



HEALTH FUNDERS ASSOCIATION

FAQ ON HFA'S LEGAL ACTION ON THE NHI ACT

Introduction:

The Health Funders Association (HFA) has launched a legal challenge to the National Health Insurance (NHI) Act. This FAQ explains the reasons for the challenge, its legal basis, and what is at stake for healthcare in South Africa.

FAQ 1: Is HFA against Universal Health Coverage (UHC)?

No. HFA fully supports the goal of UHC and addressing the unacceptable levels of inequality in access to quality healthcare in South Africa. The HFA believes this to be consistent with the constitutional obligation on the state to provide access to health care.

Our legal challenge is against the NHI Act on the basis that its proposed funding model is deeply flawed. Independent analysis of expert economists at Genesis Analytics and our legal submissions show that the chosen mechanism is fundamentally unsound, unworkable in practice, and constitutionally invalid. South Africa has a UHC score of 71 (as measured by WHO), which is above the global average of 68, as well as the 12th lowest out of pocket payments ratio of 6.7%. The Act is likely to decrease the UHC score, increase out of pocket payments and exacerbate existing inequalities thus diminish the overall standard of care.

HFA has proposed, as a less restrictive and more effective means to achieve UHC, a hybrid multi-fund model that combines the NHI with a supplementary role for private funds. This proposal is consistent with international best practices. It essentially preserves the NHI apparatus and goals. It ensures that all the objectives of efficiency, lower costs, equity and social solidarity are retained. But it also preserves choice for medical scheme beneficiaries through access to supplementary private health cover. Genesis finds that HFA's hybrid multi-fund model would better advance South Africa's progress to the goal of universal health care than the NHI Act.

FAQ 2: What is HFA's challenge to the NHI Act?

HFA has launched a constitutional challenge to the NHI Act out of concern for the severe and irreparable harm that the NHI model contained in the Act will do to South Africa's healthcare system, the economy, and the constitutional rights of individuals

to access to healthcare services. The HFA's application is brought in the interests of approximately 9.1 million South Africans who are beneficiaries of medical schemes, spanning all races and classes, as well as in the public interest and the interests of its members.

HFA's constitutional challenge is premised on 4 legal grounds which can be summarised as follows:

1. Irrationality and fiscal impossibility:

The government admits that it never undertook a costing and modelling exercise for this major structural overhaul of the healthcare system, which accounts for approximately 8.5% of GDP. This resulted in a statute that is incapable of achieving its purposes and is therefore substantively irrational.

The model is fiscally impossible, will markedly reduce access to healthcare of 9.1 million people, namely medical scheme beneficiaries, and cannot deliver comprehensive healthcare services to all South Africans.

2. Infringement of the right to healthcare:

Section 33 of the NHI Act, which will all but obliterate medical schemes by prohibiting supplementary coverage, unjustifiably limits the constitutional right of access to healthcare by reducing access for millions of medical scheme beneficiaries.

3. Unreasonable measure under section 27(2) of the Constitution:

The NHI Act contravenes the state's obligation in section 27(2) of the Constitution to adopt reasonable measures to achieve the progressive realisation of the constitutional right of everyone to access healthcare. It is an unreasonable, retrogressive measure, and will diminish rather than improve access to healthcare.

4. Unconstitutional delegation of legislative power:

The NHI Act unlawfully delegates sweeping and unchecked powers to the Minister of Health, without adequate guidance or oversight, undermining the separation of powers required by the Constitution.

HFA's case had been brought as a constitutional challenge to the legislation in the High Court, where the HFA is seeking an order declaring the entire NHI Act to be unconstitutional and invalid, and for it to be set aside. In the alternative, the HFA seeks an order declaring one or more of specific sections of the NHI Act to be unconstitutional and invalid, and for them to be set aside. The HFA is also seeking relief that any declaration of constitutional invalidity made by the High Court be referred to the Constitutional Court for confirmation.

While litigating these issues, the HFA remains hopeful that Government will amend the NHI Act to create a workable model capable of achieving UHC.

FAQ 3: Will the NHI Act cause harm if implemented as is?

Yes. The NHI Act, if implemented as is, would cause significant and wide-ranging harm to the country, the economy, and the healthcare system, even before it is fully implemented.

The HFA commissioned Genesis to conduct an independent expert economic analysis on the impact of NHI. The research modelled a "Comprehensive Care" model based on the commitment made by Government that NHI will provide the same level of access and quality of care that is provided through medical schemes. The model estimates that a Comprehensive Care model will amount to R941bn per annum. This calculation has generously adjusted for a potential 45.5% savings. These savings assumptions are based on optimal implementation. This assumption is at the extreme of the spectrum of the savings that could be achieved under the NHI Act.

To fund this scenario will require Personal Income Taxes to be increased from an average of 21% to an average of 46%, which would lead to a drastic reduction in take-home pay, with low-income taxpayers severely impacted. This would be devastating for many South African households and will affect spending across all sectors of the economy.

Even low-income earners, specifically the 1.8 million taxpayers who earn less than R92,000 per year and currently pay 18% tax, would see their tax rate increase to 41% under NHI.

The point is not merely that these levels of taxation would have a devastating impact on the South African economy (which they would), but it is simply not possible for the South African government to raise money at this scale. Genesis presents evidence showing that South Africa's narrow tax base has likely already passed the point at which higher taxes will reduce rather than increase revenue.

The raising of taxes to raise funds for the implementation of the NHI Act will also result in medical scheme membership becoming unaffordable for hundreds of thousands, if not millions, of medical scheme members, who will exit their medical schemes. Medical schemes will face an actuarial death spiral which is a scenario where rising costs force healthier members to exit, leading to further price increases and the few remaining comprehensive plans will be rendered prohibitively expensive leading to a potential collapse. Ironically, the very households who lost their medical scheme coverage will still pay the NHI tax, yet will no longer receive the robust coverage they once had. The implementation of the NHI Act would hurt all patients, damage the economy, and further restrict healthcare access. These are the adverse effects that will be felt by everyone in South Africa, and which can be averted with a collaborative approach and a sustainable model.

FAQ 4: Can the implementation of the NHI Act be funded by just combining current public and private health spending?

The HFA commissioned Genesis to conduct an independent analysis of the impact of a "Shared Resources" NHI model, which assumes that the only additional financial injection into the health budget would be the amount currently expended in the

private sector. The analysis was also based on the assumption of 45.5% efficiency savings and demonstrated the substantial risks associated with this approach.

This model nevertheless requires levels of taxation that are unachievable given the South African tax base. Personal Income Tax would need to increase from an average of 21.3% to 31.3% of taxable income. This increase would affect all income groups. For low-income earners, marginal tax rates would rise from 18% to 28%. For high-income earners, marginal tax rates would increase from 45% to 55%. These tax levels are also not realistic.

South Africans' disposable income would decrease substantially, with low-income and non-medical scheme taxpayers being hit the hardest. This would have broader consequences for every sector of the South African economy.

Genesis finds that, in the best-case scenario where NHI is able to obtain the full private contributions to health expenditure together with a full 45.5% in cost savings, medical scheme beneficiaries will nevertheless experience an average 43% decrease in access to healthcare. Not only will medical scheme beneficiaries suffer a drastic reduction in access to healthcare, but they will also not be permitted to purchase cover from their own pocket in order to make up for the diminished healthcare. This unjustifiably limits the right of access to healthcare and breaches the State's duty to take reasonable legislative and other measures, within its available resources, to progressively realise the right of access to healthcare services.

The Genesis report also warns that raising taxes to collect all of the R280 billion currently spent on private healthcare is not guaranteed. Recent experience with tax increases in South Africa has resulted in reductions in revenue rather than increases, as there are lower incentives to be productive and comply. Even if additional revenue is collected, not all of it may be allocated to health, as government must also fund priorities such as debt repayments, education, and social grants.

FAQ 5: Will the NHI Act fix the healthcare skills shortage?

No. Independent analysis by Genesis Analytics indicates that, even if the healthcare system was able to operate much more efficiently (improving its efficiency by 45.5%) South Africa would still need an additional 286,000 healthcare professionals to provide comprehensive care to all South Africans.

This would mean doubling the number of GPs, nurses, and pharmacists, and tripling the number of specialists. However, with only 3,600 new medical graduates each year and qualifications taking 9 to 13 years to complete, it would take decades to reach these targets. Without enough skilled professionals, South Africans will experience healthcare rationing.

Furthermore, the NHI Act does not provide for the capital funding required to develop healthcare infrastructure and train healthcare personnel. Conversely, the NHI Fund is likely to wield its monopsony power to push prices below sustainable levels, and healthcare providers will respond by exiting the system or reducing services. Doctors will emigrate or retire early; there will be a reduced variety of medicines available to consumers and private hospitals will scale back and stop upgrading facilities-reducing

overall capacity right when it is most needed. At the same time, the ability for South African-trained doctors to find gainful employment overseas is set to increase.

FAQ 6: What is healthcare rationing?

Healthcare rationing is the limitation or restriction of access to healthcare services because there are insufficient funds, healthcare professionals, or infrastructure to meet everyone's needs. While rationing is a common feature of health systems, under the NHI, rationing will happen when the system cannot afford to provide the promised "Comprehensive Care". This will force difficult decisions about who receives care, when, and what type of care is provided.

According to the Genesis Report, the cost of delivering comprehensive healthcare under the NHI Act is far more than South Africa can currently afford. Without enough funding or sufficient healthcare resources, the NHI Fund would be forced to contain costs and limit access by:

- Delaying treatment (longer waiting lists),
- Restricting eligibility (for example, only premature babies above a certain weight allowed to access neonatal care),
- Reducing the scope of benefits, or
- Capping the number of procedures or medications provided.

In this context, rationing is not a policy choice but an inevitable result of promising universal, comprehensive coverage without the resources to deliver it. It affects not only what care is provided, but also who gets it, how quickly, and under what conditions, often affecting vulnerable populations the most.

FAQ 7: If full implementation of the NHI Act is years away, why worry now?

Besides being fiscally impossible, the NHI Act creates legal and economic uncertainty, which in turn prompts healthcare professionals to leave the health system. This uncertainty also discourages new entrants into the profession, thereby reducing the pipeline of healthcare professionals in training.

Additionally, the NHI Act deters investment and causes immediate economic hardship for South Africans through tax increases. Long before the full implementation of NHI, medical schemes could all but disappear because medical scheme members will not afford both medical scheme contributions and additional taxes.

If this occurs, the level of access to healthcare currently available in South Africa will no longer be accessible. Other than the wealthiest individuals (who can afford to pay out-of-pocket), the public will have no option but to experience rationing of those services by the government, whether in the shape of long delays, poor quality or refusal of certain services. When implementation starts, the damage will be irreversible. That's why HFA is acting now, in the interests of all South Africans.

FAQ 8: Why does HFA's cost estimate differ from others?

Genesis' economic model is one of several developed by experts concerning the NHI Act. Each model uses different assumptions that must be justified.

The Genesis model generously assumes 45.5% efficiency savings in favour of the NHI Fund, even though the evidence suggests that the actual efficiency gains will be modest at best, if they exist at all. The modelling conducted by Genesis also favourably assumes that significant efficiencies are achievable through economies of scale and other levers under the leadership of the National Department of Health and the management of the NHI Fund, although achieving these efficiencies poses additional risks.

FAQ 9: Does the NHI Act pose any downside risks?

There are significant downside risks arising from the implementation of the NHI Act including:

- Medical schemes will be forced to close down, leaving former beneficiaries with no feasible route to the healthcare services they once had access to.
- The public sector will have to bear the burden of greater demand once medical scheme members drop off cover.
- Reduced supply of critical healthcare inputs in the form of doctors and other healthcare professionals, in a context where South Africa already suffers from low health professional ratios.
- Healthcare investment will be dissuaded.
- Significant healthcare price increases due to increased demand and constrained supply of resources, including the emigration of doctors and nurses. Complementary medical scheme cover will be prohibitively expensive, other than for a small sliver of the population.
- Driving out or reducing the existing tax base.
- Access risks associated with inefficiencies in timeous referral processes and challenges in facilities management associated with the massive system reorganisation.
- Increased medico-legal claims due to care delivery challenges.
- Increased adverse selection (see FAQ 10, below) during the transition, driving up medical scheme costs and exacerbating the impacts of tax increases on current medical scheme beneficiaries who will be expected to pay increased taxes and make contributions. This is a risk that was flagged by the Parliamentary legal advisor.
- Increased out-of-pocket expenditure as people are unable to access covered services or coverage is constrained. Such expenditure is the most regressive form of healthcare funding and combined with increased taxation, will place a greater financial burden on individuals – disproportionately affecting poorer people.

FAQ 10: Will the NHI Act lead to better healthcare equity?

No. In prohibiting supplementary cover and preventing medical schemes from covering services that are notionally included in the NHI package, the NHI does not enhance, but rather undermines, the system of cross-subsidisation that is central to healthcare equity.

- **Income cross-subsidisation:** The main mechanism for income cross-subsidisation under the NHI Act is the mandatory prepayment (through taxes or contributions) by all, regardless of whether they use NHI services or not. If supplementary cover is allowed, medical scheme beneficiaries could still pay into the NHI Fund but fund their own care through medical scheme contributions, freeing up resources for lower-income users.
- **Risk cross-subsidisation:** The Genesis report demonstrates that within any given income or age group, it is the less healthy who are more likely to contribute to medical schemes. If they are prevented from doing so, their higher risks and costs are shifted onto the NHI, raising the average risks and costs for the entire pool. Allowing supplementary cover, by contrast, supports the goals of equity and sustainability in the health system.
- **Social solidarity and adverse selection:** adverse selection is a phenomenon whereby younger, healthier members are the first to abandon their medical scheme coverage once it becomes more expensive or they are less able to afford it, given tax increases. Because these younger, healthier individuals typically pay more in contributions than they claim, they effectively cross-subsidise older or sicker beneficiaries who generally incur higher medical costs. This is the principle of social solidarity that underpins the functioning of medical schemes. Once the tax credit is removed or taxes are increased, it is precisely this low-risk group that will be most inclined to withdraw from medical schemes. The remaining pool will then be disproportionately elderly, sick and higher-risk. The cross-subsidy from younger and healthier lives will be lost, and the average per capita costs will rise significantly. This dynamic quickly escalates into an actuarial death spiral, where each round of contribution hikes prompts further departures, thereby pushing contributions even higher, jeopardising the sustainability of the entire medical scheme sector.

FAQ 11: Is a single-payer (NHI) model the only way to achieve UHC?

No. UHC systems around the world often incorporate mixed models involving both public and private sectors.

- **International comparisons:** supplementary coverage is neither unusual nor inimical to the achievement of universal health coverage. It is a feature of health systems in numerous countries, including Brazil, China, Costa Rica, Ghana, Indonesia, Mexico, Thailand and Türkiye.
- **Role of private insurance:** The Genesis report notes that in most countries, private insurers play a supplementary role, covering services that are also covered by the public scheme. This arrangement supports the public system by reducing the fiscal and operational pressure on it.

- **Unique approach:** The specific NHI model proposed for South Africa, which involves a single-payer system with a prohibition on supplementary private insurance, is not commonly used globally. The NHI model, which seeks to eliminate private insurance for services covered by the public scheme, is not the norm in countries that have enjoyed success in moving towards UHC. Instead, these countries typically allow for supplementary private insurance.

FAQ 12: What is HFA's proposed alternative model for reaching Universal Health Coverage (UHC)?

HFA supports UHC and proposes an appropriate, sustainable, and affordable model: a hybrid multi-fund model that incorporates the NHI principles of social solidarity and improved healthcare access for all South Africans.

In this model, medical schemes support the NHI by helping to provide and finance the NHI benefit package, rather than duplicating or replacing it. Medical schemes would work alongside the NHI Fund to deliver the core package of healthcare benefits and could also offer supplementary (top-up) benefits beyond the NHI package.

The model is funded by tax-based contributions to a central NHI Fund, which finances a standard package of healthcare benefits accessible at both public and private providers. Medical schemes receive a capitation fee set below the full cost of the NHI benefit package, supporting social cross-subsidisation for vulnerable groups.

Individuals may join medical schemes through their own contributions, giving them access to both the NHI-funded benefits and any additional cover their scheme provides. This blended approach ensures universal access while preserving choice, competition, financial sustainability, and social solidarity.

FAQ 13: Why is HFA's model better?

HFA's hybrid multi-fund model incorporates best practices and builds on the NHI Fund to create a more affordable, equitable and efficient health system. The model's attributes include:

- It is economically sustainable: It avoids unaffordable tax increases by using existing financial structures efficiently.
- It is redistributive and more equitable: The younger, healthier and wealthier cross subsidise the more elderly, sick and vulnerable.
- It enables choice by preserving people's ability to choose their cover.
- Promotes a healthier sector: retains competition, promoting innovation and a healthy supply chain.
- It is consistent with the Health Market Inquiry recommendations.
- It is scalable as the economy grows and the extent of coverage that can be included expands with GDP and employment trends, enabling responsible and responsive progression to UHC without damaging the overall system.

- It enables a pragmatic and efficient rollout: the hybrid approach is cheaper, faster, more efficient and less risky than the single fund approach and it leverages existing systems and private sector capacity in a collaborative framework.

Countries like Mexico, Thailand and Germany use similar models successfully as is supported by the comparative and policy analysis in the HFA's court challenge and Genesis report.

FAQ 14: Will HFA's hybrid, multi-fund model lead to better healthcare equity?

Yes. HFA's hybrid multi-fund model enables sustainability by preserving income based cross subsidies while also ensuring that the cross subsidies from the healthy to the sick are retained and enhanced.

This is a central feature of the HFA's model as described in both its founding affidavit and the Genesis report. The model is explicitly designed to maintain and strengthen social solidarity by ensuring that wealthier and healthier individuals contribute more, thereby subsidising the costs for poorer, sicker, and more vulnerable groups. This ensures both financial equity (income-based) and risk equity (healthy subsidising the sick).

The Genesis report and the HFA's founding affidavit both emphasise that the hybrid model's structure - mandatory contributions, risk equalisation, and the option for supplementary cover - ensures that the system is fair and sustainable, and that the burden of healthcare funding is shared equitably across the population.

This is critical for building a fair and sustainable healthcare system since we have only 7.4 million taxpayers contributing the majority of tax funding to support the healthcare needs of 61 million people in the population.

FAQ 15: Will the NHI Act's monopsony model lead to UHC?

No. A monopsony means a market where there is only one buyer, and this is what is entrenched in the NHI Act. The HFA's application and the Genesis report provide detailed economic analysis showing that while a monopsony may have some theoretical potential to lower prices, in practice, the NHI Fund as a fiscally constrained monopsony purchaser is likely to:

- **Reduce the Supply of Healthcare Inputs:** If the NHI Fund uses its buyer power to push prices below sustainable market levels, healthcare providers (doctors, nurses, hospitals, pharmaceutical suppliers) may exit the market, emigrate, or reduce their services. This is especially harmful in a context where South Africa already faces shortages of healthcare professionals and facilities.
- **Decreased Access and Quality:** the result is likely to be longer waiting times, rationing of services, stock-outs of medicines, and a general decline in the quality and availability of care. The Genesis report finds that on the shared model, through which the current total healthcare expenditure is equally distributed, medical scheme beneficiaries would experience a 43% or greater

reduction in access to healthcare under the NHI, even under very optimistic efficiency assumptions.

- **Increased Costs Due to Reduced Supply:** Rather than lowering costs, a monopsony will increase them if the reduction in supply leads to scarcity pricing, the need to import skills at a premium, or increased out-of-pocket expenditure as people seek care outside the system.
- **Loss of Innovation:** a single-purchaser model reduces competition and the incentives for innovation, quality improvement, and efficiency that are present in a multi-funder environment. The Health Market Inquiry findings support the view that competition between multiple funders and providers drives higher standards and innovation.

International experience shows that most countries with successful UHC systems do not rely on a strict monopsony model but rather allow for supplementary private insurance and competition among funders. The evidence suggests that a single-buyer system is not necessary for UHC and is likely to undermine access and quality.

FAQ 16: Is the NHI Act in its current form needed to solve the rising costs of medical scheme contributions?

No. While medical scheme contributions have been increasing over time, the reasons are complex and not something the NHI, in its current form, will solve—and will likely in fact exacerbate them.

The primary drivers of rising medical scheme costs are:

- An ageing membership base, which leads to higher utilisation of healthcare services,
- An increasing burden of chronic health conditions, and
- The introduction of new technologies and high-cost medicines by suppliers, which tend to be more expensive than older treatments.

In addition, the Health Market Inquiry identified several regulatory gaps that contribute to cost escalation in the private sector, including:

- The absence of mandatory membership, which limits risk pooling,
- The lack of a Risk Adjustment Mechanism (whereby medical schemes with higher-than-average risk profiles receive funds through an appropriate mechanism from those with lower-than-average risk profiles) to level the playing field between schemes,
- An outdated and unreviewed Prescribed Minimum Benefits (PMBs) package, and
- A legal requirement to pay for PMBs in full, regardless of cost or efficiency.

The NHI Act does not address these regulatory shortcomings. On the contrary, its implementation risks destabilising the medical scheme environment, particularly during the transition period, by making scheme membership less affordable and sustainable.

The HMI put forward a set of targeted reforms to improve affordability, access, and sustainability within the private healthcare system, which the HFA believes need to be urgently implemented to enable schemes to be sustainable and to work together with the NHI. As is noted in the HFA's application papers, implementing these reforms could realistically reduce medical scheme costs by 25% to 30%.

FAQ 17: Who do medical schemes cover in South Africa?

Of the 9.1 million medical scheme beneficiaries, 6.1 million (68%) are black, with 4.6 million (51%) African, and 3 million (32%) white.

Medical scheme beneficiaries are active economic contributors to South Africa. Of the 9.1 million beneficiaries, 4.1 million are employed, with the other 5 million being family dependents or pensioners. Medical scheme members contribute 74% (R443bn) of Personal Income Tax and a large part of the VAT generated for the country.

There is a pervasive myth that medical schemes are only for the elite. However, the data shows that this is not the case: of the 4.1 million employed medical scheme beneficiaries, up to 3.4 million (over 80%) earn less than R37,500 per month, and up to 1.8 million (about 44%) earn less than R16,000 per month.

A significant portion of medical scheme members are low- and middle-income earners, not just high-income individuals. These low- and middle-income taxpayers are the engine of South Africa's economy. It is critical to our economic growth to ensure that they have ongoing access to quality healthcare services while scaling up access to coverage for everyone.

The HFA's application and the Genesis report warn that undermining the medical scheme population's access to healthcare (for example, through unaffordable tax increases or the effective abolition of medical schemes) would have severe negative consequences for the country's tax base, economic productivity, and the sustainability of public finances.

Conclusion:

HFA remains committed to a collaborative path to UHC and urges government to revisit the NHI model in favour of a model that is inclusive, financially viable, and constitutionally sound.