtracting the VAT collections from the Domestic taxes on goods and services line item.

[98] Akamby, R. 2022. Cosatu calls on President Ramaphosa to scrap fuel taxes and levies. *SABC News*. 17 June. https://www.sabcnews.com/sabcnews/cosatu-calls-on-president-ramaphosa-to-scrap-fuel-taxes-and-levies/

[99] *SARS*. 2023. Media release – Destruction of smuggled and illicit cigarettes valued at R43-million. 12 June. https://www.sars.gov.za/latest-news/media-release-destruction-of-smuggled-and-illicit-cigarettes-valued-at-r43-million/

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As far as fiscal realities and trends, it is evident that South Africa finds itself in a bind as far as its state finances are concerned. Since the global financial crisis of 2008, the South African government has run fiscal deficits with increased borrowing in an attempt to stimulate domestic demand and economic growth. Despite this, South Africa's economic growth trajectory declined, with potential economic growth now estimated to average only around 1% to 1,5% per annum. The concomitant large annual deficits, before borrowing, pushed up government debt from 25% of GDP some 15 years ago to a current level of just below 75% of GDP in 2024. This creates significant pressure to stabilise (or lower) debt levels, which leaves little room for additional expenditure items.

In recent years, growth in government revenue has emanated from increases in tax rates and bracket creep (taxpayers not being compensated for the impact of higher taxation on higher wages aimed at compensating for price increases emanating from inflation). In addition, an international comparison shows that South African tax rates for individuals (personal income tax) and companies (company rate rate) are at the higher end of comparable international rates.

Nevertheless, the only way in which the South African government can afford the additional spending owing to the burden placed on the fiscus once NHI is implemented, is by means of substantial further tax increases. Given the lack of clarity from the government, the next chapter provides cost estimates and considers likely tax increases.

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Chapter Four

Funding the cost of the NHI once fully implemented: alternatives and scenarios

The NHI Act[100] provides no indication of the expected full cost of implementing the NHI. The NHI Bill,[101] submitted for consideration by the South African Parliament, was accompanied by an explanatory memorandum. However, as is explained elsewhere, this memorandum provided insufficient detail about the envisaged cost of full implementation of the NHI. It is, therefore, necessary to estimate the cost of the NHI once fully implemented.

However, before dealing with the estimate of the cost for full implementation of the NHI, two further matters require elucidation. First, there is no timeline or firm date for the full implementation of the NHI. The minister of health, Dr Aaron Motsoaledi, had indicated recently that it might take up to 15 years for the NHI to be fully implemented.[102] It is therefore necessary to decide on a date for full implementation to assess the full cost of the NHI and the funding implications for the South African government at that date. This difficulty was addressed by doing two analyses of the funding of the cost of full implementation. In the one instance, the funding is costed as if the NHI is fully implemented by 2028. In the other instance, the costing and funding estimates are done as if NHI is fully implemented in 2039, i.e., in 15 years' time. The reasoning for this approach is discussed in more detail later in this chapter.

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Secondly, the NHI Act states in Section 33 that "(o)nce National Health Insurance has been fully implemented as determined by the Minister through regulations in the *Gazette*, medical schemes may only offer complementary cover to services not reimbursable by the Fund." This implies that save for some complementary services, medical aid schemes will, for all intents and purposes, cease to exist when the NHI is fully implemented. All people currently covered by medical aid funds (for instance, academics, politicians, civil servants, private sector employees and public sector employees in municipalities, employees of state-owned enterprises, professionals in private practice and the like) will no longer have membership in medical aid funds, except in respect of services not covered by the NHI. As the services rendered by the NHI increase over time, the role of medical aid funds will diminish accordingly. This will place substantial additional pressure on the national health system, as the system currently caters only for that part of the population that utilises public health services.

In Section 3(3), the NHI Act states that "(i)f any conflict, relating to the matters dealt with in this Act, arises between this Act and the provisions of any other law, except the Constitution and the Public Finance Management Act or any Act expressly amending this Act, the provisions of this Act prevail." This is a wide-ranging provision of which the full implications will only transpire once the roll-out of the NHI commences.

However, despite this overarching provision in Section 3(3), the NHI Act also states in the same Section (Section 3(2)(a) and (b)) that:
"This Act does not apply to members of—
(a) the National Defence Force; and
(b) the State Security Agency."

In respect of members of the National Defence Force, the NHI Act states in Section 3(1) that "(t)his Act applies to all health establishments, excluding military health services and establishments." This exclusion specifically provides for health services for members of the National Defence Force outside the NHI. The memorandum accompanying the NHI Bill provided no explanation for this exclusion. It is

[100] *National Health Insurance Act*, Act No 20 of 2023
[101] Republic of South Africa. 2019. *National Health Insurance Bill* (B11 – 2019). Parliament: Cape Town.
[102] Bechard, M. 2024. Momentum's NHI cost estimate is 'mathematical hooliganism', says Health Minister. *Moonstone*. 8 August. https://www.moonstone.co.za/momentums-nhi-cost-estimate-is-mathematical-hooliganism-says-health-minister/

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also not explained what happens to members of the National Defence Force after retirement. It is unclear whether they would still be excluded from NHI or would be included after retirement. Owing to this uncertainty, the possible additional cost of providing health services to former members of the National Defence Force is not covered in the cost estimate of a fully implemented NHI.

Likewise, members of the State Security Agency are excluded from the NHI Act. In this instance, it raises more questions than the position of members of the National Defence Force. No reason is provided for this exclusion in the memorandum accompanying the NHI Bill. Moreover, no information is provided on the medical care of the members of the State Security Agency owing to their exclusion from NHI. Owing to this uncertainty, the additional cost of providing health services to members of the State Security Agency is not covered in the cost estimate of a fully implemented NHI. It is clearly an omission in the memorandum accompanying the NHI Bill not to explain this aspect.

Lastly, the provision of medical services to the President, the Deputy President and former incumbents of those positions is also unclear. This matter is not addressed in the NHI Act or in the memorandum accompanying the NHI Bill. In a written response to a question in Parliament, the minister of defence and military veterans stated that the presidential medical unit of the Department of Defence spent R472,7 million on medical care for current and former presidents, deputy presidents and the minister of defence from the 2019/20 fiscal year to the end of July 2024.[103] The NHI Act makes no specific provision for this health care to continue, although the President is the Commander in Chief of the National Defence Force. The cost of care by the presidential medical unit of the Department of Defence is not included in the estimates and calculations.

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Expected cost of the NHI

Owing to the omission of information in the memorandum accompanying the NHI Bill in Parliament, the only "government-official estimates" that can be used for estimating the cost of a fully implemented NHI are data provided in the 2015 and 2017 White Papers on the cost of health service provision in South Africa once the NHI is implemented. Nevertheless, the expected cost of implementation and operationalisation of the NHI as envisaged in the NHI Act can at best be described as a "bit of a mystery" despite the publication of two White Papers (2015 and 2017)[104] and the NHI Bill and explanatory memorandum.[105] The 2015 and 2017 White Papers[106] provide some framework projections for the cost of the NHI in 2026, but base these projections on 2010 prices and costs. It is, at the very least, a serious shortcoming of these two White Papers that no attempts were made to update the cost estimates at the time of their publication.

The cost estimates used in these White Papers were first published in 2011 in a *Policy Paper* of the National Department of Health.[107] This *Policy Paper* provides a cost estimate in 2010 values, highlighted in Table 11. The full cost of implementation, based on the *Policy Paper*, is therefore rounded as R256 billion. This amount was subsequently used, albeit with an indication that it represents 2010 values. It should also be noted that the *Policy Paper* describes the calculation as "preliminary cost estimates."[108] However, as no other "official" government estimate of the full cost of implementation is provided, this last "official" government estimate is used.

[103] Ensor, L. 2024. Presidential medical care costs nearly R500m over five years: 'Excessive' expenditure as scope of presidential medical unit widens. *Business Day*. 7 October. https://www.businesslive.co.za/bd/national/2024-10-07-presidential-medical-care-costs-nearly-r500m-over-five-years/
[104] Ibid.
[105] Ibid.
[106] Ibid.
[107] Republic of South Africa. 2011. National Health Insurance in South Africa. *Policy Paper*. National Department of Health. August.
[108] Ibid. p39.

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Table 11: Health care Delivery and National Health Insurance Implementation: Preliminary Cost Estimates 2011 – 2025

Year	Non-AIDS-related services	AIDS-related services	Additional services	Total Direct Healthcare costs	NHI Operational costs	Total costs in delivering services	NHI Implementation costs	Total costs modelled
2011	0	0	0	0	0	0	103,315,363	103,315,363
2012	57,773,124,913	17,166,207,505	42,270,916,229	117,210,248,647	586,051,243	117,796,299,890	7,562,523,092	125,358,822,983
2013	63,018,663,899	19,715,909,555	43,466,836,571	126,201,410,025	873,313,757	127,074,723,782	7,688,065,131	134,762,788,914
2014	68,743,700,878	21,986,952,564	44,663,128,851	135,393,782,293	1,196,881,035	136,590,663,329	7,817,527,358	144,408,190,686
2015	74,548,475,525	26,244,506,794	45,874,322,881	146,667,305,200	1,578,140,204	148,245,445,404	7,950,910,914	156,196,356,317
2016	80,827,911,456	28,728,750,718	47,094,626,628	158,651,288,802	1,986,338,342	158,637,627,144	8,088,221,201	166,725,848,345
2017	87,641,230,832	31,030,939,052	48,325,812,591	166,997,982,475	2,438,170,544	169,436,153,019	8,229,467,732	177,665,620,751
2018	95,052,680,344	33,149,581,757	49,568,979,121	177,771,241,221	2,936,780,905	180,708,022,128	8,374,683,993	189,082,686,119
2019	103,126,628,653	35,111,160,178	50,824,874,097	189,062,662,938	3,486,315,505	192,548,978,442	8,417,349,306	200,966,327,749
2020	111,940,398,283	36,941,489,310	52,094,075,790	200,975,963,382	4,091,870,614	205,067,833,997	8,568,371,192	213,636,205,189
2021	121,576,843,333	38,660,495,022	53,376,896,309	213,614,234,664	4,759,325,148	218,373,559,813	8,723,363,285	227,096,923,097
2022	127,854,878,098	40,285,667,400	53,611,943,556	221,752,489,054	5,366,410,235	227,118,899,289	8,882,352,922	236,001,252,211
2023	134,559,644,807	41,834,116,750	53,831,486,738	230,225,248,294	6,013,483,485	236,238,731,780	9,045,370,841	245,284,102,621
2024	141,730,835,738	43,303,832,918	54,036,013,619	239,070,682,276	6,703,541,931	245,774,224,207	9,212,451,095	254,986,675,302
2025	149,406,746,586	44,715,842,637	54,225,907,657	248,348,496,879	7,450,454,906	255,798,951,786	16,410,894	255,815,362,679

Source: Republic of South Africa. 2011. National Health Insurance in South Africa. *Policy Paper*. p39

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In addition to an assessment of the "last/only official estimate" of the South African government, different approaches to estimate the costs of a fully implemented NHI can be followed. The analysis in the rest of the chapter broadly links to two methods, namely a unit cost approach and a phased-in approach using prior government cost estimates and inflating them to current and future values. For the second approach, two different time horizons are tested. In the first instance, the funding is costed as if the NHI is fully implemented by 2028. The reasoning for this approach is that accurate medium-term fiscal numbers are available from the MTBPS of 30 October 2024.[109] The MTBPS also provides assumptions for the economic growth rate, inflation and the like for the period under consideration. These assumptions are used for the calculation of the cost and funding of NHI as if fully implemented by 2028. However, for practical reasons, the revenue and expenditure figures for a fiscal year, that is, from 1 April to 31 March, are used as if these figures are for the calendar year. In the second instance, the funding is costed as if the NHI is fully implemented by 2039, that is in 15 years' time. For this purpose, several additional assumptions are necessary, as alluded to in more detail below.

In general, the cost calculations in the 2015 and 2017 White Papers are, at best, incomplete. The problem is that these White Papers do not set out in sufficient detail the scope, structure and size of the provision of services, as these aspects have (likely) not yet been decided by the government. There is little evidence that the NHI has planned for the necessary expansion in the system's capacity to meet the very substantial increase in demand if a wide and comprehensive range of personal health care services will in future be provided free at the point of care and for South Africa's population growth. In addition, it is unclear whether the cost calculations include any allowance for improved efficiencies in the public health sector or changes in the role of private medical aid schemes. It is also not clear whether the full cost of administering the NHI has been taken into consideration.

The economic growth calculations in both White Papers are over-optimistic, using an annual economic growth rate of 3,5% per annum until 2026 as the most likely outcome for its calculations. To the contrary, this research assumes that the economy will grow by 1,5% over the next 15 years, aligned with the potential growth projections explained in the previous chapter. In addition, an average annual growth rate of 3,5% per annum was not achieved since 2015 or 2017.

The NHI will require a vast number of administrators to manage its own medical scheme "... for the establishment of a single-payer, publicly administered NHI Fund over the 15-year phased

[109] National Treasury. 2024. MTBPS. 30 October. Op cit.

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implementation period. The expertise will be drawn upon where necessary to build in-house capacity within the publicly administered Fund, rather than to outsource any component to a private entity."[110]

The 2015 White Paper stated in paragraph 252[111] that:

> *The projections set out in the Green Paper were derived from a model of aggregate costs built on projected utilisation based on demographic trends. A revised version of these projections is summarised in Table 1, based on more recent estimates of the costs of the NHI pilots and other reforms currently being implemented. In this scenario, total NHI costs in 2025 are shown as R256 billion (in 2010 terms) as in the Green Paper, but the cost increase in the early years is more moderate.*

Table 1: Projection of NHI costs adapted from Green Paper

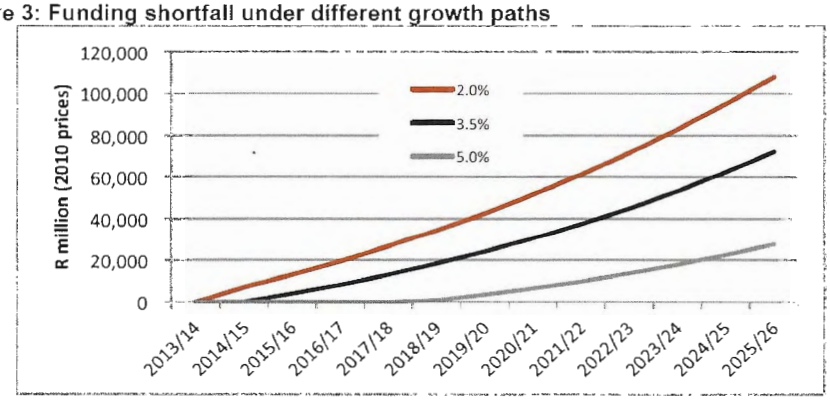
		Average annual per cent increase	Cost Projection R m (2010 prices)
Baseline public health budget:	2010/11		109 769
Projected NHI expenditure:	2015/16	4.1%	134 324
	2020/21	6.7%	185 370
	2025/26	6.7%	255 815
Funding shortfall in 2025/26 if baseline increases by:		2.0%	108 080
		3.5%	71 914
		5.0%	27 613

Source: National Treasury projection (2012)

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> *Figure 3 illustrates the funding shortfall for alternative baseline resource growth projections. The funding shortfall is R71.9 billion in 2025/26 if the baseline increases by 3.5 per cent a year. It would be R27.6 billion if baseline resources grow by 5.0 per cent a year (in real terms) and would be R108 billion if baseline resources grow by 2.0 per cent per year. Over the long run, the pace of economic growth is an important indicator of overall growth rate in health expenditure.*

Figure 3: Funding shortfall under different growth paths



Source: 2015 White Paper

It is evident from the extract that the funding shortfall of R108 billion assumes real economic growth of 2% per annum for the (historic) period to 2025. South Africa's actual average annual growth rate from 2014 to 2024 was 0,8%, implying that the funding shortfall trajectory under a 2% growth path is the closest to the actual performance of the economy over that period. Adjusted for inflation since 2010, a projected shortfall of R108 billion in 2024 real values amounts to R219,3 billion. To the degree that the

[110] 2015 White Paper at paragraph 404.
[111] Pages 45-46.

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actual economic growth of the South African economy was below 2% at an actual 0,8% since the 2013/14 fiscal year, the shortfall is estimated to increase to at least R257,0 billion by 2024.[112]

It is unclear whether the shortfall alluded to above made provision for population growth over the period since 2013/14. If no provision was made, the projected shortfall would increase by an additional amount of some R48 billion. This results in a funding shortfall of some R305 billion (R257 billion plus R48 billion) by 2024.

The total annual cost for the full annual implementation of NHI is estimated at R256 billion in the 2015 White Paper in terms of real 2010 values. Adjusted for inflation to 2024, this amounts to R519,7 billion in real terms. This is the first indication of the estimated annual cost of NHI once fully implemented. However, since 2010, the South African population grew by about 1,5% per annum. If this population increase is added to the inflation-adjusted estimate for 2024, the cost comes to some R640,2 billion.

These estimated numbers do not match the government's prior shortfall estimates. In the 2024/25 fiscal year, the government's health budget is R274,0 billion[113]. The estimated expenditure, based on a real and population growth adjustment of the government's own figures, brings the annual cost of full implementation of NHI to R640,2 billion. On this basis, the funding shortfall is R366,2 billion, notably higher than the government's projected shortfall of R219,3 billion, or even the adjusted amounts of R257,0 billion or R305,0 billion, as calculated above.

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The estimated funding shortfall for 2024, based on the government's projections, therefore lies somewhere between R219,3 billion and R366,2 billion, in the latter instance, an amount significantly larger than the current health budget of the government.

These calculations result in a problem, as assessments from different sources of the funding gap of a fully implemented NHI (in 2024 values) yield widely different answers. The funding gap ranges from some R219,3 billion to R305,0 billion (low economic growth of 0,8% and population growth of 1,5% per annum) to R366,2 billion, based on the analysis in the *Policy Paper* cited above, dependent on the assumptions and calculations used. In this research paper, the latter (R366,2 billion) is regarded as an accurate estimate rather than any of the former amounts, as the former amounts do not provide any estimate of the cost of a fully implemented NHI. Moreover, the latter is based on a calculation of 2010 values of health care in the *Policy Paper*, while the former is an adjustment of growth trajectories used in the 2015 *White Paper*. However, the adjusted estimate of R305,0 billion mentioned above amounts to 83,2% of R366,2 billion figure, which is within a reasonable range of assurance of both estimates based on the last figures and trends provided by the South African government.

Unit cost approach

Other sources also made estimates of the annual cost of NHI once fully implemented. These estimates are necessary owing to the dereliction of duty by the government in providing an updated estimate. To date, the minister of health had only discredited other estimates without providing his own or an updated estimate from the government against which other estimates could be benchmarked. For instance, the minister said that "Momentum Health Solutions' estimate that National Health Insurance ("NHI") will cost more than R1.3 trillion a year was "mathematical hooliganism" designed to scare South Africans into rejecting the new system",[114] but without providing evidence to support his remark about financial hooliganism, or providing any estimate.

A review of recent publications on the possible annual cost of the full implementation of NHI shows that:

[112] Calculated by adding the difference between actual and estimated growth (i.e. 1,2% points) to the actual annual inflation figures and then using this to inflate the R108bn (2010) value.
[113] https://www.treasury.gov.za/documents/mtbps/2024/mtbps/Chapter%204.pdf, p31
[114] Bechard, M. 2024. Op cit.

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(i) Momentum Heath Care estimates the cost at R1,3 trillion (R1 300 billion);[115]
(ii) Discovery estimates the cost at R859 billion for prescribed minimum benefits;[116]
(iii) In a joint report, Gareth Zietsman and Leon Louw estimate the cost at R1 trillion (R1 000 billion)[117]

Other than estimating the annual cost of the full implementation of the NHI, Discovery also estimated the impact on the revenue of the government. The Discovery estimate is that the tax burden will have to increase by 31% to cover the NHI funding shortfall, once fully implemented.[118]

The authors of this present paper have also produced estimates of the cost of a fully implemented NHI. In the first instance, the basis for this estimate is the expenditure of medical aid funds per member. This is calculated using the benefits paid by medical schemes in 2023 and dividing the value by the number of members. Another estimate was done using the average cost between the private and public sectors. For the private sector, the same value as explained above is used, while for the public sector, the average cost per person is proxied by dividing the health expenditure budget by the number of non-medical aid members in South Africa.

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With an annual health budget of R274,0 billion and various expenditure estimates, a basis for the calculation of a shortfall to be funded must be found. The alternatives are summarised in Table 12.

Evident from Table 12 is that there are considerable differences between the estimated costs (and thus funding gaps) between the various institutions and analysts, the calculation of the authors of this present paper, and the government estimate based on the 2010 figure provided (but adjusted for inflation and for population growth) in the *Policy Paper*, published in 2011. The differences in estimates are, *inter alia*, caused by the use of different assumptions.

Table 12: Estimates of Funding Requirement of Fully Implemented NHI by 2024, R billion

	2010 Government estimate adjusted for 2024	Momentum	Discovery	Zietsman and Louw	Own calculation (using private sector benefit costs)	Own calculation (using average of private/public benefit costs)
Estimated cost	R640.2	R1 300.0	R859.0	R1 000.0	R1 663.8	R994.1
Health budget (2024/25)[119]	R274.0	R274.0	R274.0	R274.0	R274.0	R274.0
Subtotal	R366.2	R1 026.0	R585.0	R726.0	R1 389.8	R720.1
Private medical contributions[120]	R147.6	R147.6	R147.6	R147.6	R147.6	R147.6
Medical aid credits	R36.7	R36.7	R36.7	R36.7	R36.7	R36.7
Funding requirement	R181.9	R841.7	R400.7	R541.7	R1 205.5	R535.8

Source: National Treasury, various institutions and own calculations

The International Labour Office indicates that total expenditure in respect of national health insurance can be calculated by multiplying the user population with the estimated unit cost and utilisation rates.

[115] Ibid.
[116] Ryan, C. 2023. NHI means 31% more tax and 69% less benefits for medical scheme members. *Moneyweb*. 11 December. https://www.moneyweb.co.za/news/south-africa/nhi-means-more-tax-less-benefits-for-medical-aid-members-discovery/
[117] *Moonstone Information Refinery*. 2023. Full implementation' of NHI will consume a quarter of GDP – cost analysis. 14 December. https://www.moonstone.co.za/full-implementation-of-nhi-will-consume-a-quarter-of-gdp-cost-analysis/
[118] Ryan, C. 2023. Op cit.
[119] https://www.treasury.gov.za/documents/mtbps/2024/mtbps/Chapter%204.pdf, p31
[120] This item consists of medical aid contributions, out of pocket (OOP) payments and medical insurance payments. Estimated values for the first two items are available from the Council for Medical Schemes, Annual Report 2023|24. No credible data could be found for medical insurance payments thus these were estimated to be around 10% of medical aid contributions.

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As it remains unclear what percentage of the population will utilise the NHI once fully implemented, the only reasonable assumption is a full (100 percent) utilisation rate. The calculation thus boils down to multiplying the total population with the estimated unit cost of medical care per person. For South Africa, this amounts to around R26 404[121] per person per year claim costs per beneficiary in the private health care sector. Multiplying this by South Africa's population (i.e., 63 million), the total cost balloons to R1 663.8 billion. Alternatively, if we assume that costs will be somewhere between private and public costs, we can use an average costs approach. In this case, the cost to implement NHI in 2024 is R994.1 billion.

To calculate the funding requirement (gap), we assume that the national health budget, as well as the medical aid credits, can be utilised fully to offset the costs. In addition, we assume that 50% of current private medical contributions will be "saved" by households, with services or out-of-pocket costs currently being paid for being covered by NHI. It is thus assumed that the other 50% will still be paid by households in respect of services not covered by NHI, even when fully implemented.

However, it should be evident that this amount and percentage are very difficult to determine as very little information is provided in the NHI Act regarding the role of private medical schemes (and thus private contributions) under the NHI, other than to mention that schemes will be allowed to provide 'additional' services, not already covered under NHI. In practice, it is also doubtful if the envisaged 'free to all' nature of NHI will be practically doable. Full or partial payment for all or certain services could, for example, be based on some means or income test – like tests used for people currently receiving some of the various social assistance payments from the government (also see footnote 120).

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This report used an inclusion rate of 50% of total medical aid contributions, out-of-pocket (OOP) payments, and (estimated) medical insurance payments. The reason is that even under a fully implemented NHI, only certain medical conditions/items will be covered. Thus, individuals will (likely) have the option to still finance various items privately (this is impossible to determine at this stage). Currently, various employers provide medical benefits (co-payments) to employees, and it is uncertain how/if these arrangements will continue under NHI. In addition, it is uncertain how medical-related services and items (e.g. physiotherapy, bio kineticists, optometry, dentists/orthodontists, psychologists, cosmetic procedures, pharmaceuticals, etc.) currently covered partly and/or fully by, for example, medical aid, will be included or not under NHI. Also, it is unclear how the government will collect and/or 'ring fence' the current private medical payments. Given the various uncertainties and assumptions necessitated, this item is only included in the unit costs approach and not in the phased-in approach. The item (50% of medical aid contributions as not being paid once NHI is fully phased-in) is again taken into consideration as a (possible) household saving item in the econometric modelling of the second-round effects, dealt with later in this chapter.

Based on this, estimates for the funding gap (excluding the government's adjusted value) range from R400,7 billion to R1 205,5 billion (see Table 12). Put differently: this will consume between 16,7% and 50,3% of total consolidated government expenditure in the 2024/25 fiscal year – an order of magnitude that is clearly unaffordable – but is aligned to Discovery's estimate in that the tax burden will have to increase by 31% to cover the NHI funding shortfall once fully implemented.

[121] Calculated using figure from the Council for Medical Schemes | Annual Report 2023|24

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Phased-in approach [122]

This report also considers alternative approaches to estimating the cost, including using previous government estimates and applying a phased-in approach. For this purpose, assumptions must be made about the likely implementation period. For the sake of completeness, this is done for two implementation timelines: One for 2028 (i.e., the original date indicated in earlier government reports or a 4-year implementation phase) and another for 2039 (that is over 15 years, as mentioned by the Minister of Health on various occasions, but without any clear indication when the period of 15 years commences/commenced).

The costs calculated above (i.e., 2024 values) in terms of the government's 2010 values must be adjusted to 2028 values by using the medical (health) inflation rates and population growth of 1,5% per annum. In addition, other available tax items (for example, medical tax credits) must be accounted for. The available funding from the health budget is phased in, in a similar way as the costs.

On this basis, the funding gap for 2028 is calculated as R483,1 billion, or some 16,6% of total budgeted consolidated government expenditure in that period. Also evident is that, based on the phased-in approach, the funding gap starts out relatively small but quickly balloons to (likely) fiscally unsustainable levels. See Table 13 for a summary of how the cost projections and funding gaps up to 2028 are calculated.

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These amounts are used again in the next section, where possible sources of additional government revenue to fund the deficit are identified.

Table 13: Estimates of Funding Requirement of Fully Implemented NHI by 2028, R billion

	2024	2025	2026	2027	2028
Cost of NHI (phased in)	R0.0	R172.3	R368.7	R591.7	R844.0
Less: Health expenditure (Budgeted amount phased in)	R0.0	R71.1	R148.6	R233.1	R324.2
Less: Medical tax credits phased out over period)	R0	R9.2	R18.4	R27.5	R36.7
Funding gap	R0.0	R92.0	R201.8	R331.1	R483.1
Growth rate in funding gap			119.2%	64.1%	45.9%
Funding gap as % of total government expenditure	0.0%	3.7%	7.7%	12.0%	16.6%

Source: National Treasury and own calculations

To illustrate the impact of the funding gap on state finances, we added it to the projected budget figures. As a percentage of the budget balance, the funding gap rises from 26,8 % in 2025 to 148,2% in 2028 (see Table 14). Compared to GDP, the 2027 budget deficit increases from the budgeted figure of 3,4% of GDP to 7,1%. For 2028, the impact is even more severe as the budget deficit as percentage of GDP increases from 3,6% to 8,9%. To put this into perspective, during the height of the Covid-19 lockdowns in 2020/21, the budget deficit reached 10,0% of GDP, at which point it was clearly unsustainable, given the concomitant increase in the interest burden of the South African government. To attempt to run a deficit of this size indefinitely will clearly be fiscally unsustainable.

[122] In addition to the discussion above, the private medical contributions are excluded from the phased-in analysis presented here to guard against 'double counting' as these 'savings are also included in the econometric models for household disposable income used later in the chapter.

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Table 14: Funding Gap's Impact on Budget Balance

	2024	2025	2026	2027	2028
Cost of NHI	R0.0	R172.3	R368.7	R591.7	R844.0
Funding gap	R0.0	R92.0	R201.8	R331.1	R483.1
Main Budget balance (deficit)	-R355.60	-R343.80	-R325.20	-R309	-R326.00
Main Budget balance (% GDP)	4.7%	4.3%	3.8%	3.4%	3.6%
Funding gap as % of budget balance	0.0%	26.8%	62.0%	107.1%	148.2%
Adjusted balance	-R355.60	-R435.83	-R526.97	-R640.07	-R809.14
Adjusted balance (% GDP)	4.8%	5.5%	6.3%	7.1%	8.9%

Source: National Treasury[123] and own calculations

The funding gap of R483,1 billion calculated for 2028, must also be adjusted for 2039. Likewise, the government's revenue figures for the 2028/29 fiscal year, used as figures for the 2028 calendar year, must be adjusted to 2039. For this purpose, the following assumptions are used (briefly summarised):

a. Average population growth of 1,5% per annum until 2039.
b. Average inflation rate of 5,4% per annum, based on the average health inflation recorded during the period 2010 – 2024.
c. Average real GDP growth rate of 1,5% per annum.
d. The full amount of medical tax credits will be available for the funding of the NHI, once fully implemented (phased-out over phasing-in period).
e. The current health budget can be utilised fully for NHI but is phased in over the duration of the analysis.
f. A personal income tax surcharge will be applied.
g. A payroll tax of 2% on income above the UIF threshold income of R212 544 per annum will be applied.
h. No tax changes (rate changes) for personal income tax, company tax, and VAT will be announced in the 15-year period to 2039.

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If the cost implications are calculated for the NHI phased in over a 15-year period (that is to be fully implemented by 2039), the funding gap for 2039 is calculated as R1 198,4 billion, or some 233% of estimated government health expenditure in the outer year. Also evident is that, based on the phased-in approach, the funding gap starts out relatively small but again rises quickly to (likely) fiscally unsustainable levels. See Table 15 and Figure 11 below for a summary of the cost projections and funding gaps up to 2039.

[123] https://www.treasury.gov.za/documents/mtbps/2024/mtbps/Chapter%203.pdf

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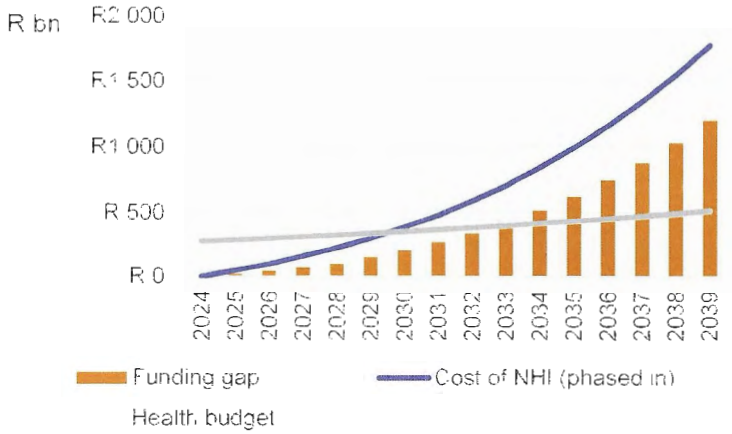
Table 15: Estimates of Funding Requirement of Fully Implemented NHI by 2039, R billion

	Cost of NHI (phased in)	Funding gap	Health budget (Phased in)
2024	R0	R0	R274
2025	R46	R18	R285
2026	R98	R40	R297
2027	R158	R68	R311
2028	R225	R102	R324
2029	R301	R150	R338
2030	R386	R205	R353
2031	R482	R269	R368
2032	R590	R341	R384
2033	R710	R424	R400
2034	R844	R518	R417
2035	R993	R624	R435
2036	R1 158	R743	R454
2037	R1 343	R878	R474
2038	R1 547	R1 029	R494
2039	R1 773	R1 198	R515

Source: Own calculations

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Figure 11: Estimates of Funding Requirement of Fully Implemented NHI by 2039, R billion



Source: Own calculations

Sources of additional government revenue to fund NHI

The funding options for the NHI were identified by the National Treasury in 2012 as some combination of a payroll tax on employers and a surcharge on the taxable income of individuals. It is noticeable that the NHI Act is silent on both an increase in company tax and VAT as sources of funding for the NHI.[124]

[124] The actual wording in the NHI Act in respect of Section 49 is:
49. (1) The Fund is entitled to money appropriated annually by Parliament in order to achieve the purpose of the Act.
(2) The money referred to in subsection (1) must be—
(a) appropriated from money collected and in accordance with social solidarity in respect of—
(i) general tax revenue, including the shifting of funds from national government departments and agencies and the provincial equitable share and conditional grants into the Fund.
(ii) reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance.
(iii) payroll tax (employer and employee); and
(iv) surcharge on personal income tax,
introduced through a money Bill by the Minister of Finance and earmarked for use by the Fund, subject to section 57; and
(b) calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act.

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The NHI Act states in Section 49 that the NHI will be funded by general tax revenue, reallocation of funding for medical scheme tax credits[125] paid to various medical schemes, a payroll tax (employer and employee) and a surcharge on personal income tax.

The approach of the National Treasury seems to be aligned with the 2015 White Paper, which considers several different tax scenarios, namely a payroll tax, a surcharge on personal incomes and an increase in VAT as the main available sources of funding for NHI.[126] It also considers various other sources of tax revenue, such as duties on alcohol and tobacco products, but recognises the problem that high rates of tax on these products can lead to increases in illicit trade and tax evasion. Other transaction taxes, such as securities transfer tax and estate duties, are considered too volatile and unreliable sources of revenue and difficult to collect. The White Paper also briefly notes other sources of revenue, such as the abolition of medical scheme tax credits and transferring current medical aid contributions for public sector employees to the NHI. The 2015 White Paper, therefore, considers more funding options than the National Treasury, stating the important principle in paragraph 266 that "(t)he proposed funding mechanism must be sustainable over the long term and ensures that the NHI reforms are appropriately funded."[127] It is unclear whether the funds will be ring-fenced, but given the proposed funding mechanisms, the bulk of these will be unlikely (impossible?) to be kept ring-fenced in practice.

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The analysis in this report shows that the government has very limited fiscal capacity, as the country has:

(i) a limited tax base;
(ii) subdued domestic economic growth, implying that the tax base is not growing;
(iii) stagnating real personal income, as the annual population growth rate is equal to or higher than the annual economic growth rate;
(iv) a lack of fiscal space to introduce new expenditure programmes; and
(v) low tax buoyancy, implying limited scope for further taxation.

Alternatives to funding the NHI have to be assessed in this environment of subdued economic growth and revenue shortfalls. Based on the calculations above, the funding gap amounts to R483,1 billion in 2028 (2028-values). For 2039, the funding gap amounts to R1 198 billion (2023-values).

Based on the budgeted tax revenue for the 2027/28 fiscal year and the estimate of total tax revenue in 2039, alternatives for the funding shortfall of NHI in those two periods can be calculated. The three main revenue sources of the government are personal income tax, VAT and company taxes. Based on the 2024 figures, these three items together contribute 83,6 % of total main budget revenue. In total, personal income tax contributes 40,7%, VAT 26,2% and CIT 16,7%. Other possible sources for raising additional revenue are also considered. In addition, the scrapping of medical tax credits is already included in the calculations in the previous section. Note that the 2024 budget provides figures for the medium term, that is, up to 2027/28[128]. To get to the 2028 (i.e. 2028/29) figures, we had to inflate the values using the assumptions highlighted earlier in this chapter.

Corporate (Company) Tax

The first funding alternative that comes to mind is an increase in the corporate tax rate. The current tax rate for companies is 27% of profit, and the estimated revenue from this source for the 2027/28 fiscal

[125] The NHI Act does not mention medical tax credits on out-of-pocket expenditure. It is unclear whether this is an accidental omission or not.

[126] Republic of South Africa. 2015. White Paper on National Health Insurance. *Government Gazette No 1230*. 11 December. pp51 to 57. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.gov.za/sites/default/files/gcis_document/201512/39506gon1230.pdf

[127] Ibid.

[128] The 2024 MTBPS provides some information in respect of the 2027/28-fiscal year, but not in the same detail as the main annual budget, tabled in Parliament in February 2024.

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year is budgeted to amount to R349,6 billion. Adjusted to a 2028 value, this becomes R392,8 bn.[129] Each increase of 1 percentage point in the company tax rate in 2028 will, therefore, raise an additional amount of some R14,5 billion in government revenue, based on these estimates and assumptions.

The estimated income from company tax for the 2039/40 fiscal year amounts to some R745,7 billion. Each increase of 1 percentage point in the company tax rate in 2039 will, therefore, raise an additional amount of some R27,6 billion in government revenue, based on these estimates and assumptions.

It is (probably incorrectly) assumed that an increase in company tax will not impact negatively on other tax sources, such as VAT or dividend withholding tax and will not impact negatively on employment by companies or on the remuneration of their employees.

However, as an increase in company tax is not stated as a revenue source in the NHI Act, the discussion of funding options excludes an increase in this revenue source.

Personal income tax surcharge

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The total collection of personal income tax in 2028 is estimated at R955,6 billion. Every 1% income tax surcharge will deliver additional revenue of some R9,5 billion in 2028. A surcharge of 10% will therefore deliver additional revenue of some R95,5 billion in 2028, based on these estimates and assumptions.

The total collection of personal income tax in the 2039/40 fiscal year is estimated at R1 814,0 billion. Every 1% income tax surcharge will deliver additional revenue of some R18,1 billion in 2039. A surcharge of 10% will therefore deliver additional revenue of some R181,4 billion in 2039, based on these estimates and assumptions.

Such a surcharge will place a comparatively heavy burden on low-income households just above the tax threshold, as their tax burden will increase in accordance with the surcharge. For purposes of calculating personal income tax to estimate the extra tax revenue raised, it is necessary to assume that a personal income tax surcharge will not negatively impact the continued willingness of taxpayers to work or diminish VAT collections. These assumptions seem somewhat unrealistic, as the underlying assumption is one of no Laffer Curve limitation/problem (explained elsewhere in this report) in South Africa. Such an assumption also disregards the negative tax buoyancy reported on occasion by the National Treasury.

Value-added Tax

South Africa's VAT rate is 15%, and the tax revenue from VAT in 2028 is estimated at some R606,5 billion. This implies that an increase of 1 percentage point in VAT will raise about R40,4 billion per annum in 2028.

Tax revenue from VAT in the 2039/40 fiscal year is estimated at some R1 151,3 billion. This implies that an increase of 1 percentage point in VAT will raise about R76,8 billion per annum in 2039.

Any increase in VAT might be problematic, following the previous experience when VAT was increased from 14% to 15%.[130] The perception is that a VAT increase impacts heavily on poor people. This perception persists despite findings by Woolard et al (2015) that VAT is "... slightly progressive. The fact that VAT is not regressive can be explained by the zero-rating of basic food items, as the poor tend to spend a greater percentage of their income on VAT-free items ...".[131] Despite this analysis by

[129] Inflated using a factor of 1,06 per annum consisting of 4,5% inflation and 1,5% GDP growth adjustments.

[130] See for instance Madia, T. 2018. Op cit.

[131] Woolard, I, Metz, R, Inchauste, G, Lustig, N, Maboshe, M and Purfield, C. (2015) *How much is inequality reduced by progressive taxation and government spending?* Economics 3x3. 28 October. Available at http://www.econ3x3.org/article/how-much-inequality-reduced-progressive-taxation-and-government-spending [Accessed on various dates].

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Woolard et al. (2015), the perception about progressivity of an increase in the VAT rate places a limitation on the ability of the South African government to raise the VAT rate. In addition, the pressure for more exclusions from VAT will increase as the VAT rate increases, with a concomitant erosion of the VAT base once more exemptions are granted. For purposes of calculating additional tax revenue from an increase in the VAT rate, it is assumed that no further exclusions will follow an increase in the VAT rate.

Payroll tax

Collections by the Unemployment Insurance Fund (UIF) can be used as a basis for the calculation of revenue that can be raised from a payroll tax. UIF contributions are raised at a rate of 1% on each of employees and employers, i.e. 2% in total, up to an annual income of R212 544. Over the 12 months to March 2023,[132] the UIF raised R23,7 billion, while collections grew by some 4,9% per annum since the 2016/17 fiscal year.[133] It is nevertheless assumed that UIF contributions will grow at the same rate as the nominal GDP over the long run. UIF contributions for 2028 (the 2028/29 fiscal year) are estimated at R33,8 billion after adjustment for inflation and economic growth. For 2039, the UIF contributions are estimated at R64,2 billion.

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If the current cap is retained for UIF contributions, taxable income above this cap can be a basis for a payroll tax. For this purpose, the total income that can be subjected to a payroll tax must be estimated. The *2024 Budget Review*[134] provides information that can be used for this purpose. The *2024 Budget Review* reports total taxable income for the 2024/25 fiscal year as R3 543,6 billion.[135] The basis on which UIF contributions are calculated differs marginally from total taxable income (for instance, the treatment of some allowances and exemptions). However, such differences are negligible for purposes of the calculations of the revenue that can be raised by introducing a payroll tax on income above R212 544 per annum.

A payroll tax of 2% (1% on employers and 1% on employees) calculated on total taxable income of R3 543,6 billion amounts to R70,9 billion in 2024/25 values. Estimated UIF collections of R25,6 billion in the 2024/25 fiscal year must be deducted to calculate the payroll tax that can be collected. This amounts to R45,3 billion (R70,8 billion minus R25,6 billion).

An adjusted estimate of income in 2028 from a payroll tax on the same basis shows a revenue estimate of R100,6 billion in 2028. However, the UIF raised on income below the level of R212 544 (estimated as R33,8 billion per annum in 2028) must be deducted to calculate the additional revenue that can be raised. This implies that additional revenue of R66,8 billion (R100,6 billion minus R33,8 billion) can be raised in 2028 by means of a payroll tax of 2% on income above R212 544. Adjusted for 2039, the extra revenue from this payroll tax is estimated at R126,8 billion per annum.

As is the case for other tax proposals discussed above, the assumption is also made in this instance that a payroll tax will not impact negatively on other tax receipts. Again, this is clearly too limiting an assumption, as a payroll tax will reduce company profits, personal taxable income and VAT receipts owing to lower personal disposable income. This aspect is addressed later in this chapter.

[132] Most-recent figure.

[133] Department of Labour. 2024. Unemployment Insurance Fund Annual Report 2024/2025 (UIF APP 2024-2025). Department of Labour: Pretoria. Available at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://static.pmg.org.za/UIF_APP_2024-25.pdf[Accessed on 15 October 2019].

[134] Ibid.

[135] This includes the income of taxpayers below the tax threshold of R79 000 taxable income per annum, although UIF is raised on this group.

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Medical tax credits

The South African government has a system of medical tax credits in respect of medical aid fund contributions and medical tax credits on out-of-pocket expenditure. In the *2024 Budget Review*[136], the relevant amounts are stated as follows:

Medical tax credits on contributions: R28,6 billion

Medical tax credits on out-of-pocket expenditure:R8,1 billion

Scrapping medical tax credits on contributions and medical tax credits on out-of-pocket expenditure with the full implementation of the NHI is an alternative that the government can use to raise additional revenue to pay for the NHI.

In the *2024 Budget Review,* medical tax credits and medical tax credits on out-of-pocket expenditure jointly amount to R36,7 billion for the 2024/25 fiscal year.[137] Adjusted to 2028 values, these credits amount to R46,3 billion. Adjusted to 2039, these credits amount to R87,9 billion.

Summary of proposals

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A calculation of combinations of revenue-raising options from the various tax proposals are summarised in various combinations in Table 16. These various combinations of increases in the different tax rates show possibilities for raising the estimated amount of R483,1 billion required for the funding gap of the NHI in 2028. Similarly, Table 16 shows various combinations of possible taxation increases for raising the estimated amount of R1 198 billion required for the funding gap of the NHI in 2039. The order of magnitude of the required increases shows beyond any doubt that raising this amount of tax will place a particularly heavy burden on the South African economy and consumers.

Table 16: Additional Revenue Sources for the South African Government to Fund an NHI Funding Gap of R483,1 billion in 2028

Personal income tax surcharge		
10% surcharge	**20% surcharge**	**31% surcharge**
95.5	191.0	295,7
Value-added tax		
+ 1 percentage point	**+ 2 percentage points**	**+ 3,5 percentage points**
40.3	80.6	142,1
Payroll tax		
2% on income above R212544	**2% on income above R212544**	**2% on income above R212544**
45,3	45,3	45,3
Medical aid tax credits already deducted in funding gap calculations		
Totals		
181,1	316.9	483,1

[136] Ibid. p122

[137] Ibid. p122.

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Table 17 provides combinations of options that can be used to fund the projected NHI shortfall of R483,1 billion in 2028. It can be restructured to show other combinations or to show how different amounts can be raised to fund the estimated shortfall in 2028 NHI funding, but the same principles will remain in play. The conclusion is that an extra funding requirement of R483,1 billion will place a heavy burden on the South African economy, equal to an increase of some 15% to 20% in total taxation estimated for 2028. The objective of raising the shortfall of R483,1 billion is achieved by a surcharge of 31% in personal income tax, an increase of 3,5 percentage points in VAT and a payroll tax of 2% on taxable income above R212 544 per annum.

The assumption that the extra personal income tax burden of 31% on each individual taxpayer (each taxpayer facing an extra tax burden of 31%), combined with a payroll tax and a VAT increase, will not have any impact on consumption and saving by individuals is clearly wrong. Funds to pay this extra tax will have to be sourced from either reducing consumption, reducing savings or a combination of both. Put differently: based on the 2024/25-tax tables, a person earning annual taxable income of R857 900 will pay an additional R77 889,98 per annum in tax, with a surcharge of 31 per cent. This amounts to an additional R6 490,83 per month income tax on a monthly taxable income of R71 491,67 (i.e., some 9,1%), on top of the current income tax burden of R20 938,17 per month (R251 258 per annum) that should be sourced by means of less consumption, less saving or a combination of both. This impact is assessed in more detail later in this chapter.

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Table 17: Additional Revenue Sources for the South African Government to Fund an NHI Funding Gap of R1 198 billion (R billion) in 2039

Personal income tax surcharge		
10% surcharge	**20% surcharge**	**38% surcharge**
181,4	363,0	687,8
Value-added tax		
+ 1 percentage point	**+ 2 percentage points**	**+ 4,0 percentage points**
76,8	153,6	307,2
Payroll tax		
2% on income above R212544	**3% on income above R212544**	**3% on income above R212544**
126,8	190,2	190,2
Medical aid tax credits already deducted in funding gap calculations		
Totals		
385,0	705,8	1185,2

Source: Own calculations

Table 17 provides combinations of options that can be used to fund the estimated NHI shortfall of R1 198 billion in 2039. It can be restructured to show other combinations or to show how different amounts

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can be raised to fund the estimated shortfall in NHI funding, but the same principles will remain in play. The conclusion is that an extra funding requirement of R1 198 billion will place a heavy (unbearable?) burden on the South African economy and South African taxpayers once NHI is fully implemented.

The underlying assumption used in this analysis, namely that increased taxes will not impact real economic activity (for instance, economic growth, company profits, other taxes) or behaviour (for instance, spending patterns, hours worked, emigration, etc.), should be borne in mind. This assumption is too limiting, with other revenue sources being placed in jeopardy owing to the tax increases that the South African government will have to implement to fund the NHI funding shortfall once it is fully implemented. At the same time, the impact of higher taxes or government spending on the inflation rate (e.g., as a result of an increase in VAT or demand pressure on price levels) is also not considered, but there is no doubt that a higher inflation rate will result in higher interest rates until the inflation rate returns to the target of 4,5% currently used by the SARB.

Second-round effects of tax proposals

A deeper analysis highlighting the possible second-round impact of these higher taxes calculated is done in this section. This analysis is limited to 2028, given the assumptions that had to be used, but a similar analysis can be done in respect of the analysis for 2039.

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The impact of the reduction in personal household expenditure, a higher VAT rate and a payroll tax on income above R212 544 on the domestic GDP will, to a degree, be offset by an increase in government expenditure on health care through the NHI. It is therefore necessary to calculate the impact of a reduction in household disposable income[138] and the stimulatory effect of the increase in government expenditure on health care through NHI.

However, a calculation of these aspects can only be based on current economic statistics. It cannot account for Laffer curve effects, i.e., a reduction in personal income taxes collected owing to an increase in the tax rate on income resulting in work hours substituted for leisure hours. As is reported elsewhere, South Africa had a negative experience in tax collection when a new marginal tax rate of 45% was introduced, thus showing a clear Laffer Curve effect.

The last increase in the marginal rate (from 41% to 45%) implied an increase of 4 percentage points, or 9,76%, in the maximum marginal tax rate. In the calculations above, an increase by means of a tax surcharge of 31% is suggested for full NHI implementation by 2028. At the lowest marginal rate of 18%, this implies an increase in the effective marginal rate to 23,58%. In the highest income tax bracket, this implies an increase in the marginal rate from 45% to 58,95%. This would raise South Africa's marginal tax rate to the second-highest in the world after the Ivory Coast (60%) and above Finland.[139]

Econometric models can be used to quantify the possible second-round effects of higher taxes and spending on economic performance. For this study, we work with time series data, which means that a time series econometric model is appropriate. The econometric modelling applied in this study is based on the Engel-Granger method,[140] in which long-term (cointegrated and *a priori* economic theoretically correct) and short-term error correcting ("ECM") components are combined to provide a final (holistic) model. The error term (equilibrium error) from the long-run model is used to link the long and short-run components. Although time series analysis is used heavily in econometric studies, it does present

[138] Household disposable income is equal to total household income minus direct taxation. Household disposable income can either be used for consumption or saving.

[139] World Population Review. n.d. *Highest Taxed Countries 2024*. https://worldpopulationreview.com/country-rankings/highest-taxed-countries

[140] See Enders W. (2004). Applied econometric time series. 2nd edit. Wiley, pp. 1-9; Stock, J.H and Watson M.M (2012) Introduction to econometrics. 3rd edit. Pearson, pp. 691-701

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specific problems, notably possible issues related to stationarity[141] properties of the data. In order to correct for this, all data used is checked using stationarity tests and used in an appropriately differenced format in the models.

Two econometric models are run. The first one considers household disposable income in which the impact of the taxation shocks (necessitated by the funding gap) is quantified. Then, a second model for GDP is used, in which the combined effects of changes in disposable income and government consumption expenditure are shown. The detailed specifications and estimated results are provided at the end of this chapter in Addendum 1 and 2.

Econometric model for household disposable income

The shock to disposable income is done by phasing in higher marginal personal income tax rates as well as higher value-added tax rates from 2025 to 2028, based on the estimates provided earlier in this chapter. See Table 18 for a summary of the phased-in percentages.

Table 18: Summary of PIT and VAT Shocks Applied

	PIT (Surcharge)	VAT (Percentage points)
2024	0	0
2025	2.5	1
2026	15	1
2027	24	2
2028	31	3.5

Source: Own calculations

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As discussed earlier in this chapter, it is necessary to make various assumptions regarding possible private medical contribution savings of households once NHI gets implemented. Uncertainties relate, amongst other things, to the behavioural finance of households and their elasticities. Given these aspects, private medical contributions are estimated and included at a rate of 50% in the model. For 2024, this amounts to some R147,6 billion. This amount is adjusted for (medical) inflation and then phased in linearly over the implementation period, i.e. 2025 to 2028. In essence, this "reduction" in medical aid contributions once NHI is fully implemented somewhat counters the negative economic impact of the taxation hikes. This provides a more comprehensive picture of the combined impact of these two effects on household finances in a fully phased-in NHI.

As far as the impact on household disposable income is concerned, we estimate a **real** decline starting at R63,8 billion in 2025 and increasing to - R364,0 billion in 2028 (see Table 19). For 2028, this amounts to a -4,3% y/y decline. The severity of this contraction becomes evident when comparing it to the previous large contraction of -5,1% recorded in 2020 during the Covid-19 lockdown.

Using **nominal values,** this effectively means that in order to fund the 2028 shortfall of R483,1 billion (as calculated earlier in this chapter), the risk is that household disposable income could drop by as much as R500,7 billion – that is a shock comparable to the Covid-19 lockdown and clearly an irrational decision.

[141] In short, stationarity can be defined as a time series for which the mean and variance do not vary systematically over time. See for instance Gujarati, D.N, & Porter, D.C. (2009). Basic Econometrics. Fifth edition. McGraw-Hill International Edition. p. 760-762

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Table 19: Impact of PIT and VAT Shocks on Household Disposable Income

	Change in disposable income (Real) R billion	Change in disposable income (Nominal) R billion
2024	R0.0	R0.0
2025	-R63.8	-R76.9
2026	-R84.7	-R106.8
2027	-R185.1	-R243.6
2028	-R364.0	-R500.7
Sum	-R697.6	-R928.0

Source: Own calculations

Econometric model for economic growth ("GDP")

To quantify the growth impact, a second model was run using, among others, household disposable income and government consumption expenditure as explanatory variables. In this case, the results from the first model (i.e. for disposable income) are used as input (forecast values) for GDP. Government consumption expenditure (G) is hypothesised to have a stimulatory impact on GDP and to forecast (G), we assume a nominal growth rate of 6% per annum (i.e. 1.5% as for GDP + 4.5% inflation) and, in addition, the values of the estimated funding gaps are added for each year.

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The results indicate that the dampening effect of lower disposable income will far outweigh the consumption stimulus from an increase in government expenditure. Compared to a base case forecast, real GDP growth for 2025 is expected to increase by a meagre 0,1% y:y compared to an expected rise of 1,3% in the base case scenario. From 2027, annual contractions are expected, which become increasingly larger as the increased tax burden takes effect, with the 2028 figure indicating a -4,3% decline (See Table 20).

Table 20: Estimated Impact of Phased-in NHI on GDP Growth (% year-on-year)

	GDP (Base case)	GDP (NHI scenario)
2023	0.5%	0.5%
2024	1.2%	1.2%
2025	1.3%	0.1%
2026	1.3%	0.2%
2027	1.3%	-2.0%
2028	1.3%	-4.3%

Source: Own calculations

This econometric analysis clearly shows that the tax increases necessary to fund the funding shortfall of NHI by 2028, once fully implemented, will result in a decline in the overall economic performance of South Africa. In nominal terms, the 2028 GDP value is expected to be around R1,01 trillion less than the baseline forecast scenario. Put differently, the phased-in shocks will result in the South African economy being around 10,7% smaller in 2028 compared to the baseline model.

Concluding remarks

The aim of this chapter is to estimate the costs of NHI and to determine possible funding options using the existing South African tax base. Cost estimates of the funding requirement (gap), using a unit costs approach of our own and other institutions' estimates, indicate that to implement NHI for 2024 will require an amount of between 16,7% and 50,3% of total consolidated government expenditure.

Using a phased-in approach, we find that the funding gap for 2028 is calculated as R483,1 billion, or some 16,6% of total budgeted consolidated government expenditure, based on the government's estimates of 2010 (the last "official" estimate). This will increase the budget deficit from the current

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budgeted level of 3,6% to around 8,9%. To attempt to run a deficit of this size indefinitely will clearly be fiscally unsustainable.

In addition, the study looked at a 15-year phased-in period that is to be fully implemented by 2039. On this basis, the funding gap for 2039 is calculated as R1 198,4 billion, or some 233% of estimated government health expenditure in the outer year. The impact of this was not assessed in an econometric model, as the results shown with respect to the 2028 values clearly show the negative impact on South African economic activity.

To fund the 2028 gap would require, amongst other things, a 31% surcharge on personal income tax as well as a 2,5-percentage point rise in VAT. For 2039, these rates are even higher as the surcharge on PIT climbs to 38% while VAT rises by 4,0 percentage points to 19,0%. The funding requirement of the gap by 2039 also requires an increase in the payroll tax on income above R212 544 to 3%.

Econometric modelling is used to quantify the second-round effects of the proposed tax changes. Findings include that to fund the 2028 shortfall of R483,1 billion (as calculated earlier in this chapter), the risk is that nominal household disposable income could drop by as much as R500,7 billion – clearly an irrational decision. By further modelling the impact of this on economic growth, this study finds that the dampening effect of lower disposable income outweighs the consumption stimulus from an increase in government expenditure. In addition, this risk pushes the economy close (2025 and 2026) or into recession (2027 to 2028) during the period in which the shocks are applied.

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Addendum to Chapter 4 (Econometric model specifications)

Addendum 1

Econometric model for household disposable income

Long run equation

Dependent Variable: LRYD
Method: Least Squares
Date: 11/12/24 Time: 14:08
Sample: 1990 2023
Included observations: 34

Variable	Coefficient	Std. Error	t-Statistic	Prob.
LPIT_P	-0.176759	0.112597	-1.569840	0.1273
LVAT_P	-0.015952	0.070743	-0.225492	0.8232
LCPI	0.242843	0.038539	6.301141	0.0000
LRM3	0.370834	0.041266	8.986365	0.0000
C	9.133889	0.865104	10.55814	0.0000

R-squared	0.994648	Mean dependent var	14.81714
Adjusted R-squared	0.993909	S.D. dependent var	0.335902
S.E. of regression	0.026214	Akaike info criterion	-4.309964
Sum squared resid	0.019929	Schwarz criterion	-4.085499
Log likelihood	78.26939	Hannan-Quinn criter.	-4.233415
F-statistic	1347.312	Durbin-Watson stat	1.182618
Prob(F-statistic)	0.000000		

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Short run (ECM) equation

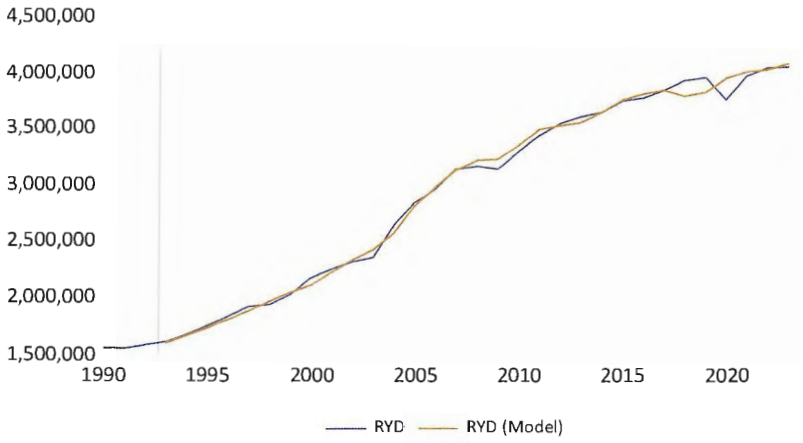
Dependent Variable: D(LRYD)
Method: Least Squares
Date: 11/12/24 Time: 14:42
Sample (adjusted): 1993 2023
Included observations: 31 after adjustments

Variable	Coefficient	Std. Error	t-Statistic	Prob.
D(LRYD(-2))	-0.248257	0.149023	-1.665896	0.1082
LINFL(-1)	-0.016699	0.010931	-1.527656	0.1392
D(LRM3)	0.305140	0.097682	3.123818	0.0045
LVAT_P	-0.361644	0.154269	-2.344248	0.0273
RES_RYD(-1)	-0.576186	0.161284	-3.572488	0.0015
C	1.012534	0.418251	2.420879	0.0231

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R-squared	0.602709	Mean dependent var	0.030015
Adjusted R-squared	0.523251	S.D. dependent var	0.029415
S.E. of regression	0.020310	Akaike info criterion	-4.783407
Sum squared resid	0.010313	Schwarz criterion	-4.505861
Log likelihood	80.14280	Hannan-Quinn criter.	-4.692934
F-statistic	7.585241	Durbin-Watson stat	2.349140
Prob(F-statistic)	0.000188		

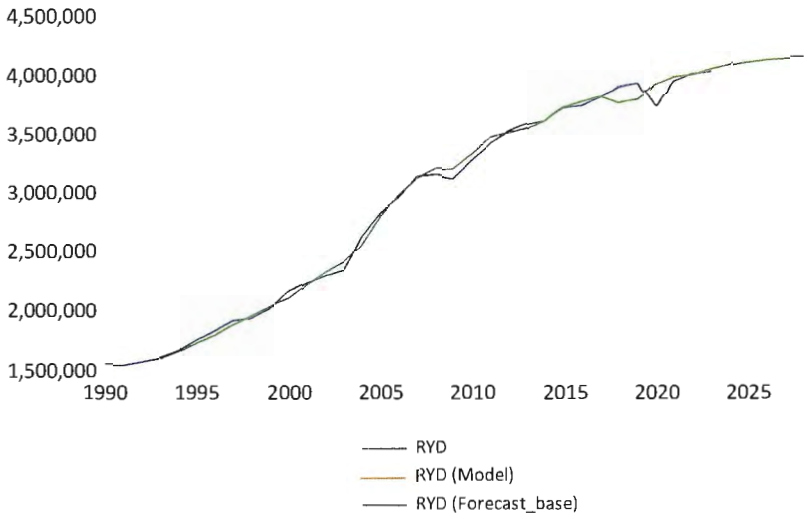
Model output



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Forecast: Base case

Assumptions (2024-2028):
CPI and Inflation: increase of 4.5% per year
RM3: increase of 1.5% per year (used as proxy for GDP, thus same assumptions apply)
PIT: Marginal rate remain at 45.0%
VAT: Rate remain at 15.0%

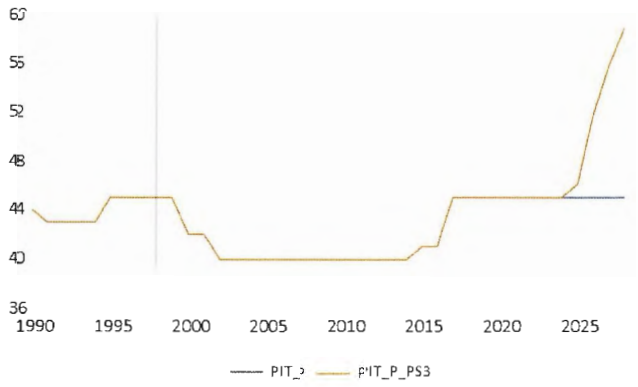


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Shocks applied	PIT (Surcharge)	VAT (Percentage points)
2024	0	0
2025	2.5	1
2026	15	1
2027	24	2
2028	31	3.5

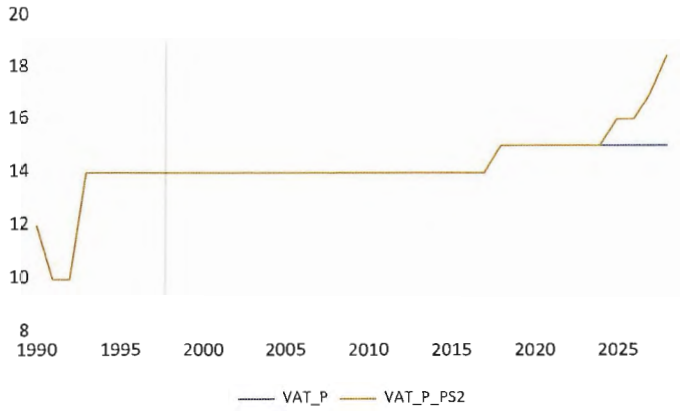
Note: The shocks were applied in a phased in approach based on the funding gap calculated for each year. Payroll taxes were included in the calculation but not explicitly modelled.

PIT: surcharges



VAT: 3.5 percentage points hike applied in 2028

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Model description

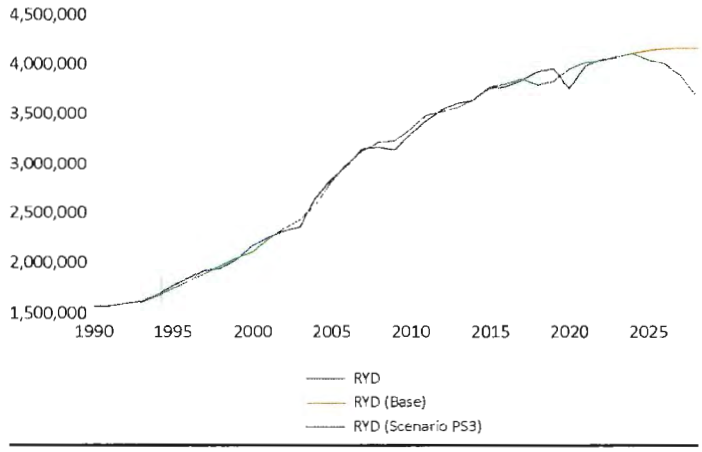
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RES_RYD = LRYD - (- 0.176758758495 * LOG(PIT_P_PS3) - 0.0159519803857 * LOG(VAT_P_PS2) + 0.242842621861 * LCPI + 0.37083351232 * LRM3 + 9.13388901886)

LRYD = - 0.2482569008 * D(LRYD(-2)) - 0.0166992346937 * LINFL(-1) + 0.305140178503 * D(LRM3) - 0.361643918605 * LOG(VAT_P_PS2) - 0.576186495118 * RES_RYD(-1) + 1.01253428182 + lryd(-1)

RYD = EXP(LRYD)

Model output: forecast with taxation shocks



	RYD	RYD_1	RYD_PS3
1990	1574421		
1991	1572357		
1992	1604287		
1993	1630208	1619367	1619367
1994	1692052	1677865	1677865
1995	1774297	1751203	1751203
1996	1853749	1825266	1825266
1997	1941352	1907894	1907894
1998	1959860	1982521	1982521
1999	2044342	2059577	2059577
2000	2184128	2124268	2124268
2001	2265529	2243166	2243166
2002	2327006	2350794	2350794
2003	2367173	2436293	2436293
2004	2662002	2586438	2586438
2005	2852210	2831136	2831136
2006	2978830	2997113	2997113
2007	3150443	3140340	3140340
2008	3171235	3223703	3223703
2009	3144529	3237543	3237543
2010	3301915	3359764	3359764
2011	3447316	3501420	3501420
2012	3551945	3534190	3534190
2013	3614834	3567362	3567362
2014	3648048	3649178	3649178
2015	3759801	3769631	3769631
2016	3788526	3819811	3819811
2017	3854087	3857785	3857785
2018	3942160	3806189	3806189
2019	3968654	3837182	3837182
2020	3767183	3964594	3964594
2021	3990820	4023854	4023854
2022	4056798	4043374	4043374
2023	4067930	4093942	4093942
2024		4126522	4126522
2025		4151079	4087301
2026		4165913	4081172
2027		4174011	3988937
2028		4179631	3815670

% y:y	RYD	RYD_1	RYD_PS3
1990			
1991	-0.1%		
1992	2.0%		
1993	1.6%		
1994	3.8%	3.6%	3.6%
1995	4.9%	4.4%	4.4%
1996	4.5%	4.2%	4.2%
1997	4.7%	4.5%	4.5%
1998	1.0%	3.9%	3.9%
1999	4.3%	3.9%	3.9%
2000	6.8%	3.1%	3.1%
2001	3.7%	5.6%	5.6%
2002	2.7%	4.8%	4.8%
2003	1.7%	3.6%	3.6%
2004	12.5%	6.2%	6.2%
2005	7.1%	9.5%	9.5%
2006	4.4%	5.9%	5.9%
2007	5.8%	4.8%	4.8%
2008	0.7%	2.7%	2.7%
2009	-0.8%	0.4%	0.4%
2010	5.0%	3.8%	3.8%
2011	4.4%	4.2%	4.2%
2012	3.0%	0.9%	0.9%
2013	1.8%	0.9%	0.9%
2014	0.9%	2.3%	2.3%
2015	3.1%	3.3%	3.3%
2016	0.8%	1.3%	1.3%
2017	1.7%	1.0%	1.0%
2018	2.3%	-1.3%	-1.3%
2019	0.7%	0.8%	0.8%
2020	-5.1%	3.3%	3.3%
2021	5.9%	1.5%	1.5%
2022	1.7%	0.5%	0.5%
2023	0.3%	1.3%	1.3%
2024		0.8%	0.8%
2025		0.6%	-1.0%
2026		0.4%	-0.1%
2027		0.2%	-2.3%
2028		0.1%	-4.3%

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Addendum 2

Econometric model for economic growth (GDP)

Long run equation

Dependent Variable: LRGDP
Method: Least Squares
Date: 11/13/24 Time: 11:11
Sample: 1990 2023
Included observations: 34

Variable	Coefficient	Std. Error	t-Statistic	Prob.
LRYD	1.209945	0.071659	16.88481	0.0000
LRG	0.013271	0.058007	0.228783	0.8206
LCPI	-0.089634	0.025482	-3.517548	0.0014
C	-2.504428	0.555936	-4.504885	0.0001

R-squared	0.998059	Mean dependent var	15.26273
Adjusted R-squared	0.997864	S.D. dependent var	0.360364
S.E. of regression	0.016653	Akaike info criterion	-5.242323
Sum squared resid	0.008320	Schwarz criterion	-5.062751
Log likelihood	93.11949	Hannan-Quinn criter.	-5.181084
F-statistic	5140.989	Durbin-Watson stat	1.216814
Prob(F-statistic)	0.000000		

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Short run (ECM) equation

Dependent Variable: D(LRGDP)
Method: Least Squares
Date: 11/13/24 Time: 11:20
Sample (adjusted): 1991 2023
Included observations: 33 after adjustments

Variable	Coefficient	Std. Error	t-Statistic	Prob.
D(LRG)	0.169031	0.081044	2.085666	0.0466
D(LRYD)	0.884073	0.109464	8.076406	0.0000
D(LRM3)	0.091387	0.052510	1.740369	0.0932
LPRIME(-1)	-0.001191	0.007399	-0.160906	0.8734
RES_GDP(-1)	-0.439732	0.174849	-2.514918	0.0182
C	-0.001971	0.018508	-0.106519	0.9160

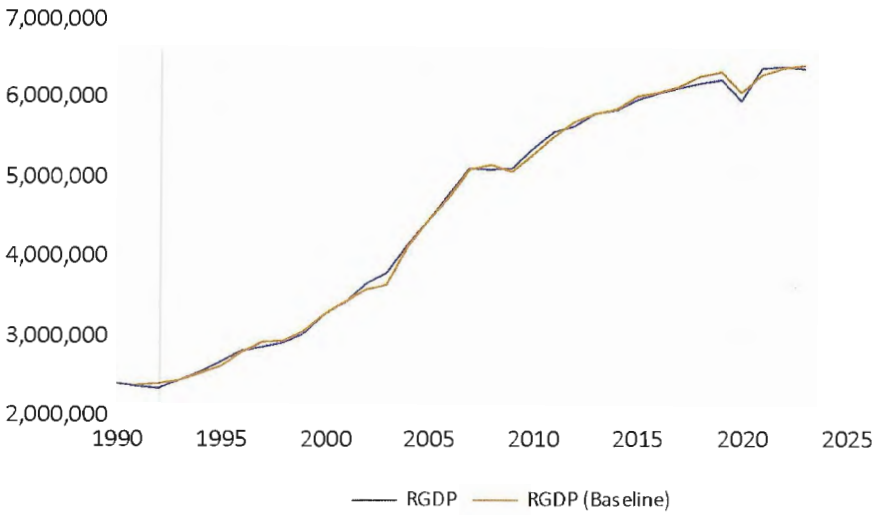
R-squared	0.838164	Mean dependent var	0.029552
Adjusted R-squared	0.808195	S.D. dependent var	0.030465
S.E. of regression	0.013342	Akaike info criterion	-5.632808
Sum squared resid	0.004806	Schwarz criterion	-5.360716
Log likelihood	98.94133	Hannan-Quinn criter.	-5.541257
F-statistic	27.96718	Durbin-Watson stat	2.110822
Prob(F-statistic)	0.000000		

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Model description and fit:

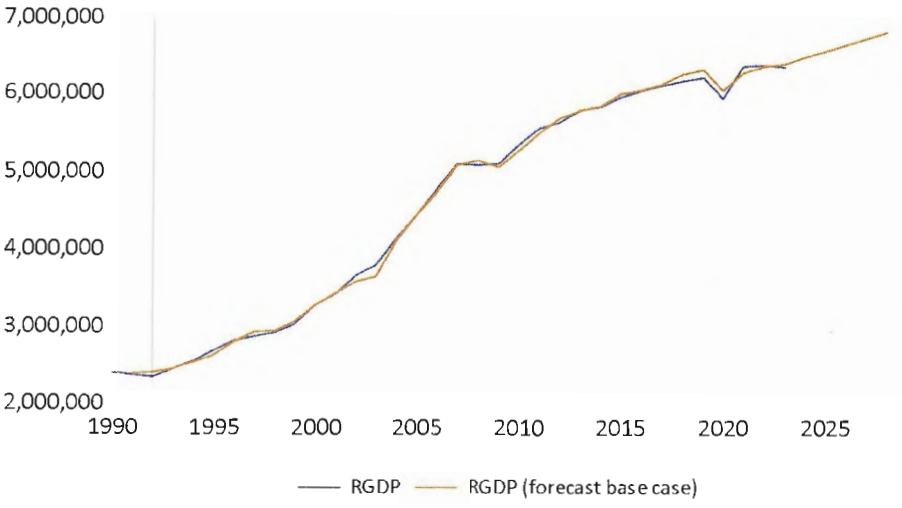
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RES_GDP = LRGDP - ( 1.20994506184 * LRYD + 0.0132709250203 * LRG - 0.0896340000037 *
LCPI - 2.50442770218)
LRGDP = 0.169031217018 * D(LRG) + 0.884072592401 * D(LRYD) + 0.0913870819486 * D(LRM3)
- 0.0011905921421 * LPRIME(-1) - 0.439731524281 * RES_GDP(-1) - 0.00197148002628 +
LRGDP(-1)
RGDP = EXP(LRGDP)
```



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Model output: forecast base case

Assumptions (2024-2028):
CPI: increase of 4.5% per year
M3: increase of 6.0% per year (nominal = 1.5 + 4.5) (used as proxy for GDP, thus same assumptions apply)
NYD: increase of 6.0% per year
G: increase of 6.0% per year
Prime: Remain at 11.5%

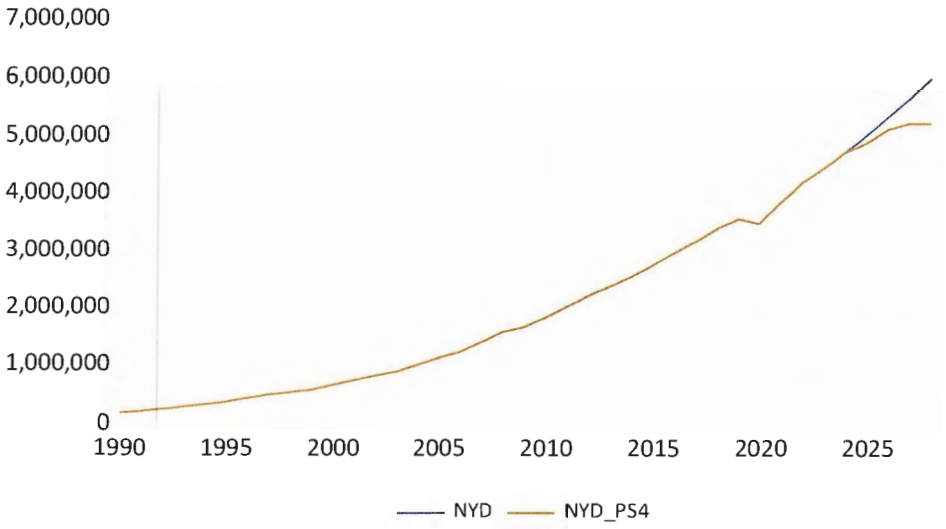


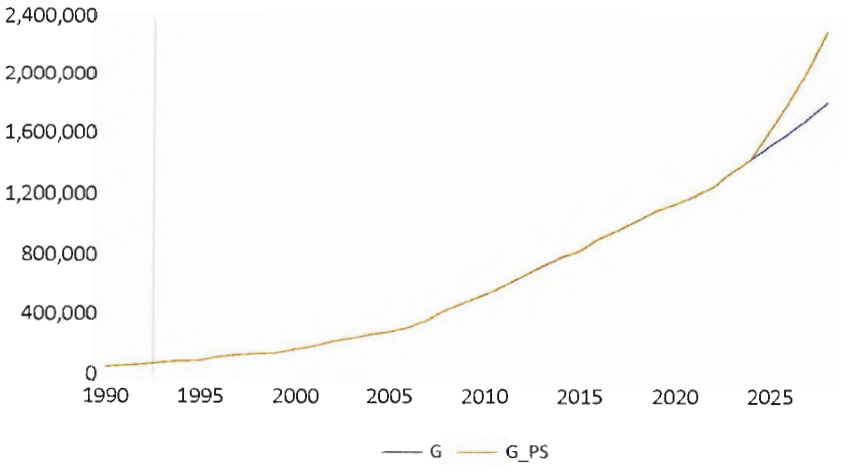
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Shocks applied	NYD	NYD_PS	G	G_PS
2024	R4 760 095	R4 760 327	R1 440 659	R1 440 659
2025	R5 045 701	R4 927 260	R1 527 098	R1 619 129
2026	R5 348 443	R5 141 266	R1 618 724	R1 820 497
2027	R5 669 350	R5 251 201	R1 715 848	R2 046 918
2028	R6 009 511	R5 249 145	R1 818 798	R2 301 937
Assumptions	6% (nom GDP)	As per disposable income model	6% (nom GDP)	6% plus additional revenue (funding gap)

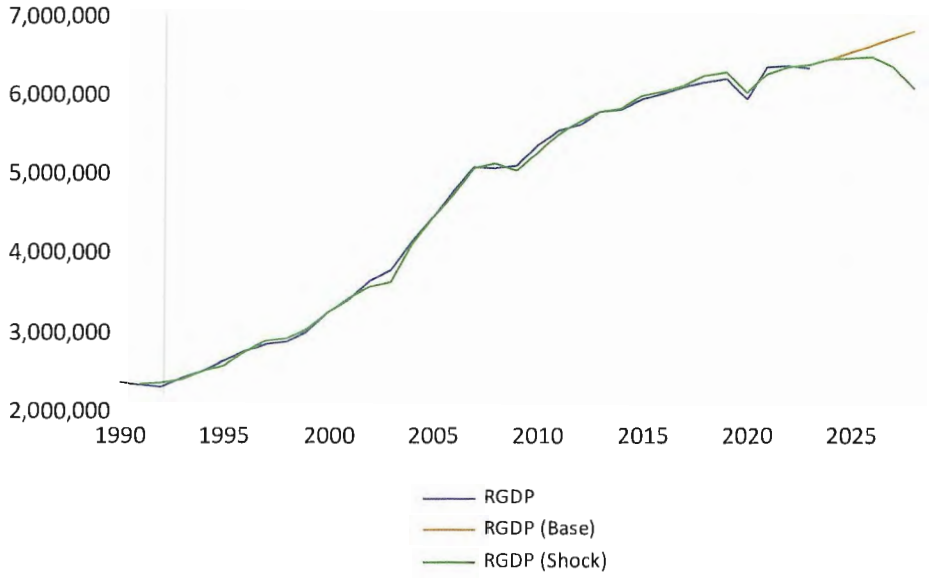
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Model description and fit (shocks applied):

```
RES_GDP  = LRGDP  - ( 1.20994506184  * LOG(RYD_PS)  + 0.0132709250203  * LOG(RG_PS3)  -
0.0896340000037  * LCPI  - 2.50442770218)
LRGDP  = 0.169031217018  * D(LOG(RG_PS))  + 0.884072592401  * D(LOG(RYD_PS3))  +
0.0913870819486  * D(LRM3)  - 0.0011905921421  * LPRIME(-1)  - 0.439731524281  * RES_GDP(-1)
- 0.00197148002628  + LRGDP(-1)
RGDP  = EXP(LRGDP)
```



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Chapter Five

Conclusion

This report focuses on the economic and fiscal aspects of the NHI Act once fully implemented. The analysis shows that the NHI is still shrouded in a great deal of uncertainty, for example, the time frame for full implementation or the expected cost of a fully implemented NHI, because the South African government has not provided any updated estimates of these since 2010. This uncertainty extends to the tax increases that will be required to fund a fully implemented NHI and the possible reduction in the supply of medical staff in a system under government control, for example, emigration.

The principles of the NHI Act are universal access to health care services; comprehensive coverage of health care services (with some anticipated exclusions); protection from the financial risk of paying for health care services (services will be free at the point of care) and the NHI as the single purchaser and single payer of health care services. Importantly, the Act states that when the NHI has been fully implemented, medical schemes may only offer complementary coverage for services not reimbursed by the Fund.

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This report shows that South Africa's economic performance has seriously declined in recent years, which puts the adoption and implementation of any new government programmes by the South African government in serious jeopardy. South Africa experiences persistently low economic growth, with annual population growth exceeding annual economic growth. Any scope in government revenue and finances should rather be used to contain the government's debt burden and the interest payable on the debt burden, as these aspects impact negatively on South Africa's international credit risk rating.

Based on the recent performance of the economy, the anticipated global economic environment and current and planned economic policies, the South African economy will continue to suffer low economic growth. For the foreseeable future, a sustained annual economic growth rate of even 2,0% per annum is beyond the ability of the economy. The country's short-term and long-term growth potential is at about 1,5% per annum.

Based on estimated 2028 values for NHI fully phased in, this report shows an annual funding gap (based on the government's estimates of 2010 and the 2015 and 2017 White Papers) of some R483,1 billion. This amounts to some 16,6% of total budgeted consolidated government expenditure. Expenditure of this magnitude will increase the budget deficit from the current level of 3,6% to around 8,9%, which is fiscally unsustainable.

The report also considered a 15-year phase-in period to 2039. For 2039, the funding gap is calculated as R1 198,4 billion, or some 233% of estimated government health expenditure in that year. The impact of this was not assessed in an econometric model, as the results shown with respect to the 2028 values clearly show the negative impact on South African economic activity. To fund the 2028 gap would require a 31% surcharge on personal income tax, a 2,5 percentage point increase in VAT, and a payroll tax on income above R212 544 per annum.

Econometric modelling is used to quantify the second-round effects of these proposed tax changes on South Africa's economic performance in 2028. The econometric model shows that annual nominal household disposable income could drop by as much as R500,7 billion per annum owing to a higher tax burden on households. A further result shown by the econometric model is that the dampening effect of lower disposable income will far outweigh the consumption stimulus from an increase in government expenditure.

This econometric analysis shows that the tax increases necessary to fund the funding shortfall of NHI by 2028, once fully implemented, will result in a decline in overall economic performance of South Africa.

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In nominal terms, GDP in 2028 is expected to be around R1,01 trillion less than the baseline forecast scenario that excludes the extra tax burden to fund a fully implemented national health insurance. Put differently, the cumulative effect of a phased-in NHI by 2028 will result in the South African economy being around 10,7% smaller in nominal terms compared to the baseline model without NHI.

With continued population growth and other demands on the economy, a decline in economic activity owing to the tax burden required to fund a fully implemented NHI is clearly not affordable currently or in South Africa's longer-term economic future.



BUSINESS REPORT ECONOMY

SA must hike borrowing or go over fiscal cliff by March 2024, warns Godongwana

Siphelele Dludla | Published 1 year ago

4min



Finance Minister Enoch Godongwana said the government needed to increase its borrowing to prevent drastic reductions in expenditure. Picture: Phando Jikelo/African News Agency(ANA)

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Finance Minister Enoch Godongwana has issued a stark warning that South Africa could go over the fiscal cliff by March 2024 if it does not make additional borrowings as the government finances have severely deteriorated on the back of rising expenditure and dwindling tax revenues due to weak economic growth.

Delivering the keynote address at the annual Kgalema Motlanthe Foundation Investment Growth Forum on Friday night, Godongwana explained a catch-22 situation in which the country found itself.

Godongwana said the government needed to increase its borrowing to prevent drastic reductions in expenditure.

"The first thing we've done is to manage this in a more prudent way through a combination of cutting expenditure and bumping up borrowing," Godongwana said.

"We've been forced to bump up borrowing a bit more than we have predicted in the year because if we didn't do that the [budget] cuts would have been more massive. So we have to do a combination of both."

However, the finance minister warned of the current state of government borrowing, saying that imminent debt repayments could deplete the fiscus by the end of this financial year.

Godongwana said debt servicing costs alone were averaging a massive R366 billion per year and exceeded the annual budget allocation to the police department.

"If you see that the police budget in this current financial year is R111bn, health is about R253bn, education is about R306bn, debt service costs are the single biggest item sitting at R366bn," he said.

Godongwana further cautioned that the government could soon face a critical shortage of funds as several government debt instruments were maturing this year.

"What complicates your problem is that not only you've got debt service costs [but] you have to redeem old debt. This year alone the amount we are going to redeem is such that if we don't do anything, we won't have cash by the end of March, starting from December," he said.

"The problem with debt is the capacity of the economy to service debt. Our ability to service debt is becoming constrained and therefore we need to do something about it."

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Real gross domestic product (GDP) growth is expected to be slightly lower than the National Treasury's February forecast of 0.9% and 1.5% in 2023 and 2024, respectively.

This is due to uncertainties surrounding load shedding, transport bottlenecks, fading global growth momentum, subdued international commodity prices and the slowdown in domestic demand due to higher interest rates.

Economists are expecting a tax revenue shortfall of around R47bn in 2023/24 and R156bn over the Medium-Term Expenditure Framework (MTEF) period, from the February 2023 budget estimates.

The consolidated budget deficit is also expected to widen to 5.5% of GDP in 2023/24, much higher than the 4% projected in the National Budget.

Nedbank economist Isaac Matshego said they were forecasting aggregate expenditure growth of 6% in nominal terms in 2023/24, overshooting the 3.4% projected in Budget 2023, as a result of higher-than-budgeted public sector wage bill and social transfers.

There is a big push to expand the Social Relief of Distress (SRD), which accounts for R36bn from the fiscus, to a permanent Basic Income Grant (BIG).

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"The rapid increase in debt does not only threaten the sovereign's debt sustainability. Higher debt will push the debt service costs even higher when South Africa already has one of the highest debt service costs compared with its emerging market peers," Matshego said.

"National Treasury faces the challenging task of ensuring that the higher public sector wage bill and debt service costs do not significantly widen the budget deficit and push the public debt stock even higher.

"To achieve this, the government will have to contain spending growth in most areas and cut spending in non-essential areas."

North West University's Business School economist Professor Raymond Parsons said government bailouts to struggling state-owned enterprises remained a persistent problem.

Transnet recently asked the government for R100bn financial support to implement its turnaround plan.

Parsons said a long-range fiscal plan was, therefore, now needed to steadily wind down spending and debt and bring them under control in a way that establishes clear priorities for the future.

"Fiscal policy will inevitably have to be pragmatic and realistic to deliver sensible trade-offs in order to project a credible medium-term budget that offers more predictability and certainty," Parsons said.

This fiscal balancing act will, therefore, require a skilful but level-headed revised Budget 'mix' and projections.

"The forthcoming medium-term Budget must be a credible fiscal plan that does enough in challenging economic circumstances to placate nervous markets and not allow excessive borrowing to 'crowd out' the private sector.

"It is apparent that, whatever other steps may be needed to 'balance the books', all roads eventually run through inclusive growth if South Africa wants fiscal sustainability in the longer term."

BUSINESS REPORT

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FRIDAY, OCTOBER 17, 2025
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KRIEK WASSENAAR & VENTER ING
PROKUREURS - ATTORNEYS

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Your ref:

23 September 2025

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Madam

MINISTER OF HEALTH & ANOTHER / PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA & OTHERS

CASE NO: 2025-125411

1. We refer to the aforementioned matter and the current application for consolidation and stay of proceedings, issued by your client under case number 2025-125411.

2. Our client has reviewed the application and has instructed us to agree to the joinder of our client's application under case number 2025-147065 to the aforementioned application for consolidation and stay of proceedings. The implication is that your clients are not required to bring a further application for our joinder to the application under case number 2025-125411.

3. However, this agreement does not restrict our client's right to oppose the application for consolidation and stay of proceedings, and our client will be making its decision regarding its opposition shortly.

Yours faithfully,

KRIEK WASSENAAR & VENTER ING
Péter Wassenaar – Director
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Your ref:

17 October 2025

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Madam

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MINISTER OF HEALTH & ANOTHER / PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA & OTHERS –

CASE NO: 2025-125411

1. We refer to the aforementioned matter, the current application for consolidation and stay of proceedings, as well as the proposed formalistic amendments to the notice of motion as received by counsel for the applicants.

2. Our client has reviewed the proposed amendments to the notice of motion and has agreed thereto. For the avoidance of doubt, we attach a copy of the notice of motion containing the amendments hereto as annexure **A**.

3. We trust you find the above in order.

Yours faithfully,

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A

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

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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

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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

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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

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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

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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

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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

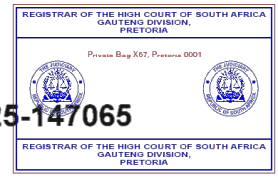
And in re:

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

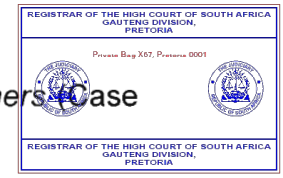
MINISTER OF HEALTH	First Respondent
MINISTER OF FINANCE	Second Respondent
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Third Respondent
SPEAKER OF THE NATIONAL ASSEMBLY	Fourth Respondent
CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES	Fifth Respondent

---

NOTICE OF MOTION

TAKE NOTICE THAT the applicants will apply on a date to be determined in case management by the Honourable Deputy Judge President for an order in the following terms:

1. The following applications are stayed and the time periods for the filing of further process are suspended:



1.1. *Solidarity Trade Union v the Minister of Health and Others* (Case No 2024-057449);

1.2. *Hospital Association of South Africa v the Minister of Health and Others* (Case No 2025-020969);

1.3. *The South African Medical Association NPC v the Minister of Health and Others* (Case No 2025-045340);

1.4. *Health Funders Association v the Minister of Health and Others* (Case No 2025-083348);

1.5. *South African Private Practitioners Forum v the President of the Republic of South Africa and Others* (Case No 2024-11209) to the extent that the applicant therein succeeds in obtaining leave to amend and effecting the amendment in its notice of intention to amend dated 13 June 2025;

1.6. *South African Private Practitioners Forum v Minister of Health and Others* (case 2025-134493); and

1.7. *Sakeliga NPC v Minister of Health and Others* (case 2025-147065).

2. The orders in paragraph 1 above are effective pending a final decision by the Constitutional Court in all of, or which have the effect of disposing of all of –

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2.1. the President of the Republic's and the Minister of Health's applications in terms of section 167(6)(b) of the Constitution for leave to appeal directly to the Constitutional Court against the judgment of Twala J dated 6 May in in *Board of Healthcare Funders of Southern Africa NPC v the President of the Republic of South Africa and Others* (Case No 2024-058172) ("**the BHF HC application**") and *South African Private Practitioners Forum v the President of the Republic of South Africa and Others* (Case No 2024-11209) ("**the SAPPF HC application**");

2.2. the President and the Minister's direct applications to the Constitutional Court in terms of section 167(6)(a) of the Constitution for relief pertaining to the reviewability of the President's decision to assent to and sign the NHI Act, the

applicability of Rule 53, and the question whether or not the President is obliged to make available the record of his decision;

2.3. any appeals for which leave is granted pursuant to paragraph 2.1;

2.4. the conditional application to the Constitutional Court of the Board of Healthcare Funders ("**BHF**") in terms of section 167(6)(a) of the Constitution for the review of the President's decision to assent to and sign the NHI Act in *Board of Healthcare Funders NPC v the President of the Republic of South Africa and the Minister of Health* (CCT254/24) ("**the BHF CC application**");

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2.5. the conditional application to the Constitutional Court of the South African Private Practitioners Forum ("**SAPPF**") in terms of section 167(4)(e) of the Constitution for the review of the President's decision to assent to and sign the NHI Act and SAPPF's conditional application for leave to intervene in the BHF CC case in *Southern African Private Practitioners Forum v the President of the Republic of South Africa and Another* ("**the SAPPF CC application**");

2.6. the application by BHF in the Constitutional Court in the *Board of Healthcare Funders NPC v Speaker of the National Assembly and 23 Others* ("**the second BHF CC application**");

2.7. the application by the Premier of the Western Cape in the Constitutional Court in *Premier of the Western Cape v the Chairperson of the National Council of Provinces and 11 Others*;

2.8. in the event of the Constitutional Court declining to grant leave to appeal directly or to hear the direct access applications referred to in paragraphs 2.1 and 2.2 above, the applications for leave to appeal to Twala J in the BHF HC case and SAPPF HC case, and, should he refuse leave, any applications for leave to appeal in terms of section 17(2)(b) of the Superior Courts Act No. 10 of 2013 and any appeals heard pursuant thereto; and

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2.9. any applications for leave to appeal to the Constitutional Court against a decision of the Supreme Court of Appeal and any appeals heard pursuant thereto.

3. The permanent withdrawal by an applicant of any of the applications or appeals referred to in paragraph 2 shall be considered a final disposal of the application.

4. Notwithstanding the final decision or disposal of the proceedings referred to in paragraphs 2.1 to 2.8, the stay of the proceedings in insofar as it pertains to the application in *South African Private Practitioners Forum v Minister of Health and Others* (case 2025-134493), referred to in

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paragraph 1.6 above, is further extended until the withdrawal (accompanied by a tender of the applicants' costs), or the final adjudication in its entirety of *South African Private Practitioners Forum v the President of the Republic of South Africa and Others* (Case No 2024-11209), referred to in paragraph 1.5 above.

5. The Minister's undertaking that unless and until the events in paragraph 2 (as read with paragraph 3) above have been fulfilled, the Minister of Health shall not promulgate regulations in the Gazette in terms of section 33 of the National Health Insurance Act, 2023 (read with section 55(1)(z)) determining that the National Health Insurance has been fully implemented, is noted.

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6. Subject to paragraph 4 above, upon the conditions in paragraphs 2 and 3 above being fulfilled:

6.1. the order in paragraph 1 shall cease to apply and the stay of proceedings shall be uplifted;

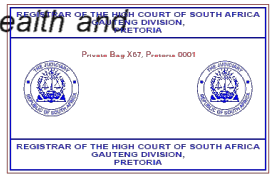
6.2. the applicants herein (the Minister of Health and Director General of the Department of Health) shall inform the Deputy Judge President in writing thereof, who shall, to the extent necessary, determine the timelines for further filing of process in case management.

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7. The following applications are consolidated in terms of Rule 11 of the Uniform Rules of Court:

7.1. *Solidarity Trade Union v the Minister of Health and Others* (Case No 2024-057449);

7.2. *Hospital Association of South Africa v the Minister of Health and Others* (Case No 2025-020969);



7.3. *The South African Medical Association NPC v the Minister of Health and Others* (Case No 2025-045340);

7.4. *Health Funders Association v the Minister of Health and Others* (Case No 2025-08334);

7.5. *South African Private Practitioners Forum v the President of the Republic of South Africa and Others* (Case No 2024-11209) to the extent that the applicant therein succeeds in obtaining leave to amend and effecting the amendment in its notice of intention to amend dated 13 June 2025;

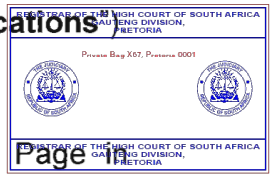
7.6. *South African Private Practitioners Forum v Minister of Health and Others* (case 2025-134493); and

RVL

7.7. *Sakeliga NPC v the Minister of Health and Others* (Case No 2025-147065).

8. The consolidation in paragraph 6 above shall apply to the following extent:

8.1. A consolidated hearing shall be held in respect of the applications in paragraphs 6.1 to 6.6 above ("**the consolidated applications**").



8.2. The Registrar shall create a consolidated Caselines Page 11 respect of the consolidated applications.

8.3. The respondents in the consolidated applications shall be entitled to:

8.3.1. treat the record as a single record; and

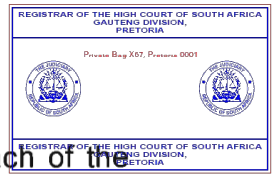
8.3.2. subject to the relief sought in paragraphs 1 and 2 above, file a consolidated answering affidavit and supporting and / or expert affidavits in terms of timelines to be determined in case management.

8.4. Each applicant in the consolidated applications shall be required to file their own replying affidavit and shall only be permitted to reply to that part of the respondents' answering affidavit (as referred to in paragraph 8.3.2) that responds directly to its

answering affidavit, whether thematically or by paragraph, and to argue only for the relief sought in their own notice of motion.

8.5. The process for the determination of interlocutory disputes shall be determined through case management.

8.6. The Court may issue a consolidated judgment.



9. The costs of this application shall be costs in the cause of each of the applications in the consolidated application.

10. The applicants are granted further and/or alternative relief

TAKE NOTICE THAT the affidavit of **NICHOLAS GILMOUR CRISP** together with the annexures thereto and confirmatory affidavits filed therewith, will be used in support of this application.

TAKE NOTICE FURTHER THAT the applicants have appointed the offices of its attorneys of record, **KGOSANA ATTORNEYS**, at the address shown below as the address at which they will accept service of all process in the above matter.

TAKE NOTICE FURTHER THAT if any respondent intends to oppose the relief, you are required to file your opposing affidavit by no later than 12 August 2025.

KINDLY ENROL THE MATTER ACCORDINGLY FOR HEARING.

DATED AT JOHANNESBURG ON THIS THE _____ DAY OF _____ 2025.



IN THE HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, PRETORIA)

CASE NO: 2025-125411

In the application between:

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

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

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**

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

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

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

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

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**

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

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**

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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**

CONFIRMATORY AFFIDAVIT

I, the undersigned,

PÈTER JOHANNES WASSENAAR



do hereby make oath and state as follows:

1 I am an adult male attorney and director at the firm Kriek Wassenaar and Venter Inc (KWV), with address at 3rd Floor, HB Forum Building, 13 Stamvrug Street, Val de Grace, Pretoria.

2 The facts deposed to are within my personal knowledge unless otherwise indicated and are, to the best of my knowledge, both true and correct.

3 KWV is the attorneys of record for the tenth respondent (Sakeliga NPC) in the above-mentioned application in the above Honourable Court issued under case number 2025-125411.

4 I confirm that I have read the answering affidavit of **RUSSEL VICTOR LAMBERTI** and confirm the correctness thereof insofar as it relates to me.

DEPONENT

I hereby certified that the deponent has declared that he understands and knows the contents of this affidavit and that to the best of his knowledge and believes it is the truth, which affidavit has been signed and sworn to before me at Pretoria on this 17th day of October 2025, and that the provisions of the Regulations contained in Government Notice R 1258 of the 21 July 1972, (as amended) and Government Notice R1648 on the 18 August 1977 (as amended) have been complied with.

COMMISSIONER OF OATHS

ANRICH MALAN OTTO
Commissioner of Oaths
HB Forum
13 Stamvrug Street
Val De Grace
Ex Officio Practising Attorney
Republic of South Africa

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

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE NUMBER 2025-125411

In the application between:

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

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

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

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

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
CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES	Fourth Respondent

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

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

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

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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NOTICE OF MOTION IN CONDITIONAL COUNTER-APPLICATION

TAKE NOTICE that, conditional upon the court granting a stay of the applications in the application launched by the applicants, the above-named tenth respondent, Sakeliga NPC, intends to make application to this court at the hearing of the application for an order in the following terms:

1. For the duration of the order granted in favour of the applicants staying the applications launched by the respondents, the first and second applicants and the first respondent are interdicted and restrained from implementing and/or giving effect to the National Health Insurance Act, Act 20 of 2023, pending the upliftment or termination of the stay;

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

2. The costs of this conditional counter-application shall be paid by any party/ies opposing the conditional counter-application, jointly and severally, the one paying the other to be absolved, including the costs of two counsel on Scale C;

3. The tenth respondent be granted such further and/or alternative relief as the Court deems meet,

and that the answering affidavit of **RUSSELL VICTOR LAMBERTI** will be used in support thereof.

KINDLY enrol the conditional counter-application accordingly.

DATED at PRETORIA on 17 OCTOBER 2025.

KRIEK WASSENAAR & VENTER INC
ATTORNEYS FOR THE TENTH RESPONDENT
3rd Floor, HB Forum Building,
13 Stamvrug Street, Val de Grace,
Pretoria
Tel: 012 803 4719
E-mail: peter@kriekprok.co.za
liam@kriekprok.co.za
charne@kriekprok.co.za
REF: P WASSENAAR/L ENSLIN/QB1179

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

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE HIGH COURT**
PRETORIA

AND TO: **KGOSANA ATTORNEYS**
ATTORNEYS FOR THE FIRST AND SECOND APPLICANTS
Chambers @ Valley Road,
133 Valley Road,
Sunnyside,
Pretoria
Tel: 012 326 1452
E-mail: info@kgosana-attorneys.co.za
makule@kgosana-attorneys.co.za

AND TO: **THE STATE ATTORNEY: PRETORIA**
ATTORNEYS FOR THE FIRST RESPONDENT
316 Salu Building,
Cnr Thabo Sehume Street & Francis Baard Street,
Pretoria
Tel: 012 309 1623
E-mail: rsebelemetsa@justice.gov.za
ramatics@gmail.com
REF: 2022/24/Z64
ENQ: RJ (JOSEPH) SEBELEMETSA

AND TO: **MINISTER OF FINANCE**
SECOND RESPONDENT

Old Reserve Bank,
40 Church Square,
Pretoria
C/O THE STATE ATTORNEY: PRETORIA
316 Salu Building,
Cnr Thabo Sehume Street & Francis Baard Street,
Pretoria

AND TO: **NATIONAL TREASURY**
THIRD RESPONDENT
40 WF Nkomo Street,
Pretoria
C/O THE STATE ATTORNEY: PRETORIA
316 Salu Building,
Cnr Thabo Sehume Street & Francis Baard Street,
Pretoria



AND TO: **SERFONTEIN VILJOEN & SWART ATTORNEYS**
ATTORNEYS FOR THE FOURTH RESPONDENT
165 Alexander Street,
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Pretoria
Tel: 012 362 2556
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jd@svslaw.co.za
monique@svslaw.co.za
REF: SWART / CLASSEN / VENTER /MJ/CS0652

AND TO: **WERKSMANS ATTORNEYS**
ATTORNEYS FOR THE FIFTH RESPONDENT
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96 Rivonia Road,
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Johannesburg
Tel: 011 535 8198
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hmichael@werksmans.com
bmoti@werksmans.com
sphakathi@werksmans.com
REF: N KIRBY/ H MICHAEL/ BOAR3329.73
C/O KLAGSBURN EDELSTEIN-BOSMAN DE VRIES INC
220 Lange Street,
New Muckleneuk,
Pretoria
Tel: 012 452 8900

REF: E MEYER

AND TO: **WEBBER WENTZEL ATTORNEYS**
ATTORNEYS FOR THE SIXTH RESPONDENT
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Sandton,
Johannesburg
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prelisha.singh@webberwentzel.com
Glenn.penfold@webberwentzel.com
Alexandra.rees@webberwentzel.com
REF: M VERSFELD/P SINGH/G PENFOLD/A REES/4008778
C/O HILLS INCORPORATED
Office B313,
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Brooklyn,
Pretoria
Tel: 087 944 1800
E-mail: admin@hillsincorporated.co.za

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

AND TO: **NORTON INC ATTORNEYS**
ATTORNEYS FOR THE SEVENTH RESPONDENT
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E-mail: anthony@nortonsinc.com
anton@nortonsinc.com
michelle@nortonsinc.com
melissa@nortonsinc.com
REF: ANTHONY NORTON/ ANTON ROETS/ MICHELLE RAWILSON/
MELISSA STEELE

AND TO: **ASSENMACHER BRANDT ATTORNEYS**
ATTORNEYS FOR THE EIGHTH RESPONDENT
Fair Office Park,
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52 Grosvenor Road,
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E-mail: carl@assenmacher.co.za

kayleigh@assenmacher.co.za
REF: C BRANDT/ KPID 1144
C/O VOSTER BRANDT ATTORNEYS
161 Garsfontein Road,
Ashlea Gardens,
Pretoria
Tel: 012 460 0027
REF: CE BRANDT

AND TO: **EDWARD NATHAN SONNENBERGS INC**
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834 Pretorius Street,
Arcadia,
Pretoria
E-mail: cfe@macintoshcross.co.za
jk@macintoshcross.co.za
REF: C ERASMUS/ J KEUS/X64/2025

