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IN THE HIGH COURT OF SOUTH AFRICA
Gauteng Division, Pretoria

CASE NO: **2025-147065**

In the matter between:

Sakeliga NPC	Plaintiff / Applicant / Appellant
and	
Minister of Health,Minister of Finance,President of the Republic of South Africa,Speaker of the National Assembly,Chairperson of the National Council of Provinces	Defendant / Respondent

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NOTICE OF MOTION

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ELECTRONICALLY SIGNED BY:



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

IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

CASE NO.: _____/2025

In the application between:

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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PRETORIA
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GAUTENG DIVISION,
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NOTICE OF MOTION

TAKE NOTICE that the above-named applicant intends to make application to this court for an order in the following terms:

1. THAT it be declared that:

   1.1. The National Health Insurance Act, Act 20 of 2023 (the "**NHI Act**"), is not rationally connected to the purpose of the NHI Act, and accordingly irrational and unconstitutional;

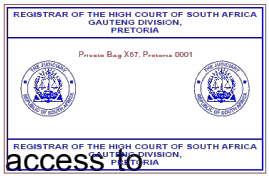
   1.2. The NHI Act is in breach of section 27 of the Constitution and unconstitutional in that:

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1.2.1. the implementation of the NHI Act is not within the state's available resources;

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

1.2.3. 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;



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

1.3. 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;

1.4. 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 of the Republic of South Africa, 1996, and accordingly invalid and set aside.

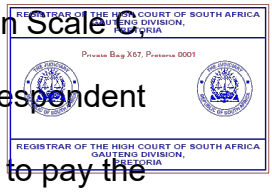
2. THAT it be declared that the NHI Act is unconstitutional and invalid.

3. In the alternative to prayers 1 and 2 above, THAT sections 2, 3(5), 7, 9, 31, 33, 35, 39, 41, 48(a) and (c), 49, 54, 55, and 56 of the NHI Act, alternatively such sections of the NHI Act that the court finds to be unconstitutional, are declared to be unconstitutional and invalid.

27/8/2025-9:45:05 AM

4. In the further alternative to all of the above, and should this Court find that any portion of the NHI Act is inconsistent with the Constitution, but that the remedies sought by the applicant are for some reason found not to be appropriate, the applicant requests this Court to make an order that is just and equitable, as envisaged by section 172 of the Constitution, which has a remedial effect in the sense that it alleviates the Constitutional infringements and/or invalidities which the applicant raises in this application.

5. THAT the costs of this application shall be paid by the first respondent on Scale C, including the costs of two counsel, and in the event that any other respondent opposes the application, then such respondent so opposing be ordered to pay the aforesaid costs jointly and severally with the first respondent, the one paying the other to be absolved;



6. THAT the applicant be granted such further and/or alternative relief as the Court deems meet,

TAKE FUTHER NOTICE that the accompanying affidavit of **RUSSELL VICTOR LAMBERTI** with annexures will be used in support thereof.

TAKE FURTHER NOTICE that the applicants have appointed **KRIEK WASSENAAR & VENTER INC.** at the address of their attorneys, as set out below, as the address at which they will accept service of all process in these proceedings.

TAKE FURTHER NOTICE that if you intend opposing this application you are required:

(a) To notify the applicant's attorneys in writing of your intention to oppose the application within 15 (fifteen) days of service hereof on you;

(b) In such notice of intention to oppose, to provide a physical address referred to in Rule 6(5)(d)(i), being within 15 (fifteen) kilometres of the office of the Registrar of the above Honourable Court, at which you will accept notice and service of all documents in these proceedings; and

(c) To file your answering affidavit, if any, within 15 (fifteen) days after you have given notice of your intention to oppose this application.

And further that you are required to appoint in such notification an address referred to in rule 6(5)(b) at which you will accept notice and service of all documents in these proceedings.

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If no such notice of intention to oppose be given, the application will be made on a date to be provided by the Registrar.

KINDLY ENROL THE MATTER ACCORDINGLY.

DATED AT PRETORIA ON 18 AUGUST 2025

KRIEK WASSENAAR & VENTER INC
ATTORNEYS FOR THE APPLICANTS
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
REF: P Wassenaar/L Enslin/QB1179

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE COURT**
PRETORIA

27/8/2025-9:45:05 AM

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE COURT**
PRETORIA

AND TO: **MINISTER OF HEALTH**
FIRST RESPONDENT
Dr AB Xuma Building,
1112 Voortrekker Road,
Pretoria Townlands,
Pretoria

SERVICE BY SHERIFF



AND TO: **MINISTER OF FINANCE**
SECOND RESPONDENT
40 Church Street,
2nd Floor,
Old Reserve Bank Building,
Pretoria

SERVICE BY SHERIFF

AND TO: **PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA**
THIRD RESPONDENT
Union Buildings,
Government Avenue,
Pretoria

SERVICE BY SHERIFF

AND TO: **SPEAKER OF THE NATIONAL ASSEMBLY**
FOURTH RESPONDENT
Parliament Building,
Room E118,
Parliament Street,
Cape Town

SERVICE BY SHERIFF

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AND TO: **CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES**
FIFTH RESPONDENT
Parliament Building,
Room S11,
Parliament Street,
Cape Town

SERVICE BY SHERIFF



IN THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

CASE NO.: _____/2025

In the application between:

SAKELIGA NPC	**APPLICANT**
and	
MINISTER OF HEALTH	**FIRST RESPONDENT**
MINISTER OF FINANCE	**SECOND RESPONDENT**
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	**THIRD RESPONDENT**
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GAUTENG DIVISION,
PRETORIA
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GAUTENG DIVISION,
PRETORIA

FOUNDING AFFIDAVIT

Contents

A. PARTIES 4

B. THE PURPOSE OF THIS APPLICATION 5

C. THE APPLICANT'S STANDING 5

D. INTRODUCTION 7

E. THE EXPERT ECONOMIC ANALYSES 8

(a) An Overview of Health Care Services in South Africa 9

(i) The structure of health care services in South Africa 11

(ii) The legislative and regulatory framework 17

(iii) Health care resources in South Africa 17

(iv) Health care outcomes in South Africa 26

(v) Health care price inflation versus consumer price inflation in South Africa 29

27/8/2025-9:45:05 AM

(b) Assessment of the Feasibility of NHI: A Comparative International Review 33
(i) Single-payer health care funding systems 34
(ii) Multi-payer health care systems 35
(iii) Analysis and assessment of single-payer systems and NHI 37
(iv) Requirements if South Africa is to achieve universal health coverage through a successful single-payer health system 46
(c) Economic Analysis and Fiscal Affordability Analysis of NHI 71
(i) Features of the NHI 72
(ii) South Africa's economic environment 74
(iii) The funding shortfall for NHI 76
(iv) Conclusion 84
F. GROUNDS OF REVIEW 85
(a) Introduction 85
(b) The NHI Act is irrational 86
(c) The NHI Act is not a reasonable legislative measure 96
(d) The state has failed to take reasonable other measures to progressively realise access to good quality health care 101
(e) Health care providers are beholden to the state in respect of health services provided and remuneration 107
(f) The NHI Act is premised on a flawed cost-saving rationale 112
(i) State procurement inefficiencies negate theoretical savings 112
(ii) Supplier margin erosion creates shortages and supply concentration 115
(iii) Limited market power in global health care markets 117
(iv) Moral hazard and health care overuse in state monopoly systems 118
(v) Lack of actuarial risk analysis undermines cost control 119
(vi) The delegation of law-making powers to the Minister 119
(vii) Medical schemes 121
G. THE LIMITATIONS ARE NOT JUSTIFIABLE 122
(a) The test for constitutional limitation 122
(b) The limitation on private medical schemes 123
(c) Health care at the expense of other rights 127
(d) Conclusion 131
H. COSTS 133
I. CONCLUSION 134

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

RUSSELL VICTOR LAMBERTI

do hereby make oath and say that:

1. I am an adult male economist. I am a director and the Chief Economist of the applicant.



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

3. I am duly authorised to institute this application on behalf of the applicant. As proof of the aforesaid, I attach hereto a copy of the delegation of authority, marked "**FA1**".

4. I am further duly qualified and experienced to opine on and make submissions in respect of economic aspects of the NHI Act (defined below) in addition to those raised in the PriceMetrics reports (referred to herein below). I attach hereto a copy of my concise *curriculum vitae*, setting out my professional qualifications and experience in the field of economics, marked "**FA2**". I confirm the content thereof, and I confirm my qualifications and experience as set out in my *curriculum vitae*.

A. PARTIES

5. The applicant is **SAKELIGA NPC**, a non-profit company duly incorporated under the laws of the Republic of South Africa bearing registration number 2012/043725/08, with its registered address and principal place of business situated at Block A, Floor 5, Loftus Park, 416 Kirkness Street, Arcadia, Pretoria, Gauteng Province ("**Sakeliga**").

6. The first respondent is the **MINISTER OF HEALTH**, cited herein in his official capacity as the cabinet minister responsible for health, with offices situated at Dr AB Xuma Building, 1112 Voortrekker Rd, Pretoria, Gauteng Province.

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GAUTENG DIVISION,
PRETORIA

7. The second respondent is the **MINISTER OF FINANCE**, cited herein in his official capacity as the cabinet minister responsible for finance, with offices situated at 40 Church Square, Pretoria, Gauteng Province.

8. The third respondent is the **PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA**, cited herein in his official capacity as the head of the national executive, with offices situated at Union Buildings, Government Avenue, Pretoria, Gauteng Province.

9. The fourth respondent is the **SPEAKER OF THE NATIONAL ASSEMBLY**, cited in her official capacity, at Parliament of the Republic of South Africa, Parliament Street, Cape Town, Western Cape.

10. The fifth respondent is the **CHAIRPERSON OF THE NATIONAL COUNCIL OF PROVINCES**, cited in her official capacity, at Parliament of the Republic of South Africa, Parliament Street, Cape Town, Western Cape.

11. A copy of this application will be served on each of the respondents as well as the Office of the State Attorney in accordance with section 2 of the State Liability Act, Act 20 of 1957.

B. THE PURPOSE OF THIS APPLICATION

12. The purpose of this application is to:

12.1. challenge the constitutional validity and legality of the National Health Insurance Act, Act 20 of 2023 (the "**NHI Act**"), alternatively certain provisions thereof, on the grounds set out herein below; and

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GAUTENG DIVISION,
PRETORIA
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GAUTENG DIVISION,
PRETORIA

12.2. place relevant evidence before the court in motivation of the above-mentioned challenge.

13. The relief sought by Sakeliga is more fully set out in its notice of motion prefixed to this affidavit.

C. THE APPLICANT'S STANDING

14. Sakeliga brings this application on behalf of its members in terms of section 38(e) of the Constitution, but also in the public interest in terms of section 38(d) of the Constitution and on behalf of persons falling under the definition of "*users*" as defined in the NHI Act. Sakeliga specifically also acts in the interest of those of its members who are "*health care service providers*", providers of "*health goods*" and "*health products*", and "*suppliers*", as defined in the NHI Act.

15. Sakeliga is largely funded by recurring donations from 8 000 individuals and businesses with active recurring financial contributions, supplemented by 500

ad hoc individual and business donors in the previous year. Sakeliga's reach extends to more than 15,000 subscribed businesses and over 50,000 subscribed individuals. These supporters live in municipalities across the country and operate across industries. In addition, more than 25 chambers of commerce and industry chambers are subscribed to Sakeliga's chamber support network.

16. Sakeliga was established in 2011 and was incorporated and registered in 2012 as a non-profit company in terms of the Companies Act, Act 71 of 2008. Sakeliga's objectives include the promotion and protection of constitutionalism, the rule of law, and a just and sustainable business environment, in the interests of its members and of the broader public.

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GAUTENG DIVISION,
PRETORIA
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GAUTENG DIVISION,
PRETORIA

17. In seeking to achieve its objectives, Sakeliga works to promote a free market and economic prosperity, to create a favourable business environment in the interest of its supporters and the common good. In order to give effect to its objectives, Sakeliga also supports its supporters and the public at large, including providing legal support. Further, to achieve its objectives and to perform its functions and mandate, as an ancillary object, Sakeliga seeks to act in the interest of its supporters and members of the public to protect their businesses, their ability to meaningfully participate in the economy.

18. What I have set out above is also evident from an extract of Sakeliga's memorandum of incorporation, a copy of which I attach hereto, marked **"FA3"**. I respectfully draw the court's attention to clause 4 of the memorandum of incorporation, which sets out in more detail the objects, ancillary objects, and the powers of Sakeliga. I request that the court incorporate the content thereof

herein as if specifically set out. I do not attach a full copy of the memorandum of incorporation to these papers, because it will make these papers unnecessarily long. Should the court or any party wish to have sight of the full memorandum of incorporation, Sakeliga shall make this available.

19. Sakeliga further represents health care practitioners and suppliers of medical and health care products and services (currently falling under the definition of "*health care service provider*") who are counted among its individual and business supporters and members.

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GAUTENG DIVISION,
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GAUTENG DIVISION,
PRETORIA

20. As is apparent from the relief sought in this application, read together with the further facts set out in this affidavit, Sakeliga contends that the NHI Act and its provisions stand to be struck down on the basis of illegality, further as being an unreasonable legislative measure in breach of the Constitution, further by virtue of its vagueness and its affront to the rule of law, and because it is in breach of various Constitutional rights. The grounds of attack are more fully set out in this affidavit and framed in the notice of motion.

D. INTRODUCTION

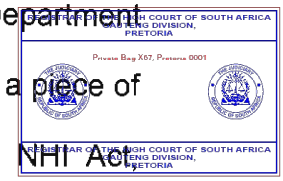
21. The Department of Health, having failed to properly and reasonably address the underlying issues in the state health system for decades, has spearheaded the NHI Act over a number of years, holding the legislation up as the panacea for the provision of universal health care and coverage.

22. However, properly considered, in the context of South Africa, the creation of a Fund, together with a proposed vast and elaborate bureaucracy, at vast further

expense to the *fiscus*, with centralisation of power in the Minister and the National Department, the NHI Act cannot achieve its stated purpose.

23. In truth and in fact, the NHI Act is seriously retrogressive.

24. Instead of focusing on improving the quality of government health care provision, ensuring efficient spending practices and accountable government health care providers in South Africa, the Department has embarked upon creating a money bill. Fundamentally, as a matter of principle, the Department of Health is ill-equipped to consider and put forth what amounts to a piece of fiscal and social security legislation such as the NHI Act. The NHI Act, notwithstanding other flaws detailed herein, ought to have originated in the National Treasury as it is, properly construed, a money bill.



25. We turn now to consider the economic and financial aspects of the NHI Act.

E. THE EXPERT ECONOMIC ANALYSES

26. 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 analysis and fiscal affordability analysis in respect of NHI.

27. In addition, Mr Michael Holland provided further analyses providing an overview of the South African Health System, and an assessment of the feasibility of NHI as a single-payer health system based on a comparative international review of other single-payer and multi-payer systems around the world.

28. The content of the reports is based on publicly available information and data, as referenced in each report. I deal with each of the respective PriceMetrics reports herein below.

29. 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. I attach hereto confirmatory affidavits by Professor Rossouw, Dr Joubert and Mr Holland, respectively, marked **"FA4", "FA5"**, and **"FA6"**.

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GAUTENG DIVISION,
PRETORIA
Private Bag X67, Pretoria 0001

30. In their respective confirmatory affidavits, Professor Rossouw, Dr Joubert and Mr Holland each confirm their qualifications and expertise, attach and confirm their respective *curricula vitae*, and confirm the content of the report/s which they authored as well as the content of this founding affidavit insofar as such pertains to them.

31. Professor Rossouw, Dr Joubert and Mr Holland have the necessary expertise to opine on *inter alia* the economic aspects of the NHI Act, its impact on South Africa's economy, and the aspects raised in their respective reports. Sakeliga requests that the expert evidence of Professor Rossouw, Dr Joubert and Mr Holland, as set out in the below-mentioned reports, be admitted into evidence in this application.

(a) An Overview of Health Care Services in South Africa

32. In order to understand the impact that the NHI Act will have on South Africa's economy and health care services, it is important to understand some of the salient features of health care services in South Africa, the challenges and

shortcomings faced and, as discussed later herein, whether the NHI Act actually addresses such challenges and shortcomings.

33. In the PriceMetrics report dated 12 February 2025, titled "*An Overview of the South African Health System*", Mr Holland provides an overview and profile of the current health care ecosystem in South Africa, including both state and private health care services. A copy of this report is attached, marked **"FA7"**.

34. I incorporate the entire report herein as if specifically stated. Without derogating from the content of the report as a whole, I proceed to highlight the most essential facts and findings therein.

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

35. The report outlines essential facts and statistics regarding the significant features and performance of both the private and state health care sectors. It emphasises the aspects and activities of private health care services that are most susceptible to the implications of the government's plans for NHI.

36. The report is in five sections:

36.1. The structure of health care services in South Africa covering the state and private sectors' provision and funding of health care services;

36.2. The legislative and regulatory framework for health care in the country;

36.3. Information and statistics on the resources used to deliver state and private health care;

36.4. An assessment of trends in health outcomes in South Africa; and a comparison to outcomes in other selected developed and developing countries; and

36.5. A summary of trends in health care price inflation.

(i) The structure of health care services in South Africa

37. The total size of state and private health care spending is currently approximately as large as 8% of gross domestic product ("**GDP**").

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION,
PRETORIA
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38. I pause to point out that it is common practice and internationally accepted to express spending in certain sectors as a percentage of GDP because the latter is a well-known aggregate measure of economic activity. However, it should be noted that total spending (turnover) in a sector is not strictly comparable to GDP, which is a figure estimating *aggregate income net of the cost of intermediate goods and services*.

39. In basic terms, the health care sector is comprised of both the state and private sectors. State-provided health care is funded by taxes, and social insurance, such as the Compensation Fund and the Road Accident Fund.

40. In 2023:

40.1. 53,2 million people were served by state health care services; and

40.2. 9,1 million people were served by private health care services.

41. State health care is provided on a 'universal health care' basis (meaning it is available to all eligible persons in South Africa) through a network of hospitals,

clinics and community health services, where many primary health care services are offered for free to users. Some services are subject to a means test.

42. State health care is a shared competency across all spheres of government.

43. The role of the national department is developing policies and regulations pertaining to health care; overseeing the overall management of state health care systems; ensuring compliance with health legislation and an equitable distribution of state-controlled health care resources; developing and implementing national health programmes to prevent and treat communicable and non-communicable diseases; overseeing primary state health care services and supporting tertiary state health care services; and improving state health infrastructure and developing human resources for the state health sector.

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

44. Provincial health departments are responsible for the implementation of national health policy norms and standards in their respective provinces, planning and managing health information systems, monitoring and evaluating health services, and controlling the quality of health services. The activities of the various provincial bodies and the national health body are coordinated by the National Consultative Health Forum. Members of the Executive Council for Health in each province may assign health functions to a municipality.

45. The delivery of health care services is generally decentralised in the provinces with a third tier of district health councils, which correspond to municipal boundaries, having the responsibility for the implementation of primary health care services and referrals for secondary, tertiary and quaternary care for

communities in each district (and subdistrict). There are currently 52 district councils in the country which plan, organise, and oversee health services within their district.

46. In accordance with Chapter 3 of the Constitution, the three spheres of government are required to cooperate with one another in the provision of government health care services.

47. Table 1, depicted below, shows the structure of government spending on health in the 2023-24 financial year. District health services expenditure, largely covering primary care, accounted for 44,7% of total spending, followed by central hospital services and provincial health services.

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Table 1: Structure of Public Sector Expenditure 2023-24 Estimate

	R million	% of total
Central hospital services	51 789	19,4%
Provincial health services	43 857	16,4%
District health services	119 450	44,7%
Emergency medical services	9 769	3,7%
Facilities management	10 594	4,0%
Health science and training	5 775	2,2%
National health laboratory service	13 812	5,2%
National Department of Health	5 807	2,2%
Grants and Transfers	6 471	2,4%
Total	**267 324**	**100,0%**

Source: National Treasury Medium Term Policy Statement, October 2024

48. I pause to note that the above features of current state health care services underscore the decentralised nature of state health care provision in accordance with constitutional principles. I respectfully ask the court to bear

this in mind when considering the extreme centralising goals and provisions of the NHI Act explained herein below.

49. Private health care comprises a set of complex markets consisting of health care services and products, health care service providers and health care funders.

50. Private health and medical insurance is a critical component of health care provision and is designed to provide individuals and families access to medical services and financial protection against the sometimes high and unaffordable costs of health care, especially for major health care interventions such as surgeries or specialised treatments.

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

51. In 2023, private health and medical insurers served approximately 15% of the population and accounted for 42% of total expenditure on health care in South Africa. The number of beneficiaries (principal members and dependants) of medical schemes has increased since 2000, from 6,73 million to 8,32 million in 2010, and then at a slower rate of increase to 9,13 million in 2023.

52. In addition to medical schemes and health insurance, patients who are not members of medical schemes pay out-of-pocket for services from health care providers. The aggregate amounts of these payments are likely to be substantial but are not known to Sakeliga.

53. I pause to emphasise three relevant implications of the data presented in the previous two paragraphs.

53.1. The first is the incredibly large scale of private health care services. Although evidently a minority of the population (though still a

27/8/2025-9:45:05 AM

significant proportion), private medical schemes have contractual obligations to almost 10 million beneficiaries, involving extensive commercial and contractual commitments with a network of health care practitioners, health care and medical facilities, product providers, and other key role-players. As is shown extensively herein, the NHI Act is an unreasonable measure because it proposes to replace this massive, vital, and functioning health care ecosystem with a state-run system that, Sakeliga is advised, is irrational and unconstitutional and can be expected to do immense social, economic, and health harm.

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Private Bag X67, Pretoria 0001
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53.2. The second implication is the unknown but likely large number of people not in medical aid schemes who nonetheless use and benefit vitally from private health care services and pay out-of-pocket or through other private financing arrangements. In addition to this, there is the significant and vital care provided to those without means by private health care practitioners and facilities *pro bono* or funded by charitable activities. This activity, though hard to measure, should not, I respectfully submit, be ignored when considering the importance of the private health care ecosystem.

53.3. The third salient implication I would like to highlight is the large reduction in the growth in the number of private medical scheme members during the period 2010-2023 (CAGR +0.7%) compared to the period 2000-2010 (CAGR +2.1%). According to Statistics South Africa data [*GDP measured by production from 1993:* Statistics South

Africa], real GDP growth was far lower during the period 2010-2023 (CAGR +1.2%) than during the period 2000-2010 (CAGR +3.5%). Formal, non-agricultural sector employment during the 2010-2023 period had a CAGR of +1.6% compared to +3.3% for 2000-2010 [South Africa. Statistics South Africa. *Labour Force Survey (P0210)*. Statistics South Africa, Sept. 2002; South Africa. Statistics South Africa. *P0211 - Quarterly Labour Force Survey (QLFS): QLFS Trends 2008-2025Q1*. Statistics South Africa, May. 2025].

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54. It is evident and logical that stronger economic and employment growth enables more people to afford and benefit from private health insurance. Had the government pursued more growth-enabling policies since 2010, allowing medical scheme membership to grow at its 2000-2010 rate, there would have been nearly 1.8 million more medical scheme members (10.9 million) by 2023 than there actually were (9.13 million).

55. This point has considerable relevance when considering the government's failure to foster a sufficiently enabling environment for economic and employment growth and the knock-on impact on private health care coverage and state health care resources. As is shown herein below (and in some detail in the PriceMetrics reports), poor economic performance lies at the heart of the country's health care challenges and is one of the key reasons why the NHI is not only completely unviable but counterproductive – it will hamper the economy even more.

56. It is evident that the government's priority of overhauling all health care services is wholly misplaced when, instead, it urgently needs to take measures

to address the policy and governance failures central to the poor economic outcomes.

(ii) The legislative and regulatory framework

57. The constitutional imperative in respect of health care under section 27 of the Constitution is dealt with in greater detail herein below.

58. The principal legislation governing the provision of health care services is the National Health Act, Act 61 of 2003, the objects of which are to regulate health care provision and to provide a framework for structured, uniform state-run health care services within the Republic.

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59. In addition, there are a number of statutory bodies that regulate various aspects related to the provision of health care services, including the Health Professions Council of South Africa, the South African Nursing Council, the South African Pharmacy Council, the South African Health Products Regulatory Authority, *et cetera*.

(iii) Health care resources in South Africa

60. In 2023, total expenditure on health care in the country is estimated at approximately R570,0 billion, being of a size approximately equal to 8,1% of the country's GDP. Table 3, depicted below, shows the breakdown of expenditure between the public sector, the private sector (benefits paid by medical schemes to their beneficiaries) and an estimate of out-of-pocket expenses paid by individuals for health care. Government spent R267,3 billion on health, 47% of total expenditure compared to 42% of the total expenditure by private medical schemes.

Table 3: Expenditure on Health Care 2023

	R billion	% of GDP	Per beneficiary: rands
Public sector	267,3	3,8%	4 962
Private sector	239,0	3,4%	26 405
Out-of-pocket	65,0	0,9%	1 032
Total	571,3	8,1%	9 046

Source: National Treasury, CMS industry Report and own calculations

61. Total health care expenditure on benefits paid to beneficiaries by medical aid schemes in 2023 was R239 billion, up by 9.4% from the 2022 reported amount of R218.4 billion. The claims paid per average beneficiary per annum increased by 8.2% from R24,395 in 2022 to R26,405 in 2023. Members of medical aid schemes also incurred out-of-pocket expenditure of R43,1 billion for medical treatment and services in 2023, 8.3% higher than expenditure of R39,8 billion in 2022.

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62. In 2023, medical aid members purchased an average of R26 405 worth of health care services per member. The state spent just under R5 000 per individual who was not a medical scheme member.

63. Spending on health care *per capita* in South Africa has gradually increased in recent years. Figure 1, depicted below, shows World Bank data on health care spending in the country as a proportion of GDP for the period 2000 to 2021. After declining from 2000 to 2007, the ratio of expenditure to GDP increased from 6,9% in 2007 to 8,6% in 2020, and has declined slightly since that year (which was characterised by more resources channelled into health care during COVID-19 lockdowns and the declared State of Disaster).

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Figure 1: South Africa Current Health Expenditure (% of GDP) 2000-2021



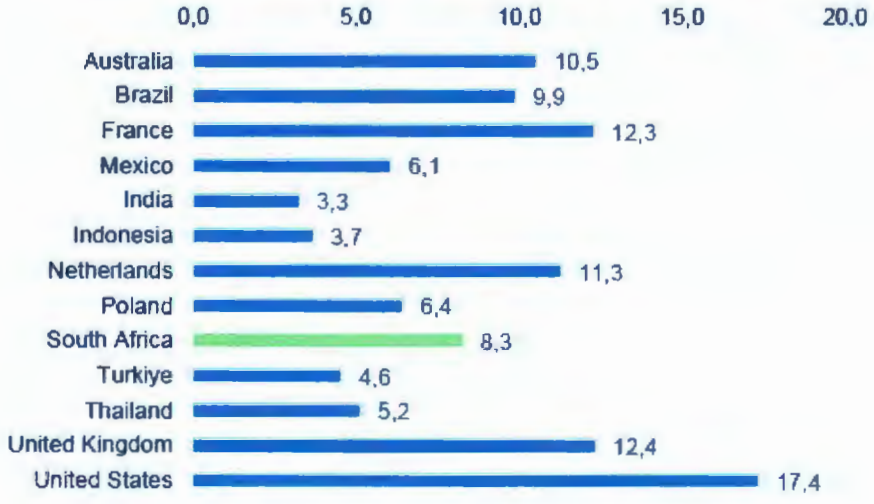
Source: World Bank

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64. The increase in health care expenditure since 2000 has been largely due to an increase in state expenditure. State health care expenditure as a percentage of GDP rose from 2,7% in 2000 to 4% in 2023.

65. Countries vary widely in their spending on health care *per capita*, although high-income countries spend more than middle and low-income countries. Figure 2, depicted below, shows a comparison of South Africa's spending on health care as a percentage of GDP compared to selected countries.

Figure 2: Total Current Health Expenditure (% of GDP) 2021



Source: World Bank

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66. South Africa is classified as an upper-middle-income country by the World Bank and spends less *per capita* than developed countries but significantly more than many other middle and low-income countries.

67. The graph in Figure 2, depicted above, shows that in 2021, health care expenditure in South Africa was 8,3% of GDP compared to 6,1% in Mexico, 5,2% in Thailand, 3,7% in Indonesia and 3,3% in India. Brazil, another upper-middle-income country, spends a comparable, though somewhat higher, 9,9% of GDP.

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68. Health care workers play a critical part in providing health care in any country and account for a large portion of health care expenditure. For example, compensation of Department of Health employees in the 2024/25 budget comprised 64% of the total budgeted national health expenditure. The proportion spent on health professionals in the private sector is significantly lower and in line with norms in other industries at 36,1%.

69. There has been a consistent but low increase of 1,4% compound annual growth rate ("**CAGR**") in the number of active, qualified health practitioners registered with the HPCSA, from 172 640 in 2020 to 181 981 in 2024, as depicted in Table 4 below. Medical practitioners accounted for 29,6% of all health professionals in 2024 and their number increased by 5,2% CAGR although due primarily to a substantial increase in 2021. The number of dentists (and dental assistants) has not increased significantly, rising by a relatively negligible 167 during the period. However, there has been a significant increase in the number of registered psychologists and radiologists.

Table 4: Number of Active Qualified Health Practitioners Registered with HPCSA 2020-2024

Number	2020	2021	2022	2023	2024
Medical Practitioners	43 901	48 021	49 514	51 579	53 773
Dentists and dental assistants	10 384	10 684	10 576	10 415	10 551
Ambulance and emergency care	50 509	44 899	41 313	38 324	36 892
Psychologists and ancillary staff	12 535	13 780	13 828	14 002	14 302
Radiologists and ancillary staff	8 853	10 007	10 240	10 522	10 873
Medical and laboratory technicians and ancillary staff	10 378	11 784	12 098	12 722	13 213
Other	36 080	38 493	39 657	40 844	42 377
Total	172 640	177 668	177 226	178 408	181 981

Source: HPCSA Annual Report 2024

70. In a research report by MG Matseke (Matseke, M.G., (2023) Taking Stock of the Health care Workforce in the Public Health Sector of South Africa During Covid-19: Implications for Future Pandemics, *Africa Journal of Public Sector Development and Governance*, Vol 6,1.), estimates of numbers of medical practitioners and other professionals in the public and private sectors are provided. The study states that of the 43 901 medical practitioners registered in 2020, 20 926 or 47,6% were employed in the public sector and 22 975 or 52,3% were in private practice.

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71. Table 5, depicted below, shows the number of registered health professionals by various categories per 10 000 of the total population in South Africa for the period 2020 to 2024.

72. The ratio of medical practitioners in South Africa has increased from 7,32 per 10 000 in 2020 to 8,54 - an increase of 3,9% CAGR. The ratio of dentists has declined slightly, from 1,73 per 10 000 in 2020 to 1,67 in 2024.

Table 5: Number of Active Qualified Health Practitioners Registered with HPCSA per 10 000 Population 2020-2024

	2020	2021	2022	2023	2024
Medical Practitioners	7,32	7,92	8,06	8,29	8,54
Dentists and dental assistants	1,73	1,76	1,72	1,67	1,67
Ambulance and emergency Care	8,42	7,41	6,73	6,16	5,86
Psychologists and ancillary staff	2,09	2,27	2,25	2,25	2,27
Radiologists and ancillary staff	1,48	1,65	1,67	1,69	1,73
Medical and laboratory technicians and ancillary staff	1,73	1,94	1,97	2,05	2,10
Other	6,02	6,35	6,46	6,57	6,73
Total	28,79	29,32	28,86	28,68	28,89

Source: HPCSA Annual Report 2024 and own calculations

73. The ratio of 7,32 per 10 000 medical practitioners in 2020 was a weighted average of the number of medical practitioners in the state and private sectors: there was an average of 3,49 medical practitioners in the state sector per 10 000 of the population using state health care services, compared to 25,8 medical practitioners in the private sector per 10 000 of the population using private services. Although reflective, these figures are somewhat imprecise as some doctors practise in both state and private health care.

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74. In terms of specialists, a 2019 report shows there were, in total, seven full-time equivalent medical specialists in state health care per *100 000* of the population (equivalent to 0,7 per 10 000), compared to 69 in private care (i.e. 6,9 per 10 000), with a weighted average for both sectors of 16,5 per 100 000 of the population (i.e. 1,65 per 10 000).

75. In 2020, there were 285 245 nursing practitioners (Professional Nurses, Staff Nurses and Pupil Nurses, Nursing Assistants, and Student Nurses) with 143 288, being 50,3% of the total, in state health care, and 141 957, 49,7% of the total, in the private sector. For nursing practitioners, there was an average of 23,9 per 10 000 of the population in state health care in 2020 and an average of 159,5 per 10 000 of the population in private care.

76. Despite the higher number of nurses per 10 000 in private care, the private hospital groups have indicated that there is a shortage of nursing professionals (particularly skilled nurses) precipitated by the closure of public nursing colleges and restrictions on private sector training of nurses, emigration of nurses, and the difficulty employing foreign nurses.

77. In 2024, there were 16 856 registered pharmacists (working and not working) in the country, excluding 971 community service pharmacists. There were 2,8 pharmacists per 10 000 population (insured and uninsured) compared to a global average ratio of 7,3 per 10 000 population. In February 2024, the state employed 5 958 pharmacists, predominantly at the 623 state hospitals. In state health care, there are approximately 1,2 pharmacists per 10 000 of the uninsured population in the country.

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78. Most pharmacists work in the almost 4 000 community pharmacies in the private sector. There are also pharmacists employed in over 300 private hospitals, as well as in manufacturing and wholesale practice. Smaller numbers of pharmacists are employed in such specialist roles as clinical trials and pharmacy benefit management services.

79. The important implication of the aforementioned statistics is that these ratios of numbers of registered health professionals to population are significantly lower than in some developing countries and substantially less than in developed countries. For example, a paper authored by Wishnia A, J., Strugnell, D., Smith, A. M. & Ranchod, S. in 2019, titled "*The supply of and need for medical specialists in South Africa*", Cape Town: Percept (referred to in Pricemetrics Report as the "Percept report") states that in Chile, in 2015, there were 110 medical specialists per 100 000 population and in OECD countries an average of 274 medical specialists per 100 000 of the population, compared to the just 16,5 per 100 000 population in South Africa cited above.

80. South Africa compares unfavourably with other countries in its human resources available to provide health care. Figure 3, depicted below, shows

the number of medical doctors per 1 000 people in the country and other selected high-income and middle- to low-income countries according to the latest World Bank data.

Figure 3: Number of Medical Doctors per 1 000 People in South Africa and Selected Countries 2020



Source: World Bank

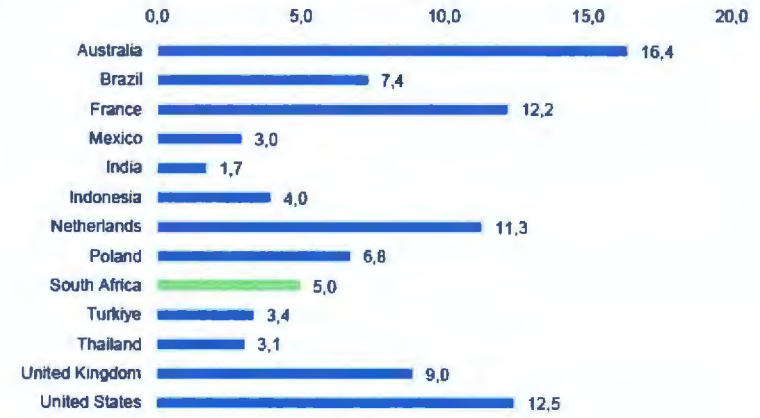
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81. The number of medical doctors in South Africa, at 0,8 per thousand people, is low, at a level similar to Indonesia and India, which have much lower *per capita* incomes, and is substantially lower than in Brazil and Mexico and far lower than the developed countries shown in the graph. Of considerable concern, the ratio in South Africa of 0,8 per thousand people has been stable and has not increased since 2017.

82. Figure 4, depicted below, shows that South Africa is somewhat better resourced in nurses compared to several other African and developing countries, but is substantially below the level in developed countries.

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Figure 4: Number of Nurses and Midwives per 1 000 People in South Africa and Selected Countries 2020



Source: World Bank

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83. In 2020, there were 5,0 nurses and midwives per 1 000 people in South Africa, above countries like Mexico, Turkiye, Indonesia and especially India. However, the ratio compares unfavourably with the U.K., Netherlands and France and particularly with Australia, and is even below the levels in Brazil and Poland. The current ratio in the country is below target levels. The Sustainable Development Goals for 2030 have a target ratio of 8,3 nurses per 1 000 population.

84. Hospitals, clinics and other establishments play a critical role in the delivery of health care in South Africa. In 2023, there were over 650 hospitals and over 3 000 clinics in the public sector. In 2024, in the private sector there were 776 hospitals (acute and day), clinics, and specialised facilities, including mental health care, renal dialysis, oncology, ophthalmology and rehabilitation establishments.

85. I pause to note that this health care resources summary, which is further contextualised herein below, is highly relevant to the NHI. The achievement of a certain desired level of quality and breadth of health care coverage in a

given population is critically dependent upon the availability, development (or cultivation), coordination, and allocation of real, finite resources and trade-offs with alternative resource requirements in crucial spheres outside of health care.

86. As is shown herein below, the state is putting the cart before the horse. With the NHI Act, it seeks to legislate health care outcomes, which are impossible to achieve given real resource constraints, before taking the appropriate policy measures to first enable the adequate development of those resources. This amounts to legislating the impossible.

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(iv) Health care outcomes in South Africa

87. State health care expenditure in the public sector is generally above average as a percentage of GDP compared to many middle- and low-income countries. Yet state health care generally performs inadequately and often poorly as a result of shortages of medical practitioners, nurses, and other health professionals, poor training and declining professionalism among public sector health professionals, ageing and non-functioning infrastructure in hospitals and clinics, and shortages of supplies of consumables, medical devices and equipment. The underlying causes include under- and misallocated funding, weak governance, poor quality management and corrupt practices at a national, provincial and district level, and a lack of coordination and integration between management and administrators at the three tiers of state service delivery.

88. In general, despite some notable exceptions in certain state settings, the results are poor quality health care, delayed or denial of health care,

particularly for serious diseases such as cancer, long wait times, rushed appointments, and poor disease control and prevention practices.

89. In a written response to a recent parliamentary question, the Minister of Health, Dr Aaron Motsoaledi revealed that *"the total number of Public Health Facilities inspected is 3092, of those inspected, 1226 [39,65%] were found to be compliant and 1866 [60,35%] were not compliant since the promulgation of the norms and standards."* A copy of the Minister of Health's written response is attached, marked **"FA8"**.

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90. There are also wide geographic disparities in the country and low levels of service delivery in rural compared to urban areas.

91. A further feature is the high and growing level of medical malpractice claims against state health authorities, which has a serious adverse impact on provincial health budgets: for example, the total amount of potential (i.e. yet to be adjudicated) medico-legal claims stood at R77 billion in March 2023.

92. State health services in South Africa generally reflect poor outcomes at both primary and tertiary levels of care in comparison to peer countries with similar levels of economic development and resource allocations to their state health systems. Also, the state's health care performance is substantially below the outcomes in developed countries.

93. State health care has deteriorated in recent years. This poor performance cannot be chiefly explained by the resources allocated to it, as many countries at a similar level of development spend significantly less on state health systems.

94. Conversely, outcomes in the private health care sector are generally similar to many developed countries, but this care is provided to those willing and able to pay for it.

95. Private health care is, despite various considerable regulatory restrictions imposed on it by the state, generally well-funded and provides a much higher level of health care both in range and quality, often comparable and sometimes exceeding the quality of care in developed countries. There is convincing evidence that health outcomes are significantly better in private hospitals than in state hospitals in the country.

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96. I pause to highlight that the state's manifest failures in health care management and delivery are another extremely relevant feature for the NHI, which is further contextualised herein below. The expert reports show that state mismanagement is a significant reason for the wide disparity in quality between private and state health care services.

97. Yet rather than taking urgent measures to enable the expansion of competent, good-quality private health care and medical scheme membership, the NHI Act places virtually all health care in the country under the control and administration of the very state that is currently exacerbating and perpetuating poor health care outcomes.

98. Moreover, since the expert reports show that the state produces poor health care services even with substantial budgets, placing more financial resources in the state's hands to manage and administer health care is irrational and does not fundamentally address the core problems associated with weak governance and mismanagement. Indeed, as is shown herein below,

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increasing the size of funds to be administered by the state can reasonably be expected to increase the scale of the mismanagement and worsen, not improve, health care services for those already receiving poor quality state care.

(v) Health care price inflation versus consumer price inflation in South Africa

99. The analysis of health care price inflation estimates provides a comparison for the past sixteen years of estimated medical price inflation and general consumer price inflation as measured by the consumer price index.

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100. Statistics South Africa has published monthly price index estimates for several categories of health care services and products for urban areas in the country since January 2008. These data comprise indices of medical products, medical services, doctors' fees, dentists' fees, hospital services, medical insurance and a composite health index of all medical products and services, excluding medical insurance.

101. Table 7, depicted below, shows the annual increases in these indices with a comparison to headline CPI inflation from 2009 to November 2024 and the arithmetic mean (average) of the price increases for the whole period.

Table 7: Annual Average Increases in Price Indices of Health Products and Services and Medical Insurance and CPI Inflation 2009-2024 (November)

	Health	Medical Products	Medical Services	Doctors	Dentists	Hospital services	Medical Insurance	CPI Headline
2009	10,7%	11,9%	10,3%	10,2%	8,9%	10,1%	11,4%	7,2%
2010	7,5%	6,4%	8,2%	9,0%	6,4%	7,1%	13,2%	4,2%
2011	5,8%	4,2%	6,8%	7,2%	6,1%	5,6%	10,2%	5,0%
2012	5,3%	3,4%	6,3%	6,9%	6,3%	4,9%	9,5%	5,7%
2013	4,8%	3,6%	6,2%	6,3%	5,5%	4,8%	10,2%	5,7%
2014	5,3%	4,5%	6,2%	6,4%	5,6%	6,2%	9,1%	6,1%
2015	6,1%	5,6%	6,4%	6,6%	6,0%	5,9%	9,6%	4,6%
2016	5,5%	4,9%	6,2%	6,2%	5,5%	5,2%	9,1%	6,3%
2017	6,6%	6,4%	6,4%	6,5%	6,2%	5,2%	10,2%	5,3%
2018	5,1%	3,7%	6,1%	6,3%	5,4%	4,8%	8,6%	4,6%
2019	4,9%	4,0%	5,5%	5,6%	5,2%	4,6%	8,8%	4,1%
2020	4,4%	3,5%	4,9%	5,0%	4,8%	3,9%	9,5%	3,3%
2021	3,6%	3,9%	3,5%	3,3%	4,3%	3,5%	5,7%	4,6%
2022	4,6%	4,2%	5,0%	5,0%	4,7%	3,3%	4,3%	6,9%
2023	5,9%	6,2%	5,6%	5,7%	5,3%	5,3%	7,5%	5,9%
2024	5,4%	6,0%	5,1%	4,8%	7,9%	5,5%	10,4%	4,6%
Mean	5,7%	5,1%	6,2%	6,3%	5,9%	5,4%	9,2%	5,3%

Source: StatsSA Statistical Release P0141 Consumer Price Index November 2024 and own calculations

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102. The above Table shows that increases in the prices of health care services and products have not substantially exceeded the average increase in the headline consumer price index since 2009, although there are fairly large variations in annual rates of increase. For medical products, the average annual increase in prices at 5,1% was marginally below the increase of 5,3% in consumer prices during the period.

103. The exception to this conclusion is the rate of increase in estimated medical insurance prices, which are principally the price increases (premiums) of medical aid schemes. The average annual estimated price increase in medical insurance prices from 2009 to 2024 was 9,2% compared to 5,3% for consumer price inflation and significantly exceeded consumer price inflation for every year from 2009 to 2024 except for 2022. It also exceeded inflation in medical products prices (5,1%) and for medical services such as doctors' and dentists' fees and hospital services (6,2%).

104. In conclusion, for the period 2008-2024, the prices of health products and services increased by 157,7%, compared to a 138,7% increase in the headline

consumer price index. The increase in the prices of medical products was slightly lower than the increase in consumer prices. Table 8, depicted below, shows that inflation in the prices of medical services, such as doctors' and dentists' fees, was significantly higher than headline CPI price inflation, as were hospital services fees, but these were due to the relatively high increases in the period 2008-2014. The outlier is medical insurance prices, which increased by 347,5% from 2008 to 2024 compared to the 138,7% increase in consumer price inflation during the period.

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Table 8: Cumulative Percentage increases in Health Price Indices and the CPI Headline Index

	Health	Medical Products	Medical Services	Doctors	Dentists	Hospital services	Medical Insurance	CPI Headline
2008-2014	56,0%	44,8%	64,5%	66,6%	53,1%	61,9%	100,7%	47,5%
2014-2019	38,2%	32,2%	42,7%	43,8%	39,1%	36,3%	69,7%	33,7%
2019-2024	32,2%	31,5%	32,8%	32,4%	36,5%	29,0%	55,9%	32,0%
2008-2024	157,7%	130,5%	179,6%	183,9%	162,8%	155,9%	347,5%	138,7%

Source: StatsSA Statistical Release P0141 Consumer Price Index November 2024 and own calculations

105. I pause to emphasise some relevant implications of the Stats SA inflation estimates presented in the previous two paragraphs:

105.1. The most striking feature of the data is the extent of estimated price inflation in medical insurance compared to other medical and health care prices and overall CPI. Reasons for such inflation disparities can include, *inter alia*, differences in particular market (supply and demand) conditions and structure, changes in consumer preferences, different relative starting points (the data arbitrarily begins in 2008), regulatory effects, and methodological and measurement errors or biases.

105.2. Rather than adopt a rational view that private medical insurers and schemes enable millions of customers to access good-quality health care, reduce the number of patients dependent on state health care,

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and facilitate a large health care economy from which businesses and health care practitioners pay considerable taxes to the government, the state has instead criticised private medical insurers, citing insurance premium inflation as a reason to further regulate the industry and as one of the rationales for the NHI, asserting demagogically that the NHI will contain costs where private insurers have been unable to. ["Some Key Messages on National Health Insurance (NHI)." *National Department of Health*, Nov. 2020, www.health.gov.za/wp-content/uploads/2020/11/some-key-messages-on-nhi.pdf]

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105.3. The NHI Act proposes to reduce health care costs through the monopsonistic and regulatory power of the single NHI Fund. I point out in F(f) herein below why this argument for the NHI is specious and economically flawed, suffice it to highlight briefly here that:

105.3.1. the NHI proposes a glaring contradiction: to set up a monopoly health care benefits provider and effectively abolish all private medical scheme competition to solve what it deems to be a cost problem resulting from an excessively concentrated market, and

105.3.2. statutory state monopolies (such as Eskom) have in fact presided over significant service cost escalations, not savings, and that the NHI, as such a statutory state monopoly, can reasonably be expected to produce the

same cost escalating problems, coupled with quality deterioration.

(b) Assessment of the Feasibility of NHI: A Comparative International Review

106. In the PriceMetrics report dated 21 May 2025, titled "*Assessment of the Feasibility of NHI as a Single-Payer Health System in South Africa: A Comparative International Review*", Mr Holland provides a comparative review of South Africa and 16 countries with single-payer health care funding systems. A copy of this report is attached, marked **"FA9"**.

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107. I incorporate the entire report herein as if specifically stated and, without derogating from the content of the report as a whole, I proceed to highlight the most essential facts and findings therein.

108. This report assesses the likelihood of NHI as a single-payer health care funding system meeting its objectives of "achieving sustainable and affordable universal access to quality health care services" in South Africa.

109. 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 as defined by the World Health Organization.

110. Health care provision constitutes a network of institutions (laws and regulations), organisations, policies, activities and resources established to deliver health care services to a population.

111. As can be expected, health care across countries varies 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 state and private sector involvement in the provision of health insurance and health services; government regulatory and policy choices; constitutional freedoms and protections for health care providers and patients; and demographic and epidemiological factors such as ageing populations, rising obesity and disease burdens such as AIDS.

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

(i) Single-payer health care funding systems

113. 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.

114. It receives funds through taxation and directly reimburses health care providers. The following criteria are commonly used to define a single-payer system:

114.1. 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.

114.2. 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.

114.3. Health risks and costs are pooled across the entire population, with the intention of achieving equitable access to health care.

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114.4. The private sector is often permitted to provide health care insurance cover in a single-payer system, for example, medical aid schemes and specialist insurance. However, given free-at-the-point-of-service government health care, private insurance and medical schemes in such systems are typically 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 care systems

115. 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 either voluntarily or are compelled 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.

116. The features of a multi-payer system include:

116.1. *Multiple financing sources.* A combination of private insurers, employer-sponsored plans, government subsidies or tax breaks, and out-of-pocket payments from individuals cover health care costs.

116.2. *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.

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116.3. *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.

116.4. *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.

117. The overwhelming majority of countries currently have a multi-payer health system, including South Africa.

27/8/2025-9:45:05 AM

(iii) Analysis and assessment of single-payer systems and NHI

118. Single-payer health care funding systems are rare globally. There are only 18 countries with fully-fledged single-payer systems out of 195 countries 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), leaving 16 single-payer countries.

119. Cuba and North Korea 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).

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120. Consequently, in the two excluded countries 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.

121. These policies are in contravention of Article 13(2) of the United Nations Universal Declaration of Human Rights, which states:

> *"Everyone has the right to leave any country, including his own, and to return to his country."*

122. Given these unique circumstances, Cuba and North Korea are not comparable with South Africa and have not been considered in the comparison of South Africa with other single-payer countries.

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

124. The single-payer health system is uncommon among all regions of the world:

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124.1. 11 countries of 49 countries in Europe (22% of the total).

124.2. 4 countries of 48 countries in Asia (8% of the total).

124.3. 1 country of 35 countries in North and South America (3% of the total).

124.4. No country in Africa (54 countries).

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

126. 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 cover that finances the delivery of health care falls solely on the state

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without any substantial funding or other contributions from the private sector to relieve the pressure on fiscal policy.

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

127.1. A high GDP per capita, which defines the country as a high-income country.

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

127.3. Comprehensive health care resources, including health professionals, pharmaceutical products, medical infrastructure (clinics, hospitals, other health establishments), and health information systems.

127.4. 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.

127.5. 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

27/8/2025-9:45:05 AM

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).

128. In addition to 127.5 above, 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:

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128.1. *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.

128.2. *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.

129. 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.

130. 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.*" If fully implemented, the NHI would include the following distinctive features compared to other single-payer systems:

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130.1. 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.*"

130.2. 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, even Canada's Medicare, probably the closest model to the NHI, restricts routine oral (dental) and optical benefits. A survey by the OECD concluded that most high-income countries (single-payer and multi-payer countries) currently implement UHC with only partial dental coverage.

130.3. Second, the NHI intends to offer a comprehensive range of benefits free of charge at the point of service. 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.*"

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130.4. 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, although there is a cap on total annual out-of-pocket spending, Norwegians pay for a primary care visit, for specialist visits, and up to a set amount for prescription drugs.

130.5. Third, the NHI will have the unique feature of being coercive in effectively prohibiting private health insurance.

131. Section 33 of the NHI Act states: "*Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the*

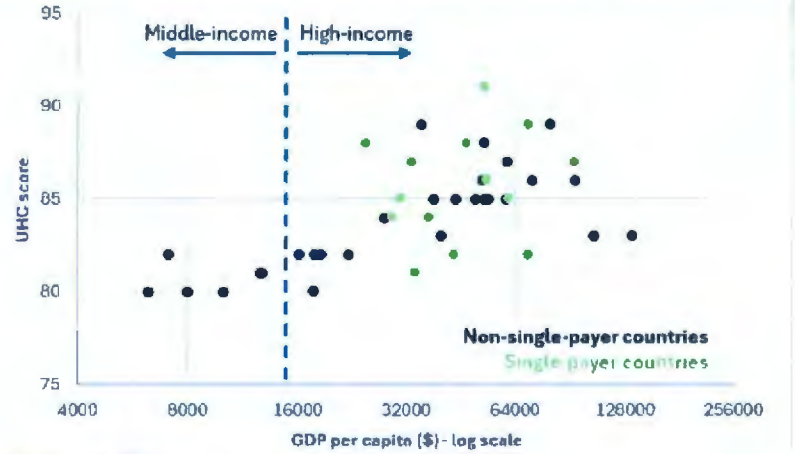
Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund."

132. In practice, section 33 of the NHI Act 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 intends to offer. All other single-payer countries, except some provinces in Canada, allow private sector health insurance to exist alongside state national health insurance.

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133. 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, depicted below, 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.

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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134. Of the 44 countries represented in the chart, 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.

135. 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*.

136. In contrast, high 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.

137. 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).

138. 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:

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138.1. 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.

138.2. 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.

138.3. 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.

139. 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

27/8/2025-9:45:05 AM

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.

140. Given this analysis and evidence, is the NHI feasible or realistic for meeting the government's universal health coverage objectives?

(iv) Requirements if South Africa is to achieve universal health coverage through a successful single-payer health system

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141. In assessing whether the NHI is a feasible strategy to achieve universal health coverage in South Africa, six criteria are analysed. In summary, these criteria are: (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; and (6) Willingness to allow the participation of the private sector to create more fiscal space and reduce the burden on a narrow taxpayer base.

142. Applying these criteria, the NHI single-payer model will not achieve the government's objectives.

Affordability given current level of GDP per capita

143. 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.

144. To afford this expenditure, these countries need high *per capita* incomes to fund health care provision.

145. In 2021, Portugal, the country with the lowest single-payer per capita income, had an annual GDP *per capita* of over $24,000 (compared to South Africa's GDP per capita of $6,843 in 2021).

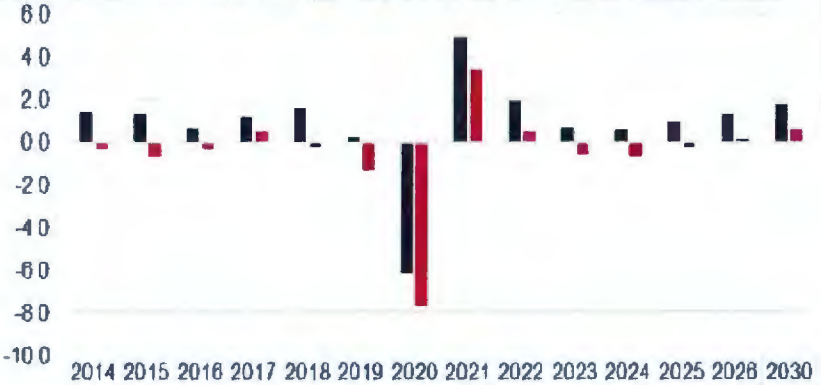
146. No middle-income country has achieved universal health coverage with a fully-fledged single-payer system. South Africa is classified as a middle-income country by the World Bank with a GNI *per capita* of $6,480 and a GDP *per capita* of $6,022 in 2023, less than half of the World Bank's lower threshold of a high-income country of $14,005 GNI *per capita*.

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147. 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.

148. Figure 3, depicted below, shows that in South Africa annual real GDP (black bars) has stagnated in the last ten years, with declining GDP *per capita* (red bars) during most years. The average standard of living is lower in 2025 than in 2014. The latest IMF forecast for South Africa 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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149. These trends show clearly that it is practically impossible for South Africa 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.

150. I pause to add to these important findings by PriceMetrics to point out that my own data analysis, in my capacity as a qualified, experienced economist and in my role as Chief Economist at Sakeliga, shows not only that countries need high-incomes to sustain functioning, fully-fledged single-payer systems, but also that, historically, single-payer systems were launched and implemented in high-income and/or fast-growing economies.

151. As has been pointed out herein above, South Africa is a middle-income country, a long way off from being considered high-income, and with a completely stagnant economy. Inflation-adjusted GDP per capita has declined over a prolonged period, falling by around 7% over the past decade [*Gross*

Domestic Product. & GDP Time Series Q1 2025. P0441; *Mid-year Population Estimates*. P0302. Statistics South Africa, 2025].

152. In the table set out below, I list the 16 comparison countries studied in the PriceMetrics reports in chronological order of when they implemented their single-payer healthcare system and compare their GDP per capita (in 2023 US dollars) at the time of implementation. For example, the UK launched the NHS in 1948. In 1948, GDP per capita in the UK, adjusted to 2023 US dollars, was $14,055. Sweden's in 1962 was $23,572, Taiwan's in 1995 was $26,247, and so on.

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153. The final column lists some features of the general economic growth of the country in question in the period leading up to and around the implementation of a single-payer system.

154. I derived the estimates from straightforward calculations and analysis of data from the following authoritative sources:

154.1. World Bank real GDP per capita in 2015 US dollars for 12 of the 16 countries [World Bank. "GDP per capita (constant 2015 US$)." *World Bank Open Data*, 2025];

154.2. The Maddison Project Database 2023 for GDP per capita for one country (Kuwait), as well as for validation and cross-checking all countries [Bolt, Jutta, and Jan Luiten van Zanden. "Maddison Project Database 2023." *University of Groningen*, 2023];

154.3. Official US CPI for adjusting country data to 2023 dollars [U.S. Bureau of Labor Statistics. "Consumer Price Index for All Urban Consumers

(CPI-U), Series ID: CUUR0000SA0." *Bureau of Labor Statistics*, 2025];

154.4. Office for National Statistics for GDP, population and inflation data for the UK [Office for National Statistics. "Gross Domestic Product: chained volume measures: Seasonally adjusted £m." *ONS*, n.d.; "RPI: All Items (RPI): Percentage change over 12 months." *ONS*, n.d.; "UK population estimates 1851 to 2014." *ONS*, n.d.];

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154.5. Official GDP per capita and inflation data for Norway [Grytten, Ola H. "The gross domestic product for Norway 1830-2003." *Historical monetary statistics for Norway*, edited by Øyvind Eitrheim, Jan T. Klovland, and Jan F. Qvigstad, Norges Bank, n.d.; Statistics Norway. "Consumer Price Index." *Statistics Norway*, n.d];

154.6. Official GDP per capita data for Taiwan [Directorate General of Budget, Accounting and Statistics. "National Accounts - Per Capita Items." *National Statistics Database*, n.d.]

27/8/2025-9:45:05 AM

List of PriceMetrics single-payer countries by implementation year and GDP per capita
Analysis by Russell Lamberti - Chief Economist, Sakeliga

Country	Single-Payer Start Year	GDP per Capita Estimate at Start Year (2023 US $)	High-income Country at Start Year?	Per Capita Growth Conditions
UK	1948	$14 055	Yes	Post war boom; avg +3%/year in early 1950s
Kuwait	1950	$39 666	Yes	No data; oil boom; rapid revenue growth
Norway	1956	$14 051	Yes	Post war boom; avg +4.3%/year in prior decade
Iceland	1957	$14 822	Yes	Post war boom; avg +4%/year in prior 5 years
Bahrain	1960	$16 557	Yes	Oil boom; avg +3%/year in prior decade
Denmark	1961	$23 795	Yes	Post war boom; avg +3%/year in prior decade
Sweden	1962	$23 572	Yes	Post war boom; avg +3%/year in prior decade
Finland	1964	$16 819	Yes	Post war boom; avg +4%/year in prior decade
UAE	1971	$73 759	Yes	Oil boom; avg +9%/year in 1970s
Canada	1972	$29 020	Yes	Post war boom; avg +3-3.5%/year in prior decade
Italy	1978	$25 819	Yes	Avg +3-3.5%/year in prior decade
Portugal	1979	$13 460	No (yet close)	Avg +4-4.5%/year in prior decade
Spain	1986	$20 577	Yes	Avg +3%/year in the 1980s
Slovenia	1992	$15 087	Yes	No growth but post-Yugoslav adjustment/efficiencies
Taiwan	1995	$26 247	Yes	Asian Tiger boom; avg +7-11%/year in prior decade
Cyprus	2019	$36 801	Yes	Avg +0.9%/year in prior decade; wealthy already
South Africa	2025*	$6 253	No	Shrinking economy; avg -0.7%/year in prior decade

*Hypothetical start year for illustrative purposes

Sources: World Bank, Maddison Project Database, Office for National Statistics (UK), US Bureau of Labour Statistics (CPI), Norges Bank, Statistics Norway, Directorate General of Budget (Taiwan), Stats SA

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155. The table shows that countries have tended overwhelmingly to implement single-payer systems when they are wealthy and growing rapidly. The median GDP *per capita* in the implementation year was $22,075, some 250% higher than in South Africa currently.

156. The lowest GDP *per capita* at implementation was Portugal, which had nevertheless been increasing at a high CAGR of over 4% for the preceding decade. By contrast, Cyprus implemented a single-payer system in 2019 after a decade of very weak GDP *per capita* growth. However, it was *already* a wealthy country with a GDP *per capita* in 2023 dollars of nearly $37,000, almost 500% larger than South Africa.

157. Slovenia implemented its system in 1992 during a tumultuous transition from Yugoslavia to an independent Slovenia. The command-economy structure was giving way to rapid resource reallocation under market conditions. Slovenia inherited, and then legislatively reformed, an already entrenched state-run healthcare system from Yugoslavia.

158. The other countries in the table all experienced periods of high economic growth, and were already wealthy, around the time of implementation. This stands to reason because, as the expert reports point out, single-payer systems are extremely expensive and resource-intensive. Small economies (relatively to population size) that are stagnant simply lack the wherewithal and capacity to render such systems viable.

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159. I also note that many of the countries implemented single-payer systems between 1945 and 1980, a period of considerably less technological sophistication in healthcare and medicine and at lower levels of care than is typically expected of such systems today. It would stand to reason that, given the long-run escalation in medical costs (highlighted in the expert reports), implementing a single-payer system at wealth and income levels that countries did in the 1945-1980 period is now less achievable. Since 1980, only one country (Slovenia) has implemented a single-payer system with a GDP *per capita* of below $20,000 in 2023 dollars.

160. GDP *per capita* is not the only important metric, but a straightforward analysis of *per capita* income provides a clear and unmistakable view of resource availability in a country. GDP *per capita* is not merely a statistical construct. It is strongly indicative of the state and scarcity of aggregate real resources

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available. These resources are not set in stone, but they also cannot simply be wished into existence. They must be produced and nurtured through very strong and sustained productive activity.

161. I now turn back to highlighting the PriceMetrics reports, which elaborate further on South Africa's lack of resources and capabilities to support a single-payer system.

Strong and sustainable fiscal capacity

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162. In a single-payer system, the burden of funding lies with taxpayers.

163. 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.

164. 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.

165. 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, 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.

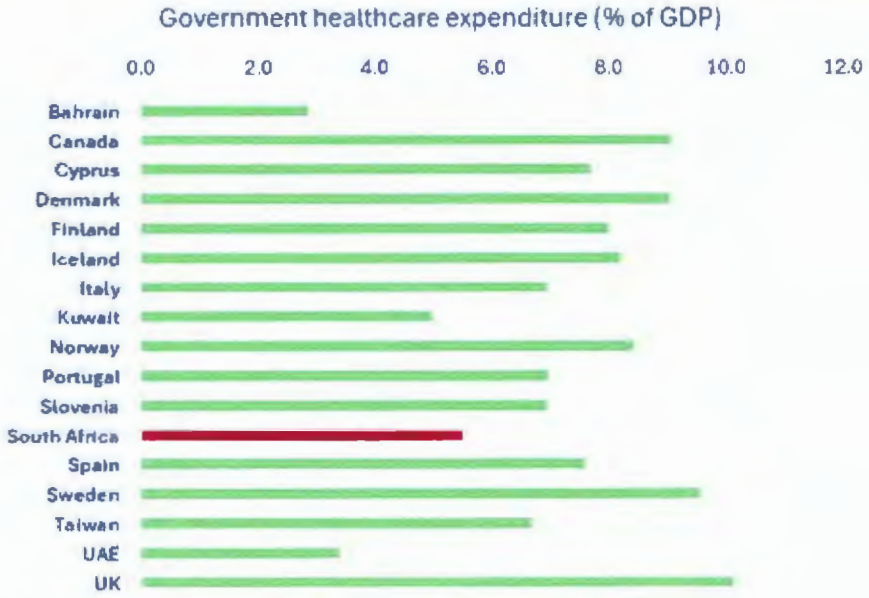
166. The report notes that per capita spend in Bahrain, Kuwait, and UAE is distorted because their public health insurance covers only citizens, not the whole population. These countries have relatively high expatriate populations.

167. 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.

168. Figure 5, depicted below, 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 was 5.5% of GDP in 2021. Government health care spending in existing single-payer countries, excluding the Middle East countries, averaged just over 8% of GDP in 2021.

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



Source: World Bank

169. Figure 5 (above) 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.

170. 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.

171. 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*.

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172. 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.

173. 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. I elaborate on this crucial point in considerably more detail in section E(c) herein below, *Economic Analysis and Fiscal Affordability Analysis of NHI*.

174. 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. These include the following:

174.1. 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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174.2. 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.

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

27/8/2025-9:45:05 AM

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



Source: World Bank

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175. The graph above 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.

176. 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.

High quality governance and administrative capacities

177. A single-payer health system requires the following attributes from the government departments and agencies that manage the system:

177.1. A capable and honest public administration, including sophisticated information systems, strong claims processing capabilities, and efficient fraud detection mechanisms.

177.2. Clear governance structures, well-defined decision-making authorities, and high levels of transparency and accountability.

177.3. Robust governance, low corruption, and effective management (e.g. cost containment mechanisms) of large-scale public financing and health care delivery.

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178. 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.

179. There is strong evidence of high levels of corruption and administrative inefficiencies in the state 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.

180. 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.

181. Underlying these deficiencies is a tolerance of inept performance and leadership, management and governance failures in the state 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.

182. 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 NHI Act gives the Minister unfettered powers to make far-reaching health regulations without necessary oversight.

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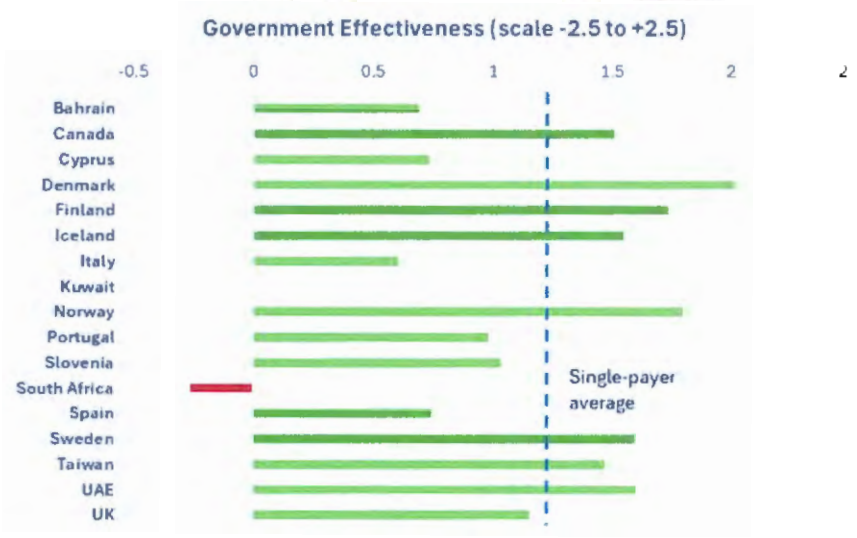
183. These governance and administrative capacity weaknesses are reflected in worldwide indicators of governance published by the World Bank.

184. The indicators cover several governance dimensions, including government effectiveness, regulatory quality and control of corruption.

185. 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.

186. Figure 9, depicted below, 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.

Figure 9: World Governance Indicators: Government Effectiveness 2023



Source World Bank

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187. 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.

188. Similarly, Figure 10, depicted below, 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 statutory monopsonist (dominant, single-buyer) in the purchase of health care products and services and monopolist in providing administrative health care management services to beneficiaries.

Figure 10: World Governance Indicators: Regulatory Quality 2023



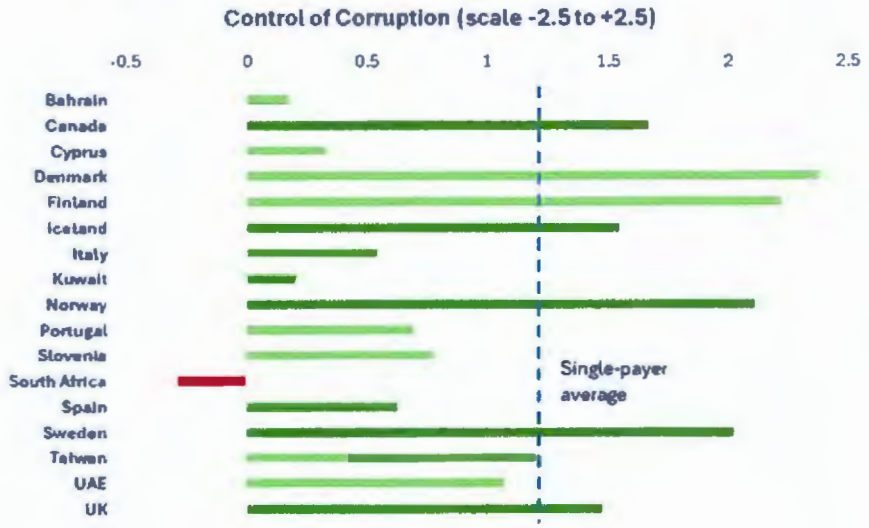
Source: World Bank

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189. Again, South Africa has a negative score of -0.22, indicating poor regulatory quality, far below the standard of all single-payer countries.

190. The final governance indicator, shown in Figure 11, depicted below, 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 power and a statutory monopoly and monopsony (the Fund will be exempt from the Competition Act) does not, given such governance weaknesses, bode well for the successful implementation of NHI.

Figure 11: World Governance Indicators: Control of Corruption 2023

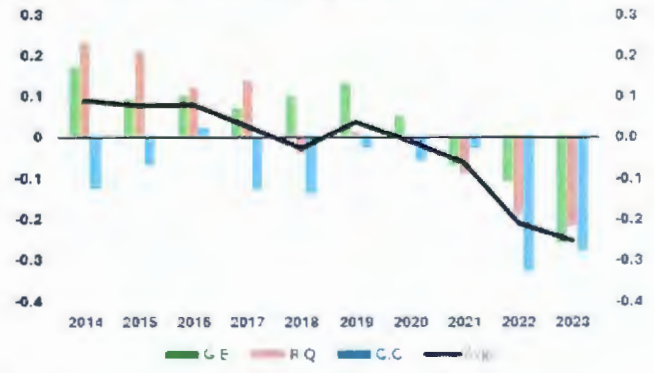


Source World Bank

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191. All three aforementioned governance indicators have deteriorated in the past decade, indicating weakening state governance and administrative capacity. Figure 12, depicted below, 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

192. In summary, these independent governance indicators compared to the standards upheld in single-payer countries, along with trends over time,

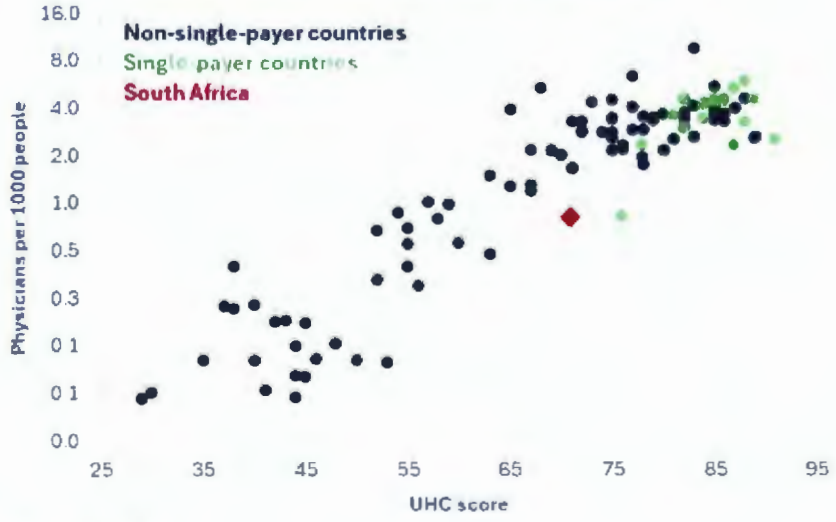
provide compelling evidence that the NHI Fund, which will have one of the, if not the, largest and most complex budgets allocated to any government department or public agency in the country, is highly unlikely to be able to achieve the governance standards and administrative capacity to implement the NHI successfully.

Sufficient health care resources: human resources and physical capital

193. Figure 13, depicted below, is a scatterplot comparing 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.

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Figure 13: Physicians per 1,000 Population, 2021



Source: World Bank

194. 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.

195. To achieve the level of single-payer countries, South Africa would, therefore, need to increase its current number of available doctors by around 350%. With 0.8 physicians per 1,000 people in South Africa, this implies around 50,000 physicians in total, a large subset of the estimated 53,773 *medical practitioners* in 2024.

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196. This, in turn, means that a staggering 175,000 physicians are needed to reach the average number of physicians *per capita* in other single-payer countries.

197. Crucial personnel constraints which prohibit the successful implementation of the NHI in the foreseeable future include:

197.1. The shortage of doctors, particularly in the state health sector;

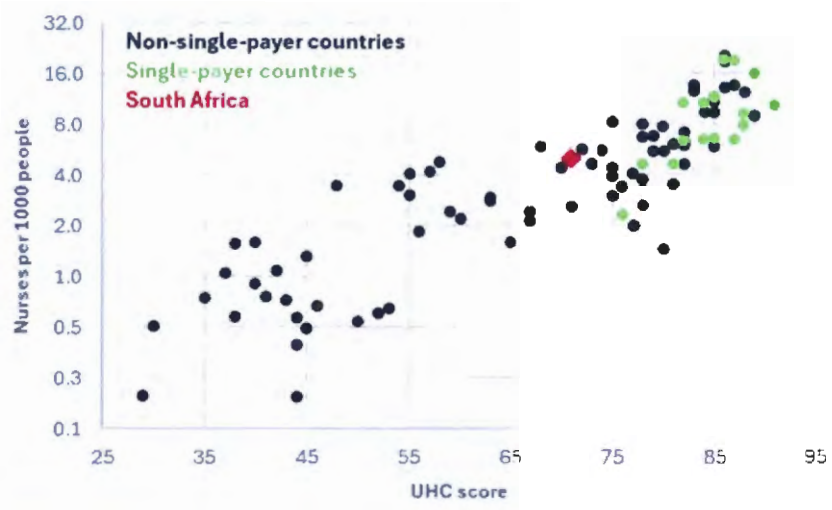
197.2. Limitations on the medical schools' capacity for training;

197.3. Restrictions on the recruitment of foreign physicians; and

197.4. The risk of emigration or exit from the profession.

198. A sufficient number of nursing staff is also essential for effective universal health coverage. Figure 14, depicted below, is a scatterplot showing 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.

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



Source: World Bank

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199. The graph shows a strong association between the number of nurses in a country and its level of health coverage.

200. 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, is 6.5 nurses and midwives per 1,000 people, and the average is 10.6 per 1,000 people.

201. 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.

202. Although relatively better than its availability of physicians, 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.

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203. Health care infrastructure is the backbone of any successful health system. However, much of the public sector health establishments and other infrastructure is dysfunctional:

203.1. A substantial number of state health facilities, many of them old, have not been adequately maintained or upgraded.

203.2. 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.

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203.3. Many facilities lack modern diagnostics and IT systems for patient records, patient referrals and supply chain management.

203.4. Rural and township areas frequently lack clinics, hospitals, and emergency care facilities.

204. These problems occur because of poor governance and administrative capacity in state health care management (referred to herein above), as well as a lack of funding for necessary investments in health facilities, particularly in primary health care.

205. 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.

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206. 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 substantive plans for major health infrastructure upgrades. The NHI cannot be implemented without adequate public sector health infrastructure and facilities.

Broad Stakeholder Support

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207. 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 poor track record in managing other public services and public enterprises such as Eskom and Transnet.

208. A recent study of health care in the country by Maphumulo, W.T. & Bengu, B.P. (2019), titled *Challenges of quality improvement in the health care of South Africa post-apartheid: A critical review,* stated:

> *"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 South Africa."*

209. 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.

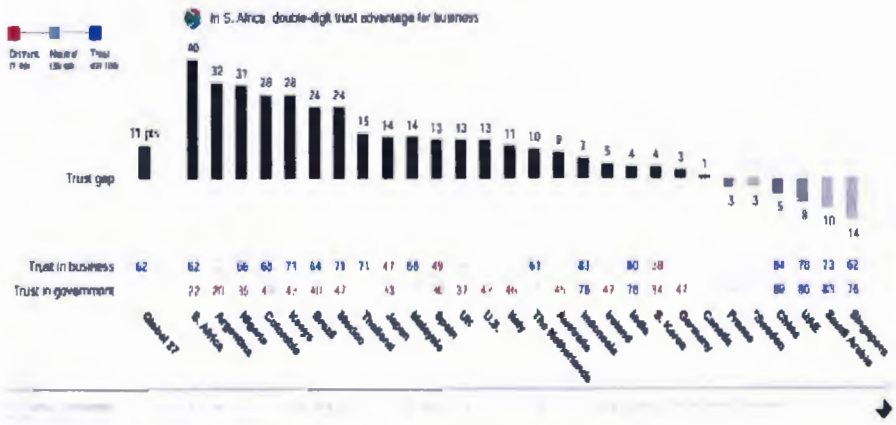
210. There is also opposition from many members of the public who have medical aid and justifiably fear they will experience inferior quality health care if NHI is implemented.

211. Figure 15, depicted below, is taken from the 2023 Edelman Trust Barometer. 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.

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Figure 15: Edelman Trust Index – Government vs Business 2023

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

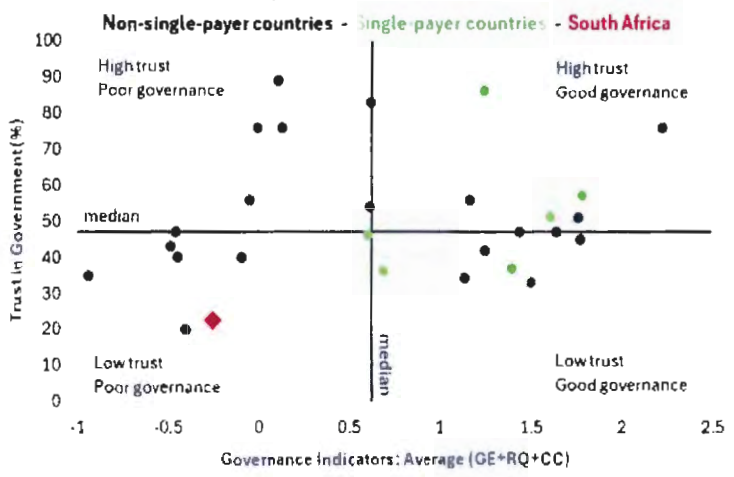


Source: Edelman Trust Index, Edelman

212. Figure 16, depicted below, 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.

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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213. Collectively, there appears to be broad support for the goal of widespread access to 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 health care services are to function well.

Willingness to allow participation of the private sector

214. All countries with single-payer health systems, except for some provinces in Canada, allow private-sector health insurance.

215. The reasons include relieving pressure on public finances by creating more fiscal space (affordability) 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 state health care coverage.

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216. 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.

217. 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.

Conclusion

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

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

219. In summary, international experience shows that the NHI, as a single-payer health system, is unaffordable, unworkable, and unattainable in South Africa. 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.

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

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221. 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 arrangements 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 insurance models.

(c) Economic Analysis and Fiscal Affordability Analysis of NHI

222. In the PriceMetrics report dated 19 December 2024, titled "*Economic Analysis and Fiscal Affordability Analysis of the National Health Insurance Act, Act No 20 of 2023*", Professor Rossouw, Dr Joubert and Mr Holland provide a comprehensive assessment of the affordability of NHI. A copy of this report is attached, marked **"FA10"**.

223. I incorporate the entire report herein as if specifically stated. Without derogating from the content of the report as a whole, I proceed to highlight the most essential facts and findings therein.

(i) Features of the NHI

224. Implementing the NHI Act will lead to fundamental changes in the provision of health care services in the country, affecting all people in South Africa.

225. 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."*

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226. 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.

227. 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.

228. 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 the report, i.e., 2028 and 2039.

229. 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.

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230. 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.

231. 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.

232. This is a serious omission on the side of the government, as it is irresponsible to expect Members of Parliament to consider a Bill such as the NHI 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.

233. The general public, members of Parliament who considered the Bill, and taxpayers in South Africa 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.

234. 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 this report as the government's estimates, as no other value(s) have – at the time of writing – 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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235. 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.

(ii) South Africa's economic environment

236. 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

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country's public finances is at or close to unsustainable levels, even before considering the NHI.

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

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

240. 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.

241. 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.

242. The 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.

(iii) The funding shortfall for NHI

243. 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.

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244. 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.

245. 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 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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246. 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.

247. 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.

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

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

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

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

249. 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.

250. The 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.

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251. 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.

252. 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.

253. 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.

254. 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.

255. 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.

256. 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.

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257. 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.

258. 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.

259. 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.

260. 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.

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

262. 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.

263. Two econometric models were run:

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

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

264. 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.

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265. 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 and declared State of Disaster.

266. 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.

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

268. 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.

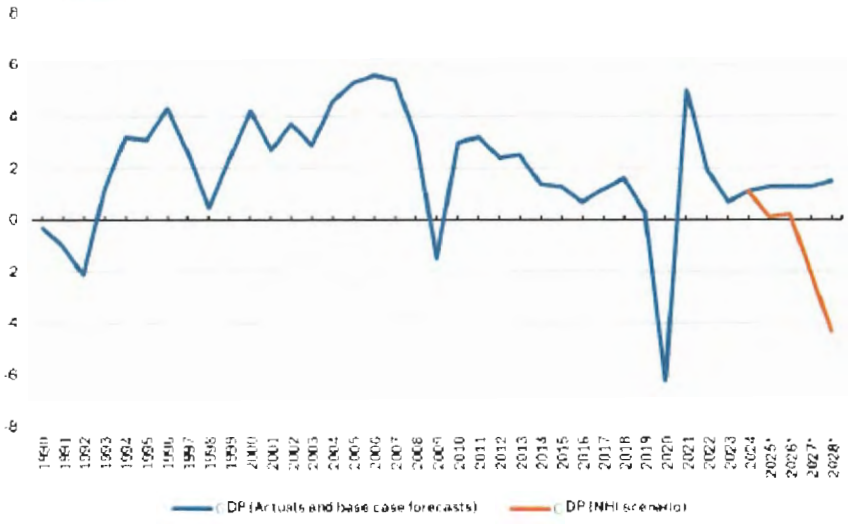
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269. The results indicate that the dampening effect of lower household disposable income will outweigh the additional consumption from an increase in government expenditure.

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

271. 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).

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



*Own forecasts. Source: SARB and StatsSA data.

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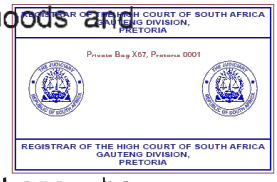
272. I must interject to clarify this point in the report. Such a contraction is not a temporary feature where the economy bounces back after the crisis dissipates, as demonstrated in the COVID-19 acute lockdown period "dip" in Figure 1 above, when economic activity recovered quite quickly in 2021/2022. 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 prolonged severe effects not only on health care but on all sectors within the economy.

273. 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.

274. 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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275. 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.



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

(iv) Conclusion

277. 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.

F. GROUNDS OF REVIEW

(a) Introduction

278. At the outset, it must be stated that any state-run health care beneficiary scheme such as the NHI ought not to be at the expense of other socio-economic ends or South Africa's already fragile economy. Yet, this is what the NHI Act will do.

279. The NHI Act creates the NHI Fund as the sole purchaser and payer for NHI-accredited health care services. All residents in South Africa (with certain exclusions) will be entitled to health care paid for by the Fund. Health professionals and health establishments are not strictly obliged to be NHI-accredited, but practising or operating outside the NHI system will be exceedingly difficult or even impossible for the vast majority of practitioners and medical establishments. This has a distinct and irreversible distortion on the market in respect of the provision of health care services and is a retrogressive rather than a progressive measure.

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280. However, the NHI Act goes beyond the mere creation of a special Fund and centralises the provision of health care services to those that may be determined by the Benefits Advisory Committee, thereby unreasonably infringing upon and interfering with the discretion of medical professionals and the autonomy of the individual to make informed decisions regarding their health.

281. The grounds of review are addressed below. I request the court to read the grounds of review together with the facts that have been addressed in the body of this affidavit already.

(b) The NHI Act is irrational

282. The overarching purpose of the NHI Act is stated to be to "*... achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution ...*" (Introduction section to the NHI Act).

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282A The Preamble provides that the NHI Act is enacted *inter alia* in order to "*achieve the progressive realisation of the right of access to quality personal health care services*" and "*make progress towards achieving Universal Health Coverage*".

283. Section 2 of the NHI Act provides that the purpose of the NHI Act is to establish a Fund "*... that aims to achieve sustainable and affordable universal access to quality health care services ...*".

284. The NHI White Paper 2017, (published in the Government Gazette on 30 June 2017), provides *inter alia* that "*... NHI is intended to move South Africa towards Universal Health Coverage (UHC) by ensuring that the population has access to quality health services and that it does not result in financial hardships for individuals and their families.*" (par 1.1.1), that "*NHI derives its mandate from Section 27 of the Bill of Rights of the Constitution of the Republic of South Africa in which a commitment is made for the State to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health care.*" (par 1.1.3), and that

"*Universal population coverage under NHI will ensure that all South Africans have access to comprehensive quality health care services. …*" (par 1.1.6).

285. The stated government purpose of the NHI Act is to achieve sustainable and affordable universal access to quality health care services.

286. However, there are a number of factual and logical fallacies with the government's stated purpose.

287. Firstly, the NHI's achievement of a particular "quality" of health care falls not within the ambit of the legislation itself but squarely within that of the executive branch of government, primarily responsible for implementing and administering it. Should the executive fail, it then falls to Parliament, exercising its oversight functions, to correct.

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288. It is plainly a misnomer and irrational to state that any legislation can create or ensure access to "quality" health care. Even if the NHI Act defined "quality" health care clearly and specifically, which it fails to do and therefore leaves the concept wholly vague and subjective, one cannot legislate "quality" health care. Rather, it may be possible to remove explicit legislative or regulatory barriers and disincentives to good quality health care provision in the state and private sectors, which then enables participants in these sectors to achieve a desired quality of health care through purposeful, directed action, subject to resource constraints. Moreover, aside from legislative provisions, the quality of health care is determined, *inter alia*, by the availability of well-directed real resources, qualified personnel, know-how, sufficient productive incentives, and institutional and governance quality.

289. Then, 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.

290. The effect of the NHI Act on the state's resources is more fully addressed in the heading below dealing with reasonableness.

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291. As to the necessary involvement of the private sector, the NHI Act assumes that both private and state health care service providers, i.e. medical doctors, specialists, nurses, pharmacists, etc., will offer their services at the rate purchased by the Fund.

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291.1. However, if medical professionals are unable to offer their services on their own terms, this is an unjustifiable infringement of the right to choose one's trade, occupation or profession freely. As a result, many medical professionals will either leave the country or their chosen profession, which necessarily impairs the ability of the state to deliver access to health care. In an ever-smaller world, it is impossible to exclude the effects of international labour markets that compete for limited medical expertise.

291.2. Furthermore, medications and medical equipment are purchased from private manufacturers. Should the price set by government not be acceptable to such manufacturers, then they will simply not sell their products to the Fund and NHI-accredited health care practices and facilities. This is particularly so if the manufacturer is expected to sell

at a loss or an insufficient margin – adversely affecting the long-term feasibility of that business. This may potentially result in some pharmaceutical companies or medical product suppliers shutting down, thereby limiting supply or removing the product altogether.

292. The NHI Act is predicated on an irrational economic fantasy, fails to take into account economic reality, and will adversely affect the provision of health care services in the country. The NHI Act is not rationally related to the achievement of a legitimate government purpose.

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293. Furthermore, there is no rational justification for a single-payer system. There is no evidence to suggest that Government or Parliament ever investigated or considered possible alternatives such as reforming and improving the current multi-payer arrangement, reducing or eliminating existing regulatory burdens that hamper health care provision in the public and private sectors.

294. The NHI Act is further fundamentally irrational due to the fact that the state has failed to adequately model the impact of the NHI Act or to determine the cost implications of the NHI Act. Such irrationality is aggravated in circumstances where the absence of such modelling results in a failure to consider the dire consequences for other socio-economic ends of implementing NHI. It is fundamentally irrational to promulgate legislation that has very substantial and fundamental ramifications on the public purse, the general public, on medical practitioners, health care providers and suppliers, and on the economy, in the absence of preceding, proper modelling and careful analysis having been performed by the state.

295. 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.

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296. In aggravation of the aforesaid, it is apparent that the state is aware of the fact that the NHI Act, and its stated purpose, is financially unaffordable – i.e. the state is aware of the fact that the legislation cannot rationally achieve its stated purpose.

297. In the 2019 Medium Term Budget Policy Statement, a relevant extract of which is attached hereto marked **"FA11"**, at p. 37, the following was stated by National Treasury (Minister TT Mboweni being the Minister of Finance at the time):

> *"**Updated cost estimates for national health insurance***
>
> *The NHI policy aims to provide health care more equitably in South Africa. Originally, NHI costs were projected to increase public health spending from about 4 per cent to 6 per cent of GDP over 15 years.* ***However, given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable.*** *The National Treasury assisted the Department of Health to develop an actuarial model with updated fiscal costs and limited policy reforms to strengthen the current health care system. The revised model estimates*

that rolling out NHI would require an additional R33 billion annually from 2025/26. These amounts are not budget commitments but indicative cost estimates." (my emphasis)

298. In the 2021 Medium Term Budget Policy Statement, a relevant extract of which is attached hereto marked **"FA12"**, at p. 55, the following was stated by National Treasury (Minister E Godongwana being the Minister of Finance):

> *"A limited costing of the national health insurance policy proposal has previously shown that it would require about R40 billion per year in additional funding in the first five years, and perhaps considerably more over time. At present, however, there is insufficient capacity in the health sector to work substantively on national health insurance."*

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PRETORIA

299. The state, particularly National Treasury, is acutely aware of the fact that the NHI will require a significant allocation of resources and is simply unaffordable. It is, moreover, noteworthy that National Treasury's relatively low estimates of additional costs for the NHI are still considered unaffordable.

300. It is equally noteworthy that National Treasury, in pronouncing negatively on NHI affordability, is evidently assuming that taxes will not be increased, at least not materially. National Treasury has often expressed its reluctance to raise taxes meaningfully, being concerned about the effect of tax hikes on tax compliance and especially economic growth. Indeed, in the 2024 Budget Review [*South Africa. National Treasury. "Revenue Trends and Tax Proposals." 2024 Budget Review, Chapter 4, National Treasury, 2024*], National Treasury states quite clearly that:

> *"Government's **long-term tax policy** remains focused on **broadening the tax base while improving tax compliance and administrative efficiency.** In combination, this approach will raise long-term revenue in*

a sustainable manner while ***limiting tax rate increases where possible****."*

"Government has given careful consideration to the proposed tax adjustments. Raising revenue in a constrained economic environment comes with ***significant risks****..."*

"The choice of revenue proposals is informed by the ***negative feedback effects of tax increases on economic growth and the tax bases...*** *" (own emphasis)*

301. It is clear that high tax increases are not part of National Treasury's long-term taxation strategy, let alone the dramatic tax increases required to fund NHI. Yet, such tax increases are precisely the implicit assumption of the Department of Health in order to implement the NHI.

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GAUTENG DIVISION,
PRETORIA
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GAUTENG DIVISION,
PRETORIA

302. It is apparent that the two departments of the national executive are pursuing two mutually incompatible policies with respect to taxation and expenditure. Furthermore, the Department of Health *depends upon* National Treasury to adopt taxation policies to implement the NHI, which are contrary the latter's taxation policies.

303. National Treasury recognises and alludes to the significant risks of raising revenue in a constrained economic environment. Raising taxes required for the implementation of the NHI Act would be fiscally and economically catastrophic.

304. When we say that the NHI proposed by the NHI Act is unaffordable, we mean that, due to the cost of NHI, it will overburden South Africa's economy to the point where economic growth will be impossible and another generation of people in South Africa, particularly the most economically and socially

vulnerable, will see their living standards decline considerably, with many locked in permanent poverty without realistic prospects of upliftment.

305. In further aggravation, the NHI Act provides no clarity or transparency in respect of the funding of the NHI. The NHI Act is fundamentally vague in material respects. A money bill that does not realistically or accurately provide for funding cannot rationally achieve any purpose, let alone a legitimate government purpose.

306. It must be made clear that the creation of such a fund and implementation of the NHI Act necessarily comes at the expense of various other state and private spending priorities and socio-economic ends.

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

307. The state has a limited budget and, as stated by Professor Rossouw, Dr Joubert, and Mr Holland under heading E(c) above, 70% of government revenue is already allocated to social grant expenditure, civil service remuneration and interest payments on government debt.

308. 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.

309. However, the creation of the NHI 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.

310. There is no rational reason to dedicate significant state resources for the creation of a fund at the expense of housing, social welfare, water and sanitation, policing, education and other objectives.

311. Moreover, the PriceMetrics reports referenced herein above show clearly that the NHI will also necessarily and inevitably compete for and draw heavily on the resources and income of private households, businesses, and communities. The NHI will displace resources and income currently allocated to acquiring food, clothing, housing, security, education and other critical goods and services, as well as that allocated to charitable giving, family aid and remittances, and other valued philanthropic activities, and that allocated to vital short- and long-term savings, insurance protection, stokvels, and the like, that provide crucial economic security to millions of individuals, families, and communities.

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GAUTENG DIVISION,
PRETORIA
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GAUTENG DIVISION,
PRETORIA

312. The NHI will also necessarily displace vital investment spending necessary to maintain and build key infrastructure and productive business ventures across all spheres of the economy, leading to further attrition in productive economic activity and even more strain on the country's already-fragile employment conditions.

313. Sakeliga is advised and submits that these constitutionally protected socio-economic ends in South Africa are profoundly interrelated, interdependent, complex, and, to a degree, fragile, and therefore that the promulgation of the NHI Act at the expense of these is irrational and unconstitutional.

314. The irrationality of the NHI Act is further exposed when regard is had to the fact that the NHI Act seeks to extend health coverage insurance to the

27/8/2025-9:45:05 AM

currently privately insured population who, by virtue of funding and insuring their own health care, are scarcely a burden on the state's finances and health care resources.

315. 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. 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.

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

316. This is not what is required by section 27 of the Constitution, and the pursuit of NHI is irrational.

317. Further, the NHI Act provides for a substantial new bureaucracy at vast expense to the state, thereby expanding the already bloated civil service.

318. The NHI Act serves to ensure a levelling down of health care for both private and public 'users' / patients contrary to the constitutional commitment to improve the quality of life of all citizens.

319. In truth and in fact, the NHI Act is not directed at improving access to health care services as contemplated in section 27(1)(a) of the Constitution.

320. It is rather aimed at creating a single National Health Insurance Fund (section 9 of the NHI Act) with the functions set out in section 10 of the NHI Act.

321. As such, the NHI Act is principally aimed at, and concerned with, the provision of tax-funded social security, specifically social assistance, as contemplated in section 27(1)(c) of the Constitution.

322. Section 27(1)(c) of the Constitution is expressly qualified by the words "*…if they are unable to support themselves and their dependants, appropriate social assistance*" such that the state is only obliged to provide – subject to its available resources – social assistance to those who are unable to support themselves. This, again, is a marker that a single-payer system is not Constitutionally sanctioned.

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

323. Sakeliga submits that, as a corollary to section 27(1)(c), there is no obligation on the state to provide social assistance to those who are able to support themselves. By the same token, the state cannot prevent those who are able to do so from supporting themselves in the manner they deem fit. Nor may the state legislatively deprive them of their choice.

324. By allowing those who are able to support themselves to do so, the state reduces both the financial and administrative burden on its limited resources so that such resources may be focused on providing to those who are unable to provide for themselves.

325. Further facts relevant to rationality are dealt with in the further grounds raised.

(c) The NHI Act is not a reasonable legislative measure

326. Section 27 of the Constitution states:

> ***27. Health care, food, water and social security***. *—(1) Everyone has the right to have access to—*

(a) *health care services, including reproductive health care;*

(b) *sufficient food and water; and*

(c) *social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.*

(2) *The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*

(3) *No one may be refused emergency medical treatment.*

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GAUTENG DIVISION,
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GAUTENG DIVISION,
PRETORIA

327. Sakeliga is advised and submits that:

327.1. the obligation in section 27(2) is for the state to take reasonable legislative measures, within its available resources;

327.2. implicit in section 27 of the Constitution, is the negative duty on the state not to impair or infringe on people's rights who are able to provide for themselves;

327.3. further implicit in section 27 of the Constitution is the recognition that the state has limited resources available to it and must seek the progressive realisation of such assistance but that no one can merely demand to be provided with any one right or form of assistance and expect to receive it.

328. As has been dealt with already, the implementation of the NHI Act in order to meet a legitimate government purpose is not "*within [the state's] available resources*". I repeat that which I have addressed above already.

329. Moreover, the NHI Act seeks to procure resources outside of the state and co-opts private resources in order to achieve its stated goal.

330. Section 27 requires the state to take reasonable legislative measures progressively to realise access to health care services. In order to comply with the Constitutional injunction that such legislative measures be 'reasonable', such measures must be comprehensive, coherent and coordinated, and must be reasonably conceived and implemented.

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

331. The NHI Act was not reasonably conceived and does not present a coherent system which can be coordinated and reasonably implemented.

332. The NHI shall lead to an overall regression in access to health care services in breach of and a violation of section 27 of the Constitution.

333. As matters stand and prior to the implementation of the NHI:

333.1. Everyone (except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases) is entitled to free primary health care services; (National Health Act, section 4(3)(b).)

333.2. All pregnant and lactating women, and children under six years of age, (who are not members or beneficiaries of medical aid schemes) are entitled to free health care services. (National Health Act, section 4(3)(a).)

333.3. Everyone is entitled to HIV care. (National Department of Health Directive, 2008.)

333.4. No one may be refused emergency medical treatment. (Constitution, section 27(3) and National Health Act, section 5.)

334. The NHI Act makes participating in the NHI system obligatory for everyone, even those who are able to provide for their own access to health care. This is an unjustifiable infringement of section 27(1) as the state impairs the ability of such users to access health care and obliges them to make use of state resources through the NHI.

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

335. This is aggravated by the fact that the state fails to adopt reasonable other measures" to enable economic growth, fight corruption within the health care sector (and the public sector as a whole), and improve the quality of health care at government-run institutions.

336. There are currently approximately 9,13 million persons (including dependants) on private medical aids in 2023, up from 9.04 million in 2022. The freedom of those persons, subject to the terms of whatever medical aid contract they are on, to obtain health care of their choice, is constitutionally recognised.

337. The NHI shall result in both a (**a**) qualitative and (**b**) quantitative regression in respect of the health care services to this portion of the population.

338. There is simply no need to do so. As stated above, multi-payer or hybrid arrangements can achieve high levels of health coverage, without jeopardising existing health care provision.

339. The NHI requires the state to assume financial responsibility for the aforesaid privately insured portion of the population.

340. Moreover, section 33 of the NHI Act effectively deprives the privately insured portion of the population and any other person that wishes to become part of a medical scheme, from contracting to obtain such benefits offered by the Fund.

341. In truth and in fact, the NHI shall achieve the equality of the grave as opposed to striving to achieve that of the vine. It will ensure a levelling down of health care for both private and public 'users'. The implementation of the NHI Act results in a long-term regression in access to health care services.

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

342. The ultimate result of the NHI Act and its provisions is a significant regression in access to health care services. This is an unreasonable legislative measure, unlawful, and unconstitutional. It constitutes a breach of section 27 of the Constitution.

343. The regressions addressed above are unreasonable and thus in breach of s 27(1)*(a)* and (c), read together with s 27(2) of the Constitution.

344. In addition, the NHI Act is unreasonable for the following further reasons:

344.1. As stated above, the NHI is unaffordable, and the implementation thereof will place unreasonable demands on government revenue and household income at the expense of other valued socio-economic ends;

344.2. This will cause serious fiscal decay in South Africa that will detrimentally affect the country's already weak economic growth outlook and drag economic activity and gross domestic product into a

deep and prolonged contraction, with concomitant sustained increases in unemployment;

344.3. The NHI will have to be funded by an increase in taxes. This will result in diminishing revenue returns even if taxes are increased, due to South Africa's low tax buoyancy. However, in light of the recent social and political revolt against the Minister of Finance's proposed increase of 2 percentage points (from 15% to 17%) in VAT in the 2025/2026 financial year, it is clear that South Africa's tax base is at its limit, and it is clear that the Government will not be able to raise the taxes necessary for NHI.

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

344.4. The proposal to increase taxes to afford NHI is a concession that the state does not have the ability to implement the NHI within its available resources.

345. The NHI Act is an unreasonable legislative measure, and it is not being coupled with the necessary structural, long-term economic and other measures that would foster the conditions that might make it a feasible system. The state does not have the financial or administrative resources available to implement the Fund.

(d) The state has failed to take reasonable other measures to progressively realise access to good quality health care

346. Section 27(2) of the Constitution obliges the state to take reasonable legislative and other measures to achieve the progressive realisation of the rights in section 27(1).

347. The PriceMetrics Reports make clear several of the key conditions for the successful implementation of the NHI as a single-payer system. In particular, South Africa must have:

347.1. A high GDP *per capita*, which defines the country as a high-income country.

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

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

347.3. Comprehensive health care resources, including health professionals, pharmaceutical products, medical infrastructure (clinics, hospitals, other health establishments), and health information systems.

347.4. 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.

347.5. High levels of stakeholder acceptance and political consensus over the electoral cycle, given the large funding requirements.

347.6. Willingness to allow the participation of the private sector to create more fiscal space and reduce the burden on a narrow taxpayer base.

348. None of these criteria are present in South Africa or the NHI Act.

349. As stated above, given the current level of economic activity in South Africa, the NHI is unaffordable. The state has and is failing to take reasonable steps

RVL

to enable productive economic activity to grow in South Africa. This is a failure of the Constitutional injunction in section 27(2) of the Constitution.

350. South Africa does not have a strong and sustainable fiscal capacity. As explained above, South Africa is experiencing serious fiscal decay, and the implementation of NHI will push it over the edge.

351. South Africa does not have high-quality governance and administrative capacities:

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

351.1. Corruption remains endemic in South Africa's governance and administration structures. In the health care sector in particular, fraud and corruption are not punished. It is shielded in order to ensure that the financial taps remain open to politically connected businesses. This is perhaps exemplified in the health care sector by the tragic assassination of Babita Deokaran in August 2021, who unsuccessfully attempted to stop irregular payments relating to Tembisa Hospital.

351.2. In the years since her assassination, the Tembisa Hospital remains the scene of deep-seated corruption, and the masterminds of her assassination are still at large.

351.3. It can thus reasonably be stated and foreseen that the creation of a massive fund in the NHI will not be utilised to advance quality health care but rather result in further procurement irregularities, graft, and endemic inefficiencies.

351.4. The government has an abysmal track record in managing funds similar to the planned NHI:

351.4.1. The Road Accident Fund is one of the most important social security funds in South Africa today. It exists in order to give effect to section 27(1)(c) of the Constitution.

351.4.2. Similar to the NHI Fund, the RAF is not a risk-based insurance system and is allegedly under-resourced.

351.4.3. The RAF is plagued by maladministration and mismanagement, resulting in beneficiaries of the RAF victims of road accidents, not being paid the compensation that they are lawfully due because the RAF does not properly or timeously process claims.

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351.4.4. After waiting years for their claims to be processed, the victims of road accidents turn to the court to enforce their rights and wait years for their day in court.

351.4.5. It can reasonably be expected that the maladministration, inefficiencies, and overload present at the RAF will also be present with the NHI Fund. However, this will be exponentially worse with the NHI Fund as it caters to all 'users' and not just a few road accident victims relative to the population of South Africa.

351.4.6. Another such fund is the Compensation Fund. I attach hereto an article, marked **''FA13"**, (also available at Fraud flagged at the Compensation Fund | GroundUp) which details *inter alia* that the Auditor-General's office has

27/8/2025-9:45:05 AM

flagged potential fraud at the Compensation Fund and advises that almost every aspect of the institution is dysfunctional.

351.5. The government has failed to take steps to improve the quality of health care provided in state hospitals and clinics.

352. As stated above, South Africa does not have sufficient health care resources at present in order to deliver the quality health care promised by the NHI Act. If anything, South Africa will lose its doctors, nurses, and other skilled health care professionals to more favourable opportunities outside of South Africa should the NHI Act be implemented.

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA GAUTENG DIVISION, PRETORIA
Private Bag X67, Pretoria 0001
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353. The NHI lacks broad stakeholder support. It lacks support from both health care professionals, health care businesses, medical aid members, and civil society.

354. The NHI Act effectively bans the private sector and places an unaffordable burden on a narrow taxpayer base. As stated above, the taxpayer base will not grow due to the deleterious effects which the NHI will have on the economy. There is no reason why private health insurers and medical schemes should be eliminated, especially in such a resource-constrained country. On the contrary, there is much scope for reducing or eliminating a myriad of existing regulatory burdens that hamper health care provision in the state and private sectors.

355. The government has failed to take such reasonable legislative, governance and economic measures, in order to achieve universal or widespread access to health care of an acceptable quality. For example:

355.1. The state has failed to take reasonable economic measures to ensure sustained, high economic growth in order to boost GDP *per capita* to put South Africa on track to becoming a high-income country.

355.2. The state has insufficient medical professionals to properly serve the population and is failing to train and retain sufficient health care professionals, specifically doctors and nurses, for this purpose.

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

355.3. The state is failing to address corruption and the endemic inefficiencies of public sector bureaucracy.

355.4. The state has failed to address its dysfunctional health care systems and institutions, including hospitals and clinics, in order to foster sufficient public trust in its health care services.

356. If the government determines through rigorous, rational analysis to implement a single-payer health care system (which it has failed to do), it is similarly constitutionally obliged to take each of these reasonable and necessary measures in order to foster the conditions without which a legislative framework such as the NHI Act is unviable and socially perilous. This too the state has failed to do.

RVL

27/8/2025-9:45:05 AM

(e) Health care providers are beholden to the state in respect of health services provided and remuneration

357. The NHI Act seeks to establish and maintain the National Health Insurance Fund as the single purchaser and single payer of health care services in the Republic. (section 2(a) and 3(5) of the NHI Act)

358. The NHI Act defines a health care service provider as follows: "*'**health care service provider**' means a natural or juristic person in the public or private sector providing health care services in terms of any law;*". Accordingly, all persons, whether natural or juristic, in the public or private sector, who/that provide "*health care services*" are included in such definition.

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

359. '*Health care services*', in turn, are very broadly defined in the NHI Act as follows:

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

259A Further aspects that are implicated by the aforesaid definitions include "*health goods*", "*health product*", "*provider payment*", "*strategic purchasing*", "*supplier*" *et cetera.*

259B One of the purposes of the NHI is stated to be the establishment of a Fund in the Republic to serve as the "*... single purchaser and single payer of health care services ...*".

360. Section 35 of the NHI provides:

> "***Purchasing of health care services***
>
> *(1) The Fund must actively and strategically purchase health care services on behalf of users in accordance with need.*
>
> *(2) The Fund must reimburse payment directly to accredited and contracted central, provincial, regional, specialised and district hospitals based on a global budget or Diagnosis Related Groups.*
>
> *(3) Funds for primary health care services must be reimbursed directly to accredited and contracted primary health care service providers and health establishments at the sub-district level as outlined in section 37.*
>
> *(4) (a) Facility-based emergency medical services provided by accredited and contracted public and private health care service providers must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary.*
>
> *(b) Mobile emergency medical services provided by accredited and contracted private health care service providers must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary.*
>
> *(c) Public ambulance services must be reimbursed through the provincial equitable allocation."*

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

RVL

361. Section 41 of the NHI provides:

> ***41 Payment of health care service providers***
>
> *(1) The Fund, in consultation with the Minister, must determine the nature of provider payment mechanisms and adopt additional mechanisms.*
>
> *(2) The Fund must ensure that health care service providers, health establishments and suppliers are properly accredited before they are reimbursed.*
>
> *(3) (a) An accredited primary health care service provider or health establishment providing primary health care services must be reimbursed by the Fund in accordance with the prescribed capitation strategy.*
>
> *(b) In the case of specialist and hospital services, payments must be all-inclusive and based on the performance of the health care service provider, health establishment or supplier of health goods, as the case may be.*
>
> *(c) Emergency medical services must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary.*
>
> *(4) Without limiting the powers of the Minister to make regulations in terms of section 55, the Minister may make regulations to-*
>
> *(a) provide that payments may be made on condition that there has been compliance with quality standards of care or the achievement of specified levels of performance;*
>
> *(b) determine mechanisms for the payment of an individual health worker and health care provider; and*
>
> *(c) provide that the whole or any part of a payment is subject to the conditions outlined in a contract and that payments must only be effected by the Fund if the conditions have been met.*

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

(5) For the purposes of subsection (4), 'health worker' and 'health care provider' have the meanings ascribed to them in section 1 of the National Health Act.

362. In addition to the aforesaid, section 33 of the NHI Act (referred to further below) effectively bans private sector insurance in respect of (undefined) health care services. This provision is a further limitation on trade and business.

363. While the practice of one's trade, occupation or profession may be regulated by law, any restriction on the freedom of the exercise of such trade, occupation or profession ought to be appropriate according to rational considerations of the common good.

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

364. As stated above, the NHI Act does not take into account rational considerations of the common good and fails to consider whether medical professionals will indeed be willing to provide their services on the basis determined in the NHI Act.

365. Individuals who enter the medical profession dedicate years to their professional training and specialisation. It is likely that, if an individual is not free to practice their chosen profession according to their chosen preferences after years of studious dedication, a proportion of prospective medical students may choose to study in fields outside of medicine.

366. Medical professionals are trained in the spirit of the Hippocratic Oath, but they are nonetheless professionals subject to open market costs to their practices (such as rental, electricity, water and other input costs and the cost of acquiring often-times highly specialised and expensive medical equipment

and machinery) and provide their labour services voluntarily. As such, they are neither public property nor slaves.

367. If they cannot practice their chosen profession under fair and reasonable conditions in South Africa, it is reasonable to expect that a substantial proportion of practitioners will seek opportunities abroad in health care settings offering more attractive professional working conditions.

368. The South African government simply cannot compel medical professionals to remain in South Africa, as is done in Cuba and North Korea, as this will be contrary to the constitutional order in South Africa.

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369. However, not all medical professionals will be able to emigrate to protect their professional autonomy. It is reasonable to expect some to choose to leave the medical profession and pursue other economic opportunities in different sectors, while others will choose early retirement. Yet for a substantial proportion of medical professionals, all these options will be unattainable, and many will be forced to work in the NHI system expressly against their will, effectively prohibited from viable professional alternatives.

370. Moreover, it is an unacceptable and unjust infringement upon medical professionals' fundamental professional freedom to be forced to leave their country to practice their profession according to their preferences and ethics, or to have to abandon their profession for an unfamiliar line of work or retire early for the same reasons.

27/8/2025-9:45:05 AM

(f) The NHI Act is premised on a flawed cost-saving rationale

371. The NHI Act seeks to establish and maintain the National Health Insurance Fund as the single purchaser and single payer of health care services in the Republic. This is neither rational nor a reasonable measure.

372. 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.

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

373. This rationale is specious and economically flawed for a number of reasons, dealt with herein below.

(i) State procurement inefficiencies negate theoretical savings

374. Due to institutional realities of state procurement in South Africa, the NHI Fund faces at least three considerable offsets to theoretical monopsonistic and regulated cost reduction.

The First Offset: Public procurement policies

375. Section 38(7) of the NHI Act mandates adherence to state procurement policies. Therefore, the NHI Fund will be subjected to similar institutional constraints that have produced considerable procurement cost premiums in large state-owned enterprises and government departments. [International Monetary Fund. "*Public Procurement in South Africa: Issues and Reform Options*." Selected Issues Papers, vol. 2023, no. 041, 26 June 2023.]

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376. The theoretical monopsony model assumes the buyer can choose from a large pool of competing suppliers. [Perloff, Jeffrey M. *Microeconomics*. 6th ed., Pearson, 2012.] However, the reality in South Africa is that current procurement regulations artificially reduce the number of potential suppliers through B-BBEE, local content requirements, and set-aside provisions for designated groups. [Fourie, David, and Cornel Malan. *"Public Procurement in the South African Economy: Addressing the Systemic Issues."* Sustainability, vol. 12, no. 20, 20 Oct. 2020, p. 8692]

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377. All else equal, standard economic theory and evidence hold that less supply available tends to raise costs and lower the quality of products and services. [Perloff, Jeffrey M. *Microeconomics*. 6th ed., Pearson, 2012.]

The Second Offset: Diseconomies of scale in centralised procurement planning

378. Monopsony cost savings assume large, centralised procurement operations.

379. For the NHI Fund to achieve this, it will be required to execute health care procurement centrally for a geographically dispersed health care system with highly diverse needs spanning urban centres, rural areas, and remote communities.

380. This level of scale and complexity, in turn, requires costly resource allocation systems, expensive logistics coordination, and high administrative overhead to calculate, coordinate, monitor, and adjust procurement for multiple dynamic health care settings.

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381. The Fund can potentially mitigate these frictions of centralised coordination by decentralising procurement budgets and decisions to local levels, but this would then negate monopsony savings effects by fragmenting the NHI Fund's purchasing power. [International Monetary Fund. *"Public Procurement in South Africa: Issues and Reform Options."* Selected Issues Papers, vol. 2023, no. 041, 26 June 2023.]

The Third Offset: State monopoly governance failures

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382. As a large state institution with an enormous budget and no competition, the NHI Fund is likely to suffer from the well-documented wasteful and irregular expenditure, misappropriation of funds, and tender corruption that has plagued state-owned enterprises and national, provincial, and municipal government departments, including the health department. [Rispel, L.C., et al. *Exploring corruption in the South African health sector.* Health Policy and Planning, vol. 31, no. 2, Mar. 2016, pp. 239-249.]

383. The reports by the Judicial Commission of Inquiry into allegations of State Capture, Corruption and Fraud in the Public Sector, including organs of state (also known as the Zondo Commission), provide extensive documentation of systematic procurement irregularities across state entities that incur high additional costs. The findings of wrongdoing at SOEs include South African Airways, Eskom, Transnet, the South African Revenue Service, and Denel. [Zondo DCJ, Raymond. *Judicial Commission of Inquiry into State Capture: Report Part 6.* Government of South Africa, 22 June 2022.]

384. State monopolies are highly exposed to inherent principal-agent problems, meaning the incentives of decision-making bureaucrats (agents) are

misaligned with the public (principals) in whose interests they are meant to be acting.

385. Weak accountability mechanisms can allow agents to act with impunity.

386. Information gaps make it hard for principals to monitor agent behaviour. [Klitgaard, Robert. *Controlling Corruption*. University of California Press, 1988.]

387. The NHI will lack competitive market discipline exercised through patient and health care provider choice, which provides the incentives to provide cost-efficient services, innovation, and customer responsiveness. NHI beneficiaries (customers) cannot even choose to withhold their spending on the NHI since it is taken from mandatory taxes, weakening accountability even further.

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(ii) Supplier margin erosion creates shortages and supply concentration

388. Paying lower prices is not an unqualified benefit in terms of overall economic welfare and efficiency.

389. A well-known feature of monopsonistic and regulated pricing that sets prices below market-clearing levels is a reduction in the supply of goods, services, and labour. [Perloff, Jeffrey M. *Microeconomics*. 6th ed., Pearson, 2012.]

390. Paying lower prices may, all else equal, initially reduce costs, but this initiates a counter-productive cycle where inadequate compensation drives suppliers and practitioners from the market, reducing competition and ultimately concentrating supply chains and creating a scarcity of medical personnel and suppliers.

391. Such concentration can undermine the very competitive supplier conditions upon which monopsony cost savings depend, as well as lead to shortages and lengthening patient waiting times, which are alternative manifestations of cost.

392. As evidenced in the PriceMetrics Reports, South Africa already faces a severe shortage of health care professionals. With 0.8 doctors and 5 nurses per 1,000 people, well below the levels required for adequate population-wide health care services, any further reduction in health care personnel capacity is fatal for system viability.

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393. Paying lower wages and fees for medical professionals can be expected to reduce their supply offered to the market through choices like reduced working hours, emigration to higher-paying international jurisdictions, earlier retirement, and less enrolment in tertiary medical training.

394. Moreover, as the NHI is to be phased in gradually, the NHI Fund would not, in fact, be able to act as a monopsonist buyer of health care in South Africa for years until full implementation is established and private medical schemes are closed.

395. While phasing in, the NHI would have to pay medical practitioners market salaries and fees to entice them away from private care to become NHI-accredited for NHI care.

396. The state could attempt to overcome this inability to reduce costs during phase-in by attempting to regulate lower fees for medical services and prices for medical and health care products. Such price controls would lead to

harmful health care market distortions and shortages as described above, and, Sakeliga is advised, would be open to judicial review.

(iii) Limited market power in global health care markets

397. Claims of NHI Fund monopsony and regulatory cost savings do not adequately account for the extremely small relative size of the NHI Fund's purchasing power in the global health care market.

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398. Total health care spending in South Africa is just 0.3% of total global health care spending. [World Health Organization. "*WHO Calls on Governments for Urgent Action to Invest in Universal Health Coverage*." WHO, 11 Dec. 2023.]

399. For globally sourced goods and services, the NHI Fund is not a dominant buyer that can unilaterally dictate pricing terms, but rather a small purchaser among many. This fact alone severely limits the NHI Fund's ability to exercise meaningful monopsony or regulatory pricing power over global suppliers.

400. The Fund will transact with numerous large multinational companies that can readily access larger, more profitable markets that dwarf South Africa's potential revenue. These companies are not mere price-takers in small markets but have considerable pricing power and global customer choice.

401. The mobility of capital, products, and skilled professionals in global health care markets means suppliers can and do readily substitute customers and withdraw products in marginal markets.

402. This fundamentally undermines the presupposed captive supplier relationships that monopsony theory or regulated pricing requires.

403. The NHI Fund, therefore, will have to either accept global market pricing for many critical products or achieve cost savings by likely forgoing the availability of certain products and the quality of some types of care.

(iv) Moral hazard and health care overuse in state monopoly systems

404. Systematic 'moral hazard' problems plague free-at-the-point-of-service health care systems, negating potential cost savings through monopsony or regulated pricing.

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405. Moral hazard (or "hidden behaviour") in health cover refers to the tendency of insured or covered individuals to over-utilise medical services when shielded from the true costs of care. [Arrow, Kenneth J. *Uncertainty and the Welfare Economics of Medical Care*. American Economic Review, vol. 53, no. 5, Dec. 1963, pp. 941-973.]

406. This drives up the volume of claims and the administrative costs associated with evaluating claims.

407. While competitive insurance markets develop sophisticated mechanisms to control moral hazard through aligned incentives, co-payments, deductibles, and fraud detection systems, the NHI's regulatory design and exposure to principal-agent problems at a statutory state monopoly mean it lacks the competitive discipline and likely the institutional capacity that would otherwise help it manage health care overuse and fraudulent claims.

408. The NHI's comprehensive envisaged free-at-point-of-service model raises moral hazard risks considerably by eliminating direct cost signals to patients, diminishing price sensitivity for health care consumption, strengthening

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demand that is constrained more by availability than by economic efficiency, and incentivising provider-induced demand where medical professionals have incentives to oversupply services or collude with overusing patients.

(v) Lack of actuarial risk analysis undermines cost control

409. The NHI is a tax-funded health care beneficiary scheme, not health insurance in the traditional sense. Traditional insurance relies on risk pooling, where a health insurance risk pool is a group of individuals whose estimated future medical costs are combined to calculate premiums. The NHI, by contrast, abandons this fundamental mechanism through premium-cost disconnection, where individual contributions (mandatory taxation) bear no relationship to individual or pool risk and realised health care demand.

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410. Without a very costly regulatory apparatus, this can create open-ended liability without rational actuarial limits. Health care payments are derived from National Treasury budgets rather than risk-based premium calculations, and are therefore characterised by political rather than actuarial management, where budget allocations reflect political priorities. Such a framework, lacking strong actuarial and financial controls, renders rational cost control more challenging.

(vi) The delegation of law-making powers to the Minister

411. The NHI Act centralises power in the Minister in respect of the Fund, its governance and management. This is contrary to the principles of transparency and accountability, and a threat to its independence and functioning.

412. In aggravation of the aforesaid, the NHI grants to the Minister the power to legislate by decree. In the definition section, it is stated that: "***"this Act"*** *includes any regulation promulgated, directive or rule made or notice issued by the Minister and directive issued by the Fund in terms of this Act*".

413. Section 55 of the NHI Act is sweeping in its scope and affords the Minister of Health virtual carte blanche in respect of material aspects of NHI and the provision of health care in South Africa. This is a wholesale abrogation of law-making powers. This is particularly egregious in respect of section 55(3)(b) of the NHI Act, which allows the Minister to publish regulations without delay "*in the public interest*".

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GAUTENG DIVISION,
PRETORIA

414. Sakeliga is advised that this improperly affords the Minister and the Fund the ability to legislate, in conflict with the doctrine of separation of powers and the rule of law and is unlawful.

415. The NHI Act does not provide adequate safeguards and independent oversight over the Minister or the Fund.

416. The Parliamentary law-making process advances the principles of openness, accountability, transparency and public participation.

417. Where the Executive is permitted to arrogate to itself such function (of law-making) or where such function is delegated by Parliament to the Executive, without the necessary checks and balances from a truly independent sphere of government, the doctrine of the separation of powers and the rule of law are breached, the principles of openness, accountability, transparency and public participation are flouted, and Parliament stalls.

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418. This is unconstitutional and contrary to the rule of law.

(vii) Medical schemes

419. Section 33 of the NHI Act provides:

> *"**Role of medical schemes***
>
> *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."*

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419A 'Complementary cover' is defined as: "*'**complementary cover**' means third party payment for personal health care service benefits not reimbursed by the Fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund;*".

420. Medical schemes, and private insurance in respect of health care services, enable millions of persons to access good quality health care using their own funding. Persons who contract with such medical schemes are enforcing their section 27 rights.

421. The source of the Medical Schemes Act is, in fact, section 27 of the Constitution.

422. The NHI Act, in effectively enforcing a ban on all services (but for vaguely defined '*complementary cover*'), constitutes a breach of section 27 of the Constitution by impairing the ability of those who are able to provide for themselves.

423. There is no rational reason why state health services cannot compete with and exist alongside private services and traditional medical schemes.

424. Section 33 of the Act, prohibits medical schemes from providing cover for services reimbursable by the NHI Fund once the Fund is declared "fully implemented." This provision removes all private alternatives for those services, effectively extinguishing parallel access channels to health care.

425. In doing so, section 33 of the NHI Act limits a constellation of rights entrenched in the bill of rights, including:

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GAUTENG DIVISION,
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425.1. The right of access to health care services (section 27(1));

425.2. The right to dignity (section 10);

425.3. The right to freedom and security of the person (section 12(2));

425.4. The right to privacy (section 14);

425.5. The right to freedom of association (section 18);

425.6. The right to freedom of trade, occupation and profession (section 22); and

425.7. The right not to be arbitrarily deprived of property (section 25(1)).

G. THE LIMITATIONS ARE NOT JUSTIFIABLE

(a) The test for constitutional limitation

426. Sakeliga is advised that, in accordance with section 36(1) of the Constitution, the rights in the bill of rights may be limited only in terms of a law of general

application to the extent that the limitation is reasonable and justifiable in an open and democratic society taking into account all relevant factors, including:

426.1. the nature of the right;

426.2. the importance of the purpose of the limitation;

426.3. the nature and extent of the limitation;

426.4. the relation between the limitation and its purpose; and

426.5. less restrictive means to achieve the purpose.



(b) The limitation on private medical schemes

427. Section 27(1) guarantees everyone the right to access health care services. This encompasses not only access to state-provided care, but also the freedom to seek and arrange private care.

428. Abolishing private medical scheme cover for individuals, as contemplated in section 33 of the NHI Act, particularly affects the working poor and middle class. It removes their ability to access timely and quality care – especially when the public healthcare system is overwhelmed or unable to provide health care within a reasonable time.

429. This provision directly undermines individuals' autonomy, self-reliance, and dignity in situations that can be life-or-death. The reach of the undermining is broader still when one appreciates that the need for health care is often most fundamentally important for one's children.

430. It cannot be merely assumed that state-provided care will be able to meet every potential future health care-related need of every person at all times and within reasonable timeframes.

431. The NHI Act invokes 'equity in health care' to seemingly justify a single funding pool in the Fund. Yet, 'equity' in a constitutional sense does not require levelling down or the process of removing better options from some to equalise all outcomes at a lower standard.

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432. The duty imposed on the state under section 27(2) of the Constitution, to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health care, cannot be construed as a blank cheque for the state to eliminate existing avenues of access in the name of 'equity'.

433. The Constitution is drafted in a manner that allows socio-economic rights to be realised in harmony with, and not at the expense of, other entrenched rights and freedoms. The state's obligation is to expand and improve access for those without it, not to degrade access for those who already have it.

434. Section 27(2) is a mandate for progressive expansion, not a licence for regress through coercive homogenisation.

435. In the context of section 36(1) of the Constitution, such a regression cannot be regarded as a necessary or proportionate limitation, especially where less restrictive models are readily available to advance equity without extinguishing choice or freedom.

436. The effect of section 33 of the NHI Act is to compel all except the ultra-wealthy into a monopolistic system. Far from fostering substantive equality, it entrenches a two-tier system where only the elite can lawfully opt out.

437. The limitation is absolute: medical schemes are barred from covering any service within the NHI's benefit package, regardless of public sector capacity, price competitiveness or quality. No exemptions exist for emergencies, specialist care unavailable in the public sector, or shortages in medicines and equipment. When the NHI system fails or is hampered by corruption and inefficiencies – a likely outcome evidenced by dysfunction in other organs of state and funds such as the RAF and Compensation Fund - affected individuals are left with no lawful recourse to access health care.

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GAUTENG DIVISION,
PRETORIA

438. There is simply no rational, evidence-based, or proportional link between eliminating private cover and achieving 'equity' or universal health care. On the contrary:

438.1. Removing competition reduces incentives for public providers to improve;

438.2. It erodes accountability and transparency;

438.3. It denies the government valuable performance benchmarks; and

438.4. It creates perverse incentives to ration care rather than improve capacity.

439. There exist numerous less restrictive measures to promote equitable access to health care without abolishing private alternatives or medical schemes, including to:

439.1. Prioritise governance, staffing, and infrastructure upgrades in public hospitals before banning alternatives;

439.2. Enforce strict supplier contract management with reputable firms that seek to promote cost efficiency rather than politically-connected companies with no experience in health care who seek to price gouge the state's resources;

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439.3. Remove regulatory barriers to entry for medical professionals and ensure work environments which are professional and patient-centred;

439.4. Create price-friendly trade and import incentives for medical goods and technology, including by taking sound economic decisions to strengthen the rand so that purchasing medical equipment (most, if not all of which, is produced outside of South Africa and traded in US dollars as the based currency in international trade) is more affordable;

439.5. Retain private choice, emergency and specialist carve-outs to ensure freedom of choice, informed consent and personal health discretion.

440. Section 33 of the NHI Act dismantles personal freedoms, completely erodes functional access channels, reduces overall system resilience, and entrenches inequality under the guise of universality. This is not the

progressive realisation of the right entrenched in section 27(1)(a) of the Constitution, as contemplated in section 27(2) of the Constitution.

441. In an open, free and democratic system, disparities may remain, but the public can lawfully seek better outcomes through private means, partnerships, and innovations. Section 27(2) obligates the state to provide public services which can provide alternatives to the private sector. It does not allow the state to ban the private sector from competing with the state.

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442. Section 33's closed monopoly instead forces the majority into a single channel, leaving only the ultra-wealthy with practical alternatives if such channel fails, including seeking private health care in foreign countries.

443. The section is overbroad, irrational, and unnecessary. It cannot satisfy the proportionality and necessity requirements of section 36(1) nor the progressive realisation requirement in section 27(2). It must be declared unconstitutional and invalid.

(c) Health care at the expense of other rights

444. Beyond section 33, the NHI Act in its entirety effects an unjustifiable limitation of constitutional rights by:

444.1. Centralising all purchasing and reimbursement powers in a single state-controlled Fund, eliminating pluralism and competition;

444.2. Imposing compulsory affiliation without meaningful opt-outs or parallel systems;

444.3. Creating criminal sanctions and administrative penalties that inhibit professional autonomy (infringing sections 18 and 22 of the Constitution); and

444.4. Vesting broad discretionary powers in the Minister and Fund without adequate checks and balances, thereby undermining the rule of law and legal certainty (sections 1(c) and 33 of the Constitution).

445. I refer to the further facts set out in the body of this affidavit that address the breaches of further constitutional rights.

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GAUTENG DIVISION,
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446. Applying the proportionality analysis in section 36(1) of the Constitution to the NHI Act as a whole, yields the same result as with section 33 of the NHI Act:

446.1. Fundamental socio-economic and civil rights directly related to life, health, and liberty are severely limited;

446.2. The limitation seeks a comprehensive restructuring of the health sector with pervasive interference in private initiative, voluntary association, and market participation;

446.3. No rational connection between monopoly structures and the rights limited under sections 27(1), 10, 12, 14, 18, 22 and 25 of the Constitution can be shown.

447. Section 27(2) of the Constitution, in fact, points directly to what the less restrictive means available to the state should be: to urgently intervene in and improve the quality of health care services at state-run facilities. The obligation in section 27(2) is to adopt reasonable legislative and other measures to

progressively realise access to health care services. This entails strengthening the existing state health system to address governance failures, infrastructure decay, staffing shortages, and clinical quality deficits, rather than attempting to bring the private health industry under the complete control of the state.

448. Plainly, if the state was meeting its obligations under section 27(1)(a) read with section 27(2) of the Constitution, and ensured that state-run facilities provide cost-effective, reliable, and high-quality care, then there would be no need to coerce the public away from private providers, as the public would migrate voluntarily to the better state-run option.

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GAUTENG DIVISION,
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GAUTENG DIVISION,
PRETORIA

449. Rather, the private sector has expanded precisely because of the failure of state-run facilities. Using those same failures as a rationale to dismantle private alternatives is contrary to the scope and purpose of section 27(1)(a) read with section 27(2) of the Constitution. It transforms a mandate for progressive improvement into a tool for coercive regression and state over-reach.

450. 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.

451. 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.

452. The state has an obligation not to unjustifiably impede people in pursuing and obtaining these goods and services necessary for their survival and flourishing, and cannot merely advance one at the expense of all the others. This is exactly what the NHI Act proposes must be done.

453. For example, due to the large-scale contraction of South Africa's economy that will be caused by NHI, many of those who become unemployed will have to move into accommodation that lacks adequate running water and sanitation systems or sufficient heating and cooking facilities. Such conditions make these people more susceptible to illness and disease. Not only will usage of the NHI system spike as a result, but they will be unable to address the root cause of their illness.

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GAUTENG DIVISION,
PRETORIA
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PRETORIA

454. Assuming that the NHI Act provides for doctors and nurses, the state will have to retrench large swathes of teachers as the state will simply not be able to pay the salaries of both nurses and teachers.

455. The purpose of advancing health care at the expense of other rights is unjustifiable. In fact, as demonstrated above, 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.

456. 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.

457. The NHI Act's scheme is not tailored to achieve its stated goals with minimal impairment of constitutional rights. It opts for the most restrictive model possible, despite viable, less intrusive alternatives.

458. Sakeliga submits that the NHI Act in its entirety fails the requirements of section 36(1) of the Constitution and undermines the constitutional promise of an open and democratic society based on human dignity, equality, and freedom.

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GAUTENG DIVISION,
PRETORIA
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GAUTENG DIVISION,
PRETORIA

459. It should be declared unconstitutional in its entirety, alternatively to the extent of its unjustifiable limitations.

(d) Conclusion

460. The NHI Act, in both its design and effect, imposes a sweeping and unprecedented restriction on the constitutional rights of South Africans.

461. In particular:

461.1. It abolishes lawful private alternatives for health services reimbursable under the NHI, forcing all but the ultra-wealthy into a single state-controlled channel;

461.2. It removes choice and autonomy in life-and-death decisions, undermining dignity, equality, personal security, and bodily and psychological integrity;

461.3. It criminalises or restricts professional activity in the health sector without adequate justification or proportionality;

461.4. It concentrates unchecked power to make decisions on behalf of the public regarding the procurement of health care services in the hands of the Minister and Fund;

461.5. It adopts the most restrictive possible model for universal health coverage, without being able to sufficiently maintain existing state-run health facilities.

462. Section 33, in particular, is the linchpin of the NHI Act's rights-infringing design. By banning private medical scheme cover for NHI services, it:

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462.1. Strips the working poor and middle class of their only practical recourse when the public system fails;

462.2. Entrenches a two-tier system in which only the politically connected and ultra-wealthy can lawfully escape system collapse;

462.3. Dismantles functioning access channels without first fixing the public system's chronic governance and capacity failures.

463. Section 36(1) of the Constitution requires that any rights limitation be reasonable and justifiable in an open and democratic society. The NHI Act, both in section 33 and in its overall scheme, fails every element of the proportionality test:

463.1. The rights affected are fundamental and far-reaching;

463.2. The limitation is absolute and unnecessary;

463.3. The claimed purpose (equity) is undermined, not advanced;

463.4. The relationship between the limitation and its stated purpose is irrational; and

463.5. Numerous, less restrictive, means are available to the state to advance access to health care.

464. In comparative perspective, South Africa's NHI prohibition is an extreme outlier. No other constitutional democracy with universal coverage - whether the UK, Canada, Australia, France, or the Netherlands - extinguishes private options in this manner.

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465. The NHI Act, in its present form, is overbroad, disproportionate, and incompatible with the foundational values of the Constitution relating to human dignity, equality, and freedom. It cannot survive constitutional scrutiny.

H. COSTS

466. If successful, Sakeliga shall seek an order that the costs of this application be paid by the first respondent, including the costs of two counsel, on Scale C. The matter is complex and of great public importance as to warrant both the employment of two counsel, including senior counsel, and costs on the aforesaid scale.

467. In the event, however, that Sakeliga's challenge is not successful, Sakeliga submits that this is a *bona fide* constitutional challenge, and it will seek an order that each party pay its own costs in accordance with the *Biowatch* principle.

I. CONCLUSION

468. The NHI Act represents the pursuit of a goal by unsustainable and ill-conceived means. Far from improving the lives of people in South Africa, the NHI Act will make all communities worse off.

WHEREFORE the applicant prays for an order in terms of the notice of motion prefixed hereto.

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The deponent has acknowledged that he knows and understands the contents of this affidavit, which was signed and sworn to before me at Stellenbosch on this 18th day of August 2025, the Regulations contained in Government Notice No. R1258 of 21 July 1972, as amended, and Government Notice No. R1648 of 19 August 1977, as amended, having been complied with.

COMMISSIONER OF OATHS

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DELEGATION OF AUTHORITY

I the undersigned

PIETER JACOBUS LE ROUX

in my capacity as a duly authorised chief executive officer and representative of Sakeliga NPC ("Sakeliga"), so duly authorised by the board of directors with the authority to delegate, do hereby delegate to **RUSSELL VICTOR LAMBERTI**, the following powers and authority:

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1) the authority to authorise and/or institute, on behalf of Sakeliga, any litigation or legal proceedings against the **National Health Insurance Act (NHI), the Minister of Health, and any other relevant or necessary party**. This includes, but is not limited to, proceedings in the High Court, applications, appeals, reviews, contempt of court proceedings, and any related or ancillary proceedings, including appeals and applications to the Supreme Court of Appeal, the Constitutional Court, and/or any other court, tribunal, arbitration panel, or forum. This delegation also includes the authority to instruct and authorise Sakeliga's legal representatives to appear, argue, support, oppose, or otherwise act in any matter before any such body in furtherance of this litigation.

2) the authority to represent Sakeliga in all matters referred to in paragraph 1) above, and to authorise and sign any process, step, affidavit or document on behalf of and in the name of Sakeliga as its lawful representative.

3) the authority to incur costs on behalf of Sakeliga and to appoint, instruct and direct attorneys, experts and/or consultants to assist Sakeliga with any matters relating to paragraph 1) above.

4) **KRIEK WASSENAAR & VENTER INC** is appointed as attorneys of record for Sakeliga in all matters relating to this delegation.

Signed at PRETORIA on 18 AUGUST 2025

Pieter J le Roux (Aug 18, 2025 13:30:59 GMT+2)

PIETER JACOBUS LE ROUX – CEO

FA2

Curriculum Vitae: Russell Lamberti

Current:

- 2021-Present : Director & Chief Economist – Sakeliga
  - *Economic analysis and strategy; policy analysis and strategy; Sakeliga growth and product strategy.*

Previous:

- 2015-2021: Founder/Chief Economist, ETM Macro Advisors
  - *Global and SA macroeconomic research and analysis; Strategic investment advisory; Business cycle, monetary system, and asset class analysis; Economic policy analysis.*
- 2010-2015: Chief Economist, ETM Analytics
  - *Global and SA macroeconomic research and analysis; Fiscal policy research and analysis; Strategic investment advisory; Business cycle and monetary system analysis.*
- 2007-2010: Senior Economist, ETM Analytics
  - *Macroeconomic research and analysis; Global and SA currency and bond market research and analysis; Economic policy analysis; Economic impact consulting.*
- 2005-2007: Economic Analyst, Econometrix
  - *Macroeconomic research and analysis; HIV economic modelling; SA municipal economic modelling and forecasting; Economic impact consulting.*

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General:

- Co-Author, *When Money Destroys Nations* (economic analysis of Zimbabwe's hyperinflationary collapse)
- Lecturer on fiscal policy 2010-2012, GIBS MBA programme

Degrees:

- Undergraduate: B.Soc.Sci. *Philosophy, Politics and Economics (PPE)*, University of Cape Town (School of Economics), 2001-2003
- Postgraduate: B.Com Hons *Economics* (Cum Laude), University of Cape Town (School of Economics), 2004

Contact:

- Residence: Stellenbosch, South Africa
- Tel: 084-447-1232
- Email: r.lamberti@sakeliga.org.za

RL

teenstrydigheid effektiewelik aan te spreek, en

3.3.3. Die aksies neem wat binne hul uitsluitlike diskresie nodig is om die oortreding, botsing en/of teenstrydigheid aan te spreek, wat insluit maar nie beperk is tot die voorstel van wysigings tot die Akte en die belê van 'n spesiale Ledevergadering ten einde daardie wysigings goed te keur.

4. DOELSTELLINGS EN MAGTE VAN DIE MAATSKAPPY

4.1. Ter nakoming van artikel 1 van bylaag 1 tot die Wet, verklaar die Maatskappy hiermee die volgende hoofdoelstellings:

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4.1.1. Die bevordering van konstitusionele orde, vryemarkbeginsels en kapitaalkragtige, regverdige, en volhoubare sake-omgewing in die Republiek;

4.1.2. Die skepping van 'n selfstandige sakegemeenskap in die Republiek;

4.1.3. Die behoud van eiendomsreg, holisties gesien, ooreenkomstig die Grondwet van die Republiek;

4.1.4. Om, sonder inperking, bydraes en skenkings te doen tot die Helpende Hand Beursfonds en/of die Solidariteit Helpende Hand NPC;

4.1.5. Om kollektief namens Lede, ondersteuners en die publiek met Owerhede te onderhandel en verhoudinge met Owerhede asook plaaslike, nasionale en internasionale instansies en persone te beding te einde die doelstellings van die Maatskappy te bevorder;

4.2. Die Maatskappy verklaar hiermee die volgende aanvullende doelstellings, maar sonder inperking van die algemene aard van die Maatskappy hoofdoelstellings:

4.2.1. Om as 'n openbare sakewaghond wat fokus op die regte en belange van sy Lede, ondersteuners en lede van die publiek in die algemeen, op te tree;

4.2.2. Om ondersoek in te stel oor gevalle waar die regte van Lede, ondersteuners asook die publiek oor die algemeen, geskend en/of ingeperk word, en om waar nodig ook op te tree ten einde daardie regte te beskerm of te bevorder.

4.3. Die volgende magte word ook, sonder inperking van die algemene magte van die Maatskappy soos uitgeoefen Direksie kragtens die Wet, aan die Maatskappy verleen:

4.3.1. Om deur selfregulering en privaat institusionele infrastruktuur 'n alternatiewe

sake-omgewing te skep waarbinne ekonomiese aktiwiteit voortgesit kan word;

4.3.2. Om die Maatskappy se Lede, ondersteuners en lede van die publiek in die uitoefen van hul belange en regte, hetsy op plaaslike, nasionale of internasionale vlak, by te staan, te adviseer, te ondersteun en/of te verteenwoordig.

4.3.3. Om die publiek oor die algemeen by te staan met die bevordering van hul regte op 'n plaaslike, nasionale en internasionale vlak;

4.3.4. Om 'n vrye, onafhanklike en goedgunstige sake-omgewing in die Republiek te beskerm, stimuleer en waar nodig te skep;

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4.3.5. Om regsgedinge in te stel, daartoe toe te tree, om sake te opponeer en/of te verdedig, om as *amicus curiae* in sake op te tree, deel te neem aan appèlle, hersienings, en om voor enige Owerheid te verskyn, submissies te maak, te argumenteer, op te tree, teen te staan en/of te ondersteun.

4.3.6. Om met die Owerhede, politieke partye, lede van die sakewêreld, die media asook enige ander lid van die publiek te kommunikeer, te onderhandel, in te debat te tree en om ook waar nodige daardie persone en/of instansies te voorsien met voorstelle, vertoë, submissies, verslae, argument en/of inligting.

4.3.7. Om navorsing ter bevordering van hierdie doelstellings te doen asook om inligting in te samel, statistiek op te bou, te verwerk en te publiseer;

4.3.8. Om onafhanklike regsadvies oor enige saak wat enige doelstelling van hierdie Akte raak, te bekom en waar nodig om ook regsverteenwoordiging aan te stel om die Maatskappy te verteenwoordig in die bevordering van hierdie doelstellings.

4.3.9. Om met ander organisasies of persone met soortgelyke doelstellings te onderhandel, ooreenkomste te sluit, projekte te hardloop, sake te bevorder, befondsing te voorsien, befondsing te ontvang, ondersteuning te bied en/of te affilieer.

4.3.10. Om deel te neem in die bestuur, beheer of aktiwiteite van enige ander organisasie wat soortgelyke doelstellings as die van die Maatskappy het en om in hulle te belê, belange te bekom en/of om vennootskappe of samewerkingsooreenkomste met hulle aan te gaan.

4.3.11. Om enige persoon of organisasie te vergoed vir hul dienste gelewer aan of

FA7

PriceMetrics

An Overview of the South African Health System

Date: 12 February 2025

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Mike Holland

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010 141 0286

27/8/2025-9:45:05 AM

Introduction

1. This report presents an overview and profile of the health system in South Africa. Given the size of the health sector (currently 8% of Gross Domestic Product) and the complexity of health care markets, the report is necessarily selective. It provides foundational facts and statistics on the major features and performance of the private and public health care sectors and focuses on those features and activities of the private health care sector that are most likely to be affected by the government's plans for National Health Insurance.

2. The report is in five sections. The first section provides information on the structure of the health system in the country covering the public and private sectors' provision and funding of health care services. The second section outlines the legislative and regulatory framework for health care in the country. The third section provides information and statistics on the resources used to deliver health care in the public and private health care sectors. The fourth section is an assessment of trends in health outcomes in South Africa and a comparison to outcomes in other selected developed and developing countries. Finally, the fifth section provides a summary of trends in health care price inflation.

3. Footnotes in the report provide extensive references to sources of more detailed data and information on the South African and international health systems should more information be required. Excel databases providing more granular statistics are available on request.[1]

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Section One: The structure of the health system in South Africa

4. Health care in South Africa consists of the public sector, which in 2023 served 53,2 million people and the private sector which served 9,1 million people who were members of medical aid schemes, and/or had other private health insurance, or paid for health care expenses personally.[2]

Public health care sector

5. The public sector consists of health care services provided by the government and funded by taxes and social insurance such as the Compensation Fund and the Road Accident Fund.[3] State provision of health care is guided by section 27 of the Constitution covering rights to health care, food, water and social security, which includes section 27(1), "Everyone has the right to have access to— (a) health care services, including reproductive health care;" with the obligation in section 27(2) that "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."

6. Public Health care services are primarily provided through a network of hospitals, clinics, and community health centres. These facilities are tasked with delivering a range of services, including preventive care, treatment of chronic and acute conditions, maternal and child health services, and emergency care. Clinics typically serve as the first point of contact for patients, with larger hospitals providing specialised care. Many primary health care services are offered for free to users, with the costs paid from taxes raised by the government, aligning with the principles of universal Health care accessibility. Other services are subject to means tests.

7. There are three tiers in the public health care sector. While the responsibility for health care services is the primary responsibility of the National Department of Health, the provincial and local health departments share this responsibility.

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[1] Including data from the World Bank and World Health Organization.

[2] Based on a population estimate of 62,3 million (StatsSA. General Household Survey 2023) and medical scheme beneficiaries of 9,127 million (Council of Medical Schemes, *Industry Report 2023*). Also, Health Systems Trust, *South African Health Review* Vol. 26, 2023, page 9. According to Affinity Health there are no more than 1.5 million beneficiaries of health insurance plans. The actual number is not known by the industry.

[3] The Compensation Fund provides compensation for employees of disability, illness and death resulting from occupational injuries and diseases. The Compensation Fund also provides funds to families of workers who die as a result of occupational injuries or diseases. The Road Accident Fund (RAF) provides compulsory cover to all users of South African roads, citizens and foreigners, against injuries sustained or death arising from accidents involving motor vehicles within the borders of South Africa. This cover is in the form of indemnity insurance to persons who cause the accident, as well as personal injury and death insurance to victims of motor vehicle accidents, and their families. Treatment is usually provided in the private sector for beneficiaries of the Funds.

27/8/2025-9:45:05 AM

8. The role of the national department is developing health policies and regulations; overseeing the overall management of the Health care system; ensuring compliance with health legislation and an equitable distribution of resources; developing and implementing national health programmes to prevent and treat communicable and non-communicable diseases; overseeing primary Health care services and supporting tertiary Health care services; and improving health infrastructure and developing human resources for the health sector.

9. Provincial health departments are responsible for the implementation of national health policy norms and standards in their respective provinces, planning and managing health information systems, monitoring and evaluating health services, and controlling the quality of health services. The activities of the various provincial bodies and the national health body are coordinated by the National Consultative Health Forum. Members of the Executive Council for Health in each province may assign health functions to a municipality.

10. The delivery of health care services is generally decentralised in the provinces with a third tier of district health councils, which correspond to municipal boundaries, having the responsibility for the implementation of primary health care services and referrals for secondary, tertiary and quaternary care for communities in each district (and subdistrict). There are currently 52 district councils in the country which plan, organise, and oversee health services within their district.

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11. The three spheres of government are required to "cooperate with one another" by, among other things, "assisting and supporting one another," "informing one another of, and consulting one another on matters of common interest," and "coordinating their actions and legislation with one another".[4]

12. Table 1 shows the structure of government spending on health in the 2023-24 financial year. District health services expenditure, largely covering primary care, accounted for 44,7% of total spending, followed by central hospital services and provincial health services.

Table 1: Structure of Public Sector Expenditure 2023-24 Estimate

	R million	% of total
Central hospital services	51 789	19,4%
Provincial health services	43 857	16,4%
District health services	119 450	44,7%
Emergency medical services	9 769	3,7%
Facilities management	10 594	4,0%
Health science and training	5 775	2,2%
National health laboratory service	13 812	5,2%
National Department of Health	5 807	2,2%
Grants and Transfers	6 471	2,4%
Total	**267 324**	**100,0%**

Source: National Treasury Medium Term Policy Statement, October 2024

13. In 2023-24, health expenditure was 12,0% of total government expenditure. The proportion of government spending on health has been relatively stable in the last ten years at around 12,0% although it was slightly higher in the Covid-19 years of the 2020-21 to 2022-23 financial years.[5]

14. A stated objective of the government is the achievement of Universal Health Coverage ("UHC"). The stated intention of the NHI is to play a fundamental role in achieving UHC. The World Health Organization has defined UHC as: "Universal health coverage is defined 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 the WHO."

[4] Competition Commission's report (2018), *Provisional Findings and Recommendations*, page 26.
[5] National Treasury various publications. The fiscal financial year ends in February of each year.

27/8/2025-9:45:05 AM

Private health care sector

15. The private sector comprises a set of complex markets consisting of health care services and products, health care service providers and health care funders. In 2023 the private sector serviced approximately 15% of the population and accounted for 42% of total expenditure on health care in the country.

16. There are two components in the sector, firstly, the provision of health care services and products by Health care practitioners and Health care establishments; and secondly, the funding of health care services and products by medical schemes, health insurers and out-of-pocket payments by patients.

Health care service providers

17. The NHI Act defines health care providers as "a natural or juristic person in the public or private sector providing health care services in terms of any law." A natural health care provider is generally a health care practitioner while a juristic person is typically a hospital, clinic or other health care establishment.

18. The National Health Act defines a health care provider or practitioner who supplies health care services[6] as "a person providing health services in terms of any law, including in terms of the: a. Allied Health Professions Act, 1982 (Act No. 63 of 1982) b. Health Professions Act, 1974 (Act No. 56 of 1974) c. Nursing Act, 1978 (Act No. 50 of 1978) d. Pharmacy Act, 1974 (Act No. 53 of 1974) e. Dental Technicians Act, 1979 (Act No. 19 of 1979).[7] In turn, the statutory professional bodies regulating Health care providers are, respectively, the Allied Health Professions Council of South Africa ("AHPCSA"), the Health Professions Council of South Africa ("HPCSA"), the South African Nursing Council ("SANC"), the South African Pharmacy Council ("SAPC") and the Dental Technicians Council.

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19. Health care service providers are health professionals (including specialists, general practitioners, dentists, psychologists, and radiographers), nurses and pharmacists.

20. Medical practitioners generally operate individually in their own private practices. However, there are some group practices which work according to business models approved by the HPCSA. These groups are confined to either specialists belonging to the same discipline or general practitioners; specialists and general practitioners do not work in the same group practice. Some medical practitioners form corporate practices, such as pathologists and radiologists with the permission of the HPCSA. Most practitioners are paid using a fee-for-service model."[8]

Health care establishments

21. The National Health Act defines health establishments as "the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative convalescent, preventative or other health services." The private sector has a wide range of establishments, including acute hospitals, day hospitals, clinics, and emergency units. Besides these general facilities, there are specialised institutions such as rehabilitation units, oncology facilities, renal dialysis facilities and nuclear medicine units.

Pharmacies

22. Pharmacies provide self-medication or prescription medication in retail stores and sell (or dispense) these products to consumers. Pharmacists are regulated by the South African Pharmacy Council. The various types of pharmacies include community, public institutional, manufacturing, wholesale, private institutional, courier and consultant pharmacies. Community pharmacies can be either corporate pharmacies owned by large public or private companies (such as Clicks and Dis-Chem) or smaller independent pharmacies. Corporate

[6] The NHI Act defines health care services as, "(a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution; (b) basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution; (c) medical treatment contemplated in section 35(2)(e) of the Constitution; and (d) where applicable, provincial, district and municipal health care services;"

[7] The NHI Act has a wider definition of a health care provider which "means a natural or juristic person in the public or private sector providing health care services in terms of any law;"

[8] Competition Commission (2019), *Health Market Inquiry, Final Findings and Recommendations Report*, page 106.

pharmacies can also own wholesale and distribution companies, and many are acquiring courier pharmacies. Smaller independent community pharmacies are typically owned by pharmacists.

Emergency medical response services ("EMRS")

23. EMRS refer primarily to ambulance services, typically involving paramedics and other emergency practitioners. Health care facilities may also provide casualty or emergency services staffed by practitioners and nursing staff.

Health care products

24. The NHI Act defines health care products that are used to deliver health care services as health goods, health products and health-related products. The NHI Fund will control the prices and supply of health care products to health care providers based on its formulary, which will comprised of the Essential Medicine List and Essential Equipment List as well as a list of health-related products used in the delivery of health care services.

25. A health good includes "medical equipment, medical devices and supplies, health technology or health research intended for use or consumption by, application to, or for the promotion, preservation, diagnosis or improvement of, the health status of a human being." Medical devices include orthotics and prosthetics, dental products, patient aids, diagnostic imaging products, consumables and more. Previously, medical devices were not regulated but this changed with the establishment of the South African Health Products Regulatory Authority ("SAHPRA") which replaced the Medicines Control Council ("MCC") on 1 June 2017.

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26. A health product is defined in the NHI Act as "a product regulated in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), the Hazardous Substances Act, 1973 (Act No. 15 of 1973), the Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972), or any other product regulated by a law governing its quality, efficacy or performance and used in the provision of health care services."

27. A health-related product is defined in the NHI Act as "any commodity other than orthodox medicine, complementary medicine, veterinary medicine, medical device or scheduled substance which is produced by human effort or some mechanical, chemical, electrical or other human engineering process for medicinal purposes or other preventive, curative, therapeutic or diagnostic purposes in connection with human health."

Medicines

28. Medicines include prescription (originator and generic) medicine, biologics (for example vaccines or antibodies), nutraceuticals (dietary supplements and complementary medicines), and over-the-counter ("OTC") drugs that do not require a prescription. Medicines are regulated by the Medicines and Related Substances Act No. 101 of 1965 and Single Exit Price ("SEP") legislation.

29. There are other organisations that support health care providers and establishments.[9] They include:
    29.1. *Medical switching companies* transmit claims between health care providers and funders electronically in real-time.
    29.2. *Practice management service providers* offer services such as medical billing and practice management solutions.
    29.3. *Software vendors* provide software to the medical switches and health care providers that enable electronic claims submissions from the provider to the switch and the switch to the scheme, administrator or MCO.
    29.4. *Clinical coding companies* offer coding, auditing and training services to health care providers, and
    29.5. *Medical malpractice insurance companies* provide health care providers with insurance protection.

Health care insurance and funders

30. Health or medical insurance is a critical component of private health care systems and is designed to provide individuals and families access to medical services and financial protection against the sometimes high and unaffordable costs of health care.

31. Typical features of health insurance include the following:
    31.1. Members of medical schemes or policyholders who pay monthly premiums to maintain their health care coverage.

[9] Competition Commission (2018), *Provisional Findings and Recommendations Report*, page 37.

27/8/2025-9:45:05 AM

31.2. Coverage for medical services and products can be comprehensive such as health care at the primary, secondary, tertiary and quaternary levels and can include minimum prescribed benefits; or alternatively provide insurance against specific health care events and conditions.

31.3. The cover often includes deductibles which are the amounts policyholders must pay out-of-pocket before the insurer begins to cover the cost of the health care. Higher deductibles generally result in lower premiums, but they require greater initial expenditure from the insured.

31.4. The cover also usually has co-payments and co-insurance. Co-payments (fixed amounts) and co-insurance (a percentage of costs) are cost-sharing mechanisms designed to reduce the overutilisation of medical services and medicines. These features ensure that policyholders contribute to their Health care expenses.

31.5. Provider networks: medical insurance plans often have networks of preferred health care providers. Policyholders may face higher costs or limited coverage if they seek care outside these networks.

31.6. Exclusions and limitations: most health insurance plans specify services or conditions that are excluded from coverage. In South Africa, however, all health care plans by medical schemes must offer minimum prescribed benefits.

32. Health care insurers are organisations involved in the funding of private medical treatment, products or services and include medical schemes, medical scheme administrators, Managed Care Organisations ("MCOs"), health insurers and health care brokers. In addition, health care service providers are also paid directly by patients ("out-of-pocket expenses").

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Medical schemes

33. Medical aid schemes are non-profit organisations that offer health insurance for members who pay a monthly premium in return for payment of their medical treatment and related medical expenses.[10] The premiums paid by members are subsidised by the government through the Medical Scheme Fees Tax Credit ("MTC").[11] All medical schemes in South Africa operate under the Medical Schemes Act 131 of 1998 and are registered with, and regulated by a statutory body, the Council for Medical Schemes ("CMS"). The regulations include a requirement that medical schemes must accept all applicants and charge them the same monthly contribution (per benefit plan), regardless of their age and health status. In addition, they are required to offer in each of their plans a set of minimum Health care benefits ("PMBs") consisting of all medical emergencies, together with 271 medical diagnoses and 26 chronic diseases or conditions.[12]

34. There are two types of medical aid schemes: open schemes which are obligated to accept anyone who wishes to join the scheme (unless the applicant is already in a closed scheme) and restricted schemes whose members are limited to the employees of specific companies, employer groups or membership of a particular profession, industry, association or union.

35. In 2023 there were 71 active medical aid schemes of which 16 were open schemes and 55 were restricted schemes.[13] Although smaller in number, open schemes during the year represented over half of the medical scheme beneficiaries, at 52.7%, while restricted schemes comprised the remaining 47.3%. The total number of medical aid schemes has declined substantially since 2000, when 144 schemes were registered with the CMS and 100 schemes in 2010.

36. Despite the fall in the number of medical aid schemes, the number of beneficiaries (principal members and dependants) has increased since 2000 although there has been slower growth in the last decade as shown in Table 2. Beneficiaries have increased from 6,73 million in 2000 to 8,32 million in 2010 and a slower rate of increase to 9,04 million in 2022 and 9,13 million in 2023.[14] The growth has occurred through an increase in the number of beneficiaries in restricted schemes, from 2,05 million in 2000, to 3,52 million in 2010, 4,18 million in 2022 and 4,32 million in 2023. Government-linked or state-funded medical schemes had 3,03 million

[10] Many employees have their premiums partially or fully paid by their employers.

[11] The MTC applies to fees paid by a taxpayer to a registered medical scheme (or similar fund outside South Africa) for that taxpayer and any "dependants" (as defined in section 6B(1) of the Income Tax Act, 1962). See https://www.sars.gov.za/types-of-tax/personal-income-tax/medical-credits/ In addition to the MTC, an individual may also claim an Additional Medical Expenses Tax Credit for certain qualifying medical expenses, subject to limitation.

[12] Cf. https://www.medicalschemes.co.za/resources/pmb/pmb-conditions/ and https://profmed.co.za/what-are-prescribed-minimum-benefits-pmbs/

[13] Council for Medical Schemes, *Industry Report 2023*.

[14] The *General Household Survey 2023* published by StatsSA provides a higher number of beneficiaries of medical aids at 9,79 million for 2023. (https://www.statssa.gov.za/publications/P0318/P03182023.pdf)

27/8/2025-9:45:05 AM

beneficiaries in 2022 and 3,17 million in 2023, 33,5% and 34,7% respectively of medical scheme beneficiaries.[15]

Table 2: Number of Beneficiaries in Medical Schemes Selected Years 2000 to 2023

Million	2000	2010	2022	2023
Open schemes	4,68	4,80	4,86	4,81
Restricted schemes	2,05	3,52	4,18	4,32
Total schemes	6,73	8,32	9,04	9,13

Source: CMS Industry Report 2023

37. The proportion of beneficiaries covered by medical schemes, relative to the national population, declined during the review period, decreasing from 16,0% in 2000 to 14,7% in 2023.

38. In line with the increase in beneficiaries the number of principal members of medical schemes grew from 4,11 million in 2022 to 4,15 million in 2023. The dependency ratio (the number of dependants divided by the number of principal members) remained unchanged at 1,20.

39. Total Health care expenditure on benefits paid to beneficiaries by medical aid schemes in 2023 was R239 billion, up by 9.4% from the 2022 reported amount of R218.4 billion. The claims paid per average beneficiary per annum increased by 8.2% from R24 395 in 2022 to R26 405 in 2023. Members of medical aid schemes also incurred out-of-pocket ("OOP") expenditure of R43,1 billion for medical treatment and services in 2023, 8.3% higher than expenditure of R39,8 billion in 2022.[16]

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PRETORIA

40. Most of the medical schemes' benefits expenditures are paid to private hospitals and specialists. In 2023 the proportion of their total Health care expenditure paid towards hospital services was 35.6%, with expenditure on all specialists accounting for 27.7%, followed by medicine dispensed at 14.5%, and supplementary and allied health professionals at 8.4% of total benefits expenditure.

41. In addition to medical schemes and health insurance, patients who are not members of medical schemes pay out of pocket for services from health care providers. The aggregate amounts of these payments are likely to be substantial but are not known.[17]

Medical scheme administrators

42. Medical scheme administrators are third-party administrators that contract with medical schemes to deliver administration and other services for medical schemes. These services include member record management, contribution management, claims management, financial management reporting, information management and data control and other general services.[18] Administrators are accredited and regulated by the Council for Medical Schemes. In 2023 there were 34 administrators registered with the Council although two administrators, Discovery Health and Afrocentric, dominate the market.[19] Some medical schemes conduct their own administration services and are known as self-administered medical schemes.

Managed Care Organisations ("MCOs")

43. Managed Care Organisations are health care providers that offer managed care health plans or services. Managed care is "clinical and financial risk assessment and management of health care, with the view to facilitating appropriateness and cost-effectiveness of relevant health care services within the constraints of what is affordable, through the use of rule-based and clinical management-based programmes."[20] MCOs are accredited and regulated by the Council for Medical Schemes. Medical schemes and other health insurers contract with MCOs to control health care costs and quality and to mitigate against moral hazard and adverse

[15] Council for Medical Schemes *Industry Report* 2023.

[16] Out of pocket expenses are medical expenses that are not reimbursed by medical aids or health insurers. They include coinsurance, copayments and deductibles for services covered by health insurance and the costs for medical services not covered by insurance.

[17] Cf. Competition Commission (2018), *Health Market Inquiry, Provisional Findings and Recommendations Report*, footnote page 61.

[18] https://www.medicalschemes.co.za/wp-content/uploads/2020/04/ReqForAdministrators.pdf

[19] Cf. Competition Commission (2019), *Health Market Inquiry, Final Findings and Recommendations Report*, page 106.

[20] https://www.medicalschemes.com/files/Guidelines%20and%20Manuals/Standard%20doc%20managed%20care%20final%2022%20Oct%2003.pdf and http://www.compcom.co.za/wp-content/uploads/2018/07/ANNEXURE-5.6-MANAGED-CARE.pdf

selection in health care services. Some medical schemes perform these services in-house. In 2023 there were 42 MCOs accredited by the Council.

Health insurers

44. Health insurers provide cover against risks associated with specific health care events and conditions such as hospital stays, critical illnesses and accidents. Products include medical schemes gap cover, hospital cash plans; primary health care plans for treatment by general practitioners, dentists, opticians and other health care providers; and medical travel insurance.

45. The major difference between health insurance and medical schemes is the nature of the cover provided. Medical aid schemes provide comprehensive health coverage with prescribed minimum benefits for a wide range of Health care services, while health insurance pays out a stipulated amount for specific health events or conditions occurring for the policyholder. Like other insurance products, the insurer will pay a pre-determined amount or payment per day, generally subject to a maximum per event and per annum for an insured event.

46. Unlike medical schemes, health insurance products are issued by for-profit organisations that rely on underwriting and actuarial knowledge to predict expected future claims over the long term. They do not have to accept all applicants, and they can permanently exclude certain medical conditions.[21] Health insurers are regulated by the Financial Sector Conduct Authority ("FSCA") and Prudential Authority through the Long Term Insurance Act No. 52 of 1998 and Short Term Insurance Act No. 53 of 1998.

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PRETORIA

Health care brokers

47. Health care brokers are persons or organisations that advise individuals and employers in the choice of medical schemes and health insurers.[22] Brokers vary based on who they service. Some brokers focus specifically on individual members. Corporate brokers advise large employer groups as well as their employees. Some brokers advise both employer groups and individuals. Brokers can be independent brokers that provide services for multiple schemes, tied brokers that are contracted to a particular scheme or insurer. or multi-tied agents that focus on selling a limited number of medical scheme or health insurance products.[23] Health care brokers are required to be accredited by the CMS and licensed by the FSCA. In 2023, there were 7 718 brokers and 2 193 broker organisations accredited by the CMS.[24]

Section Two: The health care legislative and regulatory framework

48. The regulatory framework governs the provision of health care services by health care establishments and medical doctors as well as other health professionals, the funding of Health care services by medical schemes and administrators of medical schemes, and the sale and distribution of medicines and drugs by manufacturers, distributors, pharmacies and doctors permitted to dispense medication.[25]

49. The current legislative and regulatory framework of health care in the country is guided by the Constitution. Section 27 of the Constitution covering rights to health care, food, water and social security states at Section 27(1), "Everyone has the right to have access to— (a) health care services, including reproductive health care;" with the obligation in section 27(2) that "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."

50. To comply with its obligations to Section 27 and building on previous legislation, the government created a legislative and regulatory framework for a health system primarily through the National Health Act, 2003 (Act No. 61 of 2003) ("NHA"), whose purpose is "to provide a framework for structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard health services…"

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[21] https://profmed.co.za/what-is-the-difference-between-medical-aid-and-medical-insurance/

[22] Competition Commission (2019), *Health Market Inquiry, Final Findings and Recommendations Report*: Broker services "mean: a. the provision of service or advice in respect of the introduction or admission of members to a medical scheme; b. the ongoing provision of service or advice in respect of access to, or benefit or services offered by, a medical scheme.

[23] Competition Commission (2018), *Provisional Findings and Recommendations Report*.

[24] Council for Medical Schemes, *Industry Report 2023*.

[25] Ibid.

27/8/2025-9:45:05 AM

51. The objects of the NHA Act are "to regulate national health and to provide uniformity in respect of health services across the nation by —
    (a) establishing a national health system which —
        (i) encompasses public and private providers of health services; and
        ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;
    (b) setting out the rights and duties of health care providers, health workers, health establishments and users; and
    (c) protecting, respecting, promoting and fulfilling the rights of —
    (i) the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;
    (ii) the people of South Africa to an environment that is not harmful to their health or well-being;
    (iii) children to basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution; and
    (iv) vulnerable groups such as women, children, older persons and persons with disabilities."[26]

52. The NHA Act covers the governance of the following activities:
    52.1. Responsibility for health care services
    52.2. Access to health care services;
    52.3. The rights and duties of consumers, Health care personnel;
    52.4. Gathering of information on Health care services, including the creation of a comprehensive national health information system;
    52.5. Keeping and protection of health records;
    52.6. The establishment of health facilities which includes hospitals;
    52.7. The determination of a non-mandatory reference price list for services rendered and consumables utilised;
    52.8. The determination of norms and standards for the provision of health services; and the establishment of statutory bodies that are responsible for monitoring and enforcing compliance with norms and standards.

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Statutory and other regulatory bodies[27]

53. Within the auspices of the NHA Act, statutory bodies and other private health care industry bodies provide a regulatory framework determining and influencing the provision of Health care services by hospitals, medical practitioners and other health practitioners, the provision of medical devices and medicines as well as the funding of health care services. Regulators have a significant role in implementing health care legislation and regulations as well as national health care policies, addressing matters such as registration, education and training, professional conduct and ethical behaviour, continuing professional development and promoting compliance with health care standards.

54. Key regulators affecting both the private and public sectors are:
    54.1. The Council for Medical Schemes ("CMS")
    54.2. Health Professions Council of South Africa ("HPCSA")
    54.3. South African Nursing Council ("SANC")
    54.4. South African Pharmacy Council ("SAPC")
    54.5. Dental Technicians Council ("SADTC")
    54.6. Allied Health Professions Council of South Africa ("AHPCSA")
    54.7. Office of Health Standards Compliance ("OHSC")
    54.8. National Health Research Ethics Council ("NHREC")
    54.9. The Health Ombudsman ("OHO").

The Council for Medical Schemes ("CMS")[28]

55. The Medical Schemes Act (131 of 1998) established the CMS to regulate schemes, administrators and Managed Care Organisations. The role of the Council includes protecting the interests of medical scheme members, overseeing and coordinating the running of medical schemes in a way that is aligned with the

[26] National Health Act, Section 2.

[27] The following narrative is based partly on Chapter 2 of the Competition Commission's report (2018), *Provisional Findings and Recommendations* and Chapter 2 of the Competition Commission's report (2019) *Health Market Inquiry, Final Findings and Recommendations*

[28] https://www.medicalschemes.co.za/about-cms/

national health policy, monitoring the solvency and financial soundness of medical schemes, investigating complaints and resolving disagreements about the affairs of medical schemes and making recommendations to the Minister of Health on criteria for the measurement of quality and outcomes of health services.[29]

Health Professions Council of South Africa ("HPCSA")[30]

56. The HPCSA is a statutory body established in terms of the Health Professions Act No. 56 of 1974. The Council guides and regulates members of health professions in the country relating to registration, education, training and development, professional conduct and ethical behaviour, and compliance with health care standards. All individuals who practise any of the health care professions incorporated in the scope of the HPCSA are obliged by the Act to register with the Council.

South African Nursing Council ("SANC")[31]

57. The SANC was initially established by the Nursing Act of 1944 (Act No. 45 of 1944), and currently operates under the Nursing Act of 2005 (Act No. 33 of 2005). The Council regulates the nursing profession by establishing standards for nursing practice as well as nursing education and training. Its other primary objective is to serve and protect the public in matters concerning nursing.

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58. Functions include registering nurse practitioners, allowing them to practise as professional nurses; accreditation of new nursing education institutions and nursing education programmes; inspection of nursing education institutions and clinical facilities; reviewing nursing education and training standards and providing counselling and guidance to the nursing profession regarding the implementation of the nursing education and training policies.

South African Pharmacy Council ("SAPC")[32]

59. In terms of the Pharmacy Act, 53 of 1974, as amended, the SAPC regulates the pharmacy profession responsible for establishing, developing, maintaining and controlling universally acceptable standards of practice and education in the various categories of pharmacists and pharmacies. The Council is responsible for the registrations of pharmacy professionals and pharmacies. Registration with the SAPC is a prerequisite for practicing the pharmacy profession.

60. The Council is also responsible for upholding and safeguarding the rights of the general public to universally acceptable standards of pharmacy practice in both the public and private sectors. The Council implements the above objectives by developing standards and codes of conduct for the different categories of pharmacists and the services which may be provided in pharmacies, the conditions under which these services may be provided, as well as policies to ensure good pharmacy practice. The SAPC is an independent statutory council which receives no grants or subsidies from the government or any other source but is wholly funded by the registered members of the profession.

Dental Technicians Council ("SADTC")[33]

61. The Dental Technicians Council ("SADTC") was established in terms of Section 2 of the Dental Technicians Act, No. 19 of 1979, as amended to regulate the dental profession. Dental technicians (or dental technologists) make dentures, crowns, bridges and dental braces for the medical profession. The Council's functions are to ensure effective and fair regulation and monitoring of the profession and to promote and oversee high standards of education, training and innovation for the profession.

Allied Health Professions Council of South Africa ('AHPCSA")[34]

62. The AHPCSA was established in terms of the Allied Health Professions Act, 63 of 1982 in order to control all allied or complementary health professions, including Aromatherapy, Ayurveda, Chinese medicine and acupuncture, Chiropractic, Homeopathy, Naturopathy, Osteopathy, Phytotherapy, Reflexology, Therapeutic Aromatherapy, Therapeutic Massage Therapy, Therapeutic Reflexology and Unani Tibb.

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[29] Competition Commission's report (2018), *Provisional Findings and Recommendations*, page 35.
[30] https://www.hpcsa.co.za/?contentId=462&actionName=Home
[31] https://www.sanc.co.za/
[32] https://pharmcouncil.co.za/
[33] https://sadtc.org.za/council/
[34] https://ahpcsa.co.za/

27/8/2025-9:45:05 AM

63. The functions of the Council are to manage, administer and set policies relating to the professions registered with the AHPCSA; to investigate complaints relating to the professional conduct of practitioners, interns and students; administer the registration of persons governed by the AHPCSA; set standards for the education and training of intending practitioners. The AHPCSA is also responsible for advising the Minister of Health and the National Department of Health on matters as they relate to the allied health professions and to communicate to the Minister of Health matters of public importance acquired in the course of its functions.

Office of Health Standards Compliance ("OHSC")[35]

64. The OHSC was established under the National Health Amendment Act (No. 12 of 2013), to promote and protect the health and safety of the users of health services. The OHSC is listed as a Schedule 3A public entity in terms of the Public Finance Management Act ("PFMA").

65. The functions of the OHSC include:
    65.1. Monitoring and enforcing compliance of health establishments with the norms and standards prescribed by the national health system.
    65.2. Ensuring that complaints of non-compliance with prescribed norms and standards are considered, investigated, and disposed of in a procedurally fair, economical, and expeditious manner.

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PRETORIA

66. The term "health establishments" refers to public and private Health care facilities that provide or are intended to provide inpatient or outpatient treatment, diagnostic or therapeutic procedures, nursing, rehabilitation, palliative, convalescent, preventive or other Health care services. It includes hospitals and primary Health care clinics and also extends to emergency medical services ("EMS"), hospices, private medical practices, and institutions offering frail care.

67. The NHI Act, 2023 Section 39(2)(b) states that a health care service provider or health establishment must possess and produce proof of certification by the OHSC to be accredited by the Fund. Section 39(12) states that the Fund may grant conditional accreditation to a health care service provider or health establishment as prescribed by the Minister after consultation with the OHSC.

National Health Research Ethics Council ("NHREC")[36]

68. The NHREC was established under the National Health Act. The functions of the Council include the determination of guidelines for the functioning of health research ethics committees; registering and auditing health research ethics committees; setting norms and standards for conducting research on humans and animals, including norms and standards for conducting clinical trials; adjudicating complaints regarding the functioning of health research committees; referring matters of violations of an ethical rule or professional rule by health practitioners to the ("HPCSA"); and advise the National Department of Health and provincial departments on any ethical issues concerning health care research.

The Health Ombudsman[37]

69. The Office of Health Ombud ("OHO") is an independent body established in terms of the National Health Amendment Act of 2013 and is located within the Office of Health Standards Compliance ("OHSC").

70. The object of the OHO is to protect and promote the health and safety of users of health care services by considering, investigating, and making findings and recommendations regarding complaints in the national health system (private and public health establishments) relating to non-compliance with prescribed norms and standards.

Medicines

71. Medicines are regulated by the Medicines and Related Substances Act No. 101 of 1965 and Single Exit Price ("SEP") legislation. Medicines include prescription (originator and generic) medicine, biologics (for example, vaccines or antibodies), nutraceuticals (dietary supplements and complementary medicines), and over-the-counter ("OTC") drugs that do not require a prescription. The statutory body for medicines is the South African Health Products Regulatory Authority.

[35] https://ohsc.org.za/
[36] https://www.health.gov.za/nhrec-home/
[37] https://healthombud.org.za/

27/8/2025-9:45:05 AM

South African Health Products Regulatory Authority ("SAHPRA")[38]

72. SAHPRA is a regulatory body established in terms of the Medicines and Related Substances Act and is an entity in the Department of Health. SAHPRA has replaced the Medicines Control Council and is responsible for monitoring, evaluation, regulation, investigation, inspection, registration and control of medicines, scheduled substances, clinical trials, medical devices, in-vitro diagnostic medical devices ("IVDs"), complementary medicines, cosmetics and foodstuffs. The functions include the licensing of manufacturers, wholesalers, and distributors of medicines and medical devices. SAHPRA has the final authority over the approval of new products.

Section Three: Health care resources in South Africa

73. This section provides a review of the resources of the health sector in South Africa. It covers expenditure on health care services and products; human resources (medical doctors, nurses and other health care professionals) and health care establishments (hospitals, clinics and other facilities)

Expenditure on health care

74. In 2023, total expenditure on health care in the country is estimate at approximately R570,0 billion, 8,1% of the country's Gross Domestic Product ("GDP"). Table 3 shows the breakdown of expenditure between the public sector, the private sector (benefits paid by medical schemes to their beneficiaries), and an estimate of out-of-pocket expenses paid by individuals for health care.[39] The government spent R267,3 billion on health,[40] 47% of total expenditure, compared to 42% of the total expenditure by private medical schemes.

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Table 3: Expenditure on Health Care 2023

	R billion	% of GDP	Per beneficiary: rands
Public sector	267,3	3,8%	4 962
Private sector	239,0	3,4%	26 405
Out-of-pocket	65,0	0,9%	1 032
Total	571,3	8,1%	9 046

Source: National Treasury, CMS industry Report and own calculations

75. In 2023, medical aid members purchased R239 billion worth of Health care services through their schemes (an average of R26 405 per medical aid member). The public sector spent R267 billion, equating to around R5 000 per individual who was not a medical scheme member.

76. Spending on health care per capita in South Africa has gradually increased in recent years. Figure 1 shows World Bank data on health care in the country as a proportion of GDP for the period 2000 to 2021. After declining from 2000 to 2007, the ratio of expenditure to GDP increased from 6,9% in 2007 to 8,6% in 2020 and has declined slightly since that Covid-19 year.

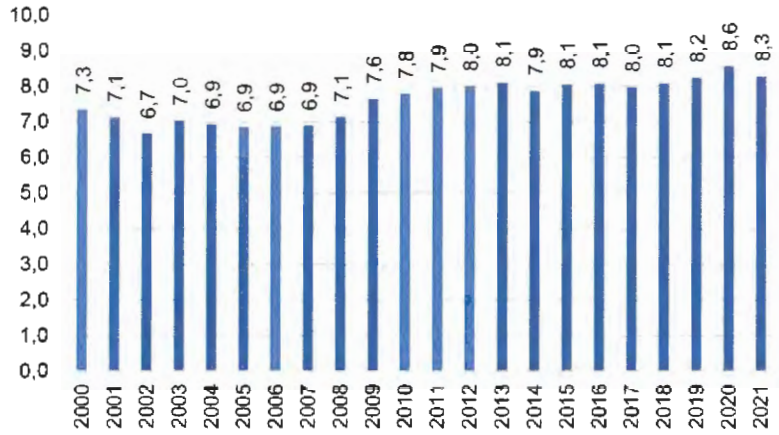
[38] https://www.sahpra.org.za/

[39] There is no aggregate amount of out-of-pocket expenses available for the year. The estimate is based on CMS data for 2023 and an estimate based on World Bank data for 2022. Most of the expenses are paid by medical schemes members but other expenditure is incurred at public sector hospitals and by individuals who purchase private sector care but are not members of a medical scheme. The expenditure estimates also exclude payments by individuals to medical insurers.

[40] In the 2023/24 financial year (National Treasury, Medium Term Budget Policy Statement 2024).

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Figure 1: South Africa Current Health Expenditure (% of GDP) 2000-2021



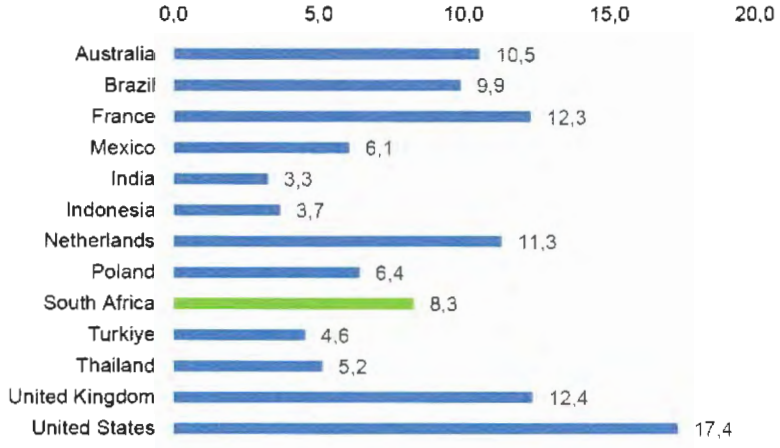
Source: World Bank

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77. The increase in health care expenditure is due to an increase in public sector expenditure relative to the private sector. Public sector health care expenditure as a percentage of GDP rose from 2,7% in 2000 to 4% in 2023.[41]

78. Countries vary widely in their spending on health care per capita, although high-income countries spend more than middle and low-income countries. Figure 2 shows a comparison of South Africa's spending compared to selected countries.

Figure 2: Total Current Health Expenditure (% of GDP) 2021



Source: World Bank

79. South Africa, classified as an upper middle-income country by the World Bank, spends less than developed countries per capita but significantly more than many other middle and low-income countries. The graph shows that in 2021, health expenditure in South Africa was 8,3% of GDP compared to 6,1% in Mexico, 5,2% in Thailand, 3,7% in Indonesia and 3,3% in India. Brazil, another upper middle-income country, spends a comparable though somewhat higher 9,9% of GDP.

Human Resources

80. Health care workers play a critical role in any country's health system and account for a large proportion of health expenditure. For example, compensation of Department of Health employees in the 2024/25 budget is R174,6 billion, 64% of the total budgeted national health expenditure. The proportion spent on health

[41] National Treasury data (*Medium Term Budget Policy Statement 2024*).

27/8/2025-9:45:05 AM

professionals in the private sector is significantly lower and in line with norms in other industries at 36,1%. Private sector health professionals received R86,7 billion in 2023 for their services from medical schemes.[42]

Registered Health professionals

81. The number of registered health professionals by various categories in South Africa for the period 2020 to 2024 is shown in Table 4. There has been a consistent but low increase of 1,4% compound annual growth rate ("CAGR") in the number, from 172 640 in 2020 to 181 981 in 2024. Medical practitioners accounted for 29,6% of all health professionals in 2024, and their number increased by 5,2% CAGR, although due primarily to a substantial increase in 2021. The number of dentists has not increased significantly, the number rising by just 167 during the period. However, there has been a significant increase in the number of registered psychologists and radiologists.

Table 4: Number of Active Qualified Health Practitioners Registered with HPCSA 2020-2024

Number	2020	2021	2022	2023	2024
Medical Practitioners	43 901	48 021	49 514	51 579	53 773
Dentists and dental assistants	10 384	10 684	10 576	10 415	10 551
Ambulance and emergency care	50 509	44 899	41 313	38 324	35 892
Psychologists and ancillary staff	12 535	13 780	13 828	14 002	14 302
Radiologists and ancillary staff	8 853	10 007	10 240	10 522	10 873
Medical and laboratory technicians and ancillary staff	10 378	11 784	12 098	12 722	13 213
Other	36 080	38 493	39 657	40 844	42 377
Total	**172 640**	**177 668**	**177 226**	**178 408**	**181 981**

Source: HPCSA Annual Report 2024

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82. In a recent research report, Matseke provides estimates of the numbers of medical practitioners and other professionals in the public and private sectors.[43] The study states that of the 43 901 medical practitioners registered in 2020, 20 926 or 47,6% were employed in the public sector, and 22 975 or 52,3% were in private practice.[44]

83. Table 5 shows the number of registered health professionals by various categories per 10 000 of the total population in South Africa for the period 2020 to 2024. The ratio of medical practitioners has increased from 7,32 per 10 000 in 2020 to 8,54 an increase of 3,9% CAGR. The ratio of dentists has declined slightly, from 1,73 per 10 000 in 2020 to 1,67 in 2024.

Table 5: Number of Active Qualified Health Practitioners Registered with HPCSA per 10 000 Population 2020-2024

	2020	2021	2022	2023	2024
Medical Practitioners	7,32	7,92	8,06	8,29	8,54
Dentists and dental assistants	1,73	1,76	1,72	1,67	1,67
Ambulance and Emergency Care	8,42	7,41	6,73	6,16	5,86
Psychologists and ancillary staff	2,09	2,27	2,25	2,25	2,27
Radiologists and ancillary staff	1,48	1,65	1,67	1,69	1,73
Medical and laboratory technicians and ancillary staff	1,73	1,94	1,97	2,05	2,10
Other	6,02	6,35	6,46	6,57	6,73
Total	**28,79**	**29,32**	**28,86**	**28,68**	**28,89**

Source: HPCSA Annual Report 2024 and own calculations

84. In 2020, there was an average of 3,49 medical practitioners per 10 000 of the country's population in the public sector compared to 25,8 medical practitioners per 10 000 of the population in the private sector.[45]

[42] CMS Annual Report 2024.

[43] Matseke, M.G., (2023) Taking Stock of the Health care Workforce in the Public Health Sector of South Africa During Covid-19: Implications for Future Pandemics, *Africa Journal of Public Sector Development and Governance*, Vol 6,1.

[44] The numbers are imprecise because some doctors in the public sector also practise in the private sector and vice versa.

[45] Ibid.

27/8/2025-9:45:05 AM

Medical specialists

85. A 2019 report shows there were, in total, seven full-time equivalent medical specialists in the public sector per 100 000 of the population, compared to 69 in the private sector with an average for both sectors of 16,5 per 100 000 of the population.

Table 6: Medical Speciality per 100 000 Population in the Public and Private Sector 2019

	Current Actual Public Sector	Current Actual Private Sector
Anaesthesiology	0.64	9.69
Family Medicine	0.66	3.78
Neurosurgery	0.09	1.12
Obstetrics and Gynaecology	0.62	6.57
Ophthalmology	0.41	1.91
Orthopaedic Surgery	0.36	5.30
Physician	0.95	9.08
Radiation Oncology	0.08	1.22
Radiology	0.48	4.65
Surgery	0.53	4.51
Urology	0.10	1.85

Source: Percept report[46]

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Nurses

86. In 2020 there were 285 245 nursing practitioners (Professional Nurses, Staff Nurses and Pupil Nurses, Nursing Assistants, and Student Nurses) with 143 288, 50,3% of the total, in the public sector and 141 957, 49,7% of the total, in the private sector.[47] For nursing practitioners, there was an average of 23,9 per 10 000 of the population in the public sector in 2020 and an average of 159,5 per 10 000 of the population in the private sector.

87. Despite the higher number of nurses per 10 000 in the private sector, the private hospital groups have indicated that there is a shortage of nursing professionals (particularly skilled nurses) precipitated by the closure of public nursing colleges and restrictions on private sector training of nurses, emigration of nurses, and the difficulty in employment of foreign nurses.[48]

Pharmacists[49]

88. In 2024, there were 16 856 registered pharmacists (working and not working) in the country excluding 971 community service pharmacists. There were 2,8 pharmacists per 10 000 population (insured and uninsured) compared to a global average ratio of 7,3 per 10 000 population. In February 2024 the public sector employed 5 958 pharmacists, predominantly at the 623 public hospitals. In the public sector, there are approximately 1,2 pharmacists per 10 000 of the uninsured population in the country.

89. Most pharmacists work in almost 4 000 community pharmacies in the private sector. There are also pharmacists employed in over 300 private hospitals, as well as in manufacturing and wholesale practice. Smaller numbers of pharmacists are employed in such specialist roles as clinical trials and pharmacy benefit management services.[50]

[46] Wishnia A. J., Strugnell, D., Smith, A. M. & Ranchod, S. 2019. *The supply of and need for medical specialists in South Africa. Cape Town*: Percept.
[47] Matseke, op. cit. Table 1, page 68.
[48] Competition Commission (2018), *Health Market Inquiry, Provisional Findings and Recommendations Report*, page 225.
[49] Based on https://www.spotlightnsp.co.za/2024/11/22/the-high-cost-of-having-too-few-pharmacists-in-sa/ and https://capetown2024.fip.org/pharmacy-in-south-africa/
[50] https://capetown2024.fip.org/pharmacy-in-south-africa/

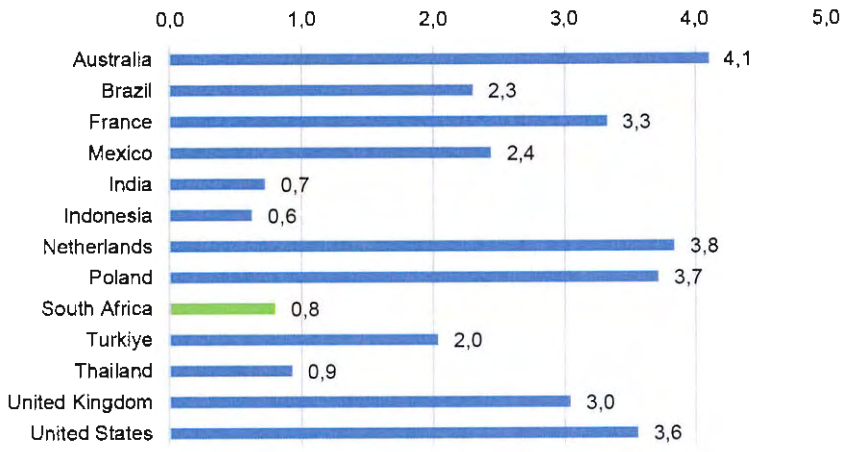
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International comparisons

90. These ratios of numbers of registered health professionals to population are significantly lower than in some developing countries and substantially less than in developed countries. For example, the Percept report[51] states that in Chile in 2015 there were 110 medical specialists per 100 000 population and in OECD countries, an average of 274 medical specialists per 100 000 of the population compared to 16,5 per 100 000 population in South Africa.[52]

91. South Africa compares unfavourably with other countries in its human resources in the health care system. Figure 3 shows the number of medical doctors per 1 000 people in the country and other selected high-income and middle to low-income countries according to the latest World Bank data. The number of medical doctors in South Africa at 0,8 per thousand people is low, at a level similar to Indonesia and India, which have much lower per capita incomes, and is substantially lower than in Brazil and Mexico and far lower than the developed countries shown in the graph. The ratio in South Africa of 0,8 per 1 000 people has been stable and has not increased since 2017.

Figure 3: Number of Medical Doctors per 1 000 People in South Africa and Selected Countries 2020



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Source: World Bank

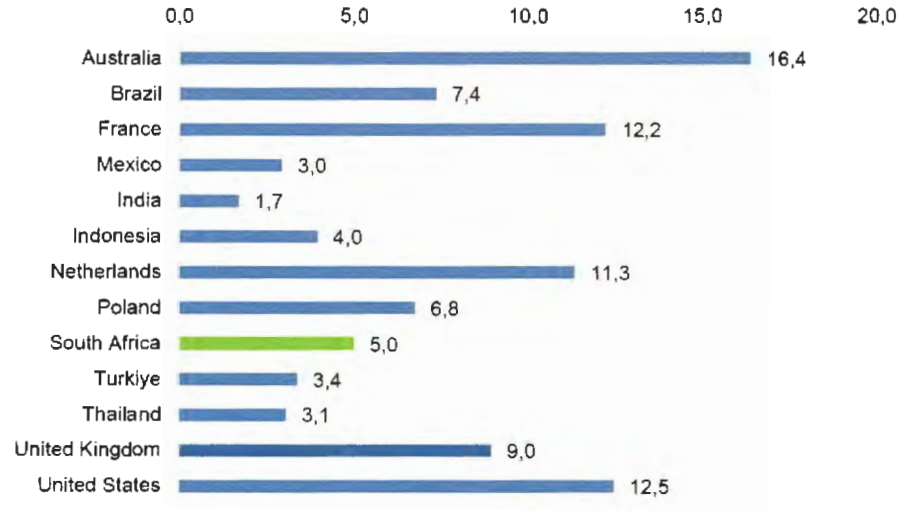
92. Figure 4 shows South Africa is better resourced in nurses compared to other African and developing countries but is substantially below the level in developed countries.

93. In 2020 there were 5,0 nurses and midwives per 1 000 people, above countries like Mexico, Turkiye, Indonesia and especially India. However, the ratio compares unfavourable with the U.K., Netherlands and France and particularly with Australia. The current ratio in the country is below target levels. The Sustainable Development Goals ("SDG") for 2030 have a target ratio of 8,3 nurses per 1 000 population.

[51] Wishnia A, J., Strugnell, D., Smith, A. M. & Ranchod, S. 2019. *The supply of and need for medical specialists in South Africa. Cape Town*: Percept
[52] Ibid.

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Figure 4: Number of Nurses and Midwives per 1 000 People in South Africa and Selected Countries 2020



Source: World Bank

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Hospitals, clinics and other health establishments

94. Hospitals, clinics and other establishments play a *critical role* in the delivery of health care in South Africa.[53] In 2023 there were over 650 hospitals and over 3 000 clinics in the public sector.[54] In 2024 in the private sector there were 776 hospitals (acute and day), clinics, and specialised facilities, including mental health care, renal dialysis, oncology, ophthalmology and rehabilitation establishments. [55]

95. In the private sector Life Health care, Mediclinic, and Netcare had a total of 493 hospitals and other facilities in 2024 which accounted for 64% of total facilities.[56] The National Hospital Network ("NHN"), a non-profit company and a cooperative venture of independent hospitals, accounted for a further 208 or 27% of total facilities.[57] There were also a small number of other independent hospital groups and individual hospitals operating during the year.

Section Four: Health care outcomes in South Africa

96. This section provides a selected overview of some of the health outcomes from the South African health care system. The data are obtained from a number of domestic and international sources and references are given where appropriate for further detail if necessary.

97. Health care expenditure in the public sector is generally above average as a percentage of GDP compared to many middle and low-income countries. Yet it generally performs inadequately and often poorly as a result of shortages of medical practitioners, nurses and other health professionals, poor training and declining professionalism by public sector health professionals, ageing and non-functioning infrastructure in hospitals and clinics, and shortages of supplies of consumables, medical devices and equipment. The underlying causes include under-funding, weak governance, poor quality management and corrupt practices at national, provincial and district levels, as well as a lack of coordination and integration between management and administrators at the three tiers of service delivery.

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[53] An excellent but now somewhat dated review of the private hospital sector is by Econex (2017), *The Economic Footprint Of Private Hospital Groups In South Africa: A Multiplier Study*.

[54] https://sahr.hst.org.za/article/122768-health-and-related-indicators-2023

[55] This number is based on a detailed and comprehensive research of private health care establishments including smaller hospital groups and individual hospitals and facilities but is not exhaustive.

[56] Details of private health care establishments can be obtained from the following websites: https://www.lifeHealth care.co.za/ https://www.mediclinic.co.za/en/corporate/about-mediclinic-southern-africa.htm https://www.netcare.co.za/ and https://nhn.co.za/

[57] The NHN operates under an exemption from the Competition Commission which permits it to bargain collectively with medical schemes on behalf of its members on tariffs and other matters.

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98. The results are poor quality health care, delayed or denial of health care, particularly for serious diseases such as cancer, long wait times, rushed appointments, and poor disease control and prevention practices. In a written response to a recent parliamentary question, the Minister of Health, Dr Aaron Motsoaledi, revealed "that of the 3,092 public Health care facilities inspected by the Office of Health Standards Compliance (OHSC) only 1,226 or 39.65% comply with the legislated standards."[58] There are also wide geographic disparities in the country and low levels of service delivery in rural compared to urban areas.

99. A further feature is the high level of medical and growing malpractice claims against public health authorities and having a serious impact on provincial health budgets: for example, the total amount of medico-legal claims stood at R77 billion in March 2023.[59]

100. The private care sector is well-funded and provides a much higher level of health care both in range and quality, often comparable and sometimes exceeding the quality of care in developed countries. There is convincing evidence that health outcomes are significantly better in private-sector hospitals than public-sector hospitals in the country.[60]

101. Some authorities take a different view of the private sector. The Competition Commission, in its Health Market Inquiry, concluded, "In our review of the South African private Health care market, we found that it is characterised by high and rising costs of Health care and medical scheme cover, and significant overutilisation without stakeholders having been able to demonstrate associated improvements in health outcomes."[61]

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102. Given this dual public and private, health system, the following review covers major health indicators in South Africa and a comparison with selected developed and developing countries. The source of the data is primarily the World Bank's database on health indicators. [62] Because 86% of the population is not covered by private medical insurance the data reflects the impact of the public sector on health outcomes as well as other factors such as the physical, political, economic, social, environmental and cultural characteristics of South Africa compared to other countries.

103. Figure 5 shows life expectancy at birth in South Africa is significantly lower at 61,5 years compared to countries both in the developed and developing world, even in lower-income countries such as India and Indonesia. However, it is higher than neighbouring countries other than Botswana (66,1 years). [63] The international data, which is the latest available from the World Bank, is affected by the Covid-19 pandemic.

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[58] https://businesstech.co.za/news/lifestyle/800461/it-doesnt-look-good-for-the-nhi-in-south-africa/

[59] https://pmg.org.za/committee-meeting/37590/ The consequences of increases in medical malpractice are covered in https://scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742013000200015

[60] Shivani Ranchodi, Cheryl Adams, ,Ronelle Burgeriii, Angeliki Carvounes, Kathryn Dreyeriv, Anja Smith, Jacqui Stewart, & Chloé van Biljon. *South Africa's hospital sector: old divisions and new developments* in chapter 10 of *South African Health Review 2017* https://www.hst.org.za/publications/South%20African%20Health%20Reviews/HST%20SAHR%202017%20Web%20Version.pdf

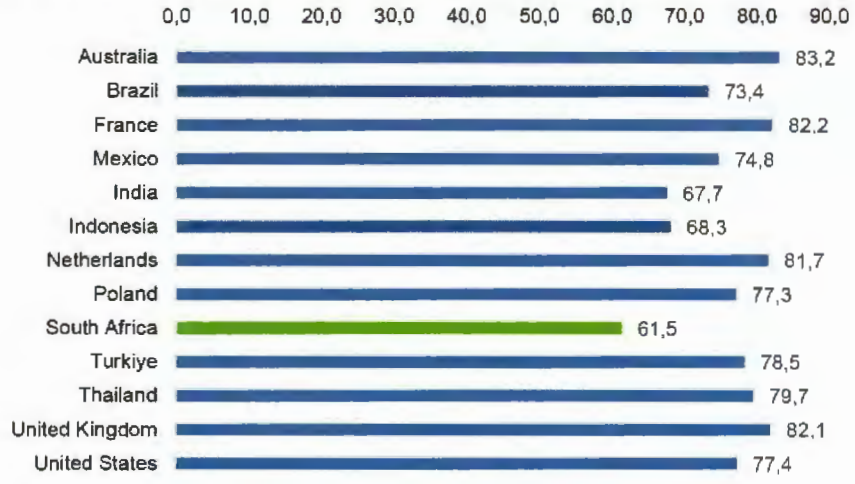
[61] Competition Commission (2019), *Health Market Inquiry, Final Findings and Recommendations Report*, Executive Summary.

[62] https://data.worldbank.org/topic/8 and https://databank.worldbank.org/source/health-nutrition-and-population-statistics

[63] https://www.statista.com/statistics/1218173/life-expectancy-in-african-countries/

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Figure 5: Life Expectancy at Birth, Total (Years) in South Africa and Selected Countries 2022

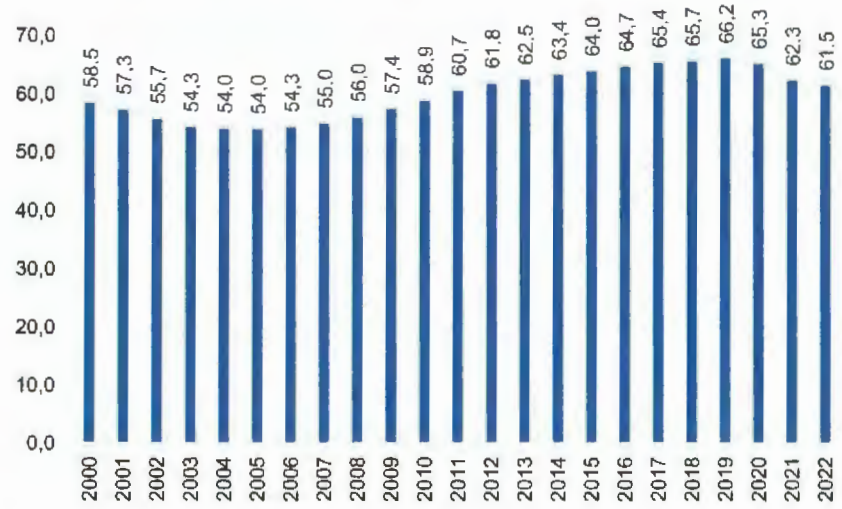


Source: World Bank

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104. Life expectancy at birth, however, has been steadily increasing except for the Covid-19 years of 2021 and 2022 as shown in Figure 6. It rose steadily from a low of 54,0 years in 2005, reflecting mainly the impact of the AIDS pandemic, to 63,4 years in 2014 before stagnating and then falling in 2021 and 2022.

Figure 6: South Africa Life Expectancy at Birth, Total (Years) 2000-2022

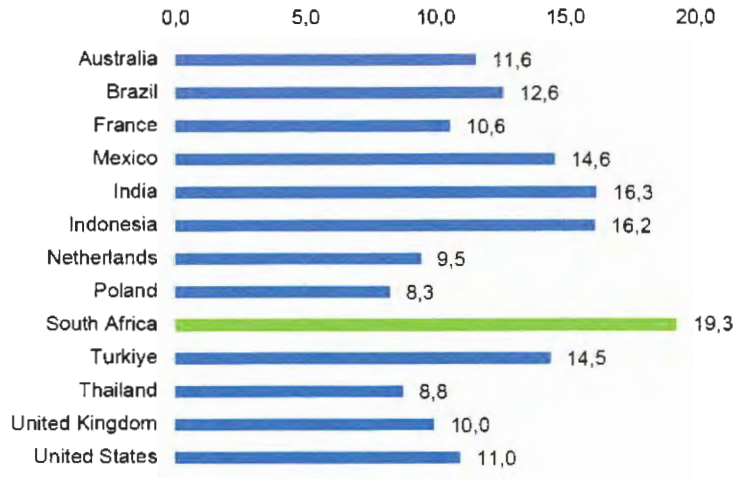


Source: World Bank

105. Figure 7 provides data on birth rates. South Africa has the highest birth rate, at 19,3 births per 1 000 population, by a significant margin compared to other developing countries and is nearly double the rate in the United States and European countries. The country's birth rate is significantly lower compared to other East and Southern African countries.

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Figure 7: Birth Rate, Crude (per 1 000 People) South Africa and Selected Countries 2022



Source: World Bank

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106. In addition, South Africa's fertility rate has declined steadily since 2008, as Figure 8 shows. After increasing from 20,7 births per 1 000 people in 2000 to 24,1 per 1 000 people in 2008, the birth rate subsequently fell to 19,3 per 1 000 people in 2022.

Figure 8: South Africa Birth Rate, Crude (per 1 000 People) 2000-2022

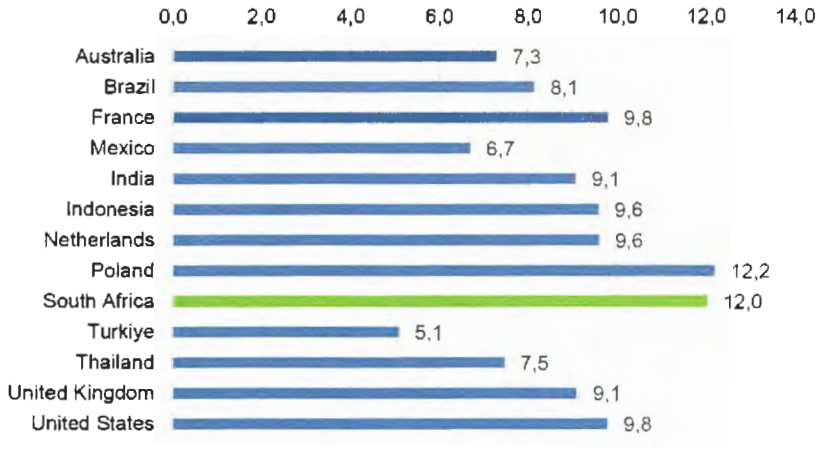


Source: World Bank

107. Figure 9 provides a comparison of death rates in South Africa compared to a selection of other countries. Given the relatively low life expectancy and higher birth rate, it is not surprising that South Africa's death rate, despite its relatively young population, is higher than most countries, even those with an ageing population.

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Figure 9: Death Rate, Crude (per 1 000 People) South Africa and Selected Countries 2022

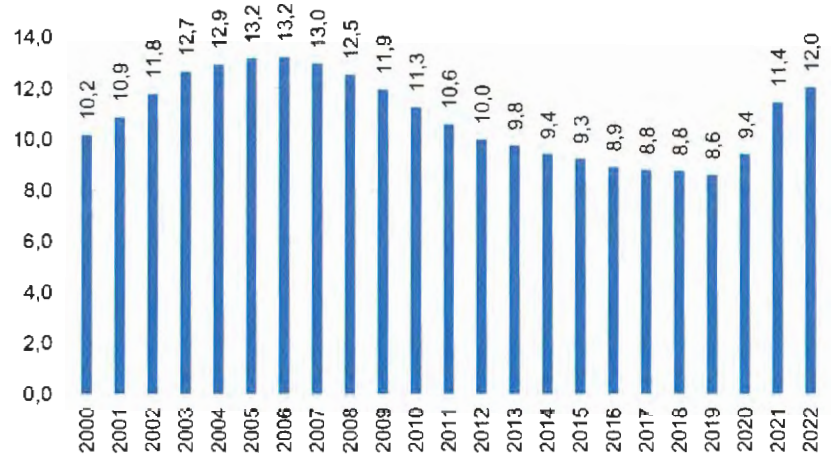


Source: World Bank

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108. The death rate in South Africa declined steadily since 2006 as shown in Figure 10. The rate rose significantly from 10,2 deaths per 1 000 population in 2000 to 13,2 in 2005, again reflecting the AIDS pandemic. The death rate fell substantially from 2005 to 8,6 deaths per 1 000 population in 2019. The trend reversed in the Covid-19 years of 2020 to 2022 but has fallen to 9,4 deaths per 1 000 population in 2024.[64]

Figure 10: South Africa Death Rate, Crude (per 1 000 People) 2000-2022



Source: World Bank

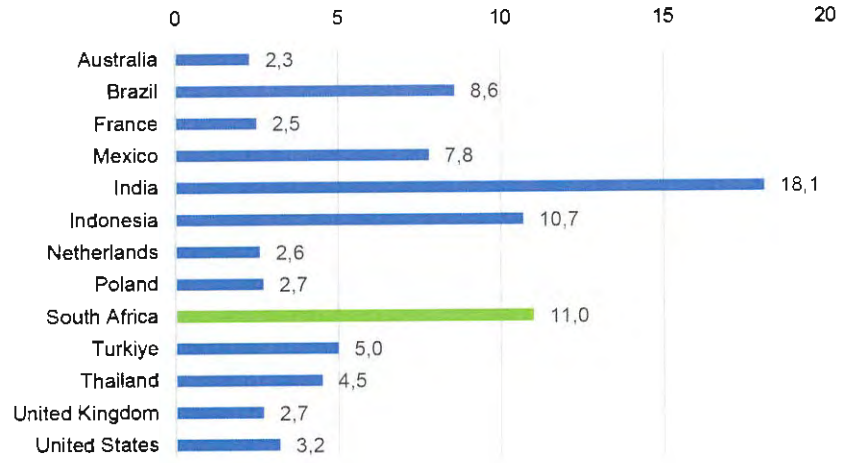
109. Major tests of a country's health care system include its maternal mortality rate, the neonatal mortality rate, and infant mortality rate. Figure 11 shows the neonatal mortality rate (deaths within 28 days of birth) per 1 000 of the population in South Africa compared to selected other countries.

110. The leading causes of death include premature birth, birth complications (birth asphyxia/trauma), neonatal infections and congenital anomalies.[65] Health care factors affecting the rate are the facilities for antenatal care, skilled obstetric and newborn care by doctors and midwives as well as the time spent by mothers in health facilities. South Africa's rate is high at 11,0 compared to rates in developed countries but considerably lower than in India.

[64] https://www.statssa.gov.za/?p=17430 for 2024 data.
[65] https://www.who.int/news-room/fact-sheets/detail/newborn-mortality

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Figure 11: Mortality Rate, Neonatal (per 1 000 Live Births) South Africa and Selected Countries 2022

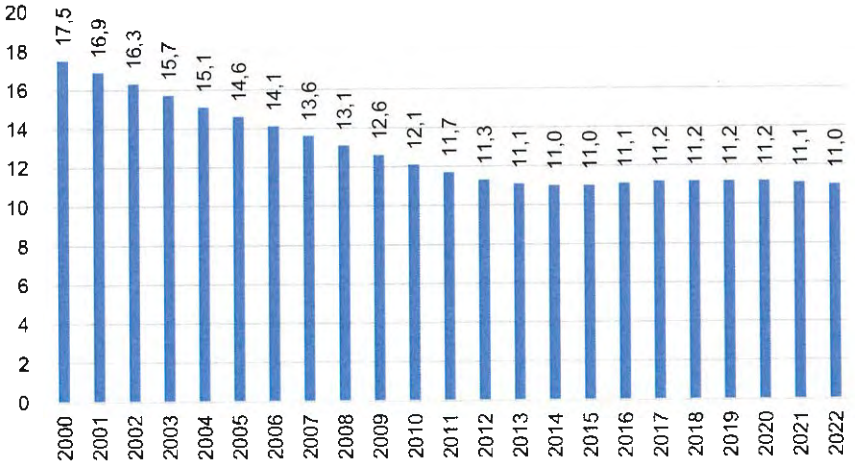


Source: World Bank

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111. Figure 12 shows there was a marked improvement in the neonatal mortality rate from 17,5 deaths per 1 000 population in 2000 to 11,0 in 2014. Since then, there has been no further progress.

Figure 12: South Africa Mortality Rate, Neonatal (per 1 000 Live Births) 2000-2022



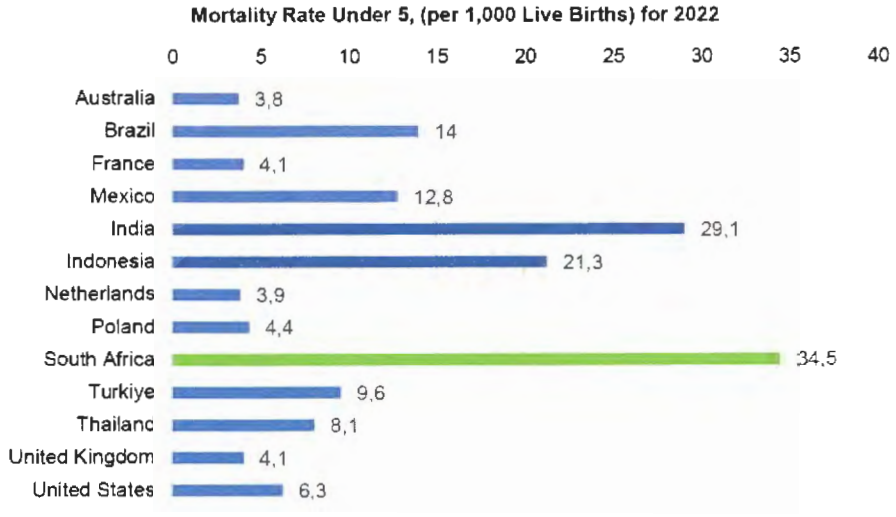
Source: World Bank

112. South Africa continues to experience poor rates of under-five mortality. Figure 13 shows the countries under five years mortality rate per 1 000 of the population compared to selected countries. The rate of 34,5 per 1 000 of the population is one of the highest in the world and is seven times higher than in the European countries shown in the graph.

113. The causes are several and include the prevalence of HIV among infants. However, deficiencies in health care, such as lack of immunisation against infectious diseases, declining attendance at clinics and shortages or poor quality services at primary care facilities and by health professionals, are also causal factors.

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Figure 13: Mortality Rate, Under 5 years (per 1 000 Live Births) South Africa and Selected Countries 2022

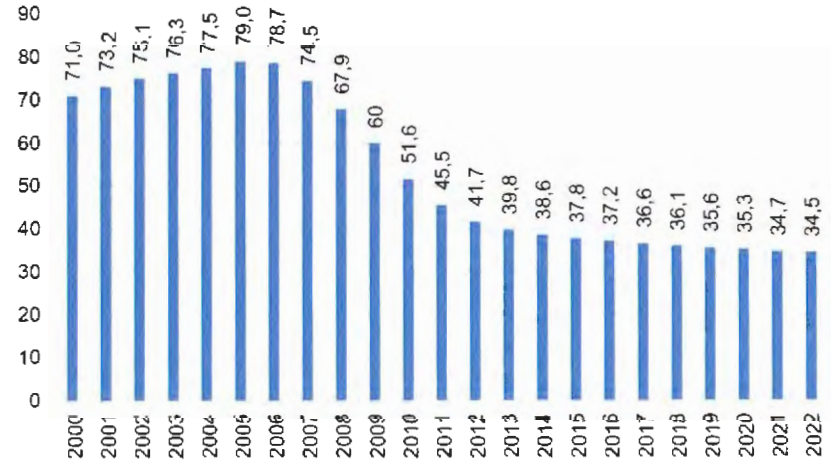


Source: World Bank

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114. Figure 14 provides evidence that there has been substantial progress since 2000 to reduce death rates among infants and young children under five years old but has stalled since 2014. After increasing from 71,0 deaths per 1 000 of population in 2000 to 79,0 in 2005 there was a steep decline to 38,6 in 2014. Since then, progress has slowed, with 34,5 deaths per 1 000 of population in 2022.

Figure 14: South Africa Mortality Rate, Under 5 years (per 1 000 Live Births) 2000-2022



Source: World Bank

Conclusion on health outcomes

115. The public sector health services in South Africa generally reflect poor outcomes at both primary and tertiary levels of care in comparison to peer countries with similar levels of economic development and resource allocations to their public health systems. Also, the public sector's performance is substantially below the outcomes in developed countries. There is evidence also that the performance of the public sector has deteriorated in recent years. This performance cannot be explained purely by the resources allocated to it, as many countries at a similar level of development spend significantly less on their public health systems. Conversely, outcomes in the private health care sector are generally similar to many developed countries but at a cost that limits access to private health care for lower-income earners.

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Section Five: Health care price inflation

116. This section provides a comparison of the last sixteen years of medical price inflation and general consumer price inflation as measured by the consumer price index. StatsSA has published monthly price index data for several categories of health care services and products for urban areas in the country since January 2008.[66] This data comprises indices of medical products, medical services, doctors' fees, dentists' fees, hospital services,[67] medical insurance and a composite health index of all medical products and services excluding medical insurance.

117. Table 7 shows the annual increases in these indices with a comparison to headline CPI inflation from 2009 to November 2024 and the arithmetic mean (average) of the price increases for the whole period.

118. The Table shows that increases in the prices of private sector health services and products have not substantially exceeded the average increase in the headline consumer price index since 2009, although there are fairly large variations in annual rates of increase. For medical products the average annual increase in prices at 5,1% was actually marginally below the increase of 5,3% in consumer prices during the period.[68]

Table 7: Annual Average Increases in Price Indices of Health Products and Services and Medical Insurance and CPI Inflation 2009-2024 (November)

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	Health	Medical Products	Medical Services	Doctors	Dentists	Hospital services	Medical Insurance	CPI Headline
2009	10,7%	11,9%	10,3%	10,2%	8,9%	10,1%	11,4%	7,1%
2010	7,5%	6,4%	8,2%	9,0%	6,4%	7,1%	13,2%	4,2%
2011	5,8%	4,2%	6,8%	7,2%	6,1%	5,6%	10,2%	5,0%
2012	5,3%	3,4%	6,3%	6,9%	6,3%	4,9%	9,5%	5,7%
2013	4,8%	3,6%	6,2%	6,3%	5,5%	4,8%	10,2%	5,7%
2014	5,3%	4,5%	6,2%	6,4%	5,6%	6,2%	9,1%	6,1%
2015	6,1%	5,6%	6,4%	6,6%	6,0%	5,9%	9,6%	4,6%
2016	5,5%	4,9%	6,2%	6,2%	5,5%	5,2%	9,1%	6,3%
2017	6,6%	6,4%	6,4%	6,5%	6,2%	5,2%	10,2%	5,3%
2018	5,1%	3,7%	6,1%	6,3%	5,4%	4,8%	8,6%	4,6%
2019	4,9%	4,0%	5,5%	5,6%	5,2%	4,6%	8,8%	4,1%
2020	4,4%	3,5%	4,9%	5,0%	4,8%	3,9%	9,5%	3,3%
2021	3,6%	3,9%	3,5%	3,3%	4,3%	3,5%	5,7%	4,6%
2022	4,6%	4,2%	5,0%	5,0%	4,7%	3,3%	4,3%	6,9%
2023	5,9%	6,2%	5,6%	5,7%	5,3%	5,3%	7,5%	5,9%
2024	5,4%	6,0%	5,1%	4,8%	7,9%	5,5%	10,4%	4,6%
Mean	**5,7%**	**5,1%**	**6,2%**	**6,3%**	**5,9%**	**5,4%**	**9,2%**	**5,3%**

Source: StatsSA Statistical Release P0141 Consumer Price Index November 2024 and own calculations

119. The exception to this conclusion is the rate of increase in medical insurance prices which are principally the price increases (premiums) of medical aid schemes.[69] The average annual price increase in medical insurance prices from 2009 to 2024 was 9,2% compared to 5,3% for consumer price inflation and significantly exceeded consumer price inflation for every year from 2009 to 2024 except for 2022 and the prices of medical products (5,1%) and medical services such as doctors' and dentists' fees and hospital services (6,2%).

120. Table 8 shows the cumulative percentage increases in health price indices and the CPI headline index in sub-

[66] https://www.statssa.gov.za/?page_id=1854&PPN=P0141

[67] Hospital services prices are surveyed by StatsSA in February, May, August and November of each year.

[68] One reason is that the prices of many pharmaceutical products are regulated by the Department of Health through its policy of annually setting maximum single-exit prices of products purchased by pharmacies and other retailers. These companies then are allowed to add a maximum dispensing fee to consumers which is also regulated annually by the Department.

[69] Medical aid scheme rates are surveyed annually in February.

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periods during the period January 2008 to November 2024. The Table shows a substantial moderation in medical inflation from 2008-2014 to 2014-2019 and a lower but still significant moderation during the 2019-2024 period, reflecting in part the decline in the rate of consumer price inflation in the country, particularly from 2014. Since 2019 health products and services inflation has been broadly similar to consumer price inflation. Again, the exception is medical insurance inflation which, although declining since 2008-2014, at 69.7% was more than double the increase in consumer prices in 2014-2019 of 33,7% and, at 55.9%, nearly double the increase of 32,0% in consumer prices from 2019-2024.

Table 8: Cumulative Percentage Increases in Health Price Indices and the CPI Headline Index

	Health	Medical Products	Medical Services	Doctors	Dentists	Hospital services	Medical Insurance	CPI Headline
2008-2014	56,0%	44,8%	64,5%	66,6%	53,1%	61,9%	100,7%	47,5%
2014-2019	38,2%	32,2%	42,7%	43,8%	39,1%	36,3%	69,7%	33,7%
2019-2024	32,2%	31,5%	32,8%	32,4%	36,5%	29,0%	55,9%	32,0%
2008-2024	**157,7%**	**130,5%**	**179,6%**	**183,9%**	**162,8%**	**155,9%**	**347,5%**	**138,7%**

Source: StatsSA Statistical Release P0141 Consumer Price Index November 2024 and own calculations

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121. For the period 2008-2024, the prices of health products and services increased by 157,7% compared to a 138,7% increase in the headline consumer price index. The increase in the prices of medical products was slightly lower than the increase in consumer prices. The Table shows medical services such as doctors' and dentists' fees were significantly higher than the general increase in prices, as were hospital services fees, but these were due to the relatively high increases in the period 2008-2014. The outlier is medical insurance prices, which increased by 347,5% from 2008 to 2024 compared to the 138,7% increase in consumer price inflation during the period.

NATIONAL ASSEMBLY

QUESTION: 1120 **FA8**

FOR WRITTEN REPLY

DATE OF PUBLICATION IN INTERNAL QUESTION PAPER: 25 OCTOBER 2024 (INTERNAL QUESTION PAPER NO. 17)

Mr S M Gana (Rise Mzansi) to ask the Minister of Health *[Interdeparetmentally transferred from Water and Sanitation with effect, Monday, 14 October 2024]*:

(1) With regard to public healthcare facilities meeting the standards of the Office of Health Standards Compliance (OHSC), what (a) total number of public healthcare facilities such as clinics and hospitals (i) meet and/or (ii) do not meet the OHSC standards and (b) is the breakdown of such facilities in each province in each case;

(2) what is the estimated cost of bringing all public healthcare facilities to be in compliance with OHSC standards;

(3) what (a) total number of public healthcare facilities are earmarked to be compliant with OHSC standards for the 2024-25 financial year and (b) are the estimated costs in each case;

(4) how will the upgrades to the public healthcare facilities be funded;

(5) whether her department will consider establishing a public-private partnership to fund the projects; if not, why not; if so, what are the relevant details?

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REPLY:

(1) (a) The total number of Public Health Facilities inspected is 3092, (i) of those inspected, 1226 were found to be compliant and (ii) 1866 were not compliant since the promulgation of the norms and standards.

(b) The breakdown of Public Health Facilities inspected in each Province is as follows:

Province	Compliant	Not Compliant	Total Inspected
Eastern Cape	181	496	677
Free State	46	182	228
Gauteng	220	87	307
KwaZulu-Natal	360	208	568
Limpopo	71	326	397
Mpumalanga	93	178	271
North West	108	191	299
Northern Cape	24	127	151
Western Cape	123	71	194
Grand Total	**1226**	**1866**	**3092**

(2) The OHSC would have to first inspect all facilities and based on the deficiencies identified then the total costs of bringing all public healthcare facilities into compliance with OHSC standards can be determined. Given that all public healthcare facilities have not been inspected it would be difficult to provide such a costing.

(3) (a) A total of 689 inspections for public health facilities are planned for the 2024/25 financial year. The number of facilities that are compliant can only be confirmed after the inspections are completed.

(b) An estimated budget of R15 723 288 has been allocated to cover the cost of the OHSC inspections to be conducted in the 2024/25 financial year, including public and private health establishments.

(4) The direct health facility revitalization grant is the largest source of funds for public health infrastructure and is transferred to provincial departments of health through the Health Facilities Infrastructure Management sub-programme in the Hospital Systems programme.

(5) The department is working with the National Treasury to develop strategies to accelerate the delivery of infrastructure in the health sector for implementation of the National Health Insurance. Although the details of these proposals are still being finalised, they are likely to draw on the budget facility for infrastructure and the Infrastructure Fund to complement existing budgets for health infrastructure.

END.

FA9

PriceMetrics

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

21 May 2025

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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.

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[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.

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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.

[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.

27/8/2025-9:45:05 AM

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 (n.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.

27/8/2025-9:45:05 AM

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.

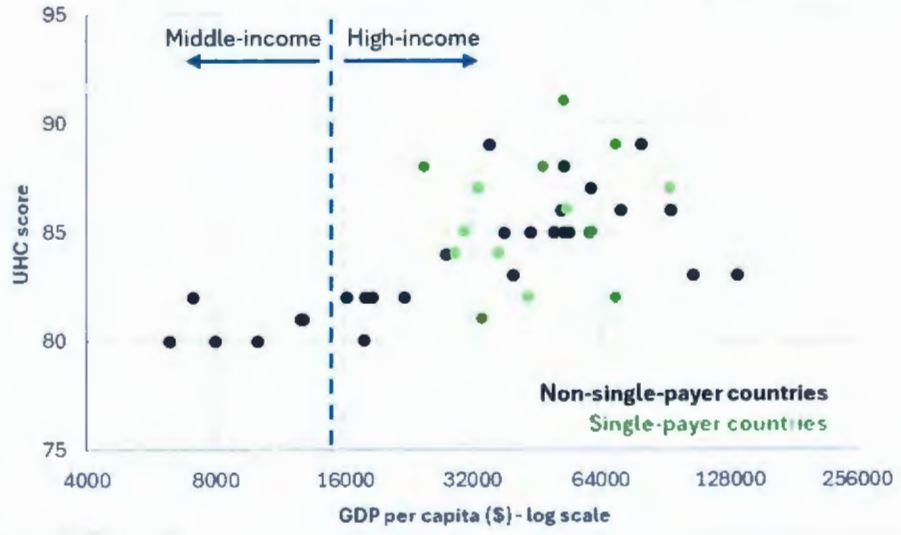
26. In contrast, levels of the UHC SCI Index can be achieved by multi-payer or hybrid systems at GDP per capita substantially below those of single-payer countries. The graph shows that 10 (36%) out of the 28 non-single-payer countries had incomes below $20,000 per capita, and six of these countries 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 M.E Guerin-Calvert, part of the HASA Notice of Motion to the High Court app[ying for an order to have the NHI Act to be declared unconstitutional and set aside.

27/8/2025-9:45:05 AM

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



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Source: World Bank

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.

27/8/2025-9:45:05 AM

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

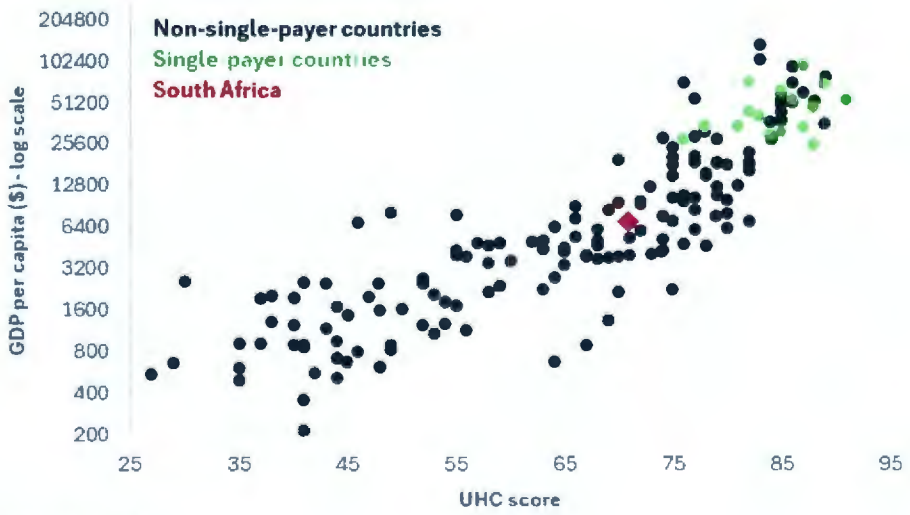
31. Countries with universal health coverage - whether multi-payer, single-payer, or hybrid health care funding systems - spend considerably more on health care per capita and have a higher ratio of health expenditure to GDP than other countries. To afford this expenditure, these countries need high 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

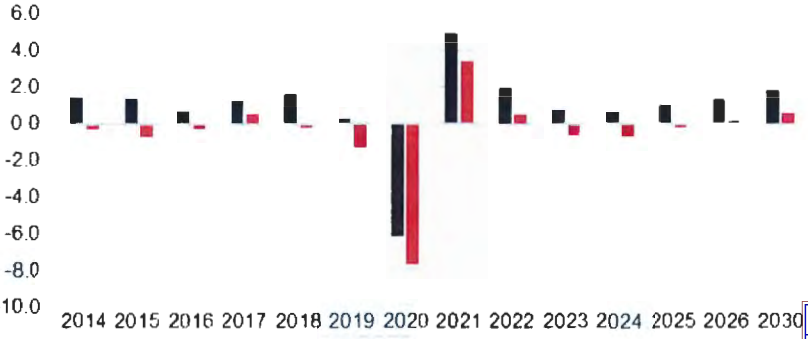
[20] South Africa's GDP per capita of $6,843 reported earlier in the report was for 2021. GDP per capita in dollars declined considerably from 2021 to 2023 due to slow growth and exchange rate fluctuations. Source: World Bank

[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.

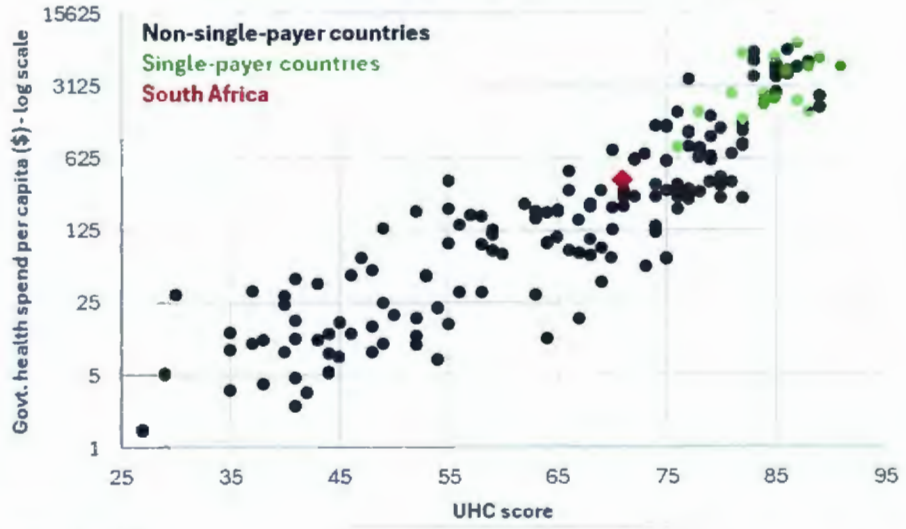
38. The South African government spent $377 on health care per capita in 2021, only around 11% of the single-payer country average of nearly $3,554 per capita and 14% of the median single-payer country of almost $2,600 per capita. Excluding the three Middle Eastern oil-producing countries of Bahrain, 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

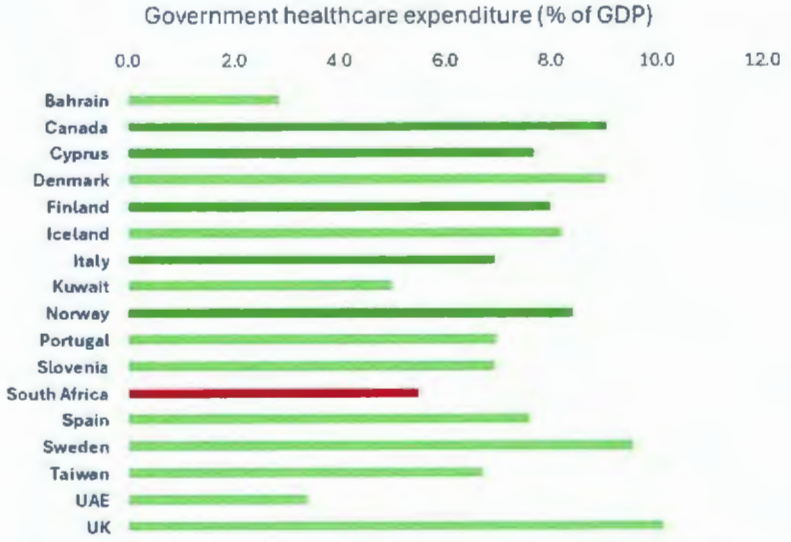


Source: World Bank

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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.

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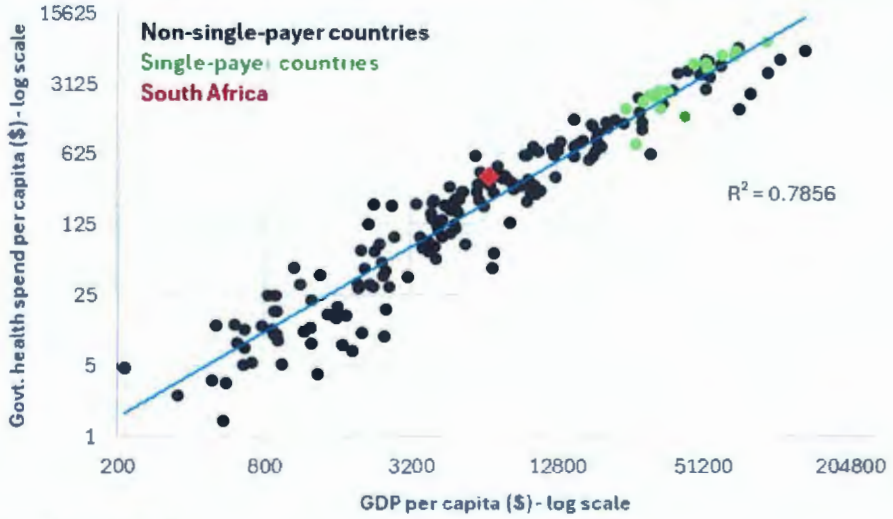
42. Even if South Africa expanded health care spending to the average single-payer level (excluding Bahrain, Kuwait, and UAE) of just over 8%, government health care spending per capita would only rise to $561 from $377. Despite this considerable – nearly 50% – increase in government health care expenditure,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

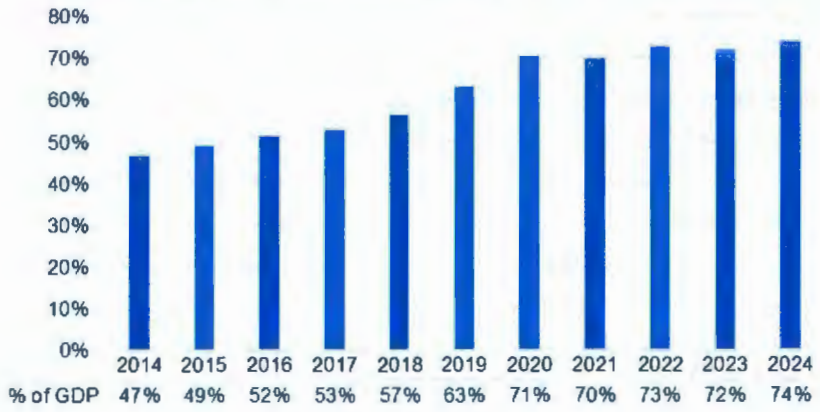
45. It is evident, therefore, that if the South African government wishes to implement a single-payer system, GDP per capita would need to expand by around 4-5 times, or 300-400%, from current levels. As noted in the section above, this would take several decades, even at high real GDP growth rates.

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



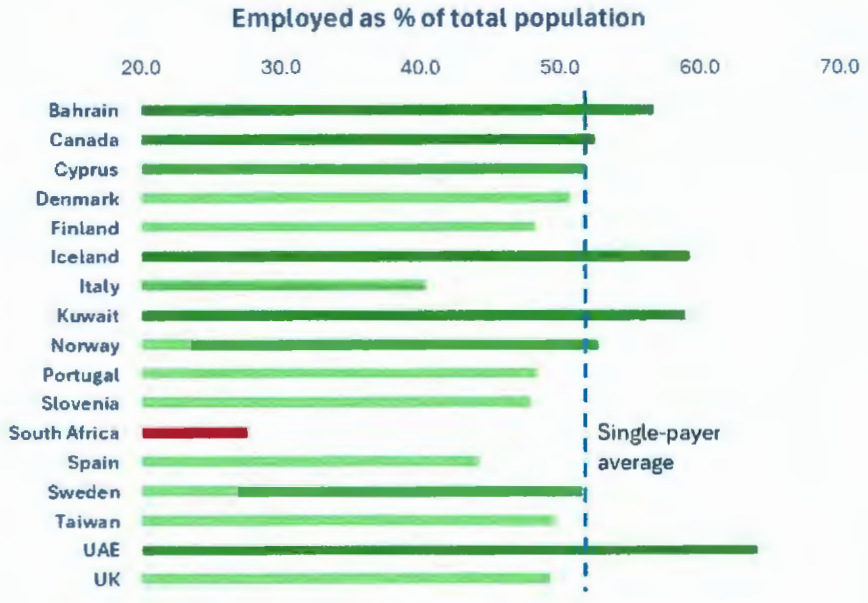
Source: Trading Economics

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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.

27/8/2025-9:45:05 AM

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.

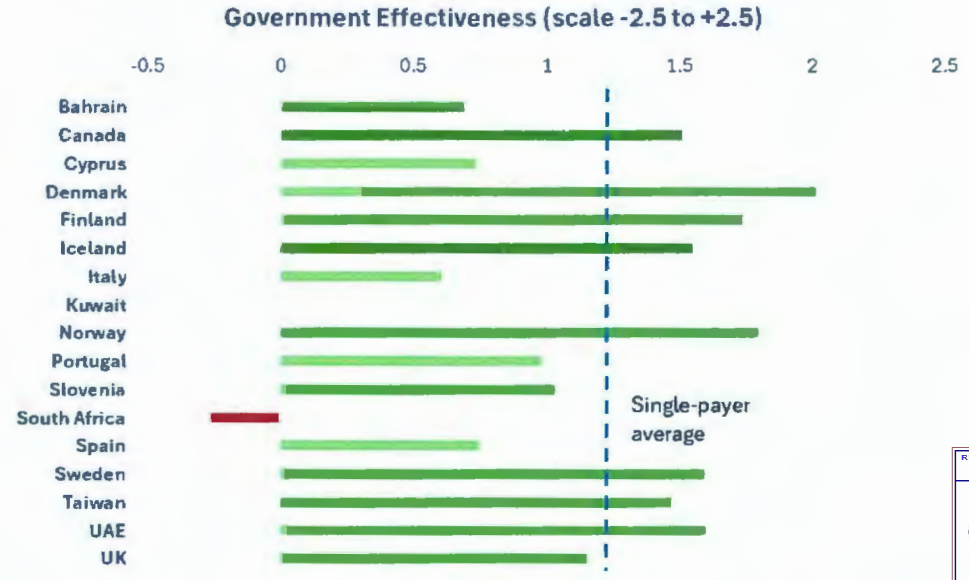
[30] Examples are Auditor-General https://pfma-2023-24.agsareports.co.za/pages/health-sector and https://www.hst.org.za/publications/South%20African%20Health%20Reviews/2%20Analysing%20the%20progress%20and%20fault%20lines%20health%20sector%20transformation%20in%20South%20Africa%20.pdf and https://www.chp.ac.za/Portals/0/FINAL%20Exploring%20Corruption%20in%20SA%20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

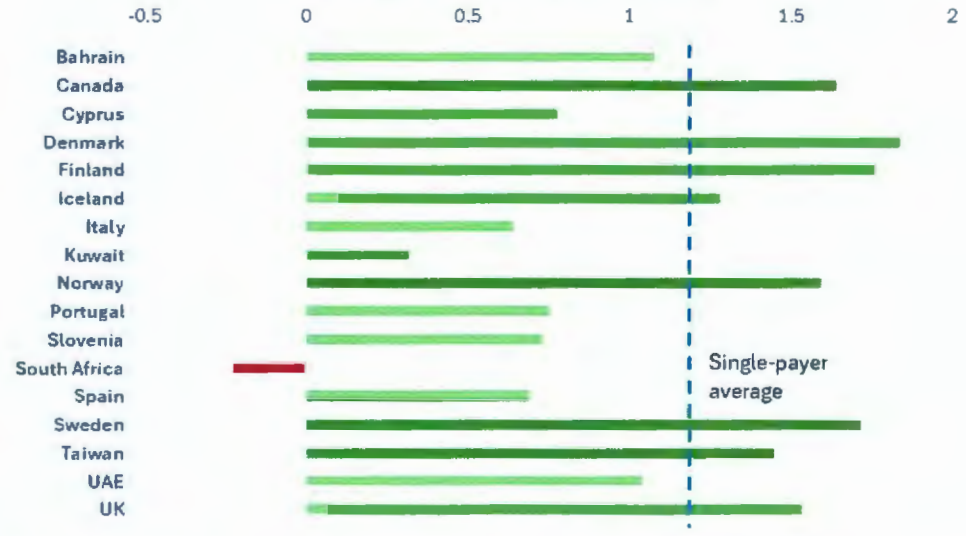


Source: World Bank

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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



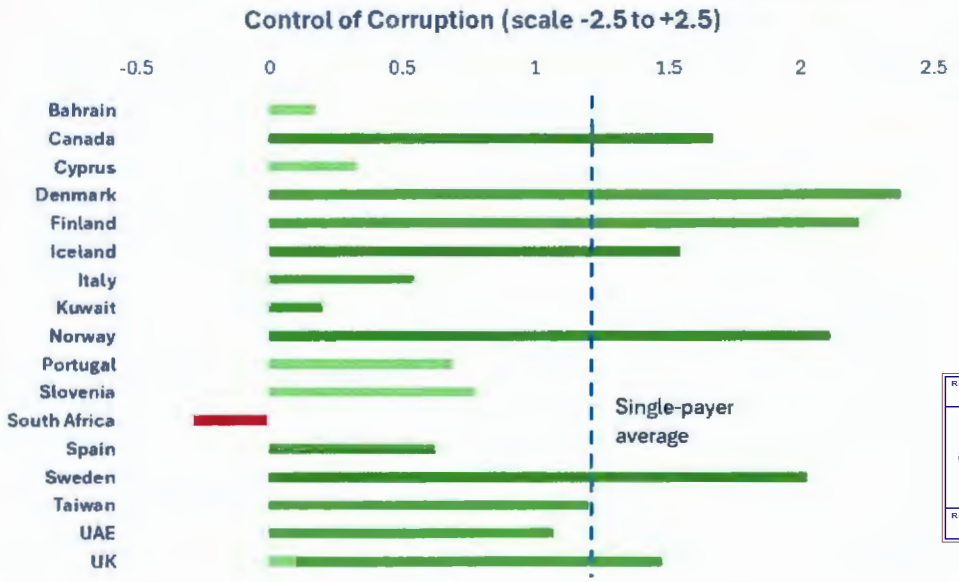
Source: World Bank

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

27/8/2025-9:45:05 AM

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."

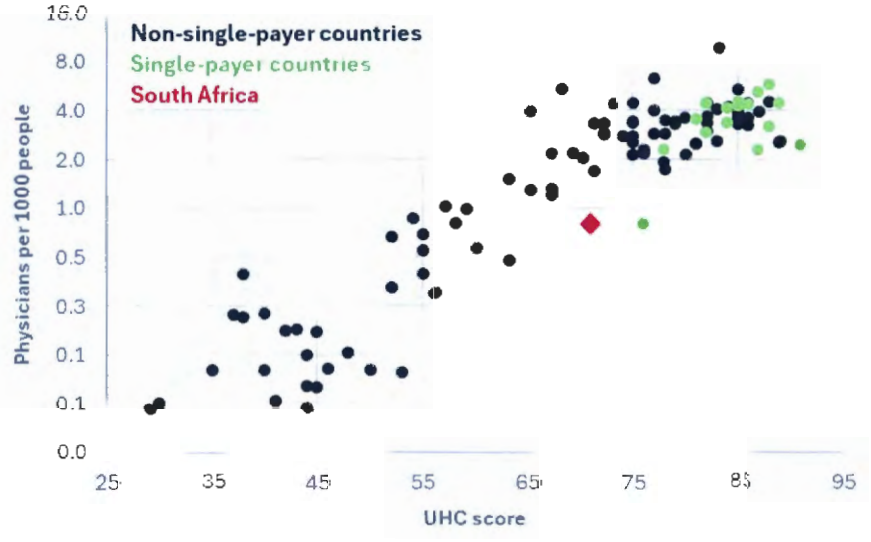
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iv. Sufficient health care resources: human resources and physical capital

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.

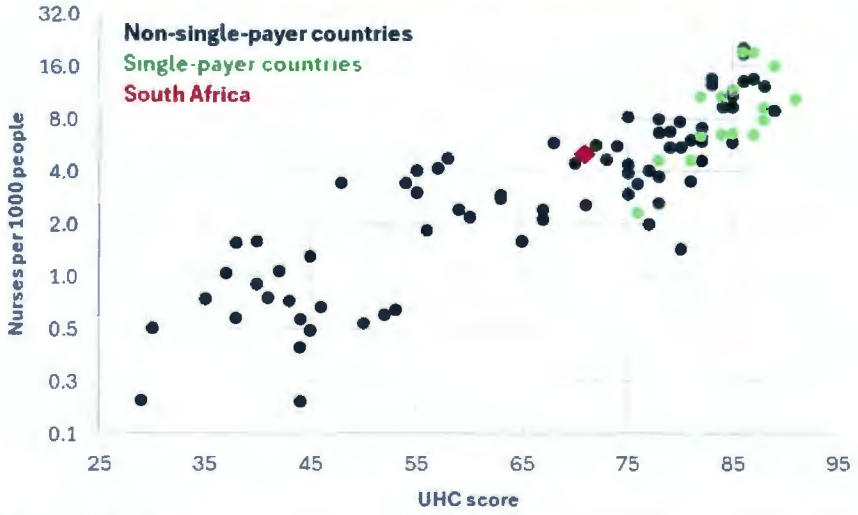
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shows clearly that South Africa has no realistic prospects of obtaining anywhere near enough medical practitioners to support a comprehensive single-payer system such as the NHI.

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



Source: World Bank

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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.

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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

27/8/2025-9:45:05 AM

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

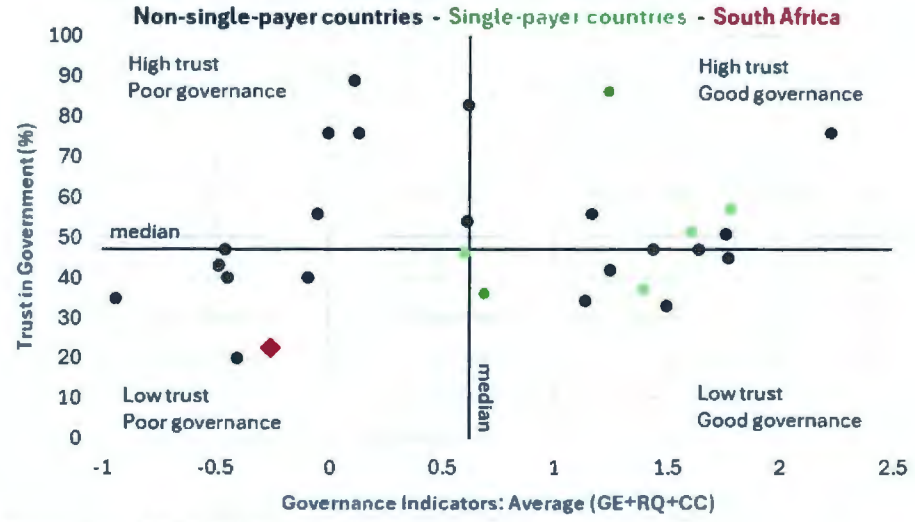
76. Figure 16 is a scatterplot comparing countries by their quality of governance and trust in government institutions. Single-payer countries (green dots) tend to have moderate to high trust in government, along with capable governance. The scatterplot shows that South Africa (red dot) lacks both, being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

27/8/2025-9:45:05 AM

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			

27/8/2025-9:45:05 AM

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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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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Index

	Page
Executive Summary	2
Chapter One: Features of the NHI	7
Chapter Two: The economic environment	9
Chapter Three: Fiscal capacity to implement the NHI – government revenue and expenditure	19
Chapter Four: Funding the cost of the NHI: alternatives and scenarios	33
Chapter Five: Conclusion	61

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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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

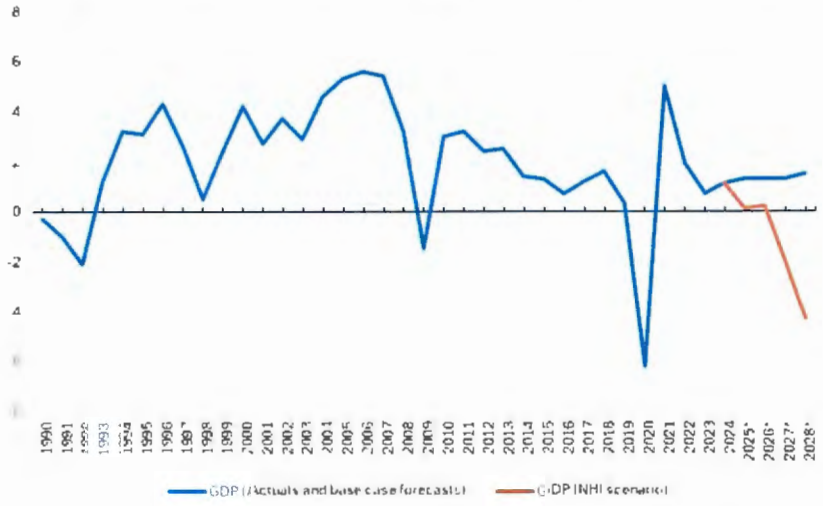
The last increase in the marginal rate (from 41% to 45%) implied an increase of 4 percentage points, or 9,76%, in the maximum marginal tax rate. In the calculations above, an increase by means of a tax surcharge of 31% is suggested for full NHI implementation by 2028. At the lowest marginal rate of 18% 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

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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

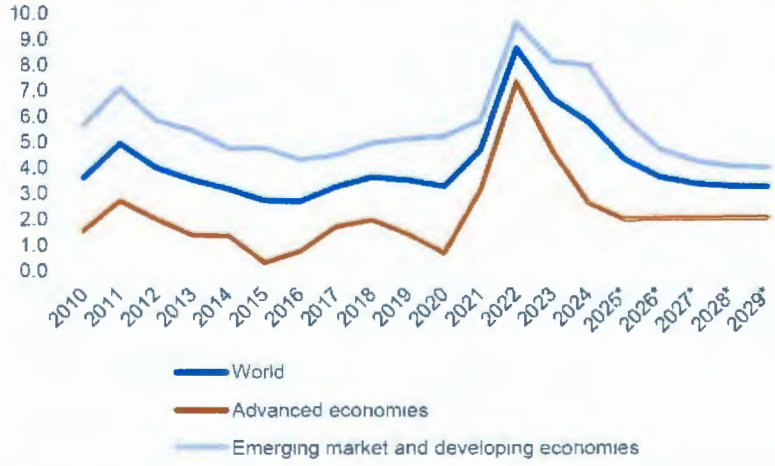
South Africa has a relatively open economy, with exports and imports together accounting for around 60% of GDP and, by emerging markets standards, highly liquid money, capital and foreign exchange markets. The economy is therefore affected substantially by trends in world output and trade as well as 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

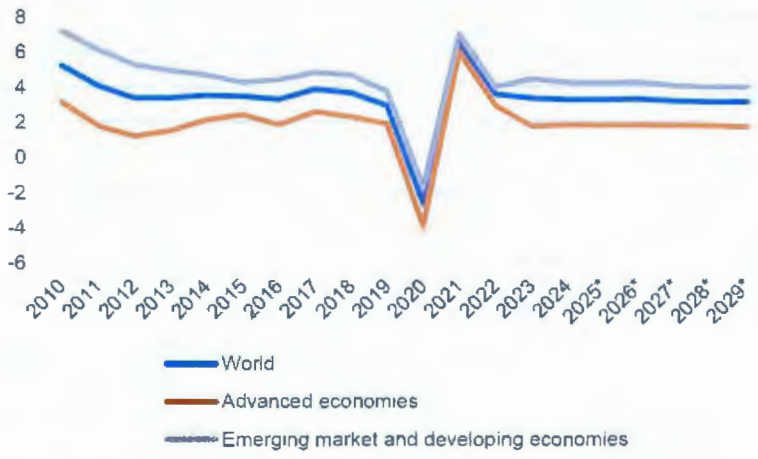
	2001-10	2011-20	2023	2024	2025	2029
World output (annual per cent change)	3,9%	2,9%	3,3%	3,2%	3,2%	3,1%
World trade volume: annual per cent change	5,0%	2,5%	0,8%	3,1%	3,4%	3,3%
Consumer prices: Advanced Economies	2,0%	1,4%	4,6%	2,6%	2,0%	2,0%
Consumer prices: Emerging market and Developing Economies	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/202410214801/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.

27/8/2025-9:45:05 AM

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.

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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.

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

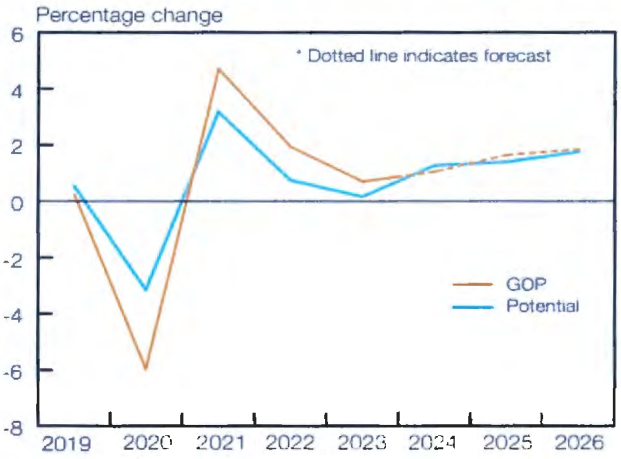
[36] Potential growth is the rate of GDP growth that could theoretically be achieved if all the productive assets in the economy were employed in a stable inflation environment. It is derived from the South African Reserve Bank's (SARB) semi-structural potential output model. The measurement accounts 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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

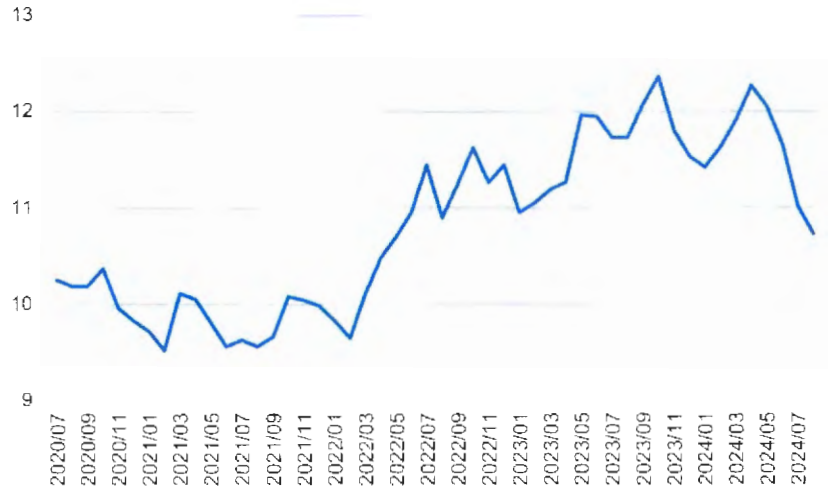
Financial markets reacted positively to the 2024 General elections. Most notable is the improvement in the 10-year bond yield by around 200 basis points in the aftermath of the election (see Figure 5). In addition, the Rand appreciated against major currencies after the elections, that is, until the 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

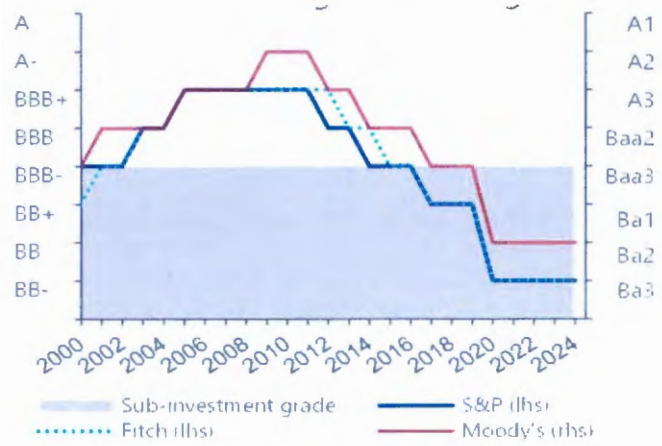


Source: SARB

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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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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]

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[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/

27/8/2025-9:45:05 AM

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.

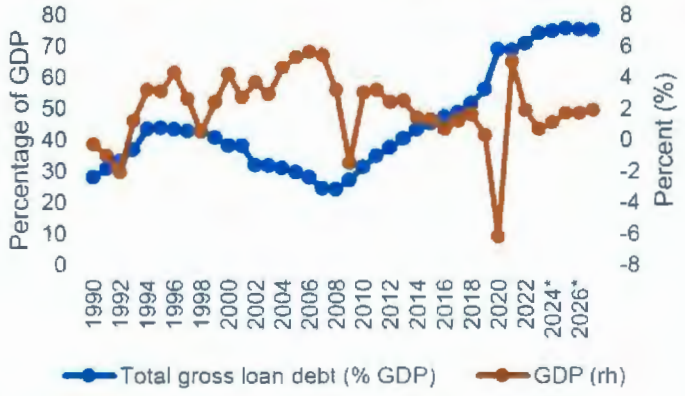
The cost estimates used in this report should be viewed against the background of the government's current levels of and trends in revenue, expenditure and borrowing requirements (annual deficit before borrowing), and fiscal constraints. An analysis of these trends in the government's fiscal position 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

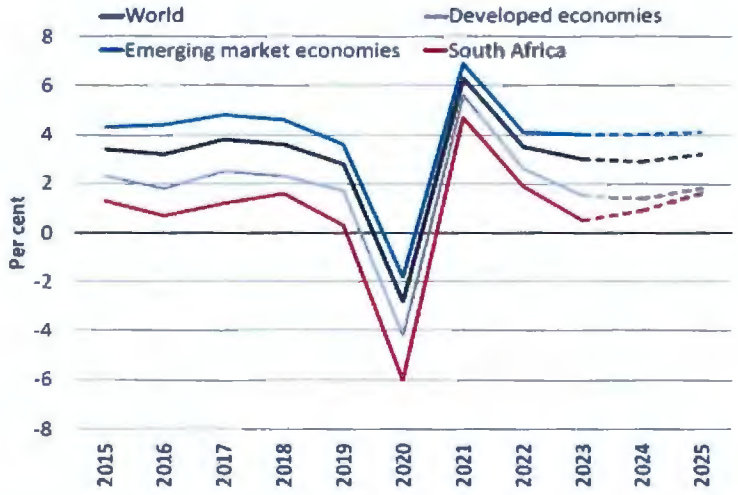
At the same time, South Africa's economic growth trajectory declined, with potential economic growth estimated to average around 1% to 1,5% per annum. Earlier research[59] published in 2014 reported the

[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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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

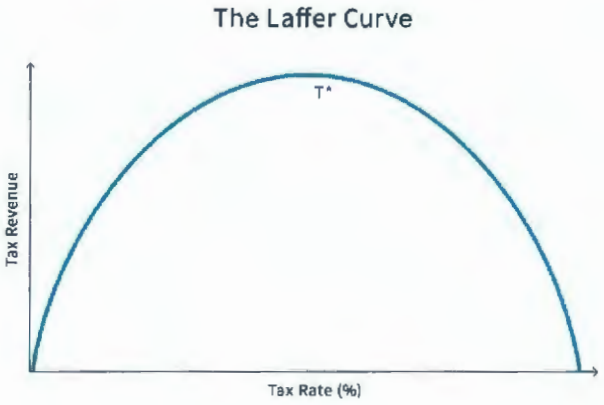
[61] *Encyclopaedia Britannica*. Online at https://www.britannica.com/topic/austerity [Accessed on 3 November 2019].
[62] Government borrowing in international capital markets serves a number of purposes, *inter alia* to set a sovereign benchmark for other borrowers of the country in the international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

27/8/2025-9:45:05 AM

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

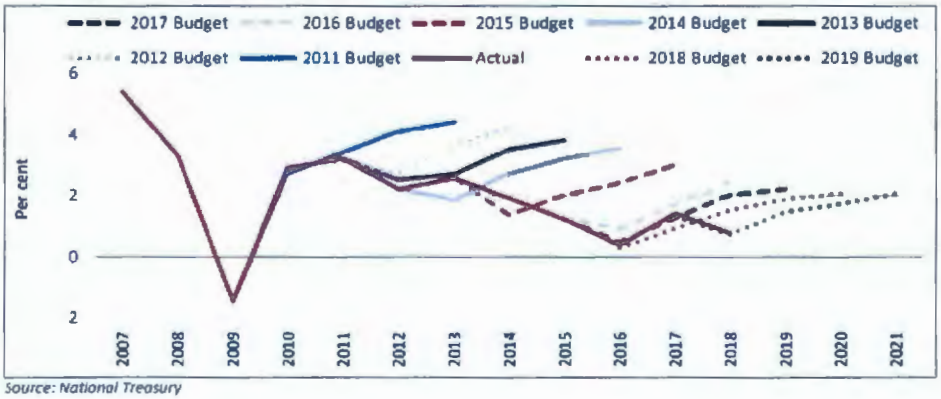


Source: Own analysis

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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.

27/8/2025-9:45:05 AM

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/

27/8/2025-9:45:05 AM

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)

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

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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.

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

27/8/2025-9:45:05 AM

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/

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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27/8/2025-9:45:05 AM

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/

27/8/2025-9:45:05 AM

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 carecosts 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.

27/8/2025-9:45:05 AM

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	156,651,288,802	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	180,708,022,126	8,374,663,993	189,082,686,119
2019	103,126,628,663	35,111,160,178	50,824,674,097	189,062,862,938	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.

27/8/2025-9:45:05 AM

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

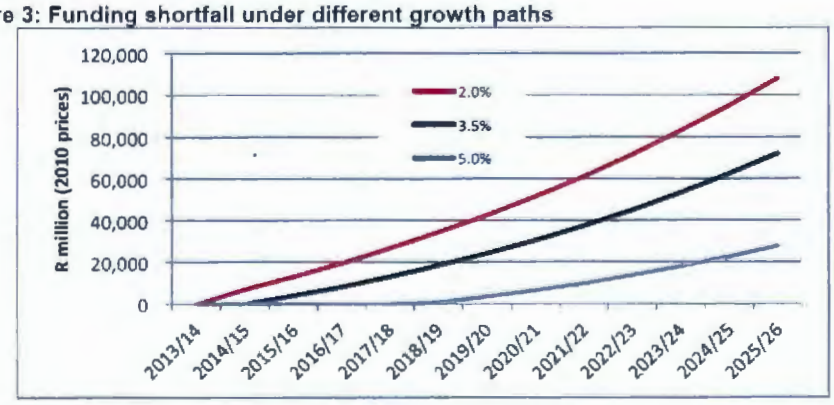
		Average annual per cent increase	Cost Projection R m (2010 prices)
Baseline public health budget:	**2010/11**		**109 769**
Projected NHI expenditure:	2015/16	4.1%	134 324
	2020/21	6.7%	185 370
	2025/26	6.7%	**255 815**
Funding shortfall in 2025/26 if baseline increases by:		2.0%	108 080
		3.5%	71 914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

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

(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] Pyan, 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.

27/8/2025-9:45:05 AM

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.

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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).

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

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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

27/8/2025-9:45:05 AM

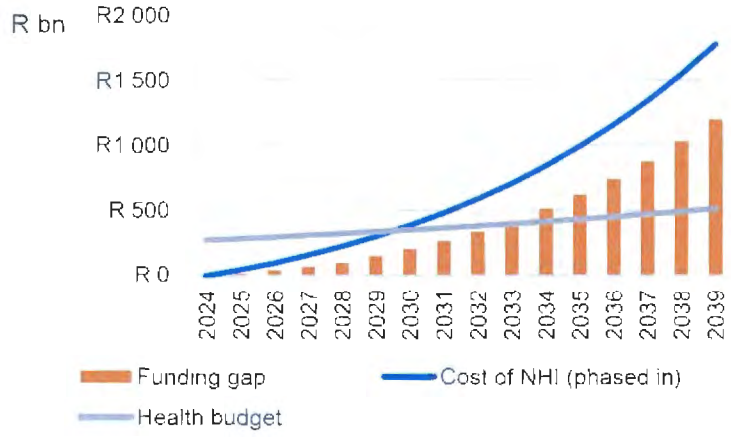
Table 15: Estimates of Funding Requirement of Fully Implemented NHI by 2039, R billion

	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.

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

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Personal income tax surcharge

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].

27/8/2025-9:45:05 AM

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.

27/8/2025-9:45:05 AM

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.

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Summary of proposals

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.

27/8/2025-9:45:05 AM

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

27/8/2025-9:45:05 AM

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

27/8/2025-9:45:05 AM

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.

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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

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

27/8/2025-9:45:05 AM

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

27/8/2025-9:45:05 AM

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

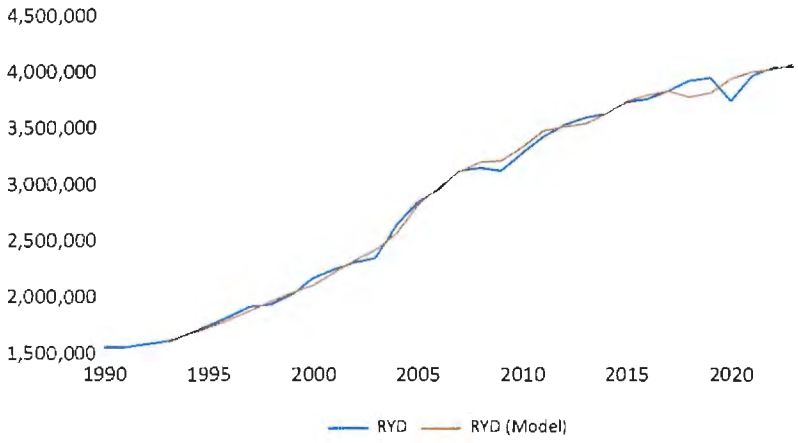
Dependent Variable: D(LRYD)
Method: Least Squares
Date: 11/12/24 Time: 14:42
Sample (adjusted): 1993 2023
Included observations: 31 after adjustments

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

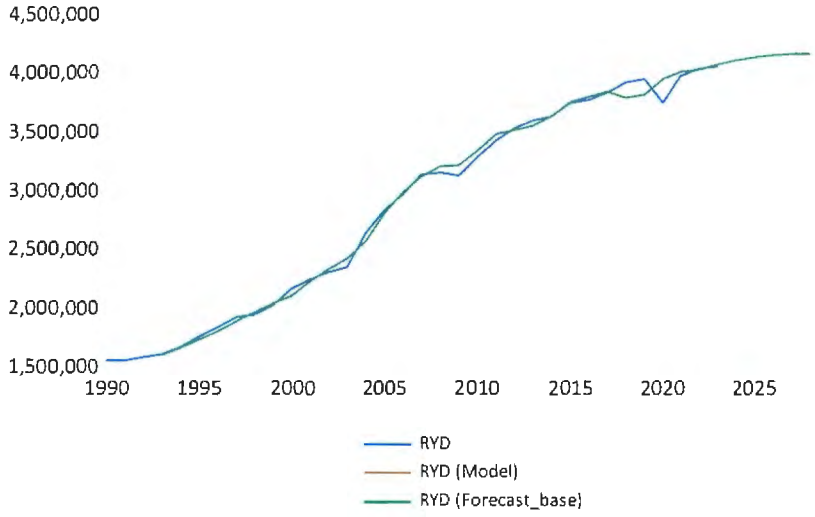


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Forecast: Base case

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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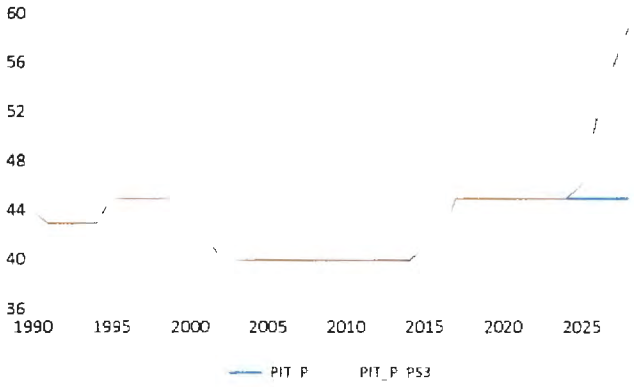


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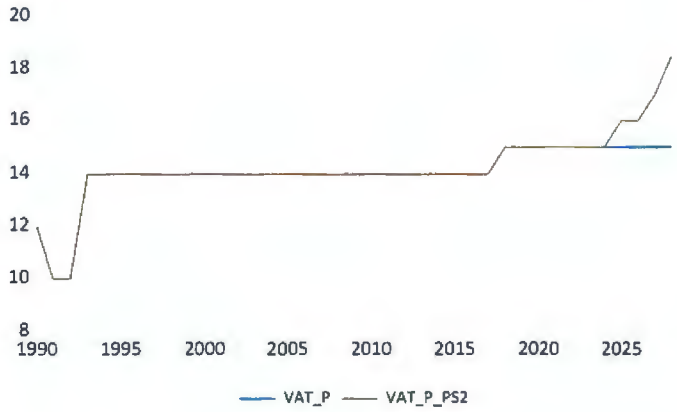
Shocks applied	PIT (Surcharge)	VAT (Percentage points)
2024	0	0
2025	2.5	1
2026	15	1
2027	24	2
2028	31	3.5

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



Model description

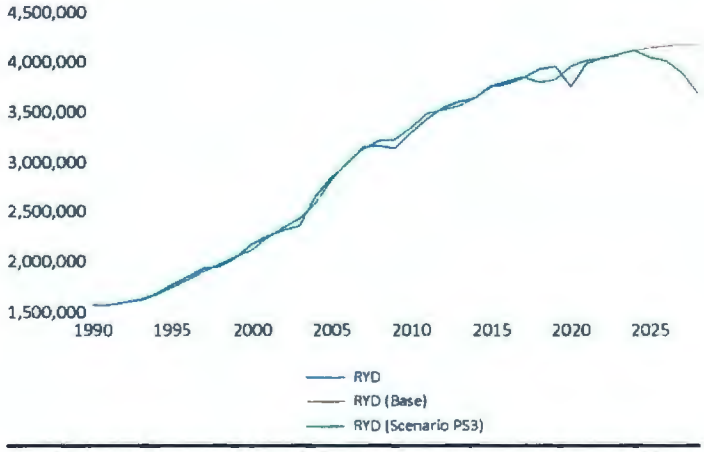
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RES_RYD = LRYD - (- 0.176758758495 * LOG(PIT_P_PS3) - 0.0159519803857 * LOG(VAT_P_PS2) + 0.242842621861 * LCPI + 0.37083351232 * LRM3 + 9.13388901886)

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



27/8/2025-9:45:05 AM

	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

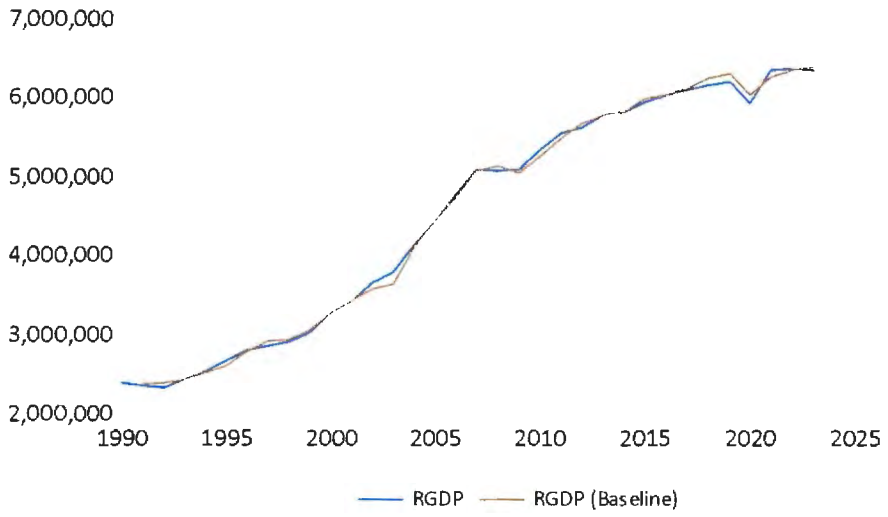
Dependent Variable: D(LRGDP)
Method: Least Squares
Date: 11/13/24 Time: 11:20
Sample (adjusted): 1991 2023
Included observations: 33 after adjustments

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		

Model description and fit:

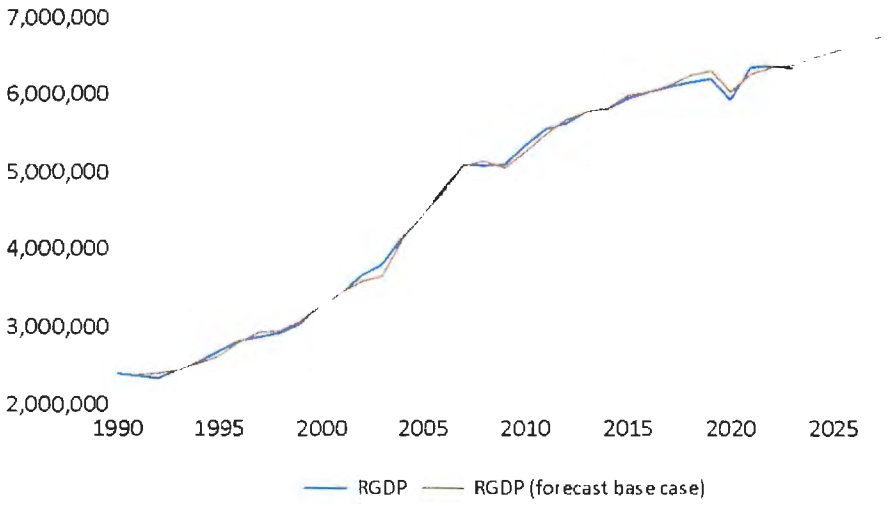
```
RES_GDP = LRGDP - ( 1.20994506184 * LRYD + 0.0132709250203 * LRG - 0.0896340000037 *
LCPI - 2.50442770218)
LRGDP = 0.169031217018 * D(LRG) + 0.884072592401 * D(LRYD) + 0.0913870819486 * D(LRM3)
- 0.0011905921421 * LPRIME(-1) - 0.439731524281 * RES_GDP(-1) - 0.00197148002628 +
LRGDP(-1)
RGDP = EXP(LRGDP)
```



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Model output: forecast base case

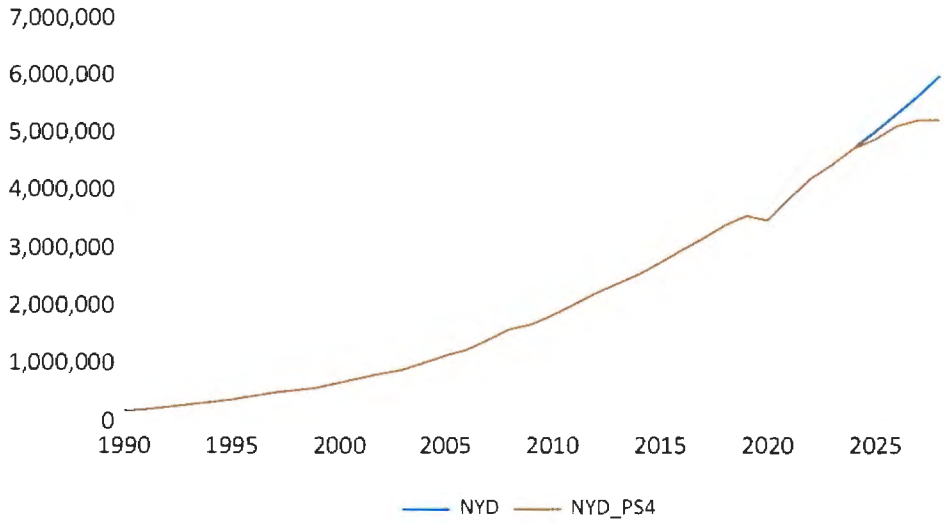
Assumptions (2024-2028):
CPI: increase of 4.5% per year
M3: increase of 6.0% per year (nominal = 1.5 + 4.5) (used as proxy for GDP, thus same assumptions apply)
NYD: increase of 6.0% per year
G: increase of 6.0% per year
Prime: Remain at 11.5%

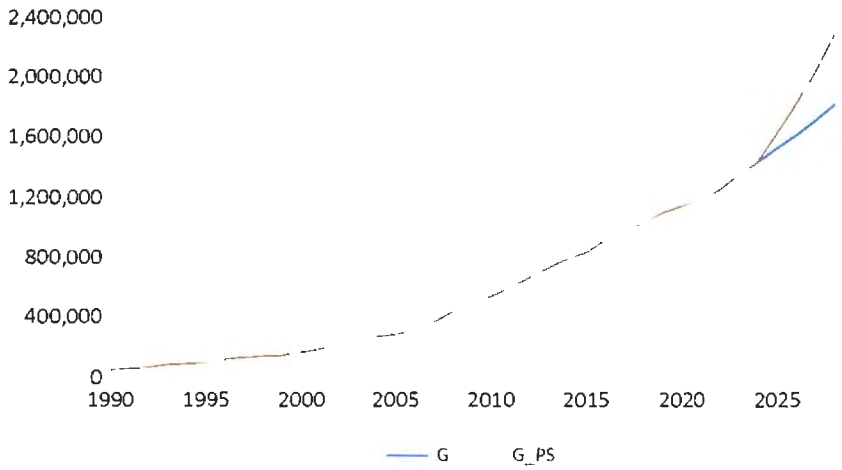


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Shocks applied	NYD	NYD_PS	G	G_PS
2024	R4 760 095	R4 760 327	R1 440 659	R1 440 659
2025	R5 045 701	R4 927 260	R1 527 098	R1 619 129
2026	R5 348 443	R5 141 266	R1 618 724	R1 820 497
2027	R5 669 350	R5 251 201	R1 715 848	R2 046 918
2028	R6 009 511	R5 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)

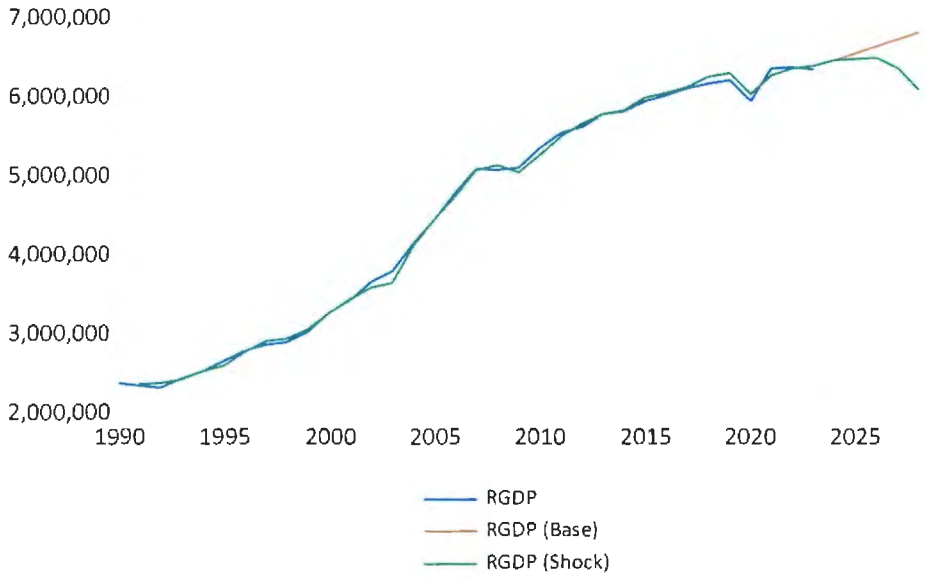
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Model description and fit (shocks applied):

```
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.



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conditional grants are included in the 2019 Division of Revenue Amendment Bill. Revised provincial appropriations will be tabled in provincial legislatures before the end of the current financial year.

FA11

Spending priorities by function group

Learning and culture

Over the medium term, spending in the basic education sector will continue to focus on eradicating pit latrines and unsafe school structures, providing learner and teacher support materials, and improving early-grade reading and mathematics. Coding and robotics will be introduced into the basic education curriculum.

The Department of Higher Education and Training bursary programme for poor and working-class students dominates spending in the post-school education and training sector. The department is developing a student funding framework that will clarify food, book, transport and accommodation allowances. Over the MTEF period, the sector will focus on improving throughput rates at universities and technical and vocational education and training (TVET) colleges by expanding student support services, improving lecturer qualifications through new hiring and training, and testing new approaches to contact and online learning.

Bursary programme for poor and working class students dominates spending

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In 2019/20, the Student Housing Infrastructure Programme receives funds to construct student housing at the universities of Limpopo and North West, and King Hintsa TVET college. This is part of a larger project, funded by the Department of Higher Education and Training, and public universities and TVET colleges, to provide 300 000 new beds at these institutions over the next 10 years.

Health

The health function priority is to improve the efficiency of service delivery. Measures being undertaken include improving the management of patient records, for example by rolling out the health patient registration system to streamline management processes in health facilities.

Following the introduction of the National Health Insurance (NHI) Bill in Parliament earlier this year, the Department of Health reprioritised funds within its 2019/20 budget to establish an NHI Office. Over the medium term, this office will receive increasing allocations for its operational costs.

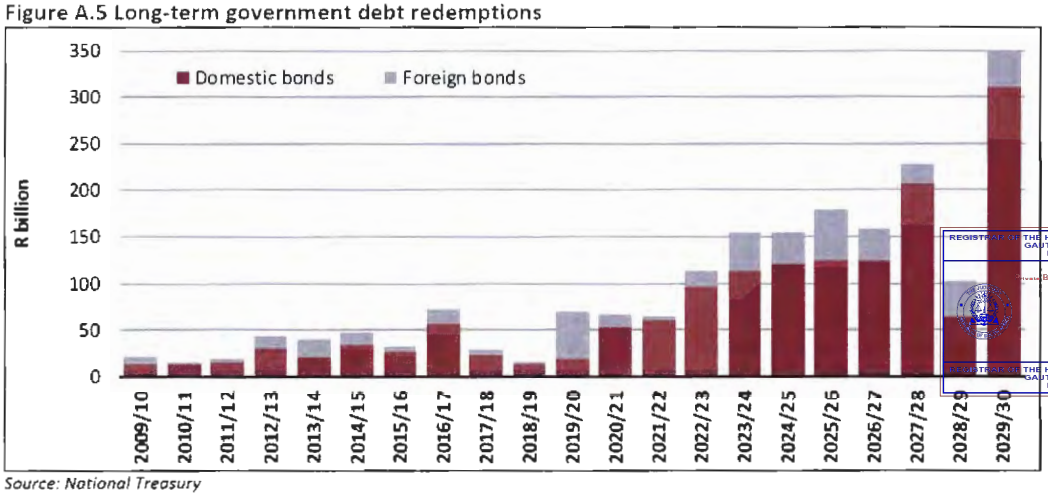
Updated cost estimates for national health insurance

The NHI policy aims to provide healthcare more equitably in South Africa. Originally, NHI costs were projected to increase public health spending from about 4 per cent to 6 per cent of GDP over 15 years. However, given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable. The National Treasury assisted the Department of Health to develop an actuarial model with updated fiscal costs and limited policy reforms to strengthen the current healthcare system. The revised model estimates that rolling out NHI would require an additional R33 billion annually from 2025/26. These amounts are not budget commitments but indicative cost estimates.

27/8/2025-9:45:05 AM

increased from about R57 billion to R365.8 billion, crowding out expenditure on essential services such as health, social development, and peace and security. To put public debt on a sustainable trajectory, government's fiscal consolidation allocates a portion of unanticipated current and future revenue towards reducing government's gross borrowing requirement. Over time, this will reduce debt levels and debt-service costs.

Figure A.5 Long-term government debt redemptions



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Source: National Treasury

Expenditure risks

Compensation spending

Employee compensation absorbs a high level of public expenditure. Government is working with public-service trade unions to find a fair and sustainable approach to remuneration. Apart from the matters described in Chapter 3 and Annexure B, a specific risk to the fiscal framework now lies with the judiciary. If the Constitutional Court overturns the Labour Appeal Court's decision that the 2018 wage agreement was unlawful and that government could not be compelled to honour it, the state may be required to implement the agreement retroactively. Such a decision would have significant effects on the fiscal framework. Should this occur, government would have to consider a reduction in the size of the public service and other fiscal adjustments.

National health insurance

A limited costing of the national health insurance policy proposal has previously shown that it would require about R40 billion per year in additional funding in the first five years, and perhaps considerably more over time. At present, however, there is insufficient capacity in the health sector to work substantively on national health insurance. The *national health insurance indirect grant* has been underspent, the National Health Insurance Fund has not yet been established and the National Health Insurance Bill still needs to be passed by Parliament. It is therefore unlikely that national health insurance will be a significant cost pressure in the medium term.

Subnational government risks

Unpaid provincial invoices increased from R22.4 billion in 2019/20 to R26.6 billion in 2020/21, with R14.2 billion due within 30 days. The accumulation of these short-term liabilities affects procurement budgets for subsequent years, as provinces will need to pay down accruals before purchasing goods and services.

FA13

Fraud flagged at the Compensation Fund

The Fund has been failing audits for 12 years and counting, Parliament told

17 February 2025 | By Steve Kretzmann (/author/29/)

News (/category/news/) | Cape Town (/region/South%20Africa/Western%20Cape/Cape%20Town)



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Workers injured on the job, such as during the collapse of a building under construction in George in May 2024, have had to wait months to obtain compensation, with some still waiting. The Auditor-General has told Parliament that all aspects of the Fund are dysfunctional. Archive photo: Daniel Steyn

- **The Auditor-General's office described failures across all areas of the Compensation Fund in Parliament earlier this month.**
- **This has been ongoing for 12 years despite the Special Investigating Unit being tasked in 2014 to investigate the Fund.**
- **A consultancy firm says it can take six months for a compensation claim to be paid, sometimes legitimate claims are not paid, and sometimes claims are paid twice.**
- **Claim payment difficulties are leading medical service providers to turn away workers injured on duty.**

The Auditor-General's office has flagged potential fraud at the Compensation Fund and advises that almost every aspect of the institution is dysfunctional.

The Fund exists for workers who suffer work related injury, illness or death. Yet a managing director of a company that assists medical service providers and workers to obtain their compensation, told GroundUp of an instance in which the Fund has taken three years to pay a legitimate claim. As a result, some medical service providers are refusing to treat workers injured on the job.

Under the Compensation for Occupational Injuries and Diseases Act, employers pay an annual amount based on their payroll to the Compensation Fund.

Employers may claim for salaries they pay employees who are sick or injured. Medical service providers can claim for treating sick or injured workers, but they must register with the Fund.

The Fund, therefore, has a list of bank accounts for medical service providers. There should be only one bank account per provider, senior manager in the Auditor-General's office Bulelwa Sikweyiya told Parliament's Standing Committee on Public Accounts (SCOPA) earlier this month. But Sikweyiya said that during the 2023/24 audit, they compared the bank accounts on the fund's database against the account numbers paid.

"What we found was there were accounts that were paid that were different to the accounts sitting on the funds system ... which highlights potential fraudulent payments," she said.

There were also payments made to multiple bank accounts listed under a single medical service provider.

She said system logs showed banking details were changed while someone else was trying to make a payment. The auditors could not see who had made these changes as the log function used to record the details of who goes into the system had been disabled. Where they could determine who the users were, the users claimed their accounts had been hacked as they had not made those changes.

Not only did this raise questions about fraud, but it created fruitless and wasteful expenditure due to payments having to be delayed once fraudulent activity was flagged, leading to the medical service providers taking the Fund to court, and the Fund being ordered to make the payments with interest.

Altered creditors' banking details are just one issue among a host of failures at the Fund, which has had the lowest audit outcome – disclaimer with findings – since the 2012/13 financial year (https://www.agsareports.co.za/wp-content/uploads/2022/09/Consolidated-general-report-on-national-and-provincial-audit-outcomes-2012-13.pdf).



Sikweyiya said internal controls at the Fund have broken down. The auditors are unable to verify what is reported by the Fund. There has been no improvement in the control environment. There is a lack of accountability and no consequence management. Issues from previous years are not addressed, and the institution has "a high tolerance of non-compliance".

An incompetent fund

The Compensation Fund was singled out as far back as the Auditor-General's Consolidated general report on national and provincial audit outcomes for 2012/13. The report stated: "Commitments and actions regarding oversight responsibilities over the public entities were not followed through, specifically at the Compensation Fund."

"Over the years the areas of concern have remained the same, and the nature of the findings have remained the same. These areas range from transactions to balances to disclosures, which means we have issues with the whole set of financials," said Sikweyiya.

Registered employers are supposed to be assessed annually to check whether they are paying the correct amount to the Fund, but this was not always done. She said where assessments were done, they were not always correct, interest was not charged at the correct rate, or the amount itself was incorrectly calculated. Additionally, revenue had been recorded for companies that had been deregistered, or were in the processes of being deregistered, dissolved or liquidated.

Regarding the Fund's investments, she said some investment companies were using accounting frameworks different from the Fund's, resulting in errors when consolidating financial statements.

There were also investments made in startups through the Public Investment Corporation (https://www.pic.gov.za/) (PIC) that were not yielding results. Questions by SCOPA members revealed the startups had dissolved or been liquidated, which meant the funds were lost.

There had been no improvement in controls when it came to losses due to irregular, and fruitless and wasteful expenditure: R485-million and R652-million respectively in the 2023/24 financial year.

"There is no area that is better. Every control area needs an intervention," she said.

Mounting frustration

Rudolf de Bruyn, managing director at COID Consult, a company that helps medical service providers claim from the Fund and assists companies to comply with their payment requirements, said they had matters they had been trying to resolve at the Fund for the past nine years.

De Bruyn said documents relating to claims often went missing after they were submitted, resulting in multiple resubmissions, and the investigation and adjudication of claims could take several months.

Even after a claim was approved, it could take six months before the payment was made, and then the payments were sometimes incorrect. He said when incorrect payments were made, an objection had to be lodged with the Fund, with the legal processes taking an additional six to 12 months.

He said he was currently dealing with a 74-year-old client who had completely lost sight in one eye due to an injury while on duty. The accident happened three years ago, in March 2022, and the client is owed 17-month's salary from the Fund. They are now waiting for the client's objection to be heard next month.

He said medical service providers experienced similar problems with delays and administration hurdles, much of it to do with the CompEasy online system the Fund introduced in 2019.

He said his company was dealing with a new medical service provider that wanted to treat injured workers on behalf of the Fund, but they had been struggling for a year to get the medical service provider's bank account verified and added to the online system.

There were "numerous" employers that were not compliant with the necessary regulations, while there were employers who wished to become compliant but were unable to make their payments to the Fund and received no assistance to do so.

This meant the employees could not get a Letter of Good Standing from the Fund, which was required by medical service providers before treating their workers injured on duty. Companies could also not submit a tender if they did not have a Letter of Good Standing.

Additionally, some companies "can wait years" for their Return of Earnings to be audited by the Fund, or for their companies to be re-classified when their business changed. This meant that despite making payments to the Fund, their workers were not covered.

At the same time, he said, medical service providers would "randomly get an overpayment or a double payment on an account". While COID as a third party would then notify the Fund, he questioned how many medical service providers would do so, especially when they were owed money for other cases.

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He said due to longstanding unresolved issues at the Fund, many medical service providers had stopped treating injured workers. This was "probably the most frustrating part of the job."

However, he said it was "not always doom and gloom". "There are times that we work well with the Fund."

He said sometimes a badly injured worker needs to be transported across provinces to be closer to their families, and these claims were resolved "in mere hours".

"These cases bring joy when seriously injured workers are reunited with their families and they can be treated closer to home."

SIU investigation

Dysfunction and possible fraud at the Fund has continued despite the Special Investigating Unit (SIU) being given a proclamation in 2014 (https://www.siu.org.za/reports/r55-of-2014-department-of-labour-and-the-compensation-fund/) to investigate the Fund.

The SIU's final report was submitted in February 2021.

The SIU did not respond to questions on whether prima facie evidence of fraud had been found, and calls to spokesperson Kaizer Kganyago went unanswered.

National Prosecuting Authority spokesperson Mahanjana said he could not assist in answering questions on whether the report had been received and what their decision on prosecutions were without knowing at which office the SIU report had been filed.

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TOPICS: Corruption (/Topic/Corruption/) Government (/Topic/Government/) Health (/Topic/Health/) Labour (/Topic/Labour/)

RVL

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE NUMBER:

In the matter between:

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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GAUTENG DIVISION,
PRETORIA

CONFIRMATORY AFFIDAVIT

I the undersigned,

MICHAEL KEITH HOLLAND

hereby make oath and say that:

1. I am an adult male economist and Director of Research at PriceMetrics (Pty) Ltd ("**PriceMetrics**"). PriceMetrics has its principal place of business at Cube Workspace, 9 The Straight, Straight Avenue, Pineslopes, Fourways, Johannesburg.

2. Save where the contrary appears from the context, the facts herein contained are within my personal knowledge. The facts herein are true and correct.

3. PriceMetrics is an independent South African economic research consultancy offering independent analysis and expertise in the economics of competition, regulation, price management, and macroeconomic analysis. PriceMetrics also supplies customised economic analysis and forecasts for companies and other organisations requiring independent assessments of current and future trends in the South African macro-economy.

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4. I am an economist with extensive experience in economic and financial analysis specialising in industrial organisation theory and competition policy and regulation. I am also an adjunct faculty lecturer in economics at the Gordon Institute of Business Science (GIBS) of the University of Pretoria.

5. I have also lectured at the University of Johannesburg, University of Pretoria and at the South African campus of Bond University, Australia.

6. My prior business experience includes Head of Research and Development in the treasuries of Rand Merchant Bank and First National Bank, and Dean of the RMB Academy, the Training Division of the bank. I also previously held positions as the Financial Planning Manager for FNB and Barclays National Bank, as a Financial Planning Manager for a U.K. Conglomerate and as an economist in the U.K. Motor Industry.

7. I hold a B.Sc. Honours Degree in Economics from the University of London and a M.Sc. from City St Georges, University of London.

8. My qualifications and experience are more fully set out in my *curriculum vitae*, a copy of which I attach hereto, marked "**H1**". I confirm the content thereof, and I confirm my qualifications and experience as set out in my *curriculum vitae*.

9. I have read the founding affidavit of Russell Lamberti on behalf of the applicant in the above matter, together with the PriceMetrics Reports, attached as FA7, FA9 and FA10 thereto ("**PriceMetrics Reports**").

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10. I am the author of the PriceMetrics Reports, attached as FA7 and FA9, and the co-author of the PriceMetrics Report, attached as FA10, together with Prof. J. J. Rossouw and Dr S. J. Joubert.

11. I confirm:

11.1. The content of the founding affidavit insofar as it relates to me;

11.2. The content and correctness of the PriceMetrics Reports; and

11.3. That I am duly qualified and experienced to consider and interpret the economic data referred to in the PriceMetrics Reports, to make calculations and provide economic modelling in respect thereof and to opine on and make submissions in respect of the economic aspects of the NHI Act raised in the PriceMetrics Reports.

12. The PriceMetrics Reports are lengthy and detailed. The content of these reports have been adequately summarised in the founding affidavit. I do not

repeat a summary of the content and findings of the PriceMetrics Reports herein in order to avoid unnecessarily burdening the application.

M.K Howard

DEPONENT

I certify that the deponent has acknowledged that he knows and understands the contents of this affidavit which was signed and sworn to, before me, at Douglasdale on this 19th day of August 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.

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FULL NAMES: COMMISSIONER OF OATHS
ADDRESS: ANGELA BILLINGHURST CJ04/08-2017
CAPACITY: Johannesburg North District:Randburg
Owner of Business - 3@1 Douglasdale
Shop 38 Douglasdale Village
Shopping Centre
Leslie Avenue, Douglasdale

MICHAEL KEITH HOLLAND

Nationality	British. Permanent Resident in South Africa
Residential Address	4 Spreeu Lane Fourways Sandton 2055 Gauteng South Africa
Telephone	010 141 0286 (work) 011 705 2710 (home) 082 495 1283 (cell)
Email:	mholland@pricemetrics.co.za



PERSONAL DETAILS

Age	77
Date of Birth	3 July 1948.
Place of Birth	Harpenden, Hertfordshire, England.
Marital Status	Married.

Qualifications

B.Sc. (Economics) Hons, University of London 1969. M.Sc. (Administrative Science), City St Georges, University of London 1975. Ordinary certificate of the SA Institute of Financial Markets (qualified to trade and advise on S.A. Futures and Traded Options markets) 1991.

EMPLOYMENT HISTORY

Current Employment (April 2003-) Economist and Director, PriceMetrics (Pty) Ltd.

Responsibilities

Economic and financial research and analysis for companies and other organisations. Assessment of the economic and financial performance of organisations including profitability, productivity and business efficiency. Consulting competition and regulatory economist to attorneys and companies. Research, analysis and advice to clients relating to the Competition Act and regulatory policy in South Africa. Price management consultant: advising companies on pricing strategies.

Current Academic Activities

Adjunct lecturer at Gordon Institute of Business Science (GIBS), University of Pretoria, in Microeconomics, Economics of Organisational Strategy and Advanced Pricing Strategies, for MBA programmes. Lecturer in Microeconomics and Macroeconomics for the PDBA programme. Research supervisor and examiner for MBA research reports. Lecturer in economics and finance on GIBS corporate programmes.

Past Academic Activities

Lecturer in Labour Markets and Labour Economics. Lecturer in Investment Decisions and Asset Management, Behavioural Strategy and external moderator for Foreign Exchange Management, M. Comm in Financial Management, University of Johannesburg. Lecturer for Bond University's South African Campus. Courses: MBA including Microeconomics, Macroeconomics and International Finance. B.Com: Financial Markets, Portfolio Analysis and Investment Management, and Corporate Finance. Past part-time lecturer in Economics and International Monetary Systems, South African Institute of Bankers examinations. Examiner for South African Institute of Bankers examinations in Financial Markets 1 and Financial Markets 2.

Previous Employment:
August 1998 to March 2003: Head, Research, Treasury, Rand Merchant Bank; and Dean, RMB Academy. Reporting to the Treasurer.

Responsibilities: Strategic research for RMB Treasury. Management of the Bank's Quantitative Analyst Internship programme. Training and development of staff and clients, management of the Academy's corporate social investment programme. Previously Head Research and Development, Treasury. Managing a team responsible for quantitative risk analysis, product and market development.

March 1988 – July 1998 Chief Manager, Research and Development, Global Markets and Treasury, First National Bank of Southern Africa Ltd. Reporting to the Group Treasurer.

Responsibilities: Managing a small proprietary trading team in third currencies, bond and equity futures markets; managing a technical analysis service for the dealing room and external clients; managing a team of research analysts. Research activities included product and market development (including derivatives and structured products); quantitative risk analysis and model-building; bank regulation and its impact on the Bank. Joined RMB following merger of RMB/FNB/Southern Life.

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August 1984 - March 1988 Senior Manager, Financial Planning, Group Financial Control Division, FNB (formerly Barclays National Bank). Responsible for the Group's budgetary, financial planning and forecasting system.

September 1975 - April 1984: Various managerial positions in corporate planning (including Head of Planning) and financial analysis, Mitchell Cotts Group in London and South Africa.

October 1974 - September 1975: Post-graduate student, City St Georges, University of London. Social Science Research Council scholarship.

February 1972 - September 1974: Economist, Market Research, Automotive Products, Leamington Spa, Warwickshire.

April 1970 - February 1972: Economist, Sales Planning, Vauxhall Motors, Luton, Bedfordshire.

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE NUMBER:

In the matter between:

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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CONFIRMATORY AFFIDAVIT

I the undersigned,

JOHANNES JACOBUS ROSSOUW

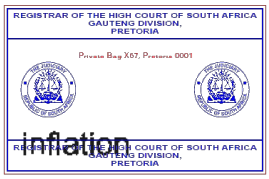
hereby make oath and say that:

1. I am an adult male and honorary professor at the Wits Business School of the University of the Witwatersrand. I also practise as a consultant on economics through my firm Jannie Rossouw Consulting (Pty) Ltd.

2. Save where the contrary appears from the context, the facts herein contained are within my personal knowledge. Such facts are true and correct.

3. I am an honorary professor at Wits Business School and, for a short term, served as its Interim Head. I was formerly the Head of the School of Economic and Business Sciences at the University of the Witwatersrand.

4. I retired as Deputy General Manager of the South African Reserve Bank (Head: Currency Management) in 2012.



5. My main academic research interests are inflation perceptions, inflation credibility and inflation expectations, and the sustainability of expenditure patterns of the South African government. I have published numerous academic and other papers on these and other research interests.

6. I hold an M.Com (Economics), an MBA degree from the University of Pretoria, and a PhD degree from the University of KwaZulu-Natal.

7. My qualifications and experience are more fully set out in my *curriculum vitae*, a copy of which I attach hereto, marked "**R1**". I confirm the content thereof, and I confirm my qualifications and experience as set out in my *curriculum vitae*.

8. I have read the founding affidavit of Russell Lamberti on behalf of the applicant in the above matter, together with the PriceMetrics Report, attached as FA10 thereto (the "**PriceMetrics Report**").

9. I am the co-author of the PriceMetrics Report.

10. I confirm:

10.1. The content of the founding affidavit insofar as it relates to me;

10.2. The content of the PriceMetrics Report; and

10.3. That I am duly qualified and experienced to consider and interpret the economic data referred to in the PriceMetrics Report, to make calculations and provide economic forecasting in respect thereof and to opine on and make submissions in respect of the economic aspects of the NHI Act raised in the PriceMetrics Report.

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11. The PriceMetrics Report is lengthy and detailed. The content of the report has been adequately summarised in the founding affidavit. I do not repeat a summary of the content and findings of the PriceMetrics Report herein in order to avoid unnecessarily burdening the application.

DEPONENT

I certify that the deponent has acknowledged that he knows and understands the contents of this affidavit which was signed and sworn to, before me, at Pretoria on this 19th day of August 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:
ADDRESS:
CAPACITY:

Herman Kelderman
Commissioner of Oaths
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ACADEMIC CURRICULUM VITAE OF J.J. ROSSOUW

PERSONAL DETAILS:

NAME	:	Johannes Jacobus (Jannie)
SURNAME	:	Rossouw
DATE OF BIRTH	:	25 January 1956 (Stellenbosch)
TELEPHONE NUMBER	:	083 288 7707
E-MAIL	:	jannie.rossouw@wits.ac.za

ACADEMIC DETAILS:

QUALIFICATIONS:

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1 SCHOLASTIC

Matric, 1973, Menlopark High School, Pretoria

2 TERTIARY

(a) PhD
University of KwaZulu-Natal, 2008

Research topic	:	"Inflation in South Africa: 1921 to 2006. History, measurement and credibility"
Supervisor	:	Prof V. Padayachee

(b) M.Com. (Econ)
University of Pretoria, 1983

Essay	:	"A study of the institutional development of credit sources and some financing problems in the South African agricultural sector" (translated title)
Supervisor	:	Prof J.J. Stadler

(c) M.B.A.
University of Pretoria, 1982

Majors	:	General Management, Marketing Management, Financial Management, Personnel Management
Essay	:	"Factors influencing remuneration" (translated title)
Supervisor	:	Prof A.B. Boshoff

27/8/2025-9:45:05 AM

(d) B.Com. (Hons)
University of Pretoria, 1978

Majors : Courses in economic theory

(e) B.Com.
University of Pretoria, 1977

Majors : Economics, Cost Accounting (aka management accounting), Accountancy (aka financial accounting), Business Economics

RESEACH OUTPUT INDICATORS:

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PRETORIA

NRF rating	C
Google scholar	
h-index	14
Citations	1 050

PROFESSIONAL CAREER - PERMANENT:

Since 1 January 2025
Honorary Professor: Wits Business School
University of the Witwatersrand

AND

Consultant
Jannie Rossouw Consulting (Pty) Ltd
Board member of various boards and board committees

Additional appointments:

Independent non-executive director of Finbond Mutual Bank, and
Chairperson of the Remuneration Committee
Member of the Risk Committee

Non-executive director of Noordelike Helpmekaar study fund, and
Member of the Audit and Risk Committee

Alternate trustee of UNISARF, the retirement fund of UNISA, and
Member of the Audit and Risk Committee

1 January 2022 to 31 December 2024
Visiting Professor: Wits Business School
University of the Witwatersrand

AND

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Consultant
Jannie Rossouw Consulting (Pty) Ltd

1 January 2021 to 31 December 2021
Professor: Wits Business School
University of the Witwatersrand

1 December 2019 to 31 December 2020
Interim Head and Director: Wits Business School
University of the Witwatersrand

1 February 2014 to 30 November 2019
Head: School of Economic and Business Sciences
University of the Witwatersrand

1 August 2012 to 31 January 2014
Professor: Department of Economics
University of South Africa

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PRETORIA

1 August 2011 to 31 July 2012
Head: Currency Management
South African Reserve Bank, Pretoria

1 April 2011 to 31 July 2011
Advisor to the Secretary of the Bank
South African Reserve Bank, Pretoria

20 March 2010 to 31 March 2011
Acting Secretary of the Bank
South African Reserve Bank, Pretoria

1 January 2007 to 19 March 2010
Deputy General Manager, Executive Management Department
South African Reserve Bank, Pretoria

1 June 2003 to 31 December 2006
On secondment as Chief Operations Officer
Amnesty Unit

16 March 2000 to 31 May 2003
Deputy General Manager, Special Projects
South African Reserve Bank, Pretoria

and (from 2002)

Secretary
South African Mint Company (Pty) Ltd, Pretoria

1 July 1998 to 15 March 2000
Secretary and Head, Secretariat Department
South African Reserve Bank, Pretoria

15 May 1995 to 30 June 1998

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Secretary of the Bank
South African Reserve Bank, Pretoria

1 January 1993 to 14 May 1995
Assistant General Manager, Communication Services
South African Reserve Bank, Pretoria

and

Secretary
South African Mint Company (Pty) Ltd, Pretoria



CV Eng1

27/8/2025-9:45:05 AM

15 June 1992 to 31 December 1992
Senior Manager, Management Services Department
South African Reserve Bank, Pretoria

1 December 1990 to 14 June 1992
Senior Manager, International Banking Department and Secretary to the SCC (Standstill Co-ordinating Committee)
South African Reserve Bank, Pretoria

1 June 1986 to 30 November 1990
Executive Assistant to the Deputy Governor
South African Reserve Bank, Pretoria

1 January 1984 to 31 May 1986
Economist
Afrikaanse Handelsinstituut (AHI), Pretoria



1 August 1983 to 31 December 1983
Assistant Manager, Economic Research
Santambank, Johannesburg

1 October 1979 to 31 July 1983
Lecturer, Economics Department
University of South Africa, Pretoria

SUMMARY OF CURRENT AND PREVIOUS RESPONSIBILITIES

I currently serve as a Visiting Professor in Wits Business School (WBS) since my retirement from the university on 31 December 2021.

I also work as a Consultant through Jannie Rossouw Consulting (Pty) Ltd. My consulting focuses on macroeconomic aspects and related matters, and on economic policy. I have done work for various clients (names withheld owing to client confidentiality) on aspects such as an economic recovery plan for South Africa, the impact of toll roads in the Western Cape, the impact and funding of national health insurance, the impact of property rates on property development, the cost of loadshedding on the South African economy, and the domestic sales of Krugerrands.

I served as Interim Head of the WBS from 1 December 2019 to 31 December 2020. The focus of the period of my appointment (2020) was the restoration of the basic structure underpinning WBS operations. The theme for 2020 was therefore "Back-to-basics", thus improving operational activity. The academic offering at WBS is world-class, but the administrative underpinnings required review and improvement. This period of service set a foundation for the rebuilding of WBS to its former glory. the

In my previous position as Head of the School of Economic and Business Sciences (SEBS) at the University of the Witwatersrand (Wits), I was responsible for the overall management of the School. The School subsequently split into the School of Economics and Finance and the School for Business Sciences. At the time of my appointment as Head, the School was in serious need of improved administration and a refocus of activities, including its role in public debate in South Africa. This was accomplished at the time of the school split.

My teaching responsibilities are limited to the supervision of post-graduate students.

27/8/2025-9:45:05 AM

COMMUNITY SERVICE (CURRENT):

Board member of Finbond Mutual Bank (independent non-executive), chairperson of the Remuneration Committee and member of the Risk Committee since 1 August 2024.

Alternate trustee of UNISARF, the retirement fund of the University of South Africa and member of the Audit and Risk Committee.

Board member of Noordelike Helpmekaar Studiefonds and member of its Audit and Risk Committee.

Board member of Satsanga Fintech Holdings Ltd and Chairperson of its Audit and Risk Committee.

External examiner at various universities.

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PUBLICATION AND OTHER RESEARCH OUTPUT:

I have published more than 250 accredited journal articles, monographs, book chapters and the like, and addressed numerous conferences. In the listing below, accredited publications are marked by an asterisk (*) and a successive number (for a total of more than 60); accredited conference proceedings are marked by (#) and a successive number (for a total of 10).

Currently my research focuses on inflation perceptions and expectations, monetary issues and central banking (including the history of central banking and monetary policy in South Africa), and South Africa's fiscal sustainability, with a focus on the fiscal cliff. I also focus on various aspects of economic development in Orania.

My accredited journal articles appeared in the main in the following journals: *African Review of Economics and Finance; Departmental Magazine, Unisa Economics Department; Economic History of Developing Regions; International Review of Applied Economics; New Agenda: South African Journal for Social and Economic Policy*; *South African Business Review; South African Journal of Economic and Management Sciences; South African Journal of Economics; South African Mercantile Law Journal; Studies in Economics and Econometrics (SEE); Suid-Afrikaanse Tydskrif vir Natuurwetenskap en Tegnologie* (SATNT, name translated *South African Journal of Science and Technology*); *The Journal of Developing Areas*; *Transformation*; and *Tydskrif vir Geesteswetenskappe* (TGW, name translated as *Journal for Humanities*).

The metrics of these publications are:

African Review of Economics and Finance:

Impact Factor:	Not calculated
h-index:	7
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	3 (co-authored)

Departmental Magazine, Unisa Economics Department:

This journal is no longer in existence.
Number of papers: 2 (sole-authored)

Economic History of Developing Regions:

27/8/2025-9:45:05 AM

Impact Factor:	0,22
h-index:	2
Accreditation:	Department of Higher Education and Training (DoHET) International Bibliography of Science (IBSS)
Number of papers:	6 (sole- and co-authored)

International Review of Applied Economics:

Impact Factor:	1,09
h-index:	33
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	2 (co-authored)

New Agenda: South African Journal for Social and Economic Policy:



Impact Factor:	Not calculated
h-index:	Not calculated
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	5 (co-authored)

South African Business Review:

Impact Factor:	Not calculated
h-index:	Not calculated
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	4 (sole- and co-authored)

South African Journal of Economics:

Impact Factor:	1,05
h-index:	26
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	6 (sole- and co-authored)

South African Journal of Economic and Management Sciences:

Impact Factor:	Not calculated
h-index:	11
Accreditation:	Department of Higher Education and Training (DoHET) Social Sciences Citation Index (Web of Science (WoS) Core Collection)
Number of papers:	8 (sole- and co-authored)

South African Mercantile Law Journal:

Impact Factor:	Not calculated
h-index:	Not calculated
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	1 (co-authored)

Studies in Economics and Econometrics (SEE):

27/8/2025-9:45:05 AM

Impact Factor:	0,19
h-index:	7
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	3 (co-authored)

Suid-Afrikaanse Tydskrif vir Natuurwetenskap en Tegnologie (SATNT, name translated *South African Journal of Science and Technology*):

Impact Factor:	Not calculated
h-index:	Not calculated
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	4 (co-authored)

The Journal of Developing Areas

Impact Factor:	0,357
h-index:	13
Accreditation:	Department of Higher Education and Training (DoHET) International Bibliography of Science (IBSS) Norwegian Register for Scientific Journals
Number of papers:	1 (co-authored)

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Transformation

Impact factor:	0,3
h-index:	17
Accreditation:	Department of Higher Education and Training (DoHET)
Number of papers:	3 (sole- and co-authored)

Tydskrif vir Geesteswetenskappe (TGW, name translated as *Journal of Humanities*):

Impact Factor:	0,19
h-index:	8
Accreditation:	Department of Higher Education and Training (DoHET) SciELO SA Social Sciences Citation Index (Web of Science (WoS) Core Collection)
Number of papers:	15 (sole- and co-authored)

MOST-CITED RESEARCH OUTPUT:

Academic papers:

Google Scholar:

78 citations:
A Bosch, J Rossouw, T Claassens and B du Plessis
A second look at measuring inequality in South Africa: A modified Gini coefficient
No 76 below

53 citations:
J Rossouw and J-B Styan
Steinhoff collapse: a failure of corporate governance

27/8/2025-9:45:05 AM

No 182 below

40 citations:
M Ade, J Rossouw, T Gwatidzo
Determinants of tax revenue performance in the Southern African Development Community (SADC)
No 178 below

33 citations:
J Rossouw
An analysis of macro-economic convergence in SADC
No 40 below

Semantic Scholar:



25 citations:
J Rossouw
An analysis of macro-economic convergence in SADC
No 40 below

10 citations:
J Rossouw and F Joubert
Supporting an inflation targeting policy with the measurement of inflation credibility
No 32 below

J Rossouw
Private Shareholding and Public Interest: An Analysis of an Eclectic Group of Central Banks
No 133 below

9 citations:
J Rossouw
Monetêre beleid in Suid-Afrika sedert 1965: die vordering vanaf direkte beheer tot inflasieteikens
No 31 below

8 citations:
J Rossouw and A Breytenbach
Identifying central banks with shareholding: a review of available literature
No 84 below

7 citations:
J Rossouw and V Padayachee
A study on inflation credibility among students at the University of Pretoria
No 46 below

J Rossouw, V Padayachee and A Bosch
A comparison of inflation expectations and inflation credibility in South Africa: results from survey data
No 85 below

J Rossouw and V Padayachee
Measuring inflation credibility: results of a first representative South African sample
No 59 below

27/8/2025-9:45:05 AM

J Rossouw, V Padayachee and A Bosch
Links or disconnect: a first consideration of inflation expectations and inflation credibility, with specific reference to South Africa
No 68 below

5 citations:
C May, G Farrell and J Rossouw
Do monetary policy announcements affect foreign exchange returns and volatility? Some evidence from high-frequency intra-day South African data

Conference proceedings:

13 citations:
South Africa's role in macroeconomic convergence in SADC
1st reported published conference proceedings below

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DETAIL OF ALL RESEARCH PUBLICATIONS, MONOGRAPHS, ETC:

1 **Kasser**, August 1980
"A study of money" (translated title)

2 **Volkshandel**, September 1980
"Real agricultural debt remains constant" (translated title)

3 **Kasser**, February 1981
"Population growth - a major problem" (translated title)

4 **Kasser**, June 1981
"Inflation and economic growth" (translated title)
(co-author)

5 **Verbruikersaksie**, October 1982
"Price determination and the consumer" (translated title)

6 **Kasser**, October 1983
"Borrowing and investment" (translated title)

7 **Volkshandel**, May 1984
"A perspective on South Africa's population growth" (translated title)

8 **Volkshandel**, November 1984
"Improved economic conditions expected for 1985" (translated title)

9 **Volkshandel**, March 1985
"Current economic realities" (translated title)

10 **Volkshandel**, April 1985
"The Cabinet's responsibility with regard to the budget" (translated title)

11 **Volkshandel**, September 1985
"The influence of the political situation on the economic upswing" (translated title)
(co-author)

27/8/2025-9:45:05 AM

12 **Volkshandel**, November 1985
"Realities alter the economic outlook" (translated title)
(co-author)

13 **Volkshandel**, February 1986
"Economic prospects for 1986" (translated title)
(co-author)

14 **Volkshandel**, May 1986
"The debt standstill's influence on the economic situation" (translated title)
(co-author)

15 (*1) **Departmental Magazine**, Unisa Economics Department, July 1989
"On issues and commissions"

16 (*2) **Departmental Magazine**, Unisa Economics Department, July 1991
"Does a recession really differ from a depression?"

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17 **Economics**, Vol. 6, No. 2, Summer 1992
"A third alternative scenario for South Africa's future"

18 Foreword to the **General Staff Remuneration Survey** of FSA-Contact, August 1999

19 **F and T Finance Week**, 30 June 2000
"Zimbabwe: Can the banks hold out?"

20 **Motorbeeld,** 16 November 2000
"Consider alcohol content before drinking and driving" (translated title)

21 **Economics and Management,** Vol. 12, 2000
"Deflation and investment decisions"

22 **Automotive World,** January 2001 (British magazine)
"Citigolf is alive and well"

23 **Central Banking,** Vol. 13, No. 1, August 2002 (British magazine)
"Establishing the credibility of inflation targets"

24 **All Africa Dairy Expo,** September 2002
"The role of the rand in exports to Africa"

25 **Beeld,** November 2002
"Villa Kruger"
(co-author)

26 **Central Banking**, Vol.13, No. 3, February 2003 (British Magazine)
"Further problems of inflation targeting"

27 **Central Banking**, Vol.13, No. 4, May 2003 (British Magazine)
"Building inflation credibility"

28 (*3) **South African Journal of Economics**, Vol. 72, No. 5, December 2004
"A brief note on Nel and Lekalake: Monetary transparency in South Africa"

27/8/2025-9:45:05 AM

29 **National Treasury,** 20 Januarie 2005
"Comment on the draft Auditing Profession Bill, 2004"
Available online at http://www.treasury.gov.za

30 (*4) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe**
(name translated as South African Academy: Journal of Humanities), Vol. 45, No. 1, March 2005
"Comments on the article of Prof Sampie Terreblanche: Poverty in South Africa" (translated title)

31 (*5) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe**
(name translated as South African Academy: Journal of Human Sciences), Vol. 45, No. 2, June 2005
"Monetary policy in South Africa since 1965: progress from direct controls to inflation targets" (translated title)

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32 (*6) **South African Journal of Economics**, Vol. 73, No. 2, June 2005
"Supporting an inflation targeting policy with the measurement of inflation credibility"
(co-author)

33 **South African Reserve Bank: *Bankindaba*** (staff magazine), November 2005
"Communication supports the Bank's inflation target"
(co-author)

34 **South Africa Reserve Bank: *Bankindaba*** (staff magazine), November 2005
"The night the Governor sang for his supper"
(co-author)

35 **Suid-Afrikaanse Akademie: Nuusbrief** (name translated as South African Academy: Newsletter), Vol. 43, No. 3&4, December 2005
"The Afrikaans Language Monument" (translated title)
(co-author)

36 **South African Reserve Bank: Discussion Paper DP/05/12,** 2005
"Communication in support of an inflation-targeting policy: A note on the South African Reserve Bank"
(co-author)

37 (*7) **South African Journal of Economic and Management Sciences,** Vol. 8, No. 4, December 2005.
"A perspective on inflation credibility".
(co-author)

38 **South African Reserve Bank: *Bankindaba*** (staff magazine), April 2006
"The exchange control and related tax amnesty process"

39 (*8) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe**
(name translated as South African Academy: Journal of Humanities) Vol. 46, No. 2, Junie 2006
"Can macro-economic convergence in SADC result in the successful establishment of a monetary union and central bank in the region?" (translated title)

27/8/2025-9:45:05 AM

40 (*9) **South African Journal of Economics**, Vol. 74, No. 3, September 2006
"An analysis of macro-economic convergence in SADC"

41 **South African Reserve Bank: Discussion Paper DP/06/08,** 2006
"Background information on the S A Reserve Bank"

42 **South African Reserve Bank: Discussion Paper DP/06/09,** 2006
"Testing inflation credibility: South African inflation and price changes since 1921"
(co-author)

43 **Alumni newsletter: GSM at the University of Pretoria,** October 2006
"The exchange control and related tax amnesty process"

44 **South African Reserve Bank: Discussion Paper DP/06/15,** 2006
"Inflation credibility barometers: Evidence from a survey of University of Pretoria students"
(co-author)

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45 (#1) **South African Reserve Bank: Conference series,** 2006
"South Africa's role in macroeconomic convergence in SADC"

46 (*10) **South African Journal of Economic and Management Science**, Vol. 10, No.1, March 2007.
"A study on inflation credibility among students at the University of Pretoria"
(co-author)

47 **CEO Magazine**, Vol. 6, No. 4, 2007.
"An overview of the South African Reserve Bank and some of its activities"

48 **South African Reserve Bank: *Bankindaba*** (staff magazine), July/August 2007
"Old cars"
(co-author)

49 **South African Reserve Bank: Discussion Paper DP/07/10,** 2007
"Brief notes on selected domestic price movements since 1974"
(co-author)

50 **South African Reserve Bank: Discussion Paper DP/07/14,** 2007
"A note on the goal of monetary policy"

51 **School of Development Studies, University of KwaZulu-Natal: Working Paper**, No. 50, April 2008
"An analysis of inflation from a central bank perspective: The South African experience since 1921"

52 (*11) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe**
(name translated as South African Academy: Journal of Humanities) Vol. 48, No. 2, June 2008
"Is wealth and poverty a zero-sum game?" (translated title)
(co-author)

53 (*12) **South African Journal of Economic and Management Science**, Vol. 11, No. 2, June 2008

27/8/2025-9:45:05 AM

"South African price changes and inflation since 1974: a note on the testing of inflation" (co-author)

54 **International Advances in Economic Research**, Vol. 14, No. 4. November 2008
"Alternatives to expedite macroeconomic convergence of the SADC countries" (400 word research note)
(co-author)

55 **Central Banking**, Vol. 19, No. 2, November 2008 (British magazine)
"Central bank employees and inflation credibility"
(co-author)

56 **South African Reserve Bank: Discussion Paper DP/09/01,** 2009
"Inflation accuracy during periods of subdued and accelerating inflation: comparing the South African experiences of 2004 to 2006 and 2006 to 2008"
(co-author)

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57 **South African Reserve Bank: *Bankindaba*** (staff magazine), Issue 178, 2009
"What did you tell us?"
(co-author)

58 **South African Reserve Bank: *Bankindaba*** (staff magazine), Issue 178, 2009
"Translating 231 million per cent inflation into English using big numbers"
(co-author)

59 (*13) **South African Journal of Economics**, Vol. 77, No. 2, June 2009
"Measuring inflation credibility: results of a first representative South African sample"
(co-author)

60 (*14) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe**
(name translated as South African Academy: Journal of Humanities) Vol. 49, No. 2, June 2009
"The implications of a constitutional state for developing countries" (translated title)
(co-author)

61 **South African Reserve Bank: *Bankindaba*** (staff magazine), Issue 180, 2009
"A note on pension provision, life expectancy and inflation"

62 **International Advances in Economic Research**, Vol .15, No. 4, November 2009.
"Why household surveys are not: Assessing surveys in inflation-targeting countries" (400 word research note)

63 (*15) **South African Journal of Economics**, Vol. 77, No. 3, September 2009
"Further down memory lane: A note reflecting on the *missing four*"

64 **South African Reserve Bank: *Bankindaba*** (staff magazine), Issue 181, 2009
"Inflation is not good"

65 **Bible Media: *Kerkbode*** Vol .183, No. 6, 2 October 2009.
"The right to complain" (translated title)

66 **South African Reserve Bank: *Bankindaba*** (staff magazine), Issue 182, 2009
"Inflation is ungood™"

27/8/2025-9:45:05 AM

67 ***BY*, supplement of *Beeld*** Saturday, 10 October 2009
"Accra declaration: read it first" (translated title)

68 (*16) **South African Journal of Economic and Management Sciences** Vol. 12, No. 4 December 2009
"Links or disconnect: a first consideration of inflation expectation and inflation credibility, with specific reference to South Africa"
(co-author)

69 **School of Development Studies, University of KwaZulu-Natal: Working Paper,** No 55, November 2009
"Comparing inflation credibility surveys in inflation-targeting countries"
(co-author)

70 **ESSA** (Economic Society of South Africa) website (http://www.essa.org.za/)
"ESSA past presidents from 1964 to 1987: The issues remain the same"

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71 **South African Reserve Bank: Discussion Paper DP/10/02,** 2010
"A first assessment: Basic principles of a CMA inflation target"
(co-author)

72 **ERSA Working paper No 173**, 2010
"A comparison of inflation expectations and inflation credibility in South Africa: results from survey data"
(co-author)

73 (*17) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe** (name translated as South African Academy: Journal of Humanities) Vol. 50, No. 2, June 2010
"Remuneration trends in the public sector during sustained inflation – an economic perspective" (translated title)
(co-author)

74 **Central Banking**, Vol. 20, No. 4, May 2010 (British magazine)
"Surveying inflation credibility: three ways"
(co-author)

75 **Bible Media: *Kerkbode*** Vol .185, No. 4, 3 September 2010.
"Media freedom: The new eleventh commandment" (translated title)

76 **School of Development Studies, University of KwaZulu-Natal: Working Paper,** No 58, October 2010
"A second look at measuring inequality in South Africa: A modified GINI coefficient"
(co-author)

27/8/2025-9:45:05 AM

77 (#2) **Published conference proceedings**
"Central bank communication: The SA Reserve Bank revisited"
Fourth International Business Conference. Victoria Falls: 13 to14 October 2010.
Published in conference proceedings: ISBN NO.: 978-0-620-47495-5

78 **South African Reserve Bank: Bankindaba** (staff magazine), Issue 186, February 2011
"A turbulent year in a turbulent world. The South African Reserve Bank was founded 90 years ago – amid great global economic challenges"

79 **South African Reserve Bank: *Bankindaba*** (staff magazine), Issue 187, April 2011
"Commemoration of the launch of the South African rand"

80 **South African Reserve Bank: *Bankindaba*** (staff magazine), Issue 187, April 2011
"The establishment of the Bank's branch offices"

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81 **South African Reserve Bank: Discussion Paper DP/11/05,** 2011
"A different perspective on 90 years of central banking: Understanding shareholding in central banks"
(co-author)

82 (*18) **Economic History of Developing Regions** Vol. 26, Supplement 1, 2011
"A selective reflection on the institutional development of the South African Reserve Bank"

83 (*19) **Economic History of Developing Regions** Vol. 26, Supplement 1, 2011
"Reflecting on ninety years of intermittent success: The experience of the South African Reserve Bank with inflation since 1921"
(co-author)

84 (*20) **Economic History of Developing Regions** Vol. 26, Supplement 1, 2011
"Identifying central banks with shareholding: A review of available literature"
(co-author)

85 (*21) **South African Journal of Economic and Management Sciences** Vol. 14, No. 3, September 2011
"A comparison of inflation expectations and inflation credibility in South Africa: results from survey data"
(co-author)

86 **International Research Journal of Applied Finance** Vol. II, No. 10, October 2011
"The Efficient Market Hypothesis: The applicability of American models to the South African stock market"
(co-author)

87 **School of Development Studies, University of KwaZulu-Natal: Working Paper,** No 59, October 2011
"Representative inflation credibility surveys since 2006: what do the results tell us?"
(co-author)

88 **Central Banking**, Vol. 22, No. 2, November 2011 (British magazine)
"When private shares meet public interest"
(co-author)

27/8/2025-9:45:05 AM

89 **School of Development Studies, University of KwaZulu-Natal: Working Paper,** No 61, December 2011
"Compiling an inflation rate for the Southern African Development Community (SADC)"
(co-author)

90 **Business Times (supplement of Sunday Times)**, 9 December 2012
"Morgan (sic, should read Margin) will not end ills"

91 (*22) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe** (name translated as South African Academy: Journal of Humanities) Vol. 53, No. 1, March 2013
"Living standards: An economic perspective on quality of life in South Africa"
(co-author)

92 **Unisa E-connect, March 2013**
"The issue of youth unemployment in South Africa"
(co-author)

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93 (#3) **EBES 2012 Anthology (ISBN: 978-605-61069-9-6)**
"Ninety years of central banking: Policy and institutional lessons from Africa's oldest central bank"
(co-author)

94 (*23) **SA Mercantile Law Journal**, Vol 25, No 1, 2013
"Taking public interest too far: Walmart Stores Inc v Massmart Holdings Ltd"
(co-author)

95 (*24) **South African Journal of Economic and Management Sciences** Vol. 16, No. 2, June 2013
"An international comparison of inflation credibility surveys"
(co-author)

96 (*25) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe** (name translated as South African Academy: Journal of Humanities) Vol. 53, No. 3, September 2013
"A small note on a big difference: Percent change and percentage point change"

97 **BY,** supplement to **Beeld** Saturday, 12 October 2013
The five commandments politians should adhere to (translated title)

98 **Nuwe Hart**, supplement to **Die Kerkbode**
A new (financial) heart (translated title)

99 (*26) **Suid-Afrikaanse Akademie: Tydskrif vir Geesteswetenskappe** (name translated as South African Academy: *Journal of Humanities*) Vol. 53, No. 4, December 2013
"An analysis of remuneration trends in the South African civil service, 2005 to 2012"
(co-author)

100 **BY,** supplement to **Beeld**, 1 February 2014
"Drie radikale planne vir ekonomiese groei"

101 **Beeld**, 15 February 2014
"Koop eerder slim as spoggerig"

102 **BY,** supplement to **Beeld**, 15 Maart 2014

27/8/2025-9:45:05 AM

"Kom ons kies ons eie vakansiedae"

103 (*27) **Suid-Afrikaanse Akademie; Tydskrif vir Geesteswetenskappe** (name translated as South African Academy: *Journal of Humanities*) Vol 54: No 1, March 2014
"South Africa's fiscal cliff: A reflection on the appropriation of government resources" (translated title)
(co-author)

104 **Business Day**, 17 June 2014
"Banking truths not as exciting as theories of intrigue"
(co-author)

105 **Business Day**, 1 August 2014
"An ardent capitalist takes aim at CEO salaries"

106 **Business Day**, 18 August 2014
"A central bank can regulate, but can it supervise?"

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107 **Economic Research South Africa**, August 2014
"Private shareholding and public interest: An analysis of an eclectic group of central banks", ERSA Working Paper No 457

108 **The Conversation**, 28 August 2014
"Why South Africa bank crisis is not is not a big thread to the country's sovereign rating"
(co-author)

109 **Mediterranean Journal of Social Sciences,** Vol 5 No 22, November 2014
"South Africa refutes one of Jeffrey Sachs' hypotheses based on commercialisation index scores" (subsequent to publication, this journal was de-accredited by the DHET)
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"What's driving the surge in South Africa's fuel price"

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27/8/2025-9:45:05 AM

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(co-author)

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27/8/2025-9:45:05 AM

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"Die wêreld van wiele na 50" (Name translated as The world of wheels after 50)

256 **Business Day**, 4 July 2023
"Bring back boring into the economy"

256 **Rapport-Weekliks**, 9 July 2023
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The big three: The GNU should ensure that South Africa's economic performance improves during 2025.

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The R60bn question

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Orania se jaarlikse openbare vakansiedag en fees ter viering van Afrikaans (name translated as Orania's annual public holiday and festival celebrating the Afrikaans language)

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Lessons from a lockdown

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27/8/2025-9:45:05 AM

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2007: "Central bank autonomy". Presented that the 18th SPACE (SPACE European Studies for Business and Languages) conference. Nicosia, Cyprus. 22 to 23 March. Sole presenter.

(#2) 2008: "Alternatives to expedite macro-economic convergence of the SADC countries". Presented at the IAES (International Atlantic Economic Society) conference in Warsaw, Poland, April 2008. Co-presenter: Johan Fourie.

(#3) 2009: "Why household surveys are not: Assessing surveys in inflation-targeting countries". Presented at the IAES (International Atlantic Economic Society) conference in Rome, Italy. March 2009. Co-presenter: Johan Fourie.

2009: ""The Efficient Market Hypothesis: The applicability of American models to the South African stock market". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA). 7 to 9 September 2009. Port Elizabeth. Co-presenters: Darrol Stanley and Paul Styger.

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2009: "Macro-economic convergence in SADC". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA). 7 to 9 September 2009. Port Elizabeth. Sole presenter.

2010: "A first specification of an inflation rate for an African region". Presented at the Economic Research of South Africa (ERSA) workshop, Eastern Cape. February 2010. Co-presenter: Adèle Breytenbach.

(#4) 2010: "Shareholding in the South African Reserve Bank". Paper presented at the IAES (International Atlantic Economic Society) conference in Prague, Czech Republic, 24 to 27 March 2010. Sole presenter.

(#5) 2010: "Methodology for compiling a regional rate of inflation". Presented at the Board-level Governance Regional seminar of the SA Reserve Bank/Bank of England. 6 to 10 september 2010. Pretoria. Co-presenter: Adèle Breytenbach.

(#6) 2010: "Setting realistic goals for a SADC monetary union". Presented at the Board-level Governance Regional Seminar of the SA Reserve Bank/Bank of England. 6 to 10 September 2010. Pretoria. Sole presenter.

2010: "Die internasionale verspreiding van Afrikaanssprekende gelowiges: 'n maatstaf van diaspora en implikasies vir Afrikaans in Suid-Afrika". Presented at the SA Akademie symposium, 30 September to 1 October 2010. Pretoria. Co-presenters: Fanie Joubert (Snr) and Fanie Joubert (jnr).

(#7) 2010: "Central bank communication: The SA Reserve Bank revisited". Presented at the Fourth International Business conference. Victoria Falls. 13 to 14 October 2010. Sole presenter.

2010: "Inflation is ungood™: A regional approach to improve economic performance". Presented at the 2010 Global Development Finance conference. November 2010. Stellenbosch. Co-presenter: Adèle Breytenbach.

2011: "Methodology for compiling an inflation rate for the Southern African Development Community (SADC)". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA). 5 to 7 September 2011. Stellenbosch. Co-presenter: Adèle Breytenbach.

2011: "An International comparison of inflation credibility surveys". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA). 5 to 7 September 2011. Stellenbosch. Co-presenters: Fanie Joubert and Vishnu Padayachee.

2011 "Inflation credibility: A comparison of the results of domestic inflation credibility surveys and inflation expectation surveys". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA), 5 to 7 September 2011. Stellenbosch. Co-presenter: Adél Bosch.

(#8) 2012: "Ninety Years of Central Banking: Policy and Institutional Lessons from Africa's Oldest Central Bank". Presented at the Eurasia Business and Economic Society (EBES) conference. May 2012. Istanbul, Turkey. Co-presenter: Adèle Breytenbach.

2012: "Lewenstandaard: 'n ekonomiese perspektief op lenwensgehalte in Suid-Afrika". Presented at the Annual symposium of the SA Academy for Science and Arts. 21 and 22 June 2012. Pretoria. Co-presenter: Fanie Joubert.

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2012: "Exiting currency unions: Lessons for the Southern African Development Community". Presented at the Global Development Finance conference on Innovative Finance for Sustainable Development. November 2012. Cape Town. Co-presenter: Adèle Breytenbach.

2013: "South Africa's fiscal cliff: A different meaning to a well-known concept". Presented at the ERSA public economics workgroup, 16 and 17 May 2013. Pretoria. Co-presenters: Adèle Breytenbach and Fanie Joubert.

(#9) 2013: "Policy lessons from South Africa's oldest central bank". Paper presented at the Southern African History Society conference. 26 to 28 June. Gaborone, Botswana. Sole presenter.

2013: "Suid-Afrika se fiskale afgrond: 'n Blik op die wanaanwending van owerheidshulpbronne". Presented at the annual symposium of the SA Academy for Science and Arts. September 2013. Stellenbosch. Co-presenters: Adèle Breytenbach and Fanie Joubert.

2013: "Focal Point Pricing: A challenge to the successful implementation of Section 10A of the Competition Amendment Act". Competition Commission conference. September 2013. Johannesburg. Co-presenters: Jessica Staples and Mike Holland.

2013: "A selected history of South African inflation perceptions: The question matters". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA), September 2013. Bloemfontein. Co-presenters: Adél Bosch and Vishnu Padayachee.

2013: "Market Timing of the FTSE/JSE Top 40 Index Utilizing Entropy Analytics". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA), September 2013. Bloemfontein. Co-presenters: Darrol Stanley, Levan Efremidze and Michael Kinsman.

2013: "Melting the golden curtain: The funding of the Millennium Development Goals". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA), September 2013. Bloemfontein. Sole presenter.

2014: "South Africa's inflation and financial stability problems in the 1980s". Paper presented at a conference at the University of Cape Town. 5 May 2014. Cape Town. Co-presenter: Stan du Plessis.

27/8/2025-9:45:05 AM

2014: "Central banks and fractional reserve banking: the case against conspiracy theories". Paper presented at the Money in the making of world society conference at the University of Pretoria. 20 and 21 August 2014. Co-presenter: Vishnu Padayachee

2014: "Beleggingsetiek". Paper presented at the Old Mutual financial advisors conference in Bloemfontein. 29 August 2014. Co-presenter: Fanie Joubert.

2014: "SA Reserwebank, banknote en inflasie" Paper presented at Hakok in Hermanus. 2 September 2014

2014: "Erodeer banknote etiek en morele waardes?" Paper presented at the SA Academy for Science and Arts annual symposium in Pretoria. 4 and 5 September 2014.

2014: "South Africa's fiscal cliff". Presentation to a joint sitting of the Parliamentary Standing and Select Committees on Appropriations of the MTBPS of 25 October 2015 in Cape Town. 5 November 2014. Co-presenters: Fanie Joubert and Adèle Breytenbach.

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2014: "Ethics and governance" Paper presented at the IPM Convention at Sun City. 11 November 2014.

2014: "Ethics: Cash as an ethical/moral dilemma" Paper presented at the Cash Management and Banknotes conference 2014 in Fourways. 13 November 2014. Co-presenter: Fanie Joubert.

2015: "Fiskale en ander verwikkelinge sedert 7 Mei 2014" Paper presented at the History Symposium of the SA Academy for Science and Arts in Pretoria. 30 January 2015.

2015: "South Africa's fiscal position". Paper presented at the Cape Town Press Club in Cape Town. 24 February 2015.

2015: "Update on South Africa's fiscal cliff". Presentation to a joint sitting of the Parliamentary Select and Standing Committees on Finance, Parliament. 4 March 2015. Co-presenters: Fanie Joubert and Adèle Breytenbach.

2015: "Implications of South Africa's fiscal cliff for civil service wage negotiations". Presentation to a meeting of FEDUSA trade unions. 19 March 2015. Co-presenters: Fanie Joubert and Adèle Breytenbach.

2015: "South Africa's fiscal cliff". Presentation to the School of Economic and Business Sciences (SEBS) seminar on South Africa's future, Wits. 31 March 2015. Co-presenters: Fanie Joubert and Adèle Breytenbach.

2015: "Various aspects of South African inflation". Presentation to the Economics Department of the University of Stellenbosch. 1 September 2015. Co-presenter: Adel Bosch

2015: "The first formal linking of inflation perceptions and inflation expectations of South African consumers". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA), September 2015. Cape Town. Co-presenters: Adél Bosch and Vishnu Padayachee.

2015: "Can currency in circulation predict South African economic activity?". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA), September 2015. Cape Town. Co-presenters: Cobus Vermeulen, Adél Bosch and Fanie Joubert.

2015: "The SARB's pioneering experiment in nominal income targeting". Presented at the bi-

ennial conference of the Economic Society of South Africa (ESSA), September 2015. Cape Town. Co-presenter: Stan du Plessis.

2015: "Trading of the South African Rand utilising entropy analytics". Presented at the bi-ennial conference of the Economic Society of South Africa (ESSA), September 2015. Cape Town. Co-presenters: Darrol Stanley and Levan Efremidze.

2015: "Interne spanning: twee scenario's vir een toekoms in Suid-Afrika". Presented at the annual SA Akademie symposium, 2 October 2015. Pretoria. Co-presenters: Fanie Joubert and Adèle Breytenbach.

2015: "South Africa cannot fool economic laws". Presentation at the AHI Conference in George. 9 October 2015. (Keynote speaker)

2015: "South Africa's fiscal position". Presentation to a joint sitting of the Parliamentary Select and Standing Committees on Finance, following on the MTBPS, Parliament. 28 October 2015. Co-presenters: Fanie Joubert and Adèle Breytenbach.

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2015: "The challenge of South Africa's fiscal cliff". Presentation at the first Western Cape Provincial Government Fiscal Conference. 5 November 2015. (Keynote speaker)

2016: "Monitoring the economy: Essential Information for Procurement Managers". Smart Procurement Conference, Cape Town. 1 March 2016. (Keynote speaker).

2016: ""South Africa's fiscal position". Presentation to a joint sitting of the Parliamentary Select and Standing Committees on Finance, following on the 2016/17-Budget Speech, Parliament. 2 March 2016. Co-presenters: Fanie Joubert and Adèle Breytenbach.

2016: "Revisiting South Africa's fiscal cliff". Presentation at the second Western Cape Provincial Government Fiscal Conference. 4 November 2016. (Keynote speaker)

2017: "Taxes everywhere". Presentation to SAIPA on the South African government's budget. 23 February 2017.

2017: "Insight from South Africa's National Budget. Presentation at the first City of Tshwane Mayoral Economic Summit 2017. 23 February 2017.

2017: Presentation on South Africa's political and economic crisis at the Stellenbosch Woordfees. 6 March 2017.

2017: Keynote speaker at the Afrisake symposium breakfast on South Africa's economic challenges. Centurion. 24 April 2017.

2017: Panellist at the Courageous Conversations Panel discussion of the Centre for Public Witness and the In-Harmonie Foundation, Franschhoek. 24 May 2017

2017: Keynote speaker at the SA Onderwysersunie conference on the South African economy. Port Elizabeth. 28 August 2017.

2017: Presentation comparing public and private universities in South Africa at the ESSA bi-ennial conference. Grahamstown. 30 August 2017.

2017: Presentation at the ESSA bi-ennial conference on SADC. Grahamstown. 1 September

27/8/2025-9:45:05 AM

2017.

2017: Presentation on a global network of smart procurement centres at Smart Procurement Conference. Midrand. 19 September 2017

2017: Keynote speaker at Project playground of the Swedish Embassy on South Africa: Prospects for a country in trouble

2017: "Authority must respect the people". Presentation to a joint sitting of the Parliamentary Select and Standing Committees on Finance, following on the MTBPS, Parliament. 3 November 2016. Co-presenters: Fanie Joubert and Adèle Breytenbach.

2017: "South Africa: A country in trouble". Presentation at the second Western Cape Provincial Government Fiscal Conference. 3 November 2016. (Key note speaker)

2018: "Update on South Africa's fiscal cliff". Presentation with the Fiscal Cliff Study Group (FCSG) at a meeting of civil service trade unions. 18 January 2018. Co-presenters: Moeletsi Mbeki, Fanie Joubert and Adèle Breytenbach.

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2018: Keynote speaker at the launch of the SA Reserve Bank Friends of the Archive initiative. 22 February 2018.

2018: Keynote speaker at the annual conference of the Red Meat Abattoir Association in Stellenbosch on 14 and 15 June 2018: South Africa's economy in a new political climate.

2018: Keynote speaker at the annual conference of Agri Western Cape at Goudini Spa on 25 June 2018: South Africa: What next will determine our future.

2018: "Markets are efficient, but … : A South African perspective". Rethinking Economics for Africa Festival on 8 September 2018 at the University of the Witwatersrand.

2018: Keynote speaker at the gala dinner of the Central Karoo Economic Development conference in Prince Albert on 12 November 2018: South Africa's economy and development opportunities for the Central Karoo.

2019: "The implication of prescribed assets for pension funds". Presentation with the Fiscal Cliff Study Group (FCSG) at a meeting of civil service trade unions in Pretoria. 5 February 2019. Co-presenter: Fanie Joubert.

2019: "Alternatives for Eskom". Presentation with the Fiscal Cliff Study Group (FCSG) at the NERSA hearings in Midrand. 18 January 2018. Co-presenter: Fanie Joubert.

2019: "Prescribed assets and the implication for pension fund members". Presentation with the Fiscal Cliff Study Group (FCSG) at the Fedusa Trade Union Conference in Isando. 7 March 2019. Co-presenter: Fanie Joubert.

2019: "South Africa's economic challenges". Keynote presentation at the AHI Western Cape, Goudini Spa. 12 April 2019.

2019: "An economic perspective on South Africa". Presentation at the Lux Mundi congregation. Pretoria. 13 April 2019.

2019: "Economic prospects for South Africa". Keynote speaker at the Noble Capital training

conference. Pretoria. 2 May 2019.

2019: "South Africa's economic challenges". Keynote speaker at the Stilbaai Sakebaai dinner. 16 May 2019.

2019: "South Africa's economic prospects". Speaker at the Drakenstein Sakekamer. 25 July 2019.

2019: "A Morally Questionable Investment (MQI) index: A South African case study". Conference paper presented at the 29th EBES conference, Lisbon, Portugal.

2020: "South Africa is a country in trouble". Presentation at the AFTB meeting of the General Synod of the NG Church. 23 January 2020.

2020: "Economic prospects of South Africa". Presentation at a local Famers' Union, Zeerust district. 11 March 2020.

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2020: Economic presentation at a webinar of the Afrikanerbond. 3 June 2020.

2020: "South Africa's fiscal prospects". Presentation at the webinar of the Democratic Alliance. 16 June 2020.

2020: "The response of the first two Governors to 'the two most eventful years in the history of the SA Reserve Bank': William Henry Clegg and Johannes Postmus in the lead up to, and in the midst of the 1931-32 crisis". Presentation at the webinar in preparation for the SA Reserve Bank centenary. 6 October 2020.

2020: "South Africa's fiscal cliff". Presentation at the Self-determination seminar/YouTube webinar of the Freedom Front+. 2 November 2020.

2020: "Is South Africa about to become a failed state?". Presentation at a Thebe webinar. 18 November 2020.

2020: "South Africa's economic realities". Keynote speaker at the municipal chief financial officers' forum lekgotla of the Western Cape Provincial Government. 3 December 2020.

2021: "South Africa's economic prospects". Speaker at the Agribiz webinar. 4 February 2021.

2021: "Is South Africa really becoming a failed state: Opportunities in times of uncertainty". Keynote speaker at a RMB webinar. 24 February 2021.

2021: "Entrepreneurship in South Africa". Keynote speaker at the launch of the Containerised Egg Layer Solution. 8 April 2021.

2021: "Is South Africa becoming a failed state?" Speaker at the Kaapse Familie-wingerde meeting. 28 April 2021.

2021: "Averting a failing state in South Africa". Keynote speaker at the AHI Weskaap Seminar, 12 November 2021

2021: "Averting a failing state in South Africa". Keynote speaker at the Goudini Agricultural Society Seminar, 9 December 2021

(#10) 2023: "Political risks to mineral beneficiation: An economic growth strategy for South Africa".

27/8/2025-9:45:05 AM

Paper presented at the 16th International Business Conference (IBC). 24 to 27 September 2023. Swakopmund Hotel, Namibia. Co-presented with Prof Piet Croucamp.

Other publications and activities:

1 **Hoofstad** (formerly a newspaper in Pretoria): Compiled a weekly review, 1980-08-01 to 1983-02-28

2 **Inflation in South Africa: 1921 to 2006. History, measurement and credibility**
Published in 2009 by VDM Verlag Dr Muller: Saarbruken (ISBN 978-3-639-10124-9)

3 **South African Reserve Bank: History, functions and institutional structure**
Published in 2009 by the SA Reserve Bank, Pretoria. (ISBN 978 0 9585044 9 2)

4 **South African Reserve Bank 2011: Commemorative publication, 90th anniversary**
(compiler and editor)
Published in 2012 by the SA Reserve Bank, Pretoria. (ISBN 978 0 9814465 6 1)

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5 **Economic History of Developing Regions** Vol. 26, Supplement 1, 2011
(ISSN Print 2078-0389/Online 2078-0397)
Joint guest editor

6 **South Africa @ 20: For better or for worse?**
Co-authored chapter *GINI co-efficient – a research based approach*

7 Contributed three chapters in Van der Merwe, E, Mollentze, S, Leshoro, TL, Rossouw, J and Vermeulen C. 2014. *Monetary Economics.* 2nd edition. Oxford University Press: Cape Town, as follows:
7.1 *The financial system* (Chapter 3)
7.2 *Inflation* (Chapter 8)
7.3 *Monetary policy co-ordination* (Chapter 15; co-author)

8 Contributed a chapter as co-author in Yağcı, M (ed). 2020. *The Political Economy of Central Banking in Emerging Economies*, as follows:
8.1 The Independence of the South African Reserve Bank: Coming full circle in 25 years?

9 Two co-authored research papers listed above were republished in Mitchie, J and Padayachee, V (eds). 2021. *Ownership and governance of companies: Essays from South Africa and the global south*, as follows:
9.1 "Volkskapitalisme" in the transition to democracy and beyond
9.2 Steinhoff collapse: a failure of corporate governance

10 Contributed seven chapters in Gillespie, A, Rossouw, J, Van Aardt, I, Naidoo, P and Van Aardt, C. 2020. *Introduction to Economics*. First impression. Oxford University Press: South Africa, as follows:
10.1 *Aggregate demand, aggregate supply, and the price level* (Chapter 16)
10.2 *Investment* (Chapter 18)
10.3 *Fiscal policy* (Chapter 19)
10.4 *Money* (Chapter 20)
10.5 *Inflation and monetary policy* (Chapter 21)
10.6 *Exchange rates* (Chapter 22)
10.7 *International trade and the balance of payments* (Chapter 23, co-author)

27/8/2025-9:45:05 AM

11 **Inflation is *ungood*™ and other sexual truths.**
Author
Book published in 2024 by Naledi, De Kelders

12 Contributed a chapter to *Political economy and critical engagement in South Africa: Essays in honour of Vishnu Padayachee*, edited by Rajend Meshtrie, Robert van Niekerk and Imraan Valodia. Published by UKZN Press, 2025
12.1 *An unfinished research agenda on the South African Reserve Bank: Linking academic scholarship and monetary policy* (Chapter 9).

MENTORSHIP:

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The following **previous mentees are now established researchers** in their own right:

Fatima Bhoola, Lecturer at the Department of Economics, University of the Witwatersrand

Dr Adél Bosch, Economist at the Development Bank of Southern Africa

Dr Adèle Breytenbach-Pretorius, previously a Senior Lecturer at the Department of Economics, University of South Africa. She subsequently emigrated to to the UK and thereafter to France, but has subsequently returned to South Africa

Dr Fanie Joubert, Senior Lecturer at the Department of Economics, University of South Africa

Dr Lumkile Mondi, Lecturer at the School of Economics and Finance, University of the Witwatersrand

Dr Cobus Vermeulen, Senior Lecturer at the Department of Economics, University of South Africa

PUBLIC ADDRESSES AND PUBLIC PROFILE:

Address numerous conferences and other audiences, including radio and TV audiences.

Monthly radio programme on RSG from 1998 to 2005.

Weekly radio programme on Radio Unisa from August 2012 to January 2014.

HONOURS/AWARDS:

Recipient of the Stals Prize for Economics in 2019.

IN THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA

CASE NUMBER:

In the matter between:

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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CONFIRMATORY AFFIDAVIT

I the undersigned,

STEPHANUS JOHANNES JOUBERT

hereby make oath and say that:

1. I am an adult male, economist and senior consultant at PriceMetrics (Pty) Ltd ("**PriceMetrics**"). I am also a doctor of economics and senior lecturer in the Department of Economics at the University of South Africa's College of Economic and Management Sciences.

2. The facts herein contained are true and correct. Save where the contrary appears from the context, such facts are within my personal knowledge.

3. I studied at the University of Pretoria, where I obtained, amongst others, an Honours degree in Economics and a Master's degree in Econometrics. During my post graduate studies, I worked as an academic tutor and later a junior lecturer at the University of Pretoria.

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4. In 2006, I moved to the private sector where I was employed as Economist at the Efficient Group.

5. In 2009, I decided to pursue further studies, and moved back to academia where I was appointed as senior lecturer in the Department of Economics at the University of South Africa ("**UNISA**").

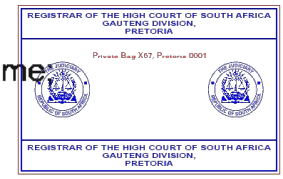
6. In 2019, I obtained my PhD (Economics) from UNISA which focussed on voluntary saving by households in South Africa. Apart from my studies, I have diverse research interests that include the financial markets, sustainable development, and fiscal sustainability.

7. My qualifications and experience are more fully set out in my *curriculum vitae*, a copy of which I attach hereto, marked "**J1**". I confirm the content thereof, and I confirm my qualifications and experience as set out in my *curriculum vitae*.

8. I have read the founding affidavit of Russell Lamberti on behalf of the applicant in the above matter, together with the PriceMetrics Report, attached as FA10 thereto (the "**PriceMetrics Report**").

9. I am the co-author of the PriceMetrics Report.

10. I confirm:



10.1. The content of the founding affidavit insofar as it relates to me;

10.2. The content and correctness of the PriceMetrics Report; and

10.3. That I am duly qualified and experienced to consider and interpret the economic data referred to in the PriceMetrics Report, to make calculations and provide economic modelling in respect thereof and to opine on and make submissions in respect of the economic aspects of the NHI Act raised in the PriceMetrics Report.

11. The PriceMetrics Report is lengthy and detailed. The content of the report has been adequately summarised in the founding affidavit. I do not repeat a summary of the content and findings of the PriceMetrics Report herein in order to avoid unnecessarily burdening the application.

DEPONENT

I certify that the deponent has acknowledged that he knows and understands the contents of this affidavit which was signed and sworn to, before me, at PRETORIA on this 19 day of AUGUST 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.

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PRETORIA

COMMISSIONER OF OATHS
FULL NAMES:
ADDRESS:
CAPACITY:

PETRUS GERHARDUS LOUWRENS KOEN
COMMISSIONER OF OATHS Ex Officio
PRACTISING ATTORNEY
REPUBLIC OF SOUTH AFRICA
LOFTUS VERSVELD NORTHERN PAVILION (Gate No. 12)
SECOND FLOOR, OFFICE NO. 4
416 KIRKNESS STREET, ARCADIA, PRETORIA, 0002
Tel: 087 0010 733 Fax: 086 276 4377

CURRICULUM VITAE: Stephanus Johannes (Fanie) Joubert

Lecturer/Economist

Phone 0731430040 **Linkedin** linkedin.com/in/fanie-joubert-79859831/

E-mail fanie4@gmail.com **ORCID** https://orcid.org/0000-0003-3880-1033

1. SUMMARY:

- DCom. Economics (Unisa), MCom. Econometrics (UP)
- Economist (4 years, private sector)
- Senior Lecturer, Economics (15 years)

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2. PROFESSIONAL EXPERIENCE:

2.1 University of South Africa (UNISA), Department of Economics
Senior Lecturer
August 2009 to date

College of Economic and Management Sciences, School of Economic Sciences, Department of Economics.

Duties:

- Academic (lecturing, course management, new module design)
- Research
- Supervision of post graduate students
- Modules taught: Advanced Econometrics (ECS4863), Honours Research Report (HRECS83), Development Economics (DEVH00L), Econometrics (ECS3706, ECM301E), Monetary Economics (ECS3701), Microeconomics (ECS2601),The South African Financial System (ECS2605)

Achievements:

- Award for best doctoral thesis in the Economics Department (2020)
- The Conversation Africa: 2021 Research Communication Recognition award: Most read author award: "*Why the South African Government should buy locally made vehicles for state use*"
- Participant in Netwerk24 Economist of the year competition, since 2010

2.2 Efficient Group Limited
Economist
2006 to July 2009

The Efficient Group (currently Efficient Financial Holdings Ltd) is a FSB registered asset management company. It actively manages and distributes investment products and knowledge for the benefit of investors, independent financial advisors and trustees. The company listed on the JSE as Efficient Financial Holdings during January 2009.

Duties:

- Economic analysis, modelling and forecasting
- Responsible for various monthly and quarterly reports including inflation, money supply, retail and wholesale trade, mining and manufacturing, GDP, monetary policy and state finances.
- Preparation and presentation of economic data to internal and external stakeholders
- Member of investment committee
- Supervised financial advice duties
- Supervision of junior economists

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Achievements:

- Publication of research reports and opinions in numerous financial and other press (Business Day, Financial Mail and Sake 24)
- Various media interviews (including SAFM, Classic FM Classic Business, SABC, CNBC Africa, Summit TV, Kyknet)
- Providing inputs to the successful listing of the company on the JSE

2.3 University of Pretoria, Department of Economics
Junior lecturer
Date: 2005

School of Economic and Management Sciences, Department of Economics

Duties:

- Teaching and learning (1st years economics)
- Academic research

Achievements:

- Carnegie Foundation: Recipient of bursary for masters program in International Trade and Investment. 2005.
- Participant in Second Annual African Trade Moot (hosted by University of Pretoria), 2005.
- Guest lecturer for MBA-preparatory course. UP School of Business and Marketing studies

2.4 Consultation and other:

South African Institute of Chartered Accountants (SAICA)
2024

Duties:

- Economic presentation

PriceMetrics Economic Research Consultancy
Senior Consultant
2020 to date

Duties:

- Economic/econometrics analysis

GOPA Group Southern Africa (Pty) Ltd
2023 to date

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Economic Impact Assessment of the Africa Aerospace & Defence (AAD) 2022 exhibition

Commercial Aviation Association of Southern Africa NPC (CAASA)
2023 to date

CAASA Aviation Activity Index (CAAI) for South Africa: 4th quarter of 2023

FAL Investments
2012 to 2016

Duties:

- Economic reports (monthly *Rand Report*)

Aristaat Financial Advisors
2009 to 2015

Duties:

- Supervised financial advice services
- Ad hoc economic reports and presentations

3. QUALIFICATIONS

3.1 Tertiary education

DCom (Economics), 2019
University of South Africa, South Africa
Thesis title: *Voluntary household saving in South Africa: 2005 to 2017*

MCom (Econometrics) degree, 2007
University of Pretoria, South Africa
Dissertation title: *The measurement of inflation credibility: Findings from pilot studies*

BCom Honours (Economics) degree, 2005
University of Pretoria, South Africa

BCom (Economics) degree, 2003
University of Pretoria, South Africa

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3.2 Other

Post Graduate Diploma in Financial Planning
Centre for Financial Planning Law, 2010
University of the Free State, South Africa

Regulatory Examination (RE1) Key Individual Level 1: Cat I, II, IIA, III and IV licences; (RE5) Representatives; and (RE3) Key Individuals and sole proprietors' category II and IIA
Completed April 2012

Certified Financial Planner (CFP®)
Since August 2012

South African Academy of Science and Art (SAAWK)
Since August 2012

Global Reporting Initiative (GRI) certificate in Sustainability Reporting, 2010
Environmental and Sustainability Solutions CC, a GRI certified training partner in South Africa.

Advanced short course in outcomes-based assessment in Higher Education and Open Distance Learning (ODL), 2010
Centre for Community Training and Development, UNISA

3.3 Schooling

Afrikaanse Hoër Seunskool Pretoria, 1994-1998
Matric subjects (all on Higher Grade):
English, Afrikaans, Mathematics, Science, Accounting, Biology, Latin

Anton van Wouw Primary School, 1987-1993
Pretoria

4. PUBLICATIONS & CONFERENCE PAPERS

4.1 Publications (Selected)

- Joubert et al, 2022. A perspective on Orania's OSC Co-operative Bank Limited. *The Journal of Humanities.* Vol 62:4. www.10.17159/2224-7912/2022/v62n4a11
- Joubert, F. & Van der Merwe, T., 2021, 'Household saving and wealth in South Africa', South African Journal of Economic and Management Sciences 24(1), a3764. https://doi.org/10.4102/ sajems.v24i1.3764
- Vermeulen, C., Joubert, F., Rossouw, J. 2019. South African stock market development: The impact of globalism and nationalism. Suid-Afrikaanse Tydskrif vir Natuurwetenskap en Tegnologie. 38(1), pp. 80-90 https://doi.org/10.36303/SATNT.2019.38.1.722
- Mbeki, M., Rossouw, J., Joubert, F., Breytenbach, A. 2018. South Africa's fiscal cliff barometer. *New Agenda: South African Journal of Social and Economic Policy* 2018, pp 29 - 33
- Vermeulen, C., Joubert, F., Bosch, A., Rossouw, J. 2017. From the business cycle to the output cycle: Predicting South African economic activity. *Studies in Economics and Econometrics.* Vol 41 No 2. August 2017.
- Bhoola, F., Rossouw, J., Joubert, F., Iyke, B. 2016. On the accuracy of private sector macroeconomic forecasts of the South African economy. *Studies in Economics and Econometrics.* Vol 40 No 2. August 2016.
- Joubert, F. 2010. *The state of sustainable development reporting in South Africa: Using a Global Reporting Initiative approach.* 1st International conference on leadership and management for sustainable development, Unisa Graduate School of Business (SBL), 6-8 October 2010. Conference proceedings: ISBN 978 1 86888 651 7
- Supporting an inflation targeting policy with the measurement of inflation credibility. Rossouw J. and Joubert F. 2005. *The South African Journal of Economics*, Volume 73:2. June 2005

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4.2 Book chapters

- Joubert, S.J. and Serfontein, B. 2012. Creativity in Economics Teaching. In *Developing student graduateness & employability: Issues, provocations, theory and practical guidelines*. Edited by Melinda Coetzee et al. Knowres publishing. ISBN: 978 1 86922 189 8

4.3 Conferences and other (Selected)

- Joubert, F. 2024. *2024 National Budget: Macroeconomic Overview and Impact.* Presentation at the South African Institute of Chartered Accountants (SAICA) regional member road show. Mbombela (Nelspruit). 1 March 2024
- Joubert, F. 2023. *Where are the sprouts in our Economy?* Keynote presentation at the Potatoes SA Research Symposium. Parys. 18 July 2023
- Joubert, F. 2023. *An overview of the South African economy: In search of green shoots.* Presented at the Business Breakfast of the Cape Chamber of Commerce and Industry. Cape Town. 17 May 2023

- Joubert and Rossouw. 2020. Warnings about SA's push towards the fiscal cliff went unheeded for years. Business Day, 6 September 2020. https://www.businesslive.co.za/bd/opinion/2020-09-06-warnings-about-sas-push-towards-the-fiscal-cliff-went-unheeded-for-years/
- Fiscal Cliff Study Group, *South Africa's 2020 MTBPS*. [Online] Presentation to a joint sitting of the Parliamentary Standing and Select Committees on Finance. Parliament of the Republic of South Africa. Cape Town. 4 November 2020.
- Joubert, F. 2019. *A Game of Chess: Global and domestic factors impacting the rand*. Presentation to the management board of TreasuryOne. Pretoria. 11 June 2019.
- Joubert, F. 2018. *The South African economy: New drivers for growth*. Presented at the Red Meat Producers (RPO) Northern Cape road show, 6 and 7 March 2018.
- Rossouw J and Joubert, F. 2014. *Cash as an ethical/moral dilemma*. Cash Management and Banknotes conference. Johannesburg. November 2014.
- Lane, I. and Joubert, F. 2011. *Quantifying sustainable development investment returns – an African approximation*. Presented at the 2011 Global Development Finance conference, Dubai, UAE. 8-10 November 2011.
- Joubert, Fanie. *The state of sustainable development reporting in South Africa: Using a Global Reporting Initiative approach*. Paper for the 1st International conference on leadership and management for sustainable development, Unisa Graduate School of Business (SBL), 6-8 October 2010. ISBN 978 1 86888 651 7

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5. EXTRA MURAL

- Triathlon: Ironman 70.3 (2009, 2012, 2022)
- Road cycling: Cape Argus cycle tour (6) and 94.7 Cycle challenge (10)
- Mountain biking: Sani2C (2015), PE-to-Plett (2013), various marathons
- Running, various marathons and half-marathons

6. REFERENCES *(contact details available on request)*

Dr Roelof Botha
Director (Gopasa Group SA)

Prof Jannie Rossouw
Adjunct Professor (University of the Witwatersrand)

Mr Dawie Roodt
Chief Economist/Director (Efficient Financial Holdings)